# DRUG POLICY IN CONTEXT: RHETORIC AND PRACTICE IN THE UNITED STATES AND THE UNITED KINGDOM

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I.	THE LEGAL AND SOCIAL HISTORY OF DRUGS, DRUG ABUSE, AND		
	DR	UG CONTROL IN THE UNITED STATES	265
	Α.	Early History	269
	В.	The Supreme Court Weighs In	
	<i>C</i> .	The Anslinger Years and the War on Drugs	
II.	DRUG PROHIBITION AND THE SOCIAL NEGOTIATION OF NORMS		291
	<i>A</i> .	The Consequentialist Basis for Drug Prohibition	292
	В.	Legal Moralism and Drug Prohibition	
III.	THE LEGAL, MEDICAL, AND SOCIAL REGULATION OF DRUGS IN THE		
	UN	ITED KINGDOM	309
	Α.	Overview of the History of British Drug Policy	309
	В.	Underlying Cultural, Economic, and Political Factors That Have	
		Contributed to the "Criminalization" of British Drug Policy	330
IV.	THE INCOMPLETE CONVERGENCE OF DRUG POLICY IN THE		
	UN	ITED STATES AND THE UNITED KINGDOM	336
	Α.	Recent Developments in United States Drug Policy	338
		Moral Anchoring	
		e e e e e e e e e e e e e e e e e e e	

Writing in 1962, Edwin Schur, a careful observer of drug policy in Britain and the United States, characterized as "rather startling" the different paths taken by the two countries with respect to the regulation of narcotics and the treatment of narcotics addiction.<sup>1</sup> At least until the latter decades of the twentieth century,

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<sup>1.</sup> EDWIN M. SCHUR, NARCOTIC ADDICTION IN BRITAIN AND AMERICA 69 (3d prtg. 1966). In everyday discussion, the term "narcotics" is often used interchangeably with the term "drugs." TROY DUSTER, THE LEGISLATION OF MORALITY: LAW, DRUGS, AND MORAL JUDGMENT 30 (1970). Technically, a narcotic is a substance that dulls the senses or produces sleep, SCHUR, *supra*, at 17, but the term most often is used to refer "to opium and its derivatives, especially morphine and heroin," and to the active element of coca, which is cocaine. DUSTER, *supra*, at 30–31. Coffee,

drug policy in Britain was heavily influenced by the recommendations contained in a report issued in 1924 by a committee of medical experts led by Sir Humphry Rolleston.<sup>2</sup> The Rolleston Committee had advised that addiction to morphine and heroin should "be regarded as a manifestation of disease and not as a mere form[] of vicious indulgence." The British "regarded [the addict] as a sick person in need of medical care and not as a criminal to be hounded by the Police."

Consistent with the Rolleston Committee's perspective, the nature of legal regulation and practice in the United Kingdom until fairly recently has been pragmatic, therapeutic in its orientation, and respectful of the central role held by physicians in dealing with the issue of drugs and drug abuse.<sup>5</sup> By contrast, the approach in the United States has been dominated by a criminal law enforcement focus that has reposed responsibility largely in the hands of law enforcement officials.<sup>6</sup> In Schur's words:

The medical profession in Britain, . . . has taken a positive stand in support of its basic responsibility for the treatment of addiction. This stand has been an important factor in the continuance of Britain's medical approach. In contrast, American doctors have by their relative apathy contributed to the persistence of this country's punitive approach.<sup>7</sup>

The trajectory of drug policy in the United States was set by the passage of the Harrison Narcotics Act of 1914, which first brought criminal prohibitions into this field, and by a series of U.S. Supreme Court decisions interpreting that statute to limit the discretion of physicians to treat addicts with maintenance

alcohol, tobacco, hemp, and other substances often used for therapeutic purposes such as amphetamines, barbiturates, and anabolic steroids, are all drugs in the broad sense, but the drugs that have "most dominated and colored the American conception of narcotics" are the opium-based substances and cocaine, *id.* at 6, and that is the usage intended in this Article.

- 2. SCHUR, supra note 1, at 71.
- 3. U.K. MINISTRY OF HEALTH, DEPARTMENTAL COMM. ON MORPHINE & HEROIN ADDICTION, REPORT 31 (1926) [hereinafter ROLLESTON COMM. REPORT].
- 4. SCHUR, *supra* note 1, at 71 (quoting Jeffrey Bishop, *A Commentary on the Management and Treatment of Drug Addicts in the United Kingdom, in MARIE NYSWANDER*, THE DRUG ADDICT AS A PATIENT 149, 150 (1956)) (internal quotation marks omitted).
- 5. See NORVAL MORRIS & GORDON HAWKINS, The Overreach of the Criminal Law, in THE HONEST POLITICIAN'S GUIDE TO CRIME CONTROL 1, 9 (1970).
  - 6. See id. at 8-9.
  - 7. SCHUR, supra note 1, at 202.
- 8. Harrison Narcotics Act of 1914, Pub. L. No. 63-223, 38 Stat. 785, repealed by Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. §§ 801–971 (2006).
- 9. See James L. Nolan, Jr., Reinventing Justice: The American Drug Court Movement 28 (2001) [hereinafter Nolan, Reinventing Justice].

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doses of narcotics.<sup>10</sup> U.S. drug policy was also influenced by the hard-headed perspective of government enforcement officials such as Harry J. Anslinger, who served for decades as the Commissioner of Narcotics in the Treasury Department.<sup>11</sup> At the core of Anslinger's philosophy was an "insistence on the idea that addicts are bad characters and that addiction essentially is a police problem . . . ."<sup>12</sup> In light of this moral judgment about narcotics users, the position of officials in the federal government that doctors should not be permitted to prescribe narcotics to maintain addicts was also framed in moralistic terms.<sup>13</sup> Thus, a Senate committee report from the 1950s asserted that "it would be absolutely immoral to give in to drug addiction" and that the government "should not adopt any program to give the drug addict 'sustaining' doses of narcotics."<sup>14</sup>

Although moral disapproval may have been directed toward narcotics misuse in the United States in the nineteenth century, such judgments probably did not function as an absolute or totalizing moral characterization of users until some time after passage of the Harrison Act. This intense moral disapproval was reflected in drug policy adopted following World War II and in the "War on Drugs" that began in the Nixon administration. That policy, in turn, has reinforced and sustained the social opprobrium that has marked drug use and drug users.

It may be tempting to think of the history of drug policy in Britain and the United States as distinct perfect types, the former a nonjudgmental medical approach and the latter a morally tinged criminal prohibition approach.

<sup>10.</sup> See Webb v. United States, 249 U.S. 96, 99–100 (1919); United States v. Doremus, 249 U.S. 86, 94 (1919); United States v. Jin Fuey Moy, 241 U.S. 394, 402 (1916).

<sup>11.</sup> See SCHUR, supra note 1, at 43, 196–98 (quoting Stanley Meisler, Federal Narcotics Czar, NATION, Feb. 20, 1960, at 159, 162).

<sup>12.</sup> Id. at 192.

<sup>13.</sup> The words "moral," "morality," and "moralistic" carry a wide range of different meanings, depending upon the context in which they are used. Duster suggests that generally "morality refers to the strong feelings which people have about *right* and *wrong*." DUSTER, *supra* note 1, at 4. These feelings (and beliefs) can be a function of the individual's "personality system," the community or social group's collective normative commitments, or the broader "cultural system," within which both the individual and the group are embedded. *Id.* at 80 (citing TOWARD A GENERAL THEORY OF ACTION 116 (Talcott Parsons & Edward A. Shils eds., Harper Torchbook 1962) (1951)). Moral judgments may be rooted in deontological commitments, or they may be founded on consequentialist considerations, or both. *See infra* note 256 and accompanying text. The enforcement of moral norms as positive legal obligations, in turn, can be seen in deontological or consequentialist terms as well. *See infra* note 256 and accompanying text. A consideration of the variety of deontological and consequentialist claims supporting the enforcement of legal prohibitions against the use of narcotics is taken up in Part II.

<sup>14.</sup> SCHUR, *supra* note 1, at 195 (quoting S. COMM. ON THE JUDICIARY, SUBCOMM. ON IMPROVEMENTS IN THE FED. CRIMINAL CODE, 84TH CONGRESS, 2D SESSION, REP. ON THE TREATMENT AND REHABILITATION OF NARCOTIC ADDICTS 9, 12 (1956)).

<sup>15.</sup> See infra Part I.A.

<sup>16.</sup> See infra Part I.C.

Throughout the twentieth century, however, the reality likely was somewhat more complex and the similarities between the two more pronounced than might have seemed the case. More recently, there has been something of a convergence of the two systems. Perhaps out of moral, political, and fiscal fatigue, the United States increasingly has signaled a willingness to declare at least a partial truce in its war on drugs, and has begun very tentatively to adopt some features of the pragmatic policy approach that long has dominated British practice. In the United Kingdom, by contrast, commentators have been writing about the "criminalization" of British drug policy and about the transplantation of American ideas and practices familiar to those who have followed the U.S. war on drugs.

This Article suggests that this pattern of convergence is likely to be incomplete. Even though actors in each country have been aware of developments in the other (and have even borrowed policy prescriptions from time to time), one critical difference in their parallel histories is likely to be determinative. The American move toward pragmatism, if it is to occur, must be executed against the inertial force generated by policy commitments and social practices of more than seventy-five years in which the most dominant feature has been an intense moral disapproval of drugs. The British, on the other hand, do not have this history of demonizing drugs and those who use them. As a consequence, their increasing reliance on criminal justice institutions is driven more by a therapeutic impulse than by a punitive one.

Part I of this Article traces the legal and social history of drugs, drug abuse, and drug control in the United States. It tells the story of the events leading to the passage of the Harrison Act, the U.S. Supreme Court's interpretation and application of that statute, and the elaboration over time of the country's prohibitionist policy, which culminated in the "War on Drugs" and the dramatic expansion of the criminal system in the 1980s. Part II considers the complex relationship between formal legal prescription and the social negotiation of norms, and addresses directly the question of how a drug policy that is centered

<sup>17.</sup> So, for example, in a special study of English drug policy undertaken by the New York State Department of Health and the New York State Department of Mental Hygiene in 1960, the authors concluded that the "British narcotic control system which appears superficially to be vastly different from that of the United States is found on closer inspection to be not dissimilar." Granville W. Larimore & Henry Brill, *The British Narcotic System: Report of Study*, 60 N.Y. St. J. MED. 107, 114 (1960).

<sup>18.</sup> See infra PART IV.A.

<sup>19.</sup> On the criminalization of British drug policy, see Karen Duke, *Out of Crime and Into Treatment?: The Criminalization of Contemporary Drug Policy Since* Tackling Drugs Together, 13 DRUGS: EDUC., PREVENTION & POL'Y 409 (2006); Toby Seddon et al., *Risk, Security and the 'Criminalization' of British Drug Policy*, 48 BRIT. J. CRIMINOLOGY 818 (2008). On the transplantation of U.S. criminal enforcement measures to the United Kingdom, see JAMES L. NOLAN, JR., LEGAL ACCENTS, LEGAL BORROWING: THE INTERNATIONAL PROBLEM-SOLVING COURT MOVEMENT 44–75 (2009).

on prohibition and criminal enforcement might be supported on either consequentialist or deontological grounds. The analysis here includes an exploration of the basis for the strong moral disapproval that, in the United States, consistently has been aimed at those who misuse narcotics. In Part III, the focus shifts to the United Kingdom. First, the Article recounts the history of the legal, medical, and social regulation of drugs that distinguished British from American practice through most of the twentieth century and that more recently has begun to migrate toward the U.S. approach. Then, in the second section it examines the underlying cultural, economic, and political factors that have contributed to the "criminalization" of British drug policy in recent years. Part IV sets out some of the evidence of convergence and some of the contrary evidence suggesting that the inertial effect of history is at play, inhibiting the ability of advocates and policymakers in the United States to truly adopt a new approach to the problem of narcotics and drug addiction. The analysis concludes with a discussion of moral anchoring—the process by which fixed normative understandings shape public discourse about risk and harm.

# I. THE LEGAL AND SOCIAL HISTORY OF DRUGS, DRUG ABUSE, AND DRUG CONTROL IN THE UNITED STATES

In thinking about the immediate and longer term future of U.S. drug policy, it is helpful to start with a set of questions about how a morality-based perspective came to dominate discourse and public policy in this area, what precisely those moral claims are, and how they relate to more pragmatic considerations. Our analysis of these interrelated questions begins in the historical period preceding the adoption of the Harrison Act in 1914. Students of this history have set out sharply divergent accounts of the causal and temporal relationships between the development of a positive legal framework for drug control policy in the United States on the one hand, and the public's moral disposition toward drug use and addiction on the other. One well-known account has been offered by Troy Duster, who has argued that the enactment of prohibitory legislation by Congress in the first decades of the twentieth century, along with the Supreme Court's interpretation of that law to preclude doctors from providing medical maintenance treatment to narcotics addicts, led to a broad societal "moral reassessment" of narcotics and narcotics addiction itself.<sup>20</sup> Duster does not argue for a simple causal relationship between the enactment of a specific legal provision and the development of widespread feelings of disapprobation toward addicts in the United States, but he does suggest that the

20. DUSTER, *supra* note 1, at 14–17 (quoting ALFRED R. LINDESMITH, THE ADDICT AND THE LAW 6 (1965)) (citing Webb v. United States, 249 U.S. 96 (1919)).

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"legislation brought about the conditions that were conducive to a reinterpretation of narcotics usage into almost purely moral terms." <sup>21</sup>

Central to Duster's history is his observation that a moral reappraisal of narcotics addiction did not occur until patterns of use had shifted from the middle and upper classes to those in the working classes and the poor, and further that this change in the allocation of drug use by class was linked to the passage of the Harrison Act.<sup>22</sup> These claims have been challenged by James Nolan, who argues that Duster's account is contrary to the empirical evidence regarding the moral stigma that attached to narcotics misuse in the first decade and a half of the twentieth century, and implausible because it cannot explain how political support for the Harrison Act could have been generated absent such popular moral disapproval.<sup>23</sup> Nolan asserts that "moral concerns were a dominant force behind anti-narcotic efforts and served as an important justificatory theme supporting passage of the legislation."<sup>24</sup>

Notwithstanding their different takes on the pre-1914 history, a notable point of agreement between Duster and Nolan is their shared view that for most of the last century, strong moral disapproval has been directed toward those who use narcotics, and has shaped America's approach to drug use and addiction. Nolan suggests that there are "three distinct 'root metaphors' or 'legitimizing values' that have informed efforts to socially control drug use in the United States." While one perspective, the "therapeutic paradigm," views drug users or abusers not as immoral but as in need of treatment, and a second paradigm, the "utilitarian perspective," views users through either a prohibitionist or libertarian lens depending on an assessment of the relative costs and benefits involved in strictly limiting access to narcotics, the perspective that has dominated U.S. thinking is the "moral or the religious perspective." From this point of view, the use of narcotics is understood to be a wrong that emanates from bad character, poor individual decisionmaking, or some other attribute of the user for which he or she is autonomously responsible.

Duster's analysis of this question begins with his apparently simple observation that some features of daily life "take on moral character while others

<sup>21.</sup> *Id.* at 22.

<sup>22.</sup> See id. at 9-10, 22-23.

<sup>23.</sup> NOLAN, REINVENTING JUSTICE, supra note 9, at 23 (quoting DUSTER, supra note 1, at 3).

<sup>24.</sup> *Id*.

<sup>25.</sup> *Id.* at 15 (quoting HOWARD S. BECKER, OUTSIDERS: STUDIES IN THE SOCIOLOGY OF DEVIANCE 142 (1963); John M. Johnson & Linda Waletzko, *Drugs and Crime: A Study in the Medicalization of Crime Control*, 3 PERSP. ON SOC. PROBS. 197, 199 (1992)).

<sup>26.</sup> Id.

<sup>27.</sup> *Id.* at 16 (quoting BECKER, *supra* note 25, at 136; H. WAYNE MORGAN, DRUGS IN AMERICA: A SOCIAL HISTORY, 1800–1980, at 37 (1981)).

<sup>28.</sup> Id. at 16.

<sup>29.</sup> See id.at 15–16; GEORGE FISHER, MARRIED TO ALCOHOL: THE DRUG WAR'S MORAL ROOTS (forthcoming) (manuscript on file with author).

do not."<sup>30</sup> Following William Graham Sumner's work, Duster argues that communities typically develop one body of rules that are enforced as customs but that are not "moral in their implications,"<sup>31</sup> and another body of rules—"mores" in Sumner's account—whose enforcement is woven into the normative character of the community.<sup>32</sup> Taking this broad distinction as his framework, Duster concludes that "drug use in the United States in the middle twentieth century is one of those moral areas."<sup>33</sup> Significantly, whether the use of narcotics is viewed as the product of psychological or characterological weakness, Duster says that the moral disapproval associated with this conduct has become so powerful over time that it has become totalizing, eclipsing all the other otherwise morally significant features of an individual user of narcotics.<sup>34</sup> He explains that "[a] person who exhibits this presumably obvious special kind of behavior (immoral, in this instance) is identified in a complete sense through a particular label; thus generating total identity."<sup>35</sup> But this has not always been the case. In Duster's telling of the story:

There was once a time when anyone could go to his corner druggist and buy grams of morphine or heroin for just a few pennies. There was no need to have a prescription from a physician. The middle and upper classes purchased more than the lower and working classes, and there was no moral stigma attached to such narcotics use. The year was 1900, and the country was the United States.<sup>36</sup>

Duster likely is over-reading the historical record when he asserts that "no moral stigma" was assigned to the use of morphine and other narcotics at the start of the twentieth century, and Nolan does a good job of documenting some examples of the kinds of disapprobation that apparently were typical.<sup>37</sup> On the other hand, the sort of totalizing moral judgment that came to characterize popular perceptions of drug addiction probably did develop only gradually over the first decades of the twentieth century, and in some fashion may have been due to the shifting legal status of drug use that resulted from the passage of the Harrison Act, other federal legislation in the area, and the Supreme Court decisions interpreting this new positive law.<sup>38</sup>

- 30. DUSTER, supra note 1 at 87.
- 31. *Id.* at 86. (internal quotation marks omitted).
- 32. See id.
- 33. Id. at 88.
- 34. See id. at 67, 91-92.
- 35. Id. at 89.
- 36. Id. at 3 (emphasis omitted).
- 37. See NOLAN, REINVENTING JUSTICE, supra note 9, at 23–25.
- 38. See infra Part I.A-B.

James Bakalar and Lester Grinspoon have turned to a work of fiction, Eugene O'Neill's Long Day's Journey into Night, a play set in the summer of 1912, for some evidence of how the misuse of morphine was understood in the United States in the moment before the adoption of the Harrison Act. Readers who know the play will recall that the story centers on four members of a New England family, a mother and father and their two grown sons.<sup>40</sup> The mother, Mary Tyrone, is a morphine addict, and her husband and two sons are all prone to alcohol misuse.<sup>41</sup> The play rightly holds a central place in the pantheon of great American literature of the twentieth century for its complex rendering of character and relationship, but Bakalar and Grinspoon focus with special attention on the ways in which Mary's dependency on morphine is understood in the context of the family system set out by O'Neill and in the broader context of the community within which the action takes place.<sup>42</sup> In some respects, Mary's addiction is regarded as a disease, not unlike the tuberculosis that afflicts her vounger son Edmund. 43 She acquired her dependency as a consequence of her doctor giving her too much morphine during childbirth (not an uncommon scenario during this period), and although it is disruptive to her relationships with her family, the addiction does not come to define Mary.<sup>44</sup> All the same, there are clear suggestions that Mary Tyrone's misuse of morphine is instrumental, a device by which she eludes intimacy with her family and avoids confronting fully what her life has become. 45 In this dimension, O'Neill seems to suggest the basis for a moral judgment of her narcotics use, the wrongfulness of her treating morphine as a means to "get beyond . . . [the] reach" of her family. 46 But what seems most important for our purposes, notwithstanding Mary's characterization of herself at one point as a "lying dope fiend," is that the moral assessment of her addiction made by her family—and perhaps by Mary herself—is related to her presumed reasons for not fighting her cravings, and is not a global judgment about the worthiness of her character. 48 In this sense, O'Neill does not treat narcotics addiction as a totalizing characteristic.

Mary Tyrone's struggles with morphine were not atypical in the period in which O'Neill's play is set. Duster and Nolan agree that a high incidence of physical dependency on narcotics was present in the United States from the middle of the nineteenth century through the first decades of the twentieth

<sup>39.</sup> James B. Bakalar & Lester Grinspoon, Drug Control in a Free Society 61–62 (1984).

<sup>40.</sup> See Eugene O'Neil, Long Day's Journey into Night 12-13, 19 (1955).

<sup>41.</sup> See BAKALAR & GRINSPOON, supra note 39, at 61.

<sup>42.</sup> BAKALAR & GRINSPOON, supra note 39, at 61–62.

<sup>43.</sup> *Id*.

<sup>44.</sup> See id. at 61-62.

<sup>45.</sup> See id.

<sup>46.</sup> *Id.* at 61 (quoting O'NEIL, *supra* note 40, at 139) (internal quotation marks omitted).

<sup>47.</sup> Id. (quoting O'NEIL, supra note 40, at 107) (internal quotation marks omitted).

<sup>48.</sup> See id. at 61-62.

century.<sup>49</sup> They also agree that this period was characterized by a virtual absence of legal regulation of narcotics and other drugs.<sup>50</sup> Of course, this regulatory vacuum did not persist beyond 1914.<sup>51</sup> Such a dramatic shift in the positive law certainly had to have had an effect on broader popular understandings of drug use and addiction. In order to better understand the moral judgments about narcotics use that developed over time and that have operated under the general umbrella of Nolan's moral/religious perspective, and to gain some greater purchase on the question of the relationship between this complex set of moral intuitions and the shifting legal landscape, a brief review of the history of drug regulation and the social position of drug users in the United States follows.

### A. Early History

Tracing the history of the development of drug regulation in the United States is a difficult task, in part because that history includes legal, political, and medical elements that relate both to "ordinary" medical drugs and to "pleasure" drugs. These two categories are neither mutually exclusive nor have they been static over time, and within the category of "pleasure" drugs, the legal, political and social narrative has not been consistent from one drug to the next. Bearing all of this in mind, however, the drug that has "dominated and colored the American conception of narcotics is opium."

During the early part of the nineteenth century, the consumption of opium took place mostly in Asia and the "Far East." In the second half of the 1800s, however, opium use became more common in the United States, partly as a

<sup>49.</sup> See DUSTER, supra note 1, at 8 ("From 1865 to 1900, . . . addiction to narcotics was relatively widespread. . . . In proportion to the population, addiction was probably eight times more prevalent then than now . . . ."); NOLAN, REINVENTING JUSTICE, supra note 9, at 18 ("[B]y the end of the nineteenth century 'approximately 200,000 Americans were addicted to opium in one form or another."" (quoting JOHN C. BURNHAM, BAD HABITS: DRINKING, SMOKING, TAKING DRUGS, GAMBLING, SEXUAL MISBEHAVIOR, AND SWEARING IN AMERICAN HISTORY 114 (1993))).

<sup>50.</sup> See DUSTER, supra note 1, at 12–14; NOLAN, REINVENTING JUSTICE, supra note 9, at 17.

<sup>51.</sup> See NOLAN, REINVENTING JUSTICE, supra note 9, at 23 (quoting DUSTER, supra note 1, at 23).

<sup>52.</sup> The terms "ordinary" and "pleasure" drugs are taken from Balkalar and Grinspoon, who trace the development of this imperfect distinction to the passage of the Food, Drug and Cosmetics Act of 1938, 24 U.S.C. § 301 (2006), which in effect established the category of prescription drugs. See BALKALAR & GRINSPOON, supra note 39, at 29–30. The distinction is problematic in part because most "pleasure" drugs also have therapeutic uses (e.g., marijuana), while most "ordinary therapeutic drugs are dangerous enough to cause illness as well as cure it[,]" (e.g., chemotherapy). Id. at 30.

<sup>53.</sup> See id. at 30-34.

<sup>54.</sup> DUSTER, supra note 1, at 6.

<sup>55.</sup> See id.

consequence of immigration patterns,<sup>56</sup> but more significantly because of the increasing frequency with which the drug and its constituents were included as an ingredient in patent medicines and other products widely available to the general public.<sup>57</sup> Physicians played an important role in supporting the increased use of morphine during this period, especially following the invention of the hypodermic needle in the 1850s.<sup>58</sup> Doctors touted the benefits of morphine in treating "female troubles" and as a painkiller more generally, and their reliance on injected morphine during the Civil War to treat injured soldiers accelerated the spread of narcotics use even more dramatically.<sup>60</sup> Along with the proliferation of patent medicines and other popular preparations containing opium, the heavy reliance of doctors on morphine led to very high levels of physical dependency.<sup>61</sup> Duster estimates that as much as two to four percent of the U.S. population was addicted to these substances by 1895.<sup>62</sup>

Even though the medical community had generally been aware of the addictive qualities of opium (and especially of injected morphine), the dominant judgment among doctors was that the medicinal benefits of the drug outweighed these dangers. Toward the end of the nineteenth century, however, as the number of physically dependent users grew, some within the medical establishment became alarmed and eventually called for greater regulation of patent medicines and other preparations that had been made available to users

<sup>56.</sup> See generally DAVID F. MUSTO, THE AMERICAN DISEASE 5–6 (3d ed. 1999) [hereinafter MUSTO, THE AMERICAN DISEASE] ("In the nineteenth century addicts were identified with foreign groups and internal minorities . . . . The Chinese and their custom of opium smoking were closely watched after their entry into the United States about 1870.").

<sup>57.</sup> See DUSTER, supra note 1, at 7 ("[M]edical companies began to include morphine in a vast number of medications that were sold directly to consumers as household remedies. This was the period before governmental regulation, and the layman was subjected to a barrage of newspaper and billboard advertisements claiming cures for everything from the common cold to cholera. 'Soothing Syrups' with morphine often contained no mention of their contents, and many men moved along the path to the purer morphine through this route."); CHARLES E. TERRY & MILDRED PELLENS, THE OPIUM PROBLEM 74 (1970) ("It would be impossible to form any accurate estimate of the influence exerted by the widespread sale and use of nostrums containing opium, but that this influence was great and contributed in an appreciable degree to the habitual use of the drug is undoubted.").

<sup>58.</sup> See DUSTER, supra note 1, at 6 (citing TERRY & PELLENS, supra note 57, at 66–67).

<sup>59.</sup> EDWARD M. BRECHER, LICIT AND ILLICIT DRUGS: THE CONSUMERS UNION REPORT ON NARCOTICS, STIMULANTS, DEPRESSANTS, INHALANTS, HALLUCINOGENS, AND MARIJUANA—INCLUDING CAFFEINE, NICOTINE, AND ALCOHOL 17 (1972) (internal quotation marks omited).

<sup>60.</sup> See Duster, supra note 1, at 6–7 (citing Terry & Pellens, supra note 57, at 69); Nolan, Reinventing Justice, supra note 9, at 18 (citing William Butler Eldridge, Narcotics and the Law 4–5 (2d ed. 1967)).

<sup>61.</sup> See DUSTER, supra note 1, at 6–7 (quoting TERRY & PELLENS, supra note 57, at 75); ELDRIDGE, supra note 60, at 5.

<sup>62.</sup> DUSTER, *supra* note 1, at 7 (citing MARIE NYSWANDER, THE DRUG ADDICT AS A PATIENT 1–13 (1956)).

<sup>63.</sup> See MUSTO, THE AMERICAN DISEASE, supra note 56, at 71–73.

<sup>64.</sup> See DUSTER, supra note 1, at 8 (citing TERRY & PELLENS, supra note 57, at 53).

outside of the context of professional medical practice.<sup>65</sup> While medical journal articles from this period demonstrate the medical community's increasing awareness that physicians also were contributing to the problem of addiction through their overreliance on morphine, these initial calls for regulation did not explicitly target that facet of the problem.<sup>66</sup>

At just about this point, heroin, an opiate derived from morphine, was first produced by a German researcher.<sup>67</sup> This new drug was made available by Bayer Pharmaceuticals in the U.S. in 1898 as a "cough suppressant,"<sup>68</sup> and was also used for a time as a treatment for morphine withdrawal.<sup>69</sup> Although heroin was originally thought to be a promising therapy in part because it was believed to be non-addicting, it did not take long for physicians to learn that it too produced a powerful physical dependency.<sup>70</sup>

Notwithstanding the large and growing population of addicts produced by these forces by the turn of the century, Duster argues that because there was a ready supply of narcotics available to manage one's addiction, middle-class users were able to maintain relatively normal and productive lives.<sup>71</sup> As a consequence, he suggests, little or no moral stigma was associated with the condition:

It was acknowledged in medical journals that a morphine addict could not be detected as an addict so long as he maintained his supply. Some of the most respectable citizens of the community, pillars of middle-class morality, were addicted. In cases where this was known, the victim was regarded as one afflicted with a physiological problem, in much the same way as we presently regard the need of a diabetic for insulin. Family histories later indicated that many went through their daily tasks, their occupations, completely undetected by friends and relatives.<sup>72</sup>

A series of shifts in the legal regulation of narcotics undertaken first by a few states and then by the federal government changed this equation by, in effect, limiting the supply of opium, morphine, and heroin that was easily and legally available to users.<sup>73</sup> Although there were several very early attempts by

<sup>65.</sup> See id. at 13 (citing NYSWANDER, supra note 62, at 2-3); id. at 22.

<sup>66.</sup> See NYSWANDER, supra note 62, at 2–3.

<sup>67.</sup> *Id.* at 8.

<sup>68.</sup> David T. Courtwright, *The Roads to H: The Emergence of the American Heroin Complex, 1898–1956, in ONE HUNDRED YEARS OF HEROIN 3, 3–4 (David F. Musto ed., 2002).* 

<sup>69.</sup> Id. at 5.

<sup>70.</sup> See id.

<sup>71.</sup> See DUSTER, supra note 1, at 9 (citing C.S. Pearson, A Study of Degeneracy as Seen Among Addicts, 1919 N.Y. MED. J. 805, 805–08).

<sup>72.</sup> Id. (citation omitted).

<sup>73.</sup> See DUSTER, supra note 1, at 13–15.

states and localities to legislate in this area, 74 there were no significant legal restrictions on the distribution of narcotics until the 1890s. 75 In the last decade of the nineteenth century and the first decade of the twentieth century, a growing concern within the medical community led a number of states to pass provisions designed to limit the availability of narcotics and to place physicians in the position of gatekeepers regulating access to these substances. <sup>76</sup> Some states also passed laws during this period that focused particularly on opium smoking, which had become a highly visible issue in the popular press.<sup>7</sup> The coalition that advocated for these provisions was complex and included temperance advocates, nativists, and others. Then, in 1906, Congress passed the Pure Food and Drug Act, which required the labeling of food and drugs with their ingredients.<sup>79</sup> This federal legislation was supported by advocates within the progressive movement often associated with the "muckraking" writing of journalists like Upton Sinclair. 80 The muckrakers' concerns included not only the dangers of adulterated foods and deplorable working conditions for laborers, but also the scourge of patent medicines.<sup>81</sup> As one writer put it: "Poisonous substances provided an issue on which prohibitionists, social reformers and proponents of federal intervention combined with enduring results."82

The Pure Food and Drug Act did not contain any prohibitions or blanket restrictions on the availability of particularly designated drugs, <sup>83</sup> but it did signal a new involvement by the federal government in the general arena of drug policy. <sup>84</sup> Over the next eight years, Congress considered a number of bills

<sup>74.</sup> In 1875, for example, San Francisco passed an ordinance clearly targeting Chinese immigrants that prohibited the smoking of opium, but that left undisturbed the many other forms of opium use by other citizens. *See* KING CNTY. BAR ASS'N, DRUG POL'Y PROJECT, EFFECTIVE DRUG CONTROL: TOWARD A NEW LEGAL FRAMEWORK 14 (2005) [hereinafter KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL], *available at* http://www.kcba.org/druglaw/pdf/effectivedrug control.pdf.

