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# 2013 POLICY RECOMMENDATIONS FOR THE OBAMA ADMINISTRATION

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# *Marijuana Prohibition: Going Up in Smoke? and Sterile Syringes for Injecting Drug Users*

*By William Martin, Ph.D.*

## Overview

### *Marijuana Prohibition: Going Up in Smoke?*

- **Recommendation 1.1:** Cease federal interference with medical-marijuana dispensaries, suppliers, and users acting in accord with state law.
- **Recommendation 1.2:** Encourage research to establish a clearer picture of the potential benefits and harms of cannabis.
- **Recommendation 1.3:** Allow states and smaller jurisdictions to experiment with regulation and taxation of marijuana for recreational use.

### *Sterile Syringes for Injecting Drug Users*

- **Recommendation 2.1:** Remove the ban on the use of federal funds for programs and projects that provide sterile syringes to injecting drug users as a proven means of reducing the spread of blood-borne diseases such as HIV/AIDS and hepatitis C.
- **Recommendation 2.2:** Authorize federal funding and encourage other forms of governmental and nongovernmental funding for programs that increase the availability of sterile syringes to injecting drug users.
- **Recommendation 2.3:** Allow funds from the President's Emergency Plan for AIDS Relief (PEPFAR) to be used to provide sterile syringes to injecting drug users.

## Marijuana Prohibition: Going Up in Smoke

### *Background*

Most Americans know that our national drug policy, which we have tried to impose on much of the world, is deeply flawed. Only 24 percent of our citizens, according to a 2008 Zogby poll, believe the policy is effective. In the 40 years since President Richard Nixon declared a War on Drugs, federal, state, and local governments have spent hundreds of billions of dollars on eradication, interdiction, and incarceration. They have seized tons of contraband, destroyed millions of acres of drug crops, and imprisoned more people than any other country, a disproportionate number of them poor and black. Despite these efforts, drugs continue to be available to meet a remarkably stable demand.

Our War on Drugs has cost more than \$1 trillion since 1970, has resulted in the incarceration of hundreds of thousands of American citizens, and has played a major role in stimulating the growth and prosperity of murderous drug trafficking organizations in Mexico and elsewhere. Like other wars we have been engaged in over this period, victory has been elusive. Illicit drugs remain readily available, are of higher quality, and sell for a cheaper price than at the beginning of this four-decade campaign to create a drug-free America.

This is not an eccentric opinion. In May 2010, the World Bank issued a scathing indictment of the War on Drugs. In June 2011, the U.S. Conference of Mayors issued a unanimous resolution declaring the War on Drugs to be a failure. A month later, the NAACP released a similar resolution. Perhaps most notable is a document prepared by the Global Commission on Drug Policy, whose members included such luminaries as George Shultz, secretary of state under Ronald Reagan; Kofi Annan, former secretary general of the United Nations; Paul Volcker, former chairman of the U.S. Federal Reserve; Ernesto Zedillo, former president of Mexico; César Gaviria, former president of Colombia; Fernando Henrique Cardoso, former president of Brazil; George Papandreou, former prime minister of Greece; Ruth Dreifuss, former president of Switzerland; writers Carlos Fuentes and Mario Vargas Llosa; and entrepreneur Richard Branson.

The Global Commission's 2011 report begins with the flat assertion, "The global war on drugs has failed, with devastating consequences for individuals and societies around the world ... Vast expenditures on criminalization and repressive measures directed at producers, traffickers, and consumers of illegal drugs have clearly failed to effectively curtail supply or consumption." One of its main recommendations is to "encourage experimentation by governments with models of legal regulation of drugs (with cannabis, for example) to undermine the power of organized crime and safeguard the health and security of their citizens" (Global Commission on Drug Policy 2012).

