

June 2004

America's War on Drugs : A Less Than Rave Review

James Robert Elderkin

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America's War on Drugs: A Less Than *Rave* Review

James Robert Elderkin

B.S., University of Notre Dame, 1976

M.D., University of Connecticut, 1981

An Essay

Submitted in Partial Fulfillment of the

Requirements for the Degree of

Master of Public Health

at the

University of Connecticut

2004

APPROVAL PAGE

Master of Public Health Essay

America's War on Drugs: A Less Than *Rave* Review

Presented by

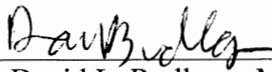
James Robert Elderkin, M.D.

Major Advisor



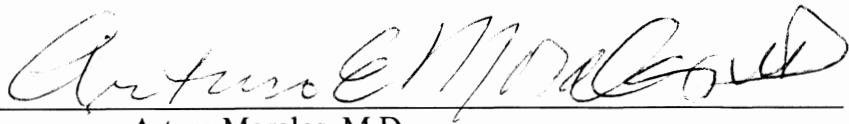
Zita Lazzarini, M.D., M.P.H.

Associate Advisor



David L. Budlong, M.A.

Associate Advisor



Arturo Morales, M.D.

University of Connecticut

2004

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INTRODUCTION

Meeting together in the hundreds and the thousands, large groups of young people have congregated to engage in collective *trance dances*, or *raves*, often fueled by the ingestion of a synthetic psychoactive substance, known as *Ecstasy*. Arousing apprehension among parents and civic authorities, perplexed by this changing pattern of behavior among youth, the phenomenon of *ecstasy* culture has riveted societal concern on the potential dangers of its increasingly notorious chemical sacrament. . . . [H]owever, full understanding of both its medical consequences and cultural impact have remained elusive. Even within the current social context of harsh Drug War era legal penalties, *Ecstasy* use has climbed sharply among young people. A vast and unanticipated social experiment has occurred with millions of adolescents and young adults worldwide consuming a drug that has eluded definitive understanding and over which societal and medical controversies persist. Given the magnitude of public health and cultural implications, an open and comprehensive review of the existing state of knowledge, from diverse perspectives, needs to be pursued. [46 p.550]

The above quote, from “Deconstructing Ecstasy: The Politics of MDMA Research” by Charles Grob, summarizes some of the current issues surrounding the recreational drug Ecstasy, a drug that has become a major focus of controversy involving federally funded drug research and federal drug policy and is the subject of enormous media attention. The Ecstasy controversy provides a way to examine U.S. drug policy in general and answer some important questions: How did we get to our current situation in

the War on Drugs? Are our federal tax dollars being spent in the best interest of our society in terms of the well being of our citizens? What are the alternatives for addressing drug use, an issue that has faced all societies throughout history?

The first section of this essay will look at Ecstasy: What is it, what are its acute and chronic effects, and what is the scientific and political controversy about? The second section will trace the history of U.S. drug policy from its origins in the early part of the twentieth century to the latest federal drug legislation, the RAVE Act, signed into law on April 30, 2003. The third section will look at current U.S. drug policy, its intended and unintended consequences, and the issue of drug policy reform, specifically harm reduction as an option for revision of the present U.S. prohibitionist policy.

SECTION I: ECSTASY

The History of MDMA/Ecstasy

Methylenedioxymethamphetamine (MDMA), commonly known as Ecstasy, is a drug that has gained enormous popularity in recent years as a recreational drug in the United States and across the globe. MDMA is the chemical name of the drug; Ecstasy is one of its street names. The two are used interchangeably although the street form of the drug often contains adulterants and thus may not be pure MDMA. In this essay, the drug will be referred to as MDMA/Ecstasy except in the context of scientific research where pharmaceutical grade MDMA is used.

MDMA/Ecstasy is related to many chemicals found in nature but requires alteration to form the end product, and therefore it is a semi-synthetic drug.[50 p.8] Myristica Fragrans is a tree that is the source of nutmeg and mace as well as safrole oil, which is the precursor of MDMA/Ecstasy; the sassafras root is a more potent source of safrole.[50 p.8] MDMA/Ecstasy is chemically related to the amphetamine group of drugs, which includes methamphetamine (the street drug speed, crystal, or meth) and 3,4-methamphetamine (MDA).[50 p.8] It belongs to the group of drugs known as phenethylamines, which also includes mescaline.[50 p.8] MDMA/Ecstasy is not a hallucinogen in the same sense as classic hallucinogens such as mescaline and LSD.[50 p.8; 113 p.1491] MDMA/Ecstasy causes a subtle, controllable experience with intensification of feelings and mild perceptual enhancement at the dosage used recreationally.[50 p.23,25] MDMA/Ecstasy leaves reality testing intact.[50 p.23] Adulterants found in the street forms of MDMA/Ecstasy are believed responsible for the

frank hallucinogenic properties of some MDMA/Ecstasy.[50 p.163] Psychoactive effects of MDMA/Ecstasy are different than any other drug.[50 p.8] It is not sedating like alcohol and the anxiolytic drugs, such as the benzodiazepine class.[50 p.8] It does not cause agitation or paranoia like cocaine and the other amphetamines.[50 p.8] “The effects resemble an immediately acting anti-depressant . . . but the euphoria and calm are more profound.”[50 p.8] It is felt that MDMA/Ecstasy deserves its own classification: “Empathogen” (to create an empathetic state) or “Entactogen” (to create a touching within) have been suggested.[50 p.8]

MDMA/Ecstasy has received a great deal of attention since the early 1980s but its history extends back one hundred years.[50 p.11] Merck, the German pharmaceutical company, first synthesized MDMA as an intermediate in the development of another drug, Hydrastatin, a medication to stop bleeding.[50 p.11] In 1912 Merck filed a patent application for Hydrastatin and MDMA was included in the application as an intermediate chemical.[50 p.11] Between 1912 and 1953 essentially nothing was done with MDMA.[50 p.11] In 1953, at the University of Michigan, the U.S. Army tested MDMA along with various other psychotropic chemicals for potential use in Cold War espionage.[46 p.551; 50 p.11] The studies were conducted on animals and MDMA was never used in humans for this purpose.[46 p.551; 50 p.11]

In 1976 chemist Sasha Shulgin synthesized MDMA and with another chemist, Dave Nichols, published the first human study of MDMA. They described its effect as “an easily controlled altered state of consciousness with emotional and sensual overtones.”[50 p.12] They introduced MDMA/Ecstasy as an adjunct in psychotherapy in California. [50 p.12] In the late seventies and early eighties MDMA was used covertly as

an aid to psychotherapy.[50 p.13] Around this same time the recreational use of MDMA/Ecstasy began.[50 p.13] Allegedly, a street dealer chose Ecstasy as the name for the drug, for marketing reasons; “Ecstasy” would sell better than “Empathy.”[50 p.13] In the early 1980s a group in Texas produced and distributed MDMA/Ecstasy for recreational use under the name “Sassafras” because the oil of saffrole is the precursor.[50 p.13] The recreational use of MDMA/Ecstasy came to the attention of Texas Senator Lloyd Bentson, who urged the Drug Enforcement Administration to make MDMA/Ecstasy illegal.[50 p.13] Senator Bentson’s efforts marked the beginning of the controversial scheduling of MDMA/Ecstasy as a Schedule I drug under the Controlled Substances Act (CSA).[50 p.14] The CSA is in the United States Code, Title 21, Chapter 13, Drug Abuse Prevention and Control, Section 812, Schedules of Controlled Substances, which was enacted as part of the Comprehensive Drug Abuse Prevention and Control Act of 1970.[23]

The Scheduling Controversy

Scheduling of drugs is a process where all substances that are regulated under federal law are placed in categories, known as schedules. There are five schedules, I through V, based on potential for abuse, currently accepted medical use, safety and potential for dependence.[132] Schedule I drugs are identified as having: “a high potential for abuse,” “no currently accepted medical use,” and “lack of accepted safety” for use of the drug under medical supervision.[132] Schedule I drugs are the most highly controlled drugs and violations relating to these drugs carry the most severe criminal penalties.

The actual scheduling of drugs is delegated by the U.S. Attorney General to the Administrator of the Drug Enforcement Administration (DEA).[60 p.2143] Requests to

add, delete or change the schedule of a drug may be initiated by the DEA, the Department of Health and Human Services (HHS), or by petition from any interested party.[60 p.2143] The process begins with a DEA investigation of the drug and includes completion by HHS of a scientific and medical evaluation followed by an HHS recommendation regarding schedule placement.[60 p.2143] HHS gathers information from the Food and Drug Administration (FDA) and the National Institute on Drug Abuse (NIDA).[60 p.2143-44] The recommendation by HHS is binding on the DEA only when HHS recommends a substance *not* be controlled.[60 p.2144] The Administrator of the DEA reviews the data and recommendation from HHS and decides into which schedule a drug should be placed.[60 p.2144] This decision is final and is subject to review only if a court of appeals finds extreme error in the scheduling process.[60 p.2144] Therefore, once a drug is scheduled by the DEA, reversal is unlikely. Schedule classification of a drug depends on interpretation of terminology in the CSA. Definitions of the terms “potential for abuse,” “accepted medical use” and “level of dependence” are not contained in the CSA. However, the House Committee Report accompanying this Act contains some guidelines on “potential for abuse”.[60 p.2145] The report states that a substance has potential for abuse if:

- 1) Individuals are taking the drug in amounts sufficient to create a hazard to their health or to the safety of other individuals or of the community.
- 2) There is significant diversion of the drug from legitimate channels.
- 3) Individuals are taking the drug on their own initiative rather than on medical advice.
- 4) The drug is related to a drug already listed as having a potential for abuse.

Of note, there is no standard or recommendation for determining “high” potential for abuse that places a drug in Schedule I.[60 p.2145]

On July 27, 1984, the DEA published in the Federal Register its intent to declare MDMA/Ecstasy a Schedule I drug.[50 p.14] A group of psychiatrists, psychotherapists and researchers requested hearings on MDMA/Ecstasy.[50 p.14] The request was granted and three hearings were scheduled.[50 p.14] On May 31, 1985, DEA Administrator John Lawn announced that he would not wait for completion of the hearings because there was sufficient data that MDMA/Ecstasy was being abused.[50 p.14] A law passed in 1984 permits the DEA to schedule a drug for a period of one year, on an emergency basis, without hearings, out of concern for public safety.[50 p.14] MDMA/Ecstasy is the only drug that has ever been scheduled by using this emergency provision.[56]

Between February and July of 1985 the three hearings on MDMA/Ecstasy were held.[50 p.14] Researchers, scientists, psychiatrists, psychotherapists and MDMA patients testified at the hearings.[50 p.14] Dr. Luis Seiden, from the University of Chicago, spoke on behalf of the DEA.[50 p.15] He presented animal data from studies conducted at the University of Chicago by himself, graduate student George Ricaurte, and other researchers, demonstrating neuron damage in rodents that were given injections of methamphetamine (MDA), a related compound, but not MDMA.[50; 78] MDMA was being implicated because injection use of an analog, MDA, was shown to cause neuron damage in animals.[50 p.14-15; 78] George Ricaurte would become a key figure in MDMA research as well as the controversy surrounding the research.

On May 22, 1986, Judge Francis Young, who presided over the MDMA/Ecstasy hearings, announced his decision.[50 p.15] He felt there was accepted medical use for MDMA/Ecstasy and recommended placement in Schedule III.[50 p.15] This would allow clinical use and research to continue. However, the definition of “accepted medical use” became a controversial issue. DEA administrator John Lawn interpreted “accepted medical use” as having FDA approval, which MDMA/Ecstasy did not have.[50 p.15] Recall from above that the recommendation of HHS is binding only if the recommendation is that the substance *not* be scheduled as a controlled substance.(see p.6) Administrator Lawn chose to ignore Judge Young’s recommendation for Schedule III placement and proceeded to place MDMA/Ecstasy in Schedule I.[7; 50 p.15]

Between December 1987 and March 1988, Dr. Lester Grinspoon, professor of psychiatry at Harvard Medical School, appealed the DEA decision to place MDMA/Ecstasy in Schedule I.[50 p.15] The First Circuit Court of Appeals in Boston ruled that the DEA could not use lack of FDA approval as the basis for their argument that MDMA/Ecstasy had no medically accepted use.[45] Grinspoon won his case. However, despite this ruling, the DEA proceeded to permanently place MDMA/Ecstasy in Schedule I on March 23, 1988.[7; 50 p.15-16]

Interestingly, also in 1988, after the hearings and after MDMA was placed in Schedule I, a related law suit was brought to the Ninth Circuit Court of Appeals and the court found that Administrator Lawn overstepped his powers when he placed MDMA/Ecstasy in Schedule I on an emergency basis in 1985. The court held that the Attorney General never properly delegated to the DEA Administrator the power to temporarily schedule substances.[7; 127]

Following the scheduling of MDMA in the mid-1980s and all its associated media attention, the recreational use of the drug increased. The social phenomenon of all night dance parties, known as “raves,” began. Raves are electronic music events with light shows, laser shows, and psychedelic image screens that usually run from late night until the following morning. Some place the beginning of raves on the Spanish Isle of Ibiza in the summer of 1987.[50 p.17] The phenomenon was brought to England in the summer of 1988 when raves took place outdoors with thousands in attendance, with an increasing number taking MDMA/Ecstasy.[50 p.17] The rave phenomenon was exported to the United States, first in New York and San Francisco, then to many cities across the country, then throughout Europe, Australia and Asia.[50 p.18] Worldwide consumption of MDMA/Ecstasy grew exponentially.[50 p.18]

Pharmacology of MDMA/Ecstasy

At this point it would be useful to look at the pharmacology and neurobiology of this drug. The pharmacology of MDMA/Ecstasy involves two brain chemicals, predominantly serotonin and to a lesser extent dopamine.[113 p.1490] They are both neurotransmitters, chemical agents that transmit a nerve impulse across a synapse, the microscopic space between two nerve cells. Nerves communicate with each other by both electrical and chemical means. An electrical impulse carries a signal along the length of the neuron. At the end of the neuron is the synapse. The electrical impulse cannot cross the synapse. Instead, the signal is carried across the space by a chemical, the neurotransmitter. The chemical is stored in the pre-synaptic neuron. Once released it crosses the synaptic space and binds on the post-synaptic neuron, on sites known as receptors. The receptors then cause induction of a new electrical signal that is

transmitted down the nerve. The neurotransmitter is thus a means of propagating a nerve impulse. The neurotransmitter not only binds post-synaptically but also binds pre-synaptically to function as negative feedback to inhibit release of more neurotransmitter. In addition, the neurotransmitter undergoes reuptake into the pre-synaptic nerve, to be stored for future use. These mechanisms of release, post-synaptic receptor binding, pre-synaptic negative feedback and reuptake, comprise a complex process. They are part of the mechanism by which the central nervous system functions and they are susceptible to numerous hormonal as well as other endogenous and exogenous chemical controls. Psychoactive drugs function by altering this complex system.

MDMA/Ecstasy acts on the serotonin neurotransmitter system in two ways. It induces serotonin release from the pre-synaptic nerve and it blocks serotonin re-uptake.[113 p.1490] The net effect is more serotonin in the synapse and thus more stimulation of the post-synaptic serotonin receptors. MDMA/Ecstasy may also have a direct stimulant effect on these receptors.[113 p.1490] Serotonin is involved in the regulation of a variety of behavioral functions including mood, anxiety, aggression, appetite and sleep.[113 p.1490] MDMA/Ecstasy acts on another neurotransmitter, dopamine, by inducing dopamine release into the synapse.[113 p.1490] Dopamine is the primary neurotransmitter of the “reward pathway” and is involved in motivational processes such as reward and reinforcement.[113 p.1490] MDMA/Ecstasy likely has other effects, not yet determined. MDMA/Ecstasy is considered to be the prototype of a new class of drugs referred to as “empathogens” (empathy producing) or “entactogens” (touching within).[50 p.22; 113 p.1490] MDMA/Ecstasy produces feelings of euphoria and well being. It also produces mild changes in perception but does not cause

hallucinations or psychosis at doses used therapeutically, prior to 1985 when therapeutic use became illegal, or at the usual recreational dose used today.[113 p.1491]

Acute Morbidity and Mortality in MDMA/Ecstasy Users

As recreational use has grown, acute effects of MDMA/Ecstasy have gained a lot of media attention and are the basis of some of the concern for the safety of people using MDMA/Ecstasy at raves. These acute effects are separate from the possible longer-term neurological, psychological and psychiatric effects. All MDMA/Ecstasy bought for recreational use is bought on the black market, produced illegally and consequently has no quality control in terms of dose and adulterants. Accepting that, the acute physiologic effects of MDMA/Ecstasy are generally related to its stimulant effects that increase heart rate, blood pressure, body temperature, muscle activity and sweating.[113 p.1494]

Couple these effects with the prolonged aerobic activity of dancing for many hours in often poorly ventilated dance venues, and the result is the acute morbidity and mortality associated with MDMA/Ecstasy use. One of the most serious and potentially fatal complications of its use in the rave setting is elevated body temperature, known as hyperthermia. The sequelae of hyperthermia, such as central nervous system damage, dehydration and rhabdomyolysis (muscle breakdown) with consequent seizures, kidney failure, and disseminated intravascular coagulation (activation of blood clotting mechanisms within the vascular system), are the cause of much of the morbidity and mortality that is associated with MDMA/Ecstasy use.[11; 50 p.73-73] In the setting of prolonged aerobic activity such as raves, this problem is exacerbated by blunting (due to the effect of MDMA/Ecstasy as well as other recreational drugs and alcohol) of the normal human response to this situation, which is rest, fluid replacement and moving to a

cooler environment.[50 p.73-74] In other words, hyperthermia and its complications are largely setting dependent and therefore preventable. Appropriate precautions can prevent much of the morbidity and mortality of hyperthermia just as an athlete avoids them by proper fluid and electrolyte replacement, appropriate pacing of aerobic activity and adequate ventilation and cooling.

Serotonin syndrome is an idiosyncratic and serious effect that can result from excessive central and peripheral nervous system stimulation by serotonin. Manifestations of serotonin syndrome include altered mental status (agitation, confusion, delirium, coma), seizures, muscle hyperactivity, as well as autonomic nervous system dysfunction including abdominal pain, diarrhea, sweating, elevated temperature, elevated blood pressure and heart rate, flushed skin, dilated pupils, salivation and shivering.[11]

Serotonin syndrome can be fatal but it is a rare event in MDMA/Ecstasy users.

Another danger, also rare, is hyponatremia (low blood sodium levels). This can be caused by drinking pure water void of electrolytes for fluid replacement, as well as a neuro-hormonal effect of MDMA/Ecstasy that leads to SIADH, Syndrome of Inappropriate Anti-Diuretic Hormone, and consequent fall in the blood sodium levels.[50 p.75-76] Hyponatremia has been implicated in some deaths from MDMA/Ecstasy use.[50 p.76]

The Neurotoxicity Controversy

Concurrent with the exponential growth of recreational MDMA/Ecstasy use, considerable research into the drug's effects on the central nervous system has been conducted. This research is controversial with many questions arising as to the effects of MDMA/Ecstasy on the brain, on cognitive function and on mood disorders. No clear

answers have emerged on these issues. These studies are at the center of the neurotoxicity controversy and subsequent political controversy surrounding MDMA/Ecstasy. The neurotoxicity controversy involves the validity of many MDMA/Ecstasy studies. A detailed critique of the scientific, psychological and psychiatric studies of MDMA/Ecstasy is beyond the scope of this essay. However, a brief look at some studies is essential to an understanding of the larger controversy of MDMA/Ecstasy, particularly in the drug-policy arena. With rare exception, all studies conducted on MDMA/Ecstasy are done on animals or on human volunteers who have used the drug recreationally. Because of its Schedule I status, the drug cannot be given to humans in prospective research protocols. One exception to this is a study done by Charles Grob where the drug was administered to volunteers who had substantial previous recreational exposure to the drug.[31]

Studies on MDMA/Ecstasy can be divided into:

- 1) Animal studies focusing on the question of neurotoxicity.
- 2) Neurobiological studies in which various measures of neural function are assessed in human subjects, including measurement of chemical indicators of serotonin activity, hormonal response to chemical challenges, brain imaging, and cerebral blood flow imaging, all designed to determine neurobiological function in MDMA/Ecstasy users.
- 3) Psychological studies looking at cognitive function in MDMA/Ecstasy users.
- 4) Studies looking at psychiatric disease in MDMA/Ecstasy users.

All these studies attempt to answer questions such as:

- 1) Does MDMA/Ecstasy cause changes and/or damage to the serotonin and/or dopamine systems in the human brain?
- 2) If there are changes and/or damage, are they dose related? Are they temporary or permanent?
- 3) What are the neurological, cognitive and psychiatric consequences of MDMA/Ecstasy induced changes and/or damage? Are they dose related? Are they temporary or permanent? Are they latent?

The scientific and clinical research of MDMA/Ecstasy focuses on its effects on serotonin in the central nervous system. Many studies have examined this issue and most are wrought with controversy. It is worthwhile to look at this topic briefly. In 2000, an entire issue of *Neuropsychobiology* was devoted to this topic.[80] Six papers are included in this issue. The first five address one aspect of the neurotoxic effects of MDMA/Ecstasy. The sixth paper is a compilation of fourteen diverse views from a symposium on MDMA/Ecstasy, each presenting an answer to the question: Is MDMA/Ecstasy a neurotoxin?

The first paper in the MDMA/Ecstasy issue of *Neuropsychobiology* is “(+/-)3,4-Methylenedioxymethamphetamine (‘Ecstasy’)-Induced Serotonin Neurotoxicity: Studies in Animals” by George Ricaurte, et al., Department of Neurology, Johns Hopkins School of Medicine.[95] This paper summarizes a number of studies done in animals looking at various neurochemical, neuroanatomical and functional measures of serotonin neurons. According to the researchers these studies “provide compelling evidence that MDMA has neurotoxic potential toward brain 5-HT [serotonin] neurons in animals.”[95 p.8] This conclusion is based on demonstration that MDMA exposure results in decrements in a

number of serotonin markers and that morphologic studies indicate that the loss of serotonin is from degeneration of serotonin nerve terminals. Using the technique of interspecies scaling, these researches conclude that the dosages that cause neurotoxicity in animals are in the range used recreationally by humans.