<sup>75.</sup> DUSTER, supra note 1, at 12.

<sup>76.</sup> See id. at 13; KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, supra note 74, at 15. The first comprehensive statute of this kind was the Boylan Act, passed by the New York legislature in 1904. DUSTER, supra note 1, at 13. A number of states also passed legislation of this kind. See id.

<sup>77.</sup> Id.

<sup>78.</sup> See DUSTER, supra note 1, at 97 ("The more liberal drug bills were consistently opposed by the liquor industry lobby, the police, and church and temperance groups—strange bed-fellows.").

<sup>79.</sup> See King Cnty. Bar Ass'n, Effective Drug Control, supra note 74, at 15.

<sup>80.</sup> *Id* 

<sup>81.</sup> See id.; RICHARD DAVENPORT-HINES, THE PURSUIT OF OBLIVION: A GLOBAL HISTORY OF NARCOTICS 212 (W.W. Norton & Co. 2002) (2001).

<sup>82.</sup> DAVENPORT-HINES, supra note 81, at 212.

<sup>83.</sup> See King Cnty. Bar Ass'n, Effective Drug Control, supra note 74, at 15. However, it did contain a provision that banned the importation of any drug that was "dangerous to the health of the people of the United States." See Musto, The American Disease, supra note 56, at 34–35.

<sup>84.</sup> See KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, supra note 74, at 16.

designed to limit in some fashion the public's access to narcotics. This multiyear legislative campaign—which culminated in the passage of the Harrison Act in 1914—was undertaken against the backdrop of an even broader effort to regulate the international distribution and sale of opium, coca, and other narcotics. That broader effort began with the organization of an international conference on opium, called at the initiative of the United States, in Shanghai in 1909. Like the domestic legislative campaign that resulted in the Harrison Act, this international initiative likely was driven by a combination of pragmatic and moralistic concerns.

The very fact that the United States had called for and was planning to convene an international meeting in order to encourage other nations to impose strict legal limitations on the distribution and sale of narcotics only pressed into greater focus the relative regulatory vacuum at home. In anticipation of the conference and to "save face," the organizers of the event pushed Congress for a federal statute that would prohibit the importation into the United States of opium prepared for smoking (and therefore, presumably, intended for non-medical use). Strictly speaking, the legislation was unnecessary, given that the Pure Food and Drug Act already contained language that would have permitted the federal government to prohibit the importation of any drug deemed to be "dangerous to the health of the people of the United States," but the bill was enacted in any event roughly a week after the Shanghai meeting had begun.

A more important legislative proposal stimulated by the Shanghai gathering was introduced in the House of Representatives a year later. The principal author of the bill was Hamilton Wright, a physician who had served as an American representative at the Shanghai Conference. Wright's proposal was introduced by Representative David Foster of Vermont, who was chariman of the House Committee on Foreign Affairs. The legislation, which would have imposed a federal tax on the sale of narcotics and would have created an extensive system of federal regulation and record keeping of drug transactions, drew vigorous opposition from the drug industry. Spokespersons for drug manufacturers testified that, while they were wholly in favor of sensible

<sup>85.</sup> See NOLAN, REINVENTING JUSTICE, supra note 9, at 23–29.

<sup>86.</sup> See id.

<sup>87.</sup> See DUSTER, supra note 1, at 13.

<sup>88.</sup> See DUSTER, supra note 1, at 13–14; NOLAN, REINVENTING JUSTICE, supra note 9, at 20–

<sup>89.</sup> See DUSTER, supra note 1, at 14.

<sup>90.</sup> See id.

<sup>91.</sup> MUSTO, THE AMERICAN DISEASE, *supra* note 56, at 34–35.

<sup>92.</sup> See id

<sup>93.</sup> See NOLAN, REINVENTING JUSTICE, supra note 9, at 21.

<sup>94.</sup> See id

<sup>95.</sup> KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, supra note 74, at 18.

<sup>96.</sup> See id

measures to limit the misuse of addictive drugs, the Foster Bill was not practicable and would impose requirements that were "too cumbersome and expensive."

The Foster Bill did not pass the House, and so U.S. representatives returned to the next international meeting—which took place at The Hague in December of 1911 and January of 1912—without new domestic legislation in place. The American delegation again pushed for international agreements limiting the production and sale of opium and cocaine. Two additional conferences were held in the same location over the next two years, resulting in formal agreements strictly limiting narcotics and narcotics trafficking worldwide. The Hague Convention eventually was incorporated into the 1919 Treaty of Versailles. These international agreements were a significant "source of pressure on the United States to intensify its own domestic drug policy" and also served as a catalyst for the development of drug control regulations in the United Kingdom.

The most important legal development in the United States attributable to this international pressure was the Harrison Narcotics Act of 1914. This bill was introduced by Representative Francis Burton Harrison of New York, who also had served as Governor General of the Philippines. The legislation was derived directly from the provisions contained in the Foster Bill, although the Harrison Act's supporters did agree to somewhat less onerous recordkeeping requirements and to permitting the continued sale of some patent medicines containing small amounts of narcotics. The legislation required manufacturers and sellers of narcotics to register with the federal government and to pay a tax on each transaction. In addition, and most significantly, the Harrison Act made most narcotics unavailable except pursuant to a doctor's prescription provided "in good faith" and "in the course of [the physician's] professional practice."

<sup>97.</sup> NOLAN, REINVENTING JUSTICE, supra note 9, at 25-26.

<sup>98.</sup> See id. at 26.

<sup>99.</sup> See id.

<sup>100.</sup> See id.

<sup>101.</sup> Id.

<sup>102.</sup> Id.

<sup>103.</sup> See SCHUR, supra note 1, at 70 ("[A]s a means of complying with the spirit and aims of the Hague International Opium Convention of 1912[,] the [British] Government introduced the Dangerous Drugs Act. This measure met with a largely favorable response in Parliament, and . . . was promptly enacted into law [in 1920].").

<sup>104.</sup> See KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, supra note 74, at 18.

<sup>105.</sup> See MUSTO, THE AMERICAN DISEASE, supra note 56, at 59.

<sup>106.</sup> See id. at 59-60.

<sup>107.</sup> NOLAN, REINVENTING JUSTICE, *supra* note 9, at 27 (quoting Harrison Narcotics Act of 1914, Pub. L. No. 63-223, 38 Stat. 785 (repealed 1970)) (internal quotation marks omitted); *see also* Diane E. Hoffmann, *Treating Pain v. Reducing Drug Diversion and Abuse: Recalibrating the* 

Although the Harrison Act initially faced opposition from the American Medical Association (as in the case of the Foster Bill) on pragmatic grounds related to the expense and inconvenience associated with its rigorous recordkeeping requirements, the overall perspective of the legislation once these logistics issues were addressed was actually quite consistent with the views of the established medical community. In this respect, the Harrison Act was mostly understood by doctors as "a law for the orderly marketing of opium, morphine, heroin, and other drugs—in small quantities over the counter and in larger quantities on a physician's prescription. In general, physicians were comfortable with the new federal provisions because they understood the legislation, "which they had a hand in drafting," as increasing the degree of discretion and control that they and their professional colleagues would be able to exert over the availability of these drugs.

Importantly, the formal legislative history of the Harrison Act does not contain much in the way of shrill moralisms about the evils of drug abuse or addiction. Instead, the legislative record is taken up with more pragmatic considerations relating to the workability of the bureaucracy that would be required for the registration, recordkeeping, and revenue collecting provisions of the Act. To the extent that broad rationales in support of the legislation were offered by its advocates during the congressional debate, these arguments tended either to relate to the obligations of the federal government to comply with international treaties calling for participating countries to regulate the manufacture and sale of narcotics, or to the utility of placing the medical profession in a position of greater control and responsibility for the distribution of these drugs. Duster makes much of this legislative record, suggesting that the absence of more explicit morality-based arguments during the debates supports his view that broad social stigma did not attach to narcotics use until after the legal landscape had shifted.

Nolan, on the other hand, while acknowledging the paucity of morality claims in the record, has argued persuasively that popular moral disapprobation directed toward drugs and drug abusers played a part in the broader campaign that ultimately culminated in the Harrison Act. Nolan conjoins the more

Balance in Our Drug Control Laws and Policies, 1 St. LOUIS U. J. HEALTH L. & POL'Y 231, 258–59 (2008) (discussing the Harrison Narcotics Act of 1914).

<sup>108.</sup> See KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, supra note 74, at 18–19.

<sup>109.</sup> See id. at 19 (quoting BRECHER, supra note 59, at 49).

<sup>110.</sup> KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, supra note 74, at 19.

<sup>111.</sup> See DUSTER, supra note 1, at 15.

<sup>112.</sup> See 50 CONG. REC. 2191-2211 (1913).

<sup>113.</sup> *Id.* at 2201–11.

<sup>114.</sup> See MORGAN, supra note 27, at 107–08; NOLAN, REINVENTING JUSTICE, supra note 9, at

<sup>115.</sup> See DUSTER, supra note 1, at 22-23.

<sup>116.</sup> See NOLAN, REINVENTING JUSTICE, supra note 9, at 27–28.

immediate legislative history of the 1914 legislation with the efforts that had been undertaken in the House of Representatives in support of the Foster Bill in 1910, and suggests that the earlier debate set the stage for and was part of the general advocacy that finally resulted in the later legislation. This broadened time frame is important because it permits Nolan to plumb the legislative record of the earlier proposal for examples of comments containing the kind of moral disapproval that Duster believes only took root after the law had changed. Thus, Nolan cites to instances in the earlier committee hearings where

drug users were variously referred to as "dopes," "fiends," "dope fiends," and "habitués." The "secret and vile habit" of drug use was described as "nefarious and soul destroying," as an "evil," a "curse," a "vice," and as that which led to "debauchery" and "crime." 119

Wrapped up in this moral condemnation of narcotics users was a related set of judgments that Nolan associates with the "status politics thesis" developed by Joseph Gusfield in his well-known history of alcohol prohibition<sup>120</sup> and also found in David Musto's important work on the history of drug policy. <sup>121</sup> It is clear that some proponents of the Foster Bill sought to garner support for the legislation on the basis of class and race biases, evoking popular myths and fears about the role that drug use played in the supposed debauchery of some African-Americans, Asian-Americans, and other groups outside of the white middle class. <sup>122</sup> Dr. Wright, for example, suggested that opium smoking had corrupted a large number of proper white women, leading them into inappropriate sexual relationships with Chinese men, while cocaine use among African-American men in the South was said to have contributed to a high incidence of sexual misconduct. <sup>123</sup> Clearly, these provocative associations of drug use with other morally charged conduct on the part of outsider groups must be understood as

<sup>117.</sup> See id.

<sup>118.</sup> See DUSTER, supra note 1, at 22–23; NOLAN, REINVENTING JUSTICE, supra note 9, at 23–26.

<sup>119.</sup> See NOLAN, REINVENTING JUSTICE, supra note 9, at 23–24.

<sup>120.</sup> See JOSEPH R. GUSFIELD, SYMBOLIC CRUSADE: STATUS POLITICS AND THE AMERICAN TEMPERANCE MOVEMENT 4, 6, 7–8 (2d ed. 1986); NOLAN, REINVENTING JUSTICE, *supra* note 9, at 22–23 (discussing "Joseph Gusfield's 1963 analysis of the Prohibition effort").

<sup>121.</sup> See MUSTO, THE AMERICAN DISEASE, supra note 56, at 5–6 ("[A]ddicts were identified with foreign groups and internal minorities who were already actively feared and the objects of elaborate and massive social and legal restraints.").

<sup>122.</sup> See id. at 5-6.

<sup>123.</sup> See KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, supra note 74, at 18 n.113 (citing OPIUM PROBLEM: MESSAGE FROM THE PRESIDENT OF THE UNITED STATES, S. DOC. NO. 61-377, at 45, 48–49 (2d Sess. 1910)); NOLAN, REINVENTING JUSTICE, supra note 9, at 24 (citing Importation and Use of Opium: Hearing on H.R. 25240, H.R. 25241, H.R. 25242 and H.R. 28971 Before the H. Comm. on Ways and Means, 61st Cong. 82–83 (1910–1911) (Statement of Mr. Hamilton Wright)).

morality-based arguments operating within the larger rhetorical structure of the debates that took place at the time, but it is not at all evident that they constitute the sort of clear assertions about the inherent immorality of drug use itself that would become common in later decades.

Finally, Nolan identifies a set of negative moral judgments leveled by supporters of the Foster Bill against drug manufacturers and wholesalers for marketing narcotics "promiscuously," for profiteering by taking advantage of the weaknesses of addicts, and for generally failing to exercise "moral restraint" in their businesses practices with respect to narcotics. <sup>124</sup> Interestingly, these judgments suggest that, while the supporters of anti-narcotics legislation viewed addicts as weak and unfortunate characters, their more pointed moral condemnation was reserved for those who exploited the mental and physical shortcomings of users by aggressively manufacturing and distributing harmful drugs. "Because of the manufacturer's failure on 'moral grounds' to institute 'sufficient safeguards' against the indiscriminate distribution of narcotics," the argument went, "it was therefore 'the duty of the Government to compel him to do it by law." <sup>125</sup>

This reading of the expanded legislative record suggests that there may have been a developing view, at least among some advocates for greater regulation, that narcotics use was morally suspect because it led users to debauchery and crime, and worked a corrosion of middle-class values. For some, drug use also may have been seen as morally wrong on the ground that it disrupted families and other social relationships and, perhaps, because it was thought to debase and corrupt the essential human attributes of rationality and autonomy. But the record does not support a conclusion that narcotics addicts were reviled generally, or that addiction was a category whose social meaning was totalizing in the way that it came to be later in the twentieth century. Viewed in this way, the Harrison Act likely was animated more by a concern that manufacturers and sellers of narcotics were taking advantage of a regulatory vacuum, and that

<sup>124.</sup> See Nolan, Reinventing Justice, supra note 9, at 25 (quoting Importation and Use of Opium: Hearing on H.R. 25240, H.R. 25241, H.R. 25242 and H.R. 28971 Before the H. Comm. on Ways and Means, 61st Cong. 86 (1910–1911) (Statement of Dr. Christopher Koch)) (internal quotation marks omitted).

<sup>125.</sup> Id. (quoting Importation and Use of Opium: Hearing on H.R. 25240, H.R. 25241, H.R. 25242 and H.R. 28971 Before the H. Comm. on Ways and Means, 61st Cong. 86 (1910–1911) (Statement of Dr. Christopher Koch)).

<sup>126.</sup> See generally MUSTO, THE AMERICAN DISEASE, supra note 56, at 65 ("By 1914 prominent newspapers, physicians, pharmacists, and congressmen believed opiates and cocaine predisposed habitués toward insanity and crime. They were widely seen as substances associated with foreigners or alien subgroups.").

<sup>127.</sup> See MORGAN, supra note 27, at 50; MUSTO, THE AMERICAN DISEASE, supra note 56, at 5.

<sup>128.</sup> See 50 CONG. REC. 2191–2211 (1913); DUSTER, supra note 1, at 22–23. During the debate over the Harrison Act of 1914, Representative Sisson referred to addicts as "unfortunate person[s]." 50 CONG. REC. 2203 (1913).

the individual and societal dangers of drug misuse made those unregulated business practices too costly for the government to ignore. Notwithstanding the comments of some who sought to use class and race fears to gain support for these bills, and notwithstanding the statements of others who characterized addicts as depraved or weak or afflicted, the use of narcotics remained, as Duster stresses, predominately a middle class phenomenon until after passage of the Harrison Act. The enactment of that legislation may have been a seminal moment in the development of a more active role for the federal government (and later for the states) in regulating the availability of narcotics, <sup>129</sup> but Duster argues that the primary mechanism contemplated—although not stated explicitly—for regularizing the distribution of harmful drugs was the prescription of these substances by physicians. <sup>130</sup> "As such," he suggests, "the bill was designed by its framers to place the addict completely in the hands of the medical profession." <sup>131</sup>

#### B. The Supreme Court Weighs In

In the decades that followed passage of the Harrison Act, the moral meanings that attached to the use of narcotics in the United States underwent a dramatic shift. As Duster points out, "there is nothing intrinsically moral or immoral about injecting an opiate into the human body." Conduct takes on a particular moral character only in the context of a larger set of social practices that makes that conduct comprehensible to members of the community. The process of "common-sense theorizing" about morality involves looking at the context within which an act is given social meaning to make sense of it as "moral" (heroin use in 1900) or "immoral" (heroin use today).

The set of explanations for the shift in the social conception of drug misuse is complex. Bakalar and Grinspoon call our attention to the important role that labeling drug addiction as a medical problem had in facilitating this change in moral meaning. This is a surprising conclusion, given the tendency in much drug policy literature to view criminal enforcement and medical approaches as mutually exclusive perspectives, <sup>136</sup> but it fits the historical data and provides a

<sup>129.</sup> See, e.g., NOLAN, REINVENTING JUSTICE, supra note 9, at 27 (describing the Harrison Act as "the most important legislative directive in the history of American legal efforts to control narcotics").

<sup>130.</sup> See DUSTER, supra note 1, at 14-15.

<sup>131.</sup> *Id.* at 15.

<sup>132.</sup> Id. at 80.

<sup>133.</sup> See id. at 85.

<sup>134.</sup> Id. at 80.

<sup>135.</sup> See BAKALAR & GRINSPOON, supra note 39, at 38.

<sup>136.</sup> See, e.g., JOINT COMM. OF THE AM. BAR ASS'N & THE AM. MED. ASS'N, DRUG ADDICTION: CRIME OR DISEASE? vii—viii (1963) [hereinafter DRUG ADDICTION] ("On the question of how to deal with drug addiction there are two opposing schools of thought. The Federal Bureau

valuable window into the complicated way that moral disapproval of narcotics use intensified over time and came to drive public policy in this area. <sup>137</sup> By contrast, Duster particularly stresses a change in the class distribution of drug use from a largely middle class profile to one centered on the poor. <sup>138</sup> He also points out the intensifying association between narcotics use and criminality, which he attributes to the federal government's interpretation of the Harrison Act as essentially prohibitory legislation. <sup>139</sup>

The key language in the Harrison Act was a provision that permitted doctors to prescribe narcotics as part of their legitimate professional practice. The precise wording of the statute left a fair amount of room for interpretation, and enforcement officials in the Treasury Department lost no time in staking out the position that the administration of drugs by a physician to an addict in order to

of Narcotics and its supporters regard addiction to narcotic drugs as an activity that is properly subject to police control. . . . Critics of this view regard addiction as a disease, or something akin to it, for which punishment is inappropriate."); NOLAN, REINVENTING JUSTICE, *supra* note 9, at 20 ("Not only did the legal world not adopt the medical world's shift to psychological explanations for addiction, it largely ignored the disease concept of addiction altogether . . . ."); MARIE NYSWANDER, THE DRUG ADDICT AS PATIENT 1 (1965).

137. In Bakalar and Grinspoon's formulation, the framing of a problem as a health matter clears the way for the operation of medical expertise. See BAKALAR & GRINSPOON, supra note 39, at 26. Once the problem is given a medical definition, they suggest, the application of seemingly objective medical expertise can serve the political function of bringing into play both the vocabulary and the tools of a public health approach that legitimates the exercise of state control over the identified subjects. See id. As Lawrence Gostin has pointed out, "the subject of public health is the health of populations—rather than the health of individuals . . . . Consequently, public health is less interested in clinical interactions between health-care professionals and patients, and more interested in devising broad strategies to prevent, or ameliorate, injury and disease." Lawrence O. Gostin, Public Health, Ethics, and Human Rights: A Tribute to the Late Jonathan Mann, 29 J.L. MED. & ETHICS 121, 122 (2001). Increasingly, public health scholars have come to recognize that denoting an issue as a problem of public health opens the way for the use of government authority because "individuals acting in their own self-interest, even if fully informed and rational, will not effectively address the problem because they do not internalize some of the major costs or benefits of action or non-action . . . . " Mark A. Hall, The Scope and Limits of Public Health Law, 46 PERSP. BIOLOGY & MED. S199, S204 (2003). Such government authority may take the form of coercive state measure, including criminal sanctions and isolation. See id. at S203; Richard A. Epstein, Let the Shoemaker Stick to His Last: A Defense of the "Old" Public Health, 46 PERSP. BIOLOGY & MED. S138, S154 (2003).

- 138. See DUSTER, supra note 1, at 10-11.
- 139. See id. at 16-17.

140. The relevant language provided: "Nothing contained in this section shall apply . . . [t]o the dispensing or distribution of any of the aforesaid drugs to a patient by a physician, dentist, or veterinary surgeon registered under this Act in the course of his professional practice only . . . ." Harrison Act of 1914, Pub. L. No. 63-223, 38 Stat. 785, 786 (repealed 1970).

141. See MUSTO, The AMERICAN DISEASE, supra note 56, at 124–25. Musto suggests two reasons why Congress may have adopted this somewhat vague language. First, was a concern that the regulation of medical practice was within the states' reserved police powers and therefore not within the regulatory authority of the federal government. See id. at 125. Second, he suggests that the vagueness was required in order to garner the necessary support of medical professionals for the legislation. See id.

prevent the suffering of physical withdrawal was not the good-faith practice of medicine. Soon, scores of doctors (and some pharmacists) who had understood the Act to permit such treatment found themselves targeted by the federal government in criminal enforcement actions. In 1915, the question found its way to the United States Supreme Court. In *United States v. Jin Fuey Moy*, the Court held that the Treasury Department could not obtain the conviction of a physician under the Harrison Act merely for prescribing narcotics to an addict. The Court reasoned that the scope of the Act depended upon the constitutional power under which it had been enacted, and that the taxing power, which was the basis of the legislation, was not a sufficient foundation for imposing limits on the exercise of professional judgment by doctors with respect to the care of their physically dependent patients.

Even given this adverse decision, federal officials pressed ahead with enforcement efforts against doctors under the claimed authority of the Harrison Act. <sup>147</sup> In 1919, the Supreme Court revisited the issue in a set of two companion cases. <sup>148</sup> In the first, *United States v. Doremus*, <sup>149</sup> the Court upheld the constitutionality of a contested portion of the Harrison Act in connection with the prosecution of a physician who had been charged with selling heroin to a patient in order to maintain the patient's addiction. <sup>150</sup> In his opinion for a majority of the Court, Justice Day concluded that the statute had a "reasonable relation" to the taxing power, and that it would not be proper for the Court to find the statute unconstitutional simply because "its effect may be to accomplish another purpose as well as the raising of revenue." <sup>151</sup> In the second of the two cases, *Webb v. United States*, <sup>152</sup> the Court held that the legitimate practice of medicine did not include the provision of maintenance doses of narcotics to addicts. <sup>153</sup>

<sup>142.</sup> See King Cnty. Bar Ass'n, Effective Drug Control, supra note 74, at 19 (citing Davenport-Hines, supra note 81, at 230); Eva Bertram et al., Drug War Politics: The Price of Denial 69 (1996).

<sup>143.</sup> See Rufus G. King, The Narcotics Bureau and the Harrison Act: Jailing the Healers and the Sick, 62 YALE L.J. 736, 737–48 (1953) (discussing "the furious blitzkrieg" involved with enforcing the Harrison Act and the judiciary's contribution to the campaign).

<sup>144. 241</sup> U.S. 394 (1916). The Supreme Court in *Jin Fuey Moy* affirmed the lower court's decision to quash an indictment against the defendant. *See id.* at 399, 402.

<sup>145.</sup> See id. at 402.

<sup>146.</sup> See id. at 401-02.

<sup>147.</sup> See KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, supra note 74, at 19.

<sup>148.</sup> See id.

<sup>149. 249</sup> U.S. 86 (1919).

<sup>150.</sup> See id. at 89-90, 95.

<sup>151.</sup> See id. at 93-94 (citing Veazie Bank v. Fenno, 75 U.S. (8 Wall.) 533, 541 (1869)).

<sup>152. 249</sup> U.S. 96 (1919).

<sup>153.</sup> See id. at 99-100.

In *Webb*, the lower appellate court had set forth three questions for the Supreme Court. The first two questions were resolved in the majority's opinion in *Doremus*. The third question in *Webb* was as follows:

If a practicing and registered physician issues an order for morphine to an habitual user thereof, the order not being issued by him in the course of professional treatment in the attempted cure of the habit, but being issued for the purpose of providing the user with morphine sufficient to keep him comfortable by maintaining his customary use, is such order a physician's prescription under exception (b) of § 2 [of the Act]?<sup>156</sup>

It took Justice Day exactly two sentences to answer the question.<sup>157</sup> He provided no reasoning as such, concluding that "no discussion of the subject is required" because it "would be so plain a perversion of meaning" to call the doctor's order in this case a "physician's prescription" within the meaning of the statute.<sup>158</sup>

The decision to define the legitimate practice of medicine either to include or exclude maintenance therapy for narcotics addiction is as much a political judgment as it is a medical one, as much a moral assessment as it is a technical one. That the Court was able to dispose so summarily of the idea that a physician's provision of narcotics to an addict could be legitimate medical treatment—an idea seemingly (if only tacitly) endorsed by the Court in *Jin Fuey Moy* just a few years earlier—suggests that important shifts had occurred in the intervening years in the broader societal understanding of drugs and addiction. To gain some understanding of the changed social and political context between 1914 and 1919 that supported the shift in policy from *Jin Fuey Moy* to *Doremus* and *Webb*, some histories have highlighted the impact of the First World War, the fear of political instability following the Russian Revolution, and the rise of nativism and nationalism in this period to suggest that the Court's impatience with the physicians in *Doremus* and *Webb* was simply a manifestation of the growing authoritarianism and xenophobia of the era.

<sup>154.</sup> Id. at 99.

<sup>155.</sup> See Doremus, 249 U.S. at 94-95; Webb, 249 U.S. at 99.

<sup>156. 249</sup> U.S. at 99 (internal quotation marks omitted).

<sup>157.</sup> Id. at 99-100.

<sup>158.</sup> Id.

<sup>159.</sup> See DUSTER, supra note 1, at 14-15.

<sup>160.</sup> See King Cnty. Bar Ass'n, Effective Drug Control, supra note 74, at 19–20 (citing Musto, The American Disease, supra note 56, at 132, 134); Musto, The American Disease, supra note 56, at 132–34. Nolan quotes Wayne Morgan for a somewhat different view, which is that the passage of the Harrison Act in 1914 "represented a popular consensus against drug addiction and the drug experience that had been building since the 1870s. . . . It represented general public fear of disorder and inefficiency, and the belief that society could purify individual conduct in the name of a common good." Nolan, Reinventing Justice, supra note 9, at 27–28 (quoting

The range of moral judgments lurking behind the *Webb* Court's summary conclusion that the physician there was not engaged in the good-faith practice of medicine might have included an unexamined antipathy toward conduct (narcotics use) that increasingly was associated with ethnic and racial outsiders. It might also have reflected an authoritarian impulse to deal harshly with those (users of narcotics and the professionals who facilitated their continued dependence) who were seen as flouting mainstream values. In addition, the apparently too-obvious-for-discussion holding in *Webb* might have rested in part on the same sort of Calvinist/Puritanical impulses that had played an important role in the temperance movement and the then-recently adopted constitutional prohibition on alcohol. These moral impulses—including harsh judgments about idleness, excessive pleasure seeking, ecstatic experience, the defiling of the human body, and the like—may also have been at work in the shifting moral understandings reflected in the opinion of the Supreme Court majority. In the summary of the supreme Court majority.

Whatever moral calculus underpinned the Supreme Court's resolution of the question presented in *Webb* regarding the unlawfulness of medically managing addiction through individual physician prescription, the Court's short conclusory opinion marked an important turning point in both the positive law and in broad lay understandings of narcotics use and addiction in the United States. In 1922, the Court reinforced its position by upholding a Treasury rule that explicitly made it illegal for doctors to prescribe narcotics to treat the "disease" of addiction. Even the Supreme Court's seemingly inconsistent 1925 holding in *Linder v. United States* failed to derail the development of a national drug control policy that was virtually entirely directed toward prohibition and criminal

MORGAN, *supra* note 27, at 107) (internal quotation marks omitted). Presumably, in this interpretation, the Supreme Court's *Jin Fuey Moy* decision represents a temporary misreading by the justices of this developing public consensus, which they corrected in fairly short order in the *Doremus* and *Webb* decisions.

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<sup>161.</sup> See generally GUSFIELD, supra note 120, at 33 ("While Temperance, as a movement, appears much later than Puritanism or the other ascetic sects, its ethical foundations are deep in this stream of Protestant thought and its resonance in the economic institutions of nineteenth-century America is profound."); id. at 123 ("In legitimating the character and style of the old middle class, Prohibition stood as a symbol of the general system of ascetic behavior with which the Protestant middle classes had been identified.").

<sup>162.</sup> Cf. BAKALAR & GRINSPOON, supra note 39, at 72–73 (discussing formal and informal institutions and the role they play in society's views of drug use); DUSTER, supra note 1, at 90 (discussing the role of Protestant views in affecting secular society).

<sup>163.</sup> See generally MUSTO, THE AMERICAN DISEASE, supra note 56, at 132 ("What had been a respectable viewpoint by 1915, although not the dominant attitude of the public—the value of addict maintenance by physicians or others—by 1919 and 1920 had come to seem a great danger and folly. . . . Vigorous protests from a few physicians, congressmen, politicians, and laymen were completely ineffective in modifying legal opposition to supplying drugs for the pleasure or comfort of addicts.").

<sup>164.</sup> See United States v. Behrman, 258 U.S. 280, 287-289 (1922).

<sup>165. 268</sup> U.S. 5, 22 (1925).

enforcement measures. 166 Some writers have suggested that the *Linder* Court's decision, that a physician "who acts *bona fide* and according to fair medical standards" might lawfully "give an addict moderate amounts of drugs for self-administration in order to relieve conditions incident to addiction," 167 did not result in greater involvement by doctors in the care and treatment of addicts because the Treasury Department's continued threats of criminal prosecution simply imposed too great a cost for risk adverse physicians. 168 More to the point, the failure of the *Linder* decision to moderate either the enforcement policies of the federal government or the professional practice decisions of doctors suggests just how fixed the political and moral stance of the country had become regarding narcotics and drug addiction. 169

The operation of positive legal restrictions, the political economy of medical practice and drug distribution, and broadly shared normative understandings about narcotics and addiction probably evolved in the United States throughout this period according to a kind of mutually reinforcing process in which developments in each realm effected the dynamics of change in the others. While changes in the legal rules and shifting public sentiments throughout this period are important components of the story, the concrete practices by which users obtained narcotics are also a critical element in the account of how addicts were transferred from one moral category in the late nineteenth century to a very different one by 1930. 171

The literal language of the Harrison Act could not have accomplished this transformative work absent the restrictive interpretation placed upon it by officials in the Treasury Department and ultimately by the Supreme Court. That restrictive interpretation, in turn, may well have been driven in part by the unintended but nevertheless distortive pressure that the new law's registration and prescription requirements exerted on the nature of physicians' practices. As Duster explains:

<sup>166.</sup> KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, *supra* note 74, at 21 (quoting BERTRAM ET AL., *supra* note 142, at 75).

<sup>167.</sup> Linder, 268 U.S. at 22.

<sup>168.</sup> See MUSTO, THE AMERICAN DISEASE, supra note 56, at 184–185.

<sup>169.</sup> See KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, supra note 74, at 21. As Diane Hoffmann has put it, "Addiction continued to be viewed as a 'vice' rather than as a treatable disease and certain drugs were 'stripped of their healing properties." Hoffmann, supra note 107, at 262 (quoting Aryeh Y. Brown, Comment, Obscured by Smoke: Medicinal Marijuana and the Need for Representation Reinforcement Review, 22 SEATTLE U. L. REV. 175, 212 (1998)).

