Abstract

For decades, the United States has waged a moral crusade against illicit drugs and people who use such drugs, responding with criminal penalties. This punitive response to illicit substance use has increasingly been refuted by medical experts, policy makers, and the public. The effects of a 50-year War on Drugs have pushed illicit substance users further into the shadows of society, destroying families and communities, while wasting over one trillion dollars of taxpayer funding. Despite harm reduction efforts taking form in the country, irreparable damage has already led to over 841,000 drug overdose deaths since 1999. Additionally, drug usage statistics have come full circle since 1979 and there are more self-reported illicit drug users in the U.S. than ever before. If drug prohibition has accomplished anything, it is proving that it does not work.

This paper outlines four high-priority issues encompassing a broad spectrum of the criminal justice, public health, and personal freedoms conversations that the topic of drug prohibition elicits in everyday life. Drug prohibition has taught us that illicit substance usage can mean a variety of things. For instance, marijuana is classified as a Schedule I substance along with heroin and fentanyl, both of which are major contributors to the 162,630 drug overdose deaths in 2019 and 2020. Conversely, there are no reported deaths from marijuana ever. An extensive background/history is provided related to drug use in America, and an evidence-based policy proposal to reform existing drug law in the U.S. through comprehensive drug decriminalization is put forth. The proposal is then evaluated qualitatively, quantitatively, and politically, with a personal recommendation closing out the memorandum.

Capstone Advisor: Paul J. Weinstein, Jr.
Acknowledgements

This project is dedicated to my husband, Lukas. Thank you for all your love and support throughout the years, you mean more to me than I could ever express. Our conversations about the issues affecting the world keep me striving to learn and do more for our fellow humans.

Additionally, I would not be where I am today without the good fortune of my family and friends — thank you each and every one of you.
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DECISION MEMORANDUM

TO: Senator Chris Van Hollen, Maryland
FROM: Jessica Larson
SUBJECT: U.S. Drug Use and Possession
DATE: May 14, 2022

1. Action Forcing Event

On November 30, 2021, the nation’s first Overdose Prevention Center (OPC) opened in New York City.\(^1\) This type of facility serves as a safe place where people who use drugs can access a sanctioned location to administer drugs, while having on-site access to medical intervention services, including addiction treatment, and other social services. Despite accessibility in other countries,\(^2\) OPC services are seen as a controversial “harm reduction” approach towards addressing drug use in the U.S.\(^3\)

2. Statement of the Problem

As of 2018, the U.S. leads the world in the number of drug-related deaths, see Figure 1,\(^4\) page 2. The drug prohibition approach to curbing illicit drug usage and prescription drug misuse has not proven effective.\(^5\) For decades, this country has waged a moral crusade against drugs and people who use drugs, responding with criminal penalties. Harm reduction efforts are taking form

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\(^2\) Ibid.


in the U.S., but irreparable damage has already led to over 841,000 drug overdose deaths since 1999.

Figure 1. Opioid epidemic in the U.S. – Drug-Related Deaths

The Deadly Toll of America's Opioid Crisis

Countries with the highest estimated number of drug-related deaths per million persons aged 15-64

<table>
<thead>
<tr>
<th>Country</th>
<th>Year(s)</th>
<th>Death Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>2018</td>
<td>314.5</td>
</tr>
<tr>
<td>Australia</td>
<td>2016-2017</td>
<td>202.6</td>
</tr>
<tr>
<td>El Salvador</td>
<td>2018</td>
<td>184.5</td>
</tr>
<tr>
<td>Canada</td>
<td>2018</td>
<td>179.8</td>
</tr>
<tr>
<td>Uruguay</td>
<td>2016</td>
<td>119.4</td>
</tr>
<tr>
<td>Iceland</td>
<td>2012-2016</td>
<td>105.2</td>
</tr>
<tr>
<td>Sweden</td>
<td>2017</td>
<td>92.9</td>
</tr>
<tr>
<td>New Zealand</td>
<td>2016</td>
<td>88.6</td>
</tr>
<tr>
<td>Finland</td>
<td>2017</td>
<td>83.9</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>2017</td>
<td>83.0</td>
</tr>
</tbody>
</table>

Source: UNODC

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The American Civil Liberties Union (ACLU) claims “drug prohibition creates more problems than it solves.”\(^8\) The following four high-priority issues related to U.S. drug prohibition support this claim.

First, the intense criminal justice response to the nation’s illicit substance use crisis has been ineffective at decreasing substance use and abuse, lending to drug overdose deaths. In 1988, there were 14 million active illicit drug users, a decrease from the 1979 estimate of 24 million.\(^9\) The 1992 National Household Survey on Drug Abuse (NHSDA) estimated 11 million current illicit drug users\(^10\) and by the 2002, 2010, and 2018 National Survey on Drug Use and Health (NSDUH) there were 19.5,\(^11\) 22.6,\(^12\) and 31.9 million current users reported, respectively.\(^13\) Results from the 2020 NSDUH estimate a record number of current illicit drug users at 37.3 million individuals aged 12 and older.\(^14\)

Second, the War on Drugs has led to the disproportionate, systematic incarceration of Black and Latino communities over non-violent drug offenses for over 50 years.\(^15\) In 1994, John Erlichman, a Nixon policy advisor, publicly revealed it was President Richard Nixon and his administration’s agenda to masquerade racial and politically biased drug prohibition policies via

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These racial motivations have been likened to the “New Jim Crow,” and the federal government’s failure to correct such overtly discriminatory public policies sends a message of promoting the mass incarceration of minorities. Figure 2 shows the historical trend of disproportionate drug-related arrests between Whites and Blacks. Whereas Figure 3, page 5, compares 2015 estimates of self-reported drug usage by race versus the 2012 incarceration rates of sentenced drug offenders by race. Even though Whites report similar illicit drug usage rates, they were sentenced less than both Hispanics and Blacks.

Figure 2. Drug-Related Arrest Rates by Race, 1980-2010

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Third, in formulating drug policy, the federal government has failed to address the socioeconomic and public health factors of which illicit drug abuse is often a symptom. The United Nations Office on Drugs and Crime (UNODC) explains that there is “no one reason” why people do drugs. Rather, individual responses can vary from curiosity, enjoyment, or boredom, to deeper underlying causes such as an escape from psychological or physical pain, or in response to traumatic life experiences, among others.

Any reason can be exacerbated or even caused by an individual's lack of access to necessities such as health care, including mental health services, and/or lacking employment or educational opportunities. It is widely recognized that substance abuse is a medical condition needing medical intervention and not a personal moral failing. Public hesitancy to address

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22 Ibid.
23 Ibid.
substance misuse and abuse as such prolongs the treatment process.

Fourth, drug prohibition not only infringes on individual civil liberties, but the federal government’s failed efforts with alcohol prohibition should serve as a case study of how not to regulate illicit substances. The government is spending unsustainable amounts of money to stop drug use and abuse, with inconclusive results. In 2016, the annual estimate of local, state, and federal government spending on drug enforcement was $47.9 billion. Despite these enforcement budgets growing, they are continually dwarfed by the increasing national “cost of drug abuse,” such as drug-related crime, health care costs, and lost productivity. Costs which exceed $270 billion every year since 2017.

As of 2020, current illicit drug users comprise 13.5 percent of the U.S. population or 21.4 percent when accounting for past year usage. This not only means that the vast majority of people are not using illicit drugs despite their wide-spread accessibility, but it costs the country a cumulative $317 billion to target more than 70 million people based on drug use and possession.

Alcohol prohibition was repealed in part because the American people continued producing and consuming alcohol despite state and federal law prohibiting such. Similarly, 38 states and the District of Columbia have implemented either medicinal programs or recreational use legislation for adult consumption of marijuana. Yet, it is still illegal at the federal level and continues to be classified as a Schedule I substance with no “accepted medical use in

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30 Ibid.
These four high-priority issues encompass a broad spectrum of the criminal justice, public health, and personal freedoms conversations that the topic of drug prohibition elicits in everyday life. Drug prohibition has taught us that illicit substance usage can mean a variety of things. For instance, marijuana is classified as a Schedule I substance along with heroin and fentanyl, both of which are major contributors to the 162,630 drug overdose deaths in 2019 and 2020. Conversely, there are no reported deaths from marijuana ever.

The U.S. punitive response to illicit substance use has increasingly been refuted by medical experts, policy makers, and the public. The effects of a 50-year War on Drugs have pushed illicit substance users further into the shadows of society, destroying families and communities, while wasting over one trillion dollars of taxpayer funding. Drug usage statistics have come full circle and there are more self-reported illicit drug users in the U.S. than ever before. If drug prohibition has accomplished anything, it is proving that it does not work.

