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Recommended Citation

Richard J. Bonnie, *The Virtues of Pragmatism in Drug Policy*, 13 J. Health Care L. & Pol'y 7 (2010).
Available at: <http://digitalcommons.law.umaryland.edu/jhclp/vol13/iss1/3>

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THE VIRTUES OF PRAGMATISM IN DRUG POLICY

RICHARD J. BONNIE*

INTRODUCTION

As part of the University of Maryland School of Law's Law & Health Care Program's conference on *Obstacles to the Development and Use of Pharmacotherapies for Addiction*, this Article focuses on the challenges of the increasing use of medical agents *if they are developed*.¹ Expanding the potential market for these drugs will increase the likelihood that they *will be developed* in the first place.² My point of departure is that the best way of responding to this challenge is to put the nation's drug policy on the right track.³ I say this because a sensible drug policy will encourage, and indeed subsidize, the use of evidence-based, cost-effective addiction treatments.⁴

The basic thrust of my argument is that we need a stable, and essentially pragmatic, drug policy that avoids the ideologically driven positions that have for so long dominated policy discourse and, because such positions are so contentious, have tended to paralyze policy-making.⁵ Just to provide a point of reference, the only time such a policy was actually in place was about thirty years ago during the Nixon and Ford administrations, extending into the early years of the Carter administration.

As background, the statement I just made is admittedly somewhat self-serving. I was Associate Director of the National Commission on Marijuana and Drug Use (the Commission) from 1971 to 1973 and was a principal architect of the Commission's two reports, the first of which recommended the

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1. See *infra* Part III.

2. Daron Acemoglu & Joshua Linn, *Market Size in Innovation: Theory and Evidence from the Pharmaceutical Industry*, 119 Q.J. ECON. 1049, 1083–84 (2004).

3. See *infra* Part III.A.

4. See *infra* Part III.B.

5. See *infra* Part II.

decriminalization of marijuana use in 1972.⁶ The final report, issued the following year, recommended a framework for drug policy that remains pertinent today.⁷ During the several years that followed, I served as an advisor to the Directors of what was then called the Special Action Office of Drug Abuse Prevention (SAODAP) (1973–77), was appointed to the position of Secretary of the first National Advisory Council on Drug Abuse (1975–80), contributed to the first of several *Federal Strategies on Drug Abuse* and helped write an important *White Paper on Drug Abuse* for the Ford Administration (1976). During this short period, I think our nation's drug policy was moving in the right direction.⁸ As this Article will discuss, however, the pendulum suddenly swung in the other direction and remained there for more than twenty years.⁹

This Article will give a brief historical account of drug policy and then draw out three implications of my views that bear most heavily on the subject of this conference.

I. A PRAGMATIC VIEW OF DRUG POLICY

Our nation's policy toward opiates and cocaine—and later marijuana and other so-called drugs of abuse—had its roots in the Progressive Era of the early twentieth century.¹⁰ The Pure Food and Drugs Act¹¹ was enacted in 1906, and the

6. NAT'L COMM'N ON MARIHUANA & DRUG ABUSE, MARIHUANA: A SIGNAL OF MISUNDERSTANDING 150–51 (1972) (“The Commission is of the unanimous opinion that marihuana use is not such a grave problem that individuals who smoke marihuana, and possess it for that purpose, should be subject to criminal procedures. . . . In general, we recommend . . . a decriminalization of possession of marihuana for personal use on both the state and federal levels.”). Except in citations, this Article spells the drug name as *marijuana* rather than *marihuana* or its alternate spellings.

7. NAT'L COMM'N ON MARIHUANA & DRUG ABUSE, DRUG USE IN AMERICA: PROBLEM IN PERSPECTIVE 408–12 (1973) (recommending a framework of decriminalization and focus on individual responsibility).

8. See generally DRUGS AND DRUG POLICY IN AMERICA: A DOCUMENTARY HISTORY (Steven R. Belenko ed., 2000) [hereinafter DRUGS AND DRUG POLICY IN AMERICA] (reviewing the U.S. drug policies, starting from the mid-nineteenth century); DAVID F. MUSTO, THE AMERICAN DISEASE: ORIGINS OF NARCOTIC CONTROL (1973) (providing an historical perspective of the origins of the American drug policy); DAVID F. MUSTO & PAMELA KORSMEYER, THE QUEST FOR DRUG CONTROL: POLITICS AND FEDERAL POLICY IN A PERIOD OF INCREASING SUBSTANCE ABUSE, 1963–1981 (2002) (contrasting the drug policies of the Johnson, Nixon, Ford, and Carter administrations).

9. See *infra* Part II.

10. See MUSTO, *supra* note 8, at 23 (“[A]t the beginning of 1908, . . . federal action was contemplated as a token of American concern about the international narcotic traffic. . . . The State Department . . . came into prominence as a leading proponent of narcotic legislation both nationally and internationally.”).

11. Pure Food and Drugs Act of 1906, Pub. L. No. 59-384, 34 Stat. 768, *repealed by* Federal Food, Drug, and Cosmetic Act of 1938, Pub. L. No. 75-717, 52 Stat. 1040 (codified as amended at 21 U.S.C. §§ 301–399 (2006)). The Pure Food and Drugs Act of 1906 sought to prevent the manufacture, sale, or transportation of adulterated, misbranded, poisonous, or deleterious foods, drugs, medicines, and liquors, *id.*, aiding in accomplishing the goal of controlling narcotic drugs.

Harrison Narcotic Act¹² was enacted in 1914. The premise of these statutes was that controlling narcotic drugs and making them available only for medical purposes would eradicate addiction and the problems that are associated with addiction, as well as the disordered behavior that can be associated with acute intoxication.¹³ In the 1920s, the federal government took the position that maintenance treatment of addiction was not a legitimate medical use.¹⁴ Although the main components of this strategy were criminalization and enforcement,¹⁵ the federal government set up two hospitals for the treatment of addiction in 1929.¹⁶

The heavy reliance on criminal enforcement, even for users, intensified after World War II in response to an epidemic of heroin use in New York City and other major cities.¹⁷ Congress and state legislatures responded by escalating penalties and

12. Harrison Narcotic Act of 1914, Pub. L. No. 63-223, 38 Stat. 785, *repealed by* Comprehensive Drug Abuse Prevention and Control Act of 1970, Pub. L. No. 91-513, 84 Stat. 1236 (codified as amended at 21 U.S.C. §§ 801–971). The Harrison Narcotic Act was another attempt to control narcotic drugs, requiring all persons who interacted at all with opium or coca leaves to register with and pay a tax to the collectors of internal revenue. *Id.*

13. See 146 CONG. REC. S7193, S7203 (daily ed. July 19, 2000) (statement of Sen. Hatch) (discussing the importance of the Food, Drug, and Cosmetic Act, among others, as “ensur[ing] that drug products [are] carefully controlled” to prevent inappropriate use of drugs other than for safe and effective purposes); 133 CONG. REC. S384 (daily ed. Jan. 6, 1987) (statement of Sen. Inouye) (recounting the historical development of heroin prohibition in the United States, noting that the Harrison Narcotics Act “banned the recreational use of heroin . . . to stem the growing number of opium addicts,” but that the statute “left the door open for the prescription of heroin by doctors . . .”).

14. See Joseph F. Spillane, *Building a Drug Control Regime, 1919–1930*, in *FEDERAL DRUG CONTROL: THE EVOLUTION OF POLICY AND PRACTICE* 26, 38–39 (Jonathon Erlen & Joseph F. Spillane eds., 2004) (discussing a series of cases in the 1920s that supported a “strict antimaintenance policy”).

15. See RICHARD J. BONNIE & CHARLES H. WHITEBREAD II, *THE MARIHUANA CONVICTION: A HISTORY OF MARIHUANA PROHIBITION IN THE UNITED STATES* 18–21 (1974) (describing the Harrison Act as a “prohibition statute” designed for “enforce[ment] against maintenance and street use,” and concluding that the removal of “any legitimate source of narcotic drugs” from the medical profession resulted in criminalization of “the user’s entire lifestyle”).

16. Porter Narcotic Farm Act, Pub. L. No. 70-672, 45 Stat. 1085, 1085 (1929) (“An Act [t]o establish two . . . narcotic farms for the confinement and treatment of persons addicted to the use of habit-forming narcotic drugs who have been convicted of offenses against the United States.”). See MUSTO, *supra* note 8, at 184, 206. Musto attributes the development of the two federal hospitals for the treatment of addiction to a “superabundance of narcotics prisoners” that resulted under enforcement of the Harrison Narcotic Act, describing the hospitals established in Fort Worth, Texas, and Lexington, Kentucky as *narcotic farms*. *Id.* at 184.

17. David T. Courtwright, *The Roads to H: The Emergence of the American Heroin Complex, 1898–1956*, in *ONE HUNDRED YEARS OF HEROIN* 3, 13 (David F. Musto ed., 2002); Joseph F. Spillane, *Federal Policy in the Post-Anslinger Era: A Guide to Sources, 1962–2001*, in *FEDERAL DRUG CONTROL: THE EVOLUTION OF POLICY AND PRACTICE* 209, 211 (Jonathon Erlen & Joseph F. Spillane eds., 2004). For specific statutes enacted after World War II, see, e.g., Boggs Act of 1951, Pub. L. No. 82-255, 65 Stat. 767, 767 (enacting significant penalties for violation of federal narcotic laws); 1955 Ohio Laws 178, 189–90 (establishing a range of penalties, including a fine of \$10,000 and imprisonment of two years to life for violation of certain Ohio narcotics provisions); 1952 Va. Acts 736, 738–39 (imposing a variety of penalties for violations of Virginia narcotics laws).

making them mandatory.¹⁸ This repressive response in the 1950s triggered a significant drug policy reform movement for the first time.¹⁹ This movement grew in strength and spanned the 1960s, drawing together several different, though overlapping, policy perspectives.²⁰ The following sections describe three such perspectives that I will call *medical*,²¹ *non-criminal*,²² and *libertarian*²³ approaches.