Taken together, these preclinical findings strongly suggest that MDMA produces toxic effects on brain 5-HT [serotonin] neurons. The neurotoxic effects of MDMA have broad species generality. Evidence of MDMA-induced 5-HT [serotonin] neurotoxicity has been found in every species that has been tested, including various nonhuman primate species. . . . When each of these factors is considered for MDMA, the conclusion that emerges is that doses of MDMA that produce neurotoxic effects in animals are squarely in the range of those used by humans. Thus, findings in animals raise concern that human MDMA users are at risk of incurring brain 5-HT [serotonin] neural injury.[95 p.9]

The second paper is “(+/-)3,4-Methylenedioxymethamphetamine (‘Ecstasy’)-Induced Serotonin Neurotoxicity: Clinical Studies” by Una McCann et al., Department of Psychiatry and Behavioral Sciences and Department of Neurology, Johns Hopkins School of Medicine.[67] McCann discusses the data from a study by Ricaurte in 1990 that looked at 5-HIAA (a serotonin metabolite) levels in cerebral spinal fluid (CSF) obtained by outpatient lumbar puncture of MDMA/Ecstasy users compared with a control group of nonusers:

In sum, existing data indicate that some MDMA users incur brain serotonergic damage, as indicated by reductions in CSF 5-HIAA and loss of brain 5-HT [serotonin] transporters. A growing body of evidence suggests that MDMA-

induced 5-HT[serotonin] neural injury is associated with functional consequences, including cognitive abnormalities (particularly memory), neuroendocrine abnormalities, sleep abnormalities and, possibly, impulsivity. Future studies are needed to confirm and extend currently available data, and to better define the relationship between MDMA exposure and development of neurotoxicity. . . . It will also be important to conduct longitudinal epidemiological studies in an effort to determine whether individuals exposed to MDMA are at a higher risk for developing neuropsychiatric problems as they age.[67 p.15]

McCann discusses the method of pharmacological challenge that has been used in MDMA/Ecstasy studies in humans. This method takes advantage of the hypothalamic-pituitary-adrenal axis, a complex mechanism of hormonal regulation. Serotonin is involved in the normal regulation of the secretion of various hormones; prolactin, cortisol and growth hormone to name a few. The Ricaurte research group at Hopkins, in collaboration with researchers from Yale, published a paper in 1989 that showed “suggestive evidence” of a blunted response, in MDMA/Ecstasy users, to a challenge of L-tryptophan, a serotonin precursor.[67] Basically, L-tryptophan is administered and then hormone levels are measured. The Ricaurte paper did not show a statistically significant difference in response to L-tryptophan challenge between MDMA/Ecstasy users and non-user controls, but the results were suggestive of altered neuroendocrine function in users.[67 p.12] These two papers, the CSF study and the L-tryptophan challenge, have been harshly criticized and will be discussed later in this essay.

The third paper in the *Neuropsychobiology* issue on MDMA is “Human Research on MDMA (3,4-Methylenedioxymethamphetamine) Neurotoxicity: Cognitive and

Behavioural Indices of Change” by A.C. Parrott, Department of Psychology, University of East London, U.K.[81] This paper concludes:

Drug free Ecstasy users often display cognitive deficits, but these seem to be limited to a few specific functions. Memory problems were the first to be reported, and have now been confirmed in several studies from different research groups. . . . The second area that seems to be effected is impulsivity, which has been shown to be increased in several studies; moreover it does not seem to be a general characteristic of all recreational drug users, but is more specific to Ecstasy users. . . . The third area is difficulty in higher cognitive tasks involving strategy and planning. . . . However, in each of the above areas, there does seem to be considerable individual variation, with some users displaying poor cognitive performance, while others show normal task performance. Moreover, some studies have found no group differences between the Ecstasy users and controls. This individual variation is confirmed in the subjective reports, since while some regular Ecstasy users complain of cognitive problems, many others do not.[81 p.23]

The fourth paper is “Potential Human Neurotoxicity of MDMA (‘Ecstasy’): Subjective Self-Reports, Evidence from an Italian Drug Addiction Centre and Clinical Case Studies” by Fabrizio Schifano, Addiction Treatment Unit No.1, Local Health Unit No. 16, Padova, Italy.[98] This paper gives some clinical case studies as well as a larger report on polydrug consumers who attended a public health addiction treatment center. The paper looks at psychopathologic states such as panic disorder, depression, impulse control disorder, social phobia, bulimia, and psychotic disorders in MDMA/Ecstasy

users. This paper suggests that longer term/higher dose MDMA/Ecstasy consumers are at higher risk of developing these psychopathologic disturbances. The paper acknowledges the complex methodological issues arising from this type of study including self-reports, polydrug use, lack of age & sex matched controls, variable content of black market MDMA/Ecstasy and the possibility of pre-existing psychopathology in MDMA/Ecstasy users. The paper concludes that the data presented does not justify any direct and straightforward conclusions as to the neurotoxicity of MDMA/Ecstasy. Nonetheless, they conclude that the data presented may help interpret the possible existence of a relationship between psychiatric disturbance and MDMA/Ecstasy neurotoxic potential in humans.

The fifth paper, “Is MDMA (‘Ecstasy’) Neurotoxic in Humans? An overview of Evidence and of Methodological Problems in Research” by H. Valerie Curran, Department of Psychology, University College of London, U.K., presents an overview of the evidence of human neurotoxicity of MDMA/Ecstasy.[28] The paper acknowledges: “As researchers cannot ‘administer’ known doses of MDMA over specified periods to people, the evidence in humans of possible neurotoxic effects is inevitably indirect and studies are fraught with methodological difficulties.”[28 p.35] This paper outlines the methodological difficulties as follows:

- 1) What drug and what dose were taken? This is impossible to determine except in rare studies. Black market MDMA/Ecstasy has been shown to contain various amphetamine analogs, ketamine, LSD, dextromethorphan and a range of other chemicals.[28 p.38]

- 2) How reliable is the drug history? Retrospective accounts of drug use rely on self-reporting as well as on memory. Self-reporting is a methodological problem. Furthermore, MDMA/Ecstasy may impair memory (this is one of the hypotheses) and concomitant use of other memory-impairing drugs compounds this problem.[28 p.38]
- 3) The vast majority of MDMA/Ecstasy users also use other drugs.[28 p.38]
- 4) Are there differences between MDMA/Ecstasy users and controls other than the use of MDMA/Ecstasy? Impulsiveness, sensation seeking and low harm avoidance may be pre-existing traits in people who use MDMA/Ecstasy. Are people with higher levels of aggression and depression using MDMA/Ecstasy as a form of self-medication?[28 p.39]
- 5) Clinical studies frequently use the recruitment procedure of self-presentation at psychiatric or drug services or volunteers responding to advertisements. These methods likely introduce unknown bias.[28 p.39]

The sixth and final paper of the *Neuropsychobiology* issue on MDMA/Ecstasy is a compilation of answers to the question “Is MDMA a Human Neurotoxin?”[121] This question was posed to discussants at a symposium on MDMA/Ecstasy. The respondents consisted of authorities from the United States, Europe and Australia and represented experts from various fields such as animal neuroscience, human cognitive testing, police pathology science, psychotherapy and psychiatry. Most of the viewpoints expressed are representative of the wide range of opinion on MDMA/Ecstasy neurotoxicity that has already been discussed above. However, Madhu Kalia, Department of Molecular

Pharmacology and Anesthesiology, Jefferson Medical College, Philadelphia, PA, raised one issue not mentioned in other papers or by other discussants:

In order to accurately evaluate the possible effects of these agents [agents that interact with serotonin] on brain structure and function, it is necessary to use standardized and validated biological measures. Merely measuring the degree and duration of depletion of 5-HT [serotonin] and its metabolites is of little value in determining neurotoxicity because those depletions are part of the pharmacologic profile of these agents and are not indicators of “brain toxicity” or “brain damage.” Classical, robust, validated biological measures of neurotoxicity include: neurodegeneration and gliosis which are routinely used in evaluating animal and human tissue. . . . There is no evidence that MDMA . . . produce[s] neurotoxicity in animals when gliosis is used as a validated measure [O’Callaghan and Miller, 1994].[121 p.45]

Gliosis is defined as “the production of a dense fibrous network of neuroglia; includes astrocytosis, which is a proliferation of astrocytes in the area of a degenerative lesion.”[30] Kalia thus questions the validity of all studies of MDMA neurotoxicity because none have used the validated standard for demonstration of neural degeneration, which is gliosis in the degenerated tissue.

This last paper concludes by acknowledging the methodological weaknesses of the human data, but notes: “Scientific evidence in many topics of practical concern is replete with methodological uncertainties, but scientists still have to weigh up all the evidence – and offer their best estimates for what it all means!”[121 p.48] This paper concludes by

pointing to the increasing body of evidence for some behavioral, psychobiological and neurological deficits in recreational MDMA/Ecstasy users.

The Political Controversy

Recreational drug use, with all of its moral and health concerns, is one aspect of the MDMA/Ecstasy issue that has led to political controversy. There is another aspect to the issue. In the late 1970s, MDMA/Ecstasy was resurrected by chemist Sasha Shulgin and introduced into the psychotherapy community in California.[50 p.12] MDMA/Ecstasy was felt to have enormous potential for treatment of mental illnesses. Since the scheduling of MDMA/Ecstasy in 1985, psychotherapeutic use, as well as human research of this use, has ceased. Proponents of the psychotherapeutic use of MDMA/Ecstasy have been among the strongest advocates of reconsideration of Schedule I placement. Charles Grob, a professor of psychiatry and pediatrics at Harbor/UCLA Medical Center in Los Angeles, has been one of the most vocal proponents of research into the therapeutic use of MDMA/Ecstasy. His paper, “Deconstructing Ecstasy: The Politics of MDMA Research” discusses the potential therapeutic use of the drug:

Early scientific investigators . . . were struck by MDMA’s capacity to help people open up and talk honestly about themselves and their relationships, without defensive conditioning appearing. For several hours anxiety and fear appeared to melt away, even in subjects who were chronically constricted and apprehensive. . . . Hailed as “penicillin for the soul,” MDMA was said to be useful in treating a wide range of conditions including post-traumatic stress, phobias, psychosomatic disorders, depression, suicidality, drug addiction, relationship difficulties and the psychological distress of terminal illness.[46 p.551]

Grob is critical of the Schedule I placement and consequent unavailability of the drug to be rigorously studied in controlled prospective clinical research designs. He has been particularly aggressive in uncovering methodological flaws in the animal and neurobiological studies of MDMA/Ecstasy that are used to support claims of MDMA/Ecstasy neurotoxicity. Grob discusses this topic in detail in his paper.[46] At the center of the controversy on MDMA/Ecstasy neurotoxicity is the government-funded research of George Ricaurte at John Hopkins School of Medicine. Ricaurte started his MDMA/Ecstasy research while a graduate student at the University of Chicago.[46 p.562-63] He is the lead author on the paper titled “Hallucinogenic Amphetamine Selectively Destroys Brain Serotonin Nerve Terminals: Neurochemical and Anatomical Evidence”.[91] This study played a key role in the DEA placement of MDMA/Ecstasy in Schedule I.[46 p.562]. This study used MDA (methylenedioxyamphetamine), not MDMA (3,4-methylenedioxymethamphetamine). The two drugs are analogs. The findings were used to implicate MDMA since it is an analog of MDA.[50 p.14-15; 78] Ricaurte has published a large number of MDMA studies, most funded by the federal government, and he is a proponent of the neurotoxicity of MDMA/Ecstasy. In 1990 he published a paper that looked at a primary metabolite of MDMA (5-HIAA) in the cerebral spinal fluid (CSF) of MDMA/Ecstasy users versus a control group (this paper was discussed above, p.15).[92] Grob reveals a major methodological flaw in this study.[46 p.571] The control group was composed of chronic pain patients. Because chronic pain is known to induce increased levels of serotonin and therefore increased levels of CSF 5-HIAA, this places the findings of comparatively low levels of CSF 5-HIAA in MDMA/Ecstasy users in doubt. Another study from the Ricaurte group was

published in 1989.[82] The study used L-tryptophan challenge to demonstrate a decreased neurohormonal response in MDMA/Ecstasy users (this paper was also discussed above, p.16). The results were not statistically significant but suggested a reduced response to L-tryptophan challenge in MDMA users. A serious flaw in this study is pointed out by Grob: The MDMA/Ecstasy subjects used in this study were pre-selected from the CSF 5-HIAA study on the basis of being at the low end of the CSF 5-HIAA spectrum.[46 p.572] Both the L-tryptophan study and the CSF-5HIAA are regularly cited as evidence of MDMA/Ecstasy neurotoxicity (see the McCann article in the *Neuropsychobiology* MDMA issue published in 2000[67]).

Ricaurte and McCann are both from Hopkins and have received considerable amounts of federal funding for their MDMA research (estimated to be at least ten million dollars).[119] Their research on MDMA continues today. In a study published in a 2002 issue of *Science*, Ricaurte claimed that a single dose of MDMA/Ecstasy, in the amount that a recreational user may use in one night, might cause permanent brain damage manifest as Parkinson's Disease.[93] This study was harshly criticized in the scientific community.[74; 134] The study used injections of MDMA in monkeys, a method criticized because injection use leads to higher blood levels than oral recreational use.[134] The study results were alarming: 20% of the animals in the study died, others showed significant effects on the dopamine system that had not previously been seen with for MDMA. (MDMA has been shown to affect the serotonin system.) Colin Blakemore, professor of physiology at Oxford University and head of Britain's Medical Research Council, and Leslie Iverson, professor of pharmacology at King's College and Oxford University, both criticized the paper; both were involved in lengthy e-mail

exchange about the paper with Donald Kennedy, the editor-in-chief of *Science*, shortly after the paper was published; neither believed the paper should have been published.[134] Blakemore said “ . . . 40% of the animals given supposed MDMA at a ‘common recreational dose’ were found to be dead or dying. . . . [P]olice [in the U.K.] estimate that one million young people take Ecstasy each weekend, yet there are only a few deaths each year.”[134] Stephen Kish, a neuropathologist at the Center for Addiction and Health in Toronto and a Parkinson’s Disease researcher, wrote “There is no epidemiological evidence that parkinsonism or any neurological abnormality, with the possible (but as yet unproven) exception of mild memory loss, is a persistent (months to years after last use) consequence of exposure to Ecstasy, a drug that has been used widely worldwide.”[3]

This study was cited by Asa Hutchinson, Administrator of the DEA at the time, in congressional testimony before the House Judiciary Committee, Subcommittee on Crime, Terrorism and Homeland Security, on October 10, 2002 in support of the RAVE Act.[52] This legislation will be discussed in more detail in Section II of this essay.

In September 2003, Ricaurte retracted the 2002 *Science* paper.[94] He reported that the drug used in the 2002 *Science* study was actually MDA, not MDMA. He has since retracted another paper for the same reason, inadvertent use of the wrong drug.[31] His retractions have fueled the fire of political controversy surrounding the MDMA/Ecstasy issue, especially because the original *Science* study was used in congressional testimony in support of the RAVE Act, which has since been signed into law by President Bush. The retractions have fueled controversy in the scientific community as well. Colin Blakemore, who criticized the paper prior to the retraction, demanded an independent

inquiry be conducted into the affair, including disclosure of the paper's referee reports; "The more I looked at it the more I felt there was an agenda." [101] He complained to the editor-in-chief of *Science* of "flaws so radical, so deep, they would have been picked up by any referee. . . . I am very concerned about drug use, but the way to tackle it is not to misrepresent scientific evidence. . . . What's going to be the impact of these studies? Young people won't believe anything they read." [101] Leslie Iverson called the incident "an outrageous scandal." [134] Iverson has also said: "It's another example of a certain breed of scientist who appear to do research on illegal drugs mainly to show what the governments want them to show. They extract large amounts of grant money from the government to do this sort of biased work." [134]

Ethan Nadelmann, Executive Director of the Drug Policy Alliance, commented on the retraction: "This is a particularly bold example of the corruption that permeates federally funded research on illicit drugs." [119] Marsha Rosenbaum, Director of the Alliance's Safety First Project, commented "This is high class Reefer Madness. . . . When young people see this kind of thing, they start to assume they're being lied to about everything – including the most important information about their safety." [119] An editorial in *Nature* about the incident commented that "Some observers . . . have questioned NIDA's ability to maintain its independence in the face of the immense pressures brought to bear by those who stand behind America's interminable war on drugs." [38] Eric Sterling, counsel to the Congressional Judiciary Committee (responsible for anti-drug legislation) during the Reagan administration and currently president of The Criminal Justice Policy Foundation, commented in a speech at the University of Virginia in April, 2004: "Drugs serve an extremely useful role in the theater of politics. . . . The government is utterly

committed to lying about the harmfulness of drugs.”[55] The *Nature* editorial concluded by referring to the original *Science* paper and its retraction as “one of the more bizarre episodes in the history of drug research.”[38]

In “Deconstructing Ecstasy” Grob points out that Ricaurte’s group has been further criticized for a 1998 study published in *Lancet* that showed by means of PET scan imaging that there is evidence of neural injury in the brains of MDMA/Ecstasy users.[46 p.575; 68] The study compared a group of fourteen users of MDMA/Ecstasy with a second group of fifteen controls who had never used the drug. The users reported, on average, 228 occasions of MDMA/Ecstasy use, 6 times per month over 4.6 years. They unarguably represent heavy users of MDMA/Ecstasy. The technique used for PET scan imaging involved injection of a radioactive marker that selectively binds to serotonin transporters. Other brain imaging researchers have criticized the imaging technique used in this study as well as the design and data interpretation of the study.[72] The key finding reported in the study was that the users showed decreased global and regional brain serotonin transporter binding compared with controls and the authors concluded that the study showed “direct evidence of a decrease in a structural component of brain 5-HT [serotonin] neurons in human MDMA users.”[68] Images showed dark areas where there was decreased marker binding. Grob points out that closer examination of the design and data interpretation reveals problems.[46 p.575-77] The data chart provided shows little difference between the users and controls; only one MDMA/Ecstasy user falls well outside the range of the rest of the subjects. Excluding that one individual, all of the remaining users are within the same range as controls. Two users are near the top of the control range and above the majority of controls. Grob points out a third serious

problem with this study: What does reduction of serotonin transporter mean?[46 p.578] Does it mean damage or might it simply be a reflection of functional adjustment in response to lower neurotransmitter levels? Recall that Kalia raised this point, that alteration of the serotonin system is part of the pharmacologic profile of MDMA/Ecstasy. (see p.19) Dr. Marc Laruelle, a Columbia University PET scan specialist, criticized this study of Ricaurte's as "something to put under the rug."[72] He cites a German PET scan study of MDMA/Ecstasy users that showed modest decreases in serotonin with return to normal within six weeks.[72]

Furthermore, this particular study is important in the MDMA/Ecstasy controversy for the following reason: After publication in the highly regarded British *Lancet*, the *Times of London* reported "Proof That Ecstasy Damages the Brain" and the media announced these findings around the world.[46 p.575] NIDA then used the *Lancet* paper as the basis of its \$42 million club drug campaign. "Plain Brain/Brain after Ecstasy," and pictures of "holes in the brain" were printed on hundreds of thousands of cards for distribution, in NIDA publications and on the Web site.[31; 72] The images used from the *Lancet* study portrayed the dark areas of decreased serotonin transporter binding as "holes in the brain" from MDMA/Ecstasy use.[31] Images from the extremes of the user and control groups were used for dramatic effect. The club drug campaign image "wasn't even an accurate representation of the data in the *Lancet* article if that data had actually been valid." [31] In a March 2001 educational program about drugs on "In The Mix", a Public Broadcasting Services program for teens, Alan Leshner, Director of the NIDA stated: "We've heard people talk about Ecstasy causing holes in the brain and of course that's a bit of an exaggeration . . ."[31]

Another MDMA/Ecstasy study that utilized brain imaging has been misrepresented in the War on Drugs. Rick Doblin, Harvard trained public policy analyst and founder of the Multidisciplinary Association for Psychedelic Studies (MAPS), discusses this study in “Exaggerating MDMA’s Risks to Justify A Prohibitionist Policy”.[31] Only three basic Phase 1 prospective studies of human volunteers to study the effects of MDMA in the hospital research setting have been done in the United States; Chang and Grob did one of them at Harbor-UCLA Medical Center in California.[17; 46 p.559] The 10 subjects in this study were scanned using MRI and SPECT brain scans at baseline and again after receiving two doses of MDMA/Ecstasy, at intervals ranging from two weeks to three months after the last dose of drug.[17] Subjects scanned at two weeks showed some reduction in cerebral blood flow while those scanned at three months showed return to baseline.[17] The subjects used in this particular study were part of a larger group participating in Grob’s Phase 1 study, a study in which the FDA required all subjects to have already had substantial MDMA/Ecstasy exposure.[31] Testifying before the Senate Subcommittee on Government Affairs on July 30, 2001, NIDA Director Alan Leshner showed a large poster with images from this study.[64] The two images showed the cerebral blood flow at baseline and then in the same subject 2 weeks post MDMA/Ecstasy administration.[64] The second image showed a decrease in cerebral blood flow in some areas of the brain compared with the first image.[64] Leshner told the legislators that MDMA/Ecstasy causes changes in cerebral blood flow. In fact, the same subject scanned at 2-3 months post MDMA/Ecstasy administration showed return to baseline blood flow. Chang’s study concluded: “low dose recreational MDMA use does not cause detectable persistent rCBF [regional cerebral blood flow] changes in

humans.[17 p.15] Leshner's statement to legislators was clearly misleading. Most importantly, the baseline image that Leshner implied was a non-MDMA/Ecstasy user was actually a heavy user, since all the study subjects had used MDMA/Ecstasy an average of 211 times.[17 p.17] This testimony, as well as others, was important in the enactment of drug policy legislation, specifically the RAVE act, which will be discussed in more detail in Section II of this paper.

Neuropathologist Stephen Kish has claimed, "There are no holes in the brains of ecstasy users. . . . And if anyone wants a straightforward answer to whether ecstasy causes any brain damage, it's impossible to get one from these papers." [24] Laruelle, from Columbia University, commented: "All the papers [brain imaging studies in MDMA/Ecstasy users] have very significant limitations that make me uneasy." [24]

Andrew Parrott, at the University of East London, conducted a study that found MDMA/Ecstasy outperforming non-users in certain cognitive task tests.[24] In an April 2002 *New Scientist* article, Parrott is quoted: "It's an open secret that some teams have failed to find deficits in Ecstasy users and had trouble publishing the findings. . . . The journals are very conservative. . . . It's a source of bias." [24] Parrott himself has had two papers that failed to find deficits in MDMA/Ecstasy users turned down for publication.[24]

In an interesting twist in the MDMA/Ecstasy controversy, Ricaurte is an author on a 2004 study in *Neuropsychopharmacology* using laboratory primates (monkeys) that were allowed to self-administer oral doses of MDMA, a study design more closely resembling human use of MDMA/Ecstasy and a design not previously used.[59] After eighteen months of self-administration, consuming a total 120-139 doses of MDMA, followed by

two months of abstinence, the animals were studied by PET scan and then euthanized and the brain tissue was studied for serotonin and dopamine toxicity. The brain scans as well as the tissue examination did not show any evidence of brain damage.[59]

Since placement of MDMA/Ecstasy in Schedule I in 1985, the psychotherapy community has aggressively sought to get approval to study the drug in prospective clinical trials. In March 2004, after 20 challenging years, this was finally accomplished. Dr. Michael Mithoefer, sponsored by the Multidisciplinary Association for Psychedelic Studies, received final approval in the form of a DEA Schedule I license to begin a prospective clinical study of MDMA in humans. The study began in early 2004 in South Carolina and is using the drug in patients with post traumatic stress disorder.[136] This is the first U.S. prospective study in humans, using MDMA in patients never exposed to the drug, since MDMA was placed in Schedule I in 1985.

