Legalization vs. Prohibition of Drugs: Historical Perspective


The history of U.S. social and legal policy in regard to psychoactive and intoxicating drug use has been characterized by periodic shifts, strong ideological presuppositions, and deep disappointment. Any analysis of current policy and the debate about drug legalization must recognize the historical roots of current policy that affect the various positions in the debate.

A brief historical note may help place the current discussion of drug policy in the United States in perspective. To borrow a phrase from Ecclesiastes, there is nothing new under the sun. Those engaged in the current, often heated, discussions about national drug policy often act as if their concerns, insights, and positions about intoxication, drug use, and society are unique to the twenty-first century. A cursory review of history indicates that the debate on the meaning and effects of alcohol and other drug use on morals, public safety, productivity, and health is at least as old as written language. Some of the earliest recorded civilizations struggled with the issue and often adopted laws and policies that attempted to regulate strictly or prohibit the use of alcohol and other drugs.

Often these laws were based on a culture's perspective on the will of the divine or combined with basic civil codes. For example, the Torah appears to be very concerned with excessive alcohol use. It was seen as leading to gross immorality. The Christian New Testament holds similar views, particularly on the excess use of alcohol. The theme seems to be one of avoiding all things that harm the body or one's relationship with God, and moderation even in all things that are good. The Qur'an takes a very strong prohibition stand against alcohol and all intoxicating substances. Since much of modern Western civilization derives from these religious traditions, they continue to influence public thinking and policy. From a less theocentric perspective, many ancient civil codes also struggled with the regulation or prohibition of intoxicating chemicals. For example, the Romans seemed especially concerned that slaves and women not use alcohol and forbade its use by them. The concern appeared to be that alcohol would make slaves less productive and more difficult to control and that it would also lead to female sexual impurity. Chinese emperors prohibited the use of opium among their subjects. In addition, during the sixteenth and seventeenth centuries, when tobacco use began to spread around the world, many societies, including the Ottoman Empire, Great Britain, Russia, and Japan, initially tried prohibiting the substance.

These ancient and more recent laws and codes show that the regulation or prohibition of socially perceived harmful substances is not new to the twenty-first century, nor is the range of views on the negative consequences of regulation or prohibition and what would constitute a more effective, less harmful policy.
PHILOSOPHICAL AND CULTURAL TRADITIONS

Among the many legacies that underpin the present discussion of drug policy in contemporary society are four at times overlapping and sometimes contradicting philosophical and cultural traditions. The first is the basic American heritage of individual liberty and limited government interference with any variety of human choice, even if that choice is harmful to the individual making the decision and morally repugnant to the majority of society. This position was eloquently argued by British philosopher and economist John Stuart Mill (1806–1873) in his essay *On Liberty* (1859).

A second major social tradition is rooted in the moral utilitarian view of government that is also a part of the nation's heritage. The utilitarian perspective, also argued by Mill in his book *Utilitarianism* (1863), emphasized that government has a legitimate right to prohibit the behaviors that actually cause real harm to others. From this viewpoint, government has the right and responsibility to protect the common welfare by legally prohibiting individuals from engaging in behavior that is demonstrably harmful, not to themselves (which would have been an interference with liberty), but to other citizens.

The moral utilitarian perspective was an important underlying element in many of the late nineteenth- and early twentieth-century social-reform movements that culminated in the many state laws prohibiting narcotics and other drug use, the national Harrison Narcotics Act of 1914 and the Volstead Alcohol Prohibition Act of 1920. The utilitarian perspective was that narcotics and alcohol use caused real harm to others and society in general in the form of family poverty, crime, violence, and health-care costs.

A third social tradition that has influenced U.S. drug policy is commercialism (Courtwright, 2001). There is ample evidence that through the nineteenth century, U.S. society had a strong commercial attitude toward alcohol use and the use of a variety of powerful drugs. As has been documented by historians, merchandise catalogs and traveling entrepreneurs legally distributed opium, barbiturates, and cocaine as wonderful cure-alls for the ills of the human condition (e.g., Spillane, 2000). These merchants were an organized, respected part of the commercial establishment. Perhaps based on British narcotics commercialism, there has always been a commercial attitude toward alcohol and drug distribution in the United States. From the commercial perspective, alcohol and drugs are a wonderful commodity. They are often rapidly metabolized, highly addictive, and easily distributed. However, by the end of the nineteenth century, this rather freewheeling distribution of drugs caused a widespread public reaction that became incorporated into a variety of health- and social-reform movements.

A fourth significant element in the development of national alcohol and drug policy is a public health perspective. As was noted, at the turn of the twentieth century the United States was in the midst of major social and health reforms. After the passage of the 1906 Pure Food and Drug Act, a host of public-health-based government bureaus and regulations emerged, focusing on improving the quality of meats and other foods and requiring the accurate labeling of drugs. In addition, the American Medical Association initiated major reforms in the medical profession, eliminating over-the-counter narcotic drug advertisements in their journal and supporting the licensing of physicians as the only legitimate prescribers of many drugs. The public-health reform movements attempted to de-commercialize drug distribution and make drug use a medical, not commercial, decision. The passage of the Harrison and Volstead Acts probably represented a significant triumph of the moral utilitarian and public-health perspectives.

Following the Harrison Act and further legislation, the U.S. government instituted various bureaus and departments to carry out law enforcement and antidrug educational programs. Any review of the education programs of the Bureau
of Narcotics would tend to conclude that they primarily constituted a heavy dose of propaganda with little basis in scientific fact. The federal proclivity for restricting the availability of drugs and arresting users and dealers continued strongly through the 1960s. During the decades following the Harrison Act and until the 1960s, the media and government were fairly united in their opposition to drug use, and there were few questions about the efficacy of drug laws or the social policy on which those laws were based.