A. The Medical Approach

Under a *medicalization* perspective, addiction should be treated rather than punished. This position has roots going back to addiction maintenance clinics that were shut down in the 1920s.²⁴ In the 1960s, the therapeutic position toward addiction was also linked to a broader faith in a *rehabilitative ideal*—a therapeutic alternative to incarceration and punishment for the *disease* of crime.²⁵ This perspective had a distinct ideological flavor since its adherents embraced a more deterministic view of the roots of criminal behavior and a correspondingly

18. See Narcotic Control Act of 1956, Pub. L. No. 84-728, 70 Stat. 567, 568 (imposing a penalty of two to ten years in prison and a fine of up to \$20,000 for violation of federal statutes relating to narcotic drugs and marijuana, even where no specific penalty is provided for the violation); DRUGS AND DRUG POLICY IN AMERICA, *supra* note 8, at 195 (noting that the Boggs Act established mandatory minimum sentences for drug trafficking laws for the first time); PRESIDENT'S COMM'N ON LAW ENFORCEMENT & ADMIN. OF JUSTICE, THE CHALLENGE OF CRIME IN A FREE SOCIETY 223 (1967) ("In 1951, following the post-World War II upsurge in reported addiction, mandatory minimum sentences were introduced for all narcotic and marihuana offenses . . ."). Compare Marihuana Tax Act of 1937, Pub. L. No. 75-238, 50 Stat. 551, 551-52 (levying a tax on, rather than criminalizing, commercial dealings in marijuana), with Boggs Act of 1951, 65 Stat. at 767 (imposing criminal penalties for import and export laws related to drugs as well as establishing mandatory minimum prison sentences for possession of marijuana, cocaine, and opiates).

19. See DRUGS AND DRUG POLICY IN AMERICA, *supra* note 8, at 209 (describing the end of the 1950s as the beginning of a shift in "the focus of American drug policy over the next 20 years . . . to a greater tolerance for drug use, and a greater distinction between the drug seller and drug user"); JAMES C. WEISSMAN, DRUG ABUSE: THE LAW AND TREATMENT ALTERNATIVES 121 (1978) (attributing the shift in drug control policies to a 1961 "joint American Bar Association-American Medical Association report on drug addiction . . . [that] criticized the popular law enforcement approach to addiction control and recommended a more balanced prevention policy").

20. WEISSMAN, *supra* note 19, at 121.

21. See *infra* Part I.A.

22. See *infra* Part I.B.

23. See *infra* Part I.C.

24. See, e.g., EVA BERTRAM ET AL., DRUG WAR POLITICS: THE PRICE OF DENIAL 73 (1996) (describing efforts in the early 1920s to close the numerous clinics that "had emerged . . . [as] an alternative to criminalization and incarceration").

25. See FRANCIS A. ALLEN, THE DECLINE OF THE REHABILITATIVE IDEAL: PENAL POLICY AND SOCIAL PURPOSE 2 (1981) ("[T]he rehabilitative ideal is the notion that a primary purpose of penal treatment is to effect changes in the character, attitudes, and behavior of convicted offenders, so as to strengthen the social defense against unwanted behavior, but also to contribute to the welfare and satisfactions of offenders."); David B. Wexler, *Therapeutic Justice*, 57 MINN. L. REV. 289, 291, 296 (1972) (noting that the United States Supreme Court in *Robinson v. California*, 370 U.S. 660 (1962), "opened the therapeutic door" for treatment of drug users).

narrowed view of when offenders should be held responsible for offending conduct that was so obviously attributable to psychopathology, or to poverty and a “rotten social background.”²⁶ This view was most famously associated with Judge David Bazelon on the Court of Appeals for the District of Columbia Circuit.²⁷ It was also reflected in statutes requiring treatment of sexual psychopaths,²⁸ in Maryland’s Defective Delinquent statute,²⁹ and in the innovative civil commitment statutes for narcotics addicts adopted in California in 1961³⁰ and by Congress in 1966.³¹

B. The Non-Criminal Approach

The *decriminalization* position overlaps with *medicalization* but, as described in this Article, it is more pragmatic and less ideological. Proponents of decriminalization argued that the criminal legal framework was overextended and should be contracted.³² This argument did not raise moral doubts about holding offenders responsible for their transgressions or imply that the underlying causes of criminal behavior are beyond their control; it focused instead on the costs of using

26. See *United States v. Alexander*, 471 F.2d 923, 965 (D.C. Cir. 1973) (Bazelon, C.J., dissenting) (“If we could remove the practical impediments to the free flow of information we might begin to learn something about the causes of crime. We might discover, for example, that there is a significant causal relationship between violent criminal behavior and a ‘rotten social background.’”).

27. See David L. Bazelon, *The Morality of the Criminal Law*, 49 S. CAL. L. REV. 385, 401–03 (1976) (“The overwhelming majority of violent street crime . . . is committed by people at the bottom of the socioeconomic-cultural ladder . . . I must conclude that those people turn to crime for reasons such as economic survival, a sense of excitement or accomplishment, and an outlet for frustration, desperation, and rage. . . . [T]he only apparent solution to the poverty-causes-crime problem is to alleviate the suffering of all deprived people”); cf. Stephen J. Morse, *The Twilight of Welfare Criminology: A Reply to Judge Bazelon*, 49 S. CAL. L. REV. 1247, 1247, 1249–50 (1976) (advocating a contrary view to Judge Bazelon’s analysis of criminal responsibility and social welfare solutions).

28. See, e.g., Edwin H. Sutherland, *The Diffusion of Sexual Psychopath Laws*, 56 AM. J. SOC. 142, 142–48 (1950) (discussing the increase in enactment of sexual psychopath laws that order indefinite confinement for those diagnosed as sexual psychopaths, not as punishment for a crime, but for societal protection); Alan H. Swanson, *Sexual Psychopath Statutes: Summary and Analysis*, 51 J. CRIM. L. CRIMINOLOGY & POLICE SCI. 215, 215 (1960) (noting sexual psychopath laws are grounded in the notion that a sexual psychopath requires special consideration and that the laws are aimed at protecting society and rehabilitating the offender).

29. Defective Delinquents Act, ch. 476, 1951 Md. Laws 1343 (repealed 1999); see also *Tippett v. State of Maryland*, 436 F.2d 1153, 1155–57 (4th Cir. 1971) (summarizing the Defective Delinquents Act as “set[ting] up a comprehensive scheme of referral, examination, commitment, treatment and release of persons suspected of being defective delinquents” and “represent[ing] an enlightened and progressive experiment aimed at rehabilitating persons whose anti-social activities are occasioned, at least in part, by mental disorders”).

30. CAL. WELF. & INST. CODE §§ 3050–3051 (West 1998). The California statute stipulates that, if the judge believes a convicted defendant “may be addicted or . . . in imminent danger of becoming addicted to narcotics,” the “judge shall . . . order the district attorney to file a petition for a commitment . . . in the narcotic detention, treatment and rehabilitation facility” of the Department of Corrections. *Id.*

31. Narcotic Addict Rehabilitation Act of 1966, Pub. L. No. 89-793, § 101, 80 Stat. 1438, 1438–40 (repealed 2000).

32. BONNIE & WHITEBREAD, *supra* note 15, at 270–71.

the criminal justice system to repress certain behavior.³³ A main case in point was illegal drug use, and the primary historical antecedent for the decriminalization argument was alcohol prohibition.³⁴ The Wickersham Commission in 1930 amply documented the costs of prohibition, including lawlessness, corruption and disrespect for law, which led to repeal of the National Prohibition Act.³⁵

This general perspective of decriminalization was widely accepted among law professors and was epitomized in a 1968 article by Professor Sanford Kadish entitled *The Crisis of Overcriminalization*.³⁶ It was also prominently reflected in the task force reports on narcotics and drunkenness prepared for the President's Commission on Law Enforcement and the Administration of Justice and in the Commission's Report.³⁷ The true hallmarks of the decriminalization approach were outright repeal of criminal sanctions (as for consensual sex offenses and gambling) and diversion from the criminal process of offenders for whom drug abuse education, social services, or therapeutic responses were appropriate.³⁸

Doubts about the use of criminal justice to control drug use became even greater in the face of the fundamental change in the social epidemiology of marijuana use and use of other drugs in the 1960s.³⁹ This overall perspective—a

33. *Id.* at 271–72.

34. Stephen J. Schulhofer, *Solving the Drug Enforcement Dilemma: Lessons from Economics*, 1994 U. CHI. LEGAL F. 207, 209.

35. See NAT'L COMM'N ON LAW OBSERVANCE & ENFORCEMENT, REPORT ON THE ENFORCEMENT OF THE PROHIBITION LAWS OF THE UNITED STATES, H.R. Doc. No. 71-722, pt. III, at 44–60 (3d Sess. 1931) (describing the negative aspects of the enforcement of the prohibition laws).

36. Sanford H. Kadish, *The Crisis of Overcriminalization*, 7 AM. CRIM. L.Q. 17, 24–26 (1968) (addressing the problems associated with prohibition, namely the creation of large-scale, black market-type organization to produce and distribute illegal product and to police corruption).