Some conclusions that can be drawn regarding scientific research on MDMA/Ecstasy:

- 1) Studies of MDMA/Ecstasy are fraught with methodologic flaws.
- 2) Media representations of the studies exaggerate the toxicity of MDMA/Ecstasy.
- 3) Misrepresentation of both valid and flawed study results are used in congressional testimony to form drug policy that serves to escalate the increasingly controversial War on Drugs.
- 4) Federally funded research on illicit drugs represents a conflict of interest because the federal government represents the executor of the U.S. prohibitionist drug policy.

- 5) 1-4 all contribute to difficulty in investigating legitimate medical use of MDMA.

SECTION II: THE HISTORY OF U.S. DRUG POLICY

Current U.S. drug policy has its origins in the early twentieth century. A brief look back at some key pieces of legislation and court cases reveals the roots of America's current prohibitionist stand on psychoactive drugs.

The Harrison Narcotics Act of 1914

A look at the history of opium is important in understanding the origins of U.S. drug laws. The milky fluid extracted from the ovary of the poppy plant is a narcotic and is known as opium.[48] The word opium derives from the Greek word for the juice of a plant, opos, or opion meaning "poppy juice." [48; 79] The first known written source that mentions opium is the works of Theophrastus in the third century B.C.; clearly man has known of opium and its effects for a long time.[48] In 1680 the English doctor Sydenham wrote, "Among the remedies which it has pleased Almighty God to give to man to relieve his sufferings, none is so universal and so efficacious as opium." [48] In the eighteenth century opium became a popular recreational drug in China.[71] In 1729 the Emperor, disturbed by this use, decided that opium must no longer be imported into China except under license.[71] The British had the monopoly on the opium trade in China, and through the East India Company, began smuggling opium into China via merchant ships from India.[48; 71] In 1830 a British House of Commons committee investigated the East India Company and recommended that it would not be desirable "to abandon so important a source of revenue," and thus the British opium trade continued.[71] Opium addiction in China reached all social classes.[71] Emperor Tao-Kwang took the throne in 1820; he lost 3 sons to opium addiction and was determined to

put an end to opium smuggling.[71] His efforts led to the Opium Wars between Britain and China, the first in 1839, the second in 1856.[71] The British prevailed in both of these conflicts. By 1860 the British had what they wanted, legal importation of opium on payment of duty. Opium use in China rose drastically.[71]

In 1898, at the end of the Spanish-American War, the United States annexed the Philippines.[48] The colonial administrators were disturbed by the high rate of opium smoking in the Philippines.[48] Many of these administrators were religious leaders and they opposed opium use on moral grounds.[48] Contemporaneous with this Philippine concern, the temperance movement was in full force in the United States. This was a powerful movement of religious fundamentalism that favored abolition of drug and alcohol use in the United States. Reverend Charles Brent, an Episcopal bishop assigned to the Philippines, investigated the opium matter.[12 p.44] He learned that opium imports to the Philippines were part of international opium trafficking.[12 p.44] The U.S.-sponsored Brent Commission recommended that narcotics be subject to international rather than merely national control.[12 p.44] Brent convinced the U.S. State Department to call for international conferences dedicated to the eradication of worldwide drug traffic.[12 p.44]

In addition to the moral element, there was an economic component in this initiative. This was a time when the United States was changing its isolationist foreign policy in favor of an increased role in world affairs.[12 p.44] America wanted to sell its products in China, but was having trouble breaking into the market: "The silver bullion China was trading for British opium could be better traded for other, perhaps American, products." [12 p.44]

In 1909, under American pressure, countries with possessions in the Far East met at Shanghai to hold the International Opium Conference, chaired by Reverend Brent.[12 p.44] This conference laid the foundation for the Opium Conferences at The Hague in 1911, 1912 and 1914.[12 p.44] The result of the Hague Conferences was The Opium Convention which required signing parties to limit the manufacture, trade and use of opiates to medical purposes; to close opium dens; to penalize unauthorized possession of opiates; and to prohibit opiate sale to unauthorized persons.[12 p.44; 25] Reverend Brent and his supporters understood that America would have to set an example in order to have credibility in the international efforts to stop drug trafficking.[12 p.44] Dr. Hamilton Wright, the U.S. Opium Commissioner at the time and the “father of American drug laws” enlisted Representative Francis Burton Harrison to introduce legislation in Congress, the Harrison Narcotics Bill, to control the prescription, sale and possession of narcotic drugs such as opium, morphine, heroin and cocaine (cocaine was erroneously believed to be a narcotic at this time).[97 sec.1]

At the end of the nineteenth and in the early twentieth century, much of the narcotic addiction in the United States was “accidental,” it resulted from physician prescribed narcotics and over-the-counter “patent medication.”[137] Recognition of “patent medication” as a source of addiction led to the first U.S. federal law to apply to narcotics: The Pure Food and Drug Act of 1906.[137] This law actually pre-dated the Harrison Narcotic Bill by a few years, but it did not regulate the sale of narcotics in any way; it required labeling of foods and drugs, to identify the ingredients.[12 p.43] Prior to this law “patent medicines,” bought over-the-counter, contained narcotics, unknown to the consumers of these medications.[137] They were sold under names such as Ayer’s

Cherry Pectoral, Mrs. Winslow's Soothing Syrup, Darby's Carminative, and Godfrey's Cordial.[12 p.4] They were sold as teething syrups, painkillers, cough medicine, for diarrhea, for "women's trouble" and various other maladies.[12 p.4] The new federal law simply required that medication contain labels identifying the contents so consumers would know what they were taking. Later amendments required quantity be stated and that drugs meet standards of purity.[12 p.43]

The Harrison Narcotics Act (HNA) was the first piece of legislation that regulated the prescription and sale of narcotic drugs in the United States.[12 p.44-45] This legislation was important for the United State's image at international conferences and to fulfill U.S. obligations under the new Hague Opium Convention.[12 p.44] Public health and the moral aspect of drug control were also factors in this legislation.[12 p.44] The secretary of state at that time was William Jennings Bryan and he was a man of prohibitionist and religious beliefs and a major advocate of the HNA.[12 p.44] It is hard to know which of these factors dominated in the decision to enact this legislation, but the Sixty-Third Congress of the United States passed the Harrison Narcotics Act in 1914.[47]

The HNA required registration of narcotic transactions, levied a tax on each, but did not directly prohibit the use or sale of narcotics. The law specified that certain people (physicians, dentists, veterinarians, pharmacists, employees of these people as well as pharmaceutical industry workers) could possess and conduct narcotic transactions by virtue of their professions.[47] The law specified that physicians, dentists and veterinary surgeons could prescribe and dispense narcotics "in the course of [their] professional practice."[47] Professional practice was not defined and subsequently became a point of controversy in the interpretation of the law. The law allowed marketing of small

quantities of narcotics over-the-counter.[47] However, the law ultimately became the means to control the prescribing of narcotics by physicians.[12 p.44-45] Some pertinent excerpts from the law:

Section 1 - An Act to provide for the registration of, with collectors of internal revenue, and to impose a special tax on all persons who produce, import, manufacture, compound, deal in, dispense, sell, distribute, or give away opium or coca leaves, their salts, derivatives, or preparations, and for other purposes. [The tax was initially \$1.00 per year.]

Section 2 – That it shall be unlawful for any person to sell, barter, exchange, or give away any of the aforesaid drugs except in pursuance of a written order of the person to whom such article is sold, bartered, exchanged, or given, on a form to be issued in blank for that purpose by the Commissioner of Internal Revenue. . . .

Nothing in this section shall apply –

(a) To 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 . . .

(b) To the sale, dispensing, or distributing of any of the aforesaid drugs by a dealer [pharmacist] to a consumer under and in pursuance of a written prescription issued by a physician, dentist, or veterinary surgeon registered under this Act.

Section 6 - That the provisions of this Act shall not be construed to apply to the sale, distribution, or giving away, dispensing, or possession of preparations and remedies which do not contain more than two grains of opium, or more than one-

fourth of a grain of morphine, or more than one-eighth of a grain of heroin, or more than one grain of codeine, or any salt or derivative of them in one fluid ounce . . .

Section 8 - That it shall be unlawful for any person not registered under the provisions of this Act, and who has not paid the special tax provided for by this Act, to have in his possession or under his control any of the aforesaid drugs; and such possession or control shall be presumptive evidence of a violation of this section, and also a violation of the provisions of section one of this Act: Provided, That this section shall not apply to any employee of a registered person, or to a nurse under the supervision of a physician, dentist, or a veterinary surgeon registered under this Act, having such possession or control by virtue of his employment or occupation and not on his own account; or to the possession of any of the aforesaid drugs which has or have been prescribed in good faith by a physician, dentist, or veterinary surgeon registered under this Act; . . .

Section 9 - That any person who violates or fails to comply with any of the requirements of this Act shall, on conviction, be fined not more than \$2000 or be imprisoned not more than five years, or both, at the discretion of the court.[47]

The immediate effect of the HNA was seen quickly as those addicted to narcotics turned to hospitals and physicians as the only place to get their drugs.[12 p.45] The federal government began the practice of arresting physicians on the charge that prescription of narcotics to addicts violated the HNA.[12 p.45]

Case Law Interpretation of the Harrison Narcotics Act

Tracing the evolution of case law shows how the HNA was the beginning of U.S. prohibitionist drug policy. A look at some Supreme Court cases that were decided in the decade following the passage of the HNA illustrates this evolution. Shortly after enactment of the HNA, *U.S. v. Jin Fuey Moy*, 241 U.S. 394 (1915), was argued before the Supreme Court.[129] The prosecution attempted to make possession of opium a crime in violation of the HNA. The indictment was made under Section 8 of the HNA (see p.37). There are exemptions delineated in Section 8 such as employees of registered persons, nurses under the supervision of a physician, dentist, or veterinary surgeon, or persons in possession of the prohibited drugs prescribed in “good faith” by a physician, dentist, or veterinary surgeon properly registered under the law. The defendant in this case, Jin Fuey Moy, was a physician who issued a written prescription for morphine to Willie Martin, a narcotic addict. The indictment alleged that Martin was not registered with the Collector of Internal Revenue and had not paid the required tax. It further alleged that the defendant had not issued the written prescription in good faith but knew that the drug was not being prescribed for medical purposes but to an addict. The question was whether such possession of narcotics by Martin was prohibited by the HNA. The district court found in favor Jin Fuey Moy. The Supreme Court affirmed the lower court’s decision and confirmed that the HNA was written as a tax law and any moral ends or regulation of the practice of medicine should only be reached through the taxing aspect of the law.

Only words from which there is no escape could warrant the conclusion that Congress meant to strain its powers almost if not quite to the breaking point in

order to make the probably very large proportion of citizens who have some preparation of opium in their possession criminal or at least *prima facie* criminal and subject to the serious punishment made possible by Section 9. It may be assumed that the statute has a moral end as well as revenue in view, but we are of the opinion that the District Court, in treating those ends as to be reached only through a revenue measure and within the limits of a revenue measure was right. Approaching the issue from this point of view we conclude that ‘any person not registered’ in Section 8 cannot be taken to mean any person in the U.S. but must be taken to refer to the class with which the statute undertakes to deal – the persons who are required to register by Section 1.[129 p.402]

The decision meant that a patient who is given a prescription for a narcotic by a physician is not required to pay the tax because they are not in the class of people required by Section 1 of the statute to register. The decision points out that a “very large proportion of citizens” have some opium preparation in their possession.[129 p.402] Thus by a 7-2 decision, in 1916, the Supreme Court struck down this early attempt to interpret the HNA as a law prohibiting possession or use of narcotics by addicted individuals with physician-prescribed narcotics.

This case, however, raised several issues that were to occupy courts for some years in interpreting the HNA. First, the federal government’s argument in *Jin Fuey Moy* contained the assumption that prescription of narcotics to maintain an addict was not consistent with “good faith” medical practice and this became the crux of the controversy in subsequent court cases involving interpretation of the HNA.[129] Second, another issue was the question of what constituted maintenance of addiction in terms of quantity

of drugs prescribed.[14; 126; 131; 135] Finally, an issue discussed in *Jin Fuey Moy* as well as subsequent cases involving the HNA and the prescribing of narcotics to addicts, was whether the HNA amounted to an unconstitutional federal effort to regulate medical practice, a power reserved to the states. This issue was the reason the HNA was constructed as a tax law, because taxation was a legitimate role for the federal government. The cases discussed below, *Doremus*, *Webb*, *Behrman*, and *Lindner*, all agree on the fact that some regulation of medical practice resulting from the tax revenue aspect the HNA was acceptable and within the power of the federal government, and therefore constitutional.[14; 126; 131; 135]

Over the next few years the political and social climate in the United States changed dramatically. World War I was in progress. The Bolsheviks, led by Lenin, had seized power in Russia during the Russian Revolution of 1917. On January 16, 1919 the required number of states ratified the Eighteenth Amendment to the U.S. Constitution, which prohibited “the manufacture, sale or transportation of intoxicating liquors within, the transportation thereof into, or exportation thereof from the United States.”[39] The prohibitionists prevailed and alcohol prohibition became the law of the land. A remarkable change in opinion by the Supreme Court is evident in twin decisions handed down on March 3, 1919, both by a court narrowly divided 5-4. The HNA was construed as a narcotic prohibition law, prohibiting the prescription of narcotics by physicians to addicts, in *U.S. v. Doremus*, 249 U.S. 86 (1918), and *Webb et al. v. U.S.*, 249 U.S. 96 (1918).

In *Doremus*, the first count in the indictment charged that:

Doremus, a physician, duly registered, and who had paid the tax required by the first section of the Act [HNA] did unlawfully, fraudulently, and knowingly sell and give away and distribute to one Ameris a certain quantity of heroin, to wit, five hundred one-sixth grain tablets of heroin, a derivative of opium, the sale not being in pursuance of a written order on a form issued on the blank for that purpose by the Commissioner of Internal Revenue.[126 p.90]

The second count charged that:

Doremus did unlawfully and knowingly sell, dispense and distribute to one Ameris five hundred one-sixth grain tablets of heroin not in the course of the regular professional practice of Doremus, and not for the treatment of any disease from which Ameris was suffering, but as was well known by Doremus, Ameris was addicted to the use of the drug as a habit, being a person popularly known as a “dope fiend,” and that Doremus did sell, dispense, and distribute the drug, heroin, to Ameris for the purpose of gratifying his appetite for the drug as an habitual user thereof.[126 p.90]

The court cites *Jin Fuey Moy*: “It may be assumed that the statute has a moral end as well as revenue in view, but we are of the opinion that the district Court, in treating those ends to be reached only through a revenue measure, was right. The question becomes have the provisions in question relation to the raising of tax revenue?”[126 p.94] The provisions of Section 2 of the HNA “aim to confine sales of the drugs to registered dealers [i.e. pharmacists], and to those dispensing the drugs as physicians and to those who come to dealers with legitimate prescriptions of physicians.”[126 p.94] The court

considered these provisions to have been included in the HNA by Congress specifically to provide for raising revenue. The court felt the provisions:

. . . tend to diminish the opportunity of unauthorized persons to obtain the drugs and sell them clandestinely without paying the tax imposed by federal law. . . .

Ameris, being as the indictment charges, an addict, may not have used this great number of doses [five hundred tablets] for himself. He might sell some to others without paying the tax, at least Congress may have deemed it wise to prevent such possible dealings because of their effect upon the collection of revenue.[126 p.94-95]

Thus, in *Doremus*, the Supreme Court found that dispensing narcotics to a heroin addict is unlawful based on its relation to raising tax revenue. An addict may sell the drugs and not pay the required tax.[126 p.94]

The second case, also handed down on March 3, 1919, was *Webb*, 249 U.S. 96 (1918). The opinion of the court states:

Webb was a practicing physician and Goldbaum a retail druggist in Memphis. It was Webb's regular custom and practice to prescribe morphine for habitual users upon their application to him therefore. He furnished these 'prescriptions' not after consideration of the applicant's individual cases, 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. Goldbaum was familiar with such practice and habitually filled such prescriptions.[135 p.97-98]

It should be noted that the Supreme Court opinion mentions the fact that the quantity of morphine, both quantity per prescription as well as the number of prescriptions written by Webb and filled by Goldbaum, were many times greater than the usual practice for a physician and for a retail pharmacist.[135 p.98] The court was faced with a question:

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 exemption (b) of [Section 2 of the HNA]? . . . to call such an order for the use of morphine a physician's prescription would be so plain a perversion of meaning that no discussion of the subject is required. That question should be answered in the negative.[135 p.99-100]

Thus, a physician's prescribing of narcotics to an addict to maintain the addict's dependence, at least prescriptions of large quantities, as was the case in *Webb*, was a violation of the HNA, and therefore a crime. After *Doremus* and *Webb*, the foundation of the United States' abstinence-based prohibitionist drug policy was established. Narcotics could only be obtained through written prescriptions by a physician and prescription of narcotics to addicts was not considered good faith practice of medicine, and was therefore criminal under the HNA. After *Doremus* and *Webb*, the government continued its practice of arresting physicians for prescribing narcotics to addicts.

The controversy continued and over the next few years several more Supreme Court opinions were handed down. The cases focused on the issue: what constitutes a prescription issued in good faith by a physician in the course of professional practice?

U.S. v. Behrman, 258 U.S. 280 (1921), decided March 27, 1922, involved the prescribing of narcotics by a physician, Behrman, to an addict, Willie King[131]. The prescriptions were for large quantities of opium, heroin, morphine and cocaine. The court found:

It may be admitted that to prescribe a single dose, or even a number of doses, may not bring a physician within the penalties of the [HNA]; but what is here charged is that the defendant physician, by means of prescriptions, has enabled one, known by him to be an addict, to obtain from a pharmacist the enormous number of doses But the quantities named in the indictment are charged to have been intrusted to a person known by the physician to be an addict, without restraint upon him in its administration or disposition by anything more than his own weakened and perverted will. Such so-called prescriptions could only result in the gratification of a diseased appetite for these pernicious drugs, or result in an unlawful parting with them to others, in violation of the [HNA] as heretofore interpreted in this court, within the principles laid down in the *Webb* and *Jin Fuey Moy* Cases . . . [131 p.288-89]

Thus, in *Behrman*, as in *Webb*, prescriptions for large quantities of narcotics were considered to be outside the realm of good faith professional practice and a violation of the HNA. However, the opinion in *Behrman* did suggest that “a single dose, or even a

number of doses” prescribed to an addict may be acceptable professional practice.[131 p.288]

A subsequent case, *Lindner v. U. S.*, 268 U.S. 5 (1924), decided April 13, 1925, addressed this issue.[14] Charles Lindner, a licensed physician, dispensed to Ida Casey, an addict, one tablet of morphine and three tablets of cocaine to be self-administered by Casey to satisfy her addiction. Casey was not prevented from disposing of the drugs in any manner she chose; she could sell it. The *Lindner* opinion reviewed previous Supreme Court decisions: *Jin Fuey Moy* found that the HNA must be strictly construed as a revenue measure; *Doremus* found that the HNA must be construed as a tax law because that was within the power of Congress, whereas regulation of medical practice was a power reserved to the states, and prescription of large quantities of narcotics violates the HNA in that an addict may subsequently sell the drugs and avoid paying the tax; *Webb* found that a physician’s prescription for large quantities of narcotics to an addict to maintain his addiction was “so plain a perversion of meaning” of the word prescription, that no discussion was required; *Behrman* validated *Webb* in that prescriptions of large quantities of narcotics to an addict constituted a violation of the HNA but suggested smaller quantities may not be a violation.[14 p.18-20] The decision in *Lindner* affirmed that the HNA was essentially a revenue measure and as such:

The opinion cannot be accepted as authority for holding that a physician who acts bona fide and according to fair medical standards may never give an addict moderate amounts of drugs for self-administration in order to relieve conditions incident to addiction. Enforcement of the tax demands no such drastic rule, and if the act had such scope it would certainly encounter grave constitutional

difficulties. . . . Federal power is delegated, and its prescribed limits must not be transcended even though the end seems desirable. The unfortunate condition of the recipient certainly created no reasonable probability that she would sell or otherwise dispose of the few tablets intrusted to her; and we cannot say that by so dispensing them the doctor necessarily transcended the limits of that professional conduct with which Congress never intended to interfere.[14 p.22]

The decision in *Lindner* seemed to permit physicians to prescribe narcotics to addicts as long as it was in small quantities. However, the “Federal Bureau of Narcotics went right on arresting doctors for doing so, simply taking the precaution of never bringing them to trial where they could be acquitted.”[85] The Federal Bureau of Narcotics was the country’s primary drug law enforcement agency at the time.

Evolution of U.S. Drug Policy 1920 - 1970

From the early 1920s until 1970 there were more than fifty pieces of federal legislation enacted relating to control of drugs referred to as narcotics or dangerous drugs.[60 p.2142] It was a mere thirteen years before the prohibition of alcohol was repealed by the Twenty First Amendment to the U.S. Constitution, ratified in 1933.[122] Sentiment regarding drug use over the fifty-year period, 1920 to 1970, has varied and has been dependant on the prevailing social and political climate in the United States and the world.

