EGUZKILORE
Número 16.
San Sebastián
Diciembre 2002
127 - 136

HARM REDUCTION PROGRAMS IN THE U.S.A.: EMERGING TRENDS

Eric L. JENSEN

Department of Sociology, Anthropology and Justice Studies - University of Idaho

Resumen: Actualmente, en E.E.U.U los esfuerzos a favor de los programas de reducción de daños en materia de drogas son mínimos, a pesar de que estos programas aparecieran en los años 70. El sistema de justicia penal se ha convertido, desde los años 80, en el elemento predominante para controlar a los usuarios de drogas ilegales. Esto se refleja en el aumento del número de detenciones relacionadas con las drogas, así como en un mayor número de personas en prisión condenadas por este tipo de delitos. A pesar de, y en algunos casos como reacción a la considerable generalización del uso del derecho penal y el encarcelamiento para hacer frente a la delincuencia relacionada con la droga, las políticas de reducción de daños están apareciendo en varios estados, particularmente en el oeste.

Laburpena: Nahiz eta 70. hamarkadan jaio ziren min murrizketa programak, gaur egun Estatu Batuetan ez da beraien alde gauza gehiegirik egiten Justizi penalaren sistema 80. hamarkadatik bihurtu da kontrol sistemarik garrantzitsuena drogen arloan. Honek bere islada hainbat eta hainbat atxiloketetan du, baita kartzelan arazo honengatik dagoen jende kopuruan. Hala ere esan daiteke, nahiz eta gero eta era orokorragoz kartzela zigorren bidez egiten zaion aurre drogen arazoei, esan beharra dago, gero eta erreztasun handiagoz erabiltzen hasten direla mina murrizten duten politika programak.

Résumé: Actuellement, en E.E.U.U les efforts en faveur des programmes de réduction de dommages en matière de drogues sont minimaux, bien que ces programmes apparaissent dans les années 70. Le système de justice pénale est devenu, depuis les années 80, l'élément prédominant pour contrôler aux consommateurs des drogues illégales. Ceci se reflète dans l'augmentation du nombre de détentions en rapport avec les drogues, ainsi que dans un plus grand nombre de personnes en prison condamnées par ce type d'infractions. Malgré, et dans quelques cas comme réaction, la généralisation de l'utilisation du droit pénal et l'emprisonnement pour faire face à la délinquance en rapport avec la drogue, les politiques de réduction des dommages apparaissent dans plusieurs états, particulièrement dans l'ouest.

Summary: The topic of harm reduction programs for illegal substances in the U.S.A. today is a rather minimal endeavor, in spite of these programs began here during the 1970s. The dominant method of handling users of illegal drugs since 1980 has increasingly become the criminal justice system. This is reflected in increases in arrests for drug offenses and increases in the numbers of persons in prisons convicted of drug offenses. Despite, and in some cases in reaction to, the immense expansion of the use of criminal law and incarceration in the handling of drug offenders, harm reduction policies are emerging in several states, particularly in the west.

Palabras clave: Drogas, Derecho penal, Sistema de justicia penal, Programas de reducción de daños.

Hitzik garrantzizkoenak: Drogak, Zuzenbide penala, justizi penalaren sistema, min murrizketarako programak.

Mots clef: Drogues, Droit Pénal, Système de justice pénale, Programmes de réduction des dommages.

Key words: Drugs, Penal Law, Penal justice system, Harm reduction programs.

Acknowledgments

The author would like to acknowledge the suggestions and assistance of the following persons in developing and writing this article: Professor Dr. Jose Luis de la Cuesta, Sarah Eilers, Andy Ko, and Volker Ratzman.

Harm reduction programs began in the U.S.A. during the 1970s[1]. The most dramatic change of the time was the depenalization of the possession of small amounts of cannabis for personal use at the state level. Beginning in 1973 with the state of Oregon, eleven states eventually depenalized possession of small amounts of cannabis. Possession became subject to a small fine, for example $100 to $200. Approximately one third of the population of the nation resides in these eleven states.