THE 1960S AND 1970S

In the 1960s, U.S. society experienced the coming of age of the first of the baby boomers—those born between 1946 and 1960. By their sheer numbers, a proportion of this generation challenged the traditional socialization mechanisms of society and significantly questioned traditional assumptions, rationales, explanations, and authority. In a drive for generational self-discovery, drug use, particularly as a means to alter consciousness, became a part of the youth movement of the late 1960s and the 1970s. Most of the baby boomers who used drugs explored the use of marijuana and hallucinogens, but over the same years heroin use was increasing in inner cities across the country; crime, too, was increasing. Despite the declaration of a “war on drugs” by the Nixon administration from 1970 through 1971, national surveys conducted during the 1970s and early 1980s showed annual increases in almost all types of drug use among high school seniors, household residents, and criminal justice populations. The one exception was heroin, the major target of the Nixon drug war. Heroin use levels declined and then remained stable, but cocaine use rose dramatically during the 1970s and early 1980s, as did marijuana use among young people. By 1985, more than 20 percent of U.S. adults had taken drugs illegally, and for persons aged eighteen to thirty-four more than 50 percent had done so.

Perhaps because of the fundamental changes in national drug-using behavior that occurred during this period, the modern movement to legalize drugs began. The basis of the argument was that (1) many of the drugs that were then illegal were not as harmful as government and media propaganda portrayed them to be, (2) marijuana in particular was argued to be relatively less harmful than alcohol and tobacco, and (3) the use of marijuana was a generational choice. In fact, the 1978 National High School Senior Survey showed that in the prior thirty days, a higher proportion of seniors had smoked marijuana than had smoked tobacco. By 1979, the media and American households were holding serious discussion about the legalization of marijuana, moving toward the British System of heroin maintenance, and considering the legalization of cocaine as a nonaddictive stimulant. Social political movements such as NORML were organized to achieve passage of laws decriminalizing marijuana use. With the tacit support of the Carter administration, there were eleven states, including Alaska, that decriminalized the possession of small amounts of marijuana for personal use. Even the director of the National Institute on Drug Abuse in the late 1970s, Robert Dupont, appeared to accept the likelihood that marijuana would be decriminalized. However, in 1977, in reaction to growing marijuana use by young people and a perception that government itself was being tolerant of drug use, groups of parents organized a grassroots campaign to buttress the resistance to drug law liberalization. By 1978, the Parents Movement had become a force to be considered, and their views had ready access to the White House policy office. The apparently about-to-be-successful national movement to legalize many drugs in the 1970s came to an abrupt end with the 1980 election of President Ronald W. Reagan.

THE 1980S

Corresponding with the election of President Reagan, there was a general conservative shift in national consciousness. First Lady Nancy Reagan, who made drug use among young people one of her prime topics of concern, was a welcome speaker at annual national meetings of the parents’ groups. The public debate on legalization during the early 1980s was also affected by increasing evidence of the physical and psychological consequences of drug use, declining illegal drug use
among high school students, decreasing use among household members, and, maybe, the initiation of maturation among the baby boomers. During the 1980s, U.S. policy was characterized by the increasing intolerance of drug addiction or even recreational drug use. On an official level, this came to be called zero tolerance.

According to the official federal policy of the 1980s, the assumption was that to a large extent drug use was an individual choice that could be affected by raising the cost of drug use to the users. It was believed that if enforcement reduced the availability of drugs, thus raising their prices, and increased the consequences of use by increasing the severity and certainty of punishment, individuals would choose to say no to illegal drug use. During the 1980s, the proportion of federal drug control spending allocated to treatment fell from 33 percent in 1981 to just 17 percent in 1992, with increasing shares going to prevention (up from 8% to 14%) and law enforcement (up from 59% to 69%). The increase in the overall size of the federal budget was even more dramatic. The total federal budget for all demand-side and supply-control activities was just $1.9 billion in 1981. This amount escalated sharply when President Reagan redeclared a war on drugs. By 1989, the total had reached $6.7 billion. The resources escalated still further during the Bush Sr. and Clinton administrations, reaching $12.2 billion in fiscal year 1993 and $18.1 billion in fiscal year 2001. (Direct comparisons with more recent budgets are complicated by definitional changes, but federal drug spending during the George W. Bush administrations has grown by an average of only 2 percent per year in real terms.)

By the end of the 1980s, the national drug-abuse policy of zero tolerance with a heavy focus on enforcement began receiving critical reviews from policymakers, public administrators, clinicians, and academic researchers. These critical reviews were generally based on civil libertarian and public health harm-reduction perspectives. The key points made by national policy critics were:

About two-thirds of all felony arrestees in major metropolitan areas were currently using cocaine. A large proportion of all criminal charges were drug charges. This had resulted in a significant expansion of prisons and the proportion of the population incarcerated. All this had occurred at a very high economic cost. The high profits from the drug trade were funding international terrorism and resulting in a rapidly increasing rate of violence in American urban areas. Because of the vast amount of cash generated in the drug trade, there was great potential for corruption of government. In an attempt to reduce illegal drug use, draconian laws focusing on search and property seizures had been passed. Treatment availability for the poor had been reduced, with many cities reporting month-long waiting lists for publicly funded treatment slots.

