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Why Has US Drug Policy Changed So Little over 30 Years?

ABSTRACT

Though almost universally criticized as overly punitive, expensive, racially disparate in impact, and ineffective, American drug policy remained largely unchanged from 1980 to 2010. Marijuana is an important exception: policy and law underwent many changes, with the strong likelihood of more, involving increased legal access to the drug, in the near future. For cocaine, heroin, and methamphetamine there has been an almost relentless increase in the numbers incarcerated for drug offenses, rising from about 50,000 in 1980 to 500,000 in 2010. African American imprisonment rates are higher for drug offenses than for other types of crime; some of this disparity results from unjustifiably harsher sentences for crack than for powder cocaine offenses. The battles necessary to achieve even modest reductions in these disparities and other overly severe sentencing regimes at the state and federal levels demonstrate how difficult it is to achieve changes in drug policy. Recent reforms in health care at the federal level offer hope for increased access to treatment services, but otherwise only drug policy rhetoric has changed much.

No one is happy with American drug policy. The standard critique is liberal; the policy is overly punitive, racially unjust, extremely expen-

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sive, and, to boot, ineffective. The last charge is what distinguishes it from the critique of criminal justice trends generally. From the right, less articulate on this specific matter, the view is more complex. The US drug problem remains awful, but any change other than increasingly vigorous enforcement is a slippery slope to legalization, an anathema. Conservatives, other than libertarians, provide less a defense of the details of current policies than a vigorous critique of proposed reforms. Libertarians have an easy answer: legalize drugs and these problems will take care of themselves. This polarization is not a temporary state; with minor variation, it has been that way since Ronald Reagan's early years and arguably even since Richard Nixon's war on drugs in the early 1970s.

Marijuana is an important exception to these broad statements, and it receives a lengthy separate treatment in a later section of this essay. Much has changed in marijuana policy and in the intellectual framing of the relevant policy issues. Except where specifically stated in the rest of the introductory remarks, I refer to illegal drugs other than marijuana. I also do not refer here to nonmedical use of prescription drugs; a later section explains why it is appropriate to treat that as a distinct problem.

The stasis in policy and discontent is particularly puzzling since the extent and nature of the problem have changed substantially over the last 40 years. After rapid growth in the number of dependent users of various problematic drugs from about 1967 to 2000, drug use and dependence have been in decline; the same is true for associated violence and public disorder, in which downturns started as early as 1990. Yet there has been scarcely any serious policy change beyond a very recent increase in treatment funding and a period during the 1970s, mostly associated with the Nixon administration, when methadone maintenance was the central drug control program for the federal government. The attention to international drug policy has waxed and waned, reflecting more the nation's concerns with particular nations (Afghanistan, Colombia, and Mexico) than the belief that these interventions would affect US drug ~~consumption~~.

Policy makers' views about the nature of the drug problem have evolved, perhaps even matured, over time. There is now at least a dim understanding that attractive drugs have limited potential reach. None will engulf the nation's youth. The policy rhetoric is less overblown in

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recent years.[1] The idea that "addiction is a brain disease," promoted initially by the National Institute on Drug Abuse and now a part of federal government rhetoric generally, whatever its programmatic and conceptual weaknesses, at least has provided a basis for talking in a more therapeutic and less exclusively moralized frame about drug addicts ~~who have been criminally active~~.

One odd feature of the drug policy debate is the reluctance to acknowledge that the US drug problem, by some of the most significant measures, is declining. The White House Office of National Drug Control Policy (ONDCP), once any president has been in office for more than a year, will defensively point to signs of improvement,[2] but that is usually dismissed as political posturing, and the debate continues without any consideration of the decline and its causes.[3] The final section of the essay considers the significance of this observation.

In this essay, I make five major claims. First, marijuana must be treated separately as a social and criminal justice problem, as well as in terms of policy and research influences. Though it is used throughout American society and generates a huge number of arrests, it hardly touches the central problem of American criminal justice, namely, the high incarceration of minorities, nor does it cause great health and social harms. Perhaps the most serious harms relate to its trafficking and production in Mexico. There have been important changes in law over the 50 years to 2012, and there is promise of even greater change in the near future.

Second, for other illicit drugs the only major legal changes over much of that period have been steady increases in the severity of sentencing at both federal and state levels. The number of persons incarcerated for drug offenses rose from 50,000 in the early 1980s to about

[1] It is hard to object to the introduction of the 2012 *National Drug Control Strategy*: "Too many Americans need treatment for substance use disorders but do not receive it. Prescription drug abuse continues to claim American lives, and those who take drugs and drive threaten safety on our Nation's roadways. Young people's perceptions of the risks of drug use have declined over the past decade, and research suggests that this often predicts future increases in drug use. There is still much left to do to reform our justice system and break the cycle of drug use and crime" (ONDCP 2012*a*, p. iii).

[2] See, e.g., the Fact Sheet accompanying the release of the 2012 *National Drug Control Strategy*, which stated that "the rate of overall drug use in America *has dropped by roughly one-third over the past three decades*. Since 2006, *meth use in America has been cut by half and cocaine use has dropped by nearly 40 percent*" (ONDCP 2012*c*; emphasis in original).

[3] The public never sees the problem as getting better. See poll results in Gallup (2007).

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500,000 in 2010. Efforts to find better ways to keep criminally active drug users out of prison (especially by use of drug courts) have achieved prominence in recent years but have had minimal success in keeping older and less violent addicts in the community. The criticism of sentencing for drug offenses has been well developed, with many claiming that the resulting racial disparities were not unintended; the disparities were both foreseeable and, at least for some policy makers, acceptable. The long battle to reduce 100-to-1 crack-powder disparities at the federal level to 18-to-1 in 2010 is another indicator of how deep is the sentiment in favor of tough penalties.

Third, harm reduction, the idea that governments should pay attention to the harmfulness of drug use, not just to the number of users of drugs, is a big idea that has importantly changed drug policy in much of the Western world, even in societies governed by otherwise conservative leaders and political parties. In the United States, among the core harm reduction programs, only methadone maintenance has been accepted. The federal government has so far rejected harm reduction both rhetorically and substantively; it refuses to consider efforts to directly reduce either the harms of drug use or ~~any~~ adverse consequences of programs aimed at lowering drug use. The slow uptake of needle exchange in the United States shows the strength of the drug war sentiment, even as the rhetoric has changed. The notion of addiction as a brain disease may be somewhat lessening the harshness of drug policies.

Fourth, legalization, the idea that drugs such as cocaine and heroin should be treated like alcohol and be made available legally under substantial regulatory restrictions, deserves separate discussion. Though it has no appeal to the general public, it continues to attract a great deal of interest from the educated elite and, very recently, from some Latin American presidents. The harms that make up the current drug problem are primarily the consequence of the policies used for control rather than the drugs. The gains from prohibition, if any, in terms of fewer users and addicts are hard to identify empirically. However, it is difficult to make a compelling empirical case for legalization.

Fifth, the prevalence of drug use, the most widely reported measure of drug problems, is not a good target for drug policy. Prevention and law enforcement are too ineffective, and treatment and harm reduction programs yield different benefits (such as lower crime and less transmission of blood-borne viruses). Nor does prevalence capture the heart

of what disturbs American society about illicit drugs. Policy should be oriented toward reducing violence, dysfunction, and disease related to drug use and to reducing the use of incarceration and reducing racial disparities in that incarceration.

This essay is organized in six sections. Section I briefly summarizes the history of drug problems and drug policy, providing a setting for what followed. Section II discusses marijuana in some detail. Marijuana needs to be set aside since it is a distinct and separate problem and discussions that fail to distinguish it from the other drugs quickly become confused. Section III reviews policies toward other drugs, focusing on the goals of policies and briefly examining and assessing the array of programs that have aimed at reducing consumption of cocaine, heroin, and methamphetamine. Section IV then considers a number of important ideas that have played a role in recent debates about drug policy: harm reduction, addiction as a brain disease, legalization, and drug courts. New drug problems are the subject of Section V. Section VI justifies the claim of policy stasis and offers some speculations about the reasons for resistance to change.

I. The Long History

The prohibition of certain psychoactive substances on the basis of their harmfulness to users and others has a long history in the United States.[4] Tobacco and alcohol were the principal targets of prohibition in the nineteenth century (Aaron and Musto 1981; Troyer and Markle 1983). Only toward the end of that century and the beginning of the twentieth century did cocaine and heroin, recent and very powerful additions to the pharmacopoeia available to physicians, come into focus (Musto 1999; Spillane 2000). Until the early twentieth century, antidrug laws were mostly state and local measures. However, growing concern that lax state and municipal laws were failing to contain narcotics addiction, as well as the problems of a legal opium regime that the United States inherited with the conquest of the Philippines, prompted federal legislation, most importantly the Harrison Act in 1914. On its face, the Harrison Act appeared only to regulate the production and distribution of opium and coca derivatives, but in practice it was interpreted by the courts to preclude doctors from prescribing

[4] This section draws on Boyum and Reuter (2005).

drugs to maintain addiction, and it ushered in a half century of increasingly punitive antidrug laws. The act itself increased the maximum penalty specified in federal narcotics laws to 5 years from 2. But by the end of the 1950s, federal and some state antinarcotics laws included life imprisonment and the death penalty; they also prescribed mandatory minimum sentences for certain drug offenses. Still, the scale of enforcement was minor, as was drug use (Courtwright 1982). In assessing the success of prohibition of cocaine and heroin, it is useful to remember that there was a period, perhaps characterized by strong informal social controls, when prohibition largely achieved its goal of keeping drug use rare without intrusive enforcement.

Until 1969, federal government action regarding illicit drugs was rather limited. Although antidrug legislation, including the Marihuana Tax Act of 1937, the Boggs Act of 1951, and the Narcotics Control Act of 1956, had been enacted with much fanfare, neither federal funding nor programs were substantial.[5] Despite the international prominence of its long-time director, Harry Anslinger, the Federal Bureau of Narcotics remained a small agency with no more than 300 agents when he retired in 1962 (Epstein 1978). Drug treatment was provided in two federal facilities that were adjuncts to prisons in Lexington, Kentucky, and Fort Worth, Texas (Ball and Cottrell 1965).

But in 1971, faced with evidence of a growing heroin problem in many cities, President Nixon became the first president to declare a "war on drugs." The president focused initially on international controls, reflecting the belief that since the drugs originated overseas, so should the solution. As most heroin was thought to come from Turkey, Nixon pressured that nation to ban opium cultivation. The Turkish government enacted such a ban in 1971 in return for US provision of compensation payments to farmers, but Turkish electoral politics led to a rescinding of the ban and to a good deal of congressional rhetoric about faithless allies (Spain 1975). Even after the ban was lifted, however, tighter control by the Turkish government resulted in a sharp

[5] The Marihuana Tax Act of 1937 imposed a $1 tax on anyone selling marijuana; the bite was that paying the tax required declaration of participation in an illegal activity. The Supreme Court ruled the act unconstitutional in 1969, leading to the passage of the Controlled Substances Act in 1970. The Boggs Act of 1951 toughened sentences for federal drug offenses, including creation of mandatory minimums for second or subsequent offenses. The Narcotics Control Act of 1956 toughened sentences still further; the minimum sentence for a first offense of distribution was 5 years (National Commission on Marihuana and Drug Abuse 1972).

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diminution in estimated heroin production in that country. Vietnam, neighboring the Golden Triangle, then the dominant source of heroin production globally, weighed in the mix. US troops were heavily involved in heroin use and, to a lesser extent, in trafficking back to the United States (Epstein 1978).

Under President Nixon, the Controlled Substances Act was passed in 1970; it remains the central statute for regulating psychoactive substances.[6] The other major initiative of the Nixon administration was the creation of a federally subsidized drug treatment system, built primarily around methadone, which had been developed as a heroin agonist in the early 1960s. Treatment dominated federal antidrug spending from 1971 to 1975, although less because of a humane attitude toward drug users than because methadone seemed to offer a "silver bullet" for the heroin problem, and Nixon's aide Egil "Bud" Krogh had little faith in drug enforcement (Goldberg 1980; Massing 1998). Methadone maintenance was a centerpiece of the first modern presidential crackdown on crime (Massing 1998).

In the mid-1970s it became clear that the heroin epidemic had passed its peak, perhaps because of the success of overseas supply efforts, including the Turkish opium ban, the spraying of Mexican opium fields, and the breaking of the "French connection" trafficking route (Paoli, Greenfield, and Reuter 2009). As a result, interest in drug policy diminished at the federal level. Federal drug control expenditures declined in real terms,[7] and both presidents Ford and Carter distanced themselves from the drug issue. President Carter's one initiative, an endorsement of the removal of criminal penalties for possession of small amounts of marijuana for personal use, had no legislative consequence.[8] Carter's most memorable quote regarding the matter in a message to Congress on August 2, 1977, "Penalties against possession

[6] The act provides for the scheduling of psychoactive substances according to their abuse liability potential and their medicinal value. Schedule I drugs have high abuse potential and no approved medical use; heroin and marijuana are Schedule I drugs. Cocaine is Schedule II (high abuse potential and an approved medical use) since it has a minor niche in medical practice as a topical anesthetic for eye surgery and in dentistry.

[7] In 1974, the final year of the Nixon administration, the total drug control budget was $788 million; in 1978, during the Carter administration, the figure was $794 million (Carnevale and Murphy 1999). In real terms this was a decline of roughly 24 percent.