37. See THE CHALLENGE OF CRIME IN A FREE SOCIETY: A REPORT BY THE PRESIDENT'S COMMISSION ON LAW ENFORCEMENT AND ADMINISTRATION OF JUSTICE 133–34, 229 (1967) (endorsing decriminalization of public drunkenness and diversion of people with alcohol, drug, and mental health problems from the criminal justice system). The Commission's Task Force Report on Narcotics and Drug Abuse included consultants' papers recommending a shift of emphasis toward treatment rather than punishment, and decriminalization of possession of marijuana. Richard H. Blum, *Mind-Altering Drugs & Dangerous Behavior: Narcotics*, in TASK FORCE ON NARCOTICS & DRUG ABUSE, PRESIDENT'S COMM'N ON LAW ENFORCEMENT & ADMIN. OF JUSTICE, TASK FORCE REPORT: NARCOTICS AND DRUG ABUSE: ANNOTATIONS AND CONSULTANTS' PAPERS 40, 58–59 (1967); Michael P. Rosenthal, *Proposals for Dangerous Drug Legislation*, in TASK FORCE ON NARCOTICS & DRUG ABUSE, *supra*, at 80, 126; see also NAT'L ADVISORY COMM'N ON CRIMINAL JUSTICE STANDARDS & GOALS, A NATIONAL STRATEGY TO REDUCE CRIME 131–37 (1973) (discussing the Commission's recommendations on reducing the scope of the criminal law, including decriminalizing drunkenness and reevaluating penalties for possession of marijuana, prostitution, pronography, and gambling).

38. WEISSMAN, *supra* note 19, at 121; Aaron Craig, *Gambling on the Internet*, 1998 COMP. L. REV. & TECH. J. 61, 65; Diana Hassel, *The Use of Criminal Sodomy Laws in Civil Litigation*, 79 TEX. L. REV. 813, 819–20 (2001).

39. See NAT'L COMM'N ON MARIHUANA & DRUG ABUSE, *supra* note 6, at 114–16 (“[A]s one proceeds through the criminal justice system, from district attorneys to court clinicians, the people responsible for the functioning of that system seem to be decreasingly enthusiastic about the appropriateness of criminal control and decreasingly insistent on any technique for formal control.”);

cost-benefit, pragmatic analysis—was clearly reflected in the 1972 and 1973 reports of the National Commission on Marijuana and Drug Abuse⁴⁰ and the simultaneous reforms of national and state drug policy that were adopted during the 1970s.⁴¹

First, the Controlled Substances Act⁴² consolidated a patchwork of drug laws and set up an integrated regulatory framework for classifying and scheduling psychoactive drugs based on a balance between their medical utility and their risk of abuse.⁴³ An important policy feature of the Controlled Substances Act was that it radically reduced penalties for drug offenses that had escalated during the 1950s, reducing simple possession to a misdemeanor, grading penalties for commercial offenses, and eliminating mandatory penalties.⁴⁴

Secondly, in the wake of the Commission reports, ten states decriminalized possession of small amounts of marijuana and other consumption-related offenses.⁴⁵ Decriminalization was widely supported by a broad range of

William B. McAllister, *Habitual Problems: The United States and International Drug Control*, in *FEDERAL DRUG CONTROL: THE EVOLUTION OF POLICY AND PRACTICE*, *supra* note 14, at 175, 195, 200 (noting the link between the growth of drug demand in the 1960s and the myriad prevention approaches as “alternatives to the dominant control and enforcement paradigm”).

40. See *Marihuana Research and Legal Controls, 1974: Hearings Before the Subcomm. on Alcoholism and Narcotics of the S. Comm. on Labor and Public Welfare*, 93d Cong. 134, 135 (1974) (statement of Richard J. Bonnie, Associate Professor of Law, University of Virginia Law School, Charlottesville, Va.) (testifying about the 1972 Commission Report); *Marijuana Decriminalization: Hearing on S. 1450 Before the Subcomm. to Investigate Juvenile Delinquency of the S. Comm. on the Judiciary*, 94th Cong. 109, 111 (1975) (statement of Richard Bonnie, Associate Professor of Law, University of Virginia, Charlottesville, Va.) (testifying about the Commission’s recommendation to discourage marijuana use without criminalization); NAT’L COMM’N ON MARIHUANA & DRUG ABUSE, *supra* note 7, at 210–11 (analyzing drug control efforts from a social cost and efficacy perspective).

41. DRUGS AND DRUG POLICY IN AMERICA, *supra* note 8, at 288, 293 (“By the early 1970s, a major policy shift had occurred as a result of the debate over marijuana use. . . . By 1972, [forty-two] of the states and the District of Columbia had . . . classified marijuana possession as a misdemeanor.”); Richard J. Bonnie, *The Meaning of “Decriminalization”: A Review of the Law*, 8 CONTEMP. DRUG PROBS. 277, 278, 283 (1981), *reprinted in* DRUGS AND DRUG POLICY IN AMERICA, *supra* note 8, at 345–46.

42. Comprehensive Drug Abuse Prevention and Control Act, Pub. L. No. 91-513, §§ 101–709, 84 Stat. 1236, 1242–84 (1970). The Controlled Substances Act is the short title for Title II of the Comprehensive Drug Abuse Prevention and Control Act. *Id.* § 101, 84 Stat. at 1242.

43. See Kenneth C. Baumgartner & Michael X. Morrell, *Pharmaceutical Industry Regulation by the Department of Justice*, 23 SYRACUSE L. REV. 785, 793–94 (1972) (summarizing the five schedule classifications that comprise the regulatory framework established under the Controlled Substances Act).

44. Compare BONNIE & WHITEBREAD, *supra* note 15, at 204–07 (discussing the endemic of drug use emerging from the 1940s into the 1950s and the repressive legal response), with Comprehensive Drug Abuse Prevention and Control Act §§ 401–404 (showing the reduction of simple possession to a misdemeanor, grading penalties for commercial offenses, and showing permissive latitude in sentencing guidelines, eliminating mandatory penalties).

45. RICHARD J. BONNIE, *MARIJUANA USE AND CRIMINAL SANCTIONS: ESSAYS ON THE THEORY AND PRACTICE OF DECRIMINALIZATION* 41 (1980); Richard J. Bonnie, *Decriminalizing the Marijuana User: A Drafter’s Guide*, 11 U. MICH. J.L. REFORM 3, 3 (1977).

constituencies,⁴⁶ not on libertarian grounds, but rather on the pragmatic ground that the costs of criminalization outweigh its benefits.⁴⁷ The theory was that the nation's compelling goal of deterring and discouraging drug use, especially by young people, could be achieved through many other tools of social control without arresting hundreds of thousands of people and putting them in jail.⁴⁸

Thirdly, the Commission recommended—and it became federal policy during this period—that the nation make a concerted effort to provide treatment for people with addictions, and specifically to deploy the criminal justice system as an instrument of therapeutic leverage, rather than punishment, for addicted offenders.⁴⁹ Community treatment agencies were set up throughout the country to provide services to offenders diverted from the criminal justice system.⁵⁰ For example, a program called *Treatment Alternative to Street Crime* was created under the Office of the White House to implement this leveraged approach,⁵¹ and a Uniform Drug Dependence Treatment and Rehabilitation Act was drafted to serve as a model for state law.⁵² Among the first programs to make widespread use of methadone maintenance was one established in the District of Columbia in 1971, with the strong support of President Nixon.⁵³ It was not based on any moral commitment to rehabilitative justice, but rather on a hard-headed determination that treating addicted offenders would reduce crime.⁵⁴ In short, the strategy was thought, based on evidence of effectiveness, to achieve measurable social benefits.⁵⁵

46. BONNIE & WHITEBREAD, *supra* note 15, at 270–78.

47. *Id.* at 271.

48. See, e.g., TRAVIS HIRSCHI, CAUSES OF DELINQUENCY 20–23 (1969) (suggesting different theories of social control including commitment to social standing, involvement in communal activities, and designing a personal belief system).

49. NAT'L COMM'N ON MARIHUANA & DRUG ABUSE, *supra* note 7, at 337–42, 405.

50. William L. White, *Trick or Treat? A Century of American Responses to Heroin Addiction, in ONE HUNDRED YEARS OF HEROIN*, *supra* note 17, at 131, 131, 138–40.

51. EDWARD JAY EPSTEIN, AGENCY OF FEAR: OPIATES AND POLITICAL POWER IN AMERICA 226 (1977).

52. WEISSMAN, *supra* note 19, at 142–43. The Act was subsequently withdrawn due to lack of adoptions. *Id.* at 143; Lawrence O. Gostin, *Compulsory Treatment for Drug-Dependent Persons: Justifications for a Public Health Approach to Drug Dependency*, 69 MILBANK Q. 561, 567 (1991) (stating that the Uniform Act was not well received by the states and that not one had adopted it in whole or in part).

53. DAN BAUM, SMOKE AND MIRRORS: THE WAR ON DRUGS AND THE POLITICS OF FAILURE 30–31 (1996) (indicating that the Narcotics Treatment Administration (NTA) received \$7.5 million in 1970, opening twenty methadone treatment centers in the District of Columbia); Robert L. DuPont, *Heroin Addiction Treatment and Crime Reduction*, 128 AM. J. PSYCHIATRY 856, 857 (1972) (noting that, by the spring of 1971, the NTA had about 2700 heroin addicts in treatment in the District of Columbia and that low-dose methadone treatment was used).