After WWII, there was first the enactment of maximum penalties for narcotic use and then a change in beliefs led to more control by physicians and psychotherapists.[75 p.230] In the early 1950s, at the beginning of the McCarthy era, the fear of the Soviets, communism in China, as well as suspicion of all groups perceived as a threat to the

government led to the 1956 Narcotic Control Act with mandatory minimum sentences on the first conviction, and the threat of the death penalty for drug offenses as well.[75 p.231] The death penalty was possible for a person over the age of 18 who sold heroin to a person under the age of 18.[75 p.231]

The 1960s saw the growth of the mental health specialty within the medical profession.[75 p.234-37] As this medical specialty grew, views on addiction changed; addiction was viewed more as a medical and mental illness and the leaders of the mental health field felt the medical profession should handle addiction.[75 p.235] This view was in contrast to that of the Federal Bureau of Narcotics, who viewed drug use and addiction as a criminal matter. In 1962 the U.S. Supreme Court case *Robinson v. California*, 370 U.S. 660 (1962), dealt with this controversy of addiction as an illness rather than a criminal matter.[96] The defendant was arrested and charged under a California statute that made it a misdemeanor, punishable by imprisonment, for any person to be “addicted to the use of narcotics.” The statute did not deal with the use, purchase, sale or possession of narcotics, or with antisocial or disorderly behavior resulting from their use. It was a statute that made the “status of narcotic addiction” a criminal offense. The California court upheld the conviction. The U.S. Supreme Court reversed the conviction:

It is unlikely that any State at this moment in history [1962] would attempt to make it a criminal offense for a person to be mentally ill, or a leper, or to be afflicted with a venereal disease. A State might determine that the general health and welfare require that the victims of these and other human afflictions be dealt with by compulsory treatment, involving quarantine, confinement, or sequestration. But, in the light of contemporary human knowledge, a law that

makes a criminal offense of such a disease would doubtless be universally thought to be an infliction of cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments. We cannot but consider the statute before us as of the same category. In this Court counsel for the State recognized that narcotic addiction is an illness. Indeed, it is apparently an illness that may be contracted innocently or involuntarily. We hold that a state law which imprisons a person thus afflicted as a criminal . . . inflicts a cruel and unusual punishment in violation of the Fourteenth Amendment. . . . Even one day in prison would be a cruel and unusual punishment for the “crime” of having a common cold.[96]

In 1963 the Presidential Commission on Narcotic and Drug Abuse, created by the Kennedy administration, issued its report and recommended: relaxation of mandatory minimum sentences, increased funding for research on drug abuse, and dismantling of the Federal Bureau of Narcotics with assignment of its functions to the Justice Department and the Department of Health, Education and Welfare.[75 p.238] The 1960s also saw the establishment of the first methadone maintenance clinics in New York City, started by the pioneering work of Dr. Vincent Dole and Dr. Marie Nyswander.[75 p.237] They promoted the belief that opiate addiction caused a permanent biochemical change in the brain and therefore maintenance treatment, possibly for life, was the best way to treat addiction.[75 p.237-38]

The Comprehensive Drug Abuse Prevention and Control Act of 1970 and The Controlled Substances Act

The Comprehensive Drug Abuse Prevention and Control Act of 1970 consolidated all federal drug laws enacted since the HNA of 1914 and created one comprehensive piece

of legislation.[75 p.241] This legislation favored flexible penalties in place of mandatory minimums.[75 p.241] The authors of the 1970 legislation were concerned that “increasingly longer sentences that had been legislated in the past had not shown the expected overall reduction in drug law violations.”[103 chap.6, sec.C.1.] There was also concern that “severe drug laws, specifically as applied to marihuana, have helped create a serious clash between segments of the youth generation and the Government and have contributed to the broader problem of alienation of youth from the general society.”[103 chap.6, sec.C.1.] The 1970 Act eliminated mandatory minimum sentences for drug law violations except for “professional criminals”.[103 chap.6, sec.C.1.]

An important part of this 1970 legislation was Title II, The Controlled Substances Act (CSA).[123] This Act now serves as the legal basis of the federal government’s prohibition of the use of certain drugs, and thus serves as the basis of the government’s prohibitionist drug policy. The CSA places all drugs that are regulated into Schedules I through V based on specific criteria: 1) potential for abuse, 2) currently accepted medical use, 3) safety and potential for dependence. This law is the basis of the scheduling of MDMA/Ecstasy as well as marijuana in Schedule I, the most restrictive category. Just after enactment of the 1970 legislation, President Nixon officially declared America’s War on Drugs. At a press conference on June 17, 1971 Nixon called drug abuse “public enemy number one in the United States.”[116]

Cocaine

In the 1980s public sentiment grew increasingly anti-drug in large part because of the crack cocaine phenomenon. Historically, cocaine use in the United States has fluctuated. In the late 1800s cocaine was introduced into this country and was widely used through

the early 1900s.[103 chap.6, sec.B.1.] After the passage of the HNA, non-medical use of cocaine became illegal. By the 1950s the use of cocaine had declined and the drug was no longer considered a problem.[103 chap.6, sec.B.1.] However, cocaine re-emerged as a drug of abuse in the 1960s.[103 chap.6, sec.B.1.] In the 1980s cocaine use, and more specifically crack cocaine use, became a major social and political issue.

It is worthwhile to look at cocaine and its various forms because crack cocaine has played a very significant role in America's War on Drugs in the last two decades. There are several forms and methods of use for cocaine. The naturally occurring form is the coca leaf from coca plants. The leaves can be chewed, rolled into cigarettes or cigars and smoked, or infused in liquid, forming a coca tea.[103 chap.2, sec.C.1.a.] Coca paste is a putty-like substance that is an intermediate product in the conversion of coca leaves into powder cocaine; coca paste is a form of base cocaine, the pure form of the psychoactive ingredient from the coca plant.[103 chap.2, sec.C.1.b.] Coca paste does not readily dissolve in water and hence cannot be injected, sniffed or ingested.[103 chap.2, sec.C.1.b.] Most coca paste is converted into powder cocaine although in some South American countries the paste is smoked.[103 chap 2, sec.C.1.b.] Powder cocaine is the stable, salt form of cocaine formed by reacting coca paste with hydrochloric acid, producing cocaine hydrochloride salt; it is the white odorless crystalline powder that is the common street drug known as cocaine.[103 chap.2, sec.C.1.c.] Powder cocaine is water-soluble and usually is sniffed.[103 chap.2, sec.C.1.c.] Because it is water-soluble it can also be dissolved and injected.[103 chap.2, sec.C.1.c.] Base cocaine is another form of cocaine; coca paste is one form of base cocaine but there are other forms.[103 chap.2, sec.C.1.b.] Base cocaine can be derived from cocaine hydrochloride salt when

chemically treated with ammonia and ether or sodium bicarbonate (baking soda).[103 chap.2, sec.C.1.d.i.] When dissolved in ammonia and ether, a solid substance separates, the base cocaine, also called “free-base” cocaine.[103 chap.2, sec.C.1.d.i.] This free-base cocaine is smoked because it is not water-soluble.[103 chap.2, sec.C.1.d.i.] Free-base cocaine became popular in the 1970s.[103 chap.2, sec.C.1.d.i.] Smoking free-base cocaine carries some risk, independent of the drug effect and dependent instead upon its mode of preparation. There is the danger when smoking free-base cocaine that it may ignite if it is smoked before the ether fully evaporates.[103 chap.2, sec.C.1.d.i.] This aspect of cocaine use received a lot of media coverage in 1980 when comedian Richard Pryor suffered severe burns while free-basing cocaine.[103 chap.2, sec.C.1.d.i.]

Crack cocaine is another form of base cocaine and is formed by dissolving powder cocaine in sodium bicarbonate (baking soda).[103 Chap. 2, sec. C.1.d.ii.] The solution is boiled, a solid substance separates from the solution and is dried and cut into pieces.[103 chap.2, sec.C.1.d. ii.] The boiling process produces a “cracking” sound, hence the name crack cocaine.[54] This crystallized form of base cocaine, crack cocaine, is insoluble in water so it can’t be easily injected or sniffed but it does vaporize at low temperature so it can be easily inhaled via a pipe.[54]

The onset, intensity and duration of the effects of cocaine differ depending on the form of cocaine used and the method of administration.[103 chap.2, sec.C.2.] Base cocaine provides more rapid, more intense euphoria than the powdered salt form. In other words, crack cocaine is a more potent form than powder cocaine but is none-the-less still cocaine. Cocaine produces the same physiological effects regardless of its form. Cocaine has been described in the following way: “. . . a drug which induces a secular

parody of heaven commonly leads the user into a biological counter part of hell.”[54]

The human brain has negative feedback mechanisms with the functional effect of making crack-induced pleasure short lived.[54] The “euphoria of a re-enforcer as uniquely powerful as crack will be followed by a crash.”[54] The crash is manifest as anxiety, depression, irritability, fatigue and sometimes paranoia.[54] An intense craving for more cocaine develops and severe depression, agitated delirium and sometimes a condition of paranoid psychosis can result.[54] There is down regulation of receptors in the brain to compensate for the cocaine induced over stimulation and the brain’s capacity to experience pleasure is diminished.[54] Profound melancholy and anhedonia are common.[54] The social consequences of crack cocaine can be equally unpleasant: “The obsession [for the drug] is so all-consuming that food, money, sleep, loved ones, morality, any sense of responsibility and even survival instincts may be eclipsed.”[22]

Anti-Drug Abuse Act of 1986: Mandatory Minimums, the Cocaine Ratio, and the Crack House Statute

The prevailing social and political climate in the United States influenced enactment of drug policy throughout the twentieth century and this was the case with crack cocaine. The crack cocaine phenomenon of the 1980s and the developing AIDS epidemic played a large part in new comprehensive drug legislation in 1986.[103 chap.8, sec.B.1.f.]

President Reagan signed the Anti-Drug Abuse Act of 1986 into law on October 27, 1986.[2] Opinion once again shifted in favor of mandatory sentencing. The 1986 Act created the basic framework of mandatory minimum penalties, also known as determinate sentencing, for federal drug offenses that are still in existence today.[103 chap.6, sec.C.3.]

The 1986 Act established two tiers of mandatory prison terms for first-time drug offenders; five-year and ten-year minimum sentences, triggered exclusively by quantity and type of drug.[103 chap.6, sec.C.3.] Higher mandatory minimum penalties apply if the offender has been previously convicted of a drug trafficking offense.[103 chap.6, sec.C.3.] This law also established the criminal law distinction between powder cocaine and crack cocaine; the 100-to-1, powder-to-crack, quantity ratio used in determinate sentencing.[103 chap.6, sec.C.3.] Crack was considered far more serious than powder cocaine, to the extent that crack in a quantity 1/100 that of powder cocaine would trigger the same penalty. Five hundred grams of powder cocaine and five grams of crack cocaine both trigger a five-year mandatory penalty for first offenders.[103 chap.6, sec.C.3.]

The 1995 report to Congress on cocaine and federal sentencing policy, submitted by the United States Sentencing Commission, contains considerable and insightful discussion of the Anti-Drug Abuse Act of 1986.[103] The 1986 Act was expedited through Congress and left behind a limited legislative record and no committee reports.[103 chap.6, sec.C.3.a.] “Congress dispensed with much of the typical deliberative legislative process, including committee hearings.”[103 chap.6, sec.C.3.a.] This expeditious development and enactment is reflected in the congressional record:

It is historic for Congress to be able to move this quickly. – Senator Chiles[103 chap.6, sec.C.4. citing 132 Cong. Rec. 31,329 Oct 15, 1986]

I know it seems to some that we are moving too fast and frenetically to pass drug legislation. – Senator Rockefeller [103 chap.6, sec.C.4. citing 132 Cong. Rec. 26,449 Sept 26, 1986]

Very candidly, none of us has had an adequate opportunity to study this enormous package. It did not emerge from the crucible of the committee process. – Senator Mathias [103 chap.6, sec.C.4. citing 132 Cong. Rec. 26,462 Sept. 26, 1986]

In our haste to paste together a drug bill - any drug bill - before we adjourn, we run the risk of ending up with a patchwork quilt . . . that may not fit together into a comprehensible whole. – Representative Lott [103 chap.6, sec.C.4. citing 132 Cong. Rec. 22,658 Sept.10, 1986]

The media played a significant role in the crack cocaine phenomenon of the 1980s. Citing the drug-related death of Boston Celtics first round basketball draft pick Len Bias, members of Congress repeatedly described the drug problem in 1986 as an “epidemic”. [103 chap.6, sec.C.4. citing Senators Joseph Biden (132 Cong. Rec. 26,436 Sept. 26, 1986), Dennis Deconcini (132 Cong. Rec. 26,444 Sept. 26, 1986), Alfonse D’Amato (132 Cong. Rec. 8,091 June 20, 1986), Mack Mattingly (132 Cong. Rec. 8,092 June 20, 1986)] Senator Paula Hawkins spoke in support of the 1986 Act: “Drugs pose a clear and present danger to America’s national security. If for no other reason we should be addressing this on an emergency basis. . . . This is a bill which has far reaching impact on the future as we know it as Americans and as we mature into the next century.” [103 chap.6, sec.C.4. citing 132 Cong. Rec. 26,436 Sept. 26, 1986]

The media portrayed crack cocaine as the number one social and political issue of the time. Time magazine called crack cocaine the “Issue of the Year” in 1986. [103 chap.6, sec.C.4.] Newsweek magazine referred to crack cocaine as the biggest news story since Vietnam and Watergate. [103 chap.6, sec.C.4.] Len Bias’s death in June 1986 was a major factor in the media frenzy. [103 chap.6, sec.C.4.] The media handling of the crack

cocaine phenomenon may have accurately reflected the situation or the media, at least in part, may have created the urgency.[103 chap.8, sec.B.] Regardless, crack cocaine was viewed as a “national epidemic” in 1986.

The legislative history of the Anti-Drug Abuse Act of 1986 in the Congressional record contains transcripts of the discussions of crack cocaine.[103 chap.8] The Congressional decision to treat crack cocaine differently from powder cocaine was deliberate. Conclusions about the dangers of crack relative to powder cocaine were based on specific assumptions:[103 chap. 8]

- 1) Crack cocaine was viewed as extraordinarily addictive, not only relative to powder cocaine, but in absolute terms.
- 2) The physiological effects of crack cocaine were considered especially perilous, with the potential of leading to psychosis and death.
- 3) The correlation between crack cocaine use and the commission of other serious crime was considered greater than with other drugs.
- 4) One of crack cocaine’s most troubling features is that young people are particularly prone to using it.
- 5) Crack’s potency, low cost, and the ease with which it is manufactured, transported, and administered were all leading to widespread use.
- 6) Crack cocaine was believed to be associated with other public health concerns such as “crack babies” and HIV transmission.

The 1986 Act created the widely criticized 100-to-1, powder-to-crack cocaine ratio[103 chap.8, sec.A.] Prior to the 1986 Act, the Sentencing Reform Act of 1984 established the United States Sentencing Commission.[100] The Commission was

charged with creating a system of uniform mandatory sentencing guidelines.[103 chap. 6, sec.A] This Act abolished parole for defendants sentenced under the guidelines.[103 chap.6, sec.B.2.] The Commission created the concept of “marijuana equivalency.”[100] Marijuana penalties are used as a common standard to which all other drugs are related mathematically. The 1986 Act established that possession of 5 grams of crack cocaine would trigger the same 5-year sentence as 500 grams of powder cocaine.[103 chap.6, sec.C.3.] The current standards are as follows:[124 p.105-7]

5-Year penalty triggered by: 100,000 grams of Marijuana

2857 grams of MDMA/Ecstasy (pre-2001)*

500 grams of Powder Cocaine

200 grams of MDMA/Ecstasy (post-2001)*

100 grams of Heroin

5 grams of Crack Cocaine

*The current ratio for MDMA/Ecstasy was established in 2001 pursuant to the Ecstasy Anti-Proliferation Act of 2000.[37] Prior to the 2000 Act, the ratio was 1 gram MDMA/Ecstasy = 35 grams of marijuana.[89 p.6] In 2001, the ratio changed to 1 gram of MDMA/Ecstasy = 500 grams of marijuana.[89 p.6] The Commission set the quantity of MDMA/Ecstasy that triggers a five-year penalty at an amount twice that of heroin and slightly less than half that of powder cocaine.

The difference in penalties for different forms of cocaine has been the focus of much controversy. The argument against this difference in penalties is that the drug in the two substances is the same, cocaine. Research has revealed that federal crack cocaine defendants are disproportionately black: 85% black in 2000 according to the *Report to*

Congress: Cocaine and Federal Sentencing Policy, May 2002.[90 Executive Summary, Findings, sec. 4.] This is despite the fact that the majority of crack cocaine users, approximately two-thirds, are white or Hispanic.[27] This disparity is believed to be the result of the case selection practices by the DEA and U.S. Attorneys Offices.[112; 114 p.5] The net effect of the case selection practices and the lower quantity of crack cocaine that triggers mandatory sentencing is a higher rate of incarceration of African-Americans. This issue of disproportionate application of drug laws to minorities will be discussed in more detail in Section III of this essay. The United States Sentencing Commission has recommended three times that the disparity be removed or reduced.[90 Executive Summary] The 100-to-1 ratio still exists as law today.

It is clear from the above discussion that crack cocaine played a very large and important role in the writing and enactment of the Anti-Drug Abuse Act of 1986. It is interesting to note that the death of Len Bias, important in the public's view of the crack cocaine phenomenon of the 1980s and in congressional debate on the 1986 Act, and so highly publicized in the media as a crack cocaine death, was in fact concluded to be powder cocaine related, based on the forensic investigation, autopsy results and testimony in the trial of Brian Tribble, the person charged with supplying the cocaine to Bias.[103 chap.6, sec.C.4.]

A part of the Anti-Drug Abuse Act of 1986 was re-establishment of mandatory minimum sentences for drug offenses. This represented a return to the sentencing philosophy that had been rejected in the passage of the Comprehensive Drug Abuse Prevention and Control Act of 1970 because "increasingly longer sentences that had been legislated in the past had not shown the expected overall reduction in drug law

violations.”[103 chap.6, sec.C.1.] In 1986, during the Reagan administration, Eric Sterling was the lead attorney for the House Subcommittee on Narcotics and helped write the mandatory minimum drug legislation.[10 2004] Since 1989, he has been president of The Criminal Justice Policy Foundation, a private non-profit educational organization that helps educate the nation about criminal justice problems and works for drug policy reform.[108] In a January 2004 interview with CBS News Sterling commented on the 1986 legislation and mandatory minimum sentences: “This has been the worst legislation I’ve ever been involved with. . . . And it’s probably the worst thing I’ve ever done professionally, as a lawyer. This was the hastiest thing, the most unusual thing I’ve ever been involved in on Capitol Hill.”[10] In August of 2003, conservative Supreme Court Justice Anthony Kennedy, a Reagan appointee, addressed the American Bar Association Annual Meeting: “. . . . I can accept neither the necessity nor the wisdom of federal mandatory minimum sentences. In too many cases, mandatory minimum sentences are unwise and unjust.”[61 2003] Mandatory minimums are widely criticized as unfair. They have greatly impacted the criminal justice system and are responsible in part for the burgeoning U.S. prison population.[114 p.1] “These laws require judges to sentence drug offenders - many of them first-time, nonviolent, low-level offenders - to long prison terms, often a minimum of 5, 10, or 20 years, without parole.”[114 p.1] There are many problems with these laws. They require application of the mandatory minimums to “conspirators,” often low-level participants, sometimes only remotely involved in large drug operations.[114 p.1] The conspirators are sentenced on the basis of the total amount of drug involved in the operation.[114 p.1] The only way a federal drug defendant can reduce a mandatory minimum sentence is by providing “substantial assistance” in

prosecuting other drug offenders.[114 p.2] Low-level offenders often have no information to offer as substantial assistance, whereas higher-level traffickers often have much information to offer and a big incentive to give exaggerated or untruthful testimony: “Ironically, the ‘substantial assistance’ exception frequently allows major drug traffickers to earn sentences substantially shorter than the ‘mules’ who work under them simply because the ‘kingpins’ have more information to give prosecutors.”[114 p.2]

Another criticism of mandatory minimums is that they shift the exercise of discretion, decreasing that of judges, while increasing discretion for prosecutors.[114 p.2] While giving more discretion to the prosecutors, who are the ones in the position to decide what charges to bring and when to negotiate the “substantial assistance” sentence reductions, mandatory minimums decrease a judges ability to consider mitigating factors.[114 p.2] This shift is notable because it takes discretion away from judges, those officials charged with upholding professional impartiality, while granting greater discretion to the government prosecutors, one party in an adversarial system. Mandatory minimums are one of the most controversial aspects of current U.S. drug policy.

Part of the Anti-Drug Abuse Act of 1986 was section 856, Establishment of Manufacturing Operations, which states:

(a) Unlawful acts

Except as authorized by this subchapter, it shall be unlawful to –

- 1) knowingly open or maintain any place for the purpose of manufacturing, distributing, or using any controlled substance;
- 2) manage or control any building, room, or enclosure, either as an owner, lessee, agent, employee, or mortgagee, and knowingly and intentionally rent,

lease, or make available for use, with or without compensation, the building, room, or enclosure for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance.

(b) Penalties

Any person who violates subsection (a) of this section shall be sentenced to a term of imprisonment of not more than 20 years or a fine of not more than \$500,000, or both, or a fine of \$2,000,000 for a person other than an individual.[2]

This section of the Anti-Drug Abuse Act of 1986 became known as the “Crack House Statute” (CHS). Following passage of this law many indictments were made and prior to 2001 all indictments under the U.S. Code, Title 21, section 856 (the CHS) involved literal crack houses, places where drugs were manufactured, stored and used or places where business owners “commit substantive drug offenses or conspire with those that are committing drug offenses”.[9 p.1] Case law has affirmed the interpretation of the CHS in application to literal crack houses, where the drug operation was the primary purpose of the business owner, as well as situations where a legitimate business operated and drug activity occurred in addition to that business. The latter cases have been upheld on appeal. Two such cases raise some important issues in the interpretation of the CHS and its eventual use, starting in 2001, in the War on Drugs to combat MDMA/Ecstasy use.

Application of the Crack House Statute: *U.S. v. Chen* and *U.S. v. Tamez*

In *U. S. v. Mei-Fen Chen*, 913 F.2d 183 (1990), the defendant, Mei-Fen Chen, acquired the Della Motel in Houston, Texas, in 1979 and operated it into the late 1980s.[130] During that time the neighborhood around the motel deteriorated and the

motel became a location used by drug traffickers. Drugs were sold in the parking lot and the motel was used for storing, selling and using drugs. Chen was indicted under the CHS, both section 856(a)(1) and (a)(2).

Two important issues discussed in *Chen* are “purpose” and “knowledge.” These are important in the subsequent application of the CHS in MDMA/Ecstasy cases.