CALLS FOR DECRIMINALIZATION

These consequences resulted in a major reinvigoration of the interest in legalizing or decriminalizing drug use. Those who argue for legalization come from a wide variety of professions and ideological positions, but they all essentially believe that U.S. society has reached the point where it can no longer afford to enforce existing law. There simply are not enough police, courts, prosecutors, or jail cells, nor is there the sense of justice that will allow U.S. society to enforce laws that have been broken by more than 20 percent of U.S. citizens.

In summary, the zero-tolerance, just-say-no policy of the 1980s had come to be viewed by critics as resulting in a virtual saturation of the criminal justice and prison system with drug law offenders, the undermining of crucial civil rights, and the decreasing availability of drug treatment for the poor accompanied by increasing violence in high drug-trafficking areas and large-scale public corruption. Many critics came to view drug laws as contrary to the very basis of a libertarian civil government. These critics saw the war on drugs declared in the 1980s and continued to the present as inimical to civil liberty. In addition to the civil libertarian perspective, there are many critics of current drug-prohibition policy who focus on a public-health harm-reduction perspective. From this perspective, current policy is not reducing the public-health harm caused by drug use. The public-health-
reduction model emphasizes that drug abuse and addiction are the product of a complex set of psychological, sociological, and economic variables that are very little affected by the threat of prison. This perspective argues that the best way to reduce the personal and public-health harm of drug use would be to increase drug education and prevention, increase drug-treatment availability, and reduce the harm caused by drug abuse by providing clean needles and, perhaps, decriminalizing use—thus significantly reducing the cost of drugs and the associated crime.

Although there are very few detailed legalization proposals, those who advocate decriminalization generally argue that national policy should move toward an approach in which the distribution of drugs such as marijuana, cocaine, and heroin would not be governed by criminal law but by governmental regulations that controlled the manufacture, distribution, and use of these substances so that they would go only to those already addicted or be dispensed under very regulated conditions. Advocates of this policy believe that the movement of drug policy from criminal law to regulatory restrictions would result in the relatively easy availability of drugs and inexpensive access to them for those who are addicted, thus resulting in a significant reduction in corruption and violence as well as an increasing willingness on the part of addicts to enter treatment. This, it is asserted, would relieve the severe overcrowding of the criminal justice system. At the same time, it is argued, because of strict regulation, this policy change would more effectively protect young people as well as public health and safety than the current policy (Nadelmann, 1988; Wisotsky, 1991).

**OPPOSITION TO LEGALIZATION**

Critics of the legalization perspective do not question many of the basic judgments of the consequences of the 1980s national policy, but they do severely question the assumptions on which legalization is based. Those who are opposed to drug legalization often draw on the moral utilitarian and public-health perspectives. They make the following arguments:

During the 1980s and continuing into the 2000s, drug use, by all measures, significantly decreased among high school and college students as well as in the general population. It is naive to assume that increasing availability, lowering cost, and reducing legal consequences will have no effect on the incidence and prevalence of marijuana, cocaine, and heroin use. From this perspective, it is argued that once these drugs are legalized, even though regulated, they will enter the arena of advocacy through free speech and thus the realm of market creation and expansion through advertising. Alcohol use, which is severely regulated and illegal for those under twenty-one years of age, is initiated in junior high school. In addition, about one-third of high school seniors report being drunk each month. In most states, tobacco cannot be sold to minors, but smoking among junior high school students is common. These facts imply that regulation to make a drug available to one age group actually makes it available to all age groups. The resulting increase in use in society and broadening of the societal base of use will result in detrimental health, behavioral, and economic consequences that will far outweigh any proposed benefit of legalization. There is no broad societal base for legalizing drugs. Surveys among high school seniors clearly show that a large majority oppose the legalization of drugs—even the legalization of marijuana. Traditionally liberal countries such as Switzerland and Sweden have tried relaxing drug laws and were forced to modify their positions by their citizens, who daily had to experience the consequences of wide drug availability. Additionally, in a referendum in November 1991, Alaskans voted to rescind a marijuana legalization law passed in the 1970s and recriminalized marijuana possession. In a democracy, governmental policy cannot ignore the voice of the public. Dr. Joycelyn Elders, the first Surgeon General in the Clinton administration, was criticized for merely suggesting that the issue of legalization should be debated. Although the costs of drug law enforcement and incarceration of offenders may seem high, it is a misconception to assume that those incarcerated are all petty first-time violators of the drug laws.
laws. DiIulio (1993) asserts that “in 1991 more than 93 percent of all state prisoners were violent offenders, repeat offenders (one or more prior felony convictions) or violent repeat offenders.” Likewise, most drug-related violators in prison are not just users

but played some (perhaps minor) role in drug distribution. For many the official conviction charge is “possession,” but that includes possession with intent to distribute, those who pled down from a trafficking charge, and couriers who possessed very large quantities.

Many of those opposed to legalizing drugs, such as former Secretary of Health, Education and Welfare Joseph A. Califano, Jr., and Mathea Falco, a former Carter administration official, argue that the existing policy should be drastically modified to increase the availability of treatment and educational and economic opportunities in societal groups with high drug-use rates. Specifically, what is called for is an increase in treatment availability in the criminal justice system, either through diversion or probation to treatment or through the provision of therapeutic services in jails and prisons, as well as a major increase in the availability of publicly funded treatment slots in the United States. Policy analysis studies began to conclude that every dollar invested in treatment results in several dollars saved in terms of other social costs, including crime (e.g., Rydell and Everingham, 1995; Gerstein et al., 1994).