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35 Ibid.
36 See 7.
42 Lee, N. (2021). America has spent over a trillion dollars fighting the war on drugs. 50 years later, drug use in the U.S. is climbing again. Accessed February 7, 2022 from https://www.cnbc.com/2021/06/17/the-us-has-spent-over-a-trillion-dollars-fighting-war-on-drugs.html
3. History/ Background

Drugs of all sorts have religious, medicinal, recreational, and ancient beginnings. Opium dates back 6,000 years\(^\text{43}\) and is referenced in Sumerian medicine.\(^\text{44}\) Marijuana’s earliest documented use indicates ritualism in Central Asia dating back 5,000 years;\(^\text{45}\) whereas the stimulant cocaine is derived from South American coca plant leaves and dates back 3,500 years.\(^\text{46}\) Psychedelic mushrooms are more difficult to place historically and research suggests such substances might be older than the rest.\(^\text{47}\) In truth, the U.S. government did not intervene with the population’s use of drugs until the turn of the 20th century. For a few hundred years, people in the U.S. legitimately decided for themselves whether they wanted to use drugs.\(^\text{48}\)

18th and 19th Century Drug Use

Opium has long been in use throughout the medical field for its pain-relieving properties. While initially imported into Pennsylvania dating back to 1781, the cultivation of domestic opium poppy crops would flourish for over a century.\(^\text{49}\) Throughout the 1860s, opiates were increasingly used to treat Civil War soldiers and for anesthesia, allowing for the advancement of “modern surgery.”\(^\text{50}\)


The drug was available as morphine, in a powder or salt form, and for smoking, but the most common administration method was drinking medicinal preparations of opiate liquids or laudanum. So, despite nontherapeutic use, over-prescription by physicians remained the largest contributor to the prevalence of 19th century opium and morphine addictions.

In 1875, San Francisco, CA passed “the nation’s first anti-drug law” by outlawing the smoking of opium, a policy targeting Chinese opium dens. Mainstream forms of opiates remained unimpeded for purchase through pharmacies, doctors, or mail orders. By the end of the 19th century, the patent medicines industry inundated American consumers with advertisements making fantastical health claims, all while these preparations contained high alcohol content, cocaine, opium, and/or morphine.

Even so, the public did not consider drugs “as a menace to society,” and as such, drugs were legal for both recreational and medicinal use. The Sears and Roebuck catalog advertised cocaine via mail order, and Bayer sold and marketed heroin as cough syrup. Since little was known about addiction at this time, it was common to substitute heroin and morphine in cases of alcohol abuse. It wasn’t until the early 1900s when the federal government intervened, passing multiple legislative measures to control the rampant drug trade.

### Federal Intervention, Prohibition, and the Marijuana Tax Act

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52 See 49, p. 5.

53 See 51, p. 36.


57 See 49, p. 7.


59 See 55.

60 See 50.
To target patent medicines, the Food and Drugs Act of 1906 “prohibits interstate commerce in misbranded and adulterated food, drinks, and drugs.”\textsuperscript{61} The Smoking Opium Exclusion Act of 1909 was the federal expansion of West Coast measures seen 30 years earlier, influenced by international pressures of the Shanghai Opium Commission of 1909.\textsuperscript{62, 63} Followed by the 1914 Harrison Narcotic Act banning recreational opium and cocaine use,\textsuperscript{64} with regulations for the medical distribution and taxation of the two drugs, including derivatives.\textsuperscript{65}

The single most sweeping attempt to control substance use at this point was the ratification of the 18th Amendment in 1919 which prohibited “the manufacture, sale, and transportation of alcoholic liquors.”\textsuperscript{66} Coupled with the Volstead Act to enforce what is known as the Prohibition Era, these measures lasted until 1933, “when the 21st Amendment was ratified, overturning the 18th.”\textsuperscript{67}

For a while Prohibition seemed to work; “Consumption dropped, arrests for drunkenness fell, and the price for illegal alcohol rose higher than the average worker could afford.”\textsuperscript{68} This pricing led to the creation of an illegal market created around the bootlegging of potent home-brewed alcohols and the operation of speakeasy clubs. After a decade, “the demand for alcohol was outweighing the demand for sobriety,” with civil disobedience on the rise.\textsuperscript{69} Even though the Prohibition Era is associated with the ban of alcohol, multiple pieces of drug legislation were passed during this time. Figure 4, page 11, shows the “trends in prohibition and crime,” both

\begin{itemize}
  \item See 58.
  \item See 58.
  \item See 66.
  \item Ibid.
\end{itemize}
during alcohol prohibition and drug prohibition which would follow 30 years later.\textsuperscript{70}

**Figure 4. Trends in Prohibition and Crime, 1920-1999**

The Narcotic Drugs Import and Export Act of 1922 tightened controls for medical production and international trade of cocaine and opium, to include morphine, heroin, and opioids.\textsuperscript{71} Two years later, heroin no longer qualifies for medical use as the U.S. takes part in international conventions concerning drug law, and physicians and government officials deliberate over domestic “addiction maintenance.”\textsuperscript{72}

It was during the 1930s that Harry J. Anslinger, head of the newly consolidated Federal Bureau of Narcotics, promotes a “criminal justice approach to drug control.”\textsuperscript{73} Concurrently, Bill Wilson and Dr. Bob Smith found the U.S. based, international Alcoholics Anonymous initiative in 1935, a program premised on a 12-step plan to sobriety.\textsuperscript{74}

\begin{flushright}
\textsuperscript{72} See 62.
\textsuperscript{73} See 71.
\end{flushright}
With opiates and cocaine under strict surveillance, amphetamine use increased, and recreational marijuana use came under federal scrutiny with the 1937 Marijuana Tax Act (MTA) — despite the 1925 Panama Report concluding “marijuana has no harmful effects on users.”

Between the public’s association of marijuana with increased Mexican immigration, and as a gateway drug to heroin use, interpretation of the MTA suggests its intention was to “tax marijuana into oblivion.”

**Minimum Sentencing, Rehabilitation, and the War on Drugs**

Over the next 20 years, Anslinger oversaw the Opium Poppy Control Act of 1942, the Boggs Act of 1951, the Durham-Humphrey Amendment in 1951, the Narcotic Control Act of 1956, and the President’s Advisory Commission on Narcotics and Drug Abuse in 1962. These legislative pieces most notably created “mandatory minimum sentences for drug offenses” under the Boggs Act, then further increased drug sentencing for the possession and sale of marijuana and heroin under the Narcotic Control Act, including the death penalty.

In 1962, the Supreme Court overturned *Robinson v. California*, in a 6-2 decision, holding “that a status or condition [including drug addiction] may not be criminalized.” This reinforced the gradual shift in society from demanding strict drug law enforcement to a “desire to more fully understand the effects of drug use” — research pursued by the National Institutes of Health throughout the 1960s. Similarly, the 1966 Narcotic Addict Rehabilitation Act promoted treatment and rehabilitation in lieu of mandatory jail time.

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75 See 71.
77 See 63.
78 Ibid.
79 Ibid.
82 Ibid.
By the early 1970s, the government had yet to “control the drug problem,” prompting President Richard Nixon to declare drugs as “Public Enemy Number One.” The government was contending with a “countercultural revolution,” which included a wave of hallucinogenic drug use in the form of LSD, PCP, MDA, DOM, DMT, and DET. In an “effort to combine all previous federal drug laws,” the Comprehensive Drug Abuse and Control Act (CDACA) of 1970, specifically Title 2, the Controlled Substance Act (CSA) was to serve “as the legal foundation” for the federal government’s all-out war against drug abuse.

The federal implementation of drug scheduling falls under the CSA but mirrors standardized requirements set forth in two international treaties: the 1961 Single Convention on Narcotic Drugs, and the 1971 Convention on Psychotropic Substances. In order for the U.S. to maintain a comprehensive “list of controlled medications and illicit substances” in accordance with the treaties drug classification groups, the Drug Enforcement Agency (DEA) was created in 1973 as a “single-mission agency to enforce the CSA.”

In doing so it partnered with the Federal Bureau of Investigation (FBI) and combined other federal drug enforcement agencies. Within two years, the DEA’s annual budget nearly doubled to $140.9 million, employing over 2,000 special agents not including “chemists, intelligence analysts, and diversion investigators.” Drug use was at an all-time high in 1979, as shown in Figure 5, page 14, and would decrease by 50 percent within a decade, only to gradually

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82 Ibid.
84 See 62.
86 Ibid.
89 Ibid.
90 Ibid.
rise thereafter. So despite 11 states and the Senate Judiciary Committee’s efforts to decriminalize marijuana between 1973 and 1977, the federal government was positioned to do otherwise, and the public had eventually come around echoing blanket drug law enforcement.

**Figure 5. Current Use of Any Illicit Drug, 1979-2013**

Illicit drug use rates are lower by one-third compared to 30 years ago. In 1979, 14.1% of Americans aged 12 or older were using an illicit drug in the past month, compared to 9.4% in 2013.

**The Crack Epidemic, Mass Incarceration, The Opioid Epidemic, and Medical Marijuana**

Cocaine had made a comeback by the late 1970s and early 1980s, with special attention drawn to crack cocaine, a smokeable version of the drug. Sensationalized political and media coverage of a crack “epidemic” further increased public support for social control and punishment.