54. DuPont, *supra* note 53, at 857, 859.

55. *Id.* at 859; see also MUSTO & KORSMEYER, *supra* note 8, at 81–82. Studies of these programs showed a lower rate of self-reported crime and arrest during and after methadone treatment than before,

Using the criminal justice system for therapeutic leverage was a component of a broader investment in prevention and treatment—in “demand reduction,” as it came to be called. Perhaps the most important federal legislative initiative during this period was the Drug Abuse Office and Treatment Act of 1972.⁵⁶ This path-breaking law not only set up SAODAP within the White House for the specific purpose of focusing on prevention and treatment,⁵⁷ but also enveloped substance abuse treatment in a nearly airtight cloak of confidentiality as a means of assuring that the patients’ health information would be protected, and thereby drew people into treatment voluntarily rather than having to push them into treatment through coercion.⁵⁸

C. The Libertarian Approach

A third intellectual thread of the discourse of drug policy reform during the 1960s was the libertarian approach. According to this perspective, people have a right to control their bodies and minds and a “right to be different,”⁵⁹ and these rights encompass a right to use drugs for “self-defined” purposes, including intoxication.⁶⁰ Obviously, this position is explicitly ideological, not pragmatic, and, quite frankly, it has never had any traction in the policy arena. Indeed, libertarian rhetoric has mainly served to contaminate the more pragmatic arguments of reform by giving defenders of the current policy an easy target, and enabling them to tar the more pragmatic position with the same brush that they criticize the libertarian position.

or as compared to program drop-outs. See, e.g., DuPont, *supra* note 53, at 859 (reporting an association between heroin treatment and a reduction in serious crime in Washington, D.C. in 1970); Robert L. DuPont & Richard N. Katon, *Development of a Heroin-Addicted Treatment Program: Effect on Urban Crime*, 216 JAMA 1320, 1323 (1971) (reporting that narcotic treatment programs “have benefited the heroin-addict patient and his family in many ways as shown by increased employment, decreased arrests, and decreased use of illicit drugs”).

56. Drug Abuse Office and Treatment Act of 1972, Pub. L. No. 92-255, 86 Stat. 65 (codified as amended at 21 U.S.C. §§ 1101–1181).

57. *Id.* § 201, 86 Stat. at 67; see also DRUGS AND DRUG POLICY IN AMERICA, *supra* note 8, at 250 (describing the establishment of the SAODAP as the first time that “a president gave priority to prevention and treatment efforts”).

58. Jerome H. Jaffe, *One Bite of the Apple: Establishing the Special Action Office for Drug Abuse Prevention*, in ONE HUNDRED YEARS OF HEROIN, *supra* note 17, at 43, 51.

59. See generally NICHOLAS N. KITTRIE, THE RIGHT TO BE DIFFERENT: DEVIANCE AND ENFORCED THERAPY (1971). In order to protect “fundamental rights and liberties of individuals” there must be a Therapeutic Bill of Rights that reflects “differing patients, goals, and methods of treatment . . .” *Id.* at 402. The Therapeutic Bill of Rights reflects “Man’s innate right to remain free of excessive forms of human modification” and his ability to act upon his “fundamental rights and liberties.” *Id.*

60. See BONNIE & WHITEHEAD, *supra* note 15, at 118 (noting that early drug policy likely failed to address “the use of drugs for pleasure or other self-defined purposes”); JACOB SULLUM, SAYING YES: IN DEFENSE OF DRUG USE (2003) (discussing various arguments for and against drug use, including “the desire to alter one’s consciousness”). See generally DOUGLAS N. HUSAK, DRUGS AND RIGHTS 44–51 (1992) (discussing the rights associated with recreational use of drugs).

II. THE REGRESSIVE PERIOD

It has been widely recognized that the reform period was short-lived. Indeed, it came to an end during the late 1970s and was followed by a repressive “war on drugs” for two decades.⁶¹ The war on drugs was predicated on a belief that unyielding reliance on criminal punishment and other sanctions and social disapproval (“zero tolerance”) was necessary to suppress drug use.⁶² Under this view, any policy or social practice that tolerates drug use is thought to encourage it, and strong punishments by the criminal law are regarded as absolutely essential. It is self-evident that this moralistic perspective rejects all of the reform perspectives described above.⁶³ The war-on-drugs approach eschews not only a rights-oriented libertarian view, but also rejects the self-restraint in the use of criminal sanctions and incarceration that is a cardinal feature of the decriminalization perspective. Finally, it also rejects the medical approach to the extent that allowing treatment in lieu of punishment could weaken the message of zero tolerance.⁶⁴

After twenty years, the pendulum is finally swinging away from the uncompromising ideologically-driven premise of the war on drugs and zero tolerance. The costs of the war in lives as well as treasure have been very high, and the benefits are at best difficult to assess.⁶⁵ In 2001, the National Research Council, an arm of the National Academy of Sciences, issued an important report on drug policy.⁶⁶ The study committee, on which I served, had been directed to assess the adequacy of the data and research for making informed drug policy.⁶⁷ The committee pointed out that the evidence base for policy-making was relatively strong on the demand side because the pertinent National Institutes of Health and other federal agencies, especially the Substance Abuse and Mental Health Services Administration (SAMHSA), had invested a great deal of funding to assess the efficacy and effectiveness of prevention interventions and treatments for addiction.⁶⁸ In contrast, the committee pointed out that virtually no evidence exists

61. For a discussion of the “war on drugs”, see BAUM, *supra* note 53, at vii; ARTHUR BENAVIDE, *DRUGS: AMERICA’S HOLY WAR* (2009); GARY L. FISHER, *RETHINKING OUR WAR ON DRUGS: CANDID TALK ABOUT CONTROVERSIAL ISSUES* 1–5 (2006); MARK A.R. KLEIMAN, *AGAINST EXCESS: DRUG POLICY FOR RESULTS* 135–50 (1992); MICHAEL MASSING, *THE FIX* 186 (1998).

62. Duane C. McBride et al., *Alternative Perspectives on the Drug Policy Debate*, in *THE DRUG LEGALIZATION DEBATE* 9, 15 (James A. Inciardi ed., 2d ed. 1999).

63. See *supra* Part I.

64. Eric Blumenson, *Recovering From Drugs and the Drug War: An Achievable Public Health Alternative*, 6 *J. GENDER RACE & JUST.* 225, 231 (2002).

65. FISHER, *supra* note 61, at 6–8; NAT’L RESEARCH COUNCIL, *INFORMING AMERICA’S POLICY ON ILLEGAL DRUGS: WHAT WE DON’T KNOW KEEPS HURTING US* 1–3 (Charles F. Manski et al. eds., 2001); Rufus King, *A Worthless Crusade*, in *THE CRISIS IN DRUG PROHIBITION* 122, 123 (David Boaz ed., 1990).

66. NAT’L RESEARCH COUNCIL, *supra* note 65.

67. *Id.* at 1–2.

68. *Id.* at 273–74.

with respect to the effectiveness of measures being taken on the supply side, not only regarding the effects of enforcement on price and availability but also regarding the effects of locking up hundreds of thousands of people who sell or use drugs.⁶⁹ There was, and is, very little research and very little evidence of effectiveness of the drug policies on which billions of dollars are spent every year.⁷⁰

The committee was charged only with assessing the science base for making drug policy, not with making policy recommendations.⁷¹ However, the committee did ask, rhetorically, how the government could have implemented a policy of this scope, expending tens of billions of scarce public dollars every year (with major collateral effects on peoples' lives) without making any effort to assess its effectiveness.⁷² We characterized the government's indifference to this lack of evidence as "unconscionable," as indeed it is.⁷³

It is long since time to return to the more pragmatic, evidence-based perspective that was ascendant for about a decade in the late 1960s and 1970s. How should we go about resurrecting and implementing this approach today?

III. SOME IMPLICATIONS

The argument in this Article entails many changes in drug policy, including a much more hard-headed look at the gains and costs of alternative enforcement strategies. However, this Article will concentrate on three basic implications regarding the treatment of addiction.⁷⁴

The first implication has to do with vocabulary, which is extremely important in policy discourse. Consider, for example, the significance of recent discussions about whether the nation is undertaking a "bailout" of the financial system or a "rescue plan" for the American economy.⁷⁵ Vocabulary has proven to be especially

69. *Id.* at 274–75.

70. *Id.* at 272, 274–75 (discussing the lack of evidence on the effectiveness of drug policies during both the early 1970s and the late 1990s).

71. *Id.* at 2.

72. *Id.* at 274, 279.

73. *Id.* at 11, 279.

74. See *infra* Parts III.A–C. For a more elaborate presentation of the issues described in this section, see generally Richard J. Bonnie, *Responsibility for Addiction*, 30 J. AM. ACAD. PSYCHIATRY & L. 405, 405–13 (2002).

75. See, e.g., Knight Kiplinger, Editorial, *Don't Call It a Bailout*, KIPLINGER.COM, Oct. 1, 2008, http://www.kiplinger.com/features/archives/2008/10/government_plan_not_a_bailout.html?kipad_id=1?kipad_id=1. The editorial implored society to use certain vocabulary when discussing the government's efforts to address the recent ailing economy:

It's time to banish the word "bailout" from our financial journalism vocabulary. The press's overuse and misuse of this pejorative, misleading word accounts for part of Washington's difficulty in crafting a plan to stabilize credit markets. . . . Call it a lifeline, a stabilization plan, a buyout—anything but a bailout. It's no sweet deal for Wall Street. But it is indeed a

important in the context of drug policy because progressive positions seem always to be successfully characterized as being more radical than they are.⁷⁶ For example, the Commission purposely selected the term “decriminalization” as a way of clearly distinguishing the policy it was recommending from “legalization.”⁷⁷ The Commission specifically rejected the view that marijuana should be lawfully available for non-medical use (legalization), and recommended instead that the prohibition against cultivation and distribution for non-medical purposes should remain in force.⁷⁸ However, we saw no strong reason to criminalize people who do obtain the drug for their own use despite the efforts that society has undertaken to keep it from them.⁷⁹ Arresting, prosecuting, and punishing people for using marijuana is much too costly a strategy for deterring the use of the drug; instead we should rely on instruments of social control other than criminal sanctions.⁸⁰ Hence, we used the term *decriminalization*.⁸¹ Recognizing the possibility that the term could be misunderstood, we also used the phrase “partial prohibition” to describe our approach.⁸² It turns out, of course, that the critics of our position characterized it as legalization in order to make it seem more radical.⁸³ In effect, calling it legalization aligns the cost-cutting, prudent, pragmatic approach of decriminalization with the libertarian position.⁸⁴

As can be easily seen, a key issue in drug policy discourse is determining who controls the vocabulary.⁸⁵ The challenge is to find exactly the right words to send the message that one is trying to convey. For instance, a key issue for addiction policy is embedded in the vocabulary of “disease” and the vocabulary of

rescue—a rescue of everyone who is involved in the U.S. economy, as a worker, small investor, pensioner or saver.