Methadone substitution programs spread rapidly in the late 1960s and early 1970s. Fueled in part by the perception of widespread intravenous use of heroin by U.S. military personnel in Vietnam –which was later shown to be false, even the conservative Nixon administration supported the spread of methadone treatment programs. By 1973, however, critics of methadone programs had mounted a "regulatory counter attack" that resulted in a complex set of restrictive regulations (see Rosenbaum, 1997).

Thirdly, programs were started to provide sterile syringes to users. These programs emerged in cities with high rates of IV heroin use such as Tacoma, Washington and San Francisco, California. Sterile syringe programs in the U.S.A. have often been quasi-legal or overlooked by local legal authorities.

The topic of harm reduction programs for illegal substances in the U.S.A. today is a rather minimal endeavor, however. As is widely known, the dominant method of handling users of illegal drugs since the Reagan Administration took office in 1980 has increasingly become the criminal justice system. This is reflected in increases in arrests for drug offenses and increases in the numbers of persons in prisons convicted of drug offenses.

From 1980 to 2001 arrests for drug offenses increased about 425 percent. In 1999, 2000, and 2001 drug offenses were the most common form of crime for which people were arrested for the first time in U.S. history. In 2001 nearly 1.6 million drug arrests were recorded. Eighty-one percent of these arrests were for possession of an illegal substance and 41 percent of the total drug offense arrests were for possession of cannabis (Maguire, and Flanagan, 1991; Maguire and Pastore, 2001; www.fbi.gov/ucr/ucr.htm).

Although the increase in arrests for drug offenses was substantial during past two decades, the increase in prison populations has been much greater. The largest prison complex in the U.S. is made up of the separate state systems. From 1980 to 2001,

---

1. See Erickson, et al. (1997) and Erickson and Butters (1998) for overviews of harm reduction principles and strategies.

the number of persons in state prisons for drug offenses increased by 1,220 percent. In the smaller federal system, the number of persons in prison for drug offenses increased by 1,370 percent during the same time period. In 2001 there were an estimated 321,000 persons in prison for drug offenses (www.ojp.usdoj.gov/bjs/prisons.htm.)[2]. The larger growth in prison populations than in arrests leads this author to conclude that a much larger proportion of persons who are arrested for drug violations are going to prison now than in the past (see also Everett, 1998).

This movement toward the increased use of prison to handle drug offenders can be conceptualized as harm maximization. Although minority racial/ethnic group members and their communities have been the most severely impacted, the harms engendered by this explosion in the use of incarceration for drug offenses in the U.S.A. has widespread adverse consequences throughout society (see Tonry, 1995; Everett, 1998; Christie, 2000; Jensen, Gerber, and Mosher, forthcoming).

MEDICINAL CANNABIS

Although the criminal law has been used as the primary mechanism with which to handle users of illegal drugs in the U.S. for approximately the past twenty years, there are new harm reduction programs emerging across the nation. These programs are coming primarily from grassroots efforts to achieve change in the punitive American model. The foremost of these policy changes is in the medicinal use of cannabis. In 1996 voters in the states of California and Arizona were the first to support propositions that allowed the use of cannabis for medical purposes.

Before we review these new state-level laws, it must be pointed out that cannabis "is a controlled substance under federal law and is classified in the most restrictive of categories of drugs by the federal government. The federal Controlled Substances Act of 1970 (CSA) places all federally controlled substances into one of five 'schedules,' depending on the drug's likelihood for abuse or dependence, and whether the drug has an accepted medical use. Marijuana is classified under Schedule I, the classification reserved for drugs that have been found by the federal government to have a high abuse potential, lack of accepted safety under medical supervision, and no currently accepted medical use… The CSA does not allow Schedule I drugs to be dispensed upon a prescription, unlike drugs in the other schedules. In particular, the CSA provides federal sanctions for possession, manufacture, distribution or dispensing of Schedule I substances… except in the context of a government-approved research project" (U.S. General Accounting Office, 2002: 6). Thus, these new state laws are in direct conflict with federal law.