Other nations have instituted approaches other than prohibition to deal with drug use and abuse. Three notable examples are the Netherlands' "coffee shops" that sell cannabis (marijuana), Switzerland's successful use of heroin maintenance programs, and Portugal's laudable decision to deal with drug abuse as a matter of public health rather than a crime. For the near future, however, there is little public or political support in this country for legal regulation of any now-illicit drug other than marijuana, but that support clearly exists and is rapidly growing. Three-quarters of Americans support legalizing medical marijuana and, with the addition of Massachusetts in the November 6, 2012, election, 18 states and the District of Columbia have done so. In that same election, four cities in Michigan voted to remove local penalties for possession of modest amounts of marijuana or to make possession the city's lowest law enforcement priority. Forty municipalities in Massachusetts voted to instruct legislators from their districts to vote in favor of decriminalizing marijuana use by adults. Far more significantly, Colorado and Washington voted to end cannabis prohibition entirely, in favor of distribution models similar to those in place for alcohol and tobacco.

All these measures violate and consciously challenge federal prohibition on the production, distribution, and use of cannabis. Response by law enforcement agents has been uneven, ranging from formal cooperation to harsh reprisal even when individuals were in full compliance with local laws. Deeply entrenched advocates of prohibition continue to resist any form of regulation and to insist that legalizing marijuana use will lead to widespread ruin. But, as Seneca observed long ago, “Laws do not persuade just because they threaten.”

*Recommendation 1.1: Cease federal interference with medical marijuana dispensaries, suppliers, and users acting in accord with state law.*

During the 2008 campaign, Mr. President, you said, “I think the basic concept of using medical marijuana for the same purposes and with the same controls as other drugs prescribed by doctors, I think that’s entirely appropriate. I’m not going to be using Justice Department resources to try to circumvent state laws on this issue” (Nelson 2008). The actions of your administration have not reflected your stated intention. In the last four years, the Drug Enforcement Administration (DEA) has conducted more raids of state-licensed dispensaries than during your predecessor’s eight years in office. In addition, the DEA and U.S. Attorneys have threatened landlords with closure or forfeiture of properties housing dispensaries and even threatened to punish governors and other state and local officials who signed medical marijuana bills into law. In addition, the Federal Deposit Insurance Corporation has warned banks not to accept accounts from entities involved in state-sanctioned medical marijuana enterprises (Wilbur 2012).

You have correctly observed that you cannot nullify congressional law or ask the Justice Department to ignore federal laws that are on the books. But you have amplified that observation by noting that you are able to say, “Use your prosecutorial discretion and properly prioritize your resources to go after things that are really doing folks damage.” A growing number of municipalities have adopted “lowest priority policies,” which do not actually legalize marijuana, but explicitly instruct law enforcement personnel not to arrest nonproblematic users unless they can find nothing else to do with their time. Seattle pioneered this approach by passing Initiative 75 in 2003. An assessment after four years found no increase in marijuana use among youth and young adults, no increase in crime, and no adverse impact on public health. A study of people involved with state-approved medical marijuana would quite likely yield even more positive results. Decisively conveying that information and making clear its implications should lead both the DEA and U.S. Attorneys to rethink their actions of the past four years, particularly since all of them are appointed, either directly or indirectly, by the executive branch.

*Recommendation 1.2: Encourage research to establish a clearer picture of the potential benefits and harms of cannabis.*

The DEA classifies cannabis as a Schedule I drug, along with LSD and heroin, asserting that it has no medical use. Millions of people, including many physicians as well as therapeutic users, emphatically dispute this assertion, but the classification remains because research that would settle the matter scientifically has been systematically blocked for decades. As a November 22, 2004, editorial in *Scientific American* explained:

“Any researcher attempting to study marijuana must obtain it through the National Institute on Drug Abuse (NIDA). The U.S. research crop, grown at a single facility, is regarded as less potent—and therefore less medically interesting—than the marijuana often easily available on the street. Thus, the legal supply is a poor vehicle for studying the approximately 60 cannabinoids that might have medical applications ... The reasonable course is to make it easier for American researchers to at least examine marijuana for possible medical benefits. Great Britain, no slacker in the War on Drugs, takes this approach: the government has authorized a pharmaceutical firm to grow different strains of marijuana for clinical trials.”