<sup>170.</sup> See generally BAKALAR & GRINSPOON, supra note 39, at 30 (discussing how "social attitudes and legal regulations" reinforce each other "at weak points to supply reasons for stricter controls"). Duster suggests that "[1]ogically and substantively it makes no sense to ask the question 'Which comes first, law or morality?' It is the nature of the relationship between them that can and should be the subject of inquiry." DUSTER, supra note 1, at 102.

<sup>171.</sup> See DUSTER, supra note 1, at 15-17.

<sup>172.</sup> See id. at 16.

[W]hen the physician became the only legal source of the drug supply, hundreds of thousands of law-abiding addicts suddenly materialized outside of doctors' offices. It was inconceivable that the relatively small number of doctors in the country could so suddenly handle over half a million new patients in any manner, and certainly it was impossible that they might handle them individually. The doctor's office became little more than a dispensing station for the addict, with only an infinitesimal fraction of addicts receiving personal care. 173

Understood in this fashion, it is possible that the federal government's policy of criminal enforcement against doctors and pharmacists was really directed toward those actors who were in effect operating prescription mills, and the facts of some of the most celebrated cases seem to support that interpretation. <sup>174</sup> Under this account, *Linder* can be read not as a divergent data point in the legal doctrinal landscape, but as an instance in which the Court sought to protect the discretion of a physician who in good faith had provided individualized care to a particular patient suffering from drug addiction. <sup>175</sup> The problem with this reading, of course, is that both the rules promulgated by Treasury and the enforcement practices it undertook painted with a far broader brush, opposing all forms of medical maintenance of addicts by physicians. <sup>176</sup> In addition, as noted above, the *Linder* decision neither carved out a safe harbor for careful physicians nor preserved the possibility that narcotics users might receive individualized care from any doctor in private practice. <sup>177</sup>

<sup>173.</sup> Id. at 15.

<sup>174.</sup> The certified facts on appeal in *Webb*, for example, included the following: It was Webb's regular custom and practice to prescribe morphine for habitual users upon their application to him therefor. He furnished these "prescriptions," not after consideration of the applicant's individual case, and in such quantities and with such direction as, in his judgment, would tend to cure the habit or as might be necessary or helpful in an attempt to break the habit, but without such consideration and rather in such quantities as the applicant desired for the sake of continuing his accustomed use.

Webb v. United States, 249 U.S. 96, 97–98 (1919).

<sup>175.</sup> See Linder v. United States, 268 U.S. 5, 22 (1925).

<sup>176.</sup> See King, supra note 143, at 737–39 ("[T]he Narcotics Division succeeded in creating a very large criminal class for itself to police ([i.e.,] the whole doctor-patient-addict-peddler community), instead of the very small one that Congress had intended (the smuggler and the peddler).").

<sup>177.</sup> See Hoffmann, supra note 107, at 262 (quoting MUSTO, THE AMERICAN DISEASE, supra note 56, at 185; JAMES C. WEISSMAN, DRUG ABUSE: THE LAW AND TREATMENT ALTERNATIVES 118 (1978); Brown, supra note 169, at 212). An additional example of the inability of therapeutic impulses to persist within the broader context of this punitive drug policy played out in the years between 1915 and 1923, when a number of states and localities set up clinics to provide transitional care to addicts who no longer had access to narcotics by way of private physician prescription. See NOLAN, REINVENTING JUSTICE, supra note 9, at 31. "The ostensible purpose of the clinics was to maintain addicts until they could get into some form of institutional treatment and/or to help cure

The development of federal "narcotics farms" in the late 1920s was yet another example of the way in which efforts designed nominally as therapeutic measures had the practical effect of extending and intensifying the coercive character of U.S. drug policy. Concerned about the growing population of federal prisoners incarcerated for Harrison Act violations, Representative Stephen Porter introduced legislation in the House of Representatives that was designed to create facilities to hold and "treat" addicts. The bill was passed, and it resulted in the establishment of one farm in Lexington, Kentucky, and another in Fort Worth, Texas. The farms were administered by officials within the new Bureau of Narcotics, which was located within the Treasury Department, thus ensuring that a criminal justice perspective would inform practice in these facilities. Addicts who were ordered to the farms "were essentially treated like offenders in any other prison," and in the end the farms "amounted to little more than 'additional prison space for convicted addicts." 182

#### C. The Anslinger Years and the War on Drugs

The appointment in 1930 of Harry J. Anslinger as the first commissioner of the new Bureau of Narcotics not only served to reinforce the federal government's unitary reliance on law enforcement and prohibition as the core elements of its national drug policy, it also provided an identifiable spokesperson for the increasingly embedded view that drug use was inherently wrongful and that addicts were essentially evil. Anslinger would continue to hold this position until the early 1960s, and during his decades of service both the nation's attitudes and its formal policies grew ever harsher and more punitive.

In the post-World War II period, the incidence of illegal narcotics use in the United States increased substantially. <sup>185</sup> Congress responded in 1951 with passage of the Narcotics Drugs Import and Export Act, <sup>186</sup> which for the first time

them of their addictions." *Id.* The federal government threatened criminal prosecution against those operating the clinics, and they disappeared by 1925. *See id.* 

- 179. See KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, supra note 74, at 21.
- 180. See id. (citing 21 U.S.C. §§ 221–237 (1934) (repealed 1944)).
- 181. See NOLAN, REINVENTING JUSTICE, supra note 9, at 32.
- 182. Id. (quoting MUSTO, THE AMERICAN DISEASE, supra note 56, at 206).
- 183. See King Cnty. Bar Ass'n Effective Drug Control, supra note 74, at 21–22; Nolan, Reinventing Justice, supra note 9, at 32–33.
- 184. See King Cnty. Bar Ass'n, Effective Drug Control, supra note 74, at 21–24; Nolan, Reinventing Justice, supra note 9, at 32–33.
- 185. See KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, supra note 74, at 23 (citing H.J. Anslinger, The Federal Narcotic Laws, 6 FOOD DRUG COSMETIC L.J. 743, 743–48 (1951)).
- 186. Narcotic Drugs Import and Export Act, Pub. L. No. 82-255, 65 Stat. 767 (1951) (codified at 21 U.S.C. § 174 (Supp. 1952)), *repealed by* Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. §§ 801–971 (2006).

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<sup>178.</sup> See NOLAN, REINVENTING JUSTICE, supra note 9, at 32. See generally MUSTO, THE AMERICAN DISEASE, supra note 56, at 204–06 (discussing the creation of federal narcotics farms).

introduced severe mandatory minimum prison sentences for certain drug offenses. In 1956, following highly publicized hearings that had been choreographed by Anslinger and his agents in the Bureau of Narcotics, Congress passed yet another provision increasing prison sentences and fines for drug offenses. The legislative record was highly critical of calls by the American Bar Association and the American Medical Association to increase the resources devoted to drug treatment, and instead the Narcotics Control Act of 1956 not only ramped up enforcement efforts, it also included a provision permitting the imposition of the death penalty for the sale of heroin to minors. In 1965, Congress passed the Drug Abuse Control Amendments Act, which set up the Bureau of Drug Abuse Control within the Food and Drug Administration, and in 1968 the Bureau of Drug Abuse Control and the Bureau of Narcotics were combined into a new agency, the Bureau of Narcotics and Dangerous Drugs, which was located in the Department of Justice.

As the federal drug control bureaucracy was consolidated and moved from Treasury and the FDA to the Department of Justice, drug use in the United States was becoming more salient in the public's consciousness and becoming more closely associated with broader challenges to established authority. These trends drove President Richard Nixon to take a particular interest in the problem of drug use, which he famously declared to be "public enemy number one." As part of his anti-drug efforts, Nixon created the National Commission on Marijuana and Drug Abuse, 197 and in 1970 Congress passed the Comprehensive Drug Abuse Prevention and Control Act, 198 which entirely replaced the Harrison Act as the basis for federal drug control policy. At about this time, President

<sup>187.</sup> See KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, supra note 74, at 23 (citing Narcotic Drugs Import and Export Act, Pub. L. No. 82-255, 65 Stat. 767 (1951) (codified at 21 U.S.C. § 174 (Supp. 1952)) (repealed 1970).

<sup>188.</sup> See id. at 24 (citing RUFUS KING, THE DRUG HANG-UP: AMERICA'S FIFTY YEAR FOLLY 119–124 (1972)).

<sup>189.</sup> See id.

<sup>190.</sup> See id.

<sup>191.</sup> Narcotics Control Act of 1956, Pub. L. No. 84–728, 70 Stat. 570 (codified at 21 U.S.C. §§ 174–198a (Supp. 1957)), *repealed by* Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. §§ 801–971 (2006).

<sup>192.</sup> See KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, supra note 74, at 24.

<sup>193.</sup> Drug Abuse Control Amendment of 1965, Pub. L. No. 89-74, 79 Stat. 226 (codified as amended in scattered sections of 21 U.S.C.).

<sup>194.</sup> See KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, supra note 74, at 25.

<sup>195.</sup> See id.

<sup>196.</sup> *Id.* at 26 (internal quotation marks omitted). Nixon has been described in one history as "a puritan . . . [who] detested the hedonism and easy gratification of many young people." DAVENPORT-HINES, *supra* note 81, at 421.

<sup>197.</sup> See KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, supra note 74, at 26.

<sup>198.</sup> Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. §§ 801–971 (2006).

<sup>199.</sup> See KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, supra note 74, at 26.

Nixon also declared a "War on Drugs," which the federal government has persisted in waging, with varying degrees of intensity, ever since. 200

The Comprehensive Drug Abuse Prevention and Control Act was, and is, wider in scope than the Harrison Act in that it regulates a great variety of substances in addition to narcotics (i.e., amphetamines, barbiturates, and anabolic steroids). The Act is organized so that controlled substances receive a classification within one of five schedules. The schedules are based on a given drug's medical uses and its potential for misuse and for creating dependency. As with the Harrison Act, the Comprehensive Drug Abuse Prevention and Control Act requires practitioners to register with the federal government and contains extensive record keeping requirements. The Act and its attendant regulations are administered and enforced by the Drug Enforcement Administration, created by Congress in 1973, which is located within the Department of Justice.

Drug policy at the federal level became somewhat more pragmatic—and the aggressive rhetoric of the Nixon years somewhat softened—during the Ford and Carter administrations. But, with the election of Ronald Reagan, a return to a heightened level of rhetoric and a redoubling of criminal enforcement efforts against drug sellers and users signaled a return to a full-scale "War on Drugs." During the 1980s, Congress actively participated in ramping up this enforcement-based drug policy by passing three key statutes. The first, the Comprehensive Crime Control Act of 1984, added new drugs to the list of scheduled (or prohibited) substances and also conferred new powers on federal prosecutors to seize property associated with drug offenses. The second, the Anti-Drug Abuse Act of 1986 which was passed on the strength of widespread concern about crack cocaine and the highly publicized death of basketball star Len Bias due to cocaine misuse—contained harsh new penalties, including a number of new mandatory minimum sentences. The third statute in the trilogy was the Anti-Drug Abuse Act of 1988.

<sup>200.</sup> See id.; Hoffmann, supra note 107, at 263.

<sup>201.</sup> Hoffmann, supra note 107, at 263-64.

<sup>202.</sup> Id. at 264.

<sup>203.</sup> See id.

<sup>204.</sup> See 21 U.S.C. § 823(b) (2006).

<sup>205.</sup> See Hoffmann, supra note 107, at 264.

<sup>206.</sup> See KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, supra note 74, at 26 (citing MUSTO, supra note 56, at 257). Serious consideration of marijuana decriminalization was even undertaken in this period. See id.; Richard J. Bonnie, The Virtues of Pragmatism in Drug Policy, 13 J. HEALTH CARE L. & POL'Y 7, 8 (2010).

<sup>207.</sup> See King Cnty. Bar Ass'n, Effective Drug Control, supra note 74, at 27.

<sup>208.</sup> Comprehensive Crime Control Act of 1984, Pub. L. No. 98-473, 98 Stat. 1976 (1984).

<sup>209.</sup> See id.

<sup>210.</sup> Anti-Drug Abuse Act of 1986, Pub. L. No. 99-570, 100 Stat. 3207 (1987).

<sup>211.</sup> See KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, supra note 74, at 27.

<sup>212.</sup> Anti-Drug Abuse Act of 1988, Pub. L. No. 100-690, 102 Stat. 4181 (1988).

criminal penalties still further, and created the Office of National Drug Control Policy (ONDCP)<sup>213</sup> and a position within this agency that has come to be known as the "Drug Czar."<sup>214</sup>

The efforts of the federal government since the declaration of the "War on Drugs" have been heavily focused on criminal enforcement strategies, as have efforts of the states who have acted in concert with the federal government. One measure of this intensive criminal enforcement focus has been the rapid growth in the number of persons brought under criminal justice system supervision as a consequence of drug offense prosecution. From the 1920s through the early 1970s, the per capita rate of persons incarcerated for all crimes in the United States had held steady at just over 100 per 100,000 residents. He end of the 1990s, however, that rate had grown to 476 persons per 100,000 residents. In 2003, more than two million people in the United States were behind bars, and 1 of every 32 adults was under the supervision of the criminal corrections system. In total, there were roughly 1.4 million people in federal and state prisons.

The central role played by the "War on Drugs" in this dramatic increase has been well documented. In the last two decades of the twentieth century, while the total number of arrests in the United States increased by 45%, arrests for possession of a controlled substance or for possession for sale or sale increased

<sup>213.</sup> See KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, supra note 74, at 27.

<sup>214.</sup> MUSTO, THE AMERICAN DISEASE, supra note 56, at 280.

<sup>215.</sup> See generally KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, supra note 74, at 27–28 (discussing "[d]rug-related enforcement activity" and the legacy of state and federal drug laws).

<sup>216.</sup> *See id.* at 28.

<sup>217.</sup> JEREMY TRAVIS ET AL., URB. INST., FROM PRISON TO HOME: THE DIMENSIONS AND CONSEQUENCES OF PRISONER REENTRY 4 (2001) (citing Alfred Blumstein & Allen J. Beck, *Population Growth in U.S. Prisons, 1980–86*, 26 CRIME & JUST. 17, 17 (1999)).

<sup>218.</sup> *Id.* In 1999, the per capita rate of imprisonment for African Americans and Latinos was dramatically higher than that for the population taken as a whole. In fact, the Bureau of Justice's statistics for that year showed that 1 out of every 29 African-American men was sentenced to at least a year of jail or prison, while 1 out of 75 Latino men was serving at least a year. By contrast, the rate of imprisonment (for a year or more) for white males was 1 in 240. *See id.* 

<sup>219.</sup> KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, supra note 74, at 35.

<sup>220.</sup> *Id.* (citing Lauren E. Glaze & Seri Palla, U.S. Dep't of Justice, *Probation and Parole in the United States, 2003*, BUREAU JUST. STAT. BULL., July 2004, at 1, 1, *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/ppus03.pdf).

<sup>221.</sup> See id. Steven Belenko reports that the number of male inmates in the U.S. increased 229% from 1980 to 1996, while the number of female inmates increased over the same time period by 439%. STEVEN BELENKO, NAT'L CTR. ON ADDICTION AND SUBSTANCE ABUSE, BEHIND BARS: SUBSTANCE ABUSE AND AMERICA'S PRISON POPULATION 5 (1998), http://www.casacolumbia.org/articlefiles/379-Behind%20Bars.pdf.

<sup>222.</sup> See generally MICHAEL TONRY, SENTENCING MATTERS (1996) (discussing the sentencing system in the United States).

<sup>223.</sup> See BELENKO, supra note 221, at 55.

by nearly 160%.<sup>224</sup> According to the FBI, approximately 1.7 million people were arrested for drug offenses in the United States in 2003, and 81% of those arrests were for possession of a controlled substance.<sup>225</sup> More persons were arrested for drug-related offenses than for any other crime category.<sup>226</sup>

As with arrests, "the lion's share of the growth in the U.S. inmate population" is attributable to the enhanced enforcement of the drug laws. From 1980 to the mid-1990s the percentage of state prisoners who were "drug law violators" increased from 6% to nearly 25%. In federal prisons during roughly the same period, the rate of drug offenders increased from 25% to 60% of the overall inmate population. These numbers reflect the more aggressive policing practices and prosecutorial priorities associated with the "War on Drugs," but they also were a function of the adoption of new sentencing policies at both the state and federal level that targeted drug offenses with mandatory minimum sentences and other increased penalties. Indeed, the amount of time that offenders served prior to their release increased dramatically during the 1990s, and the increased penalties. In the aggregate, the amount of time served prior to release increased 27% from 1990 to 1998. In addition, the percentage of released offenders who had been in prison for five or more

<sup>224.</sup> See id. Given the dramatically higher rate of increase for drug arrests than for arrests overall, it should come as little surprise that drug offenders also "represent the largest source of jail population growth" in recent years. Press Release, Bureau of Justice Statistics, Half of Local Jail Inmates Were on Probation, Parole, or Pre-Trial Release at Arrest (July 18, 2004), available at http://bjs.ojp.usdoj.gov/content/pub/press/pji02pr.cfm; see also Doris J. James, U.S. Dep't of Justice, Profile of Jail Inmates, 2002, BUREAU JUST. STAT. SPEC. REP., July 2004, at 1, 1, available at http://bjs.ojp.usdoj.gov/content/pub/pdf/pji02.pdf.

<sup>225</sup>. U.S. Dep't of Justice, Fed. Bureau of Investigation, Crime in the United States 2003, at 268, 269 tbl.4.1 (2003).

<sup>226.</sup> Id. at 268, 270 tbl.29.

<sup>227.</sup> Douglas B. Marlowe, Effective Strategies for Intervening with Drug Abusing Offenders, 47 VILL. L. REV. 989, 993 (2002).

<sup>228.</sup> See id. at 993 n.18 (citing BELENKO, supra note 221, at 6-7).

<sup>229.</sup> See id. (citing BELENKO, supra note 221, at 6–7).

<sup>230.</sup> See KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, supra note 74, at 28.

<sup>231.</sup> See JONATHAN P. CAULKINS ET AL., MANDATORY MINIMUM DRUG SENTENCES: THROWING AWAY THE KEY OR THE TAXPAYERS MONEY? (1997), available at http://www.rand.org/pubs/monograph\_reports/2006/MR827.pdf.

<sup>232.</sup> See Alfred Blumstein & Allen J. Beck, Population Growth in U.S. Prisons, 1980–1996, 26 CRIME & JUST. 17, 36 (1999).

<sup>233.</sup> See id. at 17.

<sup>234.</sup> TRAVIS ET AL., *supra* note 217, at 11 (citing Allen J. Beck, U.S. Dep't of Justice, *Prisoners in 1999*, BUREAU JUST. STAT. BULL., Aug. 2000, at 1, 12, *available at* http://bjs.ojp. usdoj.gov/content/pub/pdf/p99.pdf). In part, this trend is due to the shift toward determinate sentencing and the abandonment of parole releases in some jurisdictions. *See id.* at 4.

years nearly doubled over the same period, while the percentage of those serving sentences of one year or less fell by half.<sup>235</sup>

The focus on prohibition and criminal enforcement in the United States has also resulted in a public policy environment that has been extremely resistant to other measures that have been effective elsewhere in reducing the harms associated with drug misuse. For example, although data consistently has shown that sterile syringe or needle exchange programs reduce the risk of blood-borne diseases such as HIV and hepatitis C among injection drug users, <sup>236</sup> and even though these programs are now in operation in a majority of U.S. states, many jurisdictions have continued to treat both the possession of syringes and the distribution of sterile syringes as criminal offenses. <sup>237</sup> In addition, in a number of places, the continued operation of sterile exchange programs depends on the

235. See id. (citing James P. Lynch & William J. Sabol, Prisoner Reentry in Perspective, in 3 URB. INST., CRIME POLICY REPORT 6-8 (2001)). "These longer terms translate into further detachment from the communities to which [the ex-offenders] will return." Id. As the number of prison admissions increased in a nearly linear fashion during this period, so too did prison releases. See id. at 10, figs.3 & 4 (citing Lynch & Sabol, supra). This rapidly expanding class of exoffenders with drug convictions has faced a range of barriers to reentry into the community. See id. at 1. These barriers constitute yet another dimension of drug control policy in the United States. Some of these barriers have been explicit features of the legal regime that was put in place to fight the "war on drugs," while others have been an unofficial (but not necessarily unintended) consequence of the government's criminal enforcement strategy. A number of states impose criminal history restrictions on particular occupations, and at least a half-dozen permanently exclude drug offenders from public employment. Id. at 31. Beyond employment, federal guidelines governing public housing permit public housing authorities and other federally assisted housing providers to exclude many ex-offenders convicted of drug-related offenses. See Housing Laws Affecting Individuals with Criminal Convictions, LEGAL ACTION CTR., 1-2, http://www.lac.org/ doc library/lac/publications/housing laws.pdf. With respect to welfare benefits, federal law provides that individuals convicted of a drug felony shall be banned permanently from receiving food stamps or Temporary Assistance for Needy Families (TANF). See 21 U.S.C. § 862a (2006 & Supp. 2010). The federal law does permit individual states to modify this position, see 21 U.S.C. § 862a(d) (2006), and a number have opted to waive or modify the federal ban. See After Prison: Roadblocks to Reentry, LEGAL ACTION CTR., http://www.lac.org/roadblocks-to-reentry/main.php? view=law&subaction=5. Most of these states require persons with drug convictions who are recipients of TANF or food stamps to meet specific requirements. See id. ("[Thirty-three] states have limited the ban in some way to enable those with drug felony convictions to get public assistance if they [meet] certain conditions, such as participating in alcohol or drug treatment, meeting the waiting period, having a "possession only" conviction, or satisfying other conditions."). Finally, laws in place in many states either prohibit or limit the ability of persons with drug convictions from becoming adoptive or foster parents. See After Prison: Roadblocks to Reentry, LEGAL ACTION CTR., at http://www.lac.org/roadblocks-to-reentry/main.php?view=law& subaction=1.

236. See Reducing Harm: Treatment and Beyond—Sterile Syringe Access (Needle Exchange), DRUG POL'Y ALLIANCE, http://www.drugpolicy.org/reducingharm/needleexchan/ (last updated May 22, 2006).

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<sup>237.</sup> See id.

willingness of local government officials to grant emergency certifications, which must be renewed frequently. <sup>238</sup>

Recent anecdotal evidence suggests that the insistent focus of U.S. drug policy on criminal enforcement and these allied measures that together constitute a punitive approach may be easing.<sup>239</sup> In the past several years, there have been efforts to devise more effective systems to divert some offenders from prison, to soften somewhat the collateral consequences of the criminal enforcement approach, and to strengthen treatment and other harm-reduction strategies.<sup>240</sup> These moves toward a more pragmatic approach may or may not accelerate and they may or may not succeed, but even if they are implemented in some substantial way, the system will remain fundamentally punitive for the foreseeable future, and its target—drug users—will remain subject to intense moral condemnation.

#### II. DRUG PROHIBITION AND THE SOCIAL NEGOTIATION OF NORMS

The preceding Part sketches the story of the development of drug policy in the United States from the middle of the nineteenth century to the declaration of the "War on Drugs" in the 1970s to the present. One theme that emerges in this story is the steady intensification (and evolution in the nature) of moral disapprobation directed toward narcotics use by the public generally and reflected in the positive law.<sup>241</sup> A second theme is the government's increased reliance throughout this period on legal prohibition and, more particularly, on the use of the criminal enforcement system as the central tool in the nation's drug control policy. With this social, political, and legal history in mind, it is useful to consider how prohibition and criminal enforcement might be supported on either consequentialist or deontological grounds.<sup>242</sup>

<sup>238.</sup> A federal ban prohibiting states from spending their share of HIV/AIDS prevention funding on syringe exchange programs that had been in place for nearly twenty years was recently lifted by Congress. *See* Editorial, *Righting a Wrong, Much Too Late*, N.Y. TIMES, Dec. 26, 2009, at A22.

<sup>239.</sup> See infra Part IV.A.

<sup>240.</sup> See infra text accompanying notes 574-623.

<sup>241.</sup> There is a kind of circularity in this. As public disapproval increases, the political incentives for legislators to pass harsher laws do as well. *See* DUSTER *supra* note 1, at 96–98. Promulgation and enforcement of increasingly harsh measures, in turn, seem to stimulate more public disapproval. *See id.* at 97–98.

<sup>242.</sup> The grounds upon which theorists justify the imposition of criminal punishment are generally classified as either consequentialist or nonconsequentialist, or as a mixture of the two. See H.L.A. HART, PUNISHMENT AND RESPONSIBILITY 1–27 (1968); THE OXFORD COMPANION TO PHILOSOPHY 162–65, 200–01 (Ted Honderich ed., 2d ed. 2005). Mainstream liberal theory regards state-sponsored punishment to be "morally problematic" and in need of normative justification because, by definition, hard treatment in the form of death, incarceration, probation, or fines limits the sanctioned individual's freedom and autonomy; these values are understood as central to liberal theory. See R.A. Duff & D. Garland, Introduction: Thinking About Punishment, in A READER ON

PUNISHMENT 1, 3 (Anthony Duff & David Garland eds., paperback reprt. 1998); Kent Greenawalt, *Punishment*, *in* 4 ENCYCLOPEDIA OF CRIME AND JUSTICE 1336, 1337–45 (Sanford H. Kadish ed., 1983).

Consequentialist theories seek to justify punishment on the basis of good future results. See Duff & Garland, supra, at 6. From this perspective, a decision to punish is morally grounded only if its positive future effects outweigh the negative consequences associated with it—including the incursions on individual autonomy inherent in punishment—and only if no available alternative would achieve as much good at a lower cost. See id. at 6–7. This calculation of costs and benefits can be figured in classical utilitarian terms as "the greatest happiness of the greatest number," or it can be determined according to some other good that is deemed to be central to civil society, such as liberty, autonomy, or the welfare of the community. Id. at 6 (internal quotation marks omitted). Consequentialist theories of punishment are inherently instrumental. See id. at 8. The positive effect that punishment is meant to achieve is, in this sense, independent of the punishment itself, and the relationship between the punitive practice and its consequences is therefore contingent. See id. For this reason, consequentialist justifications of punishment turn on an evaluation of empirical information about potential future costs and benefits. See id. at 6–7.

Nonconsequentialist accounts of criminal enforcement reject the notion that criminal punishment is justified by virtue of some contingent relationship to future effects. See id. at 7. Instead, these theories, sometimes framed in terms of retribution, seek to justify penal practice on the basis of the wrongdoer's past conduct, and argue that punishment is an intrinsically appropriate response to wrongful behavior. See id. at 7-8; Greenawalt, supra, at 1338. Some commentators categorize retributive theory as "deontological." See, e.g., Kyron Huigens, What is and is Not Pathological in Criminal Law, 101 MICH. L. REV. 811, 820 (2002) ("Retribution as an end of punishment is emphasized in deontological and aretaic theories of punishment."). Joshua Dressler defines this term to mean literally the "science of duty," Joshua Dressler, Justifications and Excuses: A Brief Review of the Concepts and the Literature, 33 WAYNE L. REV. 1155, 1156 n.5 (1987) (internal quotation marks omitted), and explains that "deontological moral theory holds that certain conduct is morally obligatory whether or not it results in a beneficial consequence." Id. Most retributivists ground the justification of punishment on the concept of desert, the notion that the imposition of suffering is morally justified to the extent that it redresses in some fashion the wrongdoer's past wrongful actions. See, e.g., JEFFRIE G. MURPHY, Cruel and Unusual Punishments, in RETRIBUTION, JUSTICE, AND THERAPY 223, 229 (1979) ("[T]he criminal, having engaged in wrongful conduct in the past, deserves his punishment. It would be unjust for him not to receive it."). They assert that punishment must be figured on the basis of past conduct and must be proportionate to the wrongfulness of that conduct. See id. There are two central problems for nonconsequentialist accounts. The first is that, absent the conceded authority of some generally accepted deity or some other source of natural law, it is difficult to ground deontological notions of right and wrong. See BAKALAR & GRINSPOON, supra note 39, at 23. The second problem—even if an "accredited" source of authority can be identified—is that it is difficult to explain the intrinsic normative link between past wrongful conduct and subsequent punishment. See Duff & Garland, supra, at 7. Why is it that wrongdoers deserve to be punished? Why does hard treatment redress past wrongs?

Joel Feinberg has argued that punishment is an appropriate response to crime because it embodies a "kind of vindictive resentment" and is a "symbolic way of getting back at the criminal." JOEL FEINBERG, *The Expressive Function of Punishment, in* DOING AND DESERVING: ESSAYS IN THE THEORY OF RESPONSIBILITY 95, 100 (paperback ed. 1974). Other retributive theorists have rejected this point of view, suggesting that "denunciatory theories of punishment" are essentially utilitarian, and are not deontological in nature. Michael S. Moore, *The Moral Worth of Retribution, in* RESPONSIBILITY, CHARACTER, AND THE EMOTIONS: NEW ESSAYS IN MORAL PSYCHOLOGY 179, 181 (Ferdinand Schoeman ed., 1987). Still other writers have sought to ground retributive punishment not in theory, but on the basis of intuitions that are said to be generally shared in

## A. The Consequentialist Basis for Drug Prohibition

Attempting a consequentialist evaluation of drug prohibition by way of a utilitarian cost-benefit assessment is a complex task, precisely because of the subjectivity involved in assigning value to each of the variables to be weighed.<sup>243</sup> The process can be simplified somewhat once we recognize that, in practice, few are willing to argue that there is legitimate value to the use of pleasure drugs.<sup>244</sup> Assuming no utility to nonmedical use, then, the calculation boils down to an assessment of the harms associated with drug use, the potential reduction in those harms produced by legal prohibitions on the sale and possession of illegal drugs, and the competing harms occasioned by the effort to enforce those prohibitions.<sup>245</sup>

There is a growing literature reporting on the efforts of social scientists to assess the various components of harm associated with drug use, drug prohibition, and other drug control policies. Important and interesting questions about how to measure the harm and the reduction of harm worked by various public policies have been raised by scholars, including the question of whether "micro harm reduction" (measured in terms of the amount of harm produced by each instance of drug use or by each individual user subject to the jurisdiction of a drug control regime) or "macro harm reduction" (measured in terms of the overall amount of harm produced by all drug use within a drug control regime) should be the primary metric for determining the future direction for drug policy. 246 Alongside this work, other writers have entertained a broader inquiry into the consequentialist foundations of drug control policy by offering useful analogies to activities other than drug use that also create significant risks of serious harm to participants.<sup>247</sup> The point of these analogies (to dangerous sports and hobbies, to the use of unreasonably dangerous products, and to other unhealthy lifestyle choices) is to suggest that the policy of legally prohibiting the

society. See Jean Hampton, The Retributive Ideal, in JEFFRIE G. MURPHY & JEAN HAMPTON, FORGIVENESS AND MERCY 111, 114 (1988). Advocates of this position concede that there may be no independent source for determining right and wrong outside of social practice, and also concede that there is no answer to the question of "why suffering is suitable for wrongdoers." Id. at 113. Instead, they rely on what some term "bedrock intuition" to determine desert and to assess the legitimacy of punishment. See id.

<sup>243.</sup> See Steven Wisotsky, Commentary, Drug Facts Don't Matter: A Brief Comment on Drug Prohibition: An Unnatural Disaster, 27 CONN. L. REV. 639, 642 (1995).

<sup>244.</sup> See BAKALAR & GRINSPOON, supra note 39, at 16. It is worth noting, however, that researchers at John Hopkins Medical School have begun taking a new look at hallucinogens as a treatment for depression. See John Tierney, Hallucinogens Have Scientists Tuning In Again, N.Y. TIMES, Apr. 12, 2010, at A1.

<sup>245.</sup> On the framing of harm calculations in the development of public policy, see Bernard E. Harcourt, *The Collapse of the Harm Principle*, 90 J. CRIM. L. & CRIMINOLOGY 109 (1999).