Considerable discussion is present in *Chen* regarding “purpose” in the context of both section 856(a)(1) and (a)(2):

“Purpose” is a word of common and ordinary well understood meaning; it is “that which one sets before him to accomplish; an end, intention, or aim, object, plan, project.” Black’s Law Dictionary 1112 (5th ed. 1979). Or, “purpose” is the “object toward which one strives or for which something exists; goal; aim... intention... determination; resolution.” The American Heritage Dictionary of the English Language 1062 (4th ed 1970).[130 p.189]

Using these definitions the court found:

In examining the plain language of the statute, we find that the statute is unambiguous; the phrase *for the purpose of* [in § 856(a)(1)] applies to the person who maintains the place for the illegal activity. . . . Based on our reading of the statute, § 856(a)(2) is designed to apply to the person who may not have actually opened or maintained the place for the purpose of drug activity, but who has knowingly allowed others to engage in those activities by making the place “available for use . . . for the purpose of unlawfully” engaging in such activity. Therefore, under § 856(a)(2), the person who manages or controls the building and then rents to others, need not have the express purpose in doing so that drug

related activity take place; rather such activity is engaged in by others (i.e., others have the purpose).[130 p.190]

The court states: “. . . any other interpretation would render § 856(a)(2) essentially superfluous. It is well established that a statute should be construed so that each of its provisions is given its full effect; interpretation which render parts of a statute inoperative or superfluous are to be avoided.”[130 p.190]

The other issue addressed in *Chen* is that of knowledge as an essential element of the offense.[130 p.187] “The purpose of adding the word ‘knowingly’ is to insure that no one will be convicted for an act done because of mistake or accident, or other innocent reason.”[130 p.187] Regarding section 856(a)(1), knowledge is intrinsic in the purpose; if one has a purpose in doing something then knowledge is assumed to be part of that purpose.[130 p.189] Regarding section 856(a)(2), knowledge that others are using the building, room or enclosure for the purpose of the illegal activity is required. *Chen* claimed ignorance of the drug activity at the motel, despite the testimony of others that she was aware of the activity. Review of the case reveals that not only did *Chen* have knowledge of the drug activity, she was at least in some way involved in the activity.

Chen had witnessed drug transactions and drug use in the motel rooms; *Chen* alerted tenants when she became aware that law enforcement officers planned to search certain rooms; *Chen* would encourage the tenants to make drug sales so that their rent could be paid; *Chen* stored drugs and drug proceeds for the tenants; *Chen* loaned money to the tenants to purchase drugs for resale.[130 p.186]

Chen also directed an undercover police officer to a man in the parking lot when the officer inquired at the motel office as to where he could purchase cocaine.[130 p.185]

The defense of “deliberate ignorance” or “willful blindness” is discussed in Chen:

The element of knowledge may be satisfied by inferences drawn from proof that the defendant deliberately closed her eyes to what would otherwise have been obvious to her. A finding beyond a reasonable doubt of a conscious purpose to avoid enlightenment would permit an inference of knowledge. Stated another way, the defendant’s knowledge of a fact may be inferred from willful blindness to the existence of the fact.[130 p.187]

Thus, in the case of Chen, the elements of knowledge and purpose were clearly present; Chen had knowledge of the activity and others had the purpose to use the motel for illegal activity. Chen’s conviction under section 856(a)(2) was upheld.

U.S. v. Frank Javier Tamez is another case where an indictment was made under section 856(a)(2) of the CHS and where interpretation of the statute was questioned.[128]

In 1987 the DEA began investigating a car dealership in Washington State owned by Frank Javier Tamez and allegedly used for cocaine trafficking. Tamez was ultimately indicted and convicted under section 856(a)(2) of the CHS, as well as other statutes.

Tamez appealed on the basis that the application of the statute was intended to apply to “crack houses” or drug manufacturing operations.[128 p.773] He claimed that the building in his case was used as a successful car dealership. He argued that the statute was not intended to hold liable every person who owns a building where drug activities are conducted. Tamez cited the short title of the statute, “Establishment of manufacturing operations” and a synopsis in the Congressional Record that describes the statute as

“outlawing operation of houses or buildings, so called ‘crack houses,’ where ‘crack’ cocaine and other drugs are manufactured and used.”[128 p.773] The appeals court found:

Tamez ignores the plain language and application of the statute. Although the short title and the Congressional Record synopsis refer to manufacturing and crack houses, the words of the statute clearly imply more expansive coverage.

First, the words of the statute are not ambiguous: the statute prohibits allowing the use of a building for ‘manufacturing, storing, distributing, or using a controlled substance.’ There is no reason to believe that this language was intended to apply only to storage facilities and crack houses. There was evidence that the dealership was used as a distribution center and this is sufficient, under the plain language of the statute, to constitute a section 856(a)(2) violation.[128 p.773]

Tamez further claimed that he did not intend to use the building for drug activity but rather as a car dealership. The appeals court rejected this argument, citing *Chen*, stating that section 856(a)(2) was intended to apply when it was the purpose of others to use the building for the illegal activity and the owner could not avoid liability on the basis that it was not the owner’s purpose to engage in illegal activity: “. . . section 856(a)(2) requires only that proscribed activity was present, that Tamez knew of the activity and allowed that activity to continue.”[128 p.774]

In *Tamez*, as in *Chen*, the defendant was directly involved in the drug activity. Testimony in the case revealed that he used dealership cars and employees to transport drugs, he used drug proceeds to finance the dealership, and he used cocaine in his office at the dealership.[128 p.772] In both *Chen* and *Tamez*, the elements of knowledge and

purpose were satisfied, knowledge by the defendants and the purpose of others. Also, in both of these cases the defendants were directly involved in the illegal drug activity that led to indictment and conviction, upheld on appeal, of violation of the Crack House Statute, section 856(a)(2) of the Anti-Drug Abuse Act of 1986.

MDMA/Ecstasy: A Moral Panic?

Crack cocaine was the drug associated with the decade of the 1980s. In the late 1980s, MDMA/Ecstasy emerged as a recreational drug and over the course of the 1990s its use increased tremendously in the context of the rave culture, which exploded across the United States, Europe, Asia and Australia. MDMA/Ecstasy became a major focus of the federal government's drug policy. Faced with the rise in MDMA/Ecstasy use, the federal government, through the Drug Enforcement Administration, initiated efforts to combat this new recreational drug. DEA agent Michael Braun declared: "from the law enforcement side, MDMA, is the biggest threat that [the DEA has] ever faced." [6] The DEA produced a promotional video, "Ecstasy and Other Club Drugs: Dancing With Darkness," highlighting the use of club drugs at raves:

Lately raves are just a venue for drug purchases. They are . . . analogous to a crack house, in which you go buy the drugs and go out the back door. Although there's music being played, and the people at the raves are saying 'I come here for the music,' drugs are predominant in these rave clubs. . . . I think it is fair to say that the rapidly expanding use of these club drugs by young people is one of the most startling law enforcement and social issues facing the United States in the early part of the twenty-first century." [13]

The media has sensationalized MDMA/Ecstasy use in the setting of raves and electronic music. In his June 2000 congressional testimony before the House Committee on the Judiciary on MDMA/Ecstasy, Philip Jenkins, professor of history and religious studies at Pennsylvania State University, invoked the social scientist's term "moral panic." He was referring to societal reaction to an issue that is "massively out of proportion to the problem at hand." [58 p.1]

In such instances [moral panics], people are reacting less to the matter at hand (say, a particular drug) than to its cultural or social associations. People may latch on to a particular issue because it is an acceptable way of attacking some perceived threat that cannot be addressed openly. The panic might thus conceal tensions over age, race or gender. In addition, panics might be exploited by bureaucratic agencies that stand to gain new resources on the strength of public fears. Moral panics are socially damaging because they divert resources from more serious dangers, and also because they can result in over-sweeping laws which threaten to ruin the lives of countless relatively harmless individuals. . . . I am worried by current claims about the drug MDMA or Ecstasy. . . . I want to argue that the current wave of concern, which seems to be peaking right now [June 2000], looks like it's becoming a classic moral panic, based on exaggerated fears and misused evidence. [58 p.1]

State Palace Theater and Club La Vela

In the late 1990s the DEA adopted a new strategy to deal with the burgeoning use of MDMA/Ecstasy in the club scene of the United States. In 2001 the federal government prosecuted two cases using an unprecedented application of the 1986 Crack House

Statute, using it as the legal weapon in a new offensive in the War on Drugs.[106 p.15, 20-21] The CHS was used as the legal basis to indict the owners/operators of music venues for illegal drug activity by venue patrons, despite efforts by the owners/operators to prevent illegal drug activity at their businesses.[9 p.2] The two cases where the government used this approach are the State Palace Theatre and the Club La Vela cases. They are important in the development and enactment of the Illicit Drug Anti-Proliferation Act of 2003, commonly known as the RAVE Act.

In both cases DEA agents purchased drugs at music venues but rather than arresting the drug dealers or the purchasers of drugs, they arrested the managers of the clubs and in one case, the music promoter. In both of these cases, the defendants were indicted under the Crack House Statute, section 856(a)(2) under which it is unlawful to “manage . . . any building . . . and knowingly and intentionally . . . make available for use . . . the building . . . for the purpose of unlawfully . . . using a controlled substance.”[133] In these two cases, the defendants were charged because they had knowledge of drug use by others at venues they managed. They were not charged with involvement in drug trafficking or drug use in any way.[9] In this respect, these two cases differ from all other cases where the Crack House Statute has been applied.[106 p.15, 20-21]

A closer look at these two cases reveals serious constitutional issues with the statute as it is applied in these cases. These cases also provide important background information regarding the Illicit Drug Anti-Proliferation Act of 2003, the RAVE Act, which will be discussed later in this essay.

The first indictment followed a DEA undercover operation that began in January 2000 and resulted in indictments on January 12, 2001.[106 p.8] The defendants were the

owners of Barbecue (BBQ) of New Orleans, Inc., d/b/a the State Palace Theater.[105] BBQ of New Orleans, Inc., was the lessee of the State Palace Theater located at 1108 Canal Street in New Orleans, Louisiana.[105] Robert Brunet was the manager of the theater and an officer in BBQ of New Orleans, Inc., and his brother, Brian Brunet, was an employee and also an officer in BBQ of New Orleans, Inc.[105] James Estopinal was a music event promoter and an employee of BBQ of New Orleans, Inc., and he organized electronic music events, known as raves, at the State Palace Theatre.[105] Raves have been associated with MDMA/Ecstasy use. The charge in the State Palace Theater case was that the defendants knowingly and intentionally made available a building for the use of controlled substances by others.[19] There was no evidence, nor was it charged, that the defendants distributed or used controlled substances themselves.[105; 106 p.8] Undercover DEA agents purchased MDMA/Ecstasy from patrons inside the theater in excess of fifty times.[105] As evidence of knowledge of the use of controlled substances, the government provided the following facts:

- 1) Available for purchase at the theater were items of “paraphernalia” commonly used to enhance and support the physiological high caused by MDMA/Ecstasy such as pacifiers, chemical light sticks and flashing light rings.
- 2) Since MDMA/Ecstasy use in the rave setting is known to lead to dehydration, the defendants sold bottled water and provided “chill rooms” where patrons could cool down.
- 3) The defendants provided on-site ambulance service to transport patrons in need of emergency medical care to the hospital.

- 4) The defendants were instrumental in bringing “DanceSafe,” a group that advocates harm reduction for users of psychoactive drugs, to distribute literature to patrons.[106 p.8-9]

In a motion to dismiss, the defendants rebutted the government’s claims. Their central purpose was to provide music.[106 p.7] The State Palace Theater had a zero-tolerance policy that forbade possessing, selling or using drugs on the premises. This policy was posted on signs throughout the venue and security guards refused admission to anyone who appeared intoxicated.[106 p.7] The defendants arranged, via the New Orleans Police Department, for many drug-related arrests of patrons found selling or using drugs and even security guards found selling drugs.[106 p.7] The defendants also invited the DEA into the theater and helped them dress as undercover “ravers” and as security guards.[106 p.7] The defendants enforced their zero-tolerance policy. They claimed that the DEA and the New Orleans Police Department repeatedly ignored their notifications of drug activity discovered at the theater and on more than one occasion detainees had to be released because no one came to arrest them.[106 p.7-8] Furthermore, the defendants on multiple occasions requested the service of a New Orleans Police Department officer to assist in the prevention of drug use at the theater and the requests were denied.[106 p.8]

The second case involved the same charge under the Crack House Statute, section 856(a)(2), to “knowingly and intentionally make available for use, said building for the purpose of unlawfully distributing and using controlled substances...,” as well as other charges.[19] The case followed a DEA undercover operation at Club La Vela in Panama City Beach, Florida.[19] The defendants in this case were Sea Watch of Panama City

Beach, Inc., d/b/a Club La Vela, and the managers of the club, Patrick Pfeffer and Thorston Pfeffer.[19]

In order to appreciate the high profile of Club La Vela, the motion to dismiss reviews the club's history. The beachfront club first opened as La Vela Beach Club and Concert Hall in 1984.[20 p.3] Over the years, the facility grew from a small beach club to an enormous entertainment complex "described as the largest nightclub and event facility in the United States with a capacity of over 6,000 people." [20 p.3] The club is zoned as a place of public assembly.[20 p.4] It caters to performance artists and patrons who participate in original and recorded music, dance, and light shows.[20 p.4-5] Club La Vela is nationally known and has served as the headquarters for live and taped activities such as the Spring Break Headquarters for the MTV cable network; has hosted national events such as World Championship Wrestling, Bay Watch Talent Search, the Earthlink Live Webcast of Spring Break 1999; and has hosted nationally and internationally known pop, rock, hip-hop and country music performances.[20 p.4] Many of these performances have been broadcast and reported on the cable networks of ESPN, MSNBC, TNT, MTV, E!TV and the Travel Channel.[20 p.4] As a result of its expansion and popularity, Club La Vela's operators modified procedures to deal with the large volumes of people using the facility, particularly those patrons who engage in the consumption of alcohol and controlled substances.[20 p.6] Club La Vela had a zero-tolerance policy that forbade possession, sale and use of drugs on the premises; the policy was posted throughout the venue and security staff enforced the policy.[20 p.6-7] The defendants met with local law enforcement officials and made changes to assist in enforcement of the zero-tolerance policy: they installed additional lighting, employed

additional security, modified performance formats and initiated background checks on employees, among other things.[20 p.7] As in the State Palace Theater case, the government suggested that on-site emergency medical services as well as the sale of glow sticks, bottled water and other merchandise, at events involving thousands of dancers, is evidence of criminal activity.[20 p.9]

Both the State Palace Theater and Club La Vela cases have been criticized on several grounds. First, it has been claimed that the Crack House Statute was not intended to be used in an application such as these two cases.[20 p.12] Previous cases involving CHS violations have involved literal crack houses or in the cases of Chen and Tamez, who as owners of buildings with legitimate business purposes that secondarily served as places of storage, sale or use of controlled substances, were themselves directly involved in the drug activity in some way.[106 p.20-21] The State Palace Theater and Club La Vela cases differ from all other applications of the Crack House Statute in that the defendants were not involved in drug activity but were alleged to have had knowledge of drug use by others at their facilities.[20 p.12; 106 p.20-21]

One serious criticism of this use of the Crack House Statute in these two cases is its violation of the First Amendment rights of the defendants. “The government’s prosecution has both the effect and the purpose of shutting down concerts, of eliminating a form of expression which the government claims is associated with drug use.”[106 p.21] This violation of First Amendment rights is discussed in detail in the motions to dismiss of both cases, citing numerous U.S. Supreme Court cases:

- 1) In *Ward v. Rock Against Racism*, 491 U.S. 781 (1989), the Supreme Court found “Music, as a form of expression and communication, is protected under the First Amendment.”[20 p14; 106 p.21]
 - 2) In *Cinevision v. City of Burbank*, 471 U.S. 1054 (1985), a city’s attempt to ban hard rock concerts because the concerts tended to attract narcotic users was rejected as a violation of concert promoters First Amendment rights:

“All – political and non-political - musical expression, like other forms of entertainment, is a matter of first amendment concern. . . . A general fear that state and local narcotic or other laws will be broken by people attending the concerts cannot justify a content-based restriction on expression. . . .

Censorship cannot be used as a tool to prevent drug use; rather, law enforcement officers can deal adequately and effectively with unlawful activity . . . at the time that it occurs. That is the proper exercise of police power, censorship is not.”[20 p.16; 106 p.21]
 - 3) In *Sable Communications of California Inc. v. FCC*, 492 U.S. 115 (1989), the Supreme Court found that in the context of the First Amendment, any exercise of government regulation must be achieved in the least restrictive fashion, and must be narrowly tailored to serve any legitimate government interest.
- Prevention of illegal drug activity is a legitimate government interest but the prosecution of venue managers and music promoters is not the least restrictive way to accomplish this goal. Arresting drug dealers and purchasers is a far more restrictive means to curtail drug use without infringing on the rights of

others to engage in protected expression in the form of music and dance.[20 p.17; 106 p.22]

- 3) In *Dombrowski v. Pfister*, 380 U.S. 479 (1965), the Supreme Court found:

“the chilling effect upon the exercise of First Amendment rights may derive from the fact of the prosecution, unaffected by the prospects of its success or failure.”[20 p.16; 106 p.21] It is likely that the prosecution of the State Palace Theater and Club La Vela cases has had a chilling effect on other music venue managers, electronic music promoters, other concert promoters and on the operation of other places of public assembly.

A second serious criticism of the State Palace Theater and Club La Vela cases, on constitutional grounds, is based on the equal protection rights afforded by the Fourteenth Amendment (through the due process clause of the Fifth Amendment). In *Wayte v. United States*, 470 U.S. 598 (1985), the Supreme Court found that “a prosecution must be dismissed upon a showing that others similarly situated were not prosecuted and that the selective prosecution was based on discrimination on the basis of race, religion, or the exercise of constitutional rights.”[20 p.22; 106 p.24] Rock concerts have long been associated with various types of drug use, reggae and jazz concerts with marijuana use. Yet no other venue manager has ever been indicted under the Crack House Statute for providing a venue for music and dance where some patrons use drugs.

A third major criticism of these cases involves the Due Process Clause of the Fifth Amendment. In *Scales v. United States*, 367 U.S. 203 (1961), the Supreme Court found that membership in the Communist Party could not constitute a criminal offense:

In our jurisprudence, guilt is personal, and when the imposition of punishment on a status or on conduct can only be justified by reference to the relationship of that status or conduct to other concededly criminal activity . . . that relationship must be sufficiently substantial to satisfy the concept of personal guilt in order to withstand attack under the Due Process Clause of the Fifth Amendment.[20 p.24; 106 p.27]

Similarly, in *Weber v. Aetna Casualty & Surety Co.*, 406 U.S. 164 (1972), the Supreme Court found that denying worker's compensation benefits to illegitimate children violates due process because it punishes children for the acts of their parents. “. . . legal burdens should bear some relationship to individual responsibility or wrongdoing.”[20 p.24; 106 p.27] In the context of the State Palace Theater and Club La Vela cases, the defendants are charged not because of any drug activity on their part but because of knowledge of drug activity by others, despite their efforts to prevent the drug activity. Does this meet the requirement of personal guilt?

Yet another criticism of these cases is on the grounds that the Crack House Statute is vague and overly broad. If the CHS can be applied to venues such as the State Palace Theater and Club La Vela, then it could be applied to virtually every place of public assembly. Consider schools, parks, college dormitories, prisons, even personal residences. These are all places where it is virtually impossible to prevent surreptitious drug use. Furthermore, what constitutes a violation of this statute? If one person uses a controlled substance, is this a violation? In *Grayned v. City of Rockford*, 408 U.S. 104 (1972), the Supreme Court found:

It is a basic principle of due process that an enactment is void for vagueness if its prohibitions are not clearly defined. Vague laws offend several important values. First, because we assume that man is free to steer between lawful and unlawful conduct, we insist that laws give the person of ordinary intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly. Vague laws may trap the innocent by not providing fair warning. Second, if arbitrary and discriminatory enforcement is to be prevented, laws must provide explicit standards for those who apply them. A vague law impermissibly delegates basic policy matters to policemen, judges, and juries for resolution on an ad hoc and arbitrary basis, with the attendant dangers of arbitrary and discriminatory application. Third . . . where a vague statute ‘abuts upon sensitive areas of basic First Amendment freedoms, it operates to inhibit the exercise of those freedoms.’ Uncertain meanings inevitably lead citizens to ‘steer far wider of the unlawful zone’ than if the boundaries of the forbidden areas were clearly marked.[20 p.26-27; 106 p.28]

In the context of music venues, the question becomes what must the owners, managers, and concert promoters do to prevent illicit drug use on their premises and thereby be safe from prosecution if surreptitious drug use occurs despite their efforts to prevent it? Active enforcement of a zero-tolerance drug policy, in full cooperation with law enforcement agencies, apparently is not enough. There is no “safe harbor” that allows venue owners to know what they can do to avoid prosecution; no standard to know what is legal and what is illegal.[9 p.5]

The resolution of the State Palace Theater case was a plea bargain by two of the defendants, the Brunet brothers. They pled guilty to a charge of conspiracy to violate Title 21 of the United States Code, section 856(a)(2). They paid a \$100,000 fine, were given five year terms of probation and agreed not to sell or provide the following items at the State Palace Theater: 1) Pacifiers, 2) Objects that glow, 3) Vapor rub products and inhalers, 4) Masks of any description, 5) Masseur, Masseuse or massage tables, 6) “Chill Rooms.”[107] Furthermore they agreed to take steps to prohibit patrons from bringing items 1 – 4 above into the State Palace Theater.[107] The plea agreement assured the Brunet brothers that they would not face potential 20 year prison terms and fines of up to a half million dollars each, or a fine of up to two million dollars for their corporation, Barbecue of New Orleans, Inc.