Some who oppose drug legalization believe that the current discussion has subtly eroded the public's will to fight illegal drug use. From this perspective, the only way to retain the reduction in general societal drug use that occurred during the 1980s is to retain a vigorous enforcement of drug laws. The advocates of strict law enforcement believe that weakening the war on drugs would be a kind of backdoor legitimization, a demoralizing discussion of the failure of drug policy. Previous drug policy leaders such as William J. Bennett argue that national drug policy during the 1980s was effective in reducing drug use in the general youth and adult population by making use morally, socially, and legally unacceptable and that the drug policy reform debate of the 1990s made drug use more acceptable, resulting in subsequent increases in use (Bennett & Walters, 1995a, 1995b; Rosenthal, 1995).

THE 1990S AND BEYOND

In the mid-1990s it was very difficult to reconcile the extremes of the drug legalization debate, beyond some shared belief in the need for increasing drug education, prevention, and treatment availability. However, as drug problems in the U.S. stabilized and in some cases began to ebb, the stridency of the debate has eased. Drug law reform groups have focused attention on medical marijuana, not across the board legalization, and even the famously severe federal mandatory minimum cocaine sentences and notorious New York State Rockefeller drug laws have been modified. Local drug enforcement has put greater emphasis on controlling drug-related firearms, violence, and disorder through specific deterrence and focused crackdowns, rather than trying to suppress all forms of drug selling and use (e.g., Braga et al., 2001). In many jurisdictions, law enforcement has pushed back underground, for example, to discrete sales arranged by cell phone, resulting in greatly improved quality of life in surrounding communities. Also promising are partnership efforts such as drug courts, drug offender diversion programs including California's Proposition 36, and Hawaii's very successful Opportunities for Probation with Enforcement (HOPE) coerced abstinence program (Belenko, 1999; Hawken, 2006; Kleiman, 1997). These developments might give an optimist hope that, freed to some extent from the distraction of unrealistic “silver bullet” solutions (“create a drug-free America” or “just legalize drugs”), there is potential for a more constructive period of improving drug policy bit by bit through the hard work of pragmatic policy analysis and good governance.

See also Anslinger, Harry Jacob, and U.S. Drug Policy; Crime and Drugs; Harm Reduction; Legalization vs. Prohibition of Drugs: Policy Analysis; Opiates/Opioids;
BIBLIOGRAPHY


DUANE C. MCBRIDE REVISED BY JONATHAN P. CAULKINS (2009)
Legalization vs. Prohibition of Drugs: Policy Analysis

Whether a drug should be prohibited or legalized is perhaps the most fundamental question in drug policy. It is a moderately complex question and most who write about the issue do so from an advocacy perspective, so the debate is even more confusing than it needs to be. It is important to start with a clear definition of what is meant by legalization versus prohibition. There is a spectrum of policy positions. Some drugs can be used for medical but not recreational purposes (e.g., cocaine), whereas others cannot even be used for medical purposes (e.g., heroin). Some drugs cannot be used recreationally but are legal with a prescription (Valium) or when taken under medical supervision (methadone). Some drugs are legal only for adults (alcohol); others are legal for all ages (e.g., the caffeine in soda).

DIFFERENTIATING LEGALIZATION FROM PROHIBITION

When a sharp line needs to be drawn between legalization and prohibition, it is useful to say that a drug is legal if it is legal for that substance to be produced and distributed for unsupervised consumption by a significant portion of the population (e.g., all adults). By this definition making marijuana available for medical use is not legalization if prescriptions are restricted to those experiencing specific, medically diagnosed conditions (e.g., glaucoma), but it would be if any individual could write his or her own prescription. Likewise by this definition the Netherlands has legalized retail distribution, and use of marijuana, although wholesale (large-volume) marijuana production and distribution is still prohibited. Most other drugs in most countries are either clearly legal or clearly prohibited by this definition.

DIFFERENT CRITERIA

Having defined prohibition as compared to legalization, the next important observation is that different people use different criteria for deciding what policy should be. Some people are implicitly if not explicitly consequentialists. They think the right policy is the policy that leads to the fewest problems. Others believe that there is a moral imperative to make substances legal (e.g., libertarians who believe people should be free to consume anything, even if it hurts them) or prohibited (e.g., people who believe the substance is evil for religious reasons) regardless of the consequences.

The challenge for the moral prohibitionists is defending to others why they favor prohibiting some drugs but not others. There are defensible positions predicated on consistent principles (“all intoxication is immoral” or “being physically dependent on a drug is idolatry”), but it is hard to articulate such a defense for U.S. policy. Cigarettes are highly addictive, and alcohol is clearly an intoxicant, but they are both legal. In 1930, alcohol was prohibited, but marijuana was not. Ten years later, marijuana was prohibited, but alcohol was not. One does not have to be very cynical to believe
that the moral distinctions enshrined in public policy are just the legal formalization of arbitrary popular prejudices.

The challenge for the libertarian view is less simplistic but no less compelling (at least for those who recognize homo economicus as an ideal type, not a descriptively accurate model of human behavior).

The basic idea is that at least some addictive, mind-altering substances may merit an exception to the general rule that a liberal society should not interfere in the private consumption decisions of its citizens. Mark Kleiman, a drug policy scholar and professor at UCLA, eloquently makes the case in his 1992 book *Against Excess*. The distinguishing characteristics are a combination of factors such as in the following examples: Drugs are intoxicating, so consumption decisions are often made “under the influence”; for some, drugs cessation is physically painful; drugs offer immediate pleasures and the possibility, but not guarantee, of delayed pain; drug initiation occurs primarily among minors; social influences play a prominent role in initiation decisions. That skepticism of government regulations is healthy for a liberal democracy does not imply that prohibiting a drug is necessarily a bad idea. Liberal democracies tolerate other paternalistic infringements on freedom of behavior (e.g., a minimum wage, motorcycle helmet laws, and prohibitions against swimming where there are dangerous rip tides).