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against illicit drug use. The perception was powdered cocaine was expensive and associated with White users, while crack cocaine was considered cheap and associated with Black users.

The Anti-Drug Abuse Act of 1986 increased penalties for drug offenders, and budgeted $1.7 billion to continue the War on Drugs — of which “$97 million is allocated to build new prisons.” Of note, the 1986 Act differentiates “[crack cocaine] from powder cocaine and [requires] 100 times more powder cocaine than crack cocaine to trigger the more severe minimum sentence.” The timeline in Figure 6, page 16, shows the association of drug law sentencing with the increase of federal prison inmate counts from 1980 to 2015.

In 1989, The Office of National Drug Control Policy is formed, led by William Bennett, who campaigns on making “drug abuse socially unacceptable, an approach he calls denormalization,” meanwhile, federal spending on drug treatment increases, but “remains less than ⅓ of the total budget.” Between 1989 to 1990, state and federal governments spent $6.7 billion to add “more than 128,000 beds to prison capacity,” fueled by the idea of keeping dangerous drug offenders off the streets.

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95 See 76.
97 See 93.
98 See 88.
100 See 93.
Figure 6. Trends in Federal Drug Sentencing Laws and Inmate Count, 1980-2015
By 1991, the federal drug enforcement budget reached $10.5 billion, the media and public lost interest in “the crack phenomenon,” and “policy makers, including law enforcement and prison officials [start] to realize that arrests and imprisonment were relatively expensive and ineffective strategies for controlling illicit drug use.”\(^{102}\) Even so, the Supreme Court upholds the CDACA (1970) “no-knock” search provision on an individual case basis, in both *Wilson v Arkansas* (1995)\(^ {103}\) and *Richards v. Wisconsin* (1997).\(^ {104}\)

As cocaine lost popularity throughout the 1990s, a synthetic drug called methamphetamine reemerged throughout the Southwest region, prompting the Comprehensive Methamphetamine Control Act of 1996 to regulate “precursor chemicals such as pseudoephedrine.”\(^ {105}\) In the same year, Perdue Pharma brings OxyContin to the U.S. market,\(^ {106}\) and California defies the federal government by legalizing “medical marijuana,” a trend that has persisted throughout the nation.\(^ {107}\) Maryland was the 22nd state to adopt such a program in 2014; the year that Alaska, Oregon, and District of Columbia voters passed recreational marijuana for adults 21 or older.\(^ {108}\)

The Drug Addiction Treatment Act of 2000 allows “qualified physicians to prescribe and/or dispense narcotics” to treat opioid dependence, easing doctor patient ratio limits in 2005, 2006, and 2016.\(^ {109}\) As shown in Figure 7, page 18, these changes reflect a positive legislative response to the Centers for Disease Control and Prevention (CDC) reporting 500,000 deaths between 1999 to 2019 related to “three waves of opioid overdose deaths” in 1999, 2010, and

\(^{102}\) Ibid; See 94, p. 328-330.


\(^{105}\) See 88.


In 2010, President Barack Obama signed the Fair Sentencing Act of 2010 which addresses the disparity in crack cocaine sentencing by reducing “the statutory 100:1 ratio to 18:1, by increasing the threshold amount of crack cocaine to 28 grams” — instead of 5 grams.\(^{111}\) The 111th Congress failed to pass any of the five additional bills introduced that would have eliminated this statutory disparity completely.\(^{112}\)

From 2009 to 2013, 27 states moved “in the direction of easing” drug laws, “while 13 other states eased some laws and toughened others.”\(^ {113}\) Colorado and Washington legalize

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\(^{113}\) Desilver, D. (2014). *Feds may be rethinking the drug war, but states have been leading the way*. Accessed February 27, 2022 from https://www.pewresearch.org/fact-tank/2014/04/02/feds-may-be-rethinking-the-drug-war-but-states-have-been-leading-the-way/
marijuana “for recreational use” in 2012.\textsuperscript{114} And by 2014, the Pew Research Center reports Americans are gradually turning from a prosecutorial attitude to a treatment approach when asked about drug policy and how the government should supervise “those who use illegal drugs such as heroin and cocaine.”\textsuperscript{115}

Leading up to the 2016 election, candidate Donald Trump campaigned on building a border wall between the U.S. and Mexico, instilling and stoking fears “among many Americans that the most dangerous drugs are in fact crossing through the U.S. Mexico border.”\textsuperscript{116} This type of fear mongering may garner votes, but it does nothing to meaningfully work towards solving existing drug problems, including actual drug trafficking across this border.

With landmark legislation, in 2020, Oregon passed Measure 110, which “decriminalized possession of small amounts of almost all hard drugs,” making possession penalties “a civil citation,” with a waivable $100 fine.\textsuperscript{117} Meanwhile, 24 local and state legislations concerning psychedelic drugs and psilocybin use appear to be following the medical marijuana industry's early footsteps, as shown in Figure 8\textsuperscript{118} and Figure 9\textsuperscript{119} respectively. Figure 8 and Figure 9 are shown on page 20. These active entheogenic legislative efforts range from localized government reforms to state legalization statutes, with decriminalization or reduced penalties, extending to medical research or judicial exceptions.\textsuperscript{120}

\textsuperscript{115} See 41.
\textsuperscript{116} See 106, p. 118.
\textsuperscript{119} See 33.
\textsuperscript{120} See 118.
Figure 8. Mapping Psychedelic Drug Policy Reform

Figure 9. Mapping Marijuana Drug Policy Reform
In 2021, an estimated “500,000 Americans are incarcerated for drug offenses,” costing more than $9 million per day. These figures might be justifiable if drug use and abuse was depreciated accordingly, but it is not. People’s attitudes towards drugs and drug users have slowly gravitated towards a “harm reduction” approach, despite a long and complex journey over decades and centuries of trying to solve America’s drug problem.

**Drug Scheduling Explained**

The DEA drug scheduling system is still in use and categorizes drugs by the common physical and psychological effects people report while under the influence of that substance — whether consumed, inhaled, or injected. Biologically, drug reactions are identified as central nervous system depressants or stimulants, hallucinogens, dissociative anesthetics, narcotic analgesics, inhalants, or cannabis. Stemming from these psychophysiological responses the DEA distinguishes whether certain drugs have “acceptable medical use” and assess the potential risk for physical dependence or abuse when considering which of the five Schedules to place a drug under.

The lowest risk level for dependence and abuse are Schedule V substances, “containing limited quantities of certain narcotics,” such as Robitussin AC and Lyrica. Schedule IV substances have “low risk of dependence” and “low potential for abuse,” including Xanax, Valium, and Ambien. Schedule III substances have low to moderate potential for dependence with a similar risk level for abuse, and added potential for psychological dependence, drugs such

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121 See 114.
122 Ibid.
126 Ibid.
127 Ibid.
as Tylenol with codeine, testosterone, and ketamine.\textsuperscript{128} Schedule II substances have “high potential for abuse,” with an increased risk of physical and psychological dependence, and include methadone, oxycodone, fentanyl, methamphetamine, cocaine, codeine, morphine, and opium.\textsuperscript{129} Schedule II through V substances have recognized medical uses, whereas Schedule I has no “currently accepted medical use in the U.S.”\textsuperscript{130} Combined with “high potential for abuse” and “a lack of accepted safety for use of the drug under medical supervision,” Schedule I drugs include peyote, ecstasy, cannabis — also referred to as marijuana, LSD, and heroin.\textsuperscript{131} These Schedules in conjunction with state and federal mandatory minimum sentencing laws determine the severity of penalties drug offenders can incur.

4. Policy Proposal

\textit{Goals}

The first goal of this proposal is to reduce the number of drug overdose deaths to 19.7 per 100,000 population by 2030. This goal is derivative of the U.S. Department of Health and Human Services (HHS) \textit{Healthy People 2030} objective to “reduce drug overdose deaths” to 20.7 per 100,000 population.\textsuperscript{132}

The second goal is to reduce the number of arrests for personal use drug possession\textsuperscript{133} by 30% by 2025, for a projected 50% decrease by 2030. This goal is based on numbers provided by the Prison Policy Initiative, which estimates “1 million drug possession arrests” occur every year,
and have so since 1994, as shown in Figure 10.\footnote{Prison Policy Initiative. (n.d.). Drug Possession Arrests. Accessed March 9, 2022 from https://static.prisonpolicy.org/images/pie2017_drug_arrests.png}

**Figure 10. Trends in Drug Possession Arrests, 1980-2015**

![Graph showing trends in drug possession arrests from 1980 to 2015.](https://static.prisonpolicy.org/images/pie2017_drug_arrests.png)

**Overview**

under the CSA of 1970, Section 404, to repeal and supersede Section 405,\textsuperscript{137} wherein:

“(1) A person possessing or using a controlled substance in an amount no greater than the benchmark amount [(as outlined below)] shall not be subject to a criminal … penalty under this section.