Health Canada, roughly equivalent to the U.S. Food and Drug Administration, has produced an extensive document detailing the known and potential benefits and negative effects of marijuana used for therapeutic purposes (Health Canada 2010). It is odd and unfortunate that U.S. scientists are not able to conduct research that could establish with reasonable confidence whether and which of the claims by proponents, opponents, and disinterested researchers regarding the therapeutic potential of marijuana rest on solid ground. In addition, such research should and surely would provide valuable empirical information about the real and alleged risks of legalizing marijuana for “recreational” use. Encouragement from your administration would be an important stimulus to this important scientific endeavor.

*Recommendation 1.3: Allow states and smaller jurisdictions to experiment with regulation and taxation of marijuana for recreational use.*

As noted above, a growing number of states and cities have voted to install various alternatives to marijuana prohibition. They have not exhausted all the possibilities. Given widespread and growing support for marijuana legalization, bolstered by demographic developments that contributed importantly to your re-election, this movement will almost certainly continue, quite likely at an accelerated pace. Many parts of the country will choose some form of legalization, while other parts will remain adamantly opposed for the foreseeable future. Whichever route voters choose in the future, they will benefit from observing the results of varied experiments in other locales. This can equip them for a “race to the top” as they seek to establish regulatory regimes that strike the most efficacious balance between individual freedom and constraints required for the good of the community.

Obviously, this recommendation faces the same obstacle as discussed in Recommendation 1.1—the conflict between popularly chosen regulatory regimes and long-established federal law. Until federal law changes, and it is far more likely to follow than to lead, a “lowest priority” approach should serve your administration and the nation much better than a heavy-handed attempt to overthrow the expressed will of entire states. Your administration’s aggressive assault on state-licensed medical marijuana operations has surprised and disappointed millions of people who had expected a more realistic and progressive response. As the movement to reject marijuana prohibition becomes

increasingly widespread, it would be unfortunate if obstinate resistance is allowed to leave a lasting stain on your administration and its legacy.

## **Sterile Syringes for Injecting Drug Users**

### *Background*

The United States has a serious blood-borne disease problem. The two most important of these diseases are HIV/AIDS and hepatitis C. Treatment of these widespread diseases is enormously expensive—more than \$300,000 in lifetime costs for a single case of either disease, much of which is covered by taxpayer funds. The sharing of needles by injecting drug users (IDUs) contributes significantly to the spread of these diseases. Extensive worldwide and long-term experience with needle-exchange programs, which enable IDUs to exchange used syringes for sterile ones, are a proven means of significantly reducing the spread of these diseases.

American medical and public health personnel overwhelmingly support making sterile syringes available to injecting drug users. During the 1990s, the U.S. government funded several studies of syringe-exchange programs (SEPs), including an extensive literature review of almost 2000 U.S. and foreign research reports. Key governmental and professional bodies, including the National Academy of Science, the Centers for Disease Control, the American Medical Association, The Institute of Medicine, the National Institutes of Health, the American Public Health Association, and the American Bar Association, have conducted studies and issued reports on the topic of access to clean needles. Without exception, these studies and organizations have endorsed access to clean needles as an effective measure for reducing the incidence of blood-borne diseases and increasing access to treatment for drug users. In addition, they have persuasively documented the important finding that access to sterile needles neither encourages people to start injecting drugs nor increases drug use by those who are already users. Moreover, they take millions of potentially contaminated needles out of circulation instead of leaving them to be passed around or left in parks or public restrooms, where they could injure or infect children and others, including health workers and police who might receive needle-stick injuries in their contact with addicts. Finally, the cost-benefit is extraordinary, in terms of money saved by not having to access the health care system or rely on insurance for medical services because the services are not needed, not to mention the personal and social damage that is avoided by people now harming themselves and their partners—just by providing a clean needle that costs less than a dime.