Furthermore, few want minors to have ready access to drugs, but legalizing use by adults inevitably makes a drug readily available to minors because every adult is a potential supplier, whether consciously (e.g., adults buying alcohol for minors) or unconsciously (e.g., minors stealing cigarettes from adults). Legalizers sometimes deny this connection, asserting that cocaine is more readily available to minors than alcohol is, but those assertions are contradicted by minors’ self-reports (e.g., in the Monitoring the Future surveys). The moral arguments for or against prohibition are in one sense unassailable. Individuals are entitled to their separate values. But at the same time those values are not likely to be persuasive to people who do not hold them.

For consequentialists, opinions about legalization tend to depend on two factors: (1) how people trade off or value the problems associated with drug use and those associated with prohibition and black markets and (2) on predictions about how legalization would affect those outcomes. Prohibiting a drug will generally reduce but not eliminate its use. The use that persists despite prohibition supports a black market, which generates problems of its own. Indeed, the social cost per gram or per ounce consumed will typically be greater than would be the case if the drug were legally available. So prohibition typically reduces use but increases harm per unit of use.

Those who favor legalization tend to believe that a drug's legal status has little impact on its use. They also tend to be very mindful of the problems associated with black markets (stereotyped as drug dealers shooting people in battles over competing

territories), drug enforcement (e.g., racially biased enforcement tactics), and prohibition's increasing the damage per episode of use (e.g., restricting needle availability, increasing spread of HIV by needle sharing). Those who favor prohibition tend to believe that prohibition substantially suppresses use (tobacco and alcohol are used far more than cocaine or heroin) and that many problems stem directly from drug use (e.g., the damage addiction can do to familial relations) not primarily from the drug's illegal status. To them, legalization is tantamount to making a bad situation worse. It might eliminate the black market and associated crime, but if legalization led to a tenfold increase in the number of addicts, the country could still be worse off.

Unfortunately, the public debate about the consequences of legalization is clouded with specious arguments. For example, prohibitionists argue that drugs should be illegal because they are associated with so much crime. Indeed, the majority of arrestees in many U.S. cities test positive for illegal drugs; association does not imply causality, but a reasonable guess is that something on the order of one-fourth of crime in the United States is caused by illegal drugs. Legalizers counter that most of the drug-related crime is attributable to the illegality, not the drugs per se. Only about one-
sixth of drug-related crime is psychopharmacological in nature (i.e., driven directly by intoxication or withdrawal). Conflicts between market participants turn violent in part because they cannot resort to the court system to resolve disputes, and one reason addicts commit robberies is to get money to buy drugs that would cost far less if they were legal. Ironically, alcohol is one of the most violence-promoting substances per se, and it is legal.

To give an example from the other side, legalizers cite statistics showing that illegal drugs such as cocaine and heroin kill only thousands of people per year, whereas alcohol and cigarettes kill hundreds of thousands. What they neglect to point out is that far more people use cigarettes and alcohol, so the death statistics per user are not so different. Furthermore, the death statistics for illicit drugs are restricted to acute effects (e.g., overdose deaths), whereas the cigarette and alcohol figures include indirect effects (e.g., deaths caused by intoxicated drivers) and delayed or chronic effects (e.g., from lung cancer). Focusing on overdose deaths would make cigarettes seem safe, whereas the expansive definition suggests that they kill more people than all other drugs combined, including alcohol.

Both sides lend a patina of scientific rigor to their arguments by citing trends in data, but the divergent trends of different indicators makes it easy to tell statistical lies. An advocate of prohibition might point out that the number of drug users fell dramatically during the 1980s when enforcement expanded rapidly. A legalizer could counter that emergency room mentions of drug use rose as fast as prevalence fell. What is lost in such bickering is the observation that the legal status of the major drugs has been stable in the United States for many decades. Looking at contemporary trends might indicate the wisdom of a more or less stringent prohibition, but there is no direct experience with legal cocaine, heroin, marijuana, or methamphetamines in recent U.S. history. Many seek to draw lessons from other times (e.g., when cocaine was legal in the United States in the late nineteenth century) or places (e.g., Europe), but casual comparisons can be misleading and careful study of those analogies does not give definitive guidance (MacCoun & Reuter, 2001).

Even anecdotal evidence can be spun in different ways. Occasionally, there are accounts of a mother selling her baby for crack. Some argue this kind of action proves drugs should be legalized. If they were cheap enough, addicts would not have to resort to such extreme measures. Others counter that the fundamental problem is that the drug is so powerful that it becomes more important to a mother than her own child; therefore, everyone should be protected in whatever ways possible from exposure to such temptations that can erode basic human values and worth.