Id.

76. See, e.g., Avram Goldstein & Harold Kalant, *Drug Policy: Striking the Right Balance*, 249 SCI. 1513, 1513 (1990) (describing the cost-benefit approach as “radical steps to repeal the prohibitions of presently illicit drugs [that] would be likely, on balance, to make matters worse rather than better”).

77. See NAT’L COMM’N ON MARIHUANA & DRUG ABUSE, *supra* note 6, at 150–51 (“[W]e have . . . rejected the regulatory legalization scheme . . . [but instead] we recommend only a decriminalization of possession of marihuana for personal use on both the state and federal levels.”).

78. *Id.* at 150–53.

79. *Id.* at 150.

80. *Id.* at 143–44.

81. *Id.* at 151.

82. *Id.* at 150.

83. See MUSTO & KORSMEYER, *supra* note 8, at 114–15.

84. See BONNIE & WHITEBREAD, *supra* note 15, at 271 (describing the pragmatic approach recommended by the Commission as including policy recommendations that remove government controls, such as implementing selective enforcement and prosecution); McBride et al., *supra* note 62, at 37 (“The decriminalization perspective simply wants to eliminate laws that prohibit or regulate the manufacture or distribution of current illegal drugs. . . . [T]he basic position is that of libertarianism.”).

85. See, e.g., BONNIE & WHITEBREAD, *supra* note 15, at 97–98, 112 (discussing various efforts by government agencies, legislatures, and public opinion makers to influence the public regarding the “marihuana menace”).

“choice.”⁸⁶ This Article argues that society must learn to use both words at the same time.⁸⁷ Neither alone gets it right.

The second implication is that a core aim of addiction policy should be to do what the 1972 Act was designed to do—to create incentives and opportunities for people with addictions to choose to seek addiction treatment on their own.⁸⁸ Treatments known to be effective should be available and, given the high social cost of addiction and drug abuse, should be subsidized.⁸⁹

The third implication is that, although criminal sanctions for addicted offenders should be retained, therapeutic leverage through the criminal justice system should be broadly encouraged and funded.⁹⁰ This approach revives a key element of the progressive approach that was implemented during the 1970s.⁹¹ This change is already well underway;⁹² however, it should be reinforced and intensified.⁹³

The following sections discuss each of these three claims in a bit more depth.

A. The Vocabulary of Addiction

For over a decade, the scientific leadership of the addiction field has been waging a broad dissemination campaign to bring advances in our understanding of the neuroscience of addiction to professional and public attention—within medicine, among opinion-makers, and among the general public.⁹⁴ This campaign has a *motto*: “Addiction is a Brain Disease.”⁹⁵ The core message was reflected in

86. PETER J. COHEN, *DRUGS, ADDICTION, AND THE LAW: POLICY, POLITICS, AND PUBLIC HEALTH* 59 (2004). Evaluating the distinction between drug addiction as a disease or a choice, Cohen states that:

Society has viewed addicts as being responsible for their problems However, over time, users lose control over their drug use and become addicted. To deal with their addiction effectively requires a shift away from blaming them . . . and toward treating them. The focus must change from “who is at fault” to “what to do about the problem.”

Id.

87. See *infra* Part III.A.

88. See H.R. REP. NO. 92-775 (1972), *reprinted in* 1972 U.S.C.C.A.N. 2045, 2057 (stating one of the purposes of the SAODAP was to “provide for medical treatment or assistance” for drug addicts and to “assure that . . . agencies construe drug abuse as a health problem”); *infra* Part III.B.

89. See *infra* Part III.B.

90. See *infra* Part III.C.

91. See MUSTO & KORSMEYER, *supra* note 8, at 72 (commenting on the use of “treatment and rehabilitation as integral parts of narcotics control policy” in 1970).

92. See *infra* notes 158–60 and accompanying text.

93. See *infra* Part III.B.

94. Bonnie, *supra* note 74, at 405; see also Alan I. Leshner, *Addiction Is a Brain Disease, and It Matters*, 278 SCI. 45, 45 (1997) (“There is a wide gap between the scientific facts and public perceptions about drug abuse and addiction. . . . [The scientific community] must bridge this informational disconnection . . . to make any real progress in controlling drug abuse and addiction.”).

95. Richard J. Bonnie, *Addiction and Responsibility*, 68 SOC. RES. 813, 815 (2001); Leshner, *supra* note 94, at 46 (explaining the importance of the understanding that addiction is a brain disease).

the standard presentation delivered by Alan Leshner when he was Director of the National Institute on Drug Abuse:

That addiction is tied to changes in brain structure and function is what makes it, fundamentally, a brain disease. A metaphorical switch in the brain seems to be thrown as a result of prolonged drug use. Initially, drug use is a voluntary behavior, but when that switch is thrown, the individual moves into the state of addiction, characterized by compulsive drug seeking and use.⁹⁶

The characterization of addiction as a “brain disease” has been contested.⁹⁷ In my view, it is best understood as a political statement rather than a scientific claim.⁹⁸ To say that addiction is a brain disease is useful as a rhetorical tool in a debate about public policy; but, scientifically, it is both incomplete and premature.⁹⁹ It is *incomplete* because it fails to communicate the whole story about the behavioral and contextual components of addiction.¹⁰⁰ Behavioral components are much more substantial in addiction than in Alzheimer’s disease, Parkinson disease, epilepsy, or schizophrenia.¹⁰¹ It is *premature* because research has not connected the observed changes in the brain to behavior.¹⁰² After all, Dr. Leshner found it necessary to speak metaphorically because we cannot yet speak scientifically.¹⁰³ It is still not possible to explain the mechanisms and processes in the brain that transform controlled use of drugs to addiction.¹⁰⁴

Notwithstanding its scientific shortcomings, I embrace the characterization of addiction as a brain disease as a political statement; medicalization of addiction (as a policy choice) will have salutary effects on the lives of people enmeshed in drug use and on society, whether or not this term captures the full complexity of the condition.¹⁰⁵ Addiction is amenable to treatment—although outcome evaluations of

96. *Id.*

97. See, e.g., SALLY L. SATEL & FREDERICK K. GOODWIN, ETHICS & PUB. POLICY CTR., IS DRUG ADDICTION A BRAIN DISEASE? 22 (1998) (“Efforts to neutralize the stigma of addiction by convincing the public that the addict has a ‘brain disease’ are understandable, but in the long run they have no more likelihood of success than the use of feel-good slogans to help a child acquire ‘self-esteem.’”); Stephen J. Morse, *Hooked on Hype: Addiction and Responsibility*, 19 LAW & PHIL. 3, 49 (2000) (“Despite the exciting, undoubted advances in the biological understanding of addiction and despite the plausibility of considering addictions as diseases, the disease model does not and cannot fully explain addiction or inform social and legal policy concerning addiction.”).

98. Bonnie, *supra* note 74, at 406.

99. *Id.*

100. *Id.* In his standard presentation, Dr. Leshner is always careful to note that addiction is “not just a brain disease.” Leshner, *supra* note 94, at 46 (emphasis added).

101. Bonnie, *supra* note 74, at 406.

102. *Id.*

103. *Id.*

104. *Id.*; A. Thomas McLellan et al., *Drug Dependence, A Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation*, 284 JAMA 1689, 1693 (2000).

105. Bonnie, *supra* note 74, at 406.

treatment must take into account the high probability of relapse—and our society should be investing more resources in treatment while reducing its expenditures on incarceration and enforcement.¹⁰⁶ Moreover, continued investment in research is likely to pay off in therapeutic advances, although there is likely to be no “biological fix” for addiction.¹⁰⁷

One prominent rhetorical feature of the campaign needs much more careful scrutiny, however—the issue of “voluntariness.”¹⁰⁸ According to two leading clinical researchers on addiction, “[a]t some point after continued repetition of voluntary drug-taking, the drug ‘user’ loses the voluntary ability to control its use. At that point, the ‘drug misuser’ becomes ‘drug addicted’ and there is a compulsive, often overwhelming *involuntary* aspect to continuing drug use and to relapse after a period of abstinence.”¹⁰⁹ Dr. Leshner puts the point this way:

We need to face the fact that even if the condition initially comes about because of a voluntary behavior (drug use), an addict’s brain is different from a nonaddict’s brain, and the addicted individual must be dealt with as if he or she is in a different brain state. We have learned to deal with people in different brain states for schizophrenia and Alzheimer’s disease. Recall that as recently as the beginning of [the twentieth] century we were still putting individuals with schizophrenia in prisonlike asylums, whereas now we know they require medical treatments. We now need to see the addict as someone whose mind (read: brain) has been altered fundamentally by drugs.¹¹⁰

The emphasis on involuntariness bristles with implication for responsibility.¹¹¹

Medicalizing addiction and emphasizing its neurobiological underpinnings is meant to negate the common belief that addiction manifests a moral weakness or a flaw of character, and thereby to counteract stigmatization and punishment.¹¹² Presumably people should not be held morally and legally accountable for behavior that is involuntary.¹¹³ But we should take a much closer look at these assertions.¹¹⁴ What is meant by the concept of involuntariness in this context?

106. *Id.*

107. *Id.*

108. *Id.*

109. *Id.*; Charles P. O’Brien & A. Thomas McLellan, *Myths About the Treatment of Addiction*, 347 LANCET 237, 237 (1996).