<sup>246.</sup> See Robert J. MacCoun, Toward a Psychology of Harm Reduction, 53 AM. PSYCHOLOGIST 1199, 1201 tbl.1, 1202 (1998).

<sup>247.</sup> See BAKALAR & GRINSPOON, supra note 39, at 14–19.

sale or possession of narcotics for non-medical use is categorically different from the approach taken in the United States with respect to other significant sources of danger to the public.<sup>248</sup> Detailed questions about the precise degree of harm posed by various illegal drugs and by their prohibition are of critical importance, but gaining some understanding of the basis for the categorical distinction drawn between drugs and virtually everything else is also useful. The initial question, in short, is "[w]hy, in societies where so many actions dangerous to the actor and to others are permitted and sometimes encouraged, do we impose such strong restrictions on drug use?"<sup>249</sup>

Proponents of the heavy reliance on prohibition and criminal enforcement characteristic of American drug policy point to several features that distinguish narcotics use from other activities often mentioned as posing an equal danger to life and limb, including, for example, mountain climbing, high school football playing, or motorcycle riding. First, risky sports and dangerous products typically are not associated with either physical or psychological addiction. While avid climbers or motorcycle riders do sometimes report a craving for the euphoria produced by their hobbies and do occasionally suggest that they are driven or compelled to engage in these activities, these feelings seem to be a far cry from the mechanisms of denial, tolerance, withdrawal, and the like that constitute the loss of control associated with the misuse of narcotics and other drugs. Moreover, practitioners of other dangerous pursuits can legitimately argue that the sometimes considerable risks they carry are offset by equally considerable benefits. This is important on its own terms—drugs are different, it is argued, because they have little or no legitimate utilitarian value outside of their medicinal use—but it is also important as the basis for the

<sup>248.</sup> See id.

<sup>249.</sup> Id. at 14.

<sup>250.</sup> *Id.* at 14–19. In addition to the arguments set out in the text, proponents of prohibition also argue that illicit drug use carries significant costs for users' families, communities, and workplaces. *See, e.g.*, Bruce D. Johnson et al., *Drug Abuse in the Inner City: Impact on Hard-Drug Users and the Community*, 13 CRIME & JUST. 9, 9 (1990) ("[T]he expansion of use of hard drugs, . . . is both a symptom and an important factor in the continued relative decline of inner-city communities and persons who reside in those communities."). Aloen L. Townsend et al., *Families of Persons with Substance Use and Mental Disorders: A Literature Review and Conceptual Framework*, 55 FAM. REL. 473, 475–76 (2006) (noting the impact of "substance disorder[s]" on families). While it is certainly the case that the misuse of illegal drugs often disrupts family functioning, undermines community safety and cohesion, and interferes with employment efficiency, it is difficult to parse out the degree to which these effects are a consequence of legal prohibition and criminal enforcement policies rather than a result of the inherent risks of substance misuse itself. To the extent that these individual and group costs are intrinsic to the abuse of pleasure drugs, they are very much like the costs associated with the abuse of alcohol, which, of course, is not subject to broad legal prohibition and criminal law enforcement.

<sup>251.</sup> See Richard C. Boldt, The Construction of Responsibility in the Criminal Law, 140 U. PA. L. REV. 2245, 2299 (1992) [hereinafter Boldt, The Construction of Responsibility].

<sup>252.</sup> See BAKALAR & GRINSPOON, supra note 39, at 16.

assumption that many (most?) narcotics users are physically or psychologically dependent on their drugs of abuse. Since there is little utilitarian value to drug use, the user must be compelled to obtain and ingest these substances for irrational reasons; that is, because he or she is psychologically or physically addicted. Framed in this way, a policy of prohibition and criminal enforcement may be sensible—even given libertarian concerns about individual autonomy and choice—on the grounds that dependency or addiction by definition overcomes the capacity of free choice and rational decisionmaking normally held by autonomous individuals.

There are several problems with the effort to single out drugs by stressing both the lack of utility in their non-medical use and the close association between use and loss of control or addiction. Increasingly, experts are coming to the view that users of narcotics, like users of alcohol, fall out along a continuum, with those exhibiting the signs of physical or psychological dependence at one end and others who experience little or no loss of control at the other extreme. There is still much to be learned about the patterns of use and misuse typical of each of the major drugs subject to legal control, but it is clear that the assumption of a simple correspondence between use and dependency is not likely to hold up under close scrutiny. And, while few are willing to claim that there are benefits to illicit narcotic use, it is difficult to make compelling arguments on

<sup>253.</sup> See, e.g., George F. Koob & Floyd E. Bloom, Cellular and Molecular Mechanisms of Drug Dependence, 242 Sci. 715, 716 (1988) ("Psychic dependence has traditionally been linked to the behaviorally reinforcing properties of drugs. Both physical and psychic dependence characterize the addicted state.").

<sup>254.</sup> See id. The national "Drug Czar" William Bennett made this sort of claim in his Introduction to the National Drug Control Strategy promulgated in 1989 by the U.S. Office of National Drug Control Policy. See William J. Bennett, Introduction to WHITE HOUSE, NATIONAL DRUG CONTROL STRATEGY 1 (1989). Without citation, Bennett asserted:

There may be a *small* number of people who use drugs regularly—even frequently—but whose lives nevertheless go on for the most part unimpeded. But there remain a large number of Americans whose involvement with drugs develops into a full-fledged addiction—a craving so intense that life becomes reduced to a sadly repetitive cycle of searching for drugs, using them, and searching for them some more.

Id. at 10 (emphasis added).

<sup>255.</sup> See BAKALAR & GRINSPOON, supra note 39, at 16. Of course, framing the matter in this way conflates the dynamics of choice that attend to the first use of a drug as opposed to its continued use over time.

<sup>256.</sup> See Richard C. Boldt, Confidentiality of Alcohol and Other Drug Abuse Treatment Information for Emergency Department and Trauma Center Patients, 20 HEALTH MATRIX 387, 413–14 (2010) [hereinafter Boldt, Confidentiality of Alcohol].

<sup>257.</sup> See generally STEVE SUSSMAN & SUSAN L. AMES, THE SOCIAL PSYCHOLOGY OF DRUG ABUSE 78 (2001) ("There are many means of studying the aetiology of drug abuse, but no clear cut explanations as to why some individuals who experiment with drugs go on to abuse them and others do not.").

this basis that successfully distinguish the use of other substances, particularly alcohol and tobacco, which are equally prone to misuse but are not illegal.<sup>258</sup>

A slightly different approach to assessing the consequentialist basis for narcotics prohibition derives from the field of consumer protection law. Here, although there are frequent libertarian objections to mandatory seatbelt and helmet laws, there are plenty of examples of either government prohibition or regulation in the market for dangerous goods and services.<sup>259</sup> restrictions on individual choice are based on the premise that individuals should not be left with unlimited discretion because they possess incomplete information about risks and are prone to systematically underevaluate the dangers of certain products and activities. 260 Once again, however, this model of government intervention is an imperfect analogy for thinking about drug control policy. On the one hand, the violation of consumer protection laws typically does not trigger the kind of pejorative moral judgment normally associated with the violation of drug laws, including even simple prohibitions on the possession of a small amount of narcotics. Moreover, individuals apparently do not undervalue the risks associated with drug use at anything like the rate typical for other products subject to consumer protection laws. Indeed, contrary to the usual findings of behavioral psychologists who have studied the assessment of risk in occupational settings and other areas of daily life, 261 "[s]tudies show that the less people know about the effects of recreational drugs, the more dangerous they consider the drugs to be."262

In the final analysis, what distinguishes the possession and use of narcotics from virtually every other activity that is regulated on the grounds of posing some significant risk to human health and well-being is the degree to which drug activity is understood—perhaps by dint of the operation of the criminal enforcement system—as deeply immoral. It may be possible to construct dispassionate utilitarian rationales for other consumer protection measures, but the fact that "the sale of a few grams [of illegal drugs] is often subject to the

<sup>258.</sup> See BAKALAR & GRINSPOON, supra note 39, at 33.

<sup>259.</sup> See generally BAKALAR & GRINSPOON, supra note 39, at 13 ("The laws that govern building inspection, practicing medicine without a license, minimum wages, consent as a defense in assault charges, the dispensing of prescription drugs, seat belts in cars, gambling, obscenity, prostitution, swimming in public pools without lifeguards, laetrile, food additives, dueling, suicide, and selling oneself into slavery have little in common.").

<sup>260.</sup> See id. at 17. In the alternative, mandatory seat belt and helmet laws can be viewed as consumer protection laws enacted under a state's police powers. While it is certainly true that these laws protect people who underestimate risks, they also have been enacted, at times, in order to protect the public purse. See, e.g., MINN. STAT. § 169.686 (2008) (providing that the fines from seat belt violations go to the state treasury). If these laws are viewed more as public health laws and less as consumer protection laws, then the analogy to drug policy becomes more complex.

<sup>261.</sup> See generally Ying-Ching Lin et al., Avoiding Anxiety, Being in Denial, or Simply Stroking Self-Esteem: Why Self-Positivity?, 13 J. CONSUMER PSYCHOL. 464, 465 (2003) (reporting findings that individuals tend to underestimate risks associated with daily experiences).

<sup>262.</sup> See BAKALAR & GRINSPOON, supra note 39, at 17.

same punishment as rape, armed robbery, and second-degree murder," suggests that "more powerful feelings are at work here than those that produce the average consumer safety law." In terms that recall Lord Patrick Devlin's approach to the legal enforcement of public morality in England in the midtwentieth century, drug use is made subject to criminal prohibition because it is perceived to be "a threat to the social fabric and the moral order," and not simply an activity or product whose costs to users on balance outweigh the advantages that are offered.

## B. Legal Moralism and Drug Prohibition

In his 1965 book *The Enforcement of Morals*, Lord Devlin set out a theory of legal moralism as a partial response to recommendations made by a British study committee (the Wolfenden Report of the Committee on Homosexual Offences and Prostitution) to decriminalize private consensual same-sex relations. 266 Devlin's description of the Wolfenden Report stressed the liberal premises that had led the committee to its recommendations: "They separate very decisively crime from sin, the divine law from the secular, and the moral from the criminal." Devlin's position, by contrast, was that "the criminal law as we know it is based upon moral principle."

Devlin's argument addressed two fundamental questions: first, whether society has a right to adopt a public morality; and second, whether, if "society has the right to pass judgment, has it also the right to use the weapon of the law to enforce it." With respect to the first question, he argued that what is

<sup>263.</sup> Id. at 19.

<sup>264.</sup> See Patrick Devlin, The Enforcement of Morals (1965).

<sup>265.</sup> BAKALAR & GRINSPOON, supra note 39, at 19.

<sup>266.</sup> See DEVLIN, supra note 264, at v-x.

<sup>267.</sup> Id. at 3.

<sup>268.</sup> Id. at 7.

<sup>269.</sup> *Id.* at 7–8. The question whether and how the law should be deployed to enforce some particular conception of moral probity is ground that has been well-covered by serious thinkers, perhaps most famously by John Stuart Mill and James Fitzjames Stephen in the nineteenth century and Patrick Devlin and H.L.A. Hart in the mid-twentieth century. *See generally* Harcourt, *supra* note 245, at 120–34 (discussing the background of the "harm principle"). Notably, the propriety of maintaining criminal prohibitions on drug use has been an explicit topic within the debate, beginning with Mill's essay *On Liberty* and appearing throughout. *See id.* The starting point in the discussion is Mill's so-called harm principle, which stakes out a strong libertarian position. Mill explained:

The principle [is,] that the sole end for which humanity is warranted, individually or collectively in interfering with the liberty of action of any of its members, is self-protection. The only purpose for which power can be rightfully exercised over members of a civilized community, against their will, is to prevent harm to others. Their own good, either physical or moral, is not a sufficient warrant.

JOHN STUART MILL, ON LIBERTY 11 (Albert Anderson & Lieselotte Anderson eds., Agora Publ'ns, Inc. 2003) (1859).

constitutive of any society is that it functions as a "community of ideas," and that those ideas necessarily include both "a moral structure as well as a political one." For Devlin, the foundations of any society are made up not only of political institutions but also of shared ideas about morality and ethics. Given this organic view of the role of moral judgment in society, Devlin asserted that without "fundamental agreement about good and evil" collective life is not possible.

Devlin's treatment of the second question was more problematic. At some points in The Enforcement of Morals, he seems to suggest that a society's right to enforce a common set of moral obligations through the coercive force of the law derives from its interest in collective self-preservation. Thus, Devlin argues that just as the obligation to protect the integrity of a society's political institutions may require it to use force to combat political rebellion, so too its interest in the moral integrity of its institutions may require it to deploy the force of the law to combat immoral or wrongful conduct.<sup>273</sup> In both instances, he suggests, the danger of failing to use force is the same, that of social disintegration.<sup>274</sup> At other points, however, Devlin's arguments seem less directed toward concerns about the consequential harms likely to result from a failure to enforce a public morality and closer to the position staked out decades earlier by James Fitzjames Stephen.<sup>275</sup> Under this interpretation, Devlin's position appears to be that a society has the right to use the force of law to punish morally deviant conduct, even if there is no likelihood that the society's institutions will be endangered, simply because the conduct is sinful or wrongful.<sup>276</sup> Even in the absence of any forward-looking reasons having to do with social order, the suggestion is that the legal enforcement of public morals can properly rest directly on the normative premises upon which the society is founded 277

Once a shift is made from purely consequentialist rationales for criminal prohibition to nonconsequentialist reasoning, an underlying problem of how to ground legally enforceable notions of public morality must also be addressed. Although it is possible to identify religious or religion-like objections to the use

<sup>270.</sup> DEVLIN, supra note 264, at 9.

<sup>271.</sup> See id. at 10.

<sup>272.</sup> Id.

<sup>273.</sup> See id. at 10-14.

<sup>274.</sup> See id.

<sup>275.</sup> See, e.g., JAMES FITZJAMES STEPHEN, LIBERTY, EQUALITY, FRATERNITY 143 (R.J. White ed., Cambridge Univ. Press 1967) (1873) ("[P]ublic opinion ought to put a restraint upon vice, not to such an extent merely as is necessary for definite self-protection, but generally on the ground that vice is a bad thing from which men ought by appropriate means to restrain each other")

<sup>276.</sup> See DEVLIN, supra note 264, at 12-25.

<sup>277.</sup> See id. at 25.

of mind-altering drugs,<sup>278</sup> the more likely possibility is that the criminal prohibition regime rests on popular moral outrage or, perhaps, disgust directed toward narcotics users. This arrangement, which is much like Devlin's reliance on the common-sense morality of the "reasonable Englishman, taken at random,"<sup>279</sup> recalls the position of those retributivists who suggest that generally shared societal "bedrock intuition[s]" should be the basis for determining desert and punishment.<sup>280</sup>

Liberal critics of legal moralism, including H.L.A. Hart, Ronald Dworkin, and others, have been especially vigorous in challenging the notion that popular moral outrage should properly serve as the basis for legal proscription.<sup>281</sup> Dworkin in particular argued that, in order to support legal obligation, moral judgments should be based on good reasons that are free from "prejudice (for example, racism), personal emotion, false factual beliefs, or rationalization, and not dependent solely on the beliefs of other people."<sup>282</sup> Given these restrictions against a reliance on prejudice, false belief, and the like, the search for "good reasons" for the moral (and legal) disapproval of drug use almost inevitably leads back to consequentialist considerations regarding the effects of addiction on family functioning, economic productivity, and overall physical and psychological health.<sup>283</sup> As noted earlier, however, while these costs are

BAKALAR & GRINSPOON, *supra* note 39, at 2–3. The negative health consequences of substance misuse are especially costly. For example, recent research on tuberculosis cases reported to the

<sup>278.</sup> See DUSTER, supra note 1, at 90-91.

<sup>279.</sup> DEVLIN, *supra* note 264, at 15 (quoting FREDERICK POLLOCK, ESSAYS IN JURISPRUDENCE AND ETHICS 270 (1882)) (internal quotation marks omitted).

<sup>280.</sup> Hampton, supra note 242, at 113.

<sup>281.</sup> See BAKALAR & GRINSPOON, supra note 39, at 20–23. In Hart's calculation, to deploy the coercive authority of the law "for the sake of which we should restrict human freedom and inflict the misery of punishment on human beings," simply to indulge the strong feelings of disgust or disapproval held by the majority of the community is itself morally suspect. H.L.A. HART, LAW, LIBERTY, AND MORALITY 47, 83 (1963). As Bakalar and Grinspoon put it, "the presumed outrage of the man on the Clapham omnibus, unsupported by any broad principle, is a poor substitute for the anger of a god or an accepted conception of public virtue based on a view of humanity's natural ends." BAKALAR & GRINSPOON, supra note 39, at 23. Anita Allen's recent work takes up the morally suspect nature of these social judgments with regard to mental disability rights. See Anita L. Allen, Mental Disorders and the "System of Judgmental Responsibility," 90 B.U. L. REV. 621, 625–26 (2010). Also, Martha Nussbaum's recent book considers morally suspect judgments in the context of, among other things, gay rights and immigration policy. See MARTHA C. NUSSBAUM, HIDING FROM HUMANITY: DISGUST, SHAME, AND THE LAW (2004).

<sup>282.</sup> BAKALAR & GRINSPOON, *supra* note 39, at 20 (discussing Ronald Dworkin, *Lord Devlin and the Enforcement of Morals*, *in* MORALITY AND THE LAW 55 (Richard A. Wasserstrom ed., 1971)).

<sup>283.</sup> Bakalar and Grinspoon explain that:

Overdoses, accidents, and physical or mental illness caused by drugs may require the use of public medical resources; society may be damaged by crimes committed under the influence of drugs; drug users may neglect their families, who will require public support, or they may become unproductive and dependent on others because of chronic drug abuse

significant, they cannot account entirely for the unique legal status of pleasure drugs. In the end, it is difficult not to fall into a kind of analytic circularity at this point, in which consequentialist accounts devolve into deontological ones and deontological rationales inevitably import consequentialist considerations.

In evaluating the nature of the moral disapproval directed toward drugs and drug users, and by extension the nonconsequentialist grounds for U.S. drug policy, it may be helpful to consider the array of psychological processes that Robert MacCoun has identified in connection with his discussion of broad public resistance to so-called harm-reduction strategies.<sup>284</sup> It is likely that many of these psychological processes apply with equal force to explain the widespread condemnation of narcotics users and the correspondingly widespread support shown by the public for the general policy of prohibition and criminalization against which harm-reduction policies often are contrasted. 285 explanation offered for resistance to harm-reduction strategies is the need for predictability and control. 286 Here, MacCoun suggests that everyday interactions necessarily place individuals in a position in which their well-being depends on the care and control of others. Whether it be a reliance on other drivers to adhere to the rules of the road when using public highways, on teachers to exhibit probity and good judgment when entrusted with the care of children, or on restaurant cooks and waiters to handle food in a sanitary fashion, individuals regularly rely on others with whom they come into contact to take precautions to insure that they are safe and relatively free from accidental harm. 288 Although

Centers for Disease Control and Prevention has demonstrated that "substance abuse is the most commonly reported modifiable behavior impeding TB elimination efforts in the United States." John E. Oeltmann et al., *Tuberculosis and Substance Abuse in the United States, 1997–2006*, 169 ARCHIVES INTERNAL MED. 189, 192 (2009). These researchers found that 18.7% of TB patients reported alcohol or other drug misuse in the year before their TB diagnosis. *Id.* at 190. To take another example, in 2005, 3.7% of adults seeking emergency department treatment reported using drugs within six hours of the event, while 7% reported consuming alcohol within the same six-hour period. *See* Cheryl J. Cherpitel & Yu Ye, *Trends in Alcohol- and Drug-Related ED and Primary Care Visits: Data from Three U.S. National Surveys (1995–2005)*, 34 AM. J. DRUG & ALCOHOL ABUSE 576, 578–80 (2008). Clearly, there is a pragmatic, utilitarian basis for seeking to limit the misuse of alcohol and other drugs. The analytic problems posed in the text, however, are whether the consequentialist case for drug prohibition is distinguishable from that which might apply to alcohol, and whether prohibition is likely to be the most effective way to reduce the misuse of drugs.

<sup>284.</sup> See MacCoun, supra note 246, at 1205-07.

<sup>285.</sup> Under a harm reduction approach, the goals of public policy interventions are defined in terms of reduced drug and alcohol misuse and reduced offending, and success is measured accordingly. See Richard C. Boldt, Introduction, Obstacles to the Development and Use of Pharmacotherapies for Addiction, 13 J. HEALTH CARE L. & POL'Y 1, 4–5 (2010) (citing James L. Nolan, Jr., Harm Reduction and the American Difference: Drug Treatment and Problem-Solving Courts in Comparative Perspective, 13 J. HEALTH CARE L. & POL'Y 31, 36, 38 (2010)).

<sup>286.</sup> MacCoun, supra note 246, at 1206.

<sup>287.</sup> See id.

<sup>288.</sup> See id.

the actual impact of various illegal drugs on the ability of users to perform these functions effectively and safely is subject to dispute, MacCoun explains that most people judge their safety according to a robust bias in risk perceptions, which leads them to believe that they are less prone than most to accidents or injury, and correlatively that others they encounter are likely to be more incautious than they are.<sup>289</sup> This bias, and the public's general concern with maintaining a safe and predictable social environment, MacCoun suggests, helps to explain the discomfort that many have with permitting others to use mindaltering drugs and may therefore be an important factor in the reluctance of policymakers in the United States to diverge from a drug policy organized around blanket prohibition and criminal enforcement.<sup>290</sup>

A second explanation for the public's moral condemnation of narcotics users and its continuing support for drug prohibition policies in the U.S. centers on the strong association that has developed between the use of narcotics and crime, especially urban street crime.<sup>291</sup> Duster argues that this association was generated in part by the creation of a black market in drugs following passage of the Harrison Act and the withdrawal of physicians from the field of medical maintenance for addiction.<sup>292</sup> The association was nurtured in the post-World War II period by the policies of Harry Anslinger and the enactment of progressively harsher drug laws at the federal and state levels.<sup>293</sup> It was further reinforced in the 1980s by the government's declaration of a "war on drugs" and the news media's preoccupation with crack cocaine and the resulting public perception that the use of crack had significantly increased the level of street violence and social disorder in American cities.<sup>294</sup>

This ramped-up scrutiny and law enforcement has had a measurable impact on the link between drugs and crime. One measure of this link is the rate at which persons involved with drugs have become enmeshed in the criminal enforcement system. As mentioned earlier, from 1980 to 1995 the percentage of "drug law violators" within state prison populations increased by a factor of four, while the percentage within federal prisons more than doubled.<sup>295</sup> While the expansion in the population of drug-involved offenders in these systems clearly

<sup>289.</sup> See MacCoun, supra note 246, at 1206.

<sup>290.</sup> *Id.* Although this explanation for popular opposition to harm reduction or drug legalization has clear utilitarian features, MacCoun's discussion treats it as one of a number of psychological processes that help to shape an inchoate but powerful moral disapproval of drug users, which is at the core of nonconsequentialist approaches to drug policy. *See id.* at 1206–07.

<sup>291.</sup> See Richard C. Boldt, The "Tomahawk" and the "Healing Balm": Drug Treatment Courts in Theory and Practice, 10 U. MD. L.J. RACE, RELIGION, GENDER & CLASS 45, 45 [hereinafter Boldt, Tomahawk]; Boldt, The Construction of Responsibility, supra note 251, at 2311.

<sup>292.</sup> See DUSTER, supra note 1, at 16-18.

<sup>293.</sup> See SCHUR, supra note 1, at 191-92; Part I.C.

<sup>294.</sup> See MUSTO, THE AMERICAN DISEASE, supra note 56, at 268–71.

<sup>295.</sup> See Douglas B. Marlowe, Integrating Substance Abuse Treatment and Criminal Justice Supervision, SCI. & PRAC. PERSP., Aug. 2003, at 4, 4 (citing BELENKO, supra note 221, at 5).

was driven by law enforcement and criminal sentencing policies that targeted drug offenses, it also reflects a demonstrable relationship between drug use and criminal conduct more generally.<sup>296</sup> The correlation between alcohol and other drug misuse and criminal conduct may or may not be causal, but it is clear that there is a set of "predisposing" factors that are common to both, such as poverty and mental illness.<sup>297</sup>

Given this association between substance misuse and crime, it should come as no surprise that success in treatment appears to have a beneficial impact on the rates at which participants engage in criminal offending. The research suggests that former drug users who enter sustained periods of abstinence tend to show a decline in criminal conduct and have less involvement in the criminal system. From a purely pragmatic point of view, this data suggests that treatment interventions that effectively reduce drug use disorders should also have a beneficial impact on crime incidents, incarceration rates, and public safety. However, because drug policy has been influenced so heavily by a deontological perspective that conceives of drug use as wrongful or immoral (rather than by a more pragmatic conception that views drug addiction as a disease and drug use as a public health concern), the primary approach adopted to respond to drug use and addiction (and the criminal conduct attendant upon the abuse of drugs) has been to maintain criminal prohibitions on the possession,

296. The correlation between drug addiction and criminal involvement has long been studied. See JAMES A. INCIARDI, THE WAR ON DRUGS: HEROIN, COCAINE, CRIME, AND PUBLIC POLICY (1986); William H. McGlothlin, Distinguishing Effects from Concomitants of Drug Use: The Case of Crime, in STUDYING DRUG ABUSE 153, 153–68 (Lee N. Robins ed., 1985).

297. See Candido da Agra, The Complex Structures, Processes and Meanings of the Drug/Crime Relationship, in DRUGS AND CRIME DEVIANT PATHWAYS 9, 9–30 (Serge Brochu et al. eds., 2002); Duke, supra note 19, at 413.

298. See, e.g., Adele Harrell & John Roman, Reducing Drug Use and Crime Among Offenders: The Impact of Graduated Sanctions, 31 J. DRUG ISSUES 207 (2001) (discussing graduated sanctions programs for drug felons and noting that participation appears "highly correlated with positive outcomes").

299. However, this conclusion should be taken with a caution. As Peter Reuter and Alex Stevens have explained:

The most fundamental point to understand about drug policy is that there is little evidence that it can influence the number of drug users or the share of users who are dependent. There is no research showing that any of the tougher enforcement, more prevention or increased treatment has substantially reduced the number of users or addicts in a nation. There are numerous other cultural and social factors that appear to be much more important.

Peter Reuter & Alex Stevens, Assessing UK Drug Policy from a Crime Control Perspective, 8 CRIMINOLOGY & CRIM. JUST. 461, 474 (2008). On the other hand, Reuter and Stevens also report that "there is a great deal of evidence that, on average, treatment can help dependent drug users cut down both on the quantities of drugs they use and the volume of crime they commit, even if many treated users continue some illegal drug use and offending." *Id.* at 475.

sale, and production of controlled substances, and to rigorously enforce these prohibitions. <sup>300</sup>

Although advocates of the prohibition approach make consequentialist arguments in favor of a heavy reliance on criminal enforcement strategies by noting particularly the correlation between drug misuse and street crime, the criminal punishment approach has proven to be relatively ineffective, at least with respect to the subsequent drug use behaviors of those caught up in the system.<sup>301</sup> It appears that more than 80% of drug-abusing offenders resume drug use within one year of release from prison, and more than 90% do so within three years. 302 Some have argued that maintaining a policy centered on criminal enforcement could yield better outcomes if more effective systems were developed to exploit the leverage of criminal punishment to coerce drug offenders into treatment. 303 Drug treatment courts in particular have been established throughout the United States and in other jurisdictions around the world on precisely this rationale.<sup>304</sup> As it now stands, the outcome data on these experimental efforts at coerced treatment are promising for some offenders under some circumstances. 305 The jury, however, is still out on the utility of these courts to impact the long-term conduct of most (or even a significant minority of) drug-involved defendants, and so this variation of the consequentialist account of current drug policy must be regarded as tentative at best. 306

<sup>300.</sup> One indicator of the heavy reliance in the United States on criminal enforcement as the primary drug control strategy is the distribution of resources in the National Drug Control Budget. In the years from 2000 to 2009, the percentage of the National Budget devoted to "supply reduction" has varied from 53% to 65% of overall expenditures. Weekly Facsimile, Ctr. for Substance Abuse Research, Univ. of Md., FY2009 Federal Drug Control Budget Released; Prevention Continues to Receive Dwindling Proportion of Funding (Mar. 10, 2008), available at http://www.cesar.umd.edu/cesar/cesarfax/vol17/17-10.pdf. In contrast, the percentage devoted to "treatment" has ranged from 22% to 27%. *Id.* 

<sup>301.</sup> In addition to failing to reduce in a substantial way the problem of drug addiction, this criminal punishment approach has also produced a series of additional societal costs. *See* KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, *supra* note 74, at 56–61.

<sup>302.</sup> See Steven S. Martin et al., Three-Year Outcomes of Therapeutic Community Treatment for Drug-Involved Offenders in Delaware: From Prison to Work Release to Aftercare, 79 PRISON J. 294, 307 fig.1, 310 fig.2 (1999) (comparing the percentage of released persons that remained drugand arrest-free both one year and three years after release).

<sup>303.</sup> See, e.g., Peggy Fulton Hora et al., Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionizing the Criminal Justice System's Response to Drug Abuse and Crime in America, 74 NOTRE DAME L. REV. 439, 527 (1999) ("[T]he treatment community's beliefs concerning the incompatibility of drug treatment and the criminal justice system are unfounded."); Marlowe, supra note 227, at 990 ("The only strategy that has produced meaningful or consistent reductions in criminal recidivism and drug use is an integrated public health/public safety strategy exemplified in such programs as drug courts and work-release therapeutic communities (TCs)." (footnote omitted)).

<sup>304.</sup> See Boldt, Tomahawk, supra note 291, at 48 (citing Marlowe, supra note 227, at 990).

<sup>305.</sup> See id. at 49–50 (quoting Douglas B. Marlowe, The Verdict on Adult Drug Courts, ADVOC., Sept. 2008, at 14, 14–15).

<sup>306.</sup> See id. at 56.

Others rest the policy of prohibition and criminal enforcement on a straightforward deterrence rationale.<sup>307</sup> Even if offender relapse data is taken to show that specific deterrence has not been (and is not likely to be) achieved through a system of criminal prohibition, arrest, incarceration, and release, these supporters insist that the removal of criminal prohibitions on narcotics would undermine general deterrence and lead to an increased rate of use overall, if only because the cost of obtaining drugs likely would decline. 308 possibility of some demand-reduction benefits flowing from the current U.S. prohibition and criminal enforcement strategy may be borne out by some of the reported data, the general deterrence claims for the system have not clearly been established.<sup>309</sup> Moreover, it is difficult to rest drug control policy entirely on this explicitly consequentialist foundation given the enormous costs that the current regime imposes both financially and in terms of lost human resources.<sup>310</sup> Instead, the more salient feature of the drug-crime nexus, particularly given the powerful stigma that still attaches to drug use, is the way in which it functions to support a nonconsequentialist basis for drug prohibition.<sup>311</sup> Essentially, drug use, by virtue of its association with crime, is understood to be wrongful intentional conduct demonstrative of the bad character of those caught up in drug activity, and it is on this basis primarily that the criminal enforcement of legal prohibitions necessarily rests.312

<sup>307.</sup> See KING COUNTY BAR ASS'N, EFFECTIVE DRUG CONTROL, supra note 74, at 32.

<sup>308.</sup> William Bennett made just this argument against drug "legalization" when he served as "Drug Czar": "Cheaper, easier-to-get, and 'better' legalized drugs would likely mean more drug users, and more frequent drug use." Bennett, *supra* note 254, at 6.

<sup>309.</sup> See Reuter & Stevens, supra note 299, at 469 ("There is little evidence that targeting distributors and retailers of illicit drugs for arrest leads to reductions in drug use."); cf. Carlos Dobkin & Nancy Nicosia, The War on Drugs: Methamphetamine, Public Health, and Crime, 99 AM. ECON. REV. 324, 345–46 (2009) ("That [an] enormous reduction in the availability of methamphetamine did not discernibly reduce property and violent crime suggests . . . that supply interventions, no matter how successful, are not an effective way of reducing crime associated with methamphetamine use.").