The next important observation is that different drugs are different, and it may well make sense to prohibit some but not others because they have different properties (e.g., some drugs can trigger violent outbursts [PCP]; others tend to sedate [heroin]). It is by no means the case, however, that one can unambiguously rank substances from the most to the least dangerous because a substance can be very threatening in one respect but not in others. Cigarettes are highly addictive, but they are not intoxicating. Heroin can be deadly

<table>
<thead>
<tr>
<th>Substance</th>
<th>Caffeine</th>
<th>Tobacco</th>
<th>Alcohol</th>
<th>Marijuana</th>
<th>Heroin</th>
<th>Cocaine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute health risk</td>
<td>None</td>
<td>None</td>
<td>High</td>
<td>Minimal</td>
<td>High</td>
<td>Moderately High</td>
</tr>
<tr>
<td>Chronic health risk</td>
<td>None</td>
<td>Huge</td>
<td>High</td>
<td>Some</td>
<td>Minimal</td>
<td>Some</td>
</tr>
<tr>
<td>Use affects health of others</td>
<td>No</td>
<td>Yes</td>
<td>Fetuses</td>
<td>Possibly</td>
<td>No*</td>
<td>Fetuses</td>
</tr>
<tr>
<td>Problems caused by withdrawal</td>
<td>Minimal</td>
<td>Unpleasant</td>
<td>Physical risk</td>
<td>Minimal</td>
<td>Physical risk</td>
<td>Extremely unpleasant</td>
</tr>
</tbody>
</table>

*Injection drug use can spread blood-borne diseases (BBDs), including HIV/AIDS and hepatitis, but it is injecting with shared equipment, not the heroin use per se, that is the proximate source of the spread of BBDs.
Table 1. Substances and their risks.

<table>
<thead>
<tr>
<th>Caffeine</th>
<th>Tobacco</th>
<th>Alcohol</th>
<th>Marijuana</th>
<th>Heroin</th>
<th>Cocaine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intoxication leads to accidents</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Some</td>
<td>Moderate</td>
</tr>
<tr>
<td>Intoxication leads to violence</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Likelihood of addiction given use (as observed in the U.S. in last 30 years)</td>
<td>Minimal</td>
<td>High</td>
<td>Moderate</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Addiction disruptive to daily functioning</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Somewhat</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Injection drug use can spread blood-borne diseases (BBDs), including HIV/AIDS and hepatitis, but it is injecting with shared equipment, not the heroin use per se, that is the proximate source of the spread of BBDs.

Table 1. Substances and their risks. ILLUSTRATION BY GGS INFORMATION SERVICES. GALE, CENGAGE LEARNING

(overdose deaths are not uncommon) but in and of itself creates almost no chronic health damage. Heroin addicts are usually in poor health because they are poor, spend money on heroin rather than on food or shelter, and inject with dirty needles, but the heroin per se does not degrade organs the way alcohol destroys the liver or smoking causes emphysema. Table 1 illustrates the concept.

The table divides the substances by legal status. The legalization question asks whether any substances on one side of the line should be moved to the other. It does not address changes in laws, programs, or policies that do not move a substance across the line. It might or might not be a good idea to repeal mandatory minimum sentences, cut the number of drug arrests in half, expand treatment and prevention programs, approve marijuana for medical use, eliminate profiling as an enforcement tactic, reduce the military's role in drug control, and repeal drug-related civil forfeiture statutes. Doing so would blunt many of the criticisms of prohibition, but it would not constitute legalization. Conversely, one could raise the legal smoking age, require people to pass a drinker's test to get an alcohol consumption license, or ban smoking from all public spaces, but none of those would extend prohibition to a new substance.

There is no constituency for prohibiting caffeine, and prohibition of alcohol is perceived to have failed so badly in the last century that there is little interest for trying it again. There is some discussion of banning tobacco use, but such proposals are probably political non-starters.
The more seriously debated proposals would legalize one or more of the substances prohibited as of 2008. For discussion purposes, it is convenient to differentiate three groups of substances: (1) cocaine, heroin, and methamphetamines, (2) marijuana, and (3) all other illicit substances.

Cocaine, heroin, and methamphetamine are not similar pharmacologically, but they have key commonalities. They are expensive, are subject to stringent enforcement, can dominate the life of an abuser, and have large, established black markets. These are the substances whose use can most confidently be predicted to rise substantially and to be problematic if they were legalized. These substances are very simple to produce, but sell for many times their weight in gold because they are prohibited and subject to severe sanctions. They are also the source of most of the corruption, violence, and disorder associated with drug markets, so legalization would bring many benefits. Most observers, though, believe this would be an example of making a bad situation worse. At a minimum, legalizing these substances is a high stakes gamble that is only partially reversible. There are other, safer alternatives to exhaust first (e.g., mending rather than ending prohibition) and more information that should be gathered about how legalization would affect use before seriously contemplating such a radical change.

Marijuana presents quite a different situation. Prohibition makes marijuana more expensive than it otherwise would be, but a daily habit is no more expensive than a two-pack a day cigarette habit. Likewise, daily marijuana use is not a recipe for enhancing performance, but it does not preclude most daily functions (e.g., personal hygiene, holding down a job). So a tenfold increase in use is a less likely outcome of legalizing marijuana than for cocaine, and even if it did happen, that outcome would be less catastrophic. However, the benefits of legalizing marijuana are also far smaller than the benefits of legalizing cocaine, heroin, and methamphetamines because marijuana markets are less violent and marijuana users generally do not resort to crime to support their habit. Likewise, marijuana offenders account for only about 10 percent of those in prison for drug law violations. There is no consensus about whether legalizing marijuana is wise. Some say yes. Many say no. What is clear, though, is that the risks, uncertainties, and potential benefits are all much smaller when considering legalizing marijuana than when considering legalizing cocaine, heroin, and methamphetamines.