The California law took effect on November 6, 1996. It removes the state-level criminal penalties on the use, possession, and cultivation of cannabis by patients who possess "a written or oral recommendation" from their physician that he or she "would benefit from medical marijuana." Patients diagnosed with any debilitating ill-

---

2. A person is sentenced to prison in the U.S.A. when their sentence is one year or more of incarceration.

ness for which the medical use of cannabis has been "deemed appropriate and has been recommended by a physician" are afforded legal protection under this law. Specific medical conditions for which cannabis can be recommended are not specified in the law. No limits were set regarding the amount of cannabis patients may possess and/or cultivate in this Act. The Act did not establish a patient registry. Some local jurisdictions have developed guidelines for amounts in possession and registries, however (U.S. General Accounting Office, 2002)[3].

The Arizona Drug Medicalization, Prevention, and Control Act took effect on December 6, 1996. One part of the Act sought to seek legal protections for seriously ill patients by allowing doctors to "prescribe" Schedule I controlled substances such as cannabis. Because federal law ultimately forbids physicians from prescribing Schedule I drugs, however, this statute does not adequately protect patients from state-level criminal penalties as do similar state laws that only require "recommendation" that medical marijuana therapy may be beneficial. A separate section of this proposition which precludes prison sentences for the possession of small amounts of illegal drugs does apply to medical patients. The Arizona attorney general's office reports that physicians in the state are not advocating medicinal cannabis to their patients under this law (www.norml.org).

The Arizona state government attempted to stop the implementation of this law. A bill signed by the Governor on April 21, 1997 sought to repeal the medical marijuana law. This bill was placed on the ballot in the November 3, 1998 election and was rejected by voters with a vote of 57 percent to 43 percent (www.norml.org). Thus, the law which took effect in 1996 continues to be in effect today.

The 1996 Arizona law also contained mandated alternative sentencing for non-violent drug offenders. We will return to this harm reduction effort in the next section of the paper.

Medicinal cannabis laws have subsequently been enacted in seven other states and the District of Columbia: Alaska in 1998, Oregon in 1998, Washington in 1998, Maine in 1999, Colorado in 2000, Hawaii in 2000, and Nevada in 2000. A number of similar features are found in these state laws:

- they remove state-level criminal penalties on the use, possession, and cultivation of cannabis by patients who possess written documentation from their physician affirming that he or she suffers from a debilitating condition and advising that they may benefit from the medical use of marijuana (Alaska, California, Colorado, Hawaii, Maine –or oral recommendation, Nevada, Oregon, Washington)
- patients diagnosed with specified illnesses are afforded legal protection under these laws. Illnesses frequently specified in these laws are: cachexia, cancer with chronic pain, Crohn's disease, pain or chronic pain, epilepsy and other disorders characterized by seizures, glaucoma, HIV or AIDS, multiple sclerosis

3. It must be noted that California depenalized possession of small amounts of cannabis for personal use in 1976.

and other disorders characterized by muscle spasticity, and nausea (Alaska, Colorado, Hawaii, Maine, Oregon)

– other conditions may be added by state boards of health (Alaska, Colorado, Hawaii, Nevada, Oregon, Washington)

– an amount of cannabis allowed in possession or cultivation by patients or their primary caregivers is specified in the law (Alaska, Colorado, Hawaii, Maine, Nevada, Oregon, Washington)

– the state establishes and maintains a confidential registry that issues identifying cards to qualifying patients to avoid arrest for possession of cannabis (Alaska, Colorado, Hawaii, Nevada, Oregon)

Voters in the District of Columbia (i.e., Washington, D.C.) also passed an initiative legalizing the use of cannabis for medicinal purposes in 1998. The enactment of this initiative was blocked by the U.S. Congress as part of an appropriation bill for the District of Columbia local government (the "Barr Amendment"), however. The District of Columbia does not have the degree of autonomy that the states enjoy. It is administratively controlled by the federal government. Thus, Congress has the authority to block such local initiatives. The "Barr Amendment" also prohibits the city from ever lowering or eliminating penalties for use of Schedule I drugs (including cannabis and MDMA), even for medical use. This section of the Barr Amendment is being challenged in federal court.

ISSUES OF SUPPLY

The major obstacle in making cannabis available to patients for medicinal use is the absence of a legal supply of the drug. Cannabis currently is being supplied by illegal growers and "cannabis clubs" that exist to assist patients in obtaining the drug. This is somewhat similar to the Dutch dilemma with coffee shops where the supply coming in the back door is illegal and the cannabis going out the front door is legal[4].