[8] Nor was President Carter's standing on this issue helped when his principal adviser on drug policy, Peter Bourne, was caught having written an unauthorized prescription for an opioid for a member of his staff. Bourne resigned over the incident (Meier 1994).

of a drug should not be more damaging to an individual than the use of the drug itself," did not remain in the collective memory for long. Even a substantial growth of marijuana use in high school populations—in 1978, nearly one in nine high school seniors reported having used it on a daily basis during the previous month—did not trigger a strong response from the Carter administration, though it led to the emergence of a strong parents movement (Massing 1998; National Institute on Drug Abuse 2002).[9]

Federal interest grew rapidly again after the election of Ronald Reagan, who early in his first term gave major speeches announcing new initiatives against drugs. This time cocaine was the primary target, although marijuana also received increased attention, thanks in part to the growing influence of nonprofit antidrug organizations. For example, a Reagan speech at the Justice Department on October 14, 1982, announcing the creation of a new set of prosecutor-led units (the Organized Crime Drug Enforcement Task Force program) was given great prominence. George H. W. Bush, then vice president, made much of his chairing of a border control committee and his leadership of the South Florida Initiative, aimed at closing down the major cocaine and marijuana smuggling routes into south Florida. Federal expenditures on drug control grew massively, from about $1.5 billion in fiscal year 1981 to $6.6 billion in fiscal year 1989. The bulk of that increase was for enforcement, especially interdiction, so that by 1989 less than 30 percent of federal expenditures went to prevention and treatment. The president's wife, Nancy Reagan, became famous for her "Just Say No" program.[10]

The growth of a visible cocaine problem, reflected in the deaths of two well-known young athletes 8 days apart in 1986, energized Congress.[11] In a series of broad-scope antidrug bills, the penalties for violations of federal drug laws covering both possession and distribution

[9] For a lively discussion of what the parents movement represented in terms of class interests (i.e., whether it was primarily focused on protecting middle-class children), see the 1999 correspondence in the *New York Review of Books* (http://www.nybooks.com/articles/archives/1999/apr/22/just-say-no-an-exchange/?pagination=false).

[10] There seems to be no relatively objective history of the Reagan era of drug policy. For a critical account from the reformers' side, see Bertram et al. (1996).

[11] Len Bias was a University of Maryland basketball star, recently drafted in the first round by the Boston Celtics, one of the glamor franchises of that era. Don Rogers was a young defensive player for the Cleveland Browns and the 1984 Defensive Player of the Year. See http://sportsillustrated.cnn.com/vault/article/magazine/MAG1064997/index.htm.

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were toughened significantly.[12] Nor was this just punitive rhetoric; by creating a commission to set guidelines for sentences in 1984 and later setting high mandatory minimums, Congress ensured that those convicted in federal courts would serve long sentences. By 1992 the average time served for drug offenses in federal prison had risen to more than 6 years, up from about 2 years in 1980. Combined with increasingly aggressive investigative and prosecutorial efforts, these measures resulted in an extraordinary increase in the number and length of federal prison sentences served for drug offenses, from the equivalent of 4,500 cell-years in 1980 to over 85,000 cell-years in 1992 and over 135,000 cell-years in 2001.[13] While many in Congress expressed dissatisfaction with the emphasis on enforcement over prevention and treatment, they were unable to affect the budget division for many years.

At about this time, a sharp spike in popular concern about the drug problem briefly made it the leading national issue in polls. President George H. W. Bush made drugs the subject of his first prime-time televised address in September 1989. The ONDCP's first director, William Bennett (appointed by President Bush), provided a clear rationale for the focus on criminal penalties. The problem, said Bennett, was drug use itself rather than its consequences; in this he departed from a number of earlier statements associated with the Carter and Ford administrations. Success was to be measured not by reductions in crime or disease associated with drugs but in the numbers of users (ONDCP 1989).

The Clinton administration efforts can readily be summarized: no change (Carnevale and Murphy 1999). There were some differences in rhetoric, with greater emphasis on the small number of offenders who were frequent drug users. However, that had no material impact on the allocation of the federal drug-control budget; two-thirds continued to go to enforcement activities, predominantly inside the United States. Sentencing policy did not change either: large numbers of federal de-

[12] For example, the Anti–Drug Abuse Act of 1986 imposed mandatory minimum sentences of 5 and 10 years for those convicted of trafficking in 500 grams of crack cocaine or 5,000 grams of powder cocaine. The Anti–Drug Abuse Act of 1988 extended these sentences to anyone involved in a criminal enterprise that handled such quantities, thus bringing in those with minimal active responsibility, such as a friend who lent an apartment for the trafficking. See Sullivan (1988) for a legal assessment of the act.

[13] Cell-years of sentences is the number of sentences multiplied by the average length of expected prison time per sentenced defendant.

fendants continued to receive and serve long prison sentences for drug offenses. Between 1992 and 2000, the number of federal prisoners serving time for drug offenses almost doubled, rising from 35,398 to 63,898 (Pastore and Maguire 2003).

The administration of George W. Bush made changes in both substance and rhetoric. Internationally, much less emphasis was placed on blaming Latin America for the inflow of drugs. Meeting with Mexican President Vicente Fox in February 2001, President Bush said, "The main reason why drugs are shipped through Mexico to the United States is because United States citizens use drugs. And our nation must do a better job of educating our citizenry about the dangers and evils of drug use. Secondly, I believe there is a movement in the country to review all the certification process" (Office of the Press Secretary 2001). As a consequence, an annual fight about certification of the drug control efforts by Mexico, often the source of great indignation there, subsided.

At the same time, the administration increased emphasis on the dangers of marijuana. Between 2001 and 2008, ONDCP published many documents making the case that marijuana was more dangerous than is generally perceived by adults, and certainly more dangerous than it was 20 years earlier, when it had a lower tetrahydrocannabinol (THC) content. Rhetoric emphasized both prevention and treatment, with President Bush making a number of statements about the importance of having an adequate number of treatment slots available; the allocation of the federal drug budget did not, however, shift much to prevention and treatment over that period.[14]

President Obama has personally been silent on the subject of drug policy, though the rhetoric of his administration has distinctly softened;[15] not only does the ONDCP director eschew the "war on drugs"

[14] The statement about the drug budget is deliberately vague since the Bush administration changed the way in which it was calculated. ONDCP dropped categories of expenditures that it viewed as passive rather than proactive. These included the costs of prosecution and incarceration since these were simply a response to investigation and arrest. The result was not simply a smaller budget but one that was less dominated by enforcement. For a criticism, see Walsh (2004). The budget estimation procedure was changed back to its original form in 2012.

[15] The fact that Obama in his autobiography *Dreams from My Father* (1995) admits to having used marijuana regularly at one stage of his youth and to having tried cocaine does not appear to have affected his image as a clean-living adult. However, as was true for President Clinton, it may hamper his ability to push for reforms that would reduce the severity of the regime.

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terminology, he actively promotes more humane approaches to drug problems. The first African American president has not spoken out on the sentencing of drug offenders that has sent so many minority youths to jail or prison. The Obama administration did successfully battle with Congress to reduce the federal crack-cocaine powder sentencing disparity from 100-to-1 to 18-to-1. This is discussed below.

II. Marijuana

Marijuana needs to be separated from other illegal drugs for both substantive and rhetorical reasons.[16] It dominates many statistical series, such as drug arrests, numbers of users, and even dependent users and treatment episodes.[17] It is the only illegal drug whose use is a routine event of growing up in America, as it is in many other Western nations (Room et al. 2010). Simple possession of marijuana has accounted for about half of all drug arrests since the late 1990s.

Marijuana, however, probably contributes less than 5 percent to the numbers incarcerated for drug offenses, almost exclusively in local jails for pretrial detention.[18] The trade also generates little violence within the United States, though that is not true for Mexico.[19] To a larger extent than is true for cocaine and heroin, the harms of the drug under

[16] Prominent critiques of the drug war such as Michelle Alexander's *The New Jim Crow* (2010) or Doris Provine's *Unequal under Law: Race in the War on Drugs* (2007) give little attention to marijuana. In particular, they confound the interpretation of statistics by failing to separate out marijuana arrests from those for other drugs, for which arrestees face high risk of incarceration as a sentence. The same is true for Blumstein and Beck (2005). Tonry in his *Punishing Race* (2011) does separate it out at some points but not consistently.

[17] The number of dependent marijuana users, as estimated in the most recent National Survey on Drug Use and Health (2011), is 4.2 million. The Substance Abuse and Mental Health Services Administration (SAMHSA 2012) reports that according to the 2008 Treatment Episode Data Set, 321,000 of admission episodes are classified as having marijuana as the primary drug of abuse. This is the largest number for any single drug; the figure for cocaine is 213,000 and for heroin is 267,000.

[18] There has been considerable controversy around the extent and cost of incarceration of marijuana offenders. Legalization advocates have estimated the percentage of drug incarceration expenditures going to marijuana as high as 5.5 percent (e.g., Miron 2003, 2010). However, Miron's assumption that marijuana arrestees are as likely as other drug arrestees to end up incarcerated is implausible. For a painfully detailed analysis of California, generating much lower numbers, see Caulkins (2010).

[19] It is always difficult to document a negative, but there is little reference to homicides in the US marijuana trade. What share of Mexico's drug-related homicides can be attributed to marijuana is impossible to determine. It might be substantial, given that marijuana accounts, conservatively, for almost 25 percent of the revenues of Mexican drug-trafficking organizations (Kilmer et al. 2010).

prohibition are probably consequences of the drug itself, not of prohibition. Those harms come primarily from consuming an addicting intoxicant, with no acute deaths except through accidents. It is not clear whether, if legalized, marijuana would be consumed in a safer fashion than smoking or that high potency, prized by users now, would persist. There is indeed growing interest in other components of the drug, particularly CBD (cannabidiol), which has some positive effects that offset the harms of THC (McLaren et al. 2008). The marijuana trade generates substantial illegal earnings, about $30 billion according to the most recent estimates (ONDCP 2012*b*). In terms of the harms caused to US society by marijuana under current policies, it is much less important than cocaine or heroin, possibly even methamphetamine, notwithstanding its large user base, many dependent users, and many arrestees. It has caused great harm to Mexico, as a source of both homicides and corruption (Kleiman and Davenport 2012).

The politics of marijuana are much more contentious than those of the other drugs; it is the only currently illicit drug that might be made legal. Already medical marijuana initiatives have been passed in about one-third of states, generating growing conflict between the federal government and many states (e.g., Onishi 2012). Two states, Colorado and Washington, have recently passed initiatives that make it legal under state law to possess marijuana; they both also provide for a regulated system of production and distribution, the first such systems in modern times. All these activities remain illegal under federal law in those states, and as of this writing 6 months after the passage of the referendums in those two states, it remains unclear what the Department of Justice will do to support or thwart the will of the citizens of those states.

A. Use and Policies

Marijuana first became broadly popular in the 1960s, when it was also a symbol of generational clashes and a prominent weapon in the culture wars. Debate about policy became vigorous enough that President Nixon felt obliged to create a commission, led by former Pennsylvania governor Raymond Shaffer, to assess policy options for marijuana (National Commission on Marihuana and Drug Abuse 1972). The president was chagrined when the commission concluded that the existing prohibition might well be an error. He denounced the report even before it was delivered to him. At the time, this was thought to

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be a brief interruption in the march to sanity (e.g., Bonnie and Whitebread 1974). A dozen states did in fact remove criminal penalties for the possession of small amounts of marijuana during the 1970s.

The prevalence of marijuana use among adolescents continued to rise through the 1970s, and public concern grew.[20] According to the annual Monitoring the Future high school student survey, about one in 10 high school seniors used marijuana daily in 1980 (Johnson, Bachman, and O'Malley 1981). What might be relatively harmless for adults seemed much more dangerous to the young, particularly in a period when many people believed in the "amotivational syndrome."[21] The "parents movement," focused on the problem, emerged.[22] The decriminalization movement came to a sudden halt; until a successful ballot initiative in Massachusetts in 2008, no state decriminalized for 30 years after 1978.

The 1980s saw two surprising changes. First was the plummeting of marijuana use among adolescents: by the end of the decade, the percentage of daily users among high school seniors had fallen by 80 percent; only one in 50 fell into that category by 1990. Second, the number of arrests for marijuana possession fell even faster than the number of past-12-month users so that the probability of arrest, conditional on use in the previous year, declined. A simple explanation for this sharp decline in arrests was that the war on other drugs had now started; cocaine and heroin arrest rates rose sharply as marijuana possession arrests declined. No other explanation appears in the literature.[23]

The standard explanation for the decline in marijuana use is that, as measured in Monitoring the Future, perceptions of its dangers increased (Pacula et al. 2000). However, that merely shifts the mystery;

[20] The annual Gallup Poll (2002) data show that in 1978, 66 percent of Americans said marijuana was a serious problem in high schools or middle schools. Moreover, there was little acceptance of marijuana: 21 percent said that they would welcome increased acceptance of marijuana, while 72 percent said that they would not.

[21] Amotivation syndrome is a psychological condition characterized by lack of desire to participate in social activities, diminished motivation, and apathy (Creason and Goldman 1981).

[22] The parents movement emerged in the late 1970s as a response to the rapid escalation in drug use by children and adolescents. It emphasized educating neighbors and friends about the harms of drugs, working with community groups, and closing stores that sold drug paraphernalia and local crack houses (Lune 2002).

[23] During the 1980s, cigarette use among high school seniors remained constant, while measures of drinking fell.