110. Bonnie, *supra* note 74, at 406; Leshner, *supra* note 94, at 46.

111. Bonnie, *supra* note 74, at 406.

112. *Id.*

113. *Id.*

114. *Id.*

1. Addiction

What is meant when it is said that drug use becomes involuntary after “the switch is flipped”? Does the disease cause drug use in the way that a brain lesion causes epileptic seizures or loss of cerebral blood flow causes loss of consciousness? This is the language of mechanism, and the language of choice or voluntariness has no place.¹¹⁵ Nevertheless, something *more* is involved with addiction than mechanism.¹¹⁶ Addiction is “not just a brain disease.”¹¹⁷ The link between brain and behavior is mediated through consciousness.¹¹⁸ Thus, to characterize an addict’s drug use as “involuntary” and symptomatic of disease is quite different from describing a seizure as involuntary; in terms of responsibility, this is a very important distinction.¹¹⁹

Even within the realm of conscious experience, there are situations where we properly say that a person has no *real* choice (like grasping the edge of a cliff, where the inevitable effects of muscular fatigue will prevail, no matter how hard the victim chooses to resist).¹²⁰ This, however, is the language of mechanism. But this is not what is meant by *loss of control* in addiction; instead the term means that due to neurobiological processes deep in the brain over which the addict no longer has any control, he is experiencing a *strong need for or desire for substance, and that this need is so great that it is unlikely that he will be able to resist it*.¹²¹ This is the language of choice and compulsion rather than mechanism and causation.¹²²

The addict has a choice, just as a person experiencing “duress” (“push the button or I’ll kill you”) has a choice.¹²³ Such situations involve a *hard choice* rather than *no choice*. Clinically, we are addressing what most accurately might be called

115. Cf. Morse, *supra* note 97, at 4–5 (“[H]ypertension and infections are themselves mechanisms. The sufferer can not terminate all the signs and symptoms of the disease simply by intentionally choosing to cease being hypertensive or infected.”).

116. Stephen J. Morse, *Addiction, Genetics, and Criminal Responsibility*, 69 LAW & CONTEMP. PROBS. 165, 178 (2006).

117. See *supra* notes 99–104 and accompanying text.

118. Bonnie, *supra* note 74, at 407.

119. *Id.*

120. *Id.*; see also Morse, *supra* note 97, at 5 (noting that the brain disease model of addiction suggests that the addict has no control once prolonged use has caused the pathology).

121. Bonnie, *supra* note 74, at 407. But see Michael Louis Corrado, *Addiction and Responsibility: An Introduction*, 18 LAW & PHIL. 579, 581 (1999) (noting that, although it is generally stated that addicts cannot help themselves, they are nonetheless conscious of their actions and choose to act in that manner).

122. Bonnie, *supra* note 74, at 407; see also Morse, *supra* note 97, at 12–13 (describing *compulsive* as the key term).

123. Bonnie, *supra* note 74, at 407; see also Morse, *supra* note 97, at 31–32 (applying the defense of *duress* as a model for excuse based on “disorders of desire”); cf. Corrado, *supra* note 121, at 584 (noting that *addiction as duress* exists when the addict uses his drug to rationally avoid pain as opposed to rationally pursue greater pleasure).

“impairments of volition,” rather than “involuntary behavior.”¹²⁴ This important conceptual distinction is needed to connect scientific and clinical ideas about addiction (and other pathological conditions involving so-called compulsions, such as obsessive compulsive disorders) to the vocabulary of responsibility.¹²⁵

2. Relapse

The nature of relapse is another issue too easily blurred by the brain disease rhetoric. Even after detoxification and a period of abstinence, addicts have a strong susceptibility to relapse. In fact, forty to sixty percent of patients treated for addiction relapse within a year,¹²⁶ and the rate is highest for tobacco addiction.¹²⁷ Many suggest that this tendency to relapse is not voluntary because the person has no control over conditioned responses associated with previous drug-taking. As one group of leading addiction researchers explains:

[One neurobiological] explanation for [addicts'] tendency to relapse lies in the integration of the reward circuitry with the motivational, emotional and memory centers that are co-located within the limbic system. These interconnected regions allow the organism not only to experience the pleasure of rewards, but also to learn the signals for them and to respond in an anticipatory manner. Repeated pairing of a person (drug-using friend), place (corner bar), thing (paycheck), or even an emotional state (anger, depression) with drug use can lead to rapid and entrenched learning or conditioning. Thus, previously drug-dependent individuals who have been abstinent for long periods may encounter a person, place or thing that previously was associated with their drug use, producing significant physiologic reactions such as withdrawal-like symptoms and profound subjective desire or craving for the drug. These responses can combine to fuel the “loss of control” that is considered a hallmark of drug dependence.¹²⁸

124. Bonnie, *supra* note 74, at 407; Morse, *supra* note 97, at 31–32.

125. Bonnie, *supra* note 74, at 407; *see generally* Morse, *supra* note 97, at 5, 23–45 (discussing addiction and responsibility).

126. Bonnie, *supra* note 74, at 407; McLellan et al., *supra* note 104, at 1689.

127. Bonnie, *supra* note 74, at 407; *see also* Neal L. Benowitz, *Nicotine Addiction*, 26 PRIMARY CARE: CLINICS IN OFFICE PRACTICE 611, 615–16 (1999) (noting that an average seventy percent of smokers who try to quit relapse in three months and that the rate is similar to that observed for heroin addicts and alcoholics). *Cf.* CTRS. FOR DISEASE CONTROL & PREVENTION, U.S. DEP'T OF HEALTH & HUMAN SERVS., CIGARETTE SMOKING AMONG ADULTS—UNITED STATES, 2007, 57 MORBIDITY & MORTALITY WKLY. REP. 1221, 1224–25 (2008), *available at* <http://www.cdc.gov/mmwr/PDF/wk/mm5745.pdf> (reporting that most smokers who attempt to quit do not use recommended cessation methods and that, of these “untreated smokers,” only four to seven percent are likely to have permanent success in quitting); NAT'L INST. ON DRUG ABUSE, U.S. DEP'T OF HEALTH AND HUMAN SERVS., TOBACCO ADDICTION 3 (2009), *available at* http://www.drugabuse.gov/PDF/TobaccoRRS_v16.pdf (indicating that more than eighty-five percent of smokers who attempt to quit on their own relapse, most of them within the first week).

128. McLellan et al., *supra* note 104, at 1691.

Does it make sense to characterize relapse as “involuntary” under these circumstances? The physiologically conditioned feelings may be involuntarily aroused, and relapse may be made more likely by this conditioning and the accompanying neurobiological changes.¹²⁹ But the addict is not an automaton, responding mindlessly to the environmental cues.¹³⁰ Instead, the addict has a strong predisposition or vulnerability to relapse.¹³¹ Of course, relapse is not inevitable and its likelihood can be reduced if the addict will *choose* to avoid the contexts or environments that tend to trigger relapse and will *choose* to seek and adhere to treatment.¹³²

Note that this discussion simultaneously uses the probabilistic vocabulary of *causation* and the individual-centered language of *choice*. Clinically speaking, the experience of compulsion is the experience of feeling that one must choose to do something in order to avoid pain or dysphoria.¹³³ Similarly, whether a particular individual can avoid relapse is at least partly affected by whether he or she *chooses* to take precautions, such as to avoid exposure to the environmental cues.¹³⁴

The central claim in this Article is that the concepts of disease and choice are compatible, and that the law, which is based on our shared moral intuitions, can easily incorporate advances in our understanding of the neural substrates of addiction.¹³⁵ The advances amend, but do not displace, the vocabulary of choice.

B. The Case for Subsidizing Treatment

Public policy needs to create incentives and opportunities for people addicted to drugs to choose treatment. Treatment can work, as shown by the abundant evidence of cost-effectiveness.¹³⁶ The legal structure that is needed for increasing access has been in place since 1972.¹³⁷ The Drug Abuse Office and Treatment Act was probably the most important statute enacted during the short era of enlightened

129. Bonnie, *supra* note 74, at 407; McLellan et al., *supra* note 104, at 1691.

130. Bonnie, *supra* note 74, at 407; Morse, *supra* note 116, at 166.

131. Bonnie, *supra* note 74, at 407.

132. *Id.* See generally Carlo C. DiClemente, *Motivation for Change: Implications for Substance Abuse Treatment*, 10 PSYCHOL. SCI. 209, 209–12 (1999) (suggesting that recovery is more likely when addicts are motivated to seek and adhere to treatment and where motivation is defined broadly to include actions “shaped by contingencies, driven by unconscious motives, or directed by self-regulation”).

133. Bonnie, *supra* note 74, at 407; see also Morse, *supra* note 116, at 188 (discussing “compulsive” states and will “to remove . . . dysphoria”).

134. Bonnie, *supra* note 74, at 407.

135. *Id.* at 407–08.

136. E.g., Redonna K. Chandler et al., *Treating Drug Abuse and Addiction in the Criminal Justice System: Improving Public Health and Safety*, 301 JAMA 183, 184–85 (2009) (explaining the success of medication as part of drug treatment and the cost-effectiveness of treatment compared to incarceration).

137. See SUBSTANCE ABUSE: A COMPREHENSIVE TEXTBOOK 7 (Joyce H. Lowinson et al. eds., 3d ed. 1997) (describing the establishment of the SAODAP).

and progressive drug policy.¹³⁸ Yet most people who need treatment are not seeking it. SAMHSA has estimated that about one-in-ten people with serious substance abuse problems (2.3 million of 21.2 million) received treatment in 2007.¹³⁹ The available services are not easily accessible to those who do seek it due to waiting lists and inconvenience,¹⁴⁰ and the services offered are typically too thin and therefore not as effective as they could be.¹⁴¹ The simple fact is that funding has never been sufficient and addiction treatment has never been adequately mainstreamed as a component of health care, a problem also associated with mental health care.¹⁴²

In addition, parity in insurance is a huge development but will not get us where we need to be, mainly because the vast majority of people with severe addictive disorders—especially cocaine and opiate addictions—do not have private insurance.¹⁴³ In any given year, about twenty-five percent of the payment for substance abuse treatment is by private insurance.¹⁴⁴ If the nation ever commits itself to universal access to health care as a right,¹⁴⁵ perhaps we can then be reasonably confident that it will include addiction.¹⁴⁶ In the absence of universal health insurance, however, the policy question is whether public funds should be used to subsidize more accessible and better treatment for people who lack

138. See Jean Wellisch et al., *Criminal Justice and Drug Treatment Systems Linkage: Federal Promotion of Interagency Collaboration in the 1970s*, 20 CONTEMP. DRUG PROBS. 611, 617–18 (1993) (discussing the development of the SAODAP); *supra* note 56.