Although local authorities in California and the western portion of Washington state have generally been tolerating these illegal sources of supply, the federal Drug Enforcement Administration (DEA) has acted to close a number of the sources of supply in California.

One U.S. Supreme Court decision has been rendered on the legality of supplying medicinal cannabis to patients. In *U.S. v. Oakland Cannabis Buyers' Cooperative*, 532 U.S. 483 (2001), the Court reversed and remanded a decision from a lower federal court, and held that there was no medical-necessity exception to the Controlled Substances Act's prohibition of the medical use of cannabis. The Court ruled that although the Act did not explicitly abrogate such an exception, it was clear from the text of the Act that Congress had made a determination that cannabis had no medical benefits that deserved an exception.

---

4. I would like to thank Justin Nelson for suggesting this analogy.

The DEA raids have received very negative reactions in northern California. Recently a large demonstration was held in Sacramento, the capital of the state, protesting these raids. In addition, several local law enforcement agencies in northern California have refused future cooperation with the DEA because of their raids on medicinal cannabis suppliers.

Another sanction threatened by the federal government was to revoke a physician's license to prescribe drugs if he/she recommended cannabis to patients for medicinal purposes. A federal appeals court recently ruled on this proposed action. In October 2002 the Ninth Circuit Court of Appeals three-judge panel in San Francisco unanimously upheld the right of physicians to recommend cannabis to their patients and for patients to receive that recommendation. The Court ruled that such a prohibition would interfere with the free-speech rights of physicians and patients. Chief Circuit Judge Mary Schroeder wrote "An integral component of the practice of medicine is the communication between doctor and a patient. Physicians must be able to speak frankly and openly to patients"(*Conant v. Walters,* 309 F.3d 629, 9th Cir. 2002). In a concurring opinion, Judge Alex Kozinski wrote that there exists a wealth of evidence that may support the usefulness of medicinal cannabis. He also commented that the federal government attacked physicians as a means to paralyze California's medicinal cannabis laws. This case was brought by patients' rights groups, and physicians who said they have been fearful of recommending cannabis even if it is in a patient's best interests.

The Sociopolitical Climates of the States

Several observations can be made about the passage of these medicinal cannabis laws. First, all of these jurisdictions with the exception of Maine and the District of Columbia are in the western portion of the U.S.A. The reason(s) underlying this dominance of western states in the establishment of medicinal cannabis laws is not completely clear. One reason may be that the states of California, Oregon, and Washington are rather liberal, by U.S. standards—although California was a leader in the swing to the political right in the U.S. during much of the 1970s and the 1980s. On the other hand, Arizona and Colorado are not in the liberal camp.

In addition, residence in the west seems to engender populist reactions to many forms of imposition by the federal government. This tendency is pronounced in Arizona, Nevada, and Alaska. Other western states such as Idaho, Montana, and Wyoming share this populism but have not been involved in the medical cannabis movement, however.

Further, five of these states were among the first to depenalize the possession of cannabis in the mid-1970s. These states include Alaska, Oregon, California, Maine and Colorado. Depenalization may have laid the groundwork for the passage of medical cannabis initiatives.

Citizen Initiatives: Grassroots Efforts

Another interesting sociopolitical thread that runs through most of these new medicinal cannabis laws is that in all cases, with the exception of Hawaii, they were

enacted through the citizen initiative process. This process is rather unique in western democracies. Initiatives are organized by obtaining a specified percentage of the signatures of registered voters in a state to place a proposed new law on the ballot. It is then subject to a vote in that state. In this way, citizens can place issues on the ballot without going through the machinery of formal government—except for a verifications of the registered voter status of the signatories and of the minimum number of signatures needed to place the issue on the ballot. In my experience thus far this type of system exists only in the U.S.A., Switzerland, and the state of Berlin.

Another feature of these initiatives is that they are supported and assisted by Non-governmental Organizations (NGOs) such as the Drug Policy Alliance, the American Civil Liberties Union, the Campaign for New Drug Policies, and the Massachusetts Cannabis Reform Coalition. These NGOs provide funding, information, and/or organizational strategies to the grassroots groups that spearhead such initiatives. In some cases, they also provide direct lobbying efforts.