<sup>310.</sup> See MORRIS & HAWKINS, supra note 5, at 6; Randy E. Barnett, The Harmful Side Effects of Drug Prohibition, 2009 UTAH L. REV. 11, 22. In addition to the lost productivity of the hundreds of thousands of persons serving prison sentences for drug offenses, and the disruption to families, neighborhoods, and whole communities caused by the concentrated patterns of drug law enforcement, see TRAVIS ET AL., supra note 217, at 16, 37, the King County Bar Association Drug Policy Project identifies "racial disparities," "impaired administration of justice and civil rights," "curbs on legitimate medical practice," and "increases in drug-related harms" as other costs of the current enforcement-based strategy. KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, supra note 74, at 59–61; see also NAT'L ASS'N CRIMINAL DEF. LAWYERS, AMERICA'S PROBLEM-SOLVING COURTS: THE CRIMINAL COSTS OF TREATMENT AND THE CASE FOR REFORM 20–21 (2009) (advocating the decriminalization of drugs).

<sup>311.</sup> See BAKALAR & GRINSPOON, supra note 39, at 5; DUSTER, supra note 1, at 19–20.

<sup>312.</sup> Troy Duster points out that the reasoning that drug use demonstrates weak character (i.e., the claim that drug users are "psychologically inadequate" and morally weak) is "circular, tautological, or simply 'true' by assertion and definition." DUSTER, *supra* note 1, at 66. The fact that drug use is associated with criminal behavior and street violence helps to break the circularity

The linkage between drugs and street crime has also become overlaid with considerations of race and ethnicity. Although there is a long history of racial, ethnic, and class prejudice woven into the rhetorical strategy used to support drug prohibition policies, 313 the targeting of users of color, the poor, and urban residents in the war on drugs has further intensified the stigma associated with drug use. This has proven to be the case notwithstanding household use surveys suggesting that these enforcement efforts have been out of proportion to the actual patterns of drug use in the United States as a whole. While white residents of the United States use illegal drugs at a rate about equal to that of Latinos and African-Americans, 314 more than 70% of those in federal prison for drug offenses in recent years have been persons of color.<sup>315</sup> According to a survey published in 2001, "African Americans make up about 13% of regular (monthly) drug users; 35% of those arrested for possessing drugs; 55% of those convicted; and 74% of those sentenced to prison. These uneven enforcement practices by definition work to create a maldistribution across racial and ethnic lines of the burdens of criminal punishment. They also serve to skew the allocation of other burdens, including the exclusion from employment opportunities, public housing, and other public benefits suffered by persons with criminal histories.

The concrete consequences of a criminal enforcement policy that falls especially heavily on communities of color—including high rates of incarceration, exclusion from the employment market, and the disruption of families—are not the only outcomes worth considering. In addition, the policy contributes to the formation of stereotypes about drug users and about the communities in which they live. This process of judgment by association likely operates in two directions. On the one hand, the perception that drug dealing, drug misuse, and addiction are problems that primarily affect African-American and Latino communities has served to reinforce beliefs and practices

of this reasoning by importing another basis for the judgment that drug users are persons of weak or bad character. *See* BAKALAR & GRINSPOON, *supra* note 39, at 58. Yet another variation on this account of the immorality of narcotics addicts accepts that the misuse of drugs may be caused by "physical and mental ills," DUSTER, *supra* note 1, at 11 (quoting TERRY & PELLENS, *supra* note 57, at 499) (internal quotation marks omitted), but argues that these pathologies are themselves the consequence of morally significant intentional choices, such as leading a life of disrepute. *See id.* 

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<sup>313.</sup> See supra text accompanying notes 120–23.

<sup>314.</sup> See Office of Applied Studies, Dep't of Health & Human Servs., Results from the 2003 National Survey on Drug Use and Health: National Findings 18 fig.2.8, 19 fig.2.9 (2004) [hereinafter Office of Applied Studies, Results].

<sup>315.</sup> See MARC MAUER, THE SENTENCING PROJECT, THE CHANGING DYNAMIC OF THE WAR ON DRUGS 6 tbl.2 (2009). However, recent data shows a decline in the rate of African-American incarceration and an increase in the rate of white imprisonment for drug offenses. See Solomon Moore, Decline in Blacks in State Prisons for Drugs, N.Y. TIMES, Apr. 15, 2009, at A12.

<sup>316.</sup> KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, *supra* note 74, at 59 (citing *A Survey of Illegal Drugs: Collateral Damage*, ECONOMIST, July 28, 2001, at spec. section 13).

<sup>317.</sup> See Hurwitz & Peffley, supra note 294, at 396.

that marginalize these communities.<sup>318</sup> On the other hand, to the extent that white Americans continue to view members of racial and ethnic minorities (and especially members of these groups who are young men residing in urban areas) as social outsiders, the assumption that many within these groups are involved in illegal drug use and in criminal conduct more broadly has served to reinforce the stigma that attaches to drugs and to those who use them.<sup>319</sup>

Once again, Duster's version of the history is instructive. In the period before legal prohibition, when Americans were more likely to perceive the typical narcotics user to be a white middle-class individual holding down an ordinary job and undertaking ordinary daily responsibilities, the moral disapproval directed toward drug users fell far short of the sort of engulfing or totalizing judgment typical today.<sup>320</sup> As drug prohibition and criminal enforcement pushed drug use to the margins, it became easier to think of these more socially distant users as somehow outside the mainstream, as morally deviant, as "the other." Of course, even if Duster's description of a shift in the class (and race) distribution of narcotics users brought about by the legal developments of the early twentieth century is accurate, it is still the case that a great many users of illegal drugs did not (and do not) live on the margins of society.<sup>322</sup> It is critical to note this gap between perception and reality with respect to the distribution of illegal drug users across society, and to attend to the boundary-defining effect that the criminal prosecution of drug offenders accomplishes over time. Sociologists going back at least to Durkheim have explained that the prosecution and punishment of criminal offenders works not only to communicate that they transgressed societal norms, but also to define and reinforce ("to integrate") the collective social boundaries that those norms construct.<sup>323</sup> If the enforcement enterprise disproportionately focuses on offenders who are already in socially marginalized groups, this process of boundary marking has a double effect, influencing both the public's moral

<sup>318.</sup> See Jerry Kang, Trojan Horses of Race, 118 HARV. L. REV. 1489, 1562-63 (2005).

<sup>319.</sup> In some sense, this stigma casts members of African-American and Latino communities as outsiders, depriving them of a sense of citizenship and belonging to the broader community. *See* R.A. Lenhardt, *Understanding the Mark: Race, Stigma and Equality in Context*, 79 N.Y.U. L. REV. 803, 830 (2004).

<sup>320.</sup> See DUSTER, supra note 1, at 10.

<sup>321.</sup> MacCoun, supra note 246, at 1206.

<sup>322.</sup> See Office of Applied Studies, Results, supra note 314 at 19–20.

<sup>323.</sup> See EMILE DURKHEIM, SUICIDE: A STUDY IN SOCIOLOGY (John A. Spaulding & George Simpson trans., The Free Press 1951) (1897). See generally KAI T. ERIKSON, WAYWARD PURITANS: A STUDY IN THE SOCIOLOGY OF DEVIANCE 4 (1966) ("[D]eviance makes people more alert to the interests they share in common and draws attention to those values which constitute the 'collective conscience' of the community."); Richard C. Boldt, Restitution, Criminal Law, and the Ideology of Individuality, 77 J. CRIM. L. & CRIMINOLOGY 969, 1005 (1986) ("To the extent that any system of sanctioning public wrongs serves to assist a community in boundary-defining, community members looking to the morality play of adjudication and punishment must share some understanding of how responsibility for behavior is ascribed.").

disposition toward the use of illegal drugs and its understanding of where "the drug problem" is located. 324

MacCoun's study of the psychological processes that impede public support for harm-reduction strategies in the U.S. hints at an additional constellation of factors that may help to explain the moral disapproval directed toward narcotics users and the consequent persistence of drug prohibition policies. 325 Edwin Schur grounds these factors in the Puritan tradition, 326 while others have argued that they are part of a "middle class" psychology that has long dominated American culture.<sup>327</sup> Whatever their origin, these factors include wariness over the use of "artificial" substances as a means of escape from psychic or physical pain, 328 disgust with actions that are seen as defiling the purity of the human body, 329 and unease regarding conduct that is understood as unproductive and wasteful.<sup>330</sup> A review of some of the public opinion research on attitudes toward narcotics users reveals references to addicts as "cowards" who are prone to "selfishness," "idleness," and "a desire to escape from reality." Of course, escape, defilement, and dissipation are characteristics, to varying degrees, of alcohol abuse and alcoholism as well, and the moral objections to alcohol use raised in the temperance movement assuredly included these concerns.<sup>332</sup> But the ordinary use and sale of alcohol is not subject to criminal prohibition in most of the United States, and, although considerable stigma still accompanies alcoholism, it is difficult to argue that this disapproval carries the same social meanings that moral judgments about narcotics addiction do. The question, then, is what additional elements are at play pushing illegal drug use so far to the extreme end of the social disapprobation scale.

Perhaps the most powerful element distinguishing the use of narcotics from other similar behaviors that do not trigger such powerful moral disapproval and

<sup>324.</sup> Although there long has been a mismatch between popular beliefs about who uses illegal drugs and the available data on actual use patterns, in recent years more Americans have had the experience of watching friends and family members struggle with drug use disorders. *See* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T HEALTH & HUMAN SERVS. CARAVAN SURVEY FOR SAMHSA ON ADDICTIONS AND RECOVERY: SUMMARY REPORT 1, 4 (2008), *available at* http://www.samhsa.gov/Attitudes/CARAVAN\_LongReport.pdf (reporting the results of a nationally representative survey in which the "target audience was a national probability sample of 1,010 adults, 18 years of age and older living in private households in the continental U.S."). This changing awareness of the patterns of drug use and abuse may have an effect on public attitudes more generally.

<sup>325.</sup> See MacCoun, supra note 246, at 1205-07.

<sup>326.</sup> See SCHUR, supra note 1, at 199.

<sup>327.</sup> See MAX LERNER, AMERICA AS A CIVILIZATION 438, 488–95 (5th prtg. 1957).

<sup>328.</sup> See DUSTER, supra note 1, at 53.

<sup>329.</sup> See MacCoun, supra note 246, at 1207.

<sup>330.</sup> See DUSTER, supra note 1, at 246.

<sup>331.</sup> *Id.* at 113–114. (discussing common responses of 120 sociology students in 1964 to the question of what causes drug addiction).

<sup>332.</sup> See GUSFIELD, supra note 120, at 31.

aggressive legal prohibition is that drug use is understood to be subversive, a direct challenge to established authority. MacCoun draws on the literature on authoritarianism—"a complex trait defined as a chronic tendency to cope with anxiety by expressing hostility toward outgroup members; intolerance of unconventional behavior; and submissive, unquestioning support of authority figures"—to help explain popular support for punitive drug policies. Importantly, this framing incorporates some of the other features that also contribute to the unique moral and legal status of illegal drugs, including their association with marginal social groups and with criminality. But it is the perceived subversiveness of this conduct that sets it apart. As noted earlier, drug use in the United States became a highly visible political issue in the 1970s, particularly after the use of drugs for nonmedical purposes was linked with broader challenges to established institutions and conventional cultural and social norms. Some have argued that Richard Nixon's aggressive and very public campaign to crack down on drug users was propelled by his sense that they represented a severe threat to mainstream values and institutions.

The idea that the use of narcotics for pleasure is a subversive activity is, of course, sharpened by the fact that the behavior is illicit, a violation of the positive law.<sup>337</sup> The legal prohibitions on the possession and distribution of drugs, in turn, clearly reflect (and are likely encouraged by) popular moral disapproval of drug-using activity. The illegality and the immorality of the conduct each feed the other in a kind of ongoing feedback loop. As Duster explains, "[t]he community's ultimate rationale against heroin or marijuana consumption has been that it is a felony, while the lawmaker's ultimate rationale for strong felonious law has been the public sentiment."<sup>338</sup> The law, in this sense, both reflects and constructs public understandings about the moral meaning of drug use and addiction. The interconnectedness of these

<sup>333.</sup> See, e.g., Paul M. Kohn & G.W. Mercer, Drug Use, Drug-Use Attitudes, and the Authoritarianism-Rebellion Dimension, 12 J. HEALTH & SOC. BEHAV. 125, 125 (1971) ("[M]ore rebellious [survey] respondents are generally more permissive about drugs and more likely to use drugs, . . . than their more authoritarian peers.")

<sup>334.</sup> See MacCoun, supra note 246, at 1206; Daniel J. Levinson, Politico-Economic Ideology and Group Memberships in Relation to Ethnocentrism, in THE AUTHORITARIAN PERSONALITY 151, 151–221 (Max Horkheimer & Samuel H. Flowerman eds., 1950) (examining the correlation between prejudice and various trends such as "conventionalism" and "authoritarian submission").

<sup>335.</sup> See supra text accompanying notes 196-200.

<sup>336.</sup> See, e.g., KING CNTY. BAR ASS'N, EFFECTIVE DRUG CONTROL, supra note 74, at 26 ("Nixon exhibited personal anger toward drug users in America and 'as a puritan and as a man perennially frustrated with his circumstances . . . detested the hedonism and easy gratification of many young people." (quoting DAVENPORT-HINES, supra note 81, at 421) (omission in original)).

<sup>337.</sup> The criminal prohibition of narcotics use endows it "with the romantic glamour of a rebellion against authority." MORRIS & HAWKINS, *supra* note 5, at 5–6.

<sup>338.</sup> DUSTER, supra note 1, at 97–98.

<sup>339.</sup> See Sanford H. Kadish, The Crisis of Overcriminalization, 374 ANNALS AM. ACAD. POL. & Soc. Sci. 157, 170 (1967). Professor Kadish has noted that:

features—the subversiveness and the illicitness of drug activity—functions as a powerful engine in the rhetorical practice of government officials responsible for the promulgation and enforcement of drug policy.<sup>340</sup>

## III. THE LEGAL, MEDICAL, AND SOCIAL REGULATION OF DRUGS IN THE UNITED KINGDOM

The history of narcotics use and drug control in Great Britain before about 1920 is similar in important respects to that in the United States during the same period. Although the two countries' legal, political, and social histories relating to drugs diverged significantly over the ensuing decades, there has been a convergence of sorts in recent years. Throughout, the British have been mindful of the challenges that policymakers have faced in America and of the political and legal commitments that United States officials have made with respect to the enforcement of criminal prohibitions on narcotics. From time to time over the

It may be that the best hope for the future lies in efforts to understand more subtly and comprehensively than we do now the dynamics of the legislative (and, it must be added, popular) drive to criminalize. . . . A number of studies have already appeared which have revealed illuminating insights into the process of conversion of popular indignation into legislative designation of deviancy, the nature of the competitive struggles among rival moralities, and the use of the criminal law to solidify and manifest victory.

Id. at 170 (footnote omitted).

340. Franklin Zimring and Gordon Hawkins have offered a careful account of this rhetorical practice in their close reading of one nearly iconic document from the "war on drugs," "Drug Czar" William Bennett's 1989 drug policy "manifesto" written on behalf of the White House Office of National Drug Control Policy. See Franklin E. Zimring & Gordon Hawkins, The Search for RATIONAL DRUG CONTROL 4-5 (1992) (citing Bennett, supra note 254, at 1-14). Bennett's manifesto is a curious amalgam of utilitarian and deontological arguments against illegal drug use. See id. at 4-10. Zimring's and Hawkins's reading of the manifesto identifies several features that in combination make up its core message. See id. Most importantly, Bennett asserts that it is "use itself" that is the "essence" of the problem. Id. at 6 (quoting Bennett, supra note 254, at 8) (internal quotation marks omitted). Unlike explicitly consequentialist policy makers or those of a more pragmatic bent, Bennett is not especially interested in the variety of different harms that result from different kinds of use. See Bennett, supra note 254, at 8. His target is an undifferentiated one, it is use in all forms, "casual' use, regular use, and addiction alike." Id. Moreover, he appears to be equally disinterested in the wide range of different properties characteristic of different drugs of abuse. See ZIMRING & HAWKINS, supra, at 340 (quoting Bennett, supra note 254, at 4, 8). The fact that some substances more readily create physical dependency than do others or that some drugs are more disruptive of cognitive functioning than others seems less important to Bennett than the feature that all illicit drugs share—the fact of their illegality. See id. at 16. Bennett seems to be saying that the harm against which U.S. drug control policy should aim principally is the harm of lawbreaking. See id. This conflating of all types and degrees of drug use as equally bad, and the conflating of all types of illegal drugs as equally harmful, is especially interesting given that Bennett does draw (by inference) a distinction between illegal drugs and other drugs that are not illicit, such as alcohol (at least when used by adults), tobacco, and prescribed medications. See Bennett, supra note 254, at 1.

341. See Philip Bean, The Social Control of Drugs 69 (C.M. Campbell et al. eds., 1974).

past half-century or so, American officials and others in the United States with an interest in drug policy have paid special attention to "The British System" for dealing with narcotics and drug addiction.<sup>342</sup> Given their common starting point and the very different paths taken by these two countries, it is worth considering the ways in which their current practices both resemble one another and yet remain distinct in fundamental respects.<sup>343</sup>

## A. Overview of the History of British Drug Policy

As in the United States, in the United Kingdom during the early decades of the twentieth century, morphine and other narcotics were available to users without a prescription.<sup>344</sup> Schur suggests that "a fair amount" of addiction likely existed in Britain at the time and notes that others have observed that "the use of substances which we now know to be drugs of addiction was common in England long before there existed any effective control over their use."<sup>345</sup> As noted previously, the British participated actively in the Shanghai meeting of 1909, and had acceded to the Hague International Opium Convention of 1912.<sup>346</sup> In accord with the Hague Convention, the British government drafted a narcotics control statute, the Dangerous Drugs Act, which was passed by Parliament in 1920 "without great fanfare or controversy."<sup>347</sup> In a development somewhat parallel to that which had taken place in the United States, the English decided to place responsibility for enforcement of the new provision not in the Ministry of Health, but in the Home Office, which also had jurisdiction over the police, criminal prosecutions, and the prison system.<sup>348</sup>

Pursuant to the Dangerous Drugs Act, the government promulgated regulations controlling the manufacture, distribution, and use of narcotics.<sup>349</sup> The regulations permitted a physician to make these drugs available to patients, but "only as [was] necessary for the practice of his profession."<sup>350</sup> The statute and this regulation thus were a potential "legal handle very much like the

<sup>342.</sup> Larimore & Brill, *supra* note 17, at 107; *see also* HORACE FREELAND JUDSON, HEROIN ADDICTION IN BRITAIN: WHAT AMERICANS CAN LEARN FROM THE ENGLISH EXPERIENCE (1973); Rufus King, *An Appraisal of International, British and Selected European Narcotic Drug Laws, Regulations and Policies, in DRUG ADDICTION, <i>supra* note 136, at 121, 126–39.

<sup>343.</sup> For another, more in-depth, example of comparative analysis between British and American drug policy, see NOLAN, *supra* note 19, at 43–75.

<sup>344.</sup> SCHUR, supra note 1, at 70.

<sup>345.</sup> *Id.* (quoting Jeffrey Bishop, A Commentary on the Management and Treatment of Drug Addicts in the United Kingdom, in NYSWANDER, supra note 4, at 149–50) (internal quotation marks omitted).

<sup>346.</sup> See supra text accompanying notes 88–103.

<sup>347.</sup> SCHUR, supra note 1, at 70; see also JUDSON supra note 342, at 16.

<sup>348.</sup> See JUDSON, supra note 342, at 16–17.

<sup>349.</sup> Id. at 17.

 $<sup>350.\ \</sup>emph{Id.}$  (quoting Dangerous Drugs Act, 1920, 10 & 11 Geo. 5, c. 46 (U.K.)) (internal quotation marks omitted).

American one" to permit the government to oppose maintenance treatment of addicts by doctors on the grounds that this was not the legitimate practice of medicine. Indeed, Sir Malcolm Delevingne, the lead official in the Home Office on drug issues at the time, sought "an authoritative statement" from the Ministry of Health to this effect. Delevingne's position was that the ongoing "prescription of narcotics 'without any attempt to treat the patient for the purpose of breaking off the habit, [was] not legitimate, and [could not] be recognised as medical practice. As it happens, the Ministry of Health did not provide Delevingne with the needed support for this view, and the British approach to narcotics and the treatment of addicts was set on a course distinct from that taken in America.

In part, the decision not to follow the United States in prohibiting the prescription of narcotics to addicts was due to the widely held view that the American approach had produced significant negative consequences. Writing in a professional journal in 1923, one English physician who had visited the United States reported unfavorably on the moral opprobrium that had attached to addiction and observed:

In consequence of this stringent law . . . the country is overrun by an army of pedlars who extort exorbitant prices from their hapless victims. It appears that not only has the Harrison Law failed to diminish the number of drug takers—some contend, indeed, that it has increased their numbers—but, far from bettering the lot of the opiate addict, it has actually worsened it . . .  $^{356}$ 

In addition, however, the decision to permit maintenance treatment for addiction was a testament to the very different role played by the medical profession in the development of drug policy in the United Kingdom as compared to the United States. The fact that Delevingne believed it necessary to obtain an authoritative opinion from officials in the Ministry of Health to proceed with his preferred policy is evidence of this difference. Further evidence is provided by the central role that physicians played in the subsequent development of British policy, particularly through the recommendations of a blue-ribbon committee of medical experts known as the Rolleston Committee, assembled to advise the Ministry of Health. The permitted in the subsequent of British policy is evidence of this difference.

<sup>351</sup> Id

<sup>352.</sup> Id. (internal quotation marks omitted).

<sup>353.</sup> Id.

<sup>354.</sup> See id.

<sup>355.</sup> See id. at 17-18 (quoting 130 PARL. DEB., H.C. (5th ser.) (1920) 723-24 (U.K.)).

<sup>356.</sup> Harry Campbell, *The Pathology and Treatment of Morphia Addiction*, 20 BRIT. J. INEBRIETY 147, 150–51 (1923), *quoted in JUDSON*, *supra* note 342, at 18 (first omission in original). 357. *See* SCHUR, *supra* note 1, at 71.

equivalent panel of medical experts was not called upon to provide authoritative guidance to policymakers in the United States on the question of medical maintenance, and instead, the issue was resolved by officials in the Treasury Department and by decisions of the United States Supreme Court.<sup>358</sup> In Britain, by contrast, the arguments were put to Sir Humphry Rolleston, President of the Royal College of Physicians, and his medical colleagues who comprised the departmental advisory committee he chaired.<sup>359</sup>

The Rolleston Committee met for more than a year, held nearly two dozen meetings, and heard from numerous experts in the field. Delevingne's argument, in effect, was that a doctor's provision of narcotics to an addict had to be undertaken according to "a steady diminution of the dose, with a view to its ultimate complete discontinuance" to be therapeutic and, therefore, within the permissible limits of the regulations implementing the Dangerous Drugs Act. As one Home Office official put it, a maintenance regime that did not contemplate the ultimate withdrawal of the drug from the dependent patient was "evidence, *prima facie*, that the drugs were not being administered solely for the purposes of medical treatment." The Rolleston Committee rejected this view, anchoring its resolution of the question on the realistic conclusion that most addicts could not be "cured" by a complete withdrawal of drugs—even if withdrawal were accomplished gradually by reducing the dose incrementally over a fixed period—if "cure" meant that the patient would not likely relapse in the future. Sas

While the committee's relatively pessimistic assessment of the efficacy of withdrawal therapy as a complete cure led it to conclude that the legitimate provision of medical care could include small ongoing maintenance doses with no fixed termination point,<sup>364</sup> therapeutic pessimism was not the only factor that led Sir Rolleston and his colleagues to this conclusion. Unlike policymakers in the United States (and ultimately the American public generally), the Rolleston Committee did not see persons who were physically dependent on narcotics as

<sup>358.</sup> See supra text accompanying notes 140-58.

<sup>359.</sup> See BEAN, supra note 341, at 59; JUDSON, supra note 342, at 19.

<sup>360.</sup> See JUDSON supra note 342, at 19.

<sup>361.</sup> *Id.* at 20 (quoting ROLLESTON COMM. REPORT, *supra* note 3, at para. 13) (internal quotation marks omitted).

<sup>362.</sup> Id. at 20-21 (quoting ROLLESTON COMM. REPORT, supra note 3, at para. 13) (internal quotation marks omitted).

<sup>363.</sup> See SCHUR, supra note 1, at 78. The committee stated, "Relapse, sooner or later, appears to be the rule, and permanent cure the exception. With two exceptions, the most optimistic observers did not claim a higher percentage of lasting cures than from 15 to 20 per cent." *Id.* (quoting ROLLESTON COMMITTEE REPORT, supra note 3, at para. 43) (internal quotation marks omitted).

<sup>364.</sup> See JUDSON, supra note 342, at 21 (quoting ROLLESTON COMM. REPORT, supra note 3, at para. 18).

either inherently morally defective or as teleologically doomed. One historian of British drug policy explained the difference: in the United States the addict was "seen through the wrong end of the telescope, separated, distanced, and diminished, as though in the grip of a force, the drug itself, that relentlessly destroys his body and degrades his moral independence. He is seen as an automaton, winding down." The Rolleston Committee, on the other hand, believed that narcotics addicts were not necessarily "winding down, but stable—and stable more than in their daily dose, but socially stable, in their daily lives."

This notion of a stable addict was perhaps "the most durable contribution of the Rolleston Committee to the British approach to narcotics."<sup>368</sup> Until well into the 1960s, it informed official government policy on the legal treatment of addicts and shaped the practice of clinicians, regulators, and others in the United Kingdom. 369 The views of the Home Office on the prescription of narcotics to dependent persons were contained in a memorandum designed to inform doctors of the boundaries of legitimate medical practice.<sup>370</sup> The memo made clear that the provision of drugs to patients "solely for the gratification of addiction" would not be considered "medical need" for purposes of the strictures of the Dangerous Drugs Act.<sup>371</sup> It also raised concerns about the misuse of narcotics and about the potential for improper diversion, cautioning doctors that "[t]he supply or prescription of narcotics to any addict patient for self-administration is fraught with risks."<sup>372</sup> All the same, the memo made clear that doctors could legally prescribe heroin or other narcotics to patients, including patients who were physically dependent or addicted to these substances.<sup>373</sup> The key language, which came directly from the recommendations of the Rolleston Committee, was included in the Home Office's memorandum as an appendix:

[M]orphine or heroin may properly be administered to addicts in the following circumstances, namely, (a) where patients are under treatment by the gradual withdrawal method with a view to cure, (b) where it has been demonstrated, after a prolonged attempt at cure, that the use of the drug cannot be safely discontinued entirely, on account of the severity

<sup>365.</sup> See id. at 22.

<sup>366.</sup> *Id*.

<sup>367.</sup> *Id*.

<sup>368.</sup> *Id*.

<sup>369.</sup> See BEAN, supra note 341, at 70.

<sup>370.</sup> See Schur, supra note 1, at 75 (quoting Gr. Brit. Home Office, The Duties of Doctors & Dentists Under the Dangerous Drugs Act & Regulations 2 (6th ed., 1956)).

<sup>371.</sup> GR. BRIT. HOME OFFICE, THE DUTIES OF DOCTORS & DENTISTS UNDER THE DANGEROUS DRUGS ACT & REGULATIONS 2 (6th ed., 1956) [hereinafter HOME OFFICE], quoted in SCHUR. supra note 1. at 75.

<sup>372.</sup> Id. at 8.

<sup>373.</sup> See id. at 2-4.

of the withdrawal symptoms produced, (c) where it has been similarly demonstrated that the patient, while capable of leading a useful and relatively normal life when a certain minimum dose is regularly administered, becomes incapable of this when the drug is entirely discontinued.<sup>374</sup>

The government's position thus accorded physicians considerable discretion. They could make heroin, morphine, and other narcotics available to patients, including patients known to be addicted. They could prescribe these drugs in a course of gradually diminishing doses to withdraw an addict from drugs entirely, or they could choose to maintain a patient on a small stable dose indefinitely.<sup>3/5</sup> Notwithstanding this broad discretion, the Rolleston Committee, reflecting a certain unease with the practice, warned doctors to exercise special caution when providing care to new patients seeking narcotics, encouraged them to seek the opinion of a second doctor before doing so, and suggested providing the drugs in an amount sufficiently small that the chances of their being diverted between office visits would be minimized.<sup>376</sup> The committee also considered but chose not to recommend the adoption of procedures for the coerced treatment or institutionalization of persons addicted to narcotics.<sup>377</sup> Accordingly, specialized facilities for drug abuse treatment were neither recommended nor developed until many years later.<sup>378</sup> Finally, Rolleston and his committee colleagues reviewed proposals for a mandatory reporting requirement for physicians treating patients who were physically dependent on narcotics.<sup>379</sup> Once again, the committee ultimately decided not to endorse such a heavy-handed approach, preferring to leave the relationship between physician and addict somewhat less regulated than it otherwise might have been.<sup>380</sup>

On the other hand, a central registry of addicts was developed by officials in the Home Office and was maintained for many years, thus leading to the widely held misapprehension that all addicts in Britain were "registered" by the government.<sup>381</sup> Much of the information that comprised the registry came to the Home Office as a result of recordkeeping requirements that were set out in the Dangerous Drugs Act and subsequent drug control statutes for physicians, pharmacists, and others lawfully engaged in drug transactions.<sup>382</sup> For many

<sup>374.</sup> ROLLESTON COMM. REPORT, *supra* note 3, at para. 51, *as reprinted in* HOME OFFICE, *supra* note 371, at app. iv.

<sup>375.</sup> See id.

<sup>376.</sup> ROLLESTON COMM. REPORT, supra note 3, at paras. 53–54.

<sup>377.</sup> See BEAN, supra note 341, at 76.

<sup>378.</sup> See id. at 76-80.

<sup>379.</sup> See id. at 65.

<sup>380.</sup> See id.

<sup>381.</sup> See id. at 80.

<sup>382.</sup> See, e.g., Dangerous Drugs Act, 1951, 14 & 15 Geo. 6, c. 48, § 9(d) (U.K.) (requiring physicians who prescribe narcotics to keep records of such activity).

years, the "backbone" of the enforcement of these provisions was the periodic inspection of pharmacies ("chemists' shops") by local police officials. 383 Typically, a police officer or constable would visit a shop several times a year to "look for evidence of carelessness or fraud on the part of the chemist in maintaining his registers or in the handling of dangerous drug stocks." When inspectors noted the repeated and regular supply of narcotics to one individual, or if the name of a specific physician appeared with great frequency, the local inspectors would forward this information to the Home Office, which by the 1930s had established a "Drugs Branch" to keep track of such reports. 385 Occasionally, the forwarding of information would lead to a request for a "special inquiry" by a regional medical officer, who would seek confirmation from the prescribing physician that the drug was necessary for "legitimate therapeutic reasons." In this fashion, and through the voluntary reporting of some doctors who treated addicts, the Drugs Branch over time developed a fairly comprehensive listing of addicted patients who were receiving treatment from physicians within the United Kingdom. 387

No suggestion was made, however, that an inquiry by a regional medical officer was ever intended to place pressure on a doctor to reduce the dose of narcotics that he or she provided to a patient below that which he or she believed was medically necessary. American medical observers of the British system in 1960 reported that "[p]hysicians are not required by law to give information to, accept the advice of, or cooperate with the regional medical officer in the handling of a narcotic addiction problem in one of his own patients (or his own addiction for that matter)." In this sense, the British approach in the midtwentieth century was dramatically unlike that in the United States. Rufus King captured this difference by explaining that "the British medical profession is in full and virtually unchallenged control of the distribution of drugs, and this includes distribution, by prescription or administration, to addicts when necessary. The police function is to aid and protect medical control, rather than to substitute for it."