(2) The suspected possession or use of a controlled substance in an amount no greater than the benchmark amount [(as outlined below)] shall not constitute a basis for detaining, searching, arresting, questioning or surveilling any person, or seizing property including, controlled substances and any items used for the ingestion, consumption, preparation, packaging, or storage of a controlled substance.

(3) The suspected possession or use of a controlled substance in an amount no greater than the benchmark amount shall not constitute a basis for any referral to any immigration enforcement agency, U.S. Citizenship and Immigration Services, U.S. Immigration and Customs Enforcement, and U.S. Customs and Border Protection.”\textsuperscript{138}

For instance, the PUE will apply to every citizen and non-citizen found in possession of a less than or equal quantity of any drug, i.e., a benchmark amount. Contingent upon no other violations of law, this person cannot be criminally penalized, detained in any official capacity, or subject to forfeiture of said drugs or paraphernalia by law enforcement.

Furthermore, benchmark quantities apply to the following drugs, per person, and are not limited to such substances as, marijuana, hash, and related concentrates: possession of less than 25 grams,\textsuperscript{139} in addition to:

“LSD: Possession of fewer than 40 user units of lysergic acid diethylamide (LSD)…


\textsuperscript{138} See 135.

Psilocybin and Psilocin [to include Peyote]: Unauthorized possession of fewer than 12 grams… Methadone: Unauthorized possession of fewer than 40 user units… Oxycodone: Unauthorized possession of fewer than 40 pills, tablets, or capsules… Heroin: Possession of less than one gram… MDMA/Ecstasy, MDA, MDEA/Eve: Possession of less than one gram, or fewer than five pills, tablets, or capsules of 3,4-methylenedioxymethamphetamine (MDMA/Ecstasy)… Cocaine: Unauthorized possession of less than two grams… Methamphetamine: Unauthorized possession of less than [one] gram…”

Substances not listed should receive further analysis by the DEA and categorization with drugs of comparable psychophysiological attributes with the understanding that no criminal penalty shall be pursued against someone in possession of the substance. Instead, the possession of any combination of such substances, per person, are subject to one civil penalty per date of incident in accordance with all other decriminalized drugs. These two sets of dense verbiage outline the guidelines from which law enforcement officers will respond to drug possession offenses.

Meaning, previous criminal penalties for drug possession will be reduced to civil penalty violations “punishable by a $100 fine. In lieu of a fine, a person charged with a violation may instead complete a [qualified] health assessment [as recommended by HHS].” A qualified health assessment location can be approved through an existing 24/7 national helpline operated by the Substance Abuse and Mental Health Services Administration (SAMHSA) under HHS. In essence, those that are compelled to seek drug treatment or rehabilitative services will have a resource to inquire through, while others can elect to pay the fine, or lapse and risk further legal obligations, depending on jurisdiction.

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140 See 136.
142 See 136.
Any criminal activity leading to the arrest of a person involving drug use shall proceed with due process and without consideration of PUE benchmark limits of drug possession(s), which will incur at maximum the civil penalty violation of $100. Drug possession quantities over benchmark limits shall proceed with criminal charges under distribution and/or drug trafficking statutes per 21 USC 841.144

People receiving five or more violations within a four-year period will be subject to appearance at state level drug court to have their civil penalty violations reviewed by a judge for potential recommendations for probation, drug testing, and/or mandatory enrollment in rehabilitation or treatment services.145 Law Enforcement Assisted Diversion (LEAD) services are to be exhausted prior to drug court,146 if available within a jurisdiction.

Federal Agency Coordination: Under DDUP, the Attorney General (AG) will remain the “regulatory authority”147 because drug law enforcement will continue to be scrutinized against benchmark amounts of drug possession, with greater than quantities following standard criminal proceedings. The AG will also report state and federal drug possession arrest statistics on an annual basis to the Secretary of HHS and Director of the Office of National Drug Control Policy (ONDCP) with analysis as to the progress of enforcement effort reforms. In response, both entities will correspond with the AG as to what public health efforts and/or harm reduction training can be implemented at the federal, state, and local level to advance progress towards the 2025 and 2030 goals.

For example, these agencies and their leaders will engage in sharing of best practices with respect to harm reduction strategies, such as advocating the use of fentanyl testing strips for those who use drugs, syringe exchange programs, and related drug intervention services which promote

147 See 135.
a public health driven approach to addressing the drug use problem in the U.S. Thus, setting a
new standard for a new era of drug law. The agencies will work together to put forward suggested
best practices for police officers, teachers, health professionals, government officials, and
interested parties to further promote achieving the two policy goals.

This policy aims to target adult drug users aged 18 years and older at the receiving end of
both policy goals, in reducing drug overdose deaths and decreasing the number of drug use and
possession arrests. As for the delivery portion of this policy, it targets local and federal law
enforcement officers, including drug enforcement officers, to acknowledge and uphold the civil
penalty and benchmark limit changes regarding personal drug use and possession
decriminalization as set forth in DDUP.

Authorization Tools

This policy reforms existing legislation, the CSA of 1970. Therefore, it will need to be
proposed as a bill through the Senate and must attain majority votes in both the Senate and
House, including subcommittees, before consideration by the President to sign into law.

Congressional legal authorization is needed to establish this policy as the new federal
precedent by which personal use and possession of illicit drugs, below benchmark limits, is no
longer punishable by criminal penalties. This is due to explicit prohibition of “any illicit
production, distribution, or possession of such substances”\textsuperscript{148} under the CSA of 1970. Changing
the federal law and creating a PUE allows time for the necessary changes in drug law
enforcement to go into effect — whereas an Executive Order cannot achieve the same level of
change needed\textsuperscript{149} and is subject to revocation by Congress, the courts, and subsequent

\textsuperscript{148} CRS. (2021). The Controlled Substances Act (CSA): A Legal Overview for the 117th Congress. Accessed March 11,
2022 from https://sgp.fas.org/crs/misc/R45948.pdf

\textsuperscript{149} CRS. (2021). Does the President Have the Power to Legalize Marijuana? Accessed February 20, 2022 from
https://crsreports.congress.gov/product/pdf/LSB/LSB10655
administrations.\textsuperscript{150}

\textit{Implementation Tools}

When signed into federal law, this policy rests on federal law enforcement officers updating protocol when encountering a person using or possessing drugs “in an amount no greater than the benchmark amount.”\textsuperscript{151} This signals state governments, including law enforcement officers to do the same. In passing this policy, Congress will acknowledge, “drug decriminalization is a critical next step toward achieving a rational drug policy that puts science and public health before punishment and incarceration.”\textsuperscript{152}

By not arresting people who use or possess drugs, an estimated $3.5 billion\textsuperscript{153} annually will be available to fund law enforcement training, add HHS staff, and expand LEAD programs, in addition to covering all administrative costs. Another estimate put forward is $4.2 billion dollars,\textsuperscript{154} indicating that reducing drug use and possession arrests frees up substantial amounts of money typically used to begin criminal prosecutions. Instead, these targeted law enforcement efforts are reallocated towards harm reduction efforts. “Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use”\textsuperscript{155}—such as a criminal record, severe illness, or death.

This $3.5 billion estimate comes from a conservative calculation of 800,000 drug possession arrests, at a cost of “$4,390 per arrest.”\textsuperscript{156} To gauge the number of PUE encounters law

\textsuperscript{151} See 135.
\textsuperscript{154} See 152.
\textsuperscript{156} See 153.
enforcement will inevitably recommend for LEAD services or drug court due to severe substance use disorders, a 9.4 percent estimate was taken from the Bureau of Justice Statistics regarding “perceived drug or alcohol use by offender.”\textsuperscript{157} By this estimate, $1.51 billion will be spent annually sending 75,200 individuals to LEAD services to further assess their substance use disorders. These funds cover case worker services for two years, at $900 per month for 20 months, per individual, with costs adjusted to “$532 per month towards the end of the evaluation.”\textsuperscript{158} LEAD services “[hold] considerable promise as a way for law enforcement and prosecutors to help communities respond to public order issues stemming from unaddressed public health and human services needs [such as] addiction… through a public health framework that reduces reliance on the formal criminal justice system.”\textsuperscript{159}

$800 million will go to hiring 10,000 additional HHS employees. Half of these new hires will provide federal, state, and local law enforcement training centered around harm reduction and public health approaches to helping drug users avoid the criminal justice system. The remaining new hires will be assigned to the SAMHSA 24/7 national helpline to manage the influx of calls seeking to locate and verify drug assessment services in response to civil violations for drug use and possession.

The AG can use official reports prepared by the Department of Justice (DOJ) reporting drug possession arrest statistics for annual reporting to the Secretary of HHS and Director of the ONDCP; so long as one annual report from the AG is delivered with a thorough analysis reflecting the progress of DDUP enforcement effort reforms. The Secretary of HHS and Director of the ONDCP are to respond at minimum on a biannual basis to the AG with “evidence-based harm reduction strategies”\textsuperscript{160} to advance progress towards the 2025 and 2030 goals.