The November 2002 Elections

A number of harm reduction measures were on the ballot in the November 2002 elections in states and municipalities across the nation. Although most of these measures were defeated, several bills related to medicinal cannabis were supported by the voters. San Francisco approved an initiative that requires city officials to explore the possibility of growing and distributing medicinal cannabis.

This initiative was largely in reaction to the DEA raids on medicinal cannabis suppliers in California. A three-member committee will be appointed to hold hearings and bring professional expertise in exploring the legal and medical ramifications of the program.

Massachusetts voters supported initiatives in 21 districts to allow medical cannabis patients to grow and possess the substance. These initiatives are non-binding and are intended to inform lawmakers of the will of the people in their districts. That is, the passage of these initiatives did not create new legislation. These initiatives also asked legislators to vote in favor of legislation that would depenalize the possession of cannabis and to allow farmers in the state to grow industrial hemp.

THE MOVEMENT TOWARD TREATMENT INSTEAD OF INCARCERATION

Another part of the Drug Medicalization, Prevention and Control Act of 1996 passed by voters in Arizona, required that non-violent drug offenders arrested for simple possession or use of an illegal drug must receive drug treatment instead of a penal sentence for their first and second offenses (www.drugpolicyalliance.com). This was the first such law in the U.S. but received much less attention in the media than a similar law passed later in California.

An analysis by the Arizona Supreme Court found that this legislation diverted 2,600 non-violent offenders into drug treatment in its first year, saving Arizona taxpayers $2.56 million. Over three-fourths of the offenders tested drug-free after com-

pleting the program. A follow-up Supreme Court study in 2001 found that the law saved over $6 million in prison costs in its second year. The Supreme Court concluded, "The Drug Medicalization, Prevention, and Control Act of 1996 has allowed the judicial branch to build an effective probation model to treat and supervise substance abusing offenders…" (www.drugpolicyalliance.com).

In 2000 voters in California supported a similar initiative. Proposition 36 (the Substance Abuse and Crime Prevention Act) allows first and second time non-violent, drug possession offenders the opportunity to receive substance abuse treatment instead of incarceration. The law took effect July 1, 2001. It also allocated $120 million annually for five and one half years to pay for treatment services (www.drugpolicyalliance.com). Although this initiative followed the first one of this type in Arizona, it received much more attention in the media, possibly because California is the most populous state and it tends to be a national trend setter.

One of the factors behind voter support for this initiative was the explosion in drug offenders imprisoned in California and the associated financial costs. Between 1980 and 1999 the number of people in prison for drug offenses in California increased from 1,778 to 45,455—or 2,556 percent. In comparison, between 1980 and 1995 the adult population of the state grew by 20 percent (Longshore, Hser, Prendergast, Evans and Anglin, 2002). Those in prison for simple possession of illegal drugs comprised 12.3 percent of the state's prison population in 2000 (www.drugreform.org).

Prior to the vote on this initiative, the California Legislative Analyst's office projected that passage of the initiative would save the state $200 million to $250 million per year in reduced state prison operating costs within several years after implementation. In addition, it was projected that by slowing the growth of the prison population, this law would delay or make unnecessary the construction of a new prison, with capital savings of between $450 million and $550 million (www.drugreform.org).

Within the first ten months after it took effect, this law was responsible for diverting over 12,500 individuals into treatment instead of prison in five counties alone. In California, it costs $26,894 per year to place a person in prison, and an average of $4,500 to place a person in treatment (www.prop36.org). The decrease in incarceration of female drug offenders has been so substantial that some lawmakers are considering closing one or two of the four women's prisons to help reduce California's budget deficit (www.drugpolicyalliance.com). After the first year following enactment of the law, there were 3,955 fewer persons in prison for possession of illegal substances than in the prior year (www.drugreform.org)

In 2002 the Washington state Legislature passed two bills of interest for this article. The first made it legal for individuals to possess syringes and for pharmacies to distribute them. The second allowed for expanded community-based treatment for drug offenders and restored broader sentencing discretion to judges. This law goes further than the Arizona or California initiatives by reducing prison terms for low-level heroin or cocaine drug sellers from 24 months to 18 months, in addition to those for possession (Goodman, n.d.; www.drugpolicy.org). In addition, a specified amount of the funding saved from reduced incarceration costs due to these shorter

sentences will be spent on in-community and prison-based treatment programs (Goodman, n.d.) These changes in the laws are somewhat unique in that they were enacted by the state legislature, not a voter initiative.