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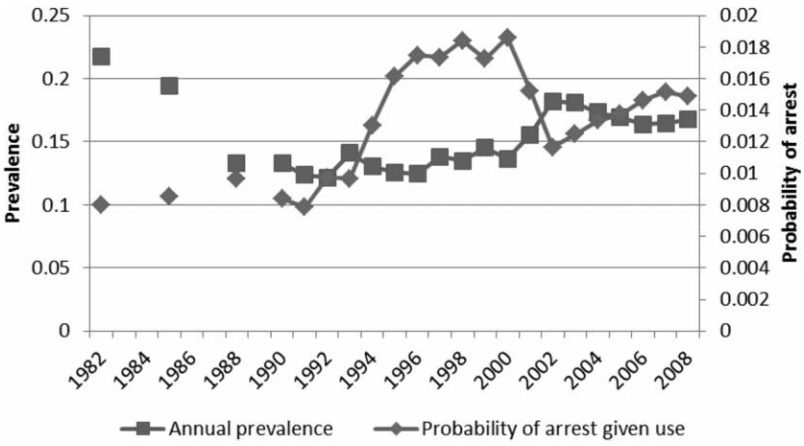

FIG. 1.—Probability of arrest for marijuana possession, conditional on use in past year and prevalence of past-year marijuana use, 1982–2008. Source: Nguyen and Reuter (2012).

why did perceptions of danger increase? Certainly no one claims that the decline was the result of effective prevention programs, which in that period took a particularly weak form, information only or fear tactics (Gottfredson 1997; Howell 2003). The list of possible factors is long and unexamined: economic events (e.g., the deep recession of 1981–83), growing conservatism generally, and the start of effective antismoking campaigns, to name just a few.

The decline in both use and arrests reversed sharply in the 1990s; again arrests and use were positively rather than negatively correlated. Prevalence of use among youths rose nearly one-third. Arrests rose even more rapidly, so that the probability of being arrested conditional on use had more than doubled (fig. 1). The unexpected positive correlation between arrest probabilities and youthful marijuana use is also unexamined.

It is worth noting the negative correlation of marijuana possession arrests with arrests for cocaine and heroin.[24] ~~Whereas in~~ 1991 marijuana arrests bottomed out, arrests for heroin and cocaine (possession and sale) totaled 558,000, compared with a total for marijuana of 327,000. By 2010 the figures had reversed: the heroin and cocaine total

[24] The Uniform Crime Reports combine cocaine and heroin arrests into one category.

had fallen to 371,000 compared with a much higher total of 853,000 for marijuana.

By the late 1970s marijuana use had become normative in the sense that about half of each birth cohort had tried the drug at least once by age 21. Despite all the fluctuations in the rates for high school seniors, that statement continues to be true.

If the increase in the prevalence of marijuana use among youths in the early 1990s is hard to explain, the increase in arrests is downright mysterious. It is perilously hard to find any evidence that the rise in marijuana arrests of the last 20 years is the consequence of strategic policy decisions at the national level. The head of the ONDCP could be relied on in any administration to utter dire warnings about the dangers of marijuana.[25] There were also plenty of warnings about the menace of decriminalization, including some remarkably intemperate words in 2002 when Canada proposed to do what a dozen US states had done in the 1970s and remove penalties for possession of small amounts.[26] However, the Department of Justice as the principal enforcement agency did not elevate marijuana in its priorities; indeed, local prosecutors in border states were unhappy that US Attorneys' offices would generally prosecute marijuana smugglers only if the case involved at least 50 pounds of the drug.[27] Federal arrests for marijuana between 1996 and 2010 increased from 4,249 to 6,320.

Nor was there a rush of announcements of a crackdown on marijuana at the state or local level. New York City Mayor Rudy Giuliani proudly announced a large increase in marijuana arrests in 1998 at the beginning of his second term (Flynn 1998). This, however, seemed to

[25] Barry McCaffery in an interview at CNN in 1997 stated, "The most dangerous drug in America is a 12-year-old smoking pot because they put themselves in this enormous statistical probability of having a compulsive drug problem." John Walters authored an op-ed in the *Washington Post* entitled "The Myth of 'Harmless' Marijuana" (2002) and wrote, "marijuana is far from 'harmless'—it is pernicious. Parents are often unaware that today's marijuana is different from that of a generation ago, with potency levels 10 to 20 times stronger than the marijuana with which they were familiar."

[26] "After Canada introduced its initial marijuana bill in May 2003, Walters, the US Drug Control Policy Director, warned that if the bill passed, the result would be increased security and lengthy delays at the border" (*Detroit News* 2003). He was quoted as saying, "We don't want the border with Canada looking like the US-Mexico border" (*Boston Globe* 2003). "You expect your friends to stop the movement of poison toward your neighbourhood" (http://www.parl.gc.ca/content/LOP/ResearchPublications/prb0433-e.htm).

[27] The argument of state and local officials is that the traffic serves national rather than local markets, and thus the federal government should take responsibility for prosecution as well as for arrests and seizures.

be claiming a victory for a war that had not previously been declared. Perhaps the rise in arrests was a consequence of "quality of life" policing that was a distinctive feature of the New York Policy Department strategy from 1993 onward, but large increases throughout the nation suggested that the source of the increase was something more fundamental than that. That arrests for marijuana distribution and cultivation rose so much less nationally from 1993 to 2010 also suggested that this increase nationally represented something less than a war on marijuana.[28]

There is little research on marijuana enforcement.[29] What empirical research has been done in recent years has mostly been about New York City, where marijuana possession arrest rates have been extraordinary. Before 1993 there had never been more than 2,500 arrests in a year for simple possession of marijuana. By 2000 the figure had reached about 50,000, a level at which it stayed through the next decade (and administration). Jeffrey Fagan, Andrew Golub, Harry Levine, and the late Bruce Johnson have all contributed empirical studies that document the extraordinarily high incidence of marijuana possession arrests in areas with high rates of poverty and proportions of minority residents (e.g., Johnson, Golub, and Dunlap 2006; Golub, Johnson, and Dunlap 2007; Levine and Small 2008). They have also documented practices that effectively mock the intent of the law criminalizing only public display of the drug;[30] this led in early 2012 to the long-term police commissioner, Raymond Kelly, reluctantly authorizing an inquiry into abusive arrest practices. In June 2012 Mayor Michael Bloomberg announced that he was backing legal changes that would decriminalize open possession of marijuana (Kaplan 2012). All this reinforces the sense that marijuana enforcement in New York City is not

[28] From 1991, the low point, to 2010, marijuana possession arrests more than tripled, whereas arrests for cultivation, distribution, and retailing increased by less than 50 percent. In 2010 the number of arrests for marijuana distribution was approximately 100,000, less than one-seventh the number of possession arrests.

[29] This lack of research is perhaps indicative of how lightly the criminological community has taken this drug, despite the ubiquity of its use and the large numbers of arrests in recent years.

[30] New York State has removed criminal penalties for the possession of less than 1 ounce of marijuana; this is subject only to a fine. However, public display of marijuana is an arrestable offense. An officer would ask an individual who had been stopped to empty his or her pockets; though this request can be refused, it rarely is. If the pocket contains marijuana, it is now in public view and an arrest can (and often will) be made (Levine and Siegel 2011).

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about preventing drug use but is primarily another method of public order control, a correlate of the stop and frisk policies that have themselves generated so much anger because of their disparate impact on minority communities.

There are, as so often, few similar studies for other big cities, but the patterns of arrests in terms of race and age are similar across the country. Beckett, in a series of articles on marijuana enforcement in Seattle, has similar findings (e.g., Beckett 2004, 2008; Beckett et al. 2005): marijuana arrests have targeted minorities and youths. Nguyen and Reuter (2012) show that the probability of arrest for marijuana possession, conditional on use, rose much more for the young and for blacks than for other demographic groups. Whereas in 1990 the black arrest rates for marijuana possession were about twice those for whites (219 vs. 108 per 100,000), by 2010 the ratio was 3.5 to 1 (716 vs. 217), even though marijuana use is similar in the two groups, according to population surveys.

The total number of marijuana arrests nationally stopped rising in 2009. This may be related to a decline in the number of police officers, as state and local governments cut payrolls (Copeland 2009).

B. Decriminalization, Medical Marijuana, and Legalization

The issue of criminal penalties for possession of marijuana has been a hardy perennial of debates about the drug. Perhaps, many have argued, production and distribution of marijuana should be kept illegal, but surely criminal penalties for possession are overly severe. That was the argument that drove the reforms in 13 states in the 1970s and was reflected in President Carter's comments on marijuana. However, political attitudes change rapidly. Thirty years ago, with the Reagan administration still relatively new, a National Academy of Sciences (NAS) panel (National Research Council 1982) suggested that the existing policies merited reexamination and that decriminalization should be considered. Even that questioning of the status quo was enough to lead Frank Press, then head of the NAS, to disown the report in his introduction to it. "My own view is that the data available to the Committee were insufficient to justify on scientific or analytical grounds changes in current policies dealing with the use of marijuana" (National Research Council 1982, p. 2). It is almost unheard of for the president of the NAS to write such a letter, let alone require that it be included in the report itself. Moreover, Press insisted that only 300 copies of

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the report be printed. His statement may have simply reflected a concern that the report endangered funding for the NAS, at least with respect to drug policy and perhaps a bit more broadly. In any case, the report, issued near the beginning of the Reagan administration's launch of the war on drugs, attracted attention only briefly, perhaps reflecting the lack of copies in the pre-Internet era.

The removal of criminal penalties for possession of small quantities has turned out to be a less important change in the law than expected. There is no evidence that it has increased prevalence substantially in the United States; that finding appears in studies of similar legal changes in Australia (e.g., Donnelly, Hall, and Christie 1995) and Germany (Pacula et al. 2005).[31] There are many potential explanations for this phenomenon across all these countries, though a few are specific to the United States.

First, many individuals in the United States are poorly informed about the penalties for simple possession of marijuana in their state. MacCoun et al. (2009) find that "citizens in decriminalization states are only about 29 percent more likely to believe the maximum penalty for possessing an ounce of marijuana is a fine or probation rather than jail" (p. 366). Decriminalization states may not have much higher prevalence because so many individuals in those states think that they still face criminal penalties while substantial percentages of those in nondecriminalized states mistakenly believe that they face no criminal penalties.

One reason for being confused about this is that the law itself is confusing. Pacula, Chriqui, and King (2003) found that the standard classification of states into two groups, decriminalization and nondecriminalization, did not reflect the legal realities of states. Some states conventionally classified as having decriminalized marijuana possession had, by 2000, more severe penalties for marijuana offenses than other states that were not classified as decriminalization. Moreover, what had been decriminalized, simple possession, was not what users were typically arrested for; smoking in public was still a criminal offense, as discussed in relation to New York City's huge arrest numbers. Arrest

[31] Australia and Germany are federal countries, like the United States. The states have powers with respect to criminal laws, so it is possible to have variation across states that allows for quasi-experimental analysis. Canada is also a federal country, but the provinces do not have powers to create criminal offenses; only the Canadian Parliament can do that.

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rates did not differ between the two groups of states, whether using the old definition of a decriminalized state or the one developed by Pacula, Chriqui, and King.

Moreover, it was not clear that decriminalization represented much change in the risks faced by marijuana users. Nguyen and Reuter (2012) estimate that the annual probability of arrest for a marijuana user is about one in 50 in recent years, even with the increased total number of arrests. A number of studies suggest that the average user consumes about 100 days per year. That would suggest a one in 5,000 risk of being arrested for lighting up a joint.[32] Moreover other research shows that penalties imposed on those convicted of marijuana possession rarely include incarceration. Reuter, Hirschfield, and Davies (2001) found that in Maryland, not a decriminalization state, not a single individual in a sample of about 1,000 arrestees received a jail or prison sentence for simple possession of marijuana, though about one-third stayed at least overnight in a jail before trial.

Ignorance of the law, confusion about what decriminalization means, and minimal penalties even without decriminalization: it is hardly surprising that decriminalization has affected few individuals' decision as to whether to use marijuana. Yet an enormous amount of political effort has been spent in the political fights over decriminalization.

Attitudes toward marijuana have changed substantially through the last 40 years as can be seen in Gallup Poll data. Figure 2 shows the percentage reporting support for removing penalties for consumption of marijuana from 1969 to 2011, along with changes in lifetime prevalence for high school seniors since 1975, the first year of Monitoring the Future. Since 1985 there has been an almost relentless increase in support for removing penalties, even as rates of use among youths have fluctuated.

What drives this increase in support for legalization? Medical marijuana initiatives may have played a role. The medical initiatives have always been presented by drug warriors as mere stalking horses for

[32] This is admittedly a very crude calculation. The one in 50 figure comes from dividing the total number of arrests by the total number of past-year users. Some users may be arrested more than once in a year; moreover, the vast majority of marijuana use sessions are accounted for by those who use frequently (weekly or more often). In addition, more frequent users may be more covert in their behavior, so that the risk per joint is unevenly spread among users, classified by frequency. If users mostly share joints, then the number of incidents in the denominator may be overstated. None of these qualifications should alter the order of magnitude.

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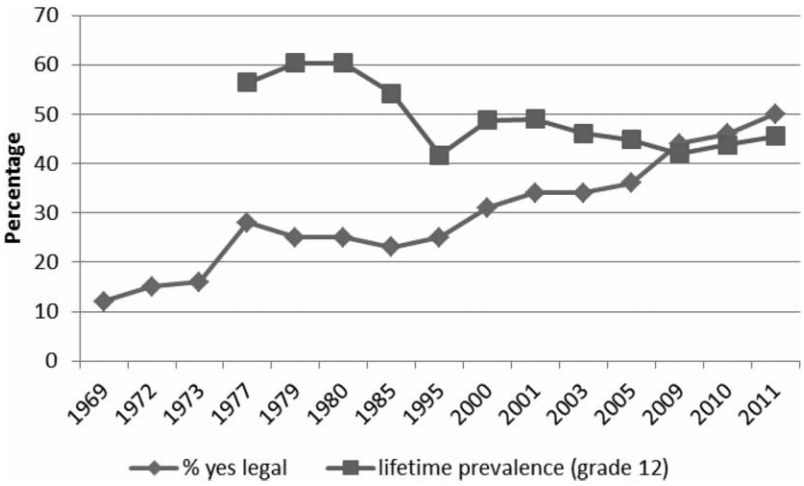

FIG. 2.—Support for making use of marijuana legal and lifetime prevalence, 1969–2011. Source: Gallup (2011) and Johnston et al. (2011).

legalization. They have probably been correct. The groups most aggressively pressing for medical marijuana are drug reform organizations, not patient advocacy groups, such as those representing the interests of AIDS patients. In California, medical marijuana has been implemented so loosely that it provides a legal protection for any user willing to perjure himself by claiming a medical problem for which the drug might be therapeutic; a good description of the anarchy at its worst is Samuels (2008). But other states have tried to create a tight access system, and the number of users with medical authorization in some states is quite small. For example, Vermont, 7 years after allowing the use of marijuana for medical purposes, had only 349 registered patients (Anderson and Rees 2011).