\textsuperscript{159} See 146.
Funding will need to be authorized via Congressional appropriations, then distributed by ONDCP. $1.16 billion from both the Treatment and Domestic Law Enforcement functions of the Federal Drug Control Budget, as shown in Table 1,\(^{161}\) will be allocated to fund LEAD services and hire HHS staff.

State, local, and federal law enforcement agencies not enforcing DDUP civil penalty violations will be subject to the withholding of federal funds.\(^ {162}\) State and local law enforcement agencies are to coordinate with state legislators to review drug policy and the best methods for implementation of PUE.

### Table 1. Federal Drug Control Funding by Function, in millions, FY 2020-2022

<table>
<thead>
<tr>
<th>Function</th>
<th>FY 2020 Final</th>
<th>FY 2021 Enacted</th>
<th>FY 2022 Request</th>
<th>FY21 - FY22 Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>$16,459.5</td>
<td>$20,069.7</td>
<td>$20,567.7</td>
<td>$+498.0 +2.5%</td>
</tr>
<tr>
<td>Percent</td>
<td>41.5%</td>
<td>49.7%</td>
<td>50.1%</td>
<td></td>
</tr>
<tr>
<td>Prevention</td>
<td>$2,177.2</td>
<td>$2,803.8</td>
<td>$2,933.3</td>
<td>$+129.5 +4.6%</td>
</tr>
<tr>
<td>Percent</td>
<td>5.5%</td>
<td>6.9%</td>
<td>7.1%</td>
<td></td>
</tr>
<tr>
<td>Domestic Law Enforcement</td>
<td>$10,237.3</td>
<td>$10,560.6</td>
<td>$10,577.2</td>
<td>$+16.5 +0.2%</td>
</tr>
<tr>
<td>Percent</td>
<td>25.8%</td>
<td>26.2%</td>
<td>25.8%</td>
<td></td>
</tr>
<tr>
<td>Interdiction</td>
<td>$9,545.8</td>
<td>$5,837.9</td>
<td>$5,872.6</td>
<td>$+34.7 +0.6%</td>
</tr>
<tr>
<td>Percent</td>
<td>24.1%</td>
<td>14.5%</td>
<td>14.3%</td>
<td></td>
</tr>
<tr>
<td>International</td>
<td>$1,263.6</td>
<td>$1,101.9</td>
<td>$1,093.2</td>
<td>$-8.8 -0.8%</td>
</tr>
<tr>
<td>Percent</td>
<td>3.2%</td>
<td>2.7%</td>
<td>2.7%</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$39,683.3</td>
<td>$40,374.0</td>
<td>$41,043.9</td>
<td>$+669.9 +1.7%</td>
</tr>
</tbody>
</table>

Enactment and enforcement of this policy would be the first major step on behalf of the federal government in removing the stigma attached with using drugs. First, it allows drug users with substance use disorders, who are at the greatest risk of overdose and death, to seek treatment

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\(^{162}\) See 135, Section 14.
without the fear of criminal penalty.\textsuperscript{163} Second, it decreases the number of arrests of non-violent drug users so that law enforcement resources can focus on “prevent[ing] serious and violent crime.”\textsuperscript{164}

Based on the stated problems related to the criminal justice approach of drug use in the U.S., this policy addresses approximately 30% of the overall illicit substance use issue. It aims to reduce drug overdose deaths to a higher percentage than other federal targets,\textsuperscript{165} and it aims to reduce the arrest rate of people who use drugs, which should further reduce the overall incarceration rate of drug offenders of all races. Both efforts restore a degree of “personal autonomy” and allow “otherwise law-abiding” people to go about their private lives.\textsuperscript{166} However, this policy does not address the overall rate of drug use, or the socioeconomic issues prompting drug use.

5. Policy Analysis

To evaluate this policy proposal for effectiveness, one must first consider whether the proposal can achieve its two stated goals. One, to reduce the number of drug overdose deaths to 19.7 per 100,000 population by 2030. Two, to reduce the number of arrests for benchmark amounts of drug possession 30\% by 2025 and 50\% by 2030. These goals are assessed within the context of the present state of the U.S. drug crisis, i.e., more people than ever overdosing and reporting to use illicit drugs, coupled with complex national problems related to the criminal justice system, lacking public health services, socioeconomic factors, and neglected civil rights issues because of outdated drug policy for 50 years.

Taking these factors under advisement, the two policy goals can be achieved in their entirety based on case study analyses of Portugal’s comprehensive drug decriminalization policy,

\textsuperscript{163} See 152, p. 3.
\textsuperscript{164} Ibid.
\textsuperscript{165} See 132.
\textsuperscript{166} See 8.
in effect since 2000, and Oregon’s passing of Measure 110 in November 2020, which is supplemented by the states historical trends of “lower than the national average” drug mortality rates.\textsuperscript{167} Portugal is the main case study for the goal of decreasing drug overdose deaths and Oregon is the primary case study regarding the goal to reduce the number of arrests for personal use drug possession.

\textbf{Achieving Goal 1}

Following Law no 30/2000,\textsuperscript{168} i.e., Portugal’s drug decriminalization measure — including heroin — overdose death rates decreased 21\% from 369 in 1999\textsuperscript{169} to 290 in 2006.\textsuperscript{170} A trend represented in Figure 11,\textsuperscript{171} page 33. In 2013, Portugal reported three drug overdose deaths per million population\textsuperscript{172} and eight deaths accordingly for 2019, a statistic below the European average of 25 overdose deaths per million population.\textsuperscript{173} Portugal’s drug decriminalization process has been coupled with widely available harm reduction measures, a tactic the U.S. has focused on under the Biden Administration.\textsuperscript{174}

\textsuperscript{171} Ibid, p. 20.
\textsuperscript{174} See 3.
Since 2008, the U.S. has more than doubled the treatment portion of the Federal Drug Control budget, allocating $15.5 billion as of 2020 in spending for drug treatment efforts, see Figure 12. There is no indication this steadily increased funding has contributed to lower drug overdose deaths during the same period as shown in Figure 13, page 34. The National Institute on Drug Abuse (NIDA) reports an increase in U.S. overdose deaths between 1999 to 2017 from a rate of 6.1 per 100,000 population to 21.7, statistics confirmed by HHS resulting in a 250% increase.

Figure 12. U.S. Federal Drug Control spending on treatment and prevention, 2008-2020

175 See 29.
178 See 176.
As the first U.S. state to decriminalize all drug use and possession in November 2020, Oregon has not released complete drug overdose death statistics for 2021 but it has maintained a lower drug overdose mortality rate “than the national average since 2012.”\(^{179}\) As of March 17, 2022, the Oregon Health Authority reported 473 “unintentional opioid overdose deaths” between January and August 2021,\(^{180}\) noting separately that opioid related deaths account for approximately 70% of the state's overall increase of drug overdose deaths,\(^{181}\) which is on par with national trends.\(^{182}\)

Portugal’s decriminalization efforts were in response to the drug crisis the country faced...
throughout the 1990s,\textsuperscript{183} see Figure 14.\textsuperscript{184} Whereas Oregon’s actions indicate preventative measures targeting an ordinarily steady drug overdose mortality rate from 2006 to 2017, as depicted in Figure 15.\textsuperscript{185} A consistent trend ending at 12.6 in 2018.\textsuperscript{186} In 2019 and 2020, Oregon saw an 11\% and 34\% increase respectively,\textsuperscript{187} with the national average increasing 4\% and 30\%\textsuperscript{188} in drug related deaths accelerated by the COVID-19 pandemic.\textsuperscript{189}

**Figure 14. Number of Acute Drug-Related Deaths, Portugal, 1987-1999**

![Graph showing number of acute drug-related deaths in Portugal from 1987 to 1999](image)

**Figure 15. Drug overdose deaths, Oregon and U.S., 2006-2017**

![Graph showing drug overdose deaths in Oregon and the U.S. from 2006 to 2017](image)

\textsuperscript{183} See 169, p. 3.
\textsuperscript{184} See 170, p. 19.
\textsuperscript{187} Ibid.
\textsuperscript{188} See 7 and 37.
By considering the drug related mortality reports from Portugal and Oregon it is projected this policy can achieve the goal to reduce the number of drug overdose deaths by 9% as of 2030. This decreases the 2019 drug-related mortality rate from 21.6 to 19.7, an entire point lower than the listed goal of 20.7 by the Healthy People 2030 initiative.\textsuperscript{190} The justification for using the 2018 National Vital Statistics System baseline of 20.7 as a target rate to return to is based on the practicality of first stopping the increase of drug overdose deaths, then reducing the number.\textsuperscript{191} This analysis considers the Healthy People 2030 goal within the scope of existing drug policy and conservatively aims to further decrease their goal another 5% provided federal drug decriminalization under DDUP.