In the November 2002 elections the voters of the District of Columbia passed a measure similar to those in Arizona and California. This initiative requires that persons convicted of drug possession for a non-violent offense receive treatment instead of incarceration. This law contains no funding to assist in implementing this change in policy, however.

CONCLUSION

Drug control policies in the U.S.A. have reached new heights of punitiveness since former President Reagan formally declared his War on Drugs in 1986 and former President Bush advocated prison sentences for persons convicted of the possession of illegal drugs (see Everett, 1998). Despite, and in some cases in reaction to, this immense expansion of the use of criminal law and incarceration in the handling of drug offenders, harm reduction policies are emerging in several states, particularly in the west. Those of us who advocate harm reduction policies are encouraged by these changes and the dedicated efforts of a number of NGOs to alter the harmful trajectory in U.S. drug policy.

REFERENCES

CHRISTIE, Nils (2000): *Crime Control as Industry: Towards Gulags, Western Style.* Third edition. New York City: Routledge.

ERICKSON, Patricia G., RILEY, Diane M., CHEUNG, Yuet W., and O'HARE, PATRICK. A. (eds.) (1997): *Harm Reduction: A New Direction for Drug Policies and Programs.* Toronto: University of Toronto Press.

ERICKSON, Patricia G. and BUTTERS, Jennifer (1998): "The Emerging Harm Reduction Movement: The De-Escalation of the War on Drugs?" Pp. 177-196. In Eric L. Jensen and Jurg Gerber (eds.). *The New War on Drugs: Symbolic Politics and Criminal Justice Policy.* Cincinnati, OH: Anderson Publishing Co. and the Academy of Criminal Justice Sciences.

EVERETT, Ronald S.: (1998): "The Evolution of the Federal Sentencing Guidelines for Crack Cocaine: Social Construction and Social Control." Pp. 91-106, in Eric L. Jensen and Jurg Gerber (eds.). *The New War on Drugs: Symbolic Politics and Criminal Justice Policy.* Cincinnati, OH: Anderson Publishing Co. and the Academy of Criminal Justice Sciences.

GOODMAN, Roger. n.d. "Washington State Drug Reform Bill–Summary."

JENSEN, Eric L.; GERBER, Jurg; and MOSHER, Clayton. Forthcoming. "The Social Consequences of the U.S. War on Drugs. *Criminal Justice Policy Review.*

LONGSHORE, Douglas; HSER, Yih-Ing; PRENDERGAST, Michael; EVANS, Liz; and ANGLIN, M. Douglas (2002): "The Statewide Prop 36 Evaluation." Paper presented at the annual meetings of the American Society of Criminology, Chicago, November.

MAGUIRE, Kathleen, and FLANAGAN, Timothy J. (eds.) (1991): *Sourcebook of Criminal Justice Statistics 1990.* Washington, D.C. United States Government Printing Office.

MAGUIRE, Kathleen and PASTORE, Ann L. (eds.) (2001): *Sourcebook of Criminal Justice Statistics 2000.* Washington, D.C.: United States Government Printing Office.

ROSENBAUM, Marsha (1997): "The De-Medicalization of Methadone Maintenance." Pp. 69-79 in Patricia G. Erickson, et al., *Harm Reduction: A New Direction for Drug Policies and Programs.* Toronto: University of Toronto Press.

TONRY, Michael (1995): *Malign Neglect: Race, Crime, and Punishment in America.* New York: Oxford University Press.

United States General Accounting Office. 2002. Marijuana: Early Experiences With Four States' Laws that Allow Use for Medical Purposes. Washington, D.C. November.

www.drugpolicy.org

www.drugpolicyalliance.com

www.drugreform.org

www.fbi.gov/ucr/ucr.htm

www.norml.org

www.ojp.usdoj.gov/bjs/prisons.htm

www.prop36.org

CASES CITED

Conant v. Walters, 309 F.3d 629 (9th Cir. 2002).

United States v. Oakland Cannabis Buyers' Cooperative, 532 U.S. 483 (2001).