After the conclusion of the State Palace Theater case there was a class action lawsuit brought against the government, *McClure v. Ashcroft*, E.D. LA 01-2573 (2002), claiming that the plea bargain, which prohibited the sale or presence of glowsticks at the State Palace Theater, violated the first amendments rights of the plaintiffs, performance artists who used glowsticks in their performance routines.[69] The judge in the case granted a permanent injunction against enforcement of the plea agreement finding that “the government cannot ban inherently legal objects . . . because a few people use the same legal item to enhance the effects of an illegal substance”[69 p.10] More importantly, the judge further noted:

Although this court recognizes the perils of drug use, especially by young people, and this Court recognizes that the intentions of the agents and prosecutors involved were pure, when the First Amendment right of Free Speech is violated

by the government in the name of the War on Drugs, and when that First Amendment violation is arguably not even helping in the War on Drugs, it is the duty of the Courts to enjoin the government from violating the rights of innocent people.[69 p.10-11]

This case was reversed on appeal, not on the merits of the First Amendment argument but on the technicality that a third party cannot challenge a plea agreement between two other parties. [70]

The absurdity of the glowstick ban in the State Palace Theater plea agreement is discussed in a 2001 Salon.com article, “Sell a Glowstick, Go to Prison.” “The [ban] seems to imply that if you take away the . . . glowsticks, you take away the drugs. It’s bafflingly backward logic, but then again, the federal government’s War on Drugs hasn’t always made sense.”[13]

The Club La Vela case went to trial. The government used arguments such as the sale of glow sticks and bottled water and provision of emergency medical service as evidence of knowledge of criminal activity, similar to the State Palace theater case. After two hours of deliberations the jurors returned a verdict of not guilty.[21]

The RAVE Act

After the failed prosecution of the Club La Vela case and the plea settlement in the State Palace Theater case, Senator Joseph Biden, a drug war legislator since the 1980s, introduced a bill in the Senate on June 18, 2002 with the short title Reducing Americans’ Vulnerability to Ecstasy Act of 2002 or the RAVE Act.[87] In his introductory remarks to the Senate, Biden cited the prosecutions in the Club La Vela and State Palace Theater cases and noted the need to tailor the Crack House Statute “more precisely to the problem

at hand,” referring to raves.[5] Section 2 of the bill contained Findings 1- 10 that specifically referred to raves, electronic music, club-drug use including Ecstasy and the brain damage resulting from Ecstasy use (citing NIDA, a major source of funding for the Ricaurte research group discussed earlier in this essay).[87] The tailoring that Biden referred to would change the Crack House Statute as follows (see appendix, p.125-27):

- 1) In section (a)(1) of the CHS, the words “lease, rent, use” would be added to “open or maintain.”[87]
- 3) In section (a)(1) & (a)(2) of the CHS, the words “whether permanently or temporarily” would be added in reference to the place used for illegal drug activity.[87] This would allow application of the law to one-time events such as a dance party. Critics of this argue that the addition of the word “temporarily” changes the initial intent of the Crack House Statute which targeted property being used for on-going drug offenses and that the CHS was not intended for isolated actions that may occur on a property. Business owners could be prosecuted for isolated incidents, rather than patterns of abuse.[9]
- 4) In Section (a)(2) of the CHS “building, room or enclosure” would be changed to “any place.”[87] Also, “occupant” would be added to the list of “owner, lessee, agent, employee or mortgagee” and “profit from” added to the phrase “rent, lease, or make available for use.”[87] The purpose of the “any place” change is to target dance parties held outdoors in open spaces such as a field, or on the beach.

- 5) The third major change to the CHS would be the addition of a civil penalty, Section 4 of the RAVE Act.[87] This would lower the burden of proof from “beyond a reasonable doubt” required for criminal guilt to “preponderance of the evidence” for civil liability. It also allows a person to be punished with a civil penalty without the right to a jury trial. Senator Biden’s introductory remarks to the Senate, as well as those of the co-sponsor, Senator Charles Grassley, did not contain any mention of the addition of this civil penalty.[5; 43]
- 6) The heading of section 856, would be changed from “Establishment of manufacturing operations” to “Maintaining drug-involved premises.”[87]

In the text of the RAVE Act, in the Findings section, note was made of the brain damage due to MDMA/Ecstasy.[87] Senator Grassely’s introductory remarks also referred to irreversible damage in the brain.[43] Prior congressional testimony by Asa Hutchinson, given during his time as Administrator of the DEA, cited the Johns Hopkins research group’s findings of brain damage from MDMA/Ecstasy.[51; 52](see p.24) The misleading congressional testimony of Alan Leshner, as Director of the National Institute on Drug Abuse (NIDA), purportedly demonstrating brain images with evidence of decreased cerebral blood flow, has already been discussed earlier in this essay.[64](see p.28) The point is that the controversial research findings on MDMA/Ecstasy have been used and even misrepresented in congressional testimony in support of the RAVE Act.

The RAVE Act died in both the House and the Senate without a vote when the 107th Congress adjourned at the end of 2002.[87; 88] In January of 2003, Senator Biden re-introduced the Act.[53] The short title was changed to the Illicit Drug Anti-Proliferation

Act of 2003. The controversial “Findings” section that discussed raves, electronic music, etc., was eliminated but the remainder of the bill was identical to the original RAVE Act. In a move that bypassed the traditional process of Congress, the new bill was attached as an amendment to an unrelated but popular bill that had versions already passed by both the House and the Senate.[84] The PROTECT Act (Prosecutorial Remedies and Other Tools to End the Exploitation of Children Today Act of 2003) is a child protection act commonly known as the Amber Alert Act.[84] Title VI, section 608 of the PROTECT Act is the Illicit Drug Anti-Proliferation Act of 2003.[84] The PROTECT Act was signed into law by President Bush on April 30, 2003.[84] The Illicit Drug Anti-Proliferation Act, a.k.a. the RAVE Act, thus became law not by the democratic committee process, not by a vote on its own merits, but as the result of a maneuver by a few supporters who negotiated its attachment to a popular child protection law.[63] This latest legislation in the War on Drugs has not yet been applied; the first indictment has yet to be made under this law.

However, recall the from the State Palace Theater and Club La Vela cases that the defendants cited *Dombrowski*, noting that the “chilling effect upon the exercise of First Amendment rights may derive from the fact of the prosecution, unaffected by the prospects of its success or failure.” [20 p.16; 106 p.21](see p.73) On May 30, 2003, just one month after the enactment of the RAVE Act, a DEA agent entered a local Eagles Lodge in Billings, Montana. The Lodge was the location for a meeting of the Montana State University chapters of the National Organization for the Reform of Marijuana Laws and Students for a Sensible Drug Policy. The agent advised the facility manager that if anyone used illegal drugs at the event the Lodge could be liable for a \$250,000 fine under

the civil penalty provision of the new RAVE Act. The event was cancelled. “It was a classic violation of the First Amendment. . . . The government targeted an event because it disagreed with the political views of its organizers,” said Harry Williams of the ACLU.[138]

SECTION III: DRUG POLICY REFORM

Drug use is unarguably one of the most important issues facing contemporary American society. It has implications in public health, criminal justice, civil rights and national security. America's drug policy has evolved over the past one hundred years. It has been debated countless times in countless forums over ten decades. There are as many opinions on the drug issue as there are people debating it. The spectrum of opinion ranges from drug warrior prohibition to free market legalization. Despite the debate and an ever-increasing body of evidence against continuation of our current policy, U.S. drug policy remains a criminally sanctioned, prohibitionist policy and the escalation of the War on Drugs continues. Enactment of the RAVE Act is the latest example of this. It is a law of questionable constitutionality that has not yet been tested in the courts. It was not a product of the democratic congressional process. It was not passed by a congressional vote on its own merits but was attached to another popular act that was sure to be passed by Congress. Recall that the Crack House Statute was expedited through Congress and enacted during the sensationalized crack cocaine "epidemic" of the 1980s. (see p.50) In the MDMA/Ecstasy "panic" of recent years, the CHS statute was modified into the RAVE Act and became law on the coattails of the Amber Alert Act.[63; 103 chap.6, sec.C.3,C4]

Drug policy reform is a difficult issue. It is politically unpopular to advocate a retreat in the War on Drugs. A tough stand on drugs makes great rhetoric. It is much more difficult to question the effectiveness of the War on Drugs, much less to challenge the overall utility of a prohibitionist approach. Throughout the twentieth century, many

individuals and groups have advocated against the War on Drugs, as will now be discussed in the third section of this essay. Today, we are seeing more and more opposition to continued advancement in this War, and more advocacy for a public health and harm reduction model for managing this important problem in our society.

Criticism of Prohibition

Criticism of prohibition is not new. Abraham Lincoln had this to say in a speech to the Illinois House of Representatives in 1840:

Prohibition will work great injury to the cause of temperance. It is a species of intemperance within itself, for it goes beyond the bounds of reason in that it attempts to control a man's appetite by legislation, and makes a crime out of things that are not crimes. A prohibition law strikes a blow at the very principles upon which our government was founded. – Abraham Lincoln, 1840.[65]

Percy Andreae was a vocal opponent of alcohol prohibition and he organized the National Association of Commerce and Labor, an organization for prohibition resistance.[1] He made the following analogy between efforts to prohibit alcohol and a literal interpretation of a biblical passage:

Somewhere in the bible it is said: 'If thy right hand offend thee, cut it off'. . . What? Merely cut off my own right hand if it offends me? What business have my neighbors to keep their right hands if I am not able to make mine behave itself? Off with the lot of them! Let there be no right hands; then I am certain that mine won't land me in trouble. - Percy Andreae, 1915.[1]

An editorial in the Illinois Journal of Medicine discussed the Harrison Narcotics Law in 1926:

The Harrison Narcotics Law should never have been placed upon the statute books of the United States. It is to be granted that the well-meaning blunderers who put it there had in mind only the idea of making it impossible for addicts to secure their supply of “dope” and to prevent unprincipled people from making their fortunes, and fattening upon the infirmities of their fellow men. As is the case with most prohibitive laws, however, this one fell far short of the mark. So far, in fact, that instead of stopping the traffic, those who deal in dope now make double their money from the poor unfortunates upon whom they prey. . . . It is costing the United States more . . . than there is good coming from the farcical laws now on the statute books. . . . As to the Harrison Narcotic Law, it is as with prohibition [of alcohol] legislation. People are beginning to ask, ‘Who did that anyway?’ - Illinois Journal of Medicine, editorial, June 1926.[12 p.47]

August Volmer served as chief of police in Berkely, California, professor of police administration at the Universities of Chicago and California, and president of the International Association of Chiefs of Police and wrote a leading textbook on police science.[12 p.47-48]

Stringent laws, spectacular police drives, vigorous prosecution, and imprisonment of addicts and peddlers have proved not only useless and enormously expensive as means of correcting this evil, but they are also unjustifiably and unbelievably cruel in their application to the unfortunate drug victims. Repression has driven this vice underground and produced the narcotic smugglers and supply agents, who have grown wealthy out of this evil practice and who, by devious methods, have stimulated traffic in drugs. . . . Drug addiction, like prostitution and like

liquor, is not a police problem; it never has been and never can be solved by policemen, but by scientific and competently trained medical experts. - August Volmer, 1936.[12 p.47-48]

Alfred Lindesmith was an Indiana University scholar and advocate of drug policy reform in the 1930s through the 1960s.

Solemn discussions are carried on about lengthening the addict's already long sentence and as to whether or not he is a good parole risk. The basic question as to why he should be sent to prison at all is scarcely mentioned. Eventually, it is to be hoped that we shall come to see, as most of the civilized countries of the world have seen, that the punishment and imprisonment of addicts is as cruel and pointless as similar treatment for persons infected with syphilis would be. . . .

The treatment of addicts in the United States today is on no higher plane than the persecution of witches of other ages, and like the latter it is to be hoped that it will soon become merely another dark chapter of history. - Alfred R. Lindesmith, 1940.[12]

Rufus King was chairman of the American Bar Association's committee on narcotics in 1953. He organized and led the Joint Committee on Narcotic Drugs of the American Bar Association and the American Medical Association that issued an unprecedented critique of the prohibition paradigm. In 1973 he authored *The Drug Hangup: America's Fifty-Year Folly*. [62]

The true addict . . . is totally enslaved to his habit. He will do anything to fend off the illness, marked by physical and emotional agony that results from abstinence.

So long as society will not traffic with him on any terms, he must remain the

abject servitor of his vicious nemesis, the peddler. The addict will commit crimes - mostly petty offenses like shoplifting and prostitution - to get the price the peddler asks. . . . Drugs are a commodity of trifling intrinsic value. All the billions our society has spent enforcing criminal measures against the addict have had the sole practical result of protecting the peddler's market, artificially inflating his prices, and keeping his profits fantastically high. No other nation hounds its addicts as we do, and no other nation faces anything remotely resembling our problem. - Rufus King, 1953.[12 p.48-49]

Dr. Karl Bowman was one of this country's most prominent psychiatrists and an authority on narcotics.[12 p.49]

For the past 40 years we have been trying the mainly punitive approach; we have increased penalties, we have hounded the drug addict, and we have brought out the idea that any person who takes drugs is a most dangerous criminal and a menace to society. We have perpetuated the myth that addiction to opiates is the great cause of crimes of violence and of sex crimes. In spite of the statements of the most eminent medical authorities in this country and elsewhere, this type of propaganda still continues, coming to a large extent from the enforcement bureaus of federal and state governments. Our whole dealing with the problem of drug addiction for the past 40 years has been a sorry mess." - Dr. Karl Bowman, 1957.[12 p.49]

Dr. Jerome Jaffe is a psychiatrist who promoted methadone treatment for heroin addicts in the 1960s. In 1971 President Nixon appointed him Director of the Special Action Office of Drug Abuse Prevention. He also served as head of NIDA's Addiction

Research Center. He is currently professor of psychiatry at the University of Maryland and the Johns Hopkins University School of Hygiene and Public Health.[57]

Much of the ill health, crime, degeneracy, and low standard of living are the result not of drug effects, but of the social structure that makes it a criminal act to obtain or to use opiates for their subjective effects. . . . It seems reasonable to wonder if providing addicts with a legitimate source of drugs might not be worthwhile, even if it did not make them our most productive citizens and did not completely eliminate the illicit market but resulted merely in a marked reduction in crime, disease, social degradation, and human misery. - Dr. Jerome Jaffe, 1965. [12]

The 1972 *Consumers Union Report on Licit and Illicit Drugs* states:

There is little likelihood that further tinkering with the laws . . . will prove more successful than the hundreds of such laws already on the books. Legislators who trust in such measures are failing to face the facts. Narcotic addiction remains endemic despite the most ingenious laws and vigorous law enforcement. The time has come to end our dependence on repressive legislation and law enforcement as a cure for the narcotics evil, and to explore more rational alternatives. The history of the narcotics laws - and of alcohol prohibition . . . should warn us against going further down a similar legislative blind alley with respect to marijuana, LSD, the amphetamines, the barbiturates, and other drugs of current concern. - Consumers Union Report on Licit and Illicit Drugs, 1972. [12 p.57]

Recommendations of the 1972 Consumers Union Report

The last quote above was taken from a comprehensive report that looked at the history of U.S. drug policy and specifically at concerns with individual drugs including opiates, caffeine, nicotine, alcohol, barbiturates, cocaine, inhalants, LSD, marijuana, and amphetamines. The 1972 report concluded with a list of six recommendations aimed to rectify fifty-seven years, from 1914, the year the Harrison Narcotic Act was passed, until 1971 when the report was completed, of “mistaken laws and policies, of mistaken attitudes toward drugs, and of futile, however well intentioned, efforts to stamp out the drug menace.”[12 p.418] The Consumers Union Report focused largely, not on the drug problem, but on the “drug problem problem – the damage that results from the ways in which society has approached the drug problem.”[12 p.418] The six recommendations of the 1972 Consumers Union Report were:[12 p.418-23]

- (1) Stop emphasizing measures designed to keep drugs away from people.
- (2) Stop publicizing the horrors of the “drug menace.”
- (3) Stop increasing the damage done by drugs.
- (4) Stop misclassifying drugs.
- (5) Stop viewing the drug problem as primarily a national problem.
- (6) Stop pursuing the goal of stamping out illicit drug use.

In reading these recommendations today, in 2004, one realizes that for the most part they are still valid. They appear to be what must be done to gain control of the drug issue in our society. None of the recommendations have been implemented. In fact, it appears that the opposite of these recommendations have continued as the basis for U.S. drug policy over the past 32 years, from 1972 to 2004. It was right around the time of the

Consumers Union Report that President Nixon officially declared the War On Drugs, taking America farther down the road of prohibition, precisely what the Consumers Union Report advised against. It is useful to look at the recommendations of the Consumers Union Report from a current perspective, with the experiences of 1972 to 2004 behind us.

#1: Stop Emphasizing Measures Designed to Keep Drugs Away From People

Prohibition has been the cornerstone of U.S. drug policy since the Harrison Narcotic Act was passed in 1914. In 1920 the “Noble Experiment” started when alcohol prohibition became the law of the land.[83] The Eighteenth Amendment to the U.S. Constitution prohibited “the manufacture, sale, or transportation of intoxicating liquors within, the importation thereof into, or the exportation thereof from the United States.”[39] The United States learned between 1920 and 1933 that alcohol prohibition did not work. In 1933 the Twenty First Amendment to the Constitution repealed alcohol prohibition.[122]

There are some valuable lessons to be learned from the Noble Experiment. Alcohol prohibition was supported by many factors and theoretically it is understandable why it could be a desirable public health policy:

1) Statistically, alcohol is linked with other public health concerns:

- a) Alcohol addiction is widespread. In 1920 alcohol addiction was second only to nicotine addiction in incidence and prevalence in the United States.[12 p.216] This remains true today.

- b) Alcohol consumption is intrinsically linked with violent crime.
Alcohol plays a significant role in homicide, child abuse, domestic violence, and suicide.[12 p.217]
 - c) Alcohol is implicated in high percentages of fatal and non-fatal motor vehicle accidents as well as other forms of accidents.[33]
- 2) Physical harm from alcohol is a major cause of morbidity and mortality in the United States. Alcohol's harmful effects include central nervous system damage, liver damage, gastrointestinal damage, and heart damage, to mention a few of the acute and chronic life-threatening effects of excessive alcohol consumption.[12 p.216-17]
 - 3) Alcohol is a drug of choice for the vulnerable youth that drug policy should protect.
 - 4) The popular temperance movement in the United States in the early twentieth century supported the moral aspect of prohibition. From this point of view alcohol use was wrong, its use was a matter of choice and weakness of the will led to addiction.

However, in 1933 the Twenty First Amendment to the U.S. Constitution ended the Noble Experiment.[83] The reason was *alcohol prohibition didn't work*. People still drank during prohibition. All of the above adverse effects of alcohol on individuals and society continued. In addition, new and unanticipated problems emerged: increased potency of the prohibited substance, black markets and organized crime are some examples.

During the 1920s, after enactment of the Eighteenth Amendment, the “Iron Law of Prohibition” took effect. This principle asserts that the more intense the law enforcement, the more potent the prohibited substance becomes, and the prohibited substance will become adulterated with unknown and dangerous substances.[118 p.1-2] The basis of this principle is that the development of a black market leads to potent, more concentrated forms of prohibited substances because of the realities of marketing, profitability and risk.[118 p.2] A case of whisky can be smuggled with the same risk as a case of beer yet bring higher profit.[26] The same effect was seen again decades later in the development of the potent form of base cocaine, crack cocaine.[26; 118] It is easier to conceal and transport small pieces of crack than bulky powder cocaine, which is in turn less bulky than the coca leaves used by drug consumers in South America.[26] This principle explains why drug users in drug-producing countries consume drugs in their natural form while in countries where drugs are prohibited consumption of drugs is in their most potent, refined forms.[26] Bootleg alcohol was not only more potent but was often adulterated and contaminated and this increased the morbidity and mortality associated with alcohol consumption. An example is the use of methyl alcohol, in place of the prohibited ethyl alcohol, which led to blindness and death.[12 p.221] We see this same problem today with adulteration of heroin, cocaine, MDMA/Ecstasy and other prohibited drugs.

The income potential from the marketing of a prohibited product leads to the development of the black market, which in turn leads to the development of organized crime.[115] The black market for alcohol led to the expansion of organized crime in the U.S. in the 1920s.[12 p.221] When goods are prohibited and markets are illegal, the usual

methods of transacting business such as marketing, advertising and settling disputes must be conducted underground.[73 chap.4] The usual and legal means available to legitimate businesses such as regulations, unions, lawyers, and the courts are all unavailable to black market businesses.[73 chap.4] The result is coercion and violence in the defense of territories, collection of unpaid debt, elimination of competitors and settlement of disputes.[73 chap.4]

Jeffery Miron asserts in his recently published book, *Drug War Crimes*, that the theory of crime and violence associated with the black markets created by prohibition is incomplete.[73 p.44] The real driving force behind the crime is not simply the prohibition but the level of enforcement of the prohibition; the amount of crime and violence increases with the degree of enforcement.[73 p.44] As America escalates its War on Drugs, “reliance on prohibition, on laws and law enforcement, lulls the country decade after decade into a false confidence that nothing more need be done - except to pass yet another law, or hire a few hundred more narcotic agents . . .”[12 p.418-19] The irony of this situation is that, according to Miron’s theory, we are increasing crime and violence as we escalate the War on Drugs.

In “Alcohol Prohibition Was A Failure,” Mark Thorton presents some data on federal convicts, federal expenditures on prisons, and homicide data during alcohol prohibition.[118] Immediately before 1914, prior to the Harrison Narcotics Act and alcohol prohibition, there were 4,000 federal convicts, about 75% of whom were in federal prisons.[118 p.4] By 1932 the number of federal convicts had increased to 25,589, representing an increase of over 550%.[118 p.4] The federal prison population grew over 360%.[118 p.4] Federal expenditures on prisons increased more than 1000%

between 1915 and 1932 and despite this the prisons were severely over crowded.[118 p.5] The increase in crime was a combination of alcohol and drug prohibition violations as well as an increase in other crimes, including violent crimes, stemming from the underground market.[118 p.5] The homicide rate increased from six per one hundred thousand to ten per one hundred thousand during this period.[118 p.5] The rising homicide rate was reversed after the repeal of alcohol prohibition in 1933 and the rate declined through the 1930's and 1940's.[118 p.5]

Miron presents homicide data in a more detailed analysis in *Drug War Crimes*. [73 chap.4] He looks at homicide rates in the United States for the period 1900 - 1995. His figures for the period 1914 - 1932 are consistent with the figures quoted by Thorton above.[73 p.47] Miron documents that the homicide rate showed a general decline from 1933 until the early 1960s.[73 p.47] In the mid-1960s the homicide rate began to rise until the mid 1970s where it reached a level slightly above the previous peak in 1933, then it fluctuated around this relatively high level through the end of the sample period in 1995.[73 p.47] Miron points out that homicide rates show two peaks during the twentieth century, the 1920 – 1933 period and the 1970 – 1995 period.[73 p.47] Miron goes a step further and looks at federal expenditures for the enforcement of alcohol and drug prohibition during the same period, 1900 – 1995.[73 p.49] There are two impressive spikes, one between 1920 – 1933 and one between 1970 – 1995.[73 p.49] Miron discusses the two possibilities for these spikes: increased homicide rates leads to increased enforcement or increased enforcement leads to increased homicide rates.[73 p.50] Based on his extensive research, he favors the latter relationship. He concludes: “the estimated impact of enforcement on homicide is not only positive but large; it

suggests that eliminating drug prohibition would reduce homicide in the United States by 25 – 75%.”[73 p.51]

Considering the numerous adverse physical and social harms of alcohol, it was believed much would be gained by making alcohol unavailable. Alcohol prohibition was intended to cure society of many ills. At the beginning of prohibition the Reverend Billy Sunday predicted: “The reign of terror is over. The slums will soon be a memory. We will turn our prisons into factories and our jails into storehouses and corncribs. Men will walk upright now, women will smile and children will laugh. Hell will be forever for rent.”[118 p.4] Yet after a thirteen year experiment, the United States rejected alcohol prohibition. America realized “prohibition does not in fact prohibit and that it brings in its wake additional adverse effects.”[12 p.221] The law of supply and demand is not one of the laws that the U.S. Congress enacted and it is not one that it could repeal.[120] America is now learning that prohibition is not the answer to the drug problem either.