\textit{Achieving Goal 2}

Even prior to drug decriminalization, Portugal did not routinely arrest and prosecute drug possession charges at a rate comparable to that of the U.S.\textsuperscript{192} See Figure 16,\textsuperscript{193} page 37, for Portugal’s rates and Figure 17,\textsuperscript{194} page 37, for the U.S. Nevertheless, Portugal continues to report an overall decrease in criminal drug sentencing following decriminalization, as shown in Figure 18,\textsuperscript{195} page 37. Subsequently, the country’s drug-related incarceration rate came in line with that of the European average as of 2018 and comprises a greater proportion of drug dealers as opposed to drug users.\textsuperscript{196}

\textsuperscript{191} See 132.
\textsuperscript{192} See 169, p. 6.
\textsuperscript{193} See 170, p. 9.
\textsuperscript{196} See 170, p.9.
Figure 16. Individuals Charged, By the Year and Drug-Related Status, Portugal, 1997-2005

Figure 17. Number of U.S. arrests, by type of drug law violations, 1982-2007

Figure 18. Percentage of Prisoners sentenced for drug offenses, Portugal and Europe, 2001-2019
One year after Oregon’s decriminalization law took effect in February of 2021, drug-related arrests decreased 59% from 9,100 to 3,700 over the same 10-month period in 2020.\footnote{Sutton, M. (2022). \textit{One Year of Drug Decriminalization in Oregon}. Accessed March 30, 2022 from https://drugpolicy.org/press-release/2022/02/one-year-drug-decriminalization-oregon-early-results-show-16000-people-have} While it remains too early to predict the success or failure of this legislation, local and state law enforcement officials have at least acknowledged the change in legal proceedings.\footnote{Ibid.} State officials commented that drug-related arrests in 2021 “tend to be for dealer quantities,”\footnote{Crombie, N. (2021). \textit{Oregon's drug decriminalization law off to a patchy start}. Accessed March 31, 2022 from https://www.police1.com/legal/articles/oregons-drug-decriminalization-law-off-to-a-patchy-start-8z2Sj7Vkk5YW1Bly/} which corresponds with Portugal’s results. As part of Measure 110, $302 million has been secured for treatment, harm reduction, recovery services, and housing for two years.\footnote{See 197.}

The Portugal and Oregon case studies indicate that this policy’s goal to reduce the number of annual personal drug possession arrests by 300,000 people as of 2025, with a continuing decrease of 500,000 people by 2030\footnote{Using a 1 million drug arrest estimate, See 168.} is attainable with the support of law enforcement and public health officials. This policy focuses on long-term sustainability and therefore relies on conservative estimates of results.

\textit{Efficiency}

With the two goals having a reasonable chance at success, this section pertains to the initial $2.32 billion required in funding as noted in the policy implementation section on pages 28 through 31. The Year 1 funding request is divided between the two largest ONDCP departments Treatment and Domestic Law Enforcement, followed by Interdiction, Prevention, and International. Exact distributions are shown in Figure 19,\footnote{Ibid.} page 39, as to the size of each department.


\footnote{See 197.}

\footnote{Using a 1 million drug arrest estimate, See 168.}

\footnote{Ibid.}

\footnote{See 29.}
The 2022 Treatment budget is $20.5 billion, and the Domestic Law Enforcement budget is $10.5 billion. Their selection is based on consideration of the continued drug trafficking law enforcement policies to remain in effect under existing legislation within the three other departments. And as a good faith effort in transitioning the applicable workforce away from the criminal justice approach for personal drug possession policy to a public health approach. These contributions amount to six percent of the Fiscal Year 2022 Treatment budget and 11 percent of the Domestic Law Enforcement budget, using the amounts from Figure 20,\textsuperscript{203} page 40.

Starting in Year 2, both departments should expect a decrease in required DDUP funding allocations from their budgets. Year 2 and onward will require $400,000 from each department to sustain the 10,000 HHS staff to oversee the national helpline and conduct harm reduction training. Closer to the 2030 deadline, budget savings from fewer drug possession arrests and associated criminal justice costs\(^{204}\) should be available to redirect financial resources to pay for this aspect of the policy. These discretionary funds would release the Treatment and Domestic Law Enforcement budgets from their financial obligation. This is contingent on appropriate enforcement and training efforts put into effect with guidance and involvement on behalf of the AG, HHS, and ONDCP. As a result, role restructuring should be under way in Year 1 to accommodate the changes to drug policy.

The unique aspect of this funding method is that each department will continue to oversee enforcement within their area of updated drug policy. It is not a loss of revenue, but a temporary

and mandatory reallocation of funds to help implement multiple aspects of the new legislation. In an administrative sense, HHS will add 10,000 staff, while federal, state, and local law enforcement agencies manage reorganization and restructuring.

Based on the $3.5 billion\textsuperscript{205} and $4.2 billion\textsuperscript{206} estimates of savings retained due to fewer arrest expenditures, by 2030 the two involved ONDCP departments should maintain self-sufficient funding for all aspects of this policy. The reasoning behind these projected savings is because up to three dollars can be “saved in crime reduction,” for every “dollar spent on treatment.”\textsuperscript{207} On this note, NIDA reports the biggest “economic benefit of treatment is seen in the avoided costs of crime,” e.g., victimization and incarceration costs.\textsuperscript{208} Existing drug policy allocates more money to the treatment facet of drug enforcement as of 2022, however, these efforts are stifled by domestic law enforcement efforts to arrest and incarcerate drug users. This proposed policy will allow predicted cost benefits to be realized.

The financial back-up plan includes withholding funds as necessary from federal, state, and local law enforcement agencies not enforcing civil penalty violations under DDUP.\textsuperscript{209} The idea is to shift funding away from old drug policies, not including drug sales or trafficking, to determine if better financial and community returns can be made by implementing a new drug policy with funds already in circulation. The FY 2023 budget is requesting $42.5 billion for the Federal Drug Control Budget, an increase of $3.2 billion over FY 2022.\textsuperscript{210} This level of spending

\textsuperscript{205} See 153.
\textsuperscript{206} See 152.
\textsuperscript{209} See 135, Section 14.
for the observed results, i.e., record number of drug overdose deaths and self-reported illicit drug use, combined with over one million annual drug possession arrests, is unsustainable given the state of the federal deficit, see Figure 21.

**Figure 21. Federal Deficit Trends Over Time, 2001-2021**

![Federal Deficit Trends Over Time, 2001-2021](chart)

*The last time the US government had a surplus was in 2001.*

**Equity**

This policy and its implementation strives to include relevant actors such as state, local, and federal law enforcement agencies, including drug courts, the AG, HHS, ONDCP, treatment and harm reduction partners, and people who use drugs in a unified effort to change the way the U.S. manages its persistent drug crises. The two goals listed within this policy aim to provide the most amount of good to the greatest number of people with sustainability in mind, while treating

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211 See 25.

people who use and abuse drugs with dignity. HHS describes harm reduction as, “Helping people where they are, without judgement, stigma, or discrimination.”\textsuperscript{213}

By accomplishing these two goals in their entirety, i.e., reducing the number of drug overdose deaths and the number of arrests for personal use drug possession by 2030 — approximately 30\% of the larger national drug problem will be addressed. For instance, consider each goal and the four broad drug issues mentioned within the scope of this policy proposal. One, reduce the number of drug overdose deaths, encompassing the larger national issue of self-reported drug use prevalence. Two, reduce the number of arrests for personal use drug possession, encompassing the larger national issue of the criminal justice system’s racial disparities. Three, acknowledge inadequate public health services and socioeconomic factors affecting people who use drugs. Four, acknowledge the civil liberty violations of people who use drugs, who have committed no other crime other than drug use and/or possession.

Achieving the two stated goals will positively influence the national issues under consideration, but to a small extent provided the severity of the drug crisis dilemma. Meeting the 2030 deadline put forth, indicates the government can expect further gains as to the continued improvement of each situation related to the high-priority national drug issues discussed. Figure 22, page 44, shows the 2030 benchmark estimates by each of the four issues and related policy goals. Each issue is divided by percent achieved and not achieved under the DDUP policy proposal. By implementing a federal drug possession policy exception, the government will address 9\% of the nation’s drug overdose deaths, 7\% of the racial disparities in the criminal justice system, 6\% of inadequate public health services and socioeconomic factors, and 8\% of civil liberties issues involving people who use drugs.

\textsuperscript{213} See 160.
Figure 22. *Measuring policy goals achieved by 2030, via high priority issues related to national drug use*

As the *Healthy People 2030* initiative states, stopping the increase of drug overdose deaths is the first step in curbing drug use rates, which will benefit people of all demographics.\(^{214}\) It is beyond the scope of this policy to reduce the number of people who use drugs; therefore, a sizable portion of this issue remains not achieved at 16%.

Shifting criminal prosecutions to civil violations for quantity threshold drug possession will reduce the number of people arrested on drug possession charges, which accounts for more than 80% of drug offense arrests.\(^{215}\) This should positively impact the racial disparities associated with criminal drug offenses because as research suggests such disparities exist between the demographics of reported drug users and the incarceration rates of sentenced drug offenders by race.\(^{216}\) Fewer overall arrests for drug possession should translate to fewer arrests of minorities. However, it is beyond the scope of this proposal to estimate the percentage of racial disparities among drug trafficking offenders, as well as producers. It is also worth noting that this proposal does not address the situations of those already convicted on drug charges, including possession. Therefore, 18% of the existing racial disparity issue as it relates to the criminal justice system and

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\(^{214}\) See 29.
\(^{215}\) See 134.
\(^{216}\) See 18 and 19.
drug arrests will remain a substantial problem.