From the 1930s through the 1960s both the number of persons in Britain receiving narcotics maintenance therapy from physicians and the number of doctors providing that treatment remained small and stable.<sup>391</sup> It appears that a

<sup>383.</sup> Larimore & Brill, supra note 17, at 110.

<sup>384.</sup> *Id*.

<sup>385.</sup> See JUDSON, supra note 342, at 24; Larimore & Brill, supra note 17, at 110.

<sup>386.</sup> Larimore & Brill, supra note 17, at 110.

<sup>387.</sup> See id. at 111.

<sup>388.</sup> See SCHUR, supra note 1, at 73-74 (quoting King, supra note 342, at 129).

<sup>389.</sup> Larimore & Brill, supra note 17, at 111.

<sup>390.</sup> King, supra note 342, at 127.

<sup>391.</sup> Cf. BEAN, supra note 341, at 78–79 (noting that "[i]n 1961, there were 470 known addicts" and chronicling the increase in addicts during the 1960s, 1970s, and 1980s).

number of British doctors chose not to treat addicts at all, feeling that these patients should be seen by psychiatrists or others with special expertise in the treatment of narcotics dependency.<sup>392</sup> Some general practitioners may have mistakenly believed that they were not permitted to treat persons suffering from addiction and refused them care on that basis, while others avoided such patients out of "personal distaste."<sup>393</sup> Among those physicians who did treat narcotics addicts, most sought to move the patient ultimately to withdrawal by making an effort to reduce the prescribed dose gradually.<sup>394</sup> Thus, it was "probably only the exceptional case in which the doctor [concluded that the patient was] incurable and therefore [was] willing to sustain him with a regular dose of narcotics."<sup>395</sup>

The Drugs Branch's index of known addicts took a characteristically British bureaucratic form. One commentator, writing in the early 1970s, described it thus:

The index is maintained by five government clerks in a cluttered room, and is nothing more prepossessing than six stacks of card files, two of them newer than the others, set on corners of a desk and a table. Each addict's card shows at least his name, his aliases (if any) and address (if known), his age and physical description, the drugs he has been reported to take, when he started taking them, and where and when he was first reported.<sup>396</sup>

What was remarkable about the index, in addition to its informality (especially when contrasted with the extraordinarily more complex and well-funded drug control bureaucracy that had been established in the United States), was the small size of the population it tracked. In the mid-1930s, a little over six hundred addicts were listed, although the overwhelming majority (nine out of ten) were morphine addicts and only "one in twenty was addicted to heroin." Virtually all had become dependent as a consequence of medical treatment for some other organic disease (therapeutic addiction) or were medical professionals. Half were women and most were middle-aged or older. By

<sup>392.</sup> See SCHUR, supra note 1, at 149.

<sup>393.</sup> See id.

<sup>394.</sup> Id. at 148-49.

<sup>395.</sup> *Id.* at 148. Apparently, however, when the process of gradual withdrawal reached a point of sufficient discomfort, some patients sought to "make new arrangements" with a different physician. *Id.* at 149–150. For many decades in Britain there was virtually no illegal market in narcotics, but to the extent that some small amount of illegal drug sharing did take place, it tended to be concentrated among patients who were "between doctors." *Id.* at 150 (internal quotation marks omitted).

<sup>396.</sup> JUDSON supra note 342, at 25.

<sup>397.</sup> Id.

<sup>398.</sup> See id. at 25.

1950, the total number of addicts listed had fallen to 306, 400 and by 1957, according to a report submitted by Britain to the United Nations Division of Narcotics Drugs, the index contained 359 addicts, 149 of whom were addicted to morphine and 52 to heroin. 401 "About 75 of the reported addicts [were] physicians, dentists, . . . pharmacists," or other healthcare professionals. 402 Only 45 of the 359 persons on the list were identified as "nontherapeutic" addicts.

In the late 1950s and early 1960s, the number of "nontherapeutic" addicts in the United Kingdom began to increase. This small but perceptible change (from 45 persons in 1957 to 72 in 1960 to 112 by 1961) worried some observers and contributed to a decision by the government to appoint a new advisory committee to review the policies derived from the Rolleston Committee's recommendations of nearly three decades earlier, which were still the foundation of the British approach to narcotics addiction. The committee, which was chaired by a leading British physician, Sir Russell Brain, concluded initially that the status quo was acceptable and that the policies that had been forged by the Rolleston Committee were still serviceable. In particular, the committee found that there was "no cause to fear" that a substantial and sustained increase in the number of addicts was likely, or that individual physicians were incapable of adequately treating those addicts who were known to the Home Office. Little by little, however, the factual foundations of those

<sup>399.</sup> See id. "Often the addiction was a secret even from the addict's husband or wife. An addict was known as such only to his doctor, and to two civil servants and a clerk." *Id.* (internal quotation marks omitted).

<sup>400.</sup> Id. at 37.

<sup>401.</sup> See Larimore & Brill, supra note 17, at 111.

<sup>402.</sup> Id. at 111-12.

<sup>403.</sup> JUDSON, *supra* note 342, at 37. Indeed, there were so few heroin addicts "whose addiction was not an accidental result of medical treatment or who were not themselves doctors or nurses" that one official in the Home Office, H.B. (Bing) Spear, knew most of them personally. *Id.* at 26–27. It is said that in the 1960s,

when a doctor with a new case telephoned him, Spear would listen to the physical description, ask a couple of questions, and identify the addict, giving his real name, his previous physician, the size of his usual prescription, the particular group of addicts he belonged to, where he lived, and, often the girl he was living with and the person who had given him his first shot of heroin.

Id. at 27.

<sup>404.</sup> See id. at 37.

<sup>105.</sup> *Id*.

<sup>406.</sup> BEAN, *supra* note 341, at 74–75. For a portion of the government's charge to this new committee, see *id.* at 74 (quoting INTERDEPARTMENTAL COMM. ON DRUG ADDICTION, MINISTRY OF HEALTH, DRUG ADDICTION: REPORT OF THE INTERDEPARTMENTAL COMMITTEE 3 (1961) [hereinafter INTERDEPARTMENTAL COMM. ON DRUG ADDICTION].

<sup>407.</sup> See JUDSON supra note 342, at 35.

<sup>408.</sup> *Id.* (internal quotation marks omitted); *see also* SCHUR, *supra* note 1, at 162–64 (quoting INTERDEPARTMENTAL COMM. ON DRUG ADDICTION, *supra* note 406, at 16–18) (setting out the twenty specific findings of the committee).

optimistic conclusions began to erode. The objective public data made clear that narcotics misuse and addiction were growing at an accelerating rate. By 1964, 329 "nontherapeutic" addicts were listed on the index, and by 1966 the number increased to 885. Equally important, the system of relying on individual physicians to treat—and in many cases medically maintain—what had been a stable population of addicts was itself overwhelmed by growing numbers and changed circumstances:

[T]he prescription system, which in the past had always kept the heroin supply in balance with the demand, so that a black market had nothing to feed on, had now become the only source of heroin for a black market so virulent that over one stretch the number of heroin addicts on the Home Office index was doubling every sixteen months.<sup>410</sup>

This steady growth in both the number of "nontherapeutic" addicts and in a secondary illegal market for narcotics led the experts in the Drugs Branch of the Home Office and many physicians to conclude that significant changes to the system were required. The Brain Committee was pressed back into service and in 1965 recommended the creation of a system of specialized clinics for the treatment of narcotics addiction. Along with the creation of this new clinic system, the committee recommended that general practitioners and other physicians outside of the clinics not be permitted to prescribe narcotics to addicts as maintenance treatment, and for the first time, they endorsed a rule that doctors be obligated to report new cases of addiction to the Home Office. Although the new specialized treatment facilities could have been created relatively quickly by officials within the National Health Service, they were not established until early 1968. Parliament eventually passed legislation adopting the Brain Committee's recommendations with respect to mandatory physician reporting of new cases and the limitation on individual doctors prescribing narcotics to

<sup>409.</sup> JUDSON, supra note 342, at 43.

<sup>410.</sup> *Id.* at 38. Reports from the period suggest that perhaps as few as a dozen "prescribing doctors" were the source of the diverted narcotics. *Id.* at 39 (internal quotation marks omitted). A few apparently sold prescriptions for cash, one was a "compulsive gambler," and another was mentally ill. *Id.* at 39–40. A few were "dedicated physicians attempting to treat patients that most doctors refused to touch." *Id.* at 40.

<sup>411.</sup> See id. at 51-54.

<sup>412.</sup> See Rufus King, The Drug Hang-Up: America's Fifty-Year Folly 204-05 (1972).

<sup>413.</sup> See JUDSON, supra note 342, at 56–57. Judson suggests that these changes to British medical practice were the result of a "consensus" that had been reached "more outside the Brain Committee's meetings than in" and that the "medical profession had badly failed to discipline itself." Id. at 55. Interestingly, Bing Spear of the Drugs Branch had testified before the Committee in favor of less radical changes that would have permitted general practitioners to continue treating a limited number of dependent patients. See id. at 54–55. In the end, the committee, although it "cleared the medical profession in general of blame," went further and adopted the changes that it asserted "the medical profession had already agreed were necessary." Id. at 56–57.

<sup>414.</sup> See id. at 57-59.

addicts. 415 With these pieces in place, a period of transition in British drug policy began that would last for another fifteen years.

During this transition period the total "number of 'addicts notified to the Home Office" continued to increase, so that by 1976 the figure was slightly less than 2,000 persons. 416 Although this was a dramatic increase from the relatively small-sized addict population measured by the Home Office from the 1930s through the late 1950s, 417 it was nothing like the explosion that was to follow. In fact, in each of the five-year periods following 1976, the number of reported addicts in the United Kingdom doubled, and by 1996 the list contained more than 40,000 persons known to be addicted to narcotics. 418 By the mid-1980s, these alarming numbers combined with other political and social dynamics to produce a fundamental shift in British drug policy. But the rate of increase in the late 1960s and 1970s was sufficiently gradual, and the surrounding policy context sufficiently resilient, that the new clinic system put into place in 1968 could be seen more as a modification of the Rolleston Committee's approach than as a sharp departure from what had come before. One observer of the scene in both the United States and Britain in the late 1960s observed in the British Medical Journal that "40 years of punishing the addict" had not served America well. 419 "[It] still has a large drug-addiction rate," he explained, "a wellestablished black market, and an addict population which is forced into varieties of criminality." <sup>420</sup> By contrast, the author argued:

The growing rate of drug addiction in Britain has forced revision of the law, but the underlying philosophy which guides the British approach remains unaltered: the thesis was and is that the interests of treatment and prevention are best served by regarding the addict as a patient, by giving him heroin if he so demands, by wooing him rather than coercing him into treatment, and by keeping addiction above ground rather than by driving it into the criminal underworld. 421

Each of these features continued to inform practice in the United Kingdom throughout the transition period. 422 Nevertheless, a number of broader

<sup>415.</sup> See id. at 57. Thus, "[c]ompulsory notification of new cases was to begin February 22. Prescribing of heroin and cocaine by general practitioners was to stop on April 16." *Id.* at 59.

<sup>416.</sup> Reuter & Stevens, supra note 299, at 463, 464 fig.2.

<sup>417.</sup> See JUDSON, supra note 342, at 37.

<sup>418.</sup> Reuter & Stevens, supra note 299, at 463, 464 fig.2.

<sup>419.</sup> Griffith Edwards, Relevance of American Experience of Narcotic Addiction to the British Scene, 3 Brit. Med. J. 425, 426 (1967).

<sup>420.</sup> Id.

<sup>421.</sup> Id. at 428 (citation omitted).

<sup>422.</sup> Although the use of heroin in maintenance treatment was replaced in great measure with methadone, even this modification was undertaken according to the discretionary judgment of doctors in the clinics and not as the result of a decision made by political officials. *See* James L.

developments took place during this period that ultimately set the stage for more fundamental changes to come, the first of which was the spread of narcotics misuse beyond London. 423 Historically, the problem of drug addiction in Britain had been limited essentially to London and its immediately surrounding areas. 424 By the end of the 1970s, however, a number of other regions had experienced a dramatic increase in the incidence of addiction, with especially significant spikes in heroin use observed by public health officials in Manchester and Glasgow. 425 A second development during this period was a shift in the way that illicit drugs, particularly heroin, found their way into the marketplace. Prior to the mid-1970s, "most of the heroin used by addicts [had been] legally produced and prescribed, [even] if illegally traded, between users." By the early 1980s, however, "an influx of heroin into Britain following the Iranian Revolution" had not only led to the creation of a black market but also had driven down the cost of the drug for users. 427 A third factor that contributed to fundamental changes in the 1980s involved modifications adopted over time by the doctors who provided treatment in the clinics or "Drug Dependence Units" (DDUs) that had been created following the Brain Committee's final report. 428 These physicians, especially the psychiatrists who staffed the London DDUs, had moved from a treatment philosophy that emphasized long-term maintenance therapy to one that relied on "a rapidly reducing course of oral methadone, with an ultimate focus on abstinence." This shift came not as a result of a formal change in the government's policy toward the treatment of addiction, but as a pragmatic decision by these clinicians in order to free up needed treatment slots. 43

The combined result of each of these changing circumstances was that by the 1980s, for the first time, a significant number of addicts throughout the United Kingdom were using narcotics outside of the context of medical supervision and treatment. The spread of the drug problem beyond London was important because sixteen of the twenty-two DDUs were located in the Thames region, mostly in London. As the incidence of addiction increased in locations removed from this concentration of medical treatment facilities, a greater percentage of users functioned outside of the clinic system. The adoption

Nolan, Jr., Separated by an Uncommon Law: Drug Courts in Great Britain and America, in DRUG COURTS: IN THEORY AND IN PRACTICE 89, 95 (James L. Nolan, Jr. ed., 2002).

<sup>423.</sup> See Alex Mold & Virginia Berridge, Crisis and Opportunity in Drug Policy: Changing the Direction of British Drug Services in the 1980s, 19 J. POL'Y HIST. 29, 32 (2007).

<sup>424.</sup> See id.

<sup>425.</sup> See id.

<sup>426.</sup> *Id*.

<sup>427.</sup> *Id*.

<sup>428.</sup> See id. at 33.

<sup>429.</sup> Id. at 34 (internal quotation marks omitted).

<sup>430.</sup> See id.

<sup>431.</sup> See id. at 32.

<sup>432.</sup> Id. at 39.

of an abstinence-based methadone withdrawal approach to treatment within the DDUs also drove many addicts away from the clinics both because it was more comfortable and easier for users to obtain relatively inexpensive heroin in the expanding black market and because the almost exclusive focus on opiate addiction in the DDUs did not match the growing "poly-drug" use of addicts. All of these trends ultimately were important in helping to produce a significant reformulation of British drug policy in the 1980s from a purely medical model to one that viewed narcotics abuse and addiction as a public health problem, a social welfare problem, and eventually a problem of crime control. 434

During this period of transition, the political significance of narcotics misuse and addiction also evolved. At the time of the Brain Committee's first examination of British policy, it was possible for observers to say that there was "little relationship between crime and narcotic addiction in England." Perhaps as a consequence of that fact, the problem of drug abuse was not "a front-rank social problem" for members of Parliament, and the public showed less concern about drug addiction than about a great variety of other social issues, such as cruelty to children or animals. In addition, the class and race/ethnicity distribution of British heroin addiction throughout most of the 1960s and 1970s was quite unlike that in the United States. 437 Although several British cities had large concentrations of relatively poor immigrants-including communities of Indians, Bengalis, and Pakistanis—most narcotics users during this period were middle class and white. 438 Thus, it was more difficult to argue, as some did in the United States, that drug abuse was essentially a problem of marginal or "outsider" groups. <sup>439</sup> As the problem of drug addiction spread to new groups and to new regions in the United Kingdom, and as the black market in heroin and other drugs necessarily linked drug users with criminal activity, the political discourse shifted from a narrative about disease to one about social risk and deviance, and the overall saliency of the issue in the media and in the public's mind also increased.440

But the constellation of forces that drove the revision of British drug policy in the 1980s away from a predominately medical model and toward a broader multidisciplinary social welfare approach also included larger political dynamics

<sup>433.</sup> See id. at 34 (internal quotation marks omitted).

<sup>434.</sup> See Seddon et al., supra note 19, at 825.

<sup>435.</sup> Larimore & Brill, supra note 17, at 112.

<sup>436.</sup> JUDSON supra note 342, at 54 (internal quotation marks omitted).

<sup>437.</sup> See id. at 47.

<sup>438.</sup> Id. at 47-48.

<sup>439.</sup> See MUSTO, THE AMERICAN DISEASE, supra note 56, at 236–37.

<sup>440.</sup> See Mold & Berridge, supra note 423, at 29–31. Alex Stevens argues that public discourse about drugs "plays a part in the 'othering' of the poor, who must be seen as deviant rather than unfortunate or oppressed if they are to be punished for their poverty." Alex Stevens, When Two Dark Figures Collide: Evidence and Discourse on Drug-Related Crime, 27 CRITICAL Soc. PoL'Y 77, 90 (2007).

characteristic of conservative welfare policy more generally in the government of Prime Minister Margaret Thatcher. Indeed, keen students of this period have argued that these changes reflected the Thatcher government's overall strategy of turning the government from a "provider" to a "purchaser" of social welfare services. His larger move to replace "welfare statism" with "welfare pluralism" met with mixed success in a variety of areas, but it had a clear impact in helping to reconfigure the way that drug abuse treatment services in the United Kingdom were conceived, funded, and deployed from the mid-1980s forward. Helping to reconceived, funded, and deployed from the mid-1980s forward.

In particular, this shift in the way the problem was framed and responses were developed can be traced to a decision by the Thatcher government to fund a multi-year program to provide community-based services for dealing with the problem of drug abuse. The program, which was known as the Central Funding Initiative (CFI), made a total of £17.5 million available between 1983 and 1989 to both governmental and voluntary organizations. Although eighteen percent of these funds went to DDUs and other hospital-based services for the treatment of drug addiction, nearly half of the money was allocated to "community-based walk-in centers," and another twenty percent went to "multidisciplinary community drug [treatment] teams." The CFI funders made clear that this reallocation of financial support away from traditional medical treatment providers reflected the government's view that community-based groups and voluntary organizations had greater "expertise, in terms of prevention and counselling" than did the physicians in the National Health Service and were "more flexible" in the services they provided.

In addition to operationalizing a preference for volunteer organizations and community-based multidisciplinary teams over traditional clinic and hospital-based National Health Service doctors, the program also involved a transition to a "new risk-based strategy for the governance of the 'drug problem." This involved a change not only in the allocation of financial resources but also in terminology and in methodology. Thus, policymakers began to refer to persons who misused drugs as "problem drug takers" rather than addicts, <sup>448</sup> and introduced a new emphasis on evaluation, accountability, and the use of social science evidence as the basis for drug policy.

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441. Mold & Berridge, supra note 423, at 42.
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<sup>442.</sup> See id. at 41–42 (internal quotation marks omitted).

<sup>443.</sup> See id. at 37.

<sup>444.</sup> Id.

<sup>445.</sup> Id. at 39.

<sup>446.</sup> Id. at 40 (internal quotation marks omitted).

<sup>447.</sup> Seddon et al., supra note 19, at 824.

<sup>448.</sup> See Mold & Berridge, supra note 423, at 39 (internal quotation marks omitted).

<sup>449.</sup> See id. at 41.

The move away from a pure medical model and the involvement of a "new policy community" concerned with drugs and addiction was critical in shaping Britain's response to the next important development in the history of drug policy in the United Kingdom—the spread of HIV infection in the late 1980s and the onset of AIDS. 450 A broad coalition of public health officials, voluntary organizations working together through an umbrella group known as the Standing Conference on Drug Abuse (SCODA), and experts from the Advisory Council on the Misuse of Drugs (ACMD), which had been established in the 1971 Misuse of Drugs Act to provide advice to the government "on measures to prevent and deal with the social problems arising from the misuse of drugs,"451 had already begun to reframe drug policy as a matter of risk assessment and harm minimization. 452 But given the particular impact of the AIDS epidemic on IV drug users, and increased mortality from the transmission of HIV infection between drug users and through their sexual partners into the broader population, it was only natural that both the policy discourse and the concrete measures that were developed to deal with this crisis, including increased funding for "opiate substitution treatment," were explicitly framed as public health responses designed to reduce the harm occasioned by the misuse of drugs. <sup>453</sup> A number of these interventions, including, for example, an extensive syringe exchange program, were institutionalized through a "national system that bypassed the DDUs."454 Thus, although the traditional clinic system that had emerged out of the Brain Committee's report and that traced its origins to the British system and the Rolleston Committee's recommendations remained as one component in a growing array of resources available for dealing with addiction, a transformation had taken place in the nature of the "liberal pragmatism" that long had characterized British drug policy. 455

The success of these harm-reduction efforts in slowing the spread of HIV infection among IV drug users and the reduced mortality brought about by the introduction of anti-retroviral medications helped to change the HIV/AIDS crisis

<sup>450.</sup> See id. at 43.

<sup>451.</sup> Id. at 35 (internal quotation marks omitted).

<sup>452.</sup> See Seddon et al., supra note 19, at 825 ("Mugford argues that the new focus on drug-related harms should be understood in the wider context of the ascendance of risk thinking in the last quarter of the twentieth century. Indeed, in its early days, the terms 'harm reduction' and 'risk reduction' were often interchanged. Building on Mugford's thesis, Pat O'Malley has also argued that there is a close affinity between the concepts of 'harm' and 'risk' in the government of drug users." (citations omitted) (citing PAT O'MALLEY, RISK, UNCERTAINTY, AND GOVERNMENT 155–71 (2004))); R. Newcombe, The Reduction of Drug-Related Harm: A Conceptual Framework for Theory, Practice and Research, in THE REDUCTION OF DRUG-RELATED HARM 1, 2 (P. O'Hare et al. eds., 1992); Stephen Mugford, Social Change and the Control of Psychotropic Drugs—Risk Management, Harm Reduction, and "Postmodernity," 12 DRUG & ALCOHOL REV. 369, 369–75 (1993)).

<sup>453.</sup> See Stevens, supra note 440, at 87.

<sup>454.</sup> Mold & Berridge, supra note 423, at 43.

<sup>455.</sup> See Seddon et al., supra note 19, at 818.

from an acute public health emergency to a lower intensity (at least in the public's mind) chronic problem. By the mid-1990s, as the health consequences of drug misuse "lost some of their discursive impact," a new narrative linking drugs with crime emerged in media discussions and in policy analyses in the United Kingdom. This new narrative was introduced by the Conservative Government in 1995 with the publication of its national drugs strategy, entitled *Tackling Drugs Together*. This document carried over the pragmatic harm-minimization perspective that had dominated drug policy in Britain since the early 1980s, but it now elevated the problem of "drug-related crime" to the head of the list of harms associated with the misuse of drugs. The statement of purpose contained in the 1995 strategy endorsed "vigorous law enforcement, accessible treatment and a new emphasis on education and prevention" in order to protect communities, safeguard young people, and promote public health. Importantly, pursuant to this strategy, the Prison Service introduced the first mandatory drug testing procedures adopted by the British government.

In the run up to the 1997 national elections, the Labour Party adopted this new narrative linking drugs and crime and put out a policy piece, Breaking the Vicious Circle, that further developed the themes set out in Tackling Drugs Together. 462 Upon their victory in 1997, Labour officials chose to intensify both the rhetoric and the policy innovations suggested by the prior government's strategy. 463 Their 1998 drugs strategy, Tackling Drugs to Build a Better Britain, once again emphasized the importance of "criminal justice involvement in drugs issues" and proposed even more resources for treatment, prevention, and education. 464 A crucial component of the New Labour approach to drug policy was the development of Drug Treatment and Testing Orders (DTTOs), probation-based court orders that contained two features, drug testing and coerced drug treatment, and that were to become increasingly important to the overall approach to drugs pursued by the Labour government. 465 Pursuant to the 1998 Crime and Disorder Act, three DTTO pilot programs were established, in Gloucestershire, Liverpool, and South London. The DTTOs, which were directed at drug-using offenders with prior involvement in the criminal system,

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456. See Stevens, supra note 440, at 77, 87.
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<sup>457.</sup> See id. at 87.

<sup>458.</sup> TACKLING DRUGS TOGETHER: A STRATEGY FOR ENGLAND 1995–1998 (1995).

<sup>459.</sup> Id. at 1.

<sup>460.</sup> Id.

<sup>461.</sup> Duke, supra note 19, at 410.

<sup>462.</sup> See id.

<sup>463.</sup> See id. at 410-11.

<sup>464.</sup> Id. at 411.

<sup>465.</sup> See id. (citing Tackling Drugs to Build a Better Britain: The Government's Ten Year Strategy for Tackling Drugs Misuse (1998)).

<sup>466.</sup> NOLAN, supra note 19, at 45.

were deemed to be a success, and by the middle of 2000 the government had allocated an additional "£60 million to roll out DTTOs in all forty-two of Britain's probation services."

The "criminalization" of British drug policy accelerated in the early years of the next decade. The Criminal Justice and Courts Services Act of 2000 broadened the class of offenders who could be tested for narcotics to include defendants charged with "trigger offenses" (mostly property crimes and drugs offenses) and "those under probation service supervision." And in 2001, lead responsibility for drug policy was transferred back from the Department of Health to the Home Office. In its updated drugs strategy, published in 2002, the government proposed increased funding and enhanced emphasis on providing drug testing and treatment to offenders at every stage of the criminal justice system, from arrest and bail through sentencing and imprisonment or community supervision. This initiative, the Drug Interventions Programme (DIP), was extended even further in the 2005 Drugs Act, which "introduced further testing powers on arrest and mandatory drug assessments for positive tests."

If there was little relationship between street crime and drug addiction at the time of the Brain Committee's investigations, 472 the central premise of the new policy, well established by the start of the millennium, was that a great deal of crime in the United Kingdom is caused by an identifiable number of offenders who are "problem drug users." This core premise, that there was (and is) a "direct and simple relationship between drugs and crime," was based on several assumptions of questionable empirical veracity, and led to a fundamental policy prescription that also was founded on a contested proposition. The category of "problem drug users" has been understood throughout to be made up almost entirely of users of heroin and crack cocaine. Those who misuse alcohol have not generally been included in this grouping and have not been targeted in either the government's strategies or in new legislation, "despite much stronger evidence of an association with a variety of serious and violent

<sup>467.</sup> Id.

<sup>468.</sup> Duke, *supra* note 19, at 411.

<sup>469.</sup> Stevens, supra note 440, at 87-88.

<sup>470.</sup> See Gr. Brit. Home Office, Updated Drug Strategy 4 (2002) [hereinafter Updated Drug Strategy].

<sup>471.</sup> Duke, *supra* note 19, at 411–12; *see also* Seddon et al., *supra* note 19, at 819 ("[DIP is] an ambitious initiative which aimed to coordinate treatment provision more effectively by working across the criminal justice system and providing an 'end-to-end' service for individuals. Under the banner 'out of crime, into treatment,' DIP has become a major policy programme in which central government has invested over £500 million in its first four years of operation.").

<sup>472.</sup> See supra text accompanying note 435.

<sup>473.</sup> Duke, supra note 19, at 413.

<sup>474.</sup> Id.

<sup>475.</sup> See Seddon et al., supra note 19, at 818.

crimes."<sup>476</sup> Further, the drug users who are "problem users" in this narrative are those thought to be involved disproportionately in "acquisitive offending," offenses undertaken "in order to feed their habit."<sup>477</sup> Thus, the criminal offenses that are taken to be caused in such great measure by narcotics misuse are what the British government has called "volume" crimes, such as "thefts from shops and cars, assaults, burglaries, robberies and minor frauds."<sup>478</sup> Excluded from this group are other serious crimes—including "domestic violence, sexual assaults and major frauds"—which the government generally does not characterize as linked causally to drug misuse.

Given this construction of the category of "problem drug users," the animating objective of British drug policy has been to get offenders "out of crime and into treatment." The notion has been that offenders who misuse heroin and crack cocaine cause an enormous amount of social harm in the form of volume crimes, that the criminal justice system is a suitable site for undertaking the screening and treatment of these offending substance abusers, that this mandatory testing and treatment is likely to be effective in reducing drug misuse and addiction, and that these positive clinical outcomes are likely to translate into reduced rates of criminal re-offending. This series of related ideas has supported the development and expansion of schemes in which workers focused on drug testing and drug treatment have been relocated to police stations and criminal courthouses throughout Britain, and in which the incidence of court-ordered treatment for offenders under probation supervision has grown dramatically.

Each of the ideas embedded in this scheme is problematic. Alex Stevens has shown that the frequency with which the concept of drug-related crime was mentioned in the British press "increased by a factor of eight" over the course of the 1990s. Although for slightly different reasons, both Conservative members of Parliament and Labour members adopted the argument that at least half of all crime in the United Kingdom could be attributed in some fashion to drugs and drug addiction. Over time, the British government has "invested substantially" in research purporting to establish the connection between drug misuse and criminal offending, particularly in the form of "large-scale surveys"

<sup>476.</sup> Stevens, supra note 440, at 79.

<sup>477.</sup> Seddon et al., supra note 19, at 818 (internal citations omitted).

<sup>478.</sup> See Stevens, supra note 440, at 78.

<sup>479.</sup> *Id*.

<sup>480.</sup> Duke, supra note 19, at 413 (internal quotation marks omitted).

<sup>481.</sup> See Seddon et al., supra note 19, at 818-19 (citing UPDATED DRUG STRATEGY, supra note 470, at 4).

<sup>482.</sup> See id. In fact, the number of people who entered treatment pursuant to a court order increased from 1,886 in 1995 to 11,286 in 2006, while many more were referred to treatment after screening upon arrest. Reuter & Stevens, supra note 299, at 473.

<sup>483.</sup> Stevens, *supra* note 440, at 79.

<sup>484.</sup> See id. at 79.

of persons interviewed in police stations following arrest and other surveys of persons entering drug treatment. Notwithstanding the increased frequency with which the drugs-crime link has been invoked by politicians, its heightened presence in the public's consciousness, and the release of new data marshaled in support of this essential claim, the reality is that the relationship between drug abuse and addiction on the one hand and criminal activity on the other is more complex, less clearly causal, and less well-established than the dominant narrative would have it.

Stevens and his colleague Peter Reuter have argued that—in addition to complications stemming from the question of whether drug-related crime is caused directly by the "psycho-pharmacological effects" of illegal drugs, the systemic effects of "the operation of illegal markets" produced by drug prohibition policies, or both—there are a number of other problems with the basic claim of a correlation and/or causal relationship between drug misuse and criminal offending. 486 First, they point out that the claim that "drug motivated crime accounts for half of all crime,"487 which was included in a recently released Welsh drug strategy as well as numerous other reports and documents issued by the Prime Minister's drug policy team, is based on an extrapolation of data taken from the various British arrestee surveys funded by the government in recent years. 488 The problem with this data is that arrestees are not a representative sample of offenders. Indeed, "offenders who report drug use are about twice as likely to come into contact with the police, when other variables. . . are taken into account." Thus, there is almost certainly an overrepresentation of drug users among the population of persons who have been subject to police arrest, and an extrapolation from their patterns of use is likely to produce an exaggerated bottom-line conclusion about the percentage of crimes that drug users commit overall. 490

A second problem with the data relates particularly to the degree of criminal offending that patients report upon entering treatment. Here, the distortion comes from the fact that the criminal activity of drug users "tends to peak in the months preceding their entry to treatment." Thus, estimates of the total amount of crime committed by all drug users based on an extrapolation from the

<sup>485.</sup> See Seddon et al., supra note 19, at 820.

<sup>486.</sup> Reuter & Stevens, supra note 299, at 466.

<sup>487.</sup> *Id.* (quoting Welsh Assembly Gov't, Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008–2018, at 14 (2008)) (internal quotation marks omitted).