The last category is diverse, so general statements are difficult. It includes drugs that can be used as a weapon in sexual assault (e.g., GHB) and drugs used not for their mind or mood altering properties but to enhance athletic performance (e.g., anabolic steroids). Two general observations are possible, however. First, prohibitions are relatively more effective and relatively less costly when preventing the spread of substances that are not commonly used than they are at reducing the use of an established drug. Second, by definition, there is more to lose in terms of increased availability and use when altering the status of drugs that are now rare. By those principles, it would be easier to make a case for legalizing XTC (Ecstasy) or LSD, for example, than for PCP, but they are not frequently the focus of legalization proposals, which typically address just marijuana or all drugs collectively.

See also Cocaine; Heroin; Legal Regulation of Drugs and Alcohol; Legalization vs. Prohibition of Drugs: Historical Perspective; Marijuana (Cannabis).

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JONATHAN P. CAULKINS
Legalization vs. Prohibition of Drugs: Policy Analysis
Before 1960, use of marijuana in the United States was generally confined to drug-using subcultures in the inner cities or in rural areas. Sale and use of the drug were prohibited both by federal law and by the laws of every state. Because marijuana was classified in 1937 as a narcotic drug, along with cocaine and opiates, penalties were severe; simple possession for personal use was a felony in most states. During the 1960s, marijuana use suddenly became prevalent on college campuses for the first time among white middle-class youth of the baby-boom generation. Marijuana use also became associated, as a protest behavior, with dissenters (both adults and youth) against the war in Vietnam, and by the U.S. military serving in Vietnam, especially from 1963 to 1973. As use of the drug increased, so did the number of arrests and so did the surrounding controversy. Questions were raised about the actual effects of marijuana on the health and behavior of those who used it and about the wisdom of prevailing social policy.

In response to swirling controversy, many proposals were introduced in Congress for a commission to undertake an authoritative study of the marijuana issue. Eventually, in the Comprehensive Drug Abuse Prevention and Control Act of 1970 Congress established the National Commission on Marihuana and Drug Abuse to undertake a two-year study—the first year on marijuana and the second year on the causes of drug abuse in general.

The commission had thirteen members—four from Congress (two each from the House and the Senate) and nine appointed by the president. President Richard M. Nixon appointed Raymond P. Shafer, formerly governor of Pennsylvania, as chairman of the commission, and he appointed Dana L. Farnsworth, M.D., director of Student Health Services at Harvard University, to be vice-chairman. The executive director was Michael R. Sonnenreich, formerly the deputy chief counsel of the Bureau of Narcotics and Dangerous Drugs of the Justice Department.

The commission assimilated the available literature on marijuana use and its effects and also sponsored its own research, including a national survey of use patterns and public attitudes, and a study of enforcement of the marijuana laws in six jurisdictions. In March 1972, the commission issued its first report, *Marihuana: A Signal of Misunderstanding*.

**PRINCIPAL FINDINGS**

The commission estimated that although 24 million Americans had used marijuana at least once,
The commission concluded that there was “little proven danger of physical or psychological harm from the experimental or intermittent use” of marijuana. “The risk of harm,” it continued, “lies instead in the heavy, long-term use of the drug, particularly of its more potent preparations.” Even this risk was of uncertain dimensions, the commission noted, because the psychological consequences of long-term heavy use were unknown. In light of the fact that 90 percent of marijuana users used the drug only experimentally or intermittently, the commission judged that “its use at the present level does not constitute a major threat to public health.” The commission also specifically found that marijuana did not induce physical dependence; did not lead, by virtue of its pharmacology, to use of other drugs; and did not cause criminal behavior.

**POLICY RECOMMENDATIONS**

The commission’s principal policy recommendation was that possession of one ounce or less of marijuana for personal use be “decriminalized.” At the same time, the commission rejected outright legalization of the drug and recommended perpetuation of prohibitions against cultivation and distribution for commercial purposes. The commission stipulated that social policy should aim to discourage use of the drug, but it emphasized that the costs of a criminal prohibition against possession far exceeded its benefits in suppressing use.

Although President Nixon disavowed the commission’s principal recommendation on marijuana, it won widespread support. In 1973, the National Conference of Commissioners on Uniform State Laws promulgated amendments to the Uniform Controlled Substances Act that codified the commission’s recommendation. Some form of decriminalization was endorsed the same year by a variety of national organizations, including the American Bar Association and numerous state and local bar associations, the National Education Association, the Consumers' Union, the National Council of Churches, the American Public Health Association, and the governing board of the American Medical Association.

In 1973, Oregon became the first state to decriminalize possession of small amounts of marijuana. Within the next five years, ten additional states eliminated incarceration as a penalty for simple possession, usually substituting a $100.00 fine. Five of these states made possession a “civil offense”; in others, it remained a criminal offense although the law typically contained a provision for expunction of criminal records after a specified period of time. Decriminalization of marijuana use was endorsed by President Jimmy Carter in 1977.

Political and legislative support for decriminalization began to wane, however, even during the Carter Administration. The more permissive stance on marijuana use implicit in decriminalization efforts led to mounting public resistance. Some of the strongest opposition came from groups of parents who organized to lobby for more focus on prevention efforts. Although these parent groups were generally conservative politically, they gained a receptive ear in the Carter White House. Their arguments against decriminalization were bolstered by findings from the National High School Senior Survey showing that, starting in 1975, daily marijuana use had been increasing progressively among high school students. During the Reagan and Bush administrations the parents' movement and their concerns about marijuana use came to have a major influence on national drug policy. In the early 1990s, possession of the drug remained a criminal offense in most states, as well as under federal law.