Harm reduction efforts will supplement lacking public health services and detrimental socioeconomic factors, a positive development in U.S. drug policy when compared to a unilateral criminal justice response for drug use problems.\textsuperscript{217} DDUP policy targets people receiving civil violations by law enforcement for drug possession, it does not address people who remain unable or unwilling to locate and/or receive other drug treatment services. Taking these criteria into consideration, this policy will not address 19% of the national public health problems related to drug use.

Restoring a degree of civil liberty to people who use drugs goes a long way to mending the breach of trust between the government and the people as it relates to drug law. The War on Drugs sought to eliminate drug use by incarcerating drug users, a costly tactic that has decidedly not worked.\textsuperscript{218} Drug use and abuse is a complex medical issue wherein not all people who use drugs go on to abuse drugs, and drug problems can persist “even in the absence of a disorder.”\textsuperscript{219} Changing drug policy to allow drug users to seek harm reduction, treatment, and other drug intervention services without fear of criminal prosecutions sets a new precedent for a new era of U.S. drug reform. Despite the ability of this policy to modestly improve and protect the civil rights of people who use drugs, it will leave 17% of this overall issue not achieved.

Pros

The positive gains from implementing this policy proposal include:

➤ Reducing the national drug overdose mortality rate

➤ Reducing the number of annual arrests for drug possession


\textsuperscript{218} Hudak, J. (2021). \textit{Biden should end America’s longest war: The War on Drugs}. Accessed April 1, 2022 from https://www.brookings.edu/blog/how-we-rise/2021/09/24/biden-should-end-americas-longest-war-the-war-on-drugs/

\textsuperscript{219} See 25.
➢ Saves $3.5 billion in annual drug related arrest costs that can be otherwise used for harm reduction efforts
➢ Reduces the racial disparity in drug possession arrests that lead to incarceration
➢ Adds drug intervention services in the form of LEAD programs resulting in alternative non-arrest pathways for drug users
➢ Restores a degree of civil liberty to people who use drugs and have committed no other crime
➢ Sets a new precedent of personal drug possession law that the U.S. can embark on, effectively ending the War on Drugs

Cons

The negative aspects of implementing this policy proposal include:

➢ $2.32 billion in Year 1 mandatory budget reallocations involving multiple federal and state level agencies
➢ Despite achieving long-term norms, following decriminalization, Portugal had sporadic years of increased population drug use rates, drug-induced deaths, and drug-related homicides
➢ The Portugal case study could be insufficient in population comparison to serve as a reliable measure of changing U.S. federal drug policy; Portugal has a population of 10 million and the U.S. has a population of 328 million
➢ The Oregon case study lacks sufficient results to analyze the positive or negative effects

of the state’s decriminalization law for scalability at the federal level

➢ Does not address the prevalence of national drug use rates
➢ Relies on federal, state, and local drug law enforcement officials to adopt civil penalties over criminal penalties for drug possession offenses, a reversal of 50 years’ worth of legislation

6. Political Analysis

Americans continue to have varied opinions concerning the nation’s chronic drug problems, but the trend over the last decade has increasingly leaned towards a more public health driven response. In 2014, the Pew Research Center reported 67 percent of Americans want the government to prioritize “treatment [not jail] for those who use illegal drugs such as heroin and cocaine.” Five years later, in September 2019, a Cato Institute survey found 55 percent of Americans supporting decriminalization of drug offenses.

Similarly, a June 2021 Bully Pulpit poll announced an increase to 66 percent of Americans in favor of “eliminating all criminal penalties for drug possession and reinvesting saved resources into treatment and addiction services.” Of particular interest, this Bully Pulpit poll notes that 83% of Democrats, 85% of Independents, and 82% of Republican participants indicate “the War on Drugs has failed.” Along these party lines, 92%, 79%, and 76% respectively, respondents “believe it is important that the President and Congress reform the country’s drug laws.”

These types of surveys provide insight into American attitudes towards drug use and its

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226 See 41.
229 Ibid.
230 Ibid.
perceived effects on society. Whether prompted by increasingly liberal state marijuana legislation or for other reasons, the majority of Americans are no longer demanding harsh criminal penalties for people who use drugs. Instead, the U.S. appears to be using state marijuana legislation as a case study for the possibility of state decriminalization measures, as seen with Oregon.

Oregon was the first state to decriminalize marijuana in 1973, then passed medical marijuana legislation in 1998, and recreational marijuana legislation in 2014. This is not to say that each state will follow Oregon’s drug policy, culminating in full drug decriminalization, but drug bills are more frequently introduced to state and federal Congresses. For instance, LD 967, a drug decriminalization measure in Maine passed the House, but failed in the Senate in July 2021. On January 14, 2022, Vermont legislators introduced H.644, a similar decriminalization bill, to the House and is awaiting further activity. According to the organization Marijuana Moment, over 1,300 drug bills were under consideration in U.S. legislative sessions during 2021, with 900 still active as of January 2022.

As for the federal government, the Drug Policy Reform Act is the first comprehensive federal drug decriminalization bill; it was introduced to the House in June 2021 and is still under consideration with the Subcommittee on Highways and Transit. Meanwhile, federal marijuana decriminalization efforts are underway by both Republicans and Democrats.

H.R. 5977, the States Reform Act, sponsored by South Carolina Representative Nancy

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236 See 135.
Mace (R) and H.R. 3617, the Marijuana Opportunity Reinvestment and Expungement (MORE) Act, sponsored by New York Representative Jerrold Nadler (D). The States Reform Act was introduced to the House in November 2021 and was referred to the Subcommittee on Health as of January 2022. The MORE Act was introduced to the House in May 2021, passed the House, and awaits a Senate vote as of April 2022.

U.S. federal law upholds that any controlled substance not in compliance with permitted commercial, recreational, or research usage is a violation of the Controlled Substances Act and subject to criminal penalty. “The CSA imposes a unified legal framework to regulate certain drugs—whether medical or recreational, legally or illicitly distributed—that are deemed to pose a risk of abuse and dependence.”

However, 19 states have passed legislation fully legalizing marijuana for adult use, 26 states have a “mixed” classification of not fully legal or illegal status, and six states remain under fully illegal classifications of the Schedule I drug. To complicate marijuana law further, 32 states have decriminalized marijuana possession, including two states that have neither passed legislation for legal or medicinal marijuana, Nebraska, and North Carolina.

In Maryland, marijuana has a mixed classification as it is decriminalized and available through medicinal provisions. In November 2022, Maryland voters will decide the state’s marijuana legal status under HB 1, and if the March 2022 Goucher College poll is correct in reporting 62 percent of residents support legalization, recreational marijuana is all but certain in

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239 See 237.
240 See 238.
242 See 33.
243 Ibid.
Maryland — given the trends in other states. Additionally, in March 2020, “Maryland State’s Attorney Marilyn Mosby announced that drug and paraphernalia possession… would no longer be prosecuted in Baltimore City.”246 This is yet another example showing that despite conflicting federal, state, and local drug laws, reform is possible, and quite possibly, inevitable.

The Drug Policy Alliance, a New York based nonprofit,247 in a comprehensive 2017 decriminalization proposal lists 17 national and international organizations openly supporting decriminalizing drug use and possession in the U.S.248 Such organizations include the Johns Hopkins–Lancet Commission, World Health Organization, Human Rights Watch, ACLU, National Latino Congreso, UNODC, National Association of Criminal Defense Lawyers, and the National Association for the Advancement of Colored People (NAACP).249 In the previous year, the DPA sent a letter to the United Nations Secretary General, Ban Ki-moon, with over 1,000 world leaders’ signatures advocating “real reform of global drug policy control,”250 in which you signed.251

Dr. João Castel-Branco Goulão, a key contributor of the Portugal decriminalization legislation, stated in an April 2021 Brookings online seminar, *The Biden administration’s drug policy strategy and lessons from Portugal*, that in deliberating solutions to Portugal’s 1990s drug crisis, “the government gave us all the freedom to propose whatever we wished… but [it] must fit
within the spirit of the treaties of the United Nations." This echoes the DPA’s 2016 letter, “Drug control efforts must never do more harm than good, or cause more harm than the drug misuse itself.” As of January 2020, there are 49 jurisdictional models of drug decriminalization across 29 countries.

Even with domestic and international examples of drug decriminalization efforts, American voters split along party lines with Republicans exhibiting more hesitance on the issue when compared to Democrats and Independents, see Figure 23.

**Figure 23. Data for Progress Poll, Drug Decriminalization response**

Would you support or oppose decriminalizing the possession of small amounts of controlled substances?