<sup>488.</sup> See id. (citing Prime Minister's Strategy Unit, No. 10 Strategy Unit Drugs Project, Phase 1 Report: Understanding the Issues 22 (2003); Welsh Assembly Gov't, Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008–2018 (2008)).

<sup>489.</sup> Id. at 467.

<sup>490.</sup> See id.

<sup>491.</sup> Stevens, supra note 440, at 81.

self-reports of users entering treatment are likely to result in a substantial overcounting of the amount of crime actually committed by this population. <sup>492</sup>

A final problem goes to the assertion of causality that is frequently included in the drugs-crime narrative. The assumption that has fueled the claim of causality derives from the simple observation that many people who engage in criminal activity also use drugs. But this "jump from correlation to causality" has not been established by the available data. Here, the studies paint a complex picture. Some drug users apparently do commit acquisitive crimes in order to pay for drugs, and some studies seem to indicate that "offending tends to peak during periods of frequent drug use." Studies also show, however, "that offending tends to precede drug use in the life course," and that, at least for some, the causal arrows may run in the opposite direction.

The claimed drugs-crime link is meant to support a drug strategy that targets drug-using offenders in the criminal system on the theory that forced testing and treatment of this group will dramatically reduce offending and produce safer communities. This formula assumes a rather simplistic conception of the relationship between drug use and crime that rests on uncertain empirical foundations, as detailed above, and that has been challenged by recent data tending to show that "socio-demographic variables—such as age, sex, employment status and school leaving age—may be more important than drug use in predicting some types of offending."<sup>496</sup> Even if the empirical basis for the connection between drugs and crime is established, however, there still may be problems with the strategy's reliance on drug testing across the criminal justice system and its use of coerced treatment. The programs of drug testing that began in the prisons in the 1990s and that were expanded through the DTTO initiative (now called Drug Rehabilitation Requirements or DRRs), 497 policies mandating the testing of arrested persons, and new requirements that drug testing be made a condition of parole, have not, taken on their own, necessarily been effective in reducing crime. In fact, "[t]here is no evidence that testing without effective treatment provision is successful in terms of deterring drug use and offending.<sup>3,498</sup> As for effective treatment, the most that responsibly can be asserted is that "drug treatment can lead to reductions in some types of offending

<sup>492.</sup> See id.

<sup>493.</sup> Id. at 82.

<sup>494.</sup> Reuter & Stevens, supra note 299, at 466.

<sup>495.</sup> *Id.* (citing Stephen Pudney, *The Road to Ruin? Sequences of Initiation into Drug Use and Offending by Many Young People in Britain, in GR. BRIT. HOME OFFICE*, HOME OFFICE RESEARCH STUDY 253, at v (2002)).

<sup>496.</sup> Id.

<sup>497.</sup> See id. at 472

<sup>498.</sup> Duke, *supra* note 19, at 412 (citing Alex Stevens et al., The Beckley Found. Drug Policy Programme, Reducing Drug Related Crime: An Overview of the Global Evidence 9 (2005)).

for some types of drug users." Offenders with co-occurring mental illnesses and those who are poly-drug users are especially difficult to treat, and the data does not conclusively support the conclusion that treatment effectively reduces their criminal involvement. There is reliable evidence that other drug users often do engage in less criminal behavior upon entry into treatment, and some research even suggests that these effects can persist over time, although at somewhat reduced rates. But overall, the cost-benefit claims made by proponents of the new drug policy likely are significantly exaggerated. In the end, the evidence suggests that drug policy, and particularly the decision to provide significant public funding for treatment, may have some effect on the amount of criminal conduct that drug users commit, but that it has a limited capacity to reduce the number of regular users of illegal drugs overall.

With respect to the frequently expressed claim that enforced treatment for drug misuse is as effective as voluntary treatment, 504 the low rate of program completion among offenders subject to DTTOs and their high rate of re-arrest and re-conviction raise legitimate questions about efficacy. 505 The government and others supporting the use of mandatory treatment frequently cite studies from the United States that show relatively successful outcomes for drug treatment court participants and others who have received coerced treatment, but at least one international literature review paints a somewhat different picture. 506 It reports that studies of the effectiveness of coerced drug treatment that have been published in French, German, Dutch, and Italian have "shown a greater range of outcomes" than do those published in English, 507 and suggests that success in treatment may depend significantly on participants' motivation and on their having been coerced to enter a program. 508

Regardless of the strength of its empirical foundations, there is no question that British drug policy in the first decade of the twenty-first century was fundamentally different than the approach to drugs and drug abuse that was followed for most of the twentieth century. There is some uncertainty, however,

<sup>499.</sup> Id. at 413.

<sup>500.</sup> See id.

<sup>501.</sup> See Michael Gossop et al., Reductions in Criminal Convictions After Addiction Treatment: 5-Year Follow-Up, 79 DRUG & ALCOHOL DEPENDENCE 295, 299 (2005).

<sup>502.</sup> See Reuter & Stevens, supra note 299, at 473.

<sup>503.</sup> See, e.g., id. at 474 ("We are quite pessimistic about the prospects of reducing drug use but believe that there are some possibilities of lowering associated crime.").

<sup>504.</sup> Karen Duke reports that the Labour Party has selectively used research to support the claim of a strong drug-crime link and the effectiveness of coerced treatment. *See* Duke, *supra* note 19, at 410–11.

<sup>505.</sup> See id. at 412-13.

<sup>506.</sup> See Alex Stevens et al., Quasi-Compulsory Treatment of Drug Dependent Offenders: An International Literature Review, 40 SUBSTANCE USE & MISUSE 269 (2005).

<sup>507.</sup> Id. at 277.

<sup>508.</sup> See id. at 274.

about where on the historical timeline this shift should be located and about how sharp this departure really was. From one point of view, the most radical shift in policy and in practice occurred during the 1980s, when the physician-dominated clinic system was overtaken by a broad-based social welfare approach that was deployed first to deal with a rapidly expanding narcotics problem and then to contain the harms posed by the spread of HIV infection among IV drug users and those with whom they came in contact. Those who hold this view see the transition from a public health focus in the 1980s to a criminal justice focus beginning in the 1990s as an evolutionary process within a larger pragmatic framework devoted to the management of social risk. 510 There is a competing perspective, though, which views the criminalization of British drug policy in the 1990s as a more fundamental rupture from the past.<sup>511</sup> Adherents of this view point out that even though the physicians in the DDUs lost some of their dominance in the 1980s, the harm-minimization policies of that period were still oriented toward managing the health risks of drugs and drug misuse (the objectives that had animated the British system from the time of the Rolleston Committee forward).<sup>512</sup> By contrast, they argue, by the late 1990s a concern for the health of drug users had been replaced by a far different policy objective: that of community safety and crime control. 513

The best historical account is likely to include elements from both of these perspectives. To be sure, the current approach to drugs and addiction is heavily focused on crime and on interventions situated in the criminal justice system that would have been markedly out of place in the United Kingdom as recently as the early 1980s. In fact, government officials and others who were influential in the development of British drug policy from the Rolleston Committee to the Brain Committee and beyond repeatedly considered and rejected calls for just the sort of mandatory testing and coerced treatment that is now the centerpiece of the government's Drug Interventions Programme and its overall approach to narcotics misuse. 514 On the other hand, even though drug policy is now viewed

<sup>509.</sup> See supra text accompanying notes 441-455.

<sup>510.</sup> For example, Tony Seddon and his colleagues have suggested:

<sup>[</sup>T]he shift in British drug policy is much better understood as a transition from the early 1980s onward[] to a new risk-based strategy for the governance of the 'drug problem.' In this emphasis on managing drug-related risks, there is in fact *continuity* in the policy approach that runs throughout this period from the 1980s.

Seddon et al., supra note 19, at 824.

<sup>511.</sup> See Duke, supra note 19, at 409.

<sup>512.</sup> See Mold & Berridge, supra note 423, at 37-41.

<sup>513.</sup> See generally Stevens, supra note 440, at 77 (noting that "[o]ver the last decade, there has been a radical transformation in drug policy in Britain" and describing the discourse associated with establishing a causal link between drugs and crime).

<sup>514.</sup> See Seddon et al., supra note 19, at 818 ("Indeed, some of the latest initiatives—for example, the establishment of drug testing of arrestees in police custody suites and the introduction of coerced drug treatment—would probably be profoundly shocking to a[] historical observer.").

through the lens of an asserted drugs-crime link, the British have placed a greater emphasis on treatment funding than have their counterparts in the United States. They have continued to invest in treatment, both rhetorically and in terms of the allocation of financial resources devoted to it, to a degree far in excess of that typical in the United States. Those responsible for the provision of treatment in Britain, both within the criminal justice system and more generally, have also been more explicitly oriented toward a harm-minimization perspective in defining the objectives of treatment than have their counterparts in the United States. Given this persistent pragmatism, it is entirely reasonable to conclude that the most fundamental changes in British policy and practice in recent years have not been "epochal," but instead have been "something new taking shape within and alongside the old arrangements." 517

## B. Underlying Cultural, Economic, and Political Factors That Have Contributed to the "Criminalization" of British Drug Policy

Whether one characterizes the criminalization of British drug policy as incremental or epochal change, it is clear that it represents something of an Americanization of the approach that previously had been in place. Meanwhile, recent events in the United States suggest that American drug policy may be taking a turn toward the more pragmatic stance that long has dominated thinking about drugs and drug control in the United Kingdom. Indeed, the Obama Administration has indicated its desire to move away from the rhetoric, and presumably some of the policies, of the "War on Drugs." However, before turning to a consideration of the ways in which drug policy in the United Kingdom and the United States have been converging, it is worth exploring the political and social dynamics that have contributed to the development of the current approach in Great Britain. This background may help to put the relative convergence of the two systems into context and elucidate the important ways in which they are likely to continue to differ.

Observers have pointed to two specific "social facts" as central to an understanding of how the drugs-crime link has come to dominate British discourse and public policy on narcotics and drug addiction. <sup>520</sup> Together, these

<sup>515.</sup> See infra text accompanying notes 569 and 634-642.

<sup>516.</sup> See NOLAN, supra note 19, at 58.

<sup>517.</sup> Seddon et al., *supra* note 19, at 821 (quoting NIKOLAS ROSE, POWERS OF FREEDOM: REFRAMING POLITICAL THOUGHT 173 (1999)) (internal quotation marks omitted).

<sup>518.</sup> See NOLAN, supra note 19, at 71-72.

<sup>519.</sup> See, e.g., Gary Fields, White House Czar Calls for End to "War on Drugs," WALL ST. J., May 14, 2009, at A3 ("The Obama administration's new drug czar says he wants to banish the idea that the U.S. is fighting 'a war on drugs,' a move that would underscore a shift favoring treatment over incarceration in trying to reduce illicit drug use.").

<sup>520.</sup> See, e.g., Seddon et al., supra note 19, at 821 ("[T]he dynamic of late modernity has changed patterns of drug use in such a way as to create a new drug policy predicament. This

two features of the contemporary social landscape are said to have created a "policy predicament" that has energized the development of a criminal justice focus by changing the political saliency of the risks thought to be associated with drug misuse. 521 The first "social fact" is the "normalization" over the past twenty years of drug-trying and "recreational drug use" in the United Kingdom, especially among young people. 522 The "normalization thesis" has been applied in particular by Howard Parker of the University of Manchester School of Law to show that the level of casual drug use and experimentation among young Britons has grown dramatically since the early 1990s, and increasingly has come to be regarded as "commonplace rather than exceptional" by young people across the categories of class, ethnicity, and gender.<sup>523</sup> There are several important "dimensions" to Parker's analysis, in addition to his observations about an overall increase in drug use by adolescents and other young people in the United Kingdom.<sup>524</sup> Perhaps most important is the data drawn from a number of longitudinal studies that show that "abstainers" (young people who have chosen not to use drugs) and "ex-users" (those who report that they have discontinued use) increasingly accept as commonplace and even "sensible" the recreational drug use of others with whom they are in close contact. 525 "There is thus a growing body of evidence that abstainers have friendship and 'going out' relationships with drug-using peers and respect, if sometimes reluctantly, their right to use certain drugs recreationally." 526 An additional dimension is the "cultural accommodation of recreational drug use" in the broader society, as demonstrated by its "ever more neutral and even positive" portrayal on television, in movies, and in other public media. 52'

predicament has its origins in two new social facts about the drug situation in the last two decades of the twentieth century: the normalization of youth drug experiences and the new heroin/crack problem.").

<sup>521.</sup> See id. at 819 (citing David Garland, Beyond the Culture of Control, CRITICAL REV. INT'L SOC. & POL. PHIL. 160, 171 (2004)).

<sup>522.</sup> See Howard Parker, Normalization as a Barometer: Recreational Drug Use and the Consumption of Leisure by Younger Britons, 13 ADDICTION RES. & THEORY 205, 205–06 (2005); Seddon et al., supra note 19, at 820. The normalization thesis is a sociological tool that has been used to study the way in which a wide variety of stigmatized groups, including, for example, people with learning disabilities, over time may become included in everyday life so that "their identities or behaviour become increasingly accommodated and perhaps eventually valued." Parker, supra, at 205.

<sup>523.</sup> See Parker, supra note 522, at 205–08; Seddon et al., supra note 19, at 821–22.

<sup>524.</sup> An important dimension is that illegal drugs, including cannabis, amphetamines, LSD, ecstasy, and cocaine, have become much more available and more easily accessible to ordinary casual users. See Parker, supra note 522, at 206.

<sup>525.</sup> See id. at 207 (internal quotation marks omitted).

<sup>526.</sup> Id. (citing MADSEN PIRIE & ROBERT M. WORCESTER, THE NEXT LEADERS? 35-36 (1999), available at http://www.adamsmith.org/images/uploads/publications/the-next-leaders.

<sup>527.</sup> Id. at 207-08.

A second "social fact" that has influenced the development of the new drug policy narrative in the United Kingdom is the profound increase in number and shift in the distribution of heroin users over the last guarter of the twentieth century. 528 As has already been noted, this increase in heroin use was linked to the creation and expansion of a British black market for heroin, which occurred in part as a result of geopolitical forces outside of the United Kingdom, most specifically the Iranian Revolution of 1979. 529 The general process of globalization within which this event took place has served to facilitate the processing, international shipping, and trafficking of drugs more broadly and has been "a key factor behind their greatly increased availability in Britain in recent decades."530 Globalization has also played a role in creating the social and economic dislocation that has especially impacted the "most deprived housing estates and neighbourhoods" in the United Kingdom where the "mainly young and unemployed" new users of heroin reside. 531 As this "problematic" drug use has grown in size and "become entangled with localized concentrations of multiple socio-economic deprivation,"532 it has emerged as the basis for new perceived social risks that have led to a demand for new policy responses from the central government. 533

The combination of the normalization of other casual or recreational drug use and the explosion and geographic spread of heroin use has formed a "dangerous political 'cocktail.'"<sup>534</sup> The normalization ingredient has contributed to a sense that drug use is pervasive and that drugs are everywhere. The expansion of an illegal market for heroin, the rapid growth in the number of persons who abuse this drug, and their concentration among the poor and marginal have all contributed to a public perception that drug addiction is dangerous, that it poses a threat to the stability and safety of communities, and that it is thus "deeply problematic." This "cocktail" emerged during a period in which both policymakers and the public were already well-accustomed to thinking and speaking about drug policy within a risk management and harmminimization framework. The Central Funding Initiative of the Thatcher years and the HIV-motivated drug policy activism later in the 1980s prepared the ground for politicians, the media, and others to begin addressing this new

<sup>528.</sup> See Mold & Berridge, supra note 423, at 31.

<sup>529.</sup> See supra text accompanying note 427.

<sup>530.</sup> Seddon et al., supra note 19, at 823.

<sup>531.</sup> See id. at 822 (citing GEOFFREY PEARSON, THE NEW HEROIN USERS 4 (1987)).

<sup>532.</sup> Id. at 820.

<sup>533.</sup> See id.

<sup>534.</sup> Id. at 824.

<sup>535.</sup> Id.

<sup>536.</sup> Id.

"cocktail" in terms of the new risks to communities that drugs were thought to present. 537

But determining which risks are the most pressing and which harms are the most important to minimize is a complex task involving considerable social and political negotiation. The fact that risk selection is an open and contested societal enterprise is inconsistent with a "realist' view [which] holds that risk selection is a neutral and rational process, involving an objective assessment of probabilities and of the scale of harms." Instead, good work both in anthropology and in legal scholarship has shown that societies actively "choose the classes of dangerous events and harms that [they] worry about," and that public debates about which risks governments should attend to and which harms they should seek to minimize are deeply normative.

In an important article entitled *The Collapse of the Harm Principle*, Bernard Harcourt shows that arguments based on the need to avoid harm have changed over time, and along the way their normative dimension has become more apparent. Originally the exclusive province of "progressives" or "liberals" concerned with limiting the reach of government enforcement efforts into activities that did not threaten harm to others, arguments about harm are now deployed both by those seeking to limit the reach of criminal enforcement and by those pushing for its expansion. Nominally, these competing harm-based arguments sound in consequentialist terms. Thus, in contemporary debates over the question of drug prohibition, advocates for strong criminal enforcement point to the negative consequences that drug abuse causes to individuals' health, to the stability of families, to economic productivity, and to community cohesion, while those seeking to limit prohibition policies cite the harms associated with enforcement efforts, including the direct and indirect costs imposed by the war on drugs.

At an earlier point, arguments about harm and about risk were exclusively consequentialist tools used against the effort of legal moralists to enlist the coercive power of the state to enforce a particular set of values or norms. 546

<sup>537.</sup> See id. at 825.

<sup>538.</sup> Id. at 826.

<sup>539.</sup> *Id.* (quoting Ian Hacking, *Risk and Dirt*, *in* RISK AND MORALITY 22, 22 (Richard V. Ericson & Aaron Doyle eds., 2003)) (internal quotation marks omitted).

<sup>540.</sup> See Harcourt, supra note 245, at 185.

<sup>541.</sup> See id. at 185-86.

<sup>542.</sup> This is the "harm principle" that has characterized libertarian thinking at least since Mill. See supra note 269.

<sup>543.</sup> See Harcourt, supra note 245, at 112–13.

<sup>544.</sup> See Bennett, supra note 254, at 1–2.

<sup>545.</sup> See Harcourt, supra note 245, at 175 (citing Ethan Nadelmann, Learning to Live With Drugs, WASH. POST, Nov. 2, 1999, at A21; Ethan A. Nadelmann, Perspective on Legalizing Drugs: Don't Get Carried Away, L.A. TIMES, Sept. 19, 1999, at M5).

<sup>546.</sup> See id. at 192-93.

Now, says Harcourt, the concern about minimizing harm runs in both directions, and this has changed how the arguments operate. S47 In particular, because both sides in policy debates now often make harm-based arguments, and because the harm principle on its face does not provide any guidance on how to weigh competing claims of harm, recourse must be had to other sources of social meaning to determine the comparative importance of identified harms and the comparative danger of potential risks. This recourse to normative considerations beyond the concrete consequentialist claims of the disputants necessarily leads back to a nonconsequentialist discourse. S49 As Harcourt puts it:

Once non-trivial harm arguments have been made, we inevitably must look beyond the harm principle. . . . We must access larger debates in ethics, law and politics—debates about power, autonomy, identity, human flourishing, equality, freedom and other interests and values *that give meaning to the claim that an identifiable harm matters*. <sup>550</sup>

The "debates beyond the harm principle" that Harcourt has in mind involve just the sort of social and political negotiation that cultural theorists of risk selection contemplate. This normative dimension has not, however, been made explicit. Instead, the move from "objective assessment of probabilities and of the scale of harms" to a subjective process of assembling a dominant "risk portfolio" according to a set of contested values and interests is neither acknowledged nor, for the most part, discussed by those engaged in the enterprise. If anything, the public conversation has become more concerned with social science data, with empiricism, and with insuring that policy decisions are "evidence based." Indeed, an important contribution of the Central Funding Initiative in the early 1980s was precisely this turn toward empiricism, to ensure that drug policy decisions were made on the basis of scientific evidence, careful assessment, and objective measurement of outcomes. 553

At the same time, though, it appears that the claims of the British government with respect to the link between drugs and crime have been "exaggerated," perhaps even reckless, and the "jump from correlation to causality" has been insufficiently supported by the available data. 555 An

<sup>547.</sup> See id. at 193.

<sup>548.</sup> See id.

<sup>549.</sup> This point is related to the analytic circularity discussed in Part II. See supra text accompanying notes 337–339.

<sup>550.</sup> Harcourt, supra note 245, at 183.

<sup>551.</sup> Seddon et al., supra note 19, at 826.

<sup>552.</sup> Id.

<sup>553.</sup> See Mold & Berridge, supra note 423, at 41, 43.

<sup>554.</sup> Stevens, supra note 440, at 78.

<sup>555.</sup> Id. at 82-83.

explanation for this apparent mismatch between the rhetoric of evidentiary rigor and the reality of a pattern of persistent empirical over-claiming may be found in work that seeks to show how "facts" find their way into policy discourse. This work demonstrates that evidence is strategically selected, assembled, and deployed by coalitions of advocates, government officials, and others who make up competing "discourse coalitions." In the case of British drug policy debates over the past ten or fifteen years, the broad universe of evidence that might have been treated as relevant to the formulation of strategies and initiatives has selectively been narrowed due to the formation and ultimate ascendancy of a discourse coalition that joined those with a health focus and those with a criminal justice focus. 557 As in the United States, the health narrative and the crime narrative often have been understood as inconsistent conceptions. In fact, however, they have coexisted and reinforced one another in recent years. It appears that the treatment community has joined the crime coalition in part because the central government's policy, which has included a commitment to expanding funding for drug treatment by more than 300% within a seven-year period, has funneled most of that money through the criminal justice system and has targeted drug-related offenders. 558 Thus. because the drugs-crime linkage has supported a policy that has "emphasized expenditure on drug treatment as an investment in crime reduction," those most concerned about the health consequences of drug misuse have found themselves in coalition with those inclined to stress the criminal justice aspects of drug policy. 559

The "structuration" of the drugs-crime discourse and its "institutionalization" in a variety of statutes and funding initiatives has tended to obscure a competing discourse and the attendant data upon which it relies. This alternative conception acknowledges a relationship between the misuse of drugs and criminal offending, but argues that causality between the two is more complex and likely mediated by a series of "underlying social factors, including inequality and deprivation, which produce both problematic drug use and

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<sup>556.</sup> See id. at 84–85 (quoting and citing Maarten A. Hajer, Discourse Coalitions and the Institutionalization of Practice: The Case of Acid Rain in Great Britain, in THE ARGUMENTATIVE TURN IN POLICY ANALYSIS AND PLANNING 43, 45–46 (Frank Fischer & John Forester eds., 1993)) (internal quotation marks omitted). In discussing the operation of "discourse coalitions" in the formulation of contemporary British drug policy, Alex Stevens uses the methodology of Maarten Hajer. Id. (internal quotation marks omitted). Hajer's basic point is that coalitions of individuals and groups who share a common conception or vision, and consequently, a common discourse, tend to compete in the public sphere with other coalitions that are organized around competing visions and discourses in order to accomplish what he terms "[d]iscourse structuration," which is a kind of conceptual dominance, and eventually "[d]iscourse institutionalization." Id. at 84 (quoting and citing Hajer, supra, at 45–46) (internal quotation marks omitted).

<sup>557.</sup> See id. at 92-93.

<sup>558.</sup> Id. at 88.

<sup>559.</sup> Id.

crime."<sup>560</sup> The predominance of the crime discourse over this alternative has led the ascendant coalition to "ignore methodological caveats and [to] present drugs as the major cause of crime."<sup>561</sup> It has also resulted in the institutionalization of that discourse in the form of mandatory drug testing regimes and the development of DTTOs and other coerced treatment requirements throughout the criminal justice system. <sup>562</sup>

## IV. THE INCOMPLETE CONVERGENCE OF DRUG POLICY IN THE UNITED STATES AND THE UNITED KINGDOM

The convergence of British and American approaches to drugs and drug misuse can be documented in a variety of ways. From the British side, two components of the government's policy have stood out over the past two decades as marking a significant departure from Britain's previously distinct past. First, as noted above, both Conservative and Labour Party leaders have shown an intensifying concern for what has been labeled "drug-related crime" and have identified the reduction of that kind of criminal conduct as "a central aim of drug policy."563 This evolving focus on criminal offending as the primary social risk posed by the misuse of drugs, and the relegation of other health-related concerns to a distinctly secondary position, has aligned the British approach both rhetorically and practically much more closely with that of the United States than had been the case for most of the twentieth century. The second component has been a move toward "the embedding of drug treatment within the criminal justice system."564 This commitment of substantial new resources devoted to drug screening and drug treatment of criminal offenders has led to "the construction of an entire infrastructure for drug interventions" in the various component parts of the criminal system, from police stations to courthouses to prisons. 565 Thus, just as the criminal justice system long has been the principal front in the United States assault on drug abuse, the shift in British drug policy has now made the criminal system in the United Kingdom a central location for its efforts to combat the problem of drugs and drug addiction.

These two related features of the new British approach can readily be measured. One metric is the dramatic increase in the use of imprisonment in the United Kingdom in recent years, especially for offenses involving the illegal distribution of drugs. From 1994 to 2004, the total "number of years of imprisonment handed out by courts" in England and Wales increased by slightly

<sup>560.</sup> Id. at 92.

<sup>561.</sup> Id. at 87, 92.

<sup>562.</sup> See id.

<sup>563.</sup> Seddon et al., supra note 19, at 820 (emphasis omitted).

<sup>564.</sup> Id. at 821 (emphasis omitted).

<sup>565.</sup> *Id*.

<sup>566.</sup> See Reuter & Stevens, supra note 299, at 470.

less than 50%. <sup>567</sup> Crucially, however, during this same ten-year period the number of years of imprisonment handed out in drug offenses went up by nearly 200%. <sup>568</sup> A second measure is the commitment of resources to treatment, both within the criminal system and more generally. Overall, the government has funded a "massive expansion" in the number of drug treatment slots in the United Kingdom, more than doubling the total capacity of the system between 1998 and 2007. <sup>569</sup> More to the point, though, the number of people ordered into drug treatment by criminal courts increased more than five-fold in roughly the same period. <sup>570</sup>

In the United States, the trend lines have moved from an active war on drugs in which criminal enforcement and punishment have been the primary rhetorical and practical targets of policy to an evolving approach, at least at the federal level, characterized by a somewhat more pragmatic tone and a more balanced set of interventions that mix enforcement, treatment, and prevention. Although the Obama Administration and its allies in the U.S. Congress have adopted a number of positions that move American drug policy away from the belligerence of a full scale war on drugs, evidence of the shift toward pragmatism was reported even before the November 2008 election. In fact, according to a Zogby poll conducted in September of 2008, three-fourths of likely voters said they thought that the drug war was failing, and a significant minority urged legalization or increased treatment and prevention.

<sup>567.</sup> See id. at fig.4.

<sup>568.</sup> See id.

<sup>569.</sup> *Id.* at 473 (citing Statistical Release, Nat'l Treatment Agency for Substance Abuse, Statistics for Drug Treatment Activity in England 2006/07: National Drug Treatment Monitoring System (Oct. 18, 2007), *available at* http://nta.shared.hosting.zen.co.uk/media/media\_releases/2007\_media\_releases/statistics\_for\_drug\_treatment\_activity\_in\_england\_2006\_07\_statistical\_release e 181007.aspx).

<sup>570.</sup> See supra note 482.

<sup>571.</sup> Indeed, the Obama Administration's 2010 National Drug Control Strategy takes as its organizing theme the idea of striking a pragmatic balance between treatment, prevention, and law enforcement efforts. See OFFICE OF NAT'L DRUG CONTROL POLICY, EXEC. OFFICE OF THE PRESIDENT, NATIONAL DRUG CONTROL STRATEGY iii (2010) [hereinafter DRUG CONTROL STRATEGY 2010]. Office of National Drug Control Policy Director R. Gil Kerlikowske states that the "balanced approach of evidence-based prevention, treatment, and enforcement presented in this Strategy will effectively address the serious drug problem faced by our Nation today." Id. at v.

<sup>572.</sup> See Fields, supra note 519.

<sup>573.</sup> Zogby/Inter-American Dialogue Survey: Public Views Clash with U.S. Policy on Cuba, Immigration, and Drugs, ZOGBY INT'L (Oct. 2, 2008), http://www.zogby.com/news/ReadNews2.cfm?ID=1568 (citing Zogby Interactive Likely Voters 9/23/08 thru 9/25/08, ZOGBY INT'L, 43, 46 (Sept. 25, 2008), http://www.zogby.com/news/x-iad.pdf); see also Weekly Facsimile, Ctr. for Substance Abuse Research, Univ. of Md., Three-Fourths of Likely Voters Think War on Drugs is Failing; Legalization, Stopping Drugs at Border, and Reducing Demand Cited as Top Three Strategies (Nov. 3, 2008), available at http://www.cesar.umd.edu/cesar/cesarfax/vol17/17-44.pdf (summarizing the results of the Zogby poll).

## A. Recent Developments in United States Drug Policy

In the first two years of the Obama Administration, a number of concrete steps have been taken to effectuate this new approach.<sup>574</sup> Evidence of the new pragmatism can be found in efforts to reform the criminal justice system and in proposed policy changes elsewhere in the federal bureaucracy. One example is the decision of the U.S. House of Representatives in September of 2009 to pass the Student Aid and Fiscal Responsibility Act,<sup>575</sup> which included language that would partially repeal the so-called aid elimination penalty that has been a part of the Higher Education Act since 2000.<sup>576</sup> Pursuant to the aid elimination penalty, more than 200,000 students with drug offense convictions have been deemed ineligible for federal loans, grants, and work-study support.<sup>577</sup> In 2006, Congress softened the law so that only those students convicted while in college would lose their aid eligibility.<sup>578</sup> Under the most recent House-passed provision, the law would be pared back even further so that students convicted of drug possession offenses (as opposed to drug distribution crimes) would once again become eligible for federal student loans and other educational financial support.<sup>579</sup>

In December of 2009, President Obama signed a bill repealing a twenty-one-year-old ban on federal funding for programs that supply clean needles to intravenous drug users. For a number of years, needle exchange programs in a wide variety of locations across the country have provided clean needles as a way to reduce the transmission of HIV and Hepatitis C. Although the programs had relied solely on state and local funding because of the federal

<sup>574.</sup> In October of 2009, for example, the Department of Justice issued a memorandum to federal prosecutors in fourteen states allowing for the medical use of marijuana and establishing a new policy not to prosecute under federal criminal laws those who use medical marijuana in "clear and unambiguous compliance" with state laws. Memorandum from David W. Ogden, U.S. Deputy Att'y Gen., to Selected United States Attorneys (Oct. 19, 2009), available at http://www.justice.gov/opa/documents/medical-marijuana.pdf; see also David Stout & Solomon Moore, U.S. Won't Prosecute in States that Allow Medical Marijuana, N.Y. TIMES, Oct. 20, 2009,

<sup>575.</sup> Student Aid and Fiscal Responsibility Act of 2009, H.R. 3221, 111th Cong.  $\S$  123(d) (as passed by House, Sept. 17, 2009) (amending 20 U.S.C.  $\S$  1091(r)(1)).

<sup>576.</sup> See id.; Campaigns: The Higher Education Act, STUDENTS FOR SENSIBLE DRUG POLICY, http://ssdp.org/campaigns/the-higher-education-act (last visited Dec. 11, 2010).

<sup>577.</sup> See id.

<sup>578.</sup> See Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 8021(c), 120 Stat. 4, 178 (2006) (codified as amended at 20 U.S.C. § 1091(r)(1) (2010)).

<sup>579.</sup> See H.R. 3221 (rendering student convicted of crime involving the sale of a controlled substance ineligible for aid for two years on a first offense and indefinitely on a second offense).