139. OFFICE OF APPLIED STUDIES, U.S. DEP'T OF HEALTH & HUMAN SERVS., TREATMENT FOR SUBSTANCE USE AND DEPRESSION AMONG ADULTS, BY RACE/ETHNICITY (2009), available at <http://www.oas.samhsa.gov/2k9/163/SusUseRaceEthnicityHTML.pdf>.

140. Cristina Redko et al., *Waiting Time as a Barrier to Treatment Entry: Perceptions of Substance Users*, 36 J. DRUG ISSUES 831, 831 (2006).

141. CTR. FOR SUBSTANCE ABUSE TREATMENT, U.S. DEP'T OF HEALTH & HUMAN SERVS., HHS PUB. NO. SMA 09-4377, IMPLEMENTING CHANGE IN SUBSTANCE ABUSE TREATMENT PROGRAMS 2 (2009) (suggesting substance abuse treatment programs lack adequate resources for “implementing more effective practices”).

142. See TINA MCREE et al., CALIFORNIA WORKFORCE INITIATIVE, THE MENTAL HEALTH WORKFORCE: WHO'S MEETING CALIFORNIA'S NEEDS? 5–6 (2003) (describing the lack of funding for mental health care in the 1990s and the inability of state and local governments to make up for the lack of federal funding); William S. Cartwright & Paul L. Solano, *The Economics of Public Health: Financing Drug Abuse Treatment Services*, 66 HEALTH POL'Y 247, 257–58 (2003) (describing insufficient funding for substance abuse programs and noting the need for mainstreaming medical and drug abuse treatments).

143. COHEN, *supra* note 86, at 331.

144. TAMI L. MARK ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., NATIONAL EXPENDITURES FOR MENTAL HEALTH SERVICES AND SUBSTANCE ABUSE TREATMENT: 1993–2003, at 15 (2007).

145. See Richard J. Bonnie, *Three Strands of Mental Health Law: Development Mileposts*, in THE EVOLUTION OF MENTAL HEALTH LAW 31, 51 (Lynda E. Frost & Richard J. Bonnie eds., 2001) (noting society's failure “to embrace the principle of universal access to health care”).

146. See *An Illness, Not a Stigma*, BALT. SUN, Sept. 28, 2009 (calling upon Congress to include substance abuse treatment in health care reform and noting that seventy-seven percent of Americans and seventy-four percent of Marylanders support including addiction treatment in health care reform).

insurance.¹⁴⁷ In short, the best argument for subsidizing drug abuse treatment today is not that people with addiction should have the same access to treatment as people with other health conditions—that is not good enough in the absence of universal coverage.¹⁴⁸ Instead, treatment for addiction should be available to everyone who needs it because treatment is known to be cost-effective and the social cost of untreated addiction is very high.¹⁴⁹

It is also important to note that the 2008 National Drug Control Strategy¹⁵⁰ endorses the “brain disease” characterization and touts the importance of providing treatment as a necessary component of the comprehensive national strategy.¹⁵¹ However, the strategy focuses its discussion of providing treatment to criminal offenders.¹⁵² This is a step forward, to be sure, but the report does not even mention the importance of helping people find their way into treatment voluntarily and providing the necessary services. This was, in fact, the core insight of the 1972 Act.¹⁵³ It is in society’s interest to make addiction treatment genuinely accessible to people who want to regain control over their lives.¹⁵⁴ Providing treatment when they are in the criminal justice system is a good idea, but a criminal arrest should not be the ticket to otherwise inaccessible addiction treatment services.

C. The Residual Role of Criminalization

Finally, what is the proper role of criminalization? Incarcerating hundreds of thousands of drug users has been a costly mistake, as many state governments have

147. NORMAN DANIELS & MARC ROBERTS, HASTINGS CTR., FROM BIRTH TO DEATH AND BENCH TO CLINIC: THE HASTINGS CENTER BIOETHICS BRIEFING BOOK FOR JOURNALISTS, POLICYMAKERS, AND CAMPAIGNS 84 (2008).

148. See COHEN, *supra* note 86, at 331–34 (detailing the failure of efforts to achieve mental health parity in Congress and in the courts based upon the argument that people with addiction and mental health problems should receive the same treatment as people with physical illnesses).

149. See NAT’L INST. ON DRUG ABUSE, NAT’L INSTS. OF HEALTH, NIH PUB. NO. 09-4180, PRINCIPLES OF DRUG ADDICTION: A RESEARCH-BASED GUIDE 12 (2d ed. 2009), available at <http://www.nida.nih.gov/PDF/PODAT/PODAT.pdf> (concluding that drug addiction treatment is cost-effective); OFFICE OF NAT’L DRUG CONTROL POLICY, EXECUTIVE OFFICE OF THE PRESIDENT, PUB. NO. NCJ-190636, THE ECONOMIC COSTS OF DRUG ABUSE IN THE UNITED STATES: 1992–1998, at 2 (2001) (stating that the societal cost of drug abuse was \$143.4 billion by 1998); Chandler et al., *supra* note 136, at 184–85 (explaining the cost-effectiveness of treating drug-involved offenders).

150. EXECUTIVE OFFICE OF THE PRESIDENT, NATIONAL DRUG CONTROL STRATEGY: 2008 ANNUAL REPORT (2008), available at <http://www.ncjrs.gov/pdffiles1/ondcp/221371.pdf>.

151. *Id.* at 31.

152. *Id.* at 29–31.

153. See H.R. REP. NO. 92-775 (1972), reprinted in 1972 U.S.C.C.A.N. 2045, 2053.

154. See COHEN, *supra* note 86, at 309 (discussing studies that indicate the effectiveness of treatment); WEISSMAN, *supra* note 19, 25–31 (discussing the substantially larger societal costs of drug abuse relative to drug treatment and asserting that society ought to be committed to the highest development of human potential); Chandler et al., *supra* note 136, at 185 (discussing the present lack of access to treatment).

finally recognized.¹⁵⁵ Providing treatment alternatives to criminal punishment was a key component of the strategy of the 1970s¹⁵⁶ that was eroded during the 1980s and early 1990s.¹⁵⁷ Finally, this sound policy has been revived.¹⁵⁸ In fact, more than two thousand drug courts have been established since 1995,¹⁵⁹ and conditional dispositions linked to drug treatment are also available in ordinary criminal courts.¹⁶⁰

Returning to the conceptual and moral puzzle that lies at the heart of our current policies toward addicted offenders, one must ask: if addiction really is a *brain disease* characterized by loss of control over drug-taking, how can we justify *punishing* addicted offenders for yielding to that compulsion? This question was much debated in the 1960s and 1970s and was addressed in a somewhat unsatisfying way by the Supreme Court in the 1960s in two pivotal decisions, in which a closely divided Court refused to constitutionalize the defense of “compulsion” for addicts.¹⁶¹

Although the issue has not received much attention in the courts over the past forty years, the case for excuse based on volitional impairment has only gotten stronger, as developments in neuroscience continue to elucidate ways in which the addicted brain is different from the non-addicted brain, and the ways in which the genes of people who are susceptible to addiction differ from those who are not.¹⁶² This body of research has led the new multi-million dollar MacArthur Foundation

155. VINCENT SCHIRALDI ET AL., JUSTICE POLICY INST., POOR PRESCRIPTION: THE COSTS OF IMPRISONING DRUG OFFENDERS IN THE UNITED STATES 2, 19 (2000), available at <http://www.drugpolicy.org/docUploads/PoorPrescription.pdf>.

156. McBride et al., *supra* note 62, at 14; Joseph F. Spillane, *Federal Policy in the Post-Anslinger Era: A Guide to Sources, 1962–2001*, in FEDERAL DRUG CONTROL: THE EVOLUTION OF POLICY AND PRACTICE 209, 214 (Jonathon Erlen & Joseph F. Spillane eds., 2004); see *supra* notes 41–58 and accompanying text.

157. McBride et al., *supra* note 62, at 15; see *supra* Part II.

158. See generally C. WEST HUDDLESTON, III ET AL., U.S. DEP’T OF JUSTICE, PAINTING THE CURRENT PICTURE: A NATIONAL REPORT CARD ON DRUG COURTS AND OTHER PROBLEM-SOLVING COURT PROGRAMS IN THE UNITED STATES 2 (2008), available at http://www.ndci.org/sites/default/files/ndci/PCPII1_web%5B1%5D.pdf (noting the importance of treatment alternatives available via drug courts and a thirty-two percent national increase in drug courts between 2004 and 2007).

159. *Id.* at 1 fig.1, 2.

160. NAT’L INST. ON DRUG ABUSE, NAT’L INSTS. OF HEALTH, NIH PUB. NO. 06-5316, PRINCIPLES OF DRUG ABUSE TREATMENT FOR CRIMINAL JUSTICE POPULATIONS: A RESEARCH-BASED GUIDE 16 (2007), available at http://www.nida.nih.gov/PDF/PODAT_CJ/PODAT_CJ.pdf; see also WEISSMAN, *supra* note 19, at 246–47 (discussing the early history of the diversion option).