Recent years have seen more radical legislative initiatives. In 2010 a very poorly formulated initiative in California received 46.5 percent of the vote.[33] In 2012 better-constructed initiatives were presented to the

[33] Proposition 19 gave regulatory powers to county and municipal governments, not to the state. The specific formulation might well have triggered a "race to the bottom" for tax rates and regulatory controls. It was particularly troubling in light of the emphasis of the advocates for marijuana legalization generally that legalization might provide substantial revenues to the state.

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voters in Colorado and Washington. Both passed with approximately 55 percent of the ballots cast.

Research on marijuana use and policy has consistently emphasized that the drug is indeed addictive and harmful and also that the effects on the prevalence of use, of criminalization, of possession, and of high arrest rates are slight; for a summary, see Room et al. (2010, chaps. 2–3). The experiences of Dutch coffee shops have been prominent in the American debate. It is generally, though not universally, accepted that these coffee shops have not led to a major increase in use of marijuana or any other drug (MacCoun and Reuter 2001; Korf 2002). That has provided support for the legalization movement, even though the Dutch policy is far from legalization; aggressive enforcement against cultivation and trafficking have kept prices in the Netherlands comparable to those in other European nations (MacCoun 2010) whereas legalization in the United States would substantially reduce marijuana prices.

The federal government has been relentless in its opposition to either medical marijuana or legalization. The rise in potency of marijuana, which has also occurred both in the United States and in many other Western countries (ONDCP 2010*c*; EMCDDA 2012), has given the federal government an additional tool in this campaign. The ONDCP and Drug Enforcement Administration (DEA) websites carry warnings to parents about extrapolating from their own benign experience with the drug because of the increase in potency and that parents should warn their children against experimentation as a consequence.[34] Not only does the federal government emphasize this but also some prominent public figures (e.g., Califano 2009). Whether higher potency has any consequences for either behavior or health is a matter of controversy; users may titrate their dose so as to maintain the same level of THC, but perhaps the titration is imperfect and the THC gets to the brain faster (Chait 1989; Justinova et al. 2005). There is no evidence on the health consequences of different potencies of marijuana.

The medical marijuana initiatives may well have prepared the way for the successful ballot initiatives for legalizing the drug by making the drug less of a fringe and suspect substance; if it is medicine, then

[34] See the DEA (http://www.justice.gov/dea/docs/marijuana_position_2011.pdf) and ONDCP (http://www.whitehouse.gov/ondcp/frequently-asked-questions-and-facts-about-marijuana).

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just how dangerous can it be? Marijuana, like alcohol in the early 1930s and various forms of gambling from about 1970 to 2000, looms as an attractive source of tax revenues for state governments that have been in chronic fiscal trouble since 2008. Why should drug smugglers and retailers make money from what could be, it is claimed, an important source of state taxes?[35] All the usual arguments about the removal of criminal markets have been made and appear to have resonated with the public.

I return to cannabis in the concluding section.

III. Drugs Other than Marijuana

The story is very different for cocaine, heroin, and methamphetamine, the principal drugs of concern; I discuss prescription drug abuse separately in Section V. Each of these three drugs has occupied center stage for a period of time and then retreated from prominence but by no means disappeared. There has been a ritualized demonization of each drug as it appears, in which it is characterized as far worse than any of its predecessors, followed by a lengthening of the maximum sentences specified in federal and many state codes. Over time problematic users are gradually transformed in prevailing stereotypes from violent and predatory youngsters to ailing, disgusting, and pathetic middle-aged street bums. The criminal justice system does not adapt to the change in perceptions but keeps locking them up for increasingly long periods. The policy debate is generally restricted to critiques of sentencing and calls for increased emphasis on prevention and treatment.

A. Drug Policy Objectives

Drug policy is partly a heritage of historical efforts at drug control, but it is also a product of a particular conception of what control efforts should try to accomplish. The stated goals, although widely accepted, are problematic; some of the failures of current policies may be as much the consequence of inadequate or misguided goals as of approaches to achieving them.

At least from 1989, when the first National Drug Control Strategy was submitted to Congress by the George H. W. Bush administration,

[35] For an assessment of the uncertainties of these projections, see Kilmer et al. (2010).

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until 2009 (the first Obama strategy), the principal (and sometimes sole) goal of federal drug policy was to reduce the number of users. "The highest priority of our drug policy," wrote ONDCP director Bennett, "must be a stubborn determination further to reduce the overall level of drug use nationwide—experimental first use, 'casual' use, regular use and addiction alike" (ONDCP 1989, p. 8). In other words, the principal goal was to reduce the percentage of Americans who used drugs, a measure commonly referred to as the prevalence of drug use. Although the National Drug Control Strategy documents produced by the Clinton administration placed less emphasis on reducing overall prevalence and called more attention to the problem of chronic drug abuse, there was, as noted earlier, little identifiable change in policy. The administration of George W. Bush returned to the emphasis on use reduction, particularly among youths. The Obama administration is the first explicitly and decisively to turn to a broader set of objectives, but the consequences are yet to be seen.[36]

Underlying the choice of prevalence indicators is the assumption that policy can indeed influence drug use, that is, that good prevention programs would lower initiation, particularly among youths. A better treatment system, with more addicts entering it, on this reasoning would reduce the extent of use in that population; treatment clients, at least while in treatment, would stop use of illicit drugs. Finally, it is assumed that effective enforcement can raise price, reduce availability, and thus lower the extent of use

Experience, in both the United States and other Western countries, raises questions about all those assumptions. Instead, drug use is driven mostly by broader social economic and cultural factors, as well as by

[36] The *2011 National Drug Control Strategy* (ONDCP 2011*b*, p. 7) lists its objectives as follows:

Goal 1: Curtail illicit drug consumption in America
1a. Decrease the 30-day prevalence of drug use among 12- to 17-year-olds by 15 percent;
1b. Decrease the lifetime prevalence of 8th graders who have used drugs, alcohol, or tobacco by 15 percent;
1c. Decrease the 30-day prevalence of drug use among young adults aged 18–25 by 10 percent;
1d. Reduce the number of chronic drug users by 15 percent.
Goal 2: Improve the public health and public safety of the American people by reducing the consequences of drug abuse
2a. Reduce drug-induced deaths by 15 percent;
2b. Reduce drug-related morbidity by 15 percent;
2c. Reduce the prevalence of drugged driving by 10 percent.

the internal dynamics of epidemics (Caulkins and Reuter 2010). All programs and laws, *within the context of prohibition*, have fairly minor effects on the prevalence of use. The major issue for drug epidemiology is the occurrence of epidemics, short periods of explosive growth in initiation, followed by comparably sharp declines in initiation and, for addictive drugs, slow declines in prevalence.[37] At present, evidence suggests that no practical policy measures can affect whether an epidemic of drug use starts, how severe that epidemic will be, or how rapidly it ends.

The basis for these broad statements can be found in the volume *Drug Policy and the Public Good* (Babor et al. 2010), which attempted to survey what was known about the effects of different kinds of programs. Prevention is focused largely on marijuana, the illegal drug of first use; few evaluations have long enough follow-up periods to detect the effects on use of more serious drugs, which typically comes after school completion. The program evaluations have been quite negative; effects are modest and not robust, particularly to the fidelity of implementation. Certainly there are no robust positive findings of substantial effects on drug use; Caulkins has pointed out that most of the benefits of prevention programs aimed at substance use derive from reductions in alcohol and cigarette use (Caulkins et al. 1999). To make matters worse, school systems systematically choose weak programs.[38] Given the choice between an effective program and a poor program with a nice label, they will choose the nice label. Hallfors and Godette (2002) studied prevention activities in schools in 11 states. The schools were formally required to adopt programs with a strong research base, but mostly they nonetheless adopted other programs; when they did adopt research-based programs, they typically implemented them poorly. Prevention science is improving, but at present drug prevention in

[37] Note again that marijuana is different. The rates of change over time, whether increases or decreases, are much smaller. Use is endemic in the United States and in many other Western nations.

[38] For many years by far the most popular school prevention program was DARE (Drug Abuse Resistance Education). Initiated by the Los Angeles Police Department in the 1970s, it brought uniformed police officers into the school room. Repeated evaluations found that DARE was ineffective (e.g., West and O'Neal 2004), but it remained popular until the program sponsors felt compelled to recognize the weaknesses of their venture and ~~undertook~~ a major redesign. Evaluations of the redesign have been generally negative (e.g., Vincus et al. 2010), but it still remains the most popular drug prevention program in American schools, albeit less popular than in the 1990s (Zilli Sloboda, personal communication).

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schools is more a slogan than an effective program (e.g., Reuter and Timpane 2001).

Research on treatment has shown evidence of effectiveness and indeed even of cost effectiveness; see again Babor et al. (2010, p. 9). The evidence is strongest for opiate substitution treatment (OST), which involves regular provision of drugs such as methadone or buprenorphine, which are themselves opiates but provide lower and more extended psychoactive effects. Research over four decades has consistently, but not always, found that patients in OST use substantially less heroin, commit many fewer crimes, and engage in fewer HIV risk behaviors (e.g., Uchtenhagen et al. 2004).

Despite decades of research efforts, no similar substitute drug has been found for cocaine. The result is that the methods for treating dependence or abuse of cocaine, or indeed any stimulant, are less effective. Some of the methods used are therapeutic communities, contingency management, and self-help groups. For all of them there is some evidence that high-quality treatment can reduce drug use and associated problems somewhat but less substantially and reliably than OST.[39]

What is striking though is that most individuals under treatment continue to use drugs. They use less of them and the use causes less harm to themselves and others. Treatment tends to generate modest reductions in the measured prevalence of drug use. Most of those in treatment are still in fact users of illicit drugs. Switzerland, which set out to provide a large variety of accessible treatment options in the 1990s, was able to drive down the number of active heroin users by 25 percent over the period 1994–2002 (Maag 2003). That might reasonably be seen as an upper bound for what treatment can do to reduce the prevalence of drug use in the medium term.

Least effective from the perspective of prevalence reduction are harm reduction efforts that seek to reduce the damage caused by drug use rather than limit drug use itself. This may help explain why needle exchange was not supported by ONDCP before 2009. The overriding focus on prevalence also helps to explain why marijuana, the most widely used illicit drug, attracts so much attention from drug policy makers, even though its contribution to crime and violence, relative to

[39] For specific treatment modality reviews, see De Leon (2000) for therapeutic communities, Stitzer and Petry (2006) for contingency management, and Gould and Clum (1993) for self-help.

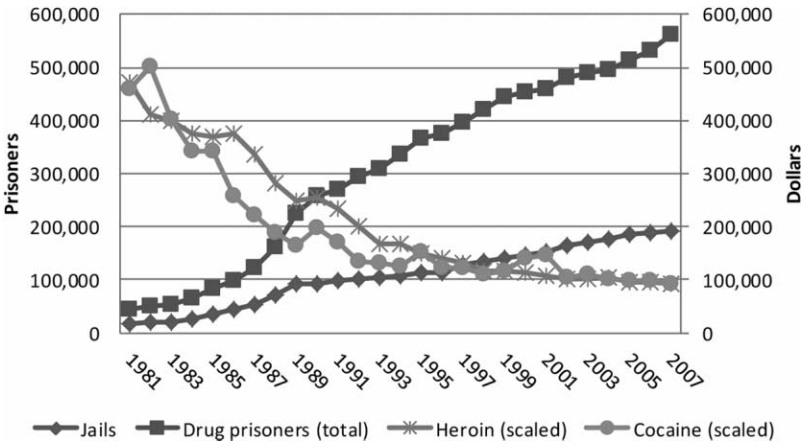

FIG. 3.—Incarceration and cocaine and heroin prices, 1981–2007. Source: For prices, Fries et al. (2008); for incarceration, Caulkins and Chandler (2006).

cocaine and heroin, is minor, as probably is its contribution to mortality and morbidity.[40]

There is very little evidence that enforcement can raise prices or reduce availability, the mechanisms through which it might reduce the prevalence of use. Figure 3 provides the most basic data. Over a nearly 30-year period (1980–2008) the number of persons incarcerated for drug offenses (i.e., for drug distribution, drug manufacturing, or drug use) in local jails and state and federal prisons increased about 10-fold, from about 50,000 to nearly 500,000; that does not include individuals incarcerated for "drug-related" crimes such as robbery to provide money for drug purchases. During that period of massively increased enforcement intensity, the retail prices of heroin and cocaine both fell about 70 percent;[41] it is interesting that price declines have been very parallel, even though the drugs are not good substitutes for each other.

It would be nice to have more sophisticated studies and not just rely on this very descriptive analysis. There is a dearth of studies at a more

[40] Marijuana may be causally related to premature death, e.g., through increased cancer risk or automobile accidents, but neither of these is included in the standard estimates of drug-related deaths, which focus only on those in which an illegal drug is the proximate cause of death.

[41] Incarceration imposes substantial costs on dealers, relative to arrests or convictions. Thus it seems a reasonable proxy for the extent of overall enforcement.