<sup>580.</sup> See Consolidated Appropriations Act of 2010, Pub. L. No. 111-117, § 505, 123 Stat. 3034, 3279; Righting a Wrong, Much Too Late, supra note 238.

<sup>581.</sup> See Lawrence O. Gostin, The Legal Environment Impeding Access to Sterile Syringes and Needles: The Conflict Between Law Enforcement and Public Health, 18 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES & HUM. RETROVIROLOGY S60, S60–61 (1998).

funding ban, their numbers and geographic reach had expanded over time so that in 2009 more than thirty million clean needles were distributed in more than thirty states. Nevertheless, as of the date of the repeal, a number of states and cities still did not have needle exchange programs, and enactment of the repeal sent a strong message of federal support to those seeking to establish additional programs in new locations. 583

A third example of the new pragmatism is the decision of the U.S. House of Representatives in the fall of 2009 to remove an eleven-year-old amendment barring the District of Columbia from implementing a medical marijuana law approved by District voters in 1998. The decision to abrogate this amendment, known as the Barr Amendment, after its original sponsor Representative Bob Barr, was contained in a District of Columbia appropriations bill. Congress had reenacted the Barr Amendment in every District of Columbia appropriations bill it had passed since 1998. Interestingly, Barr—who was defeated in his reelection bid in 2002 and has since become a libertarian—supported the repeal of the ban that bore his name.

Additional evidence of this new pragmatism is provided by the bipartisan decision of Congress to reduce the well-publicized sentencing disparity under federal law between crack and powder cocaine. Under longstanding federal law, a conviction for possession of 5 grams of crack cocaine and 500 grams of powder cocaine triggered the same five-year sentence. Fifty grams of crack cocaine and 5 kilograms of powder cocaine triggered the same ten-year sentence. The House Judiciary Committee in July of 2009 approved the Fairness in Cocaine Sentencing Act of 2009, which would have changed the 100-to-1 ratio and eliminated the five-year mandatory minimum sentence for

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<sup>582.</sup> See Susan Sharon, Ban Lifted on Federal Funding for Needle Exchange, NPR (Dec. 18, 2009), http://www.npr.org/templates/story/story.php?storyId=121511681.

<sup>583.</sup> See id.

<sup>584.</sup> See Tim Craig, Swift Action Sought on Medical Marijuana, WASH. POST, Dec. 15, 2009, at B2.

<sup>585.</sup> See Valerie Richardson, Marijuana Project Parties with Barr: Libertarians Open Convention, WASH. TIMES, May 23, 2008, at A1.

<sup>586.</sup> *Compare* Consolidated Appropriations Act of 2010, Pub. L. No. 111-117, § 813, 123 Stat. 3034, 3224 (reflecting absence of Barr amendment) *with* Omnibus Appropriations Act of 2009, Pub. L. No. 111-8, § 819(b), 123 Stat. 524, 700 ("The Legalization of Marijuana for Medical Treatment Initiative of 1998, also known as Initiative 59, approved by the electors of the District of Columbia on November 3, 1998, shall not take effect.").

<sup>587.</sup> See Richardson, supra note 585, at A1.

<sup>588.</sup> See id.

<sup>589.</sup> See U.S. SENTENCING GUIDELINES MANUAL § 2D1.1(c)(8) (2009) (defining both as "level 24" offenses); Cocaine/Crack/Coca, DRUG POLICY ALLIANCE, http://www.drugpolicy.org/drugbydrug/cocainecrack/ (last visited Dec. 11, 2010).

<sup>590.</sup> See U.S. SENTENCING GUIDELINES MANUAL § 2D1.1(c)(5) (2009) (defining both as "level 30" offenses); U.S. News Library Staff, Crack vs. Powder Cocaine: A Gulf in Penalties, U.S. NEWS & WORLD REP. (Oct. 1, 2007), http://politics.usnews.com/news/national/articles/2007/10/01/crack-vs-powder-cocaine-a-gulf-in-penalties.html.

simple possession of crack cocaine that was put into place in 1986.<sup>591</sup> The final bill,<sup>592</sup> which was supported unanimously in the Senate and on a voice vote in the House and signed by President Obama on August 3, 2010,<sup>593</sup> reduces but does not completely eliminate the crack-powder cocaine sentencing disparity. The new law decreases the 100-to-1 ratio to 18-to-1 and raises the trigger amount of crack cocaine for the five-year mandatory minimum sentence from 5 grams to 28 grams.<sup>594</sup>

Members of the House and Senate have also launched broader reform efforts focused on drug policy in the criminal justice system. Representative Barney Frank of Massachusetts has been especially active. He is the lead sponsor of the Medical Marijuana Patient Protection Act, 595 "which would prohibit the Federal government, in a state that allows marijuana to be prescribed by a physician for medical use, from preventing the prescription, possession, transportation, or distribution of marijuana for that purpose." Frank is also sponsoring the Personal Use of Marijuana by Responsible Adults Act of 2009, 597 "which would prohibit the imposition of any penalty under an Act of Congress for the possession of marijuana for personal use or for the not-for-profit transfer between adults of marijuana for personal use."598 On the Senate side, Jim Webb's proposed legislation, the National Criminal Justice Commission Act of 2010, <sup>599</sup> was approved by the House of Representatives on July 28, 2010. <sup>600</sup> The bill, which is supported by a broad array of organizations, including the International Association of Chiefs of Police, "creates a blue-ribbon bipartisan commission charged with undertaking [a] comprehensive review of the nation's

<sup>591.</sup> H.R. 3245, 111th Cong. § 2 (2009).

<sup>592.</sup> Fair Sentencing Act of 2010, Pub. L. No. 111-220, 124 Stat. 2372 (to be codified at 21 U.S.C. § 801).

<sup>593.</sup> Peter Baker, *Obama Signs Law Narrowing Cocaine Sentencing Disparities*, N.Y. TIMES CAUCUS BLOG (Aug. 3, 2010, 12:55 PM), http://thecaucus.blogs.nytimes.com/2010/08/03/obama-signs-law-narrowing-cocaine-sentencing-disparities. The Senate acted under unanimous consent, after Senators Richard Durbin (D-IL) and Jeff Sessions (R-AL) reached a compromise on the trigger amounts. *See* Editorial, *The House Should Listen and Learn*, N.Y. TIMES, July 26, 2010, at A22.

<sup>594.</sup> Id.; see also § 2, 124 Stat. at 2372.

<sup>595.</sup> H.R. 2835, 111th Cong. § 2 (2009).

<sup>596.</sup> Letter from Barney Frank, U.S. Congressman, to Constituents (2009), available at http://house.gov/frank/letters/constituents/2009/marijuana-decriminalization-letter.pdf; see also Press Release, Barney Frank, U.S. Congressman, Frank Introduces Bills to Prevent Federal Criminal Prosecution for Medical and Personal Marijuana Use (June 19, 2009), available at http://www.house.gov/frank/pressreleases/2009/06-19-09-marijuana-bills.html.

<sup>597.</sup> H.R. 2943, 111th Cong. § 2 (2009).

<sup>598.</sup> Letter from Rep. Barney Frank to Constituents, supra note 596.

<sup>599.</sup> S. 714, 111th Cong. (as passed by House of Representatives, Jul. 27, 2010).

<sup>600.</sup> Press Release, Jim Webb, U.S. Senator, Webb's National Criminal Justice Commission Act Wins Approval in House of Representatives (Jul. 28, 2010), *available at* http://webb.senate.gov/newsroom/pressreleases/07-28-2010-02.cfm.

criminal justice system" at the federal, state, and local levels. 601 After conducting the review, the commission is to make "specific, concrete recommendations for reform." 602

The impulse to moderate drug policy in the United States has been evident, albeit unevenly, at the state level as well. Given the high volume of drug offense prosecutions in the states, it should be possible to discern the effects of significant drug policy reforms in the overall functioning of state criminal justice systems. A recent report by the Sentencing Project notes that twenty states experienced "modest declines" in their prison populations during 2008, 603 and legislatures in nineteen states enacted new provisions in 2009 "that hold the potential to reduce prison populations." At the heart of these reforms are a series of measures designed to eliminate or scale back mandatory minimum sentences for drug offenses, to lower other drug offense penalties, and to offer more mechanisms for diverting drug offenders into treatment in the community. These reforms have been driven by fiscal concerns intensified by

601. Press Release, Jim Webb, U.S. Senator, Webb's National Criminal Justice Commission Act Gains Momentum with Introduction in House of Representatives (Apr. 27, 2010), *available at* http://webb.senate.gov/newsroom/pressreleases/2010-04-27-03.cfm.

The National Criminal Justice Commission Act, S. 714 was introduced in the Senate on March 26, 2009. The bill's 37 cosponsors in the Senate, include: Chairman of the Senate Judiciary Committee Senator Patrick Leahy (D-VT), Chairman of the Subcommittee on Crime and Drugs Senator Arlen Specter (D-PA) and Ranking Member Senator Lindsey Graham (R-SC), and Judiciary Committee member Senator Orrin G[.] Hatch (R-U). The legislation was voted out of the Judiciary Committee January 21, and awaits a vote on the Senate floor.

Id. Senator Webb has noted that effective criminal justice reform must deal with "the central role of drug policy in filling our nation's prisons," and has made it clear "that our approach to curbing illegal drug use is broken." ONDCP's Fiscal Year 2011 National Drug Control Budget: Are We Still Funding a War on Drugs?: Hearing Before Domestic Policy Subcomm. of the H. Comm. on Oversight & Gov't Reform, 111th Cong. 2 (2010) (statement of Ethan Nadelmann, Executive Director, Drug Policy Alliance) [hereinafter Nadelmann Testimony] (quoting Sen. Jim Webb) (internal quotation marks omitted), available at http://oversight.house.gov/images/stories/Hearings/Domestic\_Policy/2010/041410\_ONDCP/041210\_111th\_DP\_Ethan\_Nadelmann\_041410. pdf.

602. Jim Webb, *Why We Must Reform Our Criminal Justice System*, HUFFINGTON POST (June 11, 2009), http://www.huffingtonpost.com/sen-jim-webb/why-we-must-reform-our-cr\_b\_214130. html; *see also* Press Release, Jim Webb, *supra* note 600.

 $603.\ NICOLE$  D. Porter, The State of Sentencing 2009: Developments in Policy And Practice 2 (2010).

604. Id. at 1.

605. See Deborah Hastings, States Pull Back After Decades of Get-Tough Laws, HUFFINGTON POST (Apr. 4, 2009, 12:39 PM), http://www.huffingtonpost.com/2009/04/04/states-pull-back-after-de n 183200.html.

a nationwide economic downturn<sup>606</sup> and by a growing recognition that the punitive approach characteristic of the "War on Drugs" has not been effective.<sup>607</sup>

The states that have eliminated or reduced mandatory minimums for drug offenses include Minnesota, New York, and Rhode Island. A number of other states have revised sentencing, probation, or parole provisions in order to reduce the number of incarcerated drug offenders. For example, Kentucky has "expanded parole eligibility for persons convicted" of identified felonies, including some drug felonies; Louisiana has amended its provisions governing offenders "serving life sentences for heroin offenses;" Maine has eliminated jail sentences for low-level marijuana possession convictions; and Nevada has "[a]mended sentencing provisions for controlled substance offenses."

Perhaps the most striking example of this new approach can be found in New York. Between 1999 and 2009, while the total number of prisoners increased nationwide, the overall prison population in New York declined by 20%. This significant reduction in state prisoners was the result of refocused policing priorities, an increased emphasis on the diversion of drug offenders into treatment, and a rolling back of sentencing provisions for drug offenses that originated with the Rockefeller drug laws passed in the early 1970s. Under the Rockefeller-era laws, the possession of as little as four ounces of narcotics (or the sale of two or more ounces) was a Class A felony, triggering a "minimum sentence of 15 years and a maximum of life." A related provision, the Second Felony Offender Law, "mandated a prison sentence for a person convicted of any two felonies within [ten] years." Together with intensified drug enforcement by local police departments in the 1980s and 1990s, these sentencing provisions had led to an enormous increase in the absolute number of New Yorkers who were sentenced to state prison time for drug offenses, and in the relative percentage of these prisoners in the total prison inmate population.

<sup>606.</sup> See PORTER, supra note 603, at 1; Hastings, supra note 605.

<sup>607.</sup> See JUDITH GREENE & MARC MAUER, DOWNSCALING PRISONS: LESSONS FROM FOUR STATES 1 (2010). For example, the Kansas Sentencing Commission recently sponsored a public opinion survey, which found that "the vast majority of Kansans (more than 85 percent) believed that drug users could and should be given a chance for rehabilitation. Seventy-two percent of state residents favored treatment over prison for people convicted of drug possession." *Id.* at 51.

<sup>608.</sup> See PORTER, supra note 603, at 4-5.

<sup>609.</sup> See id. at 3.

<sup>610.</sup> *Id*.

<sup>611.</sup> See GREENE & MAUER, supra note 607, at 5-6.

<sup>612.</sup> See id.

<sup>613.</sup> Id. at 6.

<sup>614.</sup> Id.

<sup>615.</sup> See id. (citing N.Y. STATE DEP'T OF CRIMINAL JUSTICE SERVS., 1999 CRIME AND JUSTICE ANNUAL REPORT (1999); Factsheet, Correctional Ass'n of N.Y., The Campaign to Repeal the Rockefeller Drug Laws, (Feb. 2009), available at <a href="http://www.correctionalassociation.org/publications/download/ppp/factsheets/DTR\_Fact\_Sheet\_2009.pdf">http://www.correctionalassociation.org/publications/download/ppp/factsheets/DTR\_Fact\_Sheet\_2009.pdf</a>).

Beginning in 1999, police enforcement priorities shifted in New York City and throughout the state. Felony drug arrests declined sharply, reflecting a growing recognition by some government officials and the public generally that the all-out "war" on drug use was not working. Also in the 1990s, Brooklyn District Attorney Charles Hynes began a highly effective and well-publicized program to divert a significant number of defendants with serious drug problems away from prison and into treatment. Over time, other prosecutors around the state started similar programs. Then, in 2003, New York Governor George Pataki instituted reforms to permit a limited number of offenders serving lengthy sentences under the Rockefeller laws to "receive a merit time reduction of their minimum sentence," and to "move[] up the parole eligibility" of others who had served more than ten years in prison. 620 More significant changes were adopted in 2004 and 2005, when the legislature and the Governor agreed to "double[] the drug amount thresholds that trigger[ed] the harshest mandatory prison sentences," and to shorten prison time for virtually all drug offenses by adopting "determinate sentences" and additional "good time" reductions. 621 Finally, in 2009, Governor David Paterson signed into law legislation that fundamentally reformed the Rockefeller-era drug laws. 622 This bill "eliminated mandatory minimums for certain first- and second-time drug offenses," "expand[ed] treatment [and] alternatives to incarceration," increased judicial discretion, and "provid[ed] for the resentencing of about 1,500 individuals who were incarcerated under the original Rockefeller Drug Laws."623

The data at the state level, however, does not support the conclusion that the United States has turned a corner in its war on drugs. The new pragmatism evident in New York's Rockefeller drug law reforms has not been uniformly

<sup>616.</sup> See id. at 9.

<sup>617.</sup> See id. at 9. As reported by the Sentencing Project:

In 1999 a widely-publicized poll of New York State voters conducted by Zogby International revealed that twice as many said they would be *more* inclined to vote for state legislators who would reduce sentences and give judges greater discretion in drug cases than the number who said they'd be *less* inclined.

Id. (citing Results for Zogby International Poll (New York), DRUG POLICY ALLIANCE (April 28, 1999), http://www.drugpolicy.org/library/publicopinio/zogby.cfm).

<sup>618.</sup> See id. at 10-11.

<sup>619.</sup> Id. at 11.

<sup>620.</sup> See id. at 16-17 (internal quotation marks omitted).

<sup>621.</sup> See id. at 17-18.

<sup>622.</sup> See id. at 24.

<sup>623.</sup> PORTER, *supra* note 603, at 4–5. Notwithstanding the importance of the 2009 legislative reforms prospectively, it is crucial to note the dramatic decrease in the rate at which persons convicted of drug offenses were committed to New York state prisons in the period between 2000 and 2008. In fact, while commitments to prison for all offenses declined by 15% during this period, the number of offenders committed to prison for drug sale offenses declined by an eye-catching 54%. *See* GREENE & MAUER, *supra* note 607, at 13–14.

adopted either in that state or around the country. Thus, "the drop-off in felony drug arrests [in New York] was associated with an increase in misdemeanor drug arrests" over the same period, and the 2009 drug law reform statute also includes "sentencing enhancements and restored life sentences" for so-called drug kingpins. Recent Rhode Island legislation that eliminates mandatory minimums for some specified drug possession offenses also leaves in place the possibility of lengthy prison sentences for offenders convicted of other drug crimes, including sales offenses. And nationwide, between 2000 and 2008, the total number of persons serving time in prison increased by twelve percent. Despite the promising green shoots of reform in some states, others have experienced dramatic increases in their prison populations and in drug offender commitments to prison over the past decade. An increased interest in public health approaches to drug misuse is apparent in many state and local drug policy debates, but a persisting attachment to criminal prohibition and criminal enforcement is also a dominant component of the legal and political landscape.

A similarly mixed picture characterizes the Obama Administration's approach to drug policy. In his transmittal notice to Congress accompanying the 2010 *National Drug Control Strategy* developed by the White House Office of National Drug Control Policy (ONDCP), President Obama called for "a new direction in drug policy" and declared that his Administration is "committed to restoring balance" between "prevention, treatment, and law enforcement" efforts in the drug policy arena. The President and ONDCP Director R. Gil Kerlikowske have said that drug policy "should be guided by examining the evidence of what works," and that "drug abuse should be treated as a public health issue instead of a criminal justice issue." In his public statements, Kerlikowske has declared an end to the use of the rhetoric of a "war on drugs." At the same time, however, both the 2010 *National Drug Control Strategy* and the proposed *Federal Drug Control Budget* for fiscal year 2011 (the

<sup>624.</sup> See Greene & Mauer, supra note 607, at 23, 60-61.

<sup>625.</sup> Id. at 9.

<sup>626.</sup> PORTER, supra note 603, at 5.

<sup>627.</sup> See id.

<sup>628.</sup> GREENE & MAUER, supra note 607, at 1.

<sup>629.</sup> See id.

<sup>630.</sup> DRUG CONTROL STRATEGY 2010, supra note 571, at iii.

<sup>631.</sup> ONDCP's Fiscal Year 2011 National Drug Control Budget: Are We Still Funding the War on Drugs?: Hearing Before the Subcomm. on Domestic Policy of the H. Comm. on Oversight and Gov't Reform, 111th Cong. 1 (2010) [hereinafter Kucinich Statement] (statement of Rep. Dennis J. Kucinich, Chairman, Subcomm. on Domestic Policy) (describing statements made by ONDCP Director Kerlikowske and President Obama).

<sup>632.</sup> See Fields, supra note 519.

first developed by the Obama drug policy team), <sup>633</sup> read not as dramatic departures from similar policy statements and budgets prepared during the Bush Administration, but as evolutionary improvements and as refinements of the longstanding approach to dealing with drugs and drug misuse that has dominated United States policy for a very long time.

The proposed fiscal year 2011 budget does signal a "new direction in drug policy" in some respects. As compared to the Bush Administration's last drug control budget (for fiscal year 2009), the amount of revenue devoted to treatment in the proposed fiscal year 2011 budget increased from \$3.477 billion to \$3.883 billion. 634 This represents a substantial increase in the amount of money allocated to early intervention and other treatment initiatives. 635 Moreover, the proposed funding is targeted in ways that suggest more of a public health approach. 636 Thus, substantial new funding is focused on increasing the capacity of emergency departments and primary healthcare providers to engage in screening and brief early intervention for substance abuse in emergency rooms and other community-based health care settings. 637 In addition, the proposed budget calls for "expanding addiction treatment in community health centers," "within the Indian Health Service," and among other especially vulnerable populations. 638 Finally, the budget contains new expenditures for communitybased recovery support programs, post-incarceration re-entry efforts, and other programs designed to divert drug abusers from prison.<sup>639</sup>

On the other hand, in terms of the overall allocation of resources between supply-side and demand-side expenditures, the fiscal year 2011 drug control budget proposed by the Obama Administration and the fiscal year 2009 budget prepared by the Bush Administration are largely indistinguishable. The proposed fiscal year 2011 budget still spends more than two-thirds of the total drug control expenditure on law enforcement, interdiction, and other supply-

<sup>633.</sup> OFFICE OF NAT'L DRUG CONTROL POLICY, EXEC. OFFICE OF THE PRESIDENT, FISCAL YEAR 2011 CONGRESSIONAL BUDGET SUBMISSION (2010) [hereinafter FISCAL YEAR 2011 BUDGET SUBMISSION].

<sup>634.</sup> ONDCP's Fiscal Year 2011 National Drug Control Budget: Are We Still Funding a War on Drugs?: Hearing Before the Subcomm. on Domestic Policy of the H. Comm. on Oversight and Gov't Reform, 111th Cong. 2 (2010) [hereinafter Pacula Testimony] (testimony of Rosalie Liccardo Pacula, Co-Director RAND Corp. Drug Policy Research Center).

<sup>635.</sup> See OFFICE OF NAT'L DRUG CONTROL POLICY, EXEC. OFFICE OF THE PRESIDENT, NATIONAL DRUG CONTROL BUDGET: FY 2011 FUNDING HIGHLIGHTS 5–8 (2010) ("The FY 2011 Budget dedicates nearly \$3.9 billion in Federal funds for early intervention and treatment services for individuals with drug problems. This represents a 3.7% increase over the FY 2010 funding level.").

<sup>636.</sup> See id.

<sup>637.</sup> See id. at 5–7. See generally Boldt, Confidentiality of Alcohol, supra note 256, at 390 ("[S]ome emergency departments and, especially, trauma centers have taken the lead in integrating [substance use disorder] diagnosis and treatment services into their broader agendas.").

<sup>638.</sup> See DRUG CONTROL STRATEGY 2010, supra note 571, at 2.

<sup>639.</sup> See id. at 103-04.

reduction programs.<sup>640</sup> As a percentage of the overall budget, the amount allocated to treatment in the Obama plan is 25%, while the amount devoted to treatment in the last Bush drug control budget was 23.3%.<sup>641</sup> If anything, the real world effects of the budgeting decisions reflected in these documents may end up with even more resources being directed toward supply-side efforts than might at first appear to be the case because the proposed fiscal year 2011 budget does not include billions of the dollars the federal government will spend on prosecuting and incarcerating drug offenders.<sup>642</sup>

The 2010 *National Drug Control Strategy* is a "mixed bag" in other respects as well. On one hand, the Introduction to the *National Drug Control Strategy* prominently identifies the spread of HIV as a direct consequence of IV drug use and links substance abuse with other social costs, including automobile accidents, increased healthcare expenditures, and disrupted families and communities. On the other hand, the primary measure of drug policy performance in the 2010 *National Drug Control Strategy* remains drug use—the total number of persons who report using illegal drugs within the past year in the annual survey. As one expert has pointed out, however, "[d]rug use rates tell us surprisingly little, . . . about our nation's progress toward reducing the actual harms associated with drugs. If the number of Americans using illegal drugs decreases, but overdose fatalities, new HIV/AIDS infections, racial disparities, and addiction increases," then the policy is not a success.

This overreliance on the rate of drug use as the principal measure of policy performance is not a superficial shortcoming of the 2010 *National Drug Control Strategy*, but rather an indication of the persistence of an underlying premise that has animated United States drug policy consistently since William Bennett articulated the idea several decades ago. The premise is that the use of illicit drugs is inherently harmful, perhaps because of the very illegality of these substances. This perspective remains woven throughout the 2010 *National Drug Control Strategy* and helps to explain why the Obama team's budget proposes allocating 64% of available drug control resources to law enforcement, interdiction, and other supply-reduction efforts, and only 36% for demand reduction. These allocations were made despite repeated government-funded studies that have demonstrated that demand reduction is much more effective

<sup>640.</sup> See id. at 109 tbl.1.

<sup>641.</sup> Id.

<sup>642.</sup> See Kucinich Statement, supra note 631.

<sup>643.</sup> See DRUG CONTROL STRATEGY 2010, supra note 571, at 5.

<sup>644.</sup> See Nadelmann Testimony, supra note 545; FY 2011 BUDGET SUBMISSION, supra note 633, at 56.

<sup>645.</sup> Nadelmann Testimony, supra note 545.

<sup>646.</sup> See supra note 340.

<sup>647.</sup> See DRUG POLICY STRATEGY 2010, supra note 571, at 109 tbl.1.

than supply-side efforts. And it helps to explain Director Kerlikowske's repudiation of Tom McLellan's (formerly Deputy Director of the ONDCP) earlier endorsement of some harm-reduction strategies. The rhetoric may be a pragmatic call for balance and for evidence-based decisionmaking, but the federal government has continued to resist experimenting with the kinds of harm-reduction efforts—including supervised injection facilities—that have been subject to carefully controlled studies and been found promising elsewhere.

In his opening remarks at an oversight hearing for ONDCP's proposed fiscal year 2011 drug budget, Domestic Policy Subcommittee Chairman Dennis Kucinich pointed out that "it will take time to reverse the course of the last decade of failed drug policy."651 Among the factors identified by Representative Kucinich as contributing to the relatively slow rate of reform apparent in the Obama Administration's most recent Drug Control Budget and National Drug Control Strategy (and presumably in drug policy reform at the state level as well) are "institutional inertia, and the entrenched interests of stakeholders in the current approach."652 It may well be that the resistance to change inherent in many public institutions and the simple self-interest of those who have benefited from an enforcement-based policy paradigm in this area account for the resilience of the prohibition approach notwithstanding the increasingly pragmatic rhetoric of leaders both inside and outside of government. But the slow rate at which U.S. drug policy is converging with approaches being taken in Great Britain, and the likelihood that such convergence will not be complete is also subject to a related but different explanation. The United States, unlike the United Kingdom, has maintained a long history of moral disapproval of drug use that has been supported by legal prohibition and criminal enforcement. This moral and legal disposition toward narcotics has fostered a social understanding of those who misuse these substances that is totalizing.<sup>653</sup>

## B. Moral Anchoring

To be sure, it is not just the weight of this history that drags down the engine of pragmatic reform in the United States. Instead, it is the present anchor that this total moral understanding provides that is likely to be determinative. The idea of "anchoring" as a distorting feature of human judgment was first proposed by psychologists Amos Tversky and Daniel Kahneman, who published a classic

<sup>648.</sup> See Nadelmann Testimony, supra note 545.

<sup>649.</sup> Id. at 4-5.

<sup>650.</sup> See id. at 5.

<sup>651.</sup> Kucinich Statement, supra note 631.

<sup>652.</sup> Id.

<sup>653.</sup> See supra text accompanying notes 34-36.

paper in 1974 on the "anchoring-and-adjustment heuristic." In essence, Tversky and Kahneman sought to explain why individual judgments under conditions of uncertainty "tend to be excessively influenced by an initial impression, perspective, or value." Thus, in a standard example of the phenomenon, study subjects who were asked whether the population of Chicago is more or less than 200,000 and then asked to provide an absolute estimate tended to estimate considerably lower than other subjects who were first asked whether the population of Chicago is more or less than five million and then asked to provide an absolute estimate. Although it would be a misuse of Tversky and Kahneman's theory about the ways in which individuals make everyday judgments to attempt to map their anchoring hypothesis directly onto collective societal judgment formation, their insights and those of others who have developed the thesis do provide a metaphor for understanding the persistence in the United States of a punitive, criminal justice-focused drug policy.

The anchoring heuristic as elaborated by Tversky and Kahneman is made up of a set of secondary theories relating to observable cognitive biases. More recently, psychologists working on the anchoring thesis have suggested that anchoring effects may be the product of other predictable cognitive processes beyond insufficient adjustment and the like. These revisions have focused particularly on the "enhanced accessibility of anchor-consistent information" and on the tendency of individuals to attend actively to information that conforms to their anchor value and to tune out information that is dissonant with their starting point.

In an analogous sort of way, the extreme moral disapproval that has been fixed for most of the past century on narcotic drugs and on those who use them in the United States may serve as a kind of anchor that filters the complex array of information a pragmatist would want to consider in formulating sensible public policy in this area. In this sense, it is not just the inertia of long history

<sup>654.</sup> Amos Tversky & Daniel Kahneman, Judgment Under Uncertainty: Heuristics and Biases, 185 Sci. 1124 (1974).

<sup>655.</sup> Nicholas Epley & Thomas Gilovich, *The Anchoring-and-Adjustment Heuristic: Why the Adjustments Are Insufficient*, 17 PSYCHOL. SCI. 311, 311 (2006).

<sup>656.</sup> *Id.* (citing Karen E. Jacowitz & Daniel Kahneman, *Measures of Anchoring in Estimation Tasks*, 21 PERSONALITY & SOCIAL. PSYCHOL. BULL. 1161, 1163 (1995)).

<sup>657.</sup> See Tversky & Kahneman, supra note 654, at 1128–30. These secondary theories include "biases in the evaluation of conjunctive and disjunctive events," biases with respect to the "assessment of subjective probability distributions, and biases in terms of the range of adjustment from an anchor value necessary for an accurate prediction. *Id.* 

<sup>658.</sup> See, e.g., Epley & Gilovich, supra note 655, at 312 ("[R]esearch suggests that people adjust from values they generate themselves as starting points known to be incorrect but close to the target value.").

<sup>659.</sup> Id.

<sup>660.</sup> See id.

that determines the path of public discourse and government decisionmaking, but rather the particular way in which our fixed moral understanding of drug addiction shapes the very universe of data made available for consideration. In effect, information that is consistent with the moral disapproval of drugs and drug use is accorded greater salience in public policy discussions, while data that is inconsistent with this pejorative moral characterization is undervalued or excluded altogether.

Maarten Hajer's work on "discourse coalitions" helps clarify how this collective anchoring dynamic functions. In Hajer's terms, "systems of representation that rely on shared narratives and symbolic constructions" often come to "dominate the way a society conceptualizes the world," and eventually become institutionalized "in rules and organizations." The United States may not be committed fully to the stance adopted by Harry Anslinger many years ago, but the "shared narratives and symbolic constructions" associated with drug use that became embedded in the American perspective during the Anslinger years have persisted and have continued to restrict our vision of the range of possible policy choices to a narrow, pinched array of options for dealing with the real harms that the misuse of drugs entails.

All societies engage in persistent and ongoing social and political negotiation over how to evaluate competing risks of many kinds, and even whether to attend to certain risks through the use of coercive governmental instrumentalities. The fact that discourse about drugs in the United States is anchored by a moralistic perspective that has been embedded in our positive law and governmental institutions for decades necessarily biases the way in which the problem of drug misuse is located on the nation's risk profile. There is no doubt that a similar struggle is taking place in the United Kingdom over the place of drugs and drug misuse in the British risk profile. The important difference between the two societal negotiations is that the former is anchored by a longstanding totalizing moral depiction of drug addiction while the latter is not.

It is important to document the moral meanings associated with drug misuse in the United States and to contrast them with the somewhat different moral context that surrounds the problem in the United Kingdom (and elsewhere), in part because understanding the contingency of our moral stance opens up possibilities for change. The overwhelming moral opprobrium we associate with drugs and those who misuse them may inhibit our capacity to renegotiate this issue into a lower rank on our societal risk profile and may limit the distance we are able to travel toward a more pragmatic, balanced drug policy, but bringing this moral anchor into our active consciousness is a good first step in that process. At the least, this attention to the moral dimension has the potential to

661. Maarten A. Hajer, *Discourse Coalitions and the Institutionalization of Practice: The Case of Acid Rain in Great Britain*, in THE ARGUMENTATIVE TURN IN POLICY ANALYSIS AND PLANNING 43, 46–48 (Frank Fischer & John Forester eds., 1993).

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make policymakers more aware that the field of information on which they base public policy need not be as limited and distorted as it has been in our recent history.