#2: Stop Publicizing the Horrors of the “Drug Menace”

Scare tactics have always been part of America’s approach to drug use. A contemporary example is the 1990s television advertisement showing an egg being fried with the comment “This is your brain on drugs.” Another example is NIDA’s anti-Ecstasy campaign that showed brain images with holes in them depicting the effects of MDMA/Ecstasy use. These images were not only scare tactics but misrepresented the facts as discussed in the first section of this essay. (see p.27)

Anti-drug publicity may have the effect of popularizing drugs. This was a factor in the popularization of glue sniffing in the 1960s, as described in the Consumers Union Report, Chapter 44, “How to Launch a Nationwide Drug Menace”.[12 p.261-271]

Publicity may well have contributed to the rapid and widespread use of Ecstasy in the 1980s following all the media coverage surrounding the DEA scheduling controversy.

#3: Stop Increasing the Damage Done by Drugs

This recommendation encompasses a number of issues, both the literal (chemical) damage done by drugs as well as the collateral damage resulting from the War on Drugs. Prohibition and the black market for drugs increase the chemical damage done by drugs in several ways. The “Iron Law of Prohibition,” discussed above, leads to increased potency of the prohibited drug. This was seen with alcohol in the 1920s and with the development of crack cocaine in the 1980s. There are also the problems of unknown dosage and adulteration. Today we see the adulteration of MDMA/Ecstasy with various other drugs such as dextromethorphan, ketamine, various amphetamine analogs, PCP and LSD, to name a few.[50 p.163]

Collateral damage from drug prohibition is extensive. Consider the social and financial damage resulting from drug use in our society: “Loss of employment, expulsion from school, exclusion from respectable society similarly serve to increase the damage done by drugs – and over all of the other penalties hovers society’s ultimate sanction, imprisonment...”[12 p.421] Incarceration is one of the most damaging consequences of drug use; damaging to drug users, to their families and to society.

The U.S. Prison Population

The United States has the largest prison population in the world, totaling 2.1 million people at year-end 2002.[35] 2002 was the first year this figure exceeded the 2 million mark.[41] The second largest prison population is in China, with 1.51 million incarcerated people in 2003.[35] There are over 9 million incarcerated people

worldwide.[35] The 2.1 million prisoners in the United States represent over 23% of the world's prison population. The United States also has the highest incarceration rate in the world. At mid-year 2003 the U.S. rate of incarceration, including federal and state prisons, and local jails, was 715 inmates per 100,000 residents.[99] The second highest rate was Russia with 584 inmates per 100,000 residents.[99] Sixty percent of all countries have rates below 150 per 100,000.[99] The United Kingdom has 143 inmates per 100,000 residents and this rate represents the highest rate in the European Union.[99] Since enactment of mandatory minimum sentences in the Anti-Drug Abuse Act of 1986 the budget for the Federal Bureau of Prisons has increased 1,954%, from \$220 million in 1986 to \$4.3 billion in 2001.[35 p.5] Yet even these increases have not met the demand for prison beds created by the War on Drugs. At year-end 2002 the federal prison system was operating at 33% above capacity.[35 p.5]

The War on Drugs is the one factor that has had the greatest impact on the growth of the U.S. prison system since the mid-1980s.[86 sec.V] It is estimated that over 400,000 incarcerated people are drug offenders, representing close to 20% of the total U.S. prison population.[86 sec.V; 120 p.1] The reasons for the increased incarceration of drugs offenders are increased arrest rates, increased incarceration rates and increased length of sentences.[86 sec.V] Between 1980 and 1997 the rate of incarceration of adult drug offenders increased from 15 per 100,000 to 148 per 100,000, representing a ten-fold increase.[86 sec.V] Between 1987 and 1996, federal drug sentences doubled.[86 sec.V] Between 1980 and 1998 the number of drug offenders in state prisoners increased from 6% to 21%; for federal prisons the number of drug offenders increased from 25% in 1980 to 59% in 2000.[86 sec.V] The current number of admissions to state and federal prisons

for drug offenses is about 100,000 per year.[86 sec.V] The burgeoning U.S. prison population has been referred to as a “drug gulag” by former U.S. Drug Czar Barry McCaffrey.[86 sec.V]

Racism and U.S. Drug Policy

One aspect of the War on Drugs in general, and criminal sanctions for drug offenders in particular, that has moved to the forefront in the drug debate is the issue of racism. U.S. drug policy has allegedly been motivated by racism since its origins in the early twentieth century. David Musto discusses this in *The American Disease: Origins of Narcotic Control*:

If cocaine was a spur to violence against whites in the South, as was generally believed by whites, this reaction against its users made sense. The fear of the cocainized black coincided with the peak of lynchings, legal segregation and voting laws all designed to remove political and social power from him. Fear of cocaine might have contributed to the dread that the black would rise above ‘his place,’ as well as reflecting the extent to which cocaine may have released defiance and retribution. So far, evidence does not suggest that cocaine caused a crime wave but rather that anticipation of black rebellion inspired white alarm. Anecdotes [were] often told of superhuman strength, cunning and efficiency resulting from cocaine. . . . Another myth, that cocaine made blacks almost unaffected by mere .32 caliber bullets, is said to have caused southern police departments to switch to .38 caliber revolvers. These fantasies characterized white fear, not the reality of cocaine’s effects, and gave one more reason for the repression of blacks.[75 p.7]

The *New York Times* published a story in 1914 that claimed, “most attacks upon white women of the South are the direct result of the ‘cocaine-crazed’ Negro brain” and that “Negro cocaine fiends are now a known southern menace.”[49] These stories were used for political purpose to gain support of southern members of Congress for the Harrison Narcotic Act.[49] When marijuana became popular in the 1920s and 1930s in American jazz clubs, racist anti-marijuana propaganda was used as evidence of the “crumbling of racial barriers” because whites and blacks smoked it together in the clubs.[49]

African-Americans were not the only targets of fear-induced drug legislation. In the late 1800s and early 1900s increased immigration of Chinese into the western United States led to fears of competitive and cheap Chinese labor.[18] Strong anti-Chinese sentiment grew. It was further fueled by vivid stories of white women being “seduced into a life of prostitution and debauchery in opium dens.” [49] In 1882 the Chinese Exclusion Act was passed by the U.S. Congress.[18] It banned Chinese from immigrating into the United States and remained in effect until 1943 when China became an important ally of the United States against Japan.[18] This Act was repealed for political reasons rather than for human rights reasons.[18]

Similarly, during the Great Depression, racism was used to pass the 1937 Marijuana Tax Act. This law made marijuana use in the United States illegal. It was passed in response to marijuana use by Mexican immigrants in the southwestern United States.[137] The same Mexicans that were competing with unemployed Americans for jobs were “engaged in marijuana induced violence against Americans.”[49] In Congressional testimony on The Marijuana Tax Act of 1937 by Harry Anslinger, head of

the Federal Bureau of Narcotics, the reason for outlawing marijuana was given as its “violent effect on the degenerate races.”[97 Section 1.] Eric Sterling refers to this racist aspect of U.S. drug policy in “Drug Laws and Thought Crime”: “When you look at the history of the drug laws themselves, they are the seeds of race hatred planted in the law.”[110 p.327]

Musto summarized this aspect of early U.S drug policy: “They [drugs] were widely seen as substances associated with foreigners or alien subgroups. Cocaine raised the specter of the wild Negro, opium the devious Chinese, morphine the tramps in the slums; it was feared that use of all these drugs was spreading into the ‘higher classes’.”[75 p.657] These stories all reinforced racial stereotypes and compounded the drug problem by adding racism to all the other aspects of the issue. “American concern with narcotics is more than a medical or legal problem – it is in the fullest sense a political problem. The energy that has given impetus to drug control and prohibition came from profound tensions among races, ethnic minorities, and generations – as well as from the actual effects of certain drugs.”[75 p.244]

Over the past thirty years, as America’s War on Drugs has escalated, we have seen the emergence of another racist aspect of U.S. drug policy. We have seen the disproportionate application of drug laws in minority populations. The marked racial disparity in drug arrests and convictions do not represent racial differences in drug law violations.[86 Sec.I] Most drug offenders are white; there are five times as many white drug users as black drug users.[86 Sec.I] These proportions, however, are not reflected in who is arrested, convicted and incarcerated.

A major factor in this disproportionate application of drug laws is the crack cocaine phenomenon of the 1980s. As discussed above, crack cocaine was the focus of social and political concern in the 1980s. The enactment of the 100-to-1, powder-to-crack ratio and mandatory minimum sentences were both part of the Anti-Drug Abuse Act of 1986.[2](see p.53, 55) Human Rights Watch discusses this issue in its 2000 report, “Punishment and Prejudice: Racial Disparities in the War on Drugs”:

Although crack was the least used of all illicit drugs in the U.S., and although more whites use illicit drugs than blacks, the "war on drugs" has been targeted most notoriously at the possession and sale of crack cocaine by blacks. Crack cocaine in black neighborhoods became a lightning rod for a complicated and deep-rooted set of racial, class, political, social, and moral dynamics. To the extent that the white majority in the U.S. identified both crime and drugs with the "dangerous classes" -- i.e., poor urban blacks -- it was easier to endorse, or at least acquiesce in, punitive penal policies that might have been rejected if members of their own families and communities were being sent to prison at comparable rates.[86 sec.VII]

The United States Sentencing Commission reported in 1997 that “nearly 90 percent of the offenders convicted in federal court for crack cocaine distribution are African-American while the majority of crack cocaine users are white.”[102 p.8] A similar figure, 85%, was stated in the Commission’s 2002 report. [90 Executive Summary] This figure does not reflect a higher percentage of blacks as users of crack cocaine. Approximately two-thirds of crack users are white or Hispanic, yet the vast majority of persons convicted of possession of crack cocaine in federal courts are African-

American.[27 p.2] In 1995, the Commission reported to Congress that their research revealed because of lower state penalties for crack cocaine, the decision to prosecute in federal versus state court makes a dramatic difference in sentences.[103 chap.8, sec.B.2.e.] Federal prosecutorial power is discretionary; the Justice Department can choose which cases go to federal court.[109] They should be the high-level offenders but they are not.[109] Beyond this federal prosecutorial discretion, the jurisdictional discretion of law enforcement officers is part of this issue. The end result is that the cases going to the federal courts and thus being subjected to the “exaggerated ratio” are racial minorities.[103 chap.8, sec.B.2.c.] “Thus, sentences appear to be harsher and more severe for racial minorities as a result of this law . . .”[103 chap.8, sec. B.2.c.]

There are several other factors that contribute to the disproportionate application of drug laws in minority populations. The “major fronts” in the War on Drugs have been concentrated in urban, low-income (i.e. minority) neighborhoods and in these neighborhoods drug transactions tend to take place in public places.[86 sec.VII] Transactions occur more frequently in low-income neighborhoods because users buy smaller quantities, more frequently.[27] Both of these factors make it easier for law enforcement officers to make arrests. Tactical considerations encourage concentrating anti-drug efforts in these neighborhoods; police measure effectiveness by the number of arrests and it is easier to make arrests in these neighborhoods.[86 sec.VII] In white neighborhoods, working class through the upper class, drug transactions are more likely to take place indoors, in homes, clubs and bars, and thereby drug arrests are more difficult, take longer and cost more.[86 sec.VII] Racial profiling, the police practice of stopping, questioning and searching potential criminal suspects in vehicles or on the

street, based solely on racial appearance, leads to more minority drug arrests as well.[86, sec.VII; 114 p.4-5]

However, the well-established fact that federal crack cocaine defendants are overwhelmingly minorities stems also from practices higher up in the federal government. Key to understanding this fact is the Anti-Drug Abuse Act of 1986, its creation of the 100-to-1, powder-to-crack ratio and mandatory minimum sentences, but most importantly congressional intent surrounding enactment of this law. “The Federal government’s most intense focus ought to be on major traffickers . . . the heads of organizations who are responsible for creating and delivering very large quantities of drugs.”[112 citing House Report 99-845, Sept. 19, 1986] Yet, the United States Sentencing Commission reported to Congress in 1995 that only 5.5% of federal crack defendants and 9.2% of federal powder cocaine defendants were high-level dealers.[112] Eric Sterling was personally involved in the 1986 legislation as President Reagan’s counsel to the House Committee on the Judiciary.[108] He comments on this finding in “Racially Disproportionate Outcomes in Processing Drug Cases”:

Every Federal prosecution is the result of investigative and prosecutorial decisions by assistant U.S. attorneys, and DEA special agents, but they are frequently initiated by informants. The thousands of decisions to arrest and prosecute these low-level defendants instead of higher-level traffickers reflect the de facto policies and practices of the U.S. Department of Justice. The triggering quantities of the 1986 mandatory minimum statute were set improperly, but at every level of case review, officials of the U.S. Department of Justice have known that they are not prosecuting high-level traffickers as directed by Congress or in conformity

with the National Drug Control Strategy. Continuously, for more than a decade since Members of Congress complained to the Attorney General about this discriminatory outcome, the Justice Department has prosecuted cocaine traffickers who are predominantly low-level and are overwhelmingly black or Hispanic.

Cumulatively, these Justice Department decisions constitute a pattern or practice of racial discrimination in the choice of targets - - a pattern or practice that has been tolerated by the top management of the DEA and the U.S. Department of Justice, including the Attorney General, and ultimately the President.[112]

Sterling argues that focusing on the 100-to-1 ratio and mandatory minimums alone “misses the big picture”:

The key is that federal prosecutorial power is discretionary. The Justice Department picks which cases go to federal court. They should be the most important ones but they aren't. The U.S. Sentencing Commission's 1995 report revealed that . . . only 5% [of federal crack defendants in 1994] were high-level offenders. Federal power is being wasted on the small fry. If the Feds were focusing on high-level dealers, the racial disparity in cocaine sentencing would disappear. Federal anti-cocaine efforts should be focused on those who ship cocaine by the ton, in 1 million-gram loads, not the 5-gram, 50-gram street criminals. If there is any force on the globe that can successfully challenge the cocaine dealers' billions of dollars in revenues and private armies, it's U.S. law enforcement - - but not if the officials are running down hoodlums at the corner crack house. These low-level, non-white defendants are the least important drug

trafficking offenders even though they are getting longer sentences than high-level drug traffickers. . . . Isn't this evidence of a "pattern or practice" of racial discrimination? That is why the Congressional Black Caucus is outraged. . . . Arguing about sentences for 5-gram, 25-gram, 50-gram or 100-gram cases when cocaine floods in million-gram and multimillion-gram shipments, is a debate about the size of the minnows. We must stop letting the Justice Department, the attorney general and the "drug-czar" off the hook as the big fish get away.[109]

Consider Sterling's comments about the federal focus on the small fry while the big fish get away in the context of the MDMA/Ecstasy issue. The multibillion dollar world MDMA/Ecstasy market is believed to be controlled by Israeli and Russian drug syndicates who control production in Western-Europe, predominantly the Netherlands and Belgium.[29; 44] Would shutting down The State Palace Theater, Club La Vela or any other music venue and incarcerating the managers and the music promoters have a major impact on MDMA/Ecstasy problem in the United States?

The media's portrayal of the MDMA/Ecstasy issue also reveals a racial aspect to this current U.S. drug problem. Philip Jenkins elaborates on this in his congressional testimony on club drugs.[58] The media coverage of MDMA/Ecstasy refers to the problem in terms such as "a hot new high hits Main Street," "the latest drug invading the heartland" and the "suburban drug scene." [58 p.6] Jenkins states, "the racial codes are transparent." [58 p.6] He points out that the fear of white America is that "inner-city conditions – namely the problems afflicting minorities - could be visited upon 'nice kids' in the suburbs." [58 p.6] "Throughout media coverage, we hear repeatedly that those most at risk from the new drug culture are young and white." [58 p.6]

Consider some statistics: According to the U.S. Census, blacks represent approximately 12.5% of the U.S. population, Hispanics 12% and whites 69%.[36 p.1] Based on the National Household Survey on Drug Abuse (conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the Department of Health and Human Services) that there are five times as many whites who use drugs, as there are blacks who use drugs.[36 p.2] However, blacks represent 30% of drug arrests, 41% of persons in local jails on drug charges (awaiting trial on drug charges or with sentences less than one year on drug charges), and 49% of persons in state and federal prisons on drug charges.[86 sec.III] Nationwide, one in twenty, or 5%, of adult black males are incarcerated.[86 sec.III, table 6] One in three, or 33%, of black males aged 20–29 are under correctional supervision (incarcerated, paroled or on probation).[86 sec.III] Nationwide, adult black males are incarcerated at a rate 9.6 times the rate for adult white males.[86 sec.III, table 5] In Connecticut, the rate is 20 times.[86 sec.III, table 5] In the District of Columbia, the rate is 49 times.[86 sec.III, table 5] Look at incarceration rates a different way, as the number of people incarcerated per 100,000 residents. In Arizona, the state with the highest number of incarcerations for adult white males, 1,151 people per 100,000 residents, the number is lower than the state with the lowest figure for adult black males, which is Vermont with 1,195 people per 100,000 residents.[86 sec.III, table 5] In other words, the worst rate for whites (Arizona) is better than the best rate for blacks (Vermont).

Graham Boyd, Director of the American Civil Liberties Union (ACLU) Drug Policy Litigation Project, compares this phenomenon with slavery and the Jim Crow laws in his

article “Collateral Damage In The War On Drugs.”[8] Section IV, “The Birth of a New Slave Nation,” discusses the comparison:

Slaves were bound on plantations from which they could not escape. Now, it is prisons that deprive African descendants of their freedom. For African-American men between the ages of twenty and twenty-nine, almost one in three are currently under the thumb of the criminal justice system. The number of black men deprived of freedom is now approaching numbers seen only in the worst days of slavery.

The right to vote did not exist for slaves. . . . Today, 1.5 million black men, out of 10.4 million who would otherwise be eligible, cannot vote because of criminal convictions. In many states, like Florida and Alabama, close to one-third of black men have lost the right to vote forever. [Convicted drug offenders are denied the right to vote in states throughout the country. Forty-six states and the District of Columbia deny the vote to all convicted adults in prison, thirty-two states deny the vote to those on parole, twenty-nine states deny it to those on probation, fourteen states prevent ex-offenders who have fully served their sentences from voting and ten of those states deny the vote to ex-felons for life.[4]]

Slaves were kept purposefully illiterate and uneducated. . . . Frederick Douglass’ description of his master’s prohibition of his education reverberates with current drug policies: ‘Learning would spoil the best nigger in the world. Now, said [the master], if you teach that nigger how to read, there would be no keeping him. It would forever unfit him to be a slave. He would at once become unmanageable, and of no value to his master.’

Under the War on Drugs, Congress has once again moved to close the gates of education to many African-Americans and other minorities. Under the Higher Education Act (HEA) of 1998, federal financial aid, including loans, grants and work-study, is denied to any student convicted of a drug related offense. Given that 55% of those convicted of drug offenses are black, and the fact that this law will not affect the wealthy who do not need financial aid, the HEA plainly targets low-income people of color. Murder and rape do not render a person ineligible; however, being convicted of possessing small quantities of marijuana is enough to lose financial aid and the opportunity to better oneself through a college education.[8 sec.IV]

Boyd's comparisons also include: the higher rates of drug testing pregnant minority women vs. pregnant white women and resultant loss of custody of their children similar to the separation of mothers and children in slavery; the fact that the disproportionately high rate of AIDS in minority women is exacerbated due to the American drug policy ban on clean needles and needle exchange which he likens to the poor health care available to slaves.[8 sec.IV]

Ira Glasser, Executive Director of the ACLU, refers to this racist aspect of U.S. drug policy in his address at the 1999 ACLU Biennial Conference, “. . . it is no longer possible in this country to talk about race discrimination without talking about drug policy, and it is no longer possible to talk about drug policy without talking about race. And we must, in talking about both, confront the issue of epidemic incarceration.”[42 p.8]

Human Rights Watch has reported that the disproportionate incarceration of African-Americans, largely due to drug prosecutions, violates international human rights

treaties.[86 p.2] The International Convention on the Elimination of All Forms of Racial Discrimination does not define discrimination as intentional conduct but as conduct that has the “purpose or effect” of restricting rights on the basis of race.[86 p.2]

Boyd concludes his article, “Collateral Damage In The War On Drugs”:

Here lies the new Civil Rights Movement. As in a recurring nightmare, it revisits the same issues civil rights activists faced in the 1960s when fighting Jim Crow and the same issues abolitionists faced in the 19th century. The weakening of American democracy and the emergence of yet another institutionalized system that condones discrimination reflects our legacy of racism. . . . We chronically disavow the sin, distancing ourselves from the old, discredited form of racism. We denounce it. We say we have finally healed ourselves. Yet, . . . it rises back up to the surface and today takes form as the War on Drugs. We must recognize it and call it by its true name. It is American apartheid, the new Jim Crow.[8]

Activist Reverend Al Sharpton has referred to this issue as the reincarnation of Jim Crow as “James Crow, Esquire.”[110 p.335-36] This racist aspect of the U.S. War on Drugs is an example of a profound collateral consequence of U.S. drug policy and an appalling example of how drug policy increases the damage done by drugs.