161. Compare *Robinson v. California*, 370 U.S. 660, 667 (1962) (recognizing that narcotic addiction is an illness and holding that a state law that imprisons a person for being a narcotic addict is cruel and unusual punishment), with *Powell v. Texas*, 392 U.S. 514, 521, 536 (1968) (distinguishing *Robinson* and declining to extend *Robinson* to establish a constitutional defense of “compulsion” for addicts).

162. See Chandler et al., *supra* note 136, at 186 (discussing the studies that have identified how genes affect addiction).

Research Program on Law and Neuroscience to use addiction as a primary case study on the implications of scientific advances in neuroscience for doctrines of criminal responsibility.¹⁶³ It will surely come as no surprise that many philosophers and law professors question the moral basis for criminalization of use-related offenses by addicted offenders.¹⁶⁴ And they are supported in this position by leading addiction scientists who question the “voluntariness” of drug use by addicts and see reduced reliance on criminal sanctions as a desirable step along the path to a more therapeutic and less stigmatizing approach to addiction.¹⁶⁵

It is still important to think about the wisdom of the position that addiction should be a defense to possession and other drug use-related offenses. Who would have such a defense? Who would count as an addict? And what about the continuing grip of addiction after detoxification? Would addicts who were clean but relapsed have a defense? Moreover, presumably the same argument that erases responsibility also establishes the basis for involuntary commitment. Would it make sense to displace the current regime of criminal sanctions as applied to addicts with a regime of civil commitment and coerced treatment? And what sort of treatment can be compelled? Would we want to coerce people to take the anti-craving pharmacotherapies that are being developed?

We should not be trying to erase responsibility for addiction. As any sensible addiction therapist will say, the goal of treatment is to get the patient to accept responsibility for avoiding relapse and for getting help when temptations arise.¹⁶⁶ What is not often recognized, however, is that characterization of addiction as a chronic relapsing disorder like diabetes or asthma, or even bipolar disorder, highlights the issue of personal responsibility that is at the heart of chronic disease management.¹⁶⁷ As previously noted, a key objective of addiction policy should be

163. The Law & Neuroscience Project, <http://www.lawandneuroscienceproject.org/> (last visited Feb. 18, 2010).

164. See, e.g., Douglas N. Husak, *Addiction and Criminal Liability*, 18 LAW & PHIL. 655, 659–64 (1999) (arguing in favor of drug addiction as a defense to criminal liability). For a review of recent literature on this subject, see Gideon Yaffe, *Recent Work on Addiction and Responsible Agency*, 30 PHIL. & PUB. AFF. 178, 178–79 (2001).

165. See Steven E. Hyman, *The Neurobiology of Addiction: Implications for Voluntary Control of Behavior*, 7 AM. J. BIOETHICS 8, 8–10 (2007) (noting that results of cognitive and neuroscience studies of addicts have called into question the “folk psychology view” that all behavior is voluntarily controlled); Thomas R. Kosten, Editorial, *Addiction as a Brain Disease*, 155 AM J. PSYCHIATRY 711, 711 (1998) (commenting that scientific developments in the understanding of addictive disorders have aided in moving the view of addiction from that of a “moral failure” to a “brain disease,” but that greater investment in criminal justice over treatment indicates this shift is not complete); Leshner, *supra* note 94, at 46 (arguing that “[a]n accurate understanding of the nature of drug abuse . . . should . . . affect our criminal justice strategies,” and that if we understand addiction as a “brain disease,” then “imprisoning [addicts] without treatment is futile”).

166. Seymour M. Halleck, *Which Patients Are Responsible for Their Illnesses?*, 42 AM. J. PSYCHOTHERAPY 338, 338, 348 (1988).

167. See NAT’L INST. ON DRUG ABUSE, U.S. DEP’T OF HEALTH & HUMAN SERVS., TREATMENT APPROACHES FOR DRUG ADDICTION 1 (2008), available at <http://www.nida.nih.gov/PDF/InfoFacts/>

to provide the incentives and opportunities for addicted people (and people vulnerable to addiction) to *choose* to help themselves.¹⁶⁸

What then is the role of criminal sanctions under a pragmatic drug policy? The virtue of criminalization is that it provides an instrument for exercising therapeutic leverage. The threat of getting caught up in the criminal justice system might also serve a useful deterrent function by prodding people who are losing control to seek help on their own, but one should not rest the case for criminalization on deterrence alone. Instead, the argument should emphasize the leverage function because it is one of the reasons that the use of the criminal justice system is preferable to civil commitment—the only available legal alternative for getting addicts into treatment.¹⁶⁹ The distinction here is between coerced treatment and leveraged treatment. Arresting addicted offenders and giving them a choice—treatment in lieu of the usual disposition—is preferable to ordering them to undergo treatment or, if long-acting pharmacotherapies are developed, forcibly administering it to them.¹⁷⁰

CONCLUSION

In sum, although it may first appear as a regressive view, we cannot de-stigmatize either drug use or addiction altogether. Criminalization of consumption-related offenses is legitimate—both as an instrument of deterrence and prevention for non-addicted offenders and, most importantly, as an instrument of therapeutic leverage for addicted offenders.¹⁷¹ The ultimate aim of addiction policy is to create incentives and opportunities for people with addictive disorders (or people who are fearful of their vulnerability to addiction) to choose to get help on their own.¹⁷² Therefore, the primary strategy should not be criminalization;¹⁷³ instead, the strategy should focus on increasing access to treatment that works and taking steps to draw people into the treatment system voluntarily—or, more accurately, in

Treatment08.pdf (“For many people, drug abuse becomes chronic, with relapses . . . occur[ring] at rates similar to those for other well-characterized, chronic medical illnesses Like people with diabetes or heart disease, [drug addicts] will also need to change their behavior to adopt a more healthful lifestyle.”).

168. See *supra* Part III.B.

169. See WEISSMAN, *supra* note 19, at 252–53 (describing civil commitment schemes and enumerating criticisms of civil commitment, including procedures for certification and release of the addict, length of the civil commitment process, availability and quality of treatment, and effectiveness).

170. Bonnie, *supra* note 74, at 410.

171. See Chandler et al., *supra* note 136, at 184 (“Through monitoring, supervision, and threat of legal sanctions, the justice system can provide leverage to encourage drug abusers to enter and remain in treatment.”).

172. See *supra* Part III.B.

173. See NAT’L INST. ON DRUG ABUSE, *supra* note 149, at 35 (discussing the importance of a multifaceted approach to treating drug addiction that includes counseling, medication, and other forms of voluntary treatment); Chandler et al., *supra* 136, at 183–84 (citing statistics on the inadequacy of incarceration without treatment in addressing drug abuse and addiction).

response to the therapeutic leverage that is exercised by family members and employers.¹⁷⁴ Moreover, when effective pharmacotherapies emerge, we ought to subsidize their use.¹⁷⁵ Over time, we ought to be able to reduce our reliance on the criminal justice system substantially.

For now, though, the continued use of leveraged treatment through the criminal justice system is the most sensible policy because it would help us achieve the goals of drug policy more effectively overall than any alternative approach.¹⁷⁶ The virtue of pragmatism in drug policy is that it focuses our attention on what works best.¹⁷⁷ Development of effective medications is an essential part of that strategy.¹⁷⁸ A key aim of drug policy in the coming years is to increase use of effective pharmacotherapies for offenders in the criminal justice system.¹⁷⁹ There is every reason to believe that the science will move forward.¹⁸⁰ We also need to design drug policy to take maximum advantage of therapeutic advances when they occur, which means making novel treatments available when they are shown to be cost-effective and subsidizing their use when people are uninsured or underinsured.

174. See Douglas B. Marlowe et al., *Assessment of Coercive and Noncoercive Pressures to Enter Drug Abuse Treatment*, 42 *DRUG & ALCOHOL DEPENDENCE* 77, 81–82 (1996) (“[D]ata suggest that it may be nonproductive to rely excessively on legal mandates to enforce drug treatment compliance. More promising results might be obtained by leveraging or capitalizing on informal pressures stemming from [addicts’] natural social networks . . .”).

175. See CTR. FOR COGNITIVE LIBERTY & ETHICS, *THREATS TO COGNITIVE LIBERTY: PHARMACOTHERAPY AND THE FUTURE OF THE DRUG WAR* 40 (2004), available at <http://www.drugpolicy.org/docUploads/Pharmacotherapy2004.pdf> (recommending the partial reallocation of funds from arresting illegal drug users to reimburse people who voluntarily undergo pharmacotherapy treatment); EXECUTIVE OFFICE OF THE PRESIDENT, NATIONAL DRUG CONTROL STRATEGY: 2009 ANNUAL REPORT 22 (2009), available at <http://www.whitehousedrugpolicy.gov/publications/policy/ndcs09/2009ndcs.pdf> (noting the importance of developing pharmacotherapies as a part of the federal strategy to treat addiction).

176. See NAT’L INST. ON DRUG ABUSE, *supra* note 160, at 3 (“The coordination of drug abuse treatment with correctional planning can encourage participation in drug abuse treatment and can help treatment providers incorporate correctional requirements as treatment goals.”); Chandler et al., *supra* note 136, at 183–84 (commenting on the inadequacy of incarceration alone to treat drug addicts and the effectiveness of combining treatment through the criminal justice system).

177. See Don C. Des Jarlais, Editorial, *Harm Reduction: A Framework for Incorporating Science into Drug Policy*, 85 *AM. J. PUB. HEALTH* 10 (1995) (characterizing pragmatism in drug policies as a basic component of a harm reduction strategy).

178. EXECUTIVE OFFICE OF THE PRESIDENT, *supra* note 175, at 22.

179. See *id.* (“An ongoing research effort . . . has evaluated over 200 compounds as potential drug addiction treatments.”).

180. See *id.* (“[R]esearch continues to make key discoveries about the safety and efficacy of medications . . . to improve the treatment of . . . addiction.”).