*See also* Anslinger, Harry Jacob, and U.S. Drug Policy; Legal Regulation of Drugs and Alcohol; Monitoring the Future; Prevention.

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RICHARD J. BONNIE
Paraphernalia, Laws Against

Drug paraphernalia includes equipment, products, and materials that facilitate or enable the making, using, or concealing of illicit drugs. Some paraphernalia, such as hypodermic syringes for heroin and pipes for smoking marijuana, are used by consumers of drugs. Equipment such as scales, vials, and baggies, as well as chemicals used to dilute drugs, are examples of paraphernalia used by dealers of illicit drugs. The Federal Drug Paraphernalia Act, which is part of the Controlled Substances Act, makes it illegal to possess, sell, transport, import, or export drug paraphernalia as defined by the statute. In addition, laws prohibiting the possession and use of paraphernalia have been adopted in every state. Though constitutional objections have been raised against these laws, the U.S. Supreme Court has declined to strike down such statutes.

The first drug-paraphernalia laws, prohibitions against possessing opium pipes, were enacted by western states in the late nineteenth century as part of broad statutory efforts to suppress opium smoking by Chinese immigrants. During the first third of the twentieth century, some states, in conjunction with a legislative attempt to criminalize the non-medical use of opiates and cocaine, also prohibited the possession of hypodermic syringes without a medical prescription. By 1972, when the National Commission on Marijuana and Drug Abuse conducted a survey of state drug laws, about twenty states had adopted some type of drug-paraphernalia prohibition.

Commercialization of drug paraphernalia, especially through so-called head shops, in the early 1970s triggered a new generation of paraphernalia prohibitions, many of which criminalized the sale as well as possession of these articles. Such laws attempted to enforce comprehensive bans on drug-related devices or articles intended for use with illicit drugs.

The drug-paraphernalia industry responded to the enactment of these laws by challenging their constitutionality on grounds of vagueness and overbreadth. In most cases, courts struck down the laws as unconstitutionally vague. First, they applied to objects that had lawful as well as unlawful
uses, so these laws failed to provide fair notice of prohibited conduct. Second, the lack of explicit standards left police with discretion to enforce these laws in an arbitrary and discriminatory manner.

Since the late nineteenth century, the federal and state governments have enacted laws to regulate the possession and sale of drug paraphernalia, like the crack pipe pictured in Figure 1.

In 1979 the U.S. Drug Enforcement Administration (DEA) responded to these legal defeats by drafting a model law that could withstand constitutional scrutiny and at the same time effectively combat the drug-paraphernalia trade. The DEA drafted the Model Drug Paraphernalia Act (MDPA), which explicitly requires prosecutors to prove that the defendant knew the alleged paraphernalia would be used with illegal drugs. The addition of this intent requirement was designed to alleviate the fair-warning concern associated with the earlier generation of statutes. In addition, the MDPA attempts to provide a more specific definition of drug paraphernalia by listing objects included within the category and by providing factors that judges should consider in determining whether an object falls within the definition. Finally, the act prohibits placement of an advertisement when one knows, or “reasonably should know,” that it is intended to promote the sale of objects “designed or intended for use as drug paraphernalia.”

During the 1980s, most states enacted the MDPA or an equivalent statute, and legal challenges soon followed. In 1982 the Supreme Court upheld a local ordinance that required businesses to obtain a license in order to sell articles designed to be used with illegal drugs. Although this law did not involve a criminal statute prohibiting sale or possession of paraphernalia, lower courts subsequently upheld criminal laws modeled after the MDPA against vagueness and overbreadth challenges. In 1994 the Court addressed many of the MDPA issues when it reviewed the constitutionality of the Mail Order Drug Paraphernalia Control Act, which was part of the Anti-Drug Abuse Act of 1986.

This federal statute, which is modeled on the MDPA provisions, makes it a crime to use the U.S. mail to facilitate the sale and distribution of drug paraphernalia. The Court held that the statute was not unconstitutionally vague and that the seller need only be aware that customers in general are likely to use the merchandise with drugs. This reading of the intent requirement was a victory for law enforcement.

In the wake of the HIV/AIDS epidemic, another feature of traditional drug-paraphernalia laws has become controversial. In an effort to reduce the risk of transmission of the human immunodeficiency virus (HIV) and other blood-borne diseases among needle-sharing illicit drug users, state and local public-health authorities have sought to establish clean-needle exchange programs, usually through hospitals and clinics. To implement these programs, lawmakers have had to repeal the paraphernalia laws or prosecutors have agreed not to enforce them in this context. Many states and local governments have refused to support needle-exchange programs, and the federal government has not funded them due to concerns that dispensing needles will encourage illicit drug use. However, the National Academy of Sciences has concluded that these programs reduce the risk of HIV transmission and has found no evidence that they encourage drug use.

In general, drug-paraphernalia laws represent a type of drug legislation aimed mainly at declaring and symbolizing society's intolerance of illicit drug use. However, in 2003 the federal government's Operation Pipedream led to numerous criminal charges against eighteen companies selling drug paraphernalia. These companies accounted for annual sales of $250 million.
decriminalization or reduction in severity of criminal sanctions for possession of small amounts of marijuana, local law enforcement agencies have used paraphernalia laws as a way of exacting heavier criminal penalties. These laws are subject to highly discretionary enforcement and can have unintended costs or ramifications.

See also Legal Regulation of Drugs and Alcohol; Needle and Syringe Exchanges and HIV/AIDS; Parent Movement, The; Substance Abuse and AIDS.

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