Returning to the Consumers Union Report’s third recommendation to stop increasing the damage done by drugs, the report concludes:

Accordingly, future efforts should be directed toward minimizing the damage done by drugs. A substantial part of that damage stems not from the chemistry of the drugs but from . . . the laws punishing their use, society’s attitudes toward drug users. . . . Once a policy of minimizing damage is adopted and

conscientiously pursued, a substantial part of the “drug menace” will be eliminated – even though many people will continue to use drugs. The choice is clear: to continue trying, ineffectively, to stamp out illicit drug use by making it as damaging as possible, or to seek to minimize the damage done by drugs, licit and illicit alike.[12 p.421]

Recommendation #4: Stop Misclassifying Drugs

The Consumers Union Report finds:

Misclassification lies close to the heart of the drug problem, for what teachers tell students about drugs, and how judges sentence drug law violators depends on how the drug is classified. Most official and unofficial classifications of drugs are illogical and capricious. . . . The entire structure of official drug classification rests on a series of Congressional enactments beginning in 1914 and reaching a climax in the Comprehensive Drug Abuse Prevention and Control Act of 1970. The misclassifications built into this system are not the results of scientific study but represent compromises between Senate and House committees, between Republican and Democratic legislators, between Congress and the Nixon administration.[12 p.421-22]

The Controlled Substances Act, part of the Comprehensive Drug Abuse Prevention and Control Act of 1970, is the basis of the legal authority for classifying marijuana, a relatively benign drug, in Schedule I, the most restrictive category.[23] In an article from the Journal of the American Medical Association in March 2004, there were zero deaths attributed to marijuana while tobacco was identified as the cause of 435,000 deaths and alcohol was the cause of 101,635 deaths in 2000.[33] The classification system based on

the 1970 act also emphasizes licit versus illicit drugs. The two most damaging drugs in our society in terms of morbidity and mortality are alcohol and tobacco.[33] They are licit drugs and are often viewed as non-drugs.[12 p.422] A rational classification system should result from evidence-based scientific research of drugs, modes of drug use and the resultant harms.

#5: Stop Viewing the Drug Problem as Primarily a National Problem

This is the one recommendation of the Consumers Union Report that is not as clearly applicable today. The Report argues that many aspects of drug problems can be dealt with at the state and local level. It is true that local and state efforts can be used to address some aspects of drug use and its consequences. In California, the Substance Abuse and Crime Prevention Act of 2000, Proposition 36, is an example of this. This statute will be discussed in more detail below as a harm reduction measure. However, on another level, the globalization of our society and of organized crime as well as international terrorism linked with organized crime and drug trafficking calls for national and international management of drug problems.

#6: Stop Pursuing the Goal of Stamping Out Illicit Drug Use

Ethan Nadelmann is the Executive Director of The Drug Policy Alliance, the leading organization in the United States advocating alternatives to the War on Drugs. The Alliance was formed in 2000 when the Lindesmith Center, named after Alfred Lindesmith and formed in 1994 by the Open Society Institute, merged with the Drug Policy Foundation. The Drug Policy Alliance was formed with the objective of building a national drug policy reform network to broaden the public debate on drug policy and to promote realistic alternatives to the War on Drugs based on science, compassion, health

and human rights.[66] Nadelmann discusses drug policy reform in “The End of the Epoch of Prohibition.”[76 p.1] He states four “truths” about drugs and drug policy:

- 1) Most people who use drugs use them with little harm to themselves or others.
- 2) Drugs are here to stay. The time has come for the United States to abandon the tired and foolish rhetoric of a “drug-free society” and to focus instead on learning to live with drugs in such a way that they do the least possible harm to drug users and everyone else. Looking throughout history, one finds few if any civilized societies that did not encounter at least one powerful psychoactive drug. . . . [T]he societies that proved most successful in minimizing drug-related harms were not those that sought to banish drugs and drug users, but rather those that figured out how to control and manage drug use - through community rituals, initiation rights, the establishment and maintenance of powerful social norms, and so on.
- 3) Prohibition is no way to run a drug policy. America learned this with alcohol during the first third of [the twentieth century].
- 4) Between [the extremes of prohibition and legalization] lie a plethora of drug policy options, some of which can reduce drug related crime, disease and death more effectively, and often less expensively, than anything being done now.[76]

Harm reduction is one drug policy option that lies between the extremes of prohibition and legalization and harm reduction is a realistic alternative to current U.S. drug policy.

Harm Reduction: A Public Health Approach to Drug Use

Harm reduction is a public health philosophy. A useful definition is given by the United Kingdom Harm Reduction Alliance: “Harm Reduction is a term that defines *policies, programs, services and actions* that work to reduce the *health, social and economic* harms to *individuals, communities and society* that are associated with the use of drugs.”[125]

The harm reduction approach is used in many other aspects of our society. Motor vehicle safety is one example. In addition to the laws designed to decrease the numbers of accidents (the traffic safety laws) there are product safety designs to decrease the harm from individual accidents (seat belts, air bags, and crumple zones). Decreasing the prevalence of drug use may be a desirable goal but a drug free society is not an attainable goal any more than accident free highways can be attained. Reducing the harm to individuals from drug use can and should be a goal of reformed U.S. drug policies.

There are many examples of harm reduction that have worked. Consider tobacco use in the United States:

Cigarettes kill more than 400,000 Americans in a year and are as addictive as heroin or cocaine, according to the U.S. Surgeon General. Yet forty-four million addicted cigarette smokers have quit in the past thirty years. This is the result of a tremendous, successful public health campaign. This campaign succeeded without jailing or urine-testing cigarette smokers, without prosecuting tobacco sellers, without prohibition, and in spite of the annual expenditure of billions of dollars to promote tobacco use.[111]

Needle Exchange and Methadone Maintenance

A look at heroin addiction can illustrate in several ways the principles of harm reduction. First, a significant percentage of harm from heroin use is from injections using dirty needles. This harm results from the transmission of blood-borne diseases, particularly viral infections such as HIV and hepatitis as well as serious bacterial infections such as endocarditis. This harm, transmitted disease, is done to the user and in cases such as HIV can then be transmitted to sexual partners and subsequently transmitted via the maternal-fetal route to children. The damage mushrooms when you consider not only the transmission of disease itself but also the social and financial impact of the disease on the user, the family, the children and society. Needle exchange programs can reduce all of these harms.[32] The 1972 Consumers Union Report recommended that clean needles be available for injection drug users as a means of reducing the spread of blood-borne disease. *This recommendation was made in the pre-HIV era.* Consider how much harm could have been avoided if this recommendation had been adopted in 1972.[12 p.421] Needle exchange programs are still not standard harm reduction policy in the United States today; they are a highly controversial aspect of U.S. drug policy.

Consider another example of harm reduction in the case of heroin addiction. Many studies have shown that the majority of heroin addicts do not stay drug-free for more than short periods of time; opiate addiction is a chronic, relapsing disease.[12 p.424-25; 104] Treatment with methadone was first used to treat narcotic addicts in the 1950s; it was used to taper addicts off their narcotics.[12 p.125] It was not until the 1960s that the pioneering work done by Dr. Vincent Dole, a specialist in metabolic diseases, and Dr.

Marie Nyswander, a psychiatrist, led to the first methadone maintenance programs in New York City.[12 p.125-27] Methadone is a long acting narcotic, given in once-per-day oral dosage. It fulfills the narcotic craving and allows many addicts to go on with the activities of daily life, and in some cases even become productive citizens. It has also been shown to decrease the disease transmission and crime associated with heroin addiction.[32 p.3] According to Dr. Dole's observations in the 1960s: "The interesting thing about methadone treatment is that it permits people to become whatever they potentially are. Whereas addicts under the pressure of drug abuse and drug-seeking look very much the same, when they are freed from this slavery they differentiate and become part of the spectrum of humanity." [12 p.126-27] Dr.'s Dole and Nyswander established methadone maintenance as a result of their research at Rockefeller University and were the first to advocate "the belief that opiate addiction creates a permanent biochemical change in physiology so that methadone maintenance might well be necessary for the life of the addict." [12 p.237-38]

In essence, much of the opiate dependency research that was kicked off in the 1960s can be credited with a shifting of attitudes: that heroin addiction and its treatment is a medical problem, not a moral or political problem. This was also the first time anyone postulated that addiction was a metabolic disease, which ultimately led to the discovery – first by Drs. Dole and Nyswander – that addiction has little to do with weakness of the mind and spirit and everything to do with opiate receptors and endorphins.[104 p.29]

The heroin addict always craves the drug when cessation is attempted:

The time has come to recognize what should have been obvious since 1914 – that heroin is a drug most users go right on using despite the threat of imprisonment, despite actual imprisonment for years, despite repeated “cures” and long-term residence in rehabilitation centers, and despite the risks of disease and even death. Heroin is a drug for which addicts will prostitute themselves. It is also a drug to which most addicts return despite a sincere desire to “stay clean,” a firm resolve to stay clean, an overwhelming effort to stay clean – and even a success (sometimes enforced by confinement) in staying clean for weeks, months or even years. This is what is meant by the statement that heroin is an addicting drug.[12 p.424]

Methadone maintenance is still the most successful means available for the treatment of heroin addiction.[32 p.2] Newer drugs such as buprenorphine are being investigated and have significant advantages over methadone. The peak opiate agonist effect of buprenorphine reaches a ceiling at about 40% activity of full agonists such as heroin and methadone.[104 p.30] Once this ceiling is reached, and it is reached at moderate doses, more drug does not have any further effects.[104 p.30] Before reaching this ceiling, the drug produces sufficient agonist effect to prevent withdrawal symptoms.[104 p.30] There are several advantages of this ceiling attribute of buprenorphine. The typical opiate agonist effect of euphoria is limited by the ceiling and therefore the abuse potential and potential for diversion to the black market is reduced compared with full opiate agonists. Side effects such as respiratory depression do not occur below the ceiling and therefore the drug has a low risk for serious or fatal overdose.[104 p.30] In addition, buprenorphine has a longer half-life than methadone and dosing every 2 or 3 days is

possible.[104 p.31] Research and development of new drugs such as buprenorphine are important in advancing the maintenance treatment of narcotic addicts. However, methadone remains the prototype for maintenance treatment of narcotic addicts.

Methadone maintenance remains controversial in this country, largely due to the persistence of the American abstinence model of drug treatment. “In addition to creating methadone treatment, the United States was also the birthplace, and is still the spiritual center and home, of the world-wide abstinence approach to drug treatment.”[32 p.2] Drug-free therapeutic communities such as Synanon and Phoenix House adopted the drug-free, self-help approach from the 12-Step method of Alcoholics Anonymous.[32] This approach to drug treatment is based on the belief that drugs are evil, no compromise with drug use should be made and maintenance therapy is unacceptable. In the late 1990s, the mayor of New York City, Rudolph Guiliani, attempted to eliminate methadone maintenance programs in New York City, criticizing them as immoral and as a perpetuation of “enslavement to narcotics.”[32 p.3] He backed down after public outcry.[32 p.3] The implementation of drug maintenance programs still suffers because of this unattainable drug-free society mentality.

Methadone remains a highly controlled drug in the United States and is dispensed through highly regulated clinics. The DEA, a law enforcement agency rather than the medical profession or a health care agency, retains powerful control over many aspects of treatment in methadone programs including dosages, schedules, admission and termination criteria, and access to treatment.[32 p.3] In 2004, there remains a “treatment gap” in methadone maintenance treatment; this gap is defined as the difference between the number of opiate dependent persons and those in treatment.[34 p.2] The treatment

gap is currently over 600,000 persons and represents 75-80% of all addicts.[34 p.2] Of these, there are many individuals addicted to heroin who desire to go on methadone and much harm could be avoided if this option was available to all who desire it. “There is no good reason for this, just politics, prejudice and ignorance” says Nadelmann of the Drug Policy Alliance. A 1997 National Institute of Health Consensus Statement found:

Opiate-dependent persons are often perceived not as individuals with a disease but as “other” or “different.” Factors such as racism play a large role here but so does the popular image of dependence itself. Many people believe that dependence is self-induced or a failure of willpower and that efforts to treat it will inevitably fail. Vigorous and effective leadership is needed to inform the public that dependence is a medical disorder that can be effectively treated with significant benefits for the patient and society.[34 p.3]

The option for addicts not maintained on methadone or another form of opiate is to continue heroin use, and to get their heroin from the black market and thereby perpetuate that market and all of its consequences.

Proposition 36: Treatment Diversion

A harm reduction approach could be applied to many other aspects of the drug problem in the United States, such as revision of policies that have created “epidemic incarceration.” The state of California adopted Proposition 36, the Substance Abuse and Crime Prevention Act of 2000, and it took effect July 1, 2001.[16] Proposition 36 diverts low-level, non-violent drug offenders convicted of simple possession for personal use into community treatment programs instead of incarcerating them.[16] Implementation of Proposition 36 involves collaboration between criminal justice and public health

agencies, an innovative approach to the drug use problem. Initial reports of the program are very favorable although some problems such as lack of diversity of treatment options as well as inadequate availability of methadone maintenance programs have been identified.[15] In the first year of the program over 30,000 non-violent drug offenders were placed in treatment programs.[16] About half of these offenders were in treatment for the first time. Methamphetamine has been identified as the drug used by over 50% of Proposition 36 clients in the initial year of the program; cocaine and crack cocaine represented 15%; heroin represented 11%.[16] It is estimated that the program saved California taxpayers \$279 million in its first year.[16]

Disproportionate Impact on Racial Minorities

Revision of policies that lead to disproportionate incarceration of minorities should be a priority for a revised U.S. drug policy. The first step could be changing the 100-to-1, powder-to-crack cocaine ratio. The United States Sentencing Commission has made this recommendation three times:

1. In 1995 the Commission found the 100-to-1 ratio to be unjustified and recommended it be revised to a 1-to-1 ratio. Congress rejected the recommendation and returned the issue to the Commission for reconsideration and new recommendations.[102 p.1]
2. In 1997 the Commission sent to Congress a unanimous recommendation to make the penalty the same for simple possession of powder cocaine and crack cocaine. Also in the 1997 report, the Commission advised that for cocaine trafficking, the quantity triggering a five-year mandatory minimum sentence be reduced for powder cocaine and increased for crack cocaine (i.e.: reduce

the 100-to-1 ratio). The Commission urged the change be made “. . . as soon as possible, as hundreds of people will continue to be sentenced each month under the current law.” Congress did not act on this recommendation.[90 Executive Summary; 102]

3. In May 2002 the Commission issued a third report on cocaine and federal sentencing policy. In this report the Commission recommended increasing the amount of crack cocaine that triggers the five-year mandatory minimum from 5 grams to at least 25 grams and that this be applicable only to cases of trafficking. This would have the effect of decreasing the powder-to-crack ratio to 20-to-1. The Commission further recommended that the mandatory minimum for simple possession of crack cocaine be repealed. The 2002 Report also contains the recommendation that sentencing enhancements be adopted to reflect drug offenses that involve bodily injury from violence, distribution to persons under age twenty-one, and repeat offenders. Congress has not acted on the recommendations in the 2002 report.[90]

Eric Sterling’s assertion that the Justice Department’s choice of cases is the underlying problem in the epidemic incarceration of minorities should also be a focus of policy reform. A method could be developed for choosing cases for federal court that is blind to the race of the offender. Sterling also claims that if the federal government prosecuted the “big fish,” the high-level dealers, then the “racial disparity in cocaine sentencing would disappear.”[109]

MDMA/Ecstasy Harm Reduction

Harm reduction for users of MDMA/Ecstasy has taken several forms. In the context of dance parties: provision of “chill rooms” to avoid the complication of hyperthermia, largely believed to be setting dependant; availability of electrolyte replacement drinks to prevent dehydration, hyponatremia and hyperthermia; provision of on-site emergency medical service; and distribution of educational materials on drugs are some examples. Ironically, some of these harm reduction provisions were used as evidence for the “knowledge” requirement of the Crack House Statute by the prosecution in both the State Palace Theater and Club La Vela Cases. On-site emergency medical service at a Yankee game is in the best interest of public safety; at a rave, it is evidence of a crime. Critics of the RAVE Act are concerned that an unintended consequence of the law will be to increase harm from MDMA/Ecstasy use because its use will be driven underground, into unsafe venues where safeguards are not readily available, or that legitimate venues that would have adopted a harm reduction approach will be deterred from such measures out of fear that the measures could be used as evidence against them. This would be a manifestation of the “chilling effect” of even a few prosecutions.

CONCLUSION

Illicit drug use is without doubt one of the most important issues confronting America in the twenty-first century. This essay has touched on some aspects of this extraordinarily complex issue. I have used a contemporary drug issue, the club drug MDMA/Ecstasy, and the latest federal drug legislation, the RAVE Act, as a means to examine U.S. drug policy. Admittedly, viewing all illicit drug consumption as a single issue oversimplifies the situation. There are very different factors involved in soft drug versus hard drug use, rational versus compulsive use, and responsible versus destructive use. The RAVE Act is only one example, the most recently enacted example, of a legal weapon in the federal government's drug war arsenal. I have illustrated that America's drug policy is the cause of much of the harm resulting from illicit drugs, that American citizens are the primary casualties of the War on Drugs, and that the collateral damage from the War is profound. Continuation of the drug war is not in the best interest of our society; not for individual members of our society; not for the diverse communities that comprise our society; and not for our society as a whole. In my opinion, the RAVE Act, exemplifies yet another law that will cost more money, is unlikely to accomplish much actual benefit in terms of reduction of drug use, may violate constitutional rights of some citizens, and may increase the harm done to consumers of the "notorious chemical sacrament" of the club scene.

In discussing the current U.S. prohibition paradigm, Ethan Nadelmann refers to America's "drug-prohibition complex" as analogous to the "military-industrial complex" discussed by President Eisenhower in his farewell address to the nation in 1961.[77]

Eisenhower was referring to the “permanent armaments industry of vast proportions” established in the United States in the mid-twentieth century.[40] The “drug-prohibition complex” in 2004 is also of vast proportions; it is composed of the hundreds of thousands of law enforcement personnel, the U.S. prison system, anti-drug organizations and many others who benefit economically, politically, emotionally, and even spiritually from the ever-escalating War on Drugs. Formation of this complex began in 1914 with enactment of the Harrison Narcotics Act. Over the past century it has expanded and has become so much a part of our society that retreat in the War on Drugs will not come without incredible challenges. However, in my opinion, America cannot maintain its current policies and thereby continue to increase the damage being caused by drugs; damage that results from the intended and profound unintended consequences of the War on Drugs.

The opposite extreme from prohibition, free-market legalization, is an option that is supported by rational arguments based on the economics of the underground drug industry. Nobel prize-winning economist Milton Friedman is an advocate of drug legalization.[77; 117] The crux of the economic argument for legalization is that the prohibition of drugs and the resultant black markets generate extraordinary harm to individuals and society: violent crime, corruption of government, empowerment of criminals, and transfer of vast sums of money to criminals from the purchase of drugs and from unpaid tax revenue.[73 chap.2] (The illicit drug industry is one of the largest industries in the world. In 2000 the total revenue in the illicit drug trade in the United States alone was about \$64 billion; tax on this revenue would be about \$20 billion dollars.[73 p.17]) According to the economic argument, the way to eliminate the majority of these harms is to eliminate the black markets by legalizing drugs.[73 chap.7]

In my opinion free-market legalization is not a realistic option for America. I base this opinion not on the economic argument, which in theory is convincing, but rather on the social implications of free-market legalization of drugs. Most drug policy reformers do not advocate legalization. They don't want crack or crystal sold at the local 7-Eleven, citing an exaggerated accusation by former drug czar General Barry McCaffrey.[77]

What is a realistic alternative to the War on Drugs? Between the extremes of prohibition and legalization is the policy option of harm reduction. In my opinion this is a realistic goal for reform of U.S. drug policy. Harm reduction, as discussed in Section III of this essay, is a public health philosophy for management of the drug problem. It establishes as a priority the well being of individuals and society. The current debate on drug policy, started many decades ago but expanded in recent years, is the first step in educating the public on policy reform options and specifically on harm reduction. A prerequisite to adopting the option of harm reduction, and something that will be a great challenge for many in America, is acceptance of the fact that drug use exists and a drug-free society is not a realistic goal. Once this fact is accepted, harm reduction can take many forms, some of which were discussed in Section III of this essay. Harm reduction can be implemented gradually, within the context of our existing legal structure, making changes one step at a time, learning from other countries, learning from evidence-based research, and learning from past mistakes.

The 1972 Consumers Union Report concluded with a final thought: "We hope that when the next generation takes over, this Consumers Union Report will still remain useful - as a guide to how mankind has used and misused drugs in the past, and as a warning against repeating the errors society is making today." [12 p.434] The next

generation has taken over and it is time for change, change in the form of harm reduction as the basis for reform of American drug policy.

APPENDIX

“Crack House Statute”

US CODE COLLECTION

TITLE 21 > CHAPTER 13 > SUBCHAPTER I > Part D > Sec. 856.

Sec. 856. - Establishment of manufacturing operations

(a) Unlawful acts

Except as authorized by this subchapter, it shall be unlawful to -

(1) knowingly open or maintain any place for the purpose of manufacturing, distributing, or using any controlled substance;

(2) manage or control any building, room, or enclosure, either as an owner, lessee, agent, employee, or mortgagee, and knowingly and intentionally rent, lease, or make available for use, with or without compensation, the building, room, or enclosure for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance.

(b) Penalties

Any person who violates subsection (a) of this section shall be sentenced to a term of imprisonment of not more than 20 years or fine of not more than \$500,000, or both, or a fine of \$2,000,000 for a person other than an individual.

(c) Violation as offense against property

A violation of subsection (a) of this section shall be considered an offense against property for purposes of section 3663A(c)(1)(A)(ii) of title 18.

**Crack House Statute modification into the Illicit Drug Anti-Proliferation Act of
2003, a.k.a. the RAVE Act**

US CODE COLLECTION

TITLE 21 > CHAPTER 13 > SUBCHAPTER I > Part D > Sec. 856.

Sec. 856. – Maintaining drug-involved premises

(a) Unlawful acts

Except as authorized by this subchapter, it shall be unlawful to -

(1) knowingly open, lease, rent, use, or maintain any place, whether permanently or temporarily, for the purpose of manufacturing, distributing, or using any controlled substance;

(2) manage or control any place, whether permanently or temporarily, either as an owner, lessee, agent, employee, occupant, or mortgagee, and knowingly and intentionally rent, lease, profit from, or make available for use, with or without compensation, the place for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance.

(b) Penalties

Any person who violates subsection (a) of this section shall be sentenced to a term of imprisonment of not more than 20 years or fine of not more than \$500,000, or both, or a fine of \$2,000,000 for a person other than an individual.

(c) Violation as offense against property

A violation of subsection (a) of this section shall be considered an offense against property for purposes of section 3663A(c)(1)(A)(ii) of title 18.

(d) Civil Penalty

(1) Any person who violates subsection (a) shall be subject to a civil penalty of not more than the greater of –

(A) \$250,000 or

(B) 2 times the gross receipts, either known or estimated, that were derived from each violation that is attributable to the person.

- (2)** If a civil penalty is calculated under paragraph (1)(B), and there is more than 1 defendant, the court may apportion the penalty between multiple violators, but each violator shall be jointly and severally liable for the civil penalty under this subsection.
- (e)** Any person who violates subsection (a) shall be subject to declaratory and injunctive remedies as set forth in section 403(f).

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