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localized level. Kuziemko and Levitt (2004), using a variety of data sources and statistical modeling, found that during a period in which incarceration for cocaine offenses roughly tripled, the retail price of cocaine was 5–15 percent higher than it would otherwise have been.[42] Prohibition itself may have a profound effect on price, but tougher enforcement may not further increase it. This might reflect, for example, a very elastic supply of drug-selling labor; small increases in price could be enough to bring new players into the market, though there is no direct evidence for that proposition. A variety of other possible theoretical explanations are discussed in Reuter and Caulkins (2011); for none is there compelling evidence that can account for the decline.

If drug policy cannot affect prevalence, what can it do? We do know that bad policy choices can make drug use, drug distribution, and production more harmful. For example, if the police choose to use possession of prohibited syringes as the basis for targeting heroin injectors, they may accelerate the spread of HIV (Stimson 1988; Des Jarlais and Friedman 1992). Crackdowns on retail markets may lead to more youths becoming involved in drug selling; the unintended negative consequences of drug policy are numerous and serious (e.g., Costa 2009; Reuter 2009*b*).

B. International Policy

A feature that distinguishes drug policy from other crime control efforts is the importance of US efforts to suppress production or trafficking in other countries supplying the US market. These efforts are mostly programmatically separate and, more relevant for this essay, have their own political sources and analytic critiques.

For over 40 years the United States has been the principal bulwark of an international drug control regime that has emphasized the role of criminal law (e.g., Bruun, Pan, and Rexed 1975; McAllister 2000; Bewley-Taylor 2012). The original international treaty negotiations culminating in the Hague Convention of 1914 were initiated and dominated by the United States (Musto 1999). In recent decades, the United States has been willing to use a wide array of incentives and

[42] In an unpublished paper, Arkes et al. (2006), using more appropriate data and a model more grounded in economic theory, find no effect on cocaine prices from the increased enforcement over the same time period. The estimates have very large standard errors.

punishments to get its way in the formulation of policy at the annual meeting of the Commission on Narcotic Drugs, the United Nations body responsible for administration of the international treaties. For example, in 2004 the United States threatened to cut off funding for the UN Office on Drug Control if the executive director did not promise to end support for harm reduction programs (Bewley-Taylor 2012, p. 115).

The United States' own bilateral ventures in international drug control have been rhetorically and politically prominent. Relations with Mexico have occasionally been dominated by drug concerns, most prominently after the torture-killing of DEA agent Enrique Camarena in 1986.[43] That event led to the creation of an annual certification report (the International Narcotics Control Strategy Report [INCSR]) under the Foreign Assistance Act. Nations identified as major sources of drugs to the United States were certified as to whether they had cooperated fully with the United States in trying to reduce the flow of these drugs. Those not certified as such were at risk of losing US development assistance, US support for loans from multinational banks such as the Inter-American Development Bank, or both.

Until 2001 the assumption underlying US international drug control policy was that the United States was the victim of other nations' inability or unwillingness to control the production and export of dangerous drugs. The demonstrable corruption of so many of the source country governments gave this assumption a good deal of credibility. Thus the annual certification process involved the world's largest consumer of these drugs deciding who had done an adequate effort to stop the beast from being fed. The Mexican government and press were outraged by the process, but the government was helpless to do much about it (Cottam and Marenin 1999).[44]

Surprisingly, given his generally imperial approach to foreign policy, it was President George W. Bush who publicly conceded the obvious, namely, that suppliers can be replaced, but it was the demand that was

[43] The involvement of government officials in the crime was what generated the strong congressional reaction; see Shannon (1988).

[44] Storrs (1999), presenting arguments on congressional resolutions in support of, or in opposition to, President Clinton certifying Mexico, emphasized the fact that Mexico was, by its own calculations, spending a larger share of its budget on drug control than was the US government. This was emblematic of the reasons for the frustration that Latin American nations felt about the hypocrisy of the certification process.

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essential. As noted earlier, in a meeting with President Fox of Mexico, President Bush said that Mexico would have a drug problem as long as US residents wanted to consume drugs. That transferred the sense of culpability and took the steam out of the certification program, which became even more ritualized than before and was seen in Latin America as no longer of consequence.[45] Secretary of State Hillary Clinton reiterated President Bush's statement in 2009, but by that time, with the extraordinary surge in drug-related homicides in Mexico, it was impossible to avoid the conclusion that the United States had the original responsibility for the problem.

President Felipe Calderon, after a narrow and highly contested victory in the 2006 Mexican presidential election, chose to launch an aggressive attack on the major drug trafficking organizations such as the Sinaloa cartel and the Zetas.[46] That led to a dramatic escalation in drug-related homicides. In the course of President Calderon's 6-year administration, it is estimated that there were approximately 50,000–60,000 homicides, some of a particularly horrific nature.[47] The mass killings and rising national death toll in Mexico became a prominent topic in the US media.

Though international programs have never taken much of the drug control budget, typically less than 5 percent, they have occupied a large share of the public attention to drug policy in the last decade at least. The US invasion of Afghanistan in late 2001 brought home to Americans the difficulties involved in controlling drug production in a developing country. In the early years of NATO occupation, there was much talk of eradicating poppy cultivation in the country that in most years supplied about 85 percent of the world's total heroin production (Schweich 2008; Blanchard 2009). This bravado quickly disappeared as the political economy realities confronted the occupying forces (Caulkins, Kleiman, and Kulick 2010). To take action against an agricultural q1 product that accounted for one-quarter of gross domestic product and

[45] I can offer a small personal indicator of this. Until 2001, I routinely received press inquiries about the year's certification decisions when the INCSR was published around March 1. Since 2002 I have received no calls.

[46] For a history of the Mexican drug-trafficking problem, see Astorga and Shirk (2010). Efforts to explain the response to Calderon's crackdown continue to proliferate. See, e.g., Rios (2012).

[47] There are two sources of uncertainty. First, it is difficult to classify every homicide according to its relationship to drug trafficking. Second, the Mexican government has been secretive in its handling of these data; see Molzahn, Rios, and Shirk (2012).

was critical for the rural sector was to threaten the support of an already fragile government, America's ally in the fight against Al Quaida. By the time that Richard Holbrooke became director of President Obama's Afghanistan policies in 2009, all that remained of control efforts were a few ineffective alternative development schemes. Holbrooke, himself a skeptic on the effectiveness of eradication in Afghanistan, did nothing to expand them.

Plan Colombia, billed as a major drug control effort, has succeeded in some respects.[48] It has helped strengthen the central government, which had lost control of many areas of the country with the emergence of right-wing paramilitary groups on top of the long-standing left-wing Revolutionary Armed Forces of Colombia and the National Liberation Army. As a result of Plan Colombia, guerilla movements dependent on the drug trade became much weaker, and some of the cocaine trade moved back to Peru and Bolivia. The right-wing paramilitary agreed to surrender and was in principle integrated back into Colombian society; however, many of the paramilitary members joined the next generation of drug-trafficking organizations. The effects on flows to the United States appear to have been slight (Walsh 2004).

The critiques of these international programs have taken two forms: their lack of credibility in helping the United States and the damage that they do to the recipient countries. Despite three decades of active involvement in Bolivia, Colombia, and Peru, which account for all global production of cocaine for the illegal market, the volume of production has changed only modestly.[49] The location of production within the Andean region has been responsive to the US efforts. Tough enforcement against trafficking from Peru to Colombia in the mid-1990s helped push production to Colombia. Ten years later Plan Colombia has pushed some production back to Bolivia and Peru.[50] These shifts can hardly be claimed to represent gains for the United States.

The same shifts, and movements of production within an individual country, may, however, have serious consequences for those countries. For example, the environmental damage from coca planting, which

[48] For a micro evaluation of the interventions, focusing on cultivation and production of coca and opium poppies, as well as governmental strength, see Felbab-Brown et al. (2009). For a broader assessment, see Government Accountability Office (2008).

[49] For a recent analysis of the changes over time in production globally for cocaine and heroin, see Reuter and Trautmann (2009).

[50] For a history of the shifts in Andean coca production and the policy interventions, see Friesendorf (2007).

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leaches soil and involves destruction of forest, is exacerbated when coca farmers are forced to plant more in order to replace what is destroyed by manual and aerial eradication. Aerial eradication, using powerful chemicals, is inevitably somewhat inaccurate (wind, poor information about plantings) and causes some damage to innocent neighbors. In addition, the movement to a new location requires corruption of new authorities while leaving behind weakened institutions in the previous cultivation area.

Though the balloon effect, the idea that pushing down on production or trafficking at one location will lead only to its popping up somewhere else, is a well-worn cliché in critiques of international drug policy (e.g., Nadelmann 1989), it is omitted from any government policy documents. Nor do the environmental issues get more than a defensive reference.

IV. The Big Ideas of Drug Policy

Notwithstanding the general stagnation of drug policy in this country, a few important ideas are part of the debate. Many believe that some or all have promise of reducing one or both of America's drug problem and its drug policy problem.

A. Harm Reduction

Needle exchange is the iconic program of the harm reduction movement. Originating in Europe, where the threat of HIV among needle-sharing heroin addicts had become serious, the principle was straightforward. Policy could target the harmfulness of drug use, not just ~~the~~ extent ~~of drug use~~. Given that drug use would occur, the state had an ethical obligation to minimize ~~the~~ adverse effects ~~of that use~~. AIDS, particularly in the early years before retrovirals were available, was horrifying enough that any concerns about making drug use more attractive seemed, at least to officials outside the United States, to be sufficiently remote and incomparably less threatening that resistance was slight. As a prominent report from the Advisory Commission on the Misuse of Drugs in the United Kingdom stated, "the spread of HIV is a greater danger to individual and public health than drug misuse" (1988, p. 17). In Australia, Canada, and most Western European nations, once the connection between HIV and needle sharing was established in the research literature, the government implemented

syringe exchange programs (SEPs) and aggressively promoted them to injecting drug users. Whether as a consequence or not, most of these countries were able to keep HIV rates among injectors (primarily heroin users but also including amphetamine users) to less than 2 percent, whereas in the United States the estimate was that the infection rate reached 18 percent in the 1990s (CDC 2012*a*).[51]

There is considerable empirical backing for claims that needle exchange programs can bring about significant reductions in HIV transmission. Favorable assessments of the evidence have been provided since the 1990s by a variety of expert groups, including Des Jarlais, Friedman, and Ward (1993), the Government Accounting Office (1993), and the Institute of Medicine/NAS (Normand, Vlahov, and Moses 1995). A comparison of 81 US cities estimated a 5.9 percent increase in HIV seroprevalence in 52 cities without needle exchange and a 5.8 percent decrease in 29 cities with needle exchange during the period 1988–93 (Hurley, Jolley, and Kaldor 1997). None of the studies is methodologically strong, and there is a small dissenting literature that claims that needle exchange made little difference in the HIV epidemic (e.g., Amundsen 2006). However, there is no claim that SEPs cause any additional harm.

Yet only 211 needle exchange programs were operating in the United States in 2011 (http://www.amfar.org/uploadedFiles/On_The_Hill/SEPS.pdf). Why? Because prescription laws, paraphernalia laws, and local "drug-free zone" ordinances banned or constrained needle exchange programs in most of the country. Almost half of the existing programs operated illicitly or quasi-legally for many years. Notwithstanding the endorsement of these programs by the Centers for Disease Control (CDC), the NAS, and various leading medical journals and health organizations, drug policy officials in the federal government and most state governments actively opposed needle exchange. Even in late 1997 Congress reaffirmed its hostility to needle exchange by including in the Department of Health and Human Services (DHHS) appropriations bill a total ban on federal funding of needle exchange. This strengthened previous language, which had allowed the secretary of DHHS to fund research on the topic.

In 1998, Secretary Donna Shalala publicly endorsed the scientific

[51] "Since the epidemic began, more than 182,000 injection drug users with an AIDS diagnosis have died" (http://www.cdc.gov/hiv/resources/factsheets/us.htm).

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basis for the claim that needle exchange did not increase drug use; that announcement by the secretary of DHHS was a statutory preliminary to allowing federal funding. However, she announced that the administration had decided that such funding would be unwise. A *Washington Post* story reported that DHHS officials had already arranged a press conference in the belief that President Clinton would support funding needle exchange programs; Secretary Shalala's memo of talking points was reported to say "the evidence is airtight" and "from the beginning of this effort, it has been about science, science, science" (Harris and Goldstein 1998). General McCaffrey (the director of ONDCP) was the key figure in persuading President Clinton that funding SEPs would be a major blow to federal drug control efforts. The president instructed the secretary to change her recommendation.

During the 1998 debate, critics of needle exchange made much of two studies associating participation in needle exchanges with elevated HIV risk in Vancouver (Strathdee et al. 1997) and Montreal (Bruneau et al. 1997). These were just two studies from many that had been conducted in cities throughout the Western world. The authors of the two studies cautioned that this association might reflect features that distinguish these evaluations from others in the literature; for example, they were conducted at the peak of the HIV epidemic, their clients were heavily involved in cocaine injection, and the number of needles dispersed fell well short of the amount needed to prevent needle sharing (Bruneau and Schechter 1998). Later results and analyses (Schechter et al. 1999) indicate that the Vancouver result was spurious; the program simply attracted many of the city's highest-risk users—the young, the homeless, cocaine injectors, and sex trade workers. This is surely a desirable selection effect and brings those results back in line with the empirical literature.