[Bar chart showing support levels for drug decriminalization across parties]

This May 2021 survey by Data for Progress also reports a higher percentage of Republicans — when compared to Democrats — agree that “Federal drug policies are not working” and need reform — yet these same Republicans are torn on committing to a science-

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253 See 251.


based approach for handling drug related crime and addiction, see Figure 24\textsuperscript{256} and Figure 25,\textsuperscript{257} respectively.

**Figure 24. Data for Progress Poll, Federal Drug Policy response**

Congress is currently considering legislation that would reform federal drug policies. Which of the following comes closer to your view, even if neither is exactly right?

- Federal drug policies are not working and we need to reform them
- Don’t know
- The current federal drug policies are working, and there is no need to reform them

<table>
<thead>
<tr>
<th>Party</th>
<th>Not Working</th>
<th>Don’t Know</th>
<th>Working</th>
</tr>
</thead>
<tbody>
<tr>
<td>Democrat</td>
<td>67%</td>
<td>11%</td>
<td>22%</td>
</tr>
<tr>
<td>Independent</td>
<td>80%</td>
<td>15%</td>
<td>5%</td>
</tr>
<tr>
<td>Republican</td>
<td>70%</td>
<td>9%</td>
<td>21%</td>
</tr>
</tbody>
</table>

**Figure 25. Data for Progress Poll, War on Drugs response**

How convincing do you find this argument?
Overly harsh and outdated “War on Drugs” policies focus too much on politics and punishment rather than public safety. It’s time to try approaches to drug crime and addiction based on science.

<table>
<thead>
<tr>
<th>Convincing</th>
<th>Very Convincing</th>
<th>Somewhat Convincing</th>
<th>Not Very Convincing</th>
<th>Not At All Convincing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Democrat</td>
<td>40%</td>
<td>42%</td>
<td>13%</td>
<td>5%</td>
</tr>
<tr>
<td>Independent</td>
<td>30%</td>
<td>34%</td>
<td>21%</td>
<td>15%</td>
</tr>
<tr>
<td>Republican</td>
<td>17%</td>
<td>36%</td>
<td>26%</td>
<td>20%</td>
</tr>
</tbody>
</table>

\textsuperscript{256} Ibid.  
\textsuperscript{257} Ibid.
As drug decriminalization becomes a more widely discussed issue in the U.S., it is important for politicians, medical professionals, and constituents to stay abreast of evidence-based approaches to countering the nation’s lingering drug problem. The 2016 letter to the UN Secretary General emphasized, “Humankind cannot afford a 21st century drug policy as ineffective and counterproductive as the last century’s.” When all is said and done, American voters are responsible for deciding how the next era of drug legislation unfolds at the local, state, and federal levels — and if there is any semblance of a united front.

7. Recommendation

The data I have represented indicates that despite the U.S. government spending more money than ever before to combat drug use, people report using drugs at record high numbers, and deaths from drug overdoses have also reached annual record-breaking numbers. Under no circumstance could this have been the goal of drug prohibition. My humble recommendation is for you to sponsor the Decriminalization of Drug Use and Possession policy proposal and introduce it as a bill on the Senate floor.

The Drug Policy Reform Act of 2021, which this proposal is based on, attempts to make too many changes to existing drug legislation. As an alternative, DDUP focuses on a framework for implementing comprehensive federal decriminalization of drug possession within the agencies already charged with enforcing drug law. The strength of this policy comes from the positive externalities experienced by society when the federal government adopts a science-based, public health approach to treating drug abuse. This is an approach the government has been slow to adopt since criminal penalties still take precedence. While there is a 2030 timeline to evaluate preliminary policy goals, the real value comes after decades of people surviving, and choosing to recover from their drug addiction.

See 251.
For over 50 years, the U.S. government has made countless attempts to stop drug use and abuse — two actions that went unimpeded in the early centuries of this nation. Throughout the course of the War on Drugs certain states have experienced higher than average drug overdose mortality rates, like West Virginia. From 2014 to 2020, West Virginia ranked first in the annual number of drug overdose deaths; meanwhile, Maryland has fluctuated in the national ranking, see Table 2.\footnote{See 186.}

**Table 2. Maryland Drug Overdose Mortality, 2014-2020**

<table>
<thead>
<tr>
<th>Year</th>
<th>Rank</th>
<th>Death rate per 100,000 population</th>
<th>Total number of overdose deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>6th</td>
<td>44.6</td>
<td>2,771</td>
</tr>
<tr>
<td>2019</td>
<td>4th</td>
<td>38.2</td>
<td>2,369</td>
</tr>
<tr>
<td>2018</td>
<td>3rd</td>
<td>37.2</td>
<td>2,324</td>
</tr>
<tr>
<td>2017</td>
<td>7th</td>
<td>36.3</td>
<td>2,247</td>
</tr>
<tr>
<td>2016</td>
<td>6th</td>
<td>33.2</td>
<td>2,044</td>
</tr>
<tr>
<td>2015</td>
<td>14th</td>
<td>20.9</td>
<td>1,285</td>
</tr>
<tr>
<td>2014</td>
<td>20th</td>
<td>17.4</td>
<td>1,070</td>
</tr>
</tbody>
</table>

With state level marijuana reform taking place across the country since 1996, as well as state and local reforms for other drugs, one must ask themselves: If the War on Drugs did not achieve its goal of eliminating drug use by using criminal penalties as the primary deterrent, why

\footnote{See 186.}
does it remain the default drug policy, despite public support for an alternative approach? The negative side effects attributed to Portugal’s decriminalization measure, i.e., increased drug use rates, drug-related deaths, and drug-related homicide rates, were sporadic observations that eventually found lower than average rates,\textsuperscript{260} with speculative drug-related homicide rates.\textsuperscript{261}

The American people deserve the opportunity to decide for themselves whether they want to use drugs, not out of fear from incarceration, but whether it benefits their physical and mental well-being. People who choose to use drugs or suffer from drug abuse deserve health resources to prevent unintended illnesses or death until a time when they decide to seek rehabilitative services. The U.S. government needs to end the War on Drugs and begin a new era of prevention, treatment, harm reduction, and drug decriminalization to protect the people within its borders.

Such efforts are taking form at grassroot stages across the country — but the severity of the national drug problem will take an equally serious solution. Drug law as it currently exists in the 21st century is unconstitutional. I am asking you, Senator Van Hollen, to support total drug decriminalization efforts at the federal, state, and local levels by sponsoring the DDUP policy. I believe in doing so you will gain respect from your peers and constituency alike because this is an evidence-based effort to improve the national drug prohibition problem by 30 percent within the next eight years.

This policy proposal supplies an in-depth evaluation of four high-priority issues related to the U.S. illicit drug problem by chronicling drug law since 1875, and putting forth policy that achieves two measurable goals with net positive externalities. Even if this policy does not pass the Senate, it will move the conversation forward concerning drug law reform in the U.S., including sharing of best practices as it relates to harm reduction “[as] a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use.”\textsuperscript{262}

\textsuperscript{260} See 220.  
\textsuperscript{261} See 222, p. 108.  
\textsuperscript{262} See 155.
abuse has inflicted a sustained national crisis, and the criminalization of illicit substance use has succeeded in making the situation worse. This policy is a framework for the federal government to amend existing drug law to more accurately reflect the individual right to possess personal amounts of otherwise illegal substances, allowing law enforcement to dedicate budgetary resources to other areas of the law and to harm reduction services, like LEAD.

By sponsoring this policy, you are advocating for personal freedoms, expanding health services, addressing racial disparities in the criminal justice system, saving lives, giving hope to people who use drugs, as well as their families and communities. I am asking you to champion the people most vulnerable to the consequences of the War on Drugs — a domestic war which continues to label people who use drugs as the enemy. In closing, with your support this proposal can help contribute to a sustainable and thriving democracy, wherein every life is important to the government, and drug possession is decriminalized.
Curriculum Vitae

Jessica was born and raised in Southern California in 1989; she is the youngest of four siblings. She married in 2011 and moved to Las Vegas, Nevada where she finished her Bachelor of Science in Health Administration from the University of Phoenix in 2013. While living in Las Vegas, Jessica volunteered with the Court Appointed Special Advocates (CASA) program, where she represented the best interest of children in foster care and advocated on behalf of their physical, emotional, medicinal, educational, and social needs.

In 2016, Jessica enlisted in the Army as a Medical Laboratory Technician. She was stationed at Fort Sill in Lawton, Oklahoma, Fort Sam Houston in San Antonio, Texas, Walter Reed National Military Medical Center in Bethesda, Maryland, and the United States Army Medical Research Institute of Infectious Diseases (USAMRIID) at Fort Detrick in Frederick, Maryland. She completed her initial contract with the Army after four and half years.

Jessica is a Presidential Management Fellow (PMF) Finalist for the Class of 2022. She will graduate with a Master of Arts in Public Management, and Certificate in Data Analytics and Policy from Johns Hopkins University in May 2022. She currently lives in Baltimore, Maryland. Her research interests include government transparency, civic engagement, socioeconomic development, and vulnerable populations.