*Recommendation 2.1: Remove the ban on the use of federal funds to programs and projects that provide sterile syringes to injecting drug users as a proven means of reducing the spread of blood-borne diseases such as HIV/AIDS and hepatitis C.*

Syringe exchange is an accepted part of public health programs in almost all countries of Western and Eastern Europe, Central Asia, and Australia and New Zealand. Even in Iran, the hyperconservative ruling mullahs have approved of syringe exchange as a way to fight

an HIV/AIDS epidemic spread mainly by drug users. Forty-nine states and the District of Columbia allow some form of syringe exchange, but resistance to funding at federal, state, and local levels has hampered the success of SEPs in some areas.

In 2009, the 111th Congress lifted a long-standing ban on the use of federal funds for SEPs in the FY2010 Consolidated Appropriations Act. In December 2011, however, ideological opponents to SEPs in the 112th Congress reinserted that ban in the FY2012 omnibus spending bill. The 2013 budget proposal includes reinstatement of such funding. We urge the administration to contend strongly for this eminently sensible and compassionate measure.

*Recommendation 2.2: Authorize federal funding and encourage other forms of governmental and nongovernmental funding for programs that increase the availability of sterile syringes to injecting drug users.*

As of 2011, approximately 200 SEPs operate in the United States. Some are legal; some are not. Some do little more than exchange needles, while others provide various ancillary services and make significant efforts to link addicts to treatment programs.

Although they save far more money than they cost, needle-exchange programs do cost money—for staff, facilities, utilities, and, of course, for needles and other items dispensed to clients. Some programs are well-funded; many, perhaps most, operate on shaky financial ground. Lack of federal money and reliance on volunteer staffers make their existence precarious.

Funding SEPs is economically sound. Many people infected with these diseases receive little or no medical treatment, but for those who do, Medicaid or other public funds bear a high proportion of the cost. The net savings for each case of HIV prevented is approximately \$300,000, with a similar figure for each case of hepatitis C prevented. Preventing just one case of either disease would save far more than the annual cost of a first-rate needle exchange program.

*Recommendation 2.3: Allow funds from the President's Emergency Plan for AIDS Relief (PEPFAR) to be used to provide sterile syringes to injecting drug users.*

Despite the scientific evidence, PEPFAR has not funded SEPs, even in countries where IDUs account for a much larger proportion of HIV/AIDS cases than in the United States. In some areas, including Russia and its former satellite countries and significant parts of Asia, injecting drug use is believed to be the primary cause of an explosive growth in HIV infections.

All of the arguments listed above apply at least as strongly to funding of SEPs under PEPFAR. In addition, since people and many of the affected countries have little chance of receiving the kind of treatment available in the United States, prevention is even more important.

## Conclusion

No responsible person wants to encourage drug abuse. No fiscally prudent person wants to waste money simply to satisfy a sense of righteous indignation. No compassionate person wants to consign people unnecessarily to death or a living hell. Fortunately, providing injecting drug users with access to sterile syringes allows us to be responsible, prudent, and compassionate— admirable criteria for good public policy.

## References

- Global Commission on Drug Policy. June 2012. *The War on Drugs and HIV/AIDS*, 3, 11. <http://www.globalcommissionondrugs.org/reports/>.
- Health Canada. September 2010. “Marihuana (marijuana, cannabis) dried plant for administration by ingestion or other means.”
- Nelson, Gary. 2008. Interview with Barack Obama. *Oregon Mail Tribune*, March 23. <http://bit.ly/loMyND>.
- Scientific American Editors. 2004. “Marijuana Research—Current restrictions on marijuana research are absurd.” *Scientific American*, November 22. <http://bit.ly/egPtwF>.
- Wilbur, Robert. 2012. “Medical Marijuana: Obama Administration Continues Reefer Madness.” *Truthout*, November 4. <http://bit.ly/RHL2dC>.

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