Out of office, in 2002 President Clinton admitted regret that he had not ended the ban on SEPs.[52] The George W. Bush administration hardly discussed the issue, though there were occasional claims that needle exchange encouraged drug use. The National Institute on Drug Abuse, preserving its tradition of apolitical research, in 2002 published

[52] Nor was this the only hand-wringing of President Clinton on drug policy. In December 2000, on his way out of the White House, he also expressed regret that he had not done more to reduce penalties for marijuana use. He chose *Rolling Stone* as the outlet for that revelation, a symbolically important statement by our first baby boomer president, notorious for his line "but I didn't inhale." He also regretted his failure to tackle the 100 to 1 ratio in crack-powder sentencing (Tonry 2011, p. 79).

a research-based guide to preventing HIV in drug-using populations. Concerning needle exchange programs, the guide stated, "Evaluations of these programs indicate that they are an effective part of a comprehensive strategy to reduce the injection drug use-related spread of HIV and other blood-borne infections. In addition they do not encourage the use of illicit drugs" (National Institute on Drug Abuse 2002, p. 18). However, with Republicans in charge of both houses of Congress through most of the period, there was no effective congressional pressure for lifting the ban.

Candidate Obama pledged to reverse the policy but did not push hard for the reversal once in office. Finally, congressional actions led to a lifting of the ban in 2009, signed into law by the president in 2010. It had taken almost 25 years to accomplish this simple policy intervention. Given that the HIV epidemic had largely run its course, the change was more a recognition of the human rights of injecting drug users than an important policy intervention. In 2012, Congress eliminated all federal funding for needle exchange programs, indicative of continued political hostility to this intervention.

The other programs spawned by the harm reduction movement have barely registered in the American drug policy discussions. One is heroin maintenance, whereby heroin addicts who have failed in methadone maintenance programs are provided with their drug at government expense in medically supervised settings. This program has done well in every experimental evaluation; it has substantial benefits for some of the most methadone-resistant and criminally active users. There is no indication that it increases the extent of heroin use. It also has not turned out to be attractive to most heroin addicts; the enrollment in Switzerland is less than 10 percent of the current heroin-dependent population (Reuter 2009*a*). It is now a routine treatment option in Switzerland, the Netherlands, and some parts of Germany (Fischer et al. 2007); other countries are considering it. Drug consumption rooms, again aimed at reducing the risks of injecting drug use, this time by providing supervision and assistance at the time of injecting, have been established in 27 cities in eight countries including Canada, many European countries, and Australia (Dooling and Rachlis 2010). Neither is part of the debate in the United States.

Why has harm reduction fared so poorly here? A simple answer is that it rests on a pragmatic premise that is unacceptable in a nation that still prides itself on its idealism, no matter how soiled the historical

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record. Accepting that something as dangerous as injecting drug use will continue no matter what the government does is to admit limits that the national rhetoric, as in No Child Left Behind, will not permit.

It is also true that the programmatic implications are quite radical. After all, the state is not simply acknowledging that addicts will misbehave; the state is literally supplying them with the means to do so. No doubt there will be nonprofits that hand out the needles, without any sign that the government is helping them, but if the program is to take off, there will need to be government funding.

These are both relatively charitable interpretations of the resistance. A darker view is that the resistance does not pertain to this specific program but to the threat that harm reduction poses to the underpinnings of the drug war. Though there is now a consensus that the term "war on drugs" is inappropriate and misleading, there are clearly many former drug warriors who cling to the basic ideas that fueled the war. Harm reduction programs give the drug user a sympathetic face, undermining the fundamental message that "nicotine shortens life; cocaine debases it" (Wilson 1990).

The public health research community became substantially involved in drug policy debates through the fight over needle exchange, which it strongly supported. Prior to that there were small communities of researchers specialized in epidemiology, prevention, and treatment, but the emergence of AIDS as a major health problem in America brought attention to the draconian and inflexible nature of US drug policy. The public health community has, however, not taken up the issue of how to reduce the number of incarcerated drug users, though that is easily represented as a public health issue.

B. Drug Addiction as a Brain Disease

q2 Alan Leshner, director of the National Institute on Drug Abuse (NIDA) from 1993 to 2002, was the first senior official to make this a key insight for policy purposes: "A core concept that has been evolving with scientific advances over the past decade is that drug addiction is a brain disease that develops over time as a result of the initially voluntary behavior of using drugs. The consequence is virtually uncontrollable compulsive drug craving, seeking, and use that interferes with, if not destroys, an individual's functioning in the family and in society. This medical condition demands formal treatment" (Leshner 2001). While the idea is compelling and the evidence from computer axial

tomography and similar scans to back it up is vivid and persuasive, there is a vast amount of direct evidence that contradicts it; there has been a good deal of skepticism about its general validity (e.g., Satel and Goodwin 2003). Most dependent users of drugs, legal or illegal, quit without any formal treatment (Babor et al. 2010). Recent experiments in the criminal justice system in which incentives (frequent drug testing accompanied by immediate and modest sanctions for failure) have been enough to induce abstinence in populations with long histories of dependent use (Hawken and Kleiman 2009) also provide a challenge to the idea for many problem users. There may well be an important subgroup of addicted users for whom the brain disease model is valid, at least for specific drugs, and the large NIDA research program on these matters will probably eventually yield a qualified version of the statement that has a good empirical base.

Whatever its scientific merit, the idea appears now to provide an important platform for policy reform efforts, within the context of drug prohibition. In an increasingly therapeutically oriented society, this is a credible basis for sending criminally active addicts to treatment rather than to the criminal justice system. Enunciated first during the Bush administration, it has become a standard part of the rhetoric of Obama administration officials. For example, in releasing the 2012 National Drug Control Strategy (ONDCP 2012*a*), which emphasized shifts away from enforcement, ONDCP director Kerlikowske in a statement to the press said, "My colleagues—police and others—simply put often say that we can't arrest our way out of the drug problem. . . . Current thinking by health experts views drug addiction as a disease of the brain that can be prevented and treated." What is particularly striking about this emphasis on the brain disease model is the lack of new treatment methods that reflect the new neurological insights. The major treatment innovations of recent years are screening, brief intervention, and referral to treatment and cognitive behavioral therapy, which may refer to the brain disease concept but are certainly not dependent on it.[53] For patients it may be changes in the organizing and financing of treatment that have made the most difference in recent years.

[53] One reviewer of a draft of this essay noted that this model of addiction can also appeal to drug hawks. If adolescent use, whether from curiosity or peer pressure, has the power to throw a switch, leading to an irreversible, lifetime, relapsing condition, so much more important is it to have a zero tolerance policy.

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C. Legalization

Hanging over all discussions of drug policy is the widespread belief among intellectuals that until these drugs are made legal, there cannot be sensible policies; we should regulate rather than prohibit. Having written extensively on the possible consequences (MacCoun and Reuter 2001, 2011), I here confine myself to how the idea has affected the policy debate.

The arguments for legalization are compelling. Almost all the costs associated with prohibited drugs in contemporary society (overdoses, blood-borne viruses, corruption, violence, and property crime) are a consequence of prohibition and its enforcement rather than the drugs themselves. Thus the elimination of prohibitions would greatly reduce these problems.

The difficult question is how much use and addiction would increase if drugs were legal and regulated. In *Drug War Heresies*, MacCoun and I argued that it is impossible to project even roughly how much prevalence of use or dependence would increase. Heroin addiction might increase only 50 percent or it might increase by as much as 500 percent; there is no compelling evidence that would allow one to choose a particular figure. Further, it is also impossible to know how to weigh the increased addiction against the gains in terms of reduced crime, disease, and so forth. Economists believe that crime and addiction itself can all be given dollar values; such calculations are more convincing to economists themselves than to others and in any case ignore the much subtler but comparably important factors such as the intrusiveness of the state or the apparently unavoidable racial disparities in sentencing. Finally, the change would have different consequences for specific population groups; some might benefit greatly (urban minority communities) while large groups would be somewhat worse off (perhaps the suburban middle class). MacCoun and I concluded that whether the United States would benefit from legalization would be difficult to show and that this inability to make more than a theoretical case was a major handicap.

The American population does not need such sophisticated arguments. Except concerning marijuana, support for drug legalization has been minimal; the Gallup Poll in 2010 found fewer than 10 percent of respondents favoring legalization of any of cocaine, ecstasy, heroin, or methamphetamine. This number has scarcely budged over the years.

Yet the voices of legalization advocates are very much heard by policy

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officials. Successive directors of ONDCP have devoted considerable time to rubbishing the arguments of legalizers. For example, the 2012 ONDCP website, in addition to a number of documents critiquing the legalization of marijuana, includes a two-page refutation of a study issued by the Cato Institute on decriminalization of drug use in Portugal (Greenwald 2009). Though decriminalization is far from legalization, the ONDCP (2010*b*) critique keeps referring to the weakness of the Cato study as evidence of the weakness of legalization arguments. One almost comes to suspect that officials are troubled by the very plausibility of the argument, that one day there will be enough dissatisfaction with the current system and its continuing failure for radical alternatives to be taken seriously.

Indeed that has, in a way, happened. The presidents of Colombia, Guatemala, and Mexico, all ~~of~~ which have been severely harmed by drug-related violence fueled by the American drug market, have said that it is worth considering the legalization of drugs in their countries (Calmes 2012). They are less sure that drugs should be legalized than that the current situation is intolerable. For these countries, as well as for El Salvador and Honduras, drug-related violence has been the leading social problem of the last few years. It is hard to see any credible basis for optimism that US interventions are likely to help them substantially. President Obama tried to fend them off in the Summit of the Americas discussion in Cartagena in April 2012 but had at least to concede that the Organization of American States should be authorized to do a study of drug policy options for the region.[54]

The fear of legalization has probably made resistance to sensible reforms of US policies more difficult. Any softening of the system can be presented as a move along the path to the unacceptable, namely, availability of cocaine and other drugs comparable to current availability of alcohol.

D. Drug Courts

In a "drug court" a judge effectively acts as a probation officer, monitoring the behavior of a drug-involved offender who has pled guilty to a specific offense and receives a nonincarcerative sentence in return for entering a rehabilitation program, getting a job, and so forth.[55]

[54] Full disclosure: I am a coauthor of one draft chapter of this study.

[55] This section draws heavily on collaborative work with Harold Pollack and Eric Sevigny (Sevigny, Pollack, and Reuter 2013).

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Drug courts emerged and proliferated because they had broad appeal across the range of stakeholders concerned with drug policy. Originated during the crack epidemic when the population of drug-involved offenders was expanding rapidly, they offered some promise to judges and policy makers as a strategy to conserve prison and jail bed space while retaining close monitoring of criminal offenders (Fluellen and Trone 2000). Implemented at the local level, drug courts vary greatly in their specific strategies, effectiveness, and populations served. The National Association of Drug Court Professionals has identified 10 core principles of effective drug court implementation, but the fidelity of the adhesion to these principles is unknown (King and Pasquarella 2009).

Drug courts hold considerable appeal to the treatment and public health communities because they offer the possibility of closer coordination between the criminal justice system and the treatment providers who serve the same offending populations. Finally, drug courts held considerable appeal to the defense bar and to advocates of less punitive drug policies who wished to support credible alternatives to incarceration. ONDCP identifies drug courts as a "smart approach to criminal justice" (ONDCP 2010*a*).

Drug court research conducted over the past two decades indicates that, on average, these programs are more effective than conventional correctional options at reducing the drug use and criminal activity of drug-involved offenders (e.g., Belenko 2001; Mitchell et al. 2012). The National Institute of Justice–sponsored Multi-site Adult Drug Court Evaluation, for example, found that drug court participants relapsed significantly less often and that those who did relapse reported significantly fewer days of drug consumption than a comparison group of offenders at the 18-month follow-up (Rossman et al. 2011). Likewise, meta-analyses confirm that drug courts reduce recidivism rates by 8–14 percent over other criminal justice interventions (e.g., Wilson, Mitchell, and MacKenzie 2006; Drake, Aos, and Miller 2009).

While drug courts may effectively reduce drug use and recidivism for individual offenders, there has been considerable debate over the ability of drug courts to reduce aggregate prison and jail populations, that is, to serve as an effective alternative to incarceration at the population level (Fluellen and Trone 2000; Drug Policy Alliance 2011). Some observers credit drug courts with helping to "bend the curve" of incarceration downward (Huddleston and Marlowe 2011, p. 16). Oth-

ers suggest that drug courts and similar programs have a "low ceiling of possible impact on correctional populations" (Clear and Schrantz 2011, p. 14). Still others claim that drug courts "may ultimately serve not as an alternative but as an *adjunct* to incarceration" (Drug Policy Alliance 2011, p. 14; italics in original).

Even though the drug court movement is almost 20 years old and over 2,300 separate programs have been created (Bureau of Justice Assistance Drug Court Clearinghouse Project 2009), a 2008 study estimated that only 55,000 drug-involved defendants were processed in such courts around 2005. The same study estimated that over 1 million drug-abusing or dependent defendants entered the criminal justice system each year (Bhati, Roman, and Chalfin 2008).

Sevigny, Pollack, and Reuter (2013) show that many drug-involved offenders are precluded from participation in drug courts because of overriding sentencing laws, including sentencing guidelines, mandatory minimums, habitual offender laws, and other sentence enhancements. Eligibility rules also are often very tight. For example, most drug courts do not accept offenders with convictions for violent offenses, even if the conviction is long past. The result is that few of those who have been heavy users of cocaine and heroin over many years, a group that accounts for most cocaine and heroin users by now, can become drug court clients. Drug court advocates can reasonably be accused of cream skimming, avoiding clients at high risk of failure. While understandable as a strategy for a new program, it limits the value of the innovation.

As a consequence, it is unlikely that drug courts will have much impact on the number of drug users incarcerated. Prison and jail populations have grown rapidly through 2005, but they have aged at least since about 1990. Some of that aging is accounted for by inmates dependent on cocaine, heroin, or methamphetamine, many incarcerated for nondrug offenses (Pollack, Sevigny, and Reuter 2011). Unless drug courts are restructured to serve riskier clients, they will not have much impact on the number of drug users in American prisons and jails.[56]

[56] The federal courts have begun to experiment with drug courts for minor drug offenders facing long sentences, typically because they were caught in operations involving large quantities of drugs. According to the *New York Times*, as of March 2013, these efforts involved just 400 offenders nationwide (Secret 2013).

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V. The Future

The drug problem changes in unforeseen ways with occasional epidemics that are unpredictable in their occurrence and magnitude. In this section, I describe first the emergence in the last decade of a new kind of drug problem, the use of diverted prescription drugs. Prescription drugs constitute a significant and disturbing public health problem; the appropriate policy response is almost certainly different from that for the wholly illegal drugs ~~I have considered~~ so far. I then consider the ever-present fear of new drugs, so called "legal highs," the expectation that some new psychoactive substance developed by "backyard chemists" will become a major new drug problem. It turns out surprisingly to be a very modest problem to date, but it is hard to understand why and ~~it~~ cannot be dismissed as a future threat.

A. Prescription Drug Misuse

Over the last decade there has been an important change in patterns of drug abuse in the United States and Canada (Babor et al. 2010).[57] Misuse of prescription drugs collectively has become more prevalent than any illegal drug except marijuana. For example, Monitoring the Future, the survey of high school seniors, reported that in 2011 the percentage of twelfth graders who had used a prescription drug in the previous 12 months was 21.7 percent, exceeded only by marijuana at 45.5 percent (Johnston et al. 2012). The drugs involved include opioid analgesics (e.g., hydrocodone and fentanyl) and benzodiazepines.

It is not just the use of these drugs that has increased; so have the harmful consequences. The CDC (2010) reports that emergency room visits "for nonmedical use of opioid analgesics increased 111 percent during 2004–2008 (from 144,600 to 305,900 visits), and increased 29 percent during 2007–2008" (p. 705). Further, deaths from poisonings from opiate pain killers alone now exceed the number of deaths from heroin and cocaine combined (as shown in fig. 4; CDC 2010). Interestingly, since 2002, more than twice as many people have died from methadone poisoning as from heroin poisoning (CDC 2012*b*). In some states deaths from prescription overdoses exceed automobile fatalities.

Part of the reason for the increase in use and harm is that more people are being prescribed these substances. For example, methadone

[57] This subsection draws on work done collaboratively with Jonathan Caulkins, Beau Kilmer, and Rosalie Pacula. See Kilmer et al. (2012).

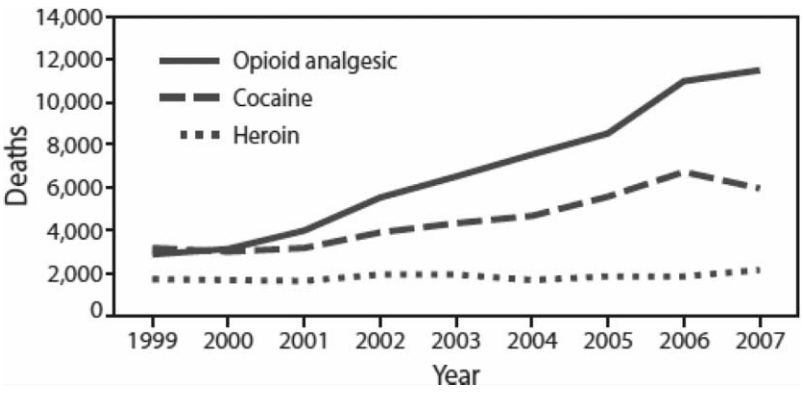

FIG. 4.—Unintentional drug overdose deaths involving opioid analgesics, cocaine, and heroin, United States, 1999–2007. Source: Reproduced from CDC (2012*b*).

is increasingly prescribed as a painkiller as well as a substitute for heroin; in 2009, more than 4 million methadone prescriptions were written for pain even though the US Food and Drug Administration published warnings about the risks associated with methadone (Fareed et al. 2010). All these drugs are dangerous, even for the patient for whom they are prescribed. Some of the increase in deaths may then just represent the rise in total prescriptions. Compton and Volkow (2006) show that there is a close correlation for some major prescription drugs between the number of doses marketed and the number of emergency room cases.

Not much is known about how these prescription drugs reach the final users. A recent article by Coleman (2012) suggests that there is substantial leakage from the wholesale distribution system. Three corporations account for 90 percent of the distribution business, that is, the transfer from manufacturers to retailers such as CVS and Walgreens.[58] These firms are subject to extensive regulation and monitoring by the DEA. Occasionally they have been detected selling the drugs to retailers whose practices make clear that they do little to prevent leakage into nonprescribed use. For example, in 2008, Cardinal Health was fined $34 million for selling 8 million dosage units of hydrocodone to pharmacies that were suspected of facilitating nonprescribed use.

[58] The three corporations are McKesson, Cardinal Health, and AmerisourceBergen.

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One of the minor distributors, KeySource Medical, reached a settlement with the DEA after the agency alleged that the company had filled suspicious orders for 48 million dosage units of oxycodone products.

Doctor shopping is a common practice, as publicized in a lengthy, front-page *New York Times* story (Schwarz 2013). An individual visits multiple doctors and obtains multiple prescriptions for the same ostensible problem. In an era when doctors are under time pressures, diagnoses of psychiatric problems are often casual, so that a student who wants prescriptions of Adderall, initially to improve concentration, will be able to obtain many, both for himself and for friends, through either gifts or purchases.

In addition to leakage from the distribution system, survey data indicate that many users acquire the drugs in other ways, including thefts from the family medicine cabinet, websites (domestic and international), and friends—all difficult outlets to control. The websites seem particularly unpromising as a policing target (Jena et al. 2011). A 2007 survey of 581 online pharmacies found that only two were registered with the appropriate national association and that none of the rest made a serious effort to establish the legitimacy of the claimed need (Jena et al. 2011). Given the ease with which websites can change their identities, federal legislation does not seem likely to make much difference.

Prescription drug misuse has not so far been associated much with illegal markets and violence. According to the 2011 National Survey on Drug Use and Health, 71 percent of those reporting nonprescribed use of a prescription drug gave the source as a gift, theft, or purchase from a friend. Only 3.9 percent acquired the drug from a dealer or stranger. Rogue pain clinics have received serious attention from law enforcement agencies, but they operate in a very different fashion than street drug markets. Davis and Johnson (2008) found that prescribed opiates are used by about one-third of street drug users in New York and are sold by a similar fraction of drug sellers.

These drugs have not as yet generated much treatment demand. The share of admissions for opiates other than heroin (most of which are prescription drugs such as Oxycontin and codeine) rose from 1.6 percent to 8.6 percent between 2000 and 2010; the share of admissions involving other prescription drugs (tranquilizers, sedatives, etc.) rose only from 1.7 percent to 2.4 percent (SAMHSA 2012). This relatively

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modest flow into the treatment system, compared with marijuana-related admissions, could be explained by many factors, including (1) the relative recency of most initiates, since entry admission typically comes after some years of use; and (2) the low risk of arrest for possession or use, since arrest often motivates treatment seeking. Too little is yet known about the characteristics of the population using these drugs and their careers of use to make confident predictions about whether they will become an important source of treatment demand.

Thus, the methods for reducing the prescription drug problem will likely be different from those traditionally used when targeting wholly illegal drugs. For example, many states have developed online systems for recording prescriptions so as to detect patients who visit multiple doctors in order to acquire large and perhaps marketable quantities of abusable drugs (ONDCP 2011*a*). Because these drugs are primarily produced and distributed through legally regulated entities, there is the possibility of at least partly effective suppression without much enforcement against street markets, which generate so much of the incarceration and violence around distribution of the illegally produced drugs. Websites may be difficult to suppress, but as of 2011 less than 0.5 percent of users reported acquiring the drug through the Internet. The policy and political challenges for dealing with prescription drugs will be distinct.

B. "Legal Highs"

There has long been a concern about the development of new psychoactive substances, not covered by the existing system of drug-specific regulations and prohibitions.[59] Two recent prominent examples are mephedrone and Spice. Many, but not all, of these substances are the creation of entrepreneurial chemists operating clandestinely. Some are natural substances, for which new and more dangerous modes of ingestion have been developed or whose intoxicating properties have not previously been understood. Yet others are legally manufactured substances for which new uses as intoxicants have been found. Some examples include bath salts, poppers, and Salvia. A wide range of terms have been used to describe such substances, including legal highs, synthetics, research chemicals, designer drugs, and party drugs, all of which are within the scope of this brief subsection.

[59] This subsection draws on Reuter (2011).

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The problem is not an entirely new one. Late twentieth-century chemistry was advanced enough to produce a rapid flow of new psychoactive drugs that found their niches in recreational markets (e.g., ketamine and GHB). Alexander Shulgin, a prominent chemist in the development of new psychedelics in the United States, notes that there were only two such substances in 1900 (marijuana and mescalin, both naturally occurring), 20 by 1950, and over 200 by 2000 (quoted in Kau 2008, pp. 1079–80). Governments throughout the Western world struggled throughout the twentieth century with how to respond to these new entities whose effects were poorly understood, generally choosing to prohibit them for precautionary reasons. The number of drugs on the list banned by international conventions has risen sharply, very much as Shulgin sketched for psychedelics. When the Single Convention passed in 1961, there were 85 prohibited drugs; by 1995 there were 282 (Babor et al. 2010).

What is striking is how narrow or ephemeral are the niches that these new drugs have so far occupied in the recreational market. Even LSD, perhaps the most venerable of them, has almost disappeared in the United States, after 40 years, following a major enforcement success in the year 2000 (Grimm 2009).[60] Others simply lose popularity, either because that particular experience is unattractive to a new generation or because of fears about adverse effects, usually reflecting the experiences of recreational users rather than government announcements.[61]

Consider, for example, a very recent scare over some synthetic cathinones often marketed as "bath salts." These have been associated with some horrifying incidents (e.g., Kasic, McKnight, and Kilsovic 2011) and have attracted headlines in the media, including the *New York Times* (Goodnough and Zezima 2011). In early 2011 the director of the NIDA warned about the rising tide (pun intended) of bath salts; she noted that the number of emergency department admissions related to these drugs in the first 2 months of 2011 exceeded the total number for 2010 (Volkow 2011).

[60] In 1999, 8.1 percent of high school seniors reported use of LSD in the previous month; that figure was 1.6 percent in 2009 (http://monitoringthefuture.org/data/09data/pr09t2.pdf).

[61] For example, in 1996, 4 percent of US high school students reported use of PCP (phencyclidine) in the previous 12 months. That figure fell steadily over the next 13 years; by 2009 it had fallen by almost 60 percent to just 1.7 percent. There have been no claims of enforcement success involving this particular drug.

These are dangerous drugs, and they provide only a moderately interesting experience; that can be seen in reports from users (Measham, Moore, and Newcombe 2010). By late 2012 the tide had mostly receded. The Monitoring the Future research group, in releasing its results for 2012, headlined that "use of bath salts is very low." It noted also that the number of calls to poison centers in the last 6 months of 2012 had fallen by half compared to the previous year.

It is puzzling that the wonders of modern chemistry have not yet turned up substances that can outcompete the long-standing sources of illicit altered states. One conjecture is that this is already occurring but through a different channel, namely, the misuse of prescription drugs. However, the prescription drugs that are causing the most problems are themselves remarkably close to substances that have long been used, in particular to heroin and morphine. It would be foolish to exclude the possibility that an entirely new drug might appear on the black market that provides a distinctive and attractive experience without posing too much risk to the user.

VI. The Resistance to Change

It is difficult to write about drug policy in the United States without becoming convinced that much of what is done in the name of reducing human suffering from drug addiction and its consequences is misguided and causes more harm than it alleviates, and also being convinced that the prospects of change continue to be slight. The nation's drug problem, at least if one restricts it to the wholly illegal as opposed to the relatively new and different phenomenon of misuse of prescription drugs, is falling. The populations dependent on cocaine, heroin, and methamphetamine are declining and aging; relatively few of those who experiment with these drugs go on to become dependent users, even though prices have fallen substantially. There is not much change in the numbers of related deaths and emergency department admissions, but this flatness may reflect (1) the aging of the dependent user populations; for example, longer exposure to adulterated heroin with dirty needles may increase vulnerability to fatal overdoses since it so negatively affects the user's health; and (2) the increasing number of heroin addicts released from prison each year.[62] One might have ex-

[62] Another source of overdose deaths is reduced tolerance, as may occur following release from prison. A small number of studies have found that heroin addicts have

pected that the lower profile of drug problems would lead to a willingness to relax the ferocious grasp of the system that has been created. Alexander in *The New Jim Crow* (2010) makes a powerful case that the war on drugs has transformed the lives of African Americans in cities. There is growing consciousness of racial disparities. That has not been enough to trigger much reform.

Marijuana is a major exception to this statement. Two states have legalized the drug as a result of a ballot initiative; that is to say, they have eliminated all penalties under state law. The federal government has still not stated its position beyond a broad statement from President Obama that the federal government has better things to do with its resources than chase marijuana users (Dwyer 2012). The federal government has many tools to block a legal production and distribution system at the state level. Even if it never arrests another user, the Department of Justice can make it essentially impossible to sell the drug legally in Colorado and Washington. Indeed the department has turned out to be persistent and quite ingenious in its efforts to complicate the task of anything approaching legal production or distribution of medical marijuana in California, for example, threatening to seize property that a landlord has rented to a marijuana distributor (Eckholm 2011). The result of the Colorado and Washington initiatives may be a long and tangled series of court battles between state and federal authorities.

The explosion of drug-related violence in Mexico since 2006 may change American attitudes toward the drug problem. Colombia, Mexico, and Central America are now seen as victims of America's drug habit rather than as villains that profit from it. Optimistically, this will generate a reexamination of whether current policies that cause so much harm to other nations can be defended.

There is indeed one important change in process. The Affordable Care Act (ACA) provides access to treatment services for an important population of drug addicts who previously had no or very limited access. The individual exchanges that will provide insurance for many poor people are required to offer mental health services equivalent to what they offer for physical ailments (Buck 2011). Mental health services explicitly include substance abuse treatment. So males aged 18–

high rates of death following release from prison; this probably reflects their failure to realize that their tolerance has fallen as a result of a long period of abstinence (Merrell et al. 2010).

64 without dependent children will, for the first time, be able to enter into drug treatment without being reliant on specific grant programs such as the Substance Abuse and Mental Health Block Grant, the size of which has varied from year to year and has never been large enough to provide decent quality services to all those who sought them.

There are important ACA details to be worked out. For example, reimbursement rates in these exchange insurance programs and in related Medicaid programs may be set too low for many providers; access may be limited on the supply side. It may turn out that few of those needing treatment will seek it. Many treatment facilities are poorly designed to participate in Medicaid as well; for example, they may lack required information technology systems or medical staff. Nonetheless, the ACA offers the prospect for major improvement for low-income male addicts who constitute a large part of the US drug problem.

A. Sentencing Reforms

More broadly, the forces of reform seem weak. The future expansion of treatment finance is a consequence of fundamental changes in health policy rather than a deliberate drug policy decision. The likely future is at best modest change in drug policy.

The severity of sentencing for drug offenses is at the heart of the liberal critique of current drug policy. Though there seems to be considerable agreement that a less harsh sentencing regime is needed, it has proven exceptionally difficult to accomplish any meaningful change. This can be illustrated by consideration of the efforts to roll back two widely acknowledged excesses: the discrepancy between federal court sentences for crack cocaine and powder cocaine and the Rockefeller drug laws in New York State that imposed heavy sentences on minor drug offenders.

Federal Crack-Powder Disparity. Powder cocaine can be transformed into crack through a simple chemical process. In 1986 as part of the Anti–Drug Abuse Act, Congress specified a relationship between the penalties for crack and powder cocaine; for distributing 5 grams of crack the maximum sentence was 5 years, the same sentence that would be given for the distribution of 500 grams of powder. This represented the prevailing belief that crack was a much more dangerous drug than powder.

On its face, even if it were a mistake, it would be of only modest significance; some offenders would receive longer sentences than they

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should, which is known to happen anyway. What made this so significant was its racially disparate impact. In the federal system, an extraordinarily high percentage of those sentenced for crack offenses are African American: 79 percent in 2009 compared to 28 percent for cocaine powder offenses (US Sentencing Commission 2009, table 34). Moreover, this disparity was entirely predictable at time of passage in 1986, a point emphasized by Michael Tonry in his 1995 *Malign Neglect*.

Over time it became clear that crack, though indeed more harmful than cocaine powder, was certainly not 100 times worse (Hatsukami and Fishman 1996). It was impossible to justify the continued difference. Even the US Sentencing Commission, which has rarely pushed for reductions in mandatory minimum sentences, weighed in for a reduction in the crack penalties and the disparities. In 1996 Attorney General Janet Reno and the prominent head of ONDCP, Barry McCaffrey, also pushed for reductions in crack sentences. All to no avail. Congress was uninterested.

Only in 2010 did Congress finally agree to changes in sentencing rules, with the passage of the Fair Sentencing Act. The minimum amount of crack powder for a felony was raised from 5 grams to 28 grams (an ounce), so that the disparity between powder and crack cocaine was reduced to 18 to 1. Certainly that lowered the facial inequity of federal sentencing and should lead to fewer African Americans in federal prison at any one time as the result of convictions for crack offenses. It was far from the level appropriate to the harms of the substance. Moreover, the change was accomplished only after extensive and acrimonious hearings.

Indicative of how reluctant Congress was to make this change, it was done on a voice vote; no member of the House had to be on record declaring less vigor in his opposition to drugs. The battle then shifted to the question of retroactive application of the rule. Many members of Congress were opposed to allowing those sentenced under the old law from benefiting and having their sentences reduced. The Supreme Court ruled in favor of allowing that benefit (*Dorsey v. the United States*, US Court of Appeals for the Seventh Circuit, 11-5683 [2012]).

What is so striking is the depth of the opposition to a change in an indefensible law.

The Rockefeller Laws. In 1973, on the urging of Governor Nelson Rockefeller, who was responding to the sharp increase in heroin addiction, the New York State Legislature enacted draconian penalties

for minor drug offenses. For example, possession of 4 ounces of heroin was subject to a mandatory sentence of 15 years to life. Weiman and Weiss (2009) found that there was little change in prison populations initially as prosecutors, who had opposed the rigidity of these laws, shifted their charging practices. Eventually, however, these provisions contributed to a dramatic rise in the New York State prison population, from 10,000 in 1975 to 70,000 in 2003, with nearly 20,000 of the 2003 prisoners being held for drug offenses (Mancuso 2010).

Despite decades of protest by a broad spectrum of law enforcement officials, including Chief Justice Judith Kaye of the state's highest court, in addition to the usual advocacy groups, the laws survived unchanged to 2005. Governor George Pataki, who was elected in 1994 with a promise of reforming these laws, was able to make only very modest changes, and those in 2005 near the end of his 12 years in office. For example, the new laws still required a sentence of incarceration for first-time offenders in possession of small amounts of cocaine or heroin (Mancuso 2010).

Only in 2009 were substantial changes made, and even those left behind a harsh set of penalties. For example, sentences for second-time B-class felony offenders were lowered only from 2 years to 1.5 years. Penalties for sales to an individual under age 17 were actually raised; determinate sentences went from 1 year to 2 years, with probation being increased to 25 years rather than 5 (Mancuso 2010).

Lofgren (2011) argues that the principal argument for the reforms in 2009 was the changed view of the addict. The 2009 reforms were focused on offenders who had a substance abuse problem; other offenders were in principle still subject to severe penalties.

As with the fight over federal sentencing disparities for crack and powder cocaine, a great deal of effort was expended on accomplishing modest changes. Those changes were certainly worthwhile, but they point to the difficulty of disassembling the machinery of excessive punishment that was created during specific drug scares, 1970s heroin in the case of the Rockefeller laws and the mid-1980s crack epidemic in the case of the federal laws.

B. Why?

The title of this essay promised more than a discussion of the past. It also promised an explanation for the long stasis in drug policy, dur-

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ing a period in which the problem has been through many phases if not full transformations. There are three possible forms of explanation.

One rests simply in popular attitudes. The American public became fearful of drugs in the 1970s and 1980s, with the heroin epidemic, two separate cocaine epidemics (powder and then crack), and the associated crime. The connection between drugs and crime was real, and violent crime was at its worst during the 1980s. It is not surprising that there is popular resistance to major changes in policy toward illegal drugs, a suspicion that anything other than tough enforcement of tough laws will be insufficient to protect society from a return to the horrible times of the 1980s, with their bloody battles between drug-selling gangs. In 2001, well after the worst of the drug problems had passed, the public still believed that the problem was worsening (74 percent agreed that the war on drugs was being lost) and was more supportive of interdiction and arresting sellers than of treatment or prevention, though they had little faith in any specific program (Pew Research Center for the People and the Press 2001).

Many observers expected that popular attitudes toward drugs as a class would become less harsh as the adult population became richer in experienced drug users. In 1982, the share of persons aged 26 or over who had used any illicit drug was only 37 percent; by 2010 that had risen to 48.1 percent, mostly reflecting individuals experienced with marijuana and no other illegal drug. Most of those who have used marijuana report no resulting problems; thus the increased support for marijuana decriminalization and legalization discussed earlier is hardly surprising. That has not led to comparable changes in policy attitudes with respect to other drugs.

A second factor that may help explain the stasis is general policy inertia. Big changes in any policy domain occur rarely and usually in response to a confluence of factors, a theory developed famously by John Kingdon (2010). Drug policy made major shifts in the mid- to late 1980s in response to a moral panic; readjusting after such panics have ended is notoriously a slow process. In this view, there will come a time, perhaps a response to fiscal strains and a series of scandals around overcrowded prisons, when the public will accept substantially less harsh policies.

There is one hopeful sign at this level, namely, a shift in conservative views about the desirability of continued growth of incarceration (Dagan and Teles 2012*a*, 2012*b*). In states as historically punitive as Mis-

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sissippi and Texas, Republican leaders in the state legislatures have passed laws and funded programs that allow for early release and more intense supervision of parolees and probationers. Dagan and Teles suggest that this reflects a new view of criminal justice personnel; once seen as the defenders of society; they are now viewed as bureaucrats, yet another emanation of the modern state. Those fighting to shrink government no longer exempt correctional facilities.

The 2007–11 period certainly saw a straining of state and local budgets plus a great deal of hand-wringing about excessive federal deficits. The overcrowding and dangerousness of prisons, particularly those of California, have become a staple of the media and of federal judicial decrees. Actual incarceration has declined slightly, from 2,307,000 in 2008 (local jails, federal, and state prisons) to 2,239,000 in 2011.[63] Though with no particular focus on drugs, the decline in incarceration generally should help reduce the number of minor drug offenders incarcerated. Teles (personal communication) argues that the change is facilitated by the rapid turnover in state legislatures. The new conservative members, without a memory of when drugs were the nation's "scourge," as President George H. W. Bush put it, are more open to rational arguments about the undesirability of locking up minor offenders for long terms.

The third factor, and the most common explanation for the stasis, particularly at the federal level, is the timidity of politicians. It is routinely asserted that no politician wants to be seen to be soft on crime, and drugs are equated in the public mind with crime. It is easy rhetorically to claim that any softening of the severe sentences imposed on drug dealers, who account for the vast bulk of drug offenders in prison (Sevigny and Caulkins 2004), is a move toward undue leniency and would worsen the drug problem. The counter to that is a statement that actually there is no evidence that lighter sentences would make drugs more available or cheaper; that statement is not very convincing to the public. Having argued this often myself, I have a sense of how hard it is to make a case that rests on a lack of evidence rather than on grand experimental results.

The argument that other countries have managed to avoid the seriousness of the US drug problem without high incarceration rates has

[63] The per capita rate, a more appropriate measure for many purposes, has fallen further given the continued growth of the US population, from one per 100 in 2008 to one per 107 in 2011.

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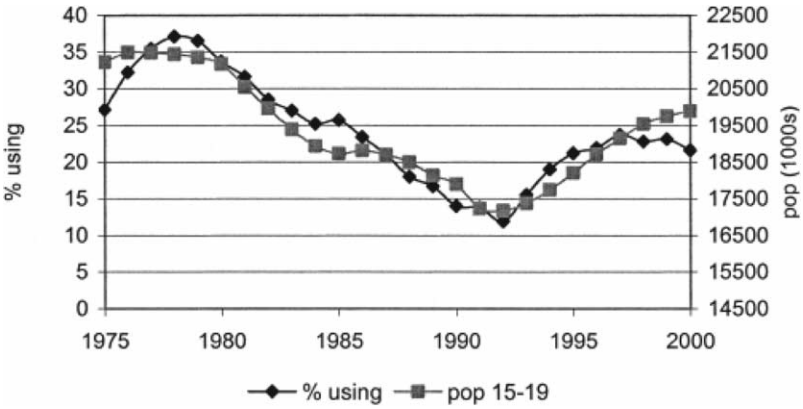

FIG. 5.—Prevalence of marijuana use and size of age cohorts, 1975–2000. Source: Jacobson (2004); Johnston et al. (2012).

no purchase. Except for Dutch coffee shops and, in recent years, the experience of Portugal with the decriminalization of drug possession generally, other countries' experiences hardly enter into the debate in the United States. Again, this parochialism is not confined to drug policy but is characteristic of many domains of policy discussion in the United States.

My own hypothesis is that the stasis is very much a consequence of the fact that the problem has been declining. Why risk change when existing policies are working? There are lots of good answers to that: the policies are expensive, divisive, and intrusive, to return to the starting point of this essay, and the problem is declining for reasons other than policy. Excessive punishment is itself offensive to Western sensibilities. These have not been persuasive arguments. The problem has declined, if you accept my argument about the distinct nature of the prescription drug misuse problem, and that may be enough to protect the status quo.

I conclude by again emphasizing the limited capacity of targeted drug policy to reduce use via prohibition. Consider figure 5, a graph from Jacobson (2004). It shows past-month marijuana use among high school seniors, a well-tracked figure, and the size of the age 15–19 cohort each year from 1975 to 2000. There is a remarkable positive correlation between cohort size and drug use in that age group. Ja-

cobson concludes that the relationship reflects "strained monitoring resources" and scale economies in drug markets. "Strained monitoring resources" are the hypotheses "that efforts to prevent youth drug use are overwhelmed when cohorts are large, reducing the risk of punishment and increasing use. 'Scale economies' suggests that due to the fixed costs of illicit drug distribution, increases in cohort size lower the per-unit costs of drugs, reducing prices and increasing use" (Jacobson 2004, pp. 1482–83). This is consistent with the work of Easterlin (1987), which shows the influence of cohort size on many aspects of individual behavior. Jacobson conducted other subanalyses that further supported the notion that cohort size was a very important driver of prevalence.

The proposition that policy can do little to influence prevalence of use may seem nihilistic. Far from it. We know that bad policy choices can make drug use, drug distribution, and production more harmful. All that policy changes can in fact do is to reduce the harmfulness of these activities. I believe that this proposition has enormously liberating effects for policy. At present, many laws and interventions are justified because they might reduce drug use, even though we know with greater confidence that they cause harms. If prevalence of use is no longer seen as a plausible policy goal, then the harms can be avoided. Finding a way of making this persuasive to the public is the difficult task.

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QUERIES TO THE AUTHOR

q1. Journal style is not to capitalize common economic terms, including gross domestic product.

q2. Titles used in apposition to a name are lowercased according to the Chicago Manual of Style. If you had said "NIDA Director Alan Leshner," it would be capitalized.

q3. FYI: References that were cited in text you deleted and not elsewhere were also deleted.

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