A New Model for Drug Policy:
Working Toward Individual Freedom, Health, and Racial Justice

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Table of Contents

Introduction .......................................................................................................................... 1

Methodology ...................................................................................................................... 5

Scope .................................................................................................................................... 6

Existing Models of Drug Enforcement ............................................................................. 6
  a) Prohibitionist Model ................................................................................................. 7
  b) Classical Liberalism ................................................................................................. 8
  c) Public Health Model ................................................................................................. 11

Theoretical Frameworks ................................................................................................. 13
  a) Structural Injustice ................................................................................................. 14
  b) Critical Race Theory ............................................................................................... 14
  c) Democratic Theory ................................................................................................. 15

Objections to Existing Models ....................................................................................... 17
  a) Objections to the War on Drugs/Prohibitionist Model ........................................... 18
     1. Economic Injustice in the War on Drugs ............................................................ 18
     2. Racial Disparities in the War on Drugs ............................................................... 20
     3. Misconceptions and Ineffective Policy in the War on Drugs ............................ 23
  b) Objections to Classical Liberalism .......................................................................... 25
  c) Objections to the Public Health Model ................................................................... 27

Targeted Equitable Intervention Model ......................................................................... 28
  a) Individual Freedom in Targeted Equitable Intervention ....................................... 28
  b) Treatment, Health-Oriented Policy in Targeted Equitable Intervention ............. 32
Introduction

On June 17, 1971, President Richard Nixon spoke to the United States Congress about legislation that would launch a “full-scale attack on the problem of drug abuse in America” (Nixon), beginning the rhetoric of what has since been dubbed the “War on Drugs.” This ideology has supported the U.S. government in imposing harsh penalties, namely incarceration, on drug users, in the name of defeating what was, according to Nixon, the country’s “public enemy number one”: recreational drug use. Over the course of the last five decades, associated policies have made drugs the scapegoat for any number of America’s societal issues, and primarily punished the individuals and communities who were already structurally disadvantaged due to race, class, and geographic location.

A major element of the U.S. sociopolitical landscape is mass incarceration. There are currently 2.3 million people incarcerated in America’s prisons and jails. This is the highest incarceration rate of any country in the world. The arrests and convictions carried out as part of the War on Drugs, which was once again embraced by President Reagan in 1982 (Cooper), are a huge part of this problem. “Between 1982 and 2007, the number of arrests for drug possession tripled, from approximately 500,000 to 1.5 million, and drug arrests constitute the largest category of arrests in the U.S.” (Cooper). One in five of America’s incarcerated individuals was convicted of a drug related offense (Rabuy, Wagner). The incarceration of these hundreds of thousands of people has a profound effect on their families and communities, and society as a whole. This points to broad questions regarding whether the U.S. can be considered a healthy democracy given the proportion of people incarcerated, unable to vote or otherwise participate in society, and regarding what steps are necessary to end this unjust system.
One of mass incarceration’s societal effects is the continued oppression of African American people and other minority groups. While people of all races use and sell illegal drugs at similar rates, people of color, especially African Americans, are disproportionately incarcerated due to disparities in policing, sentencing, and other elements of the criminal justice system (Alexander). The War on Drugs is unfair in its methods and consequences. Regardless of moral issues, this war has clearly failed in defeating its “enemy.” Even with hundreds of thousands of people incarcerated for drug-related crimes, drug use is still prevalent, and problems relating to addiction and violence are far from eradicated. In fact, while the U.S government is estimated to have spent about 1.5 trillion dollars on drug war efforts between 1970 and 2010, the percent of Americans addicted to illicit drugs has consistently hovered around 1.3% throughout that same time period (Groff).

In recent years, a large portion of dangerous drug use has been related to the use and abuse of substances prescribed by doctors to treat pain. High rates of prescriptions for opioids have led to what is referred to as the “opioid epidemic,” in which about 28,000 people die each year (Conrad). This is due to overdoses of prescription drugs themselves or heroin, which is often used as a result of drug dependence originating from the use of legitimately prescribed drugs. Although this crisis affects people of all races, it is largely portrayed in the media as a problem that affects white, middle-class people. Furthermore, this population is often portrayed as a group of sympathetic victims of addiction, as opposed to more traditional media representation of “criminalized urban black and Latino heroin injectors” (Netherland 664). This media bias is reflected in government policy as well; laws calling for arrests and long prison
sentences for most defendants in the War on Drugs do not seem to apply to this demographic of drug users, showing further racial bias in drug enforcement.

It is clear that this country’s last several decades of criminal justice policy and specifically drug enforcement policy have caused more problems and led to more injustice than they have solved. Given this, the challenge for policy-makers, theorists, researchers, and all people invested in working toward racial justice and an end to mass incarceration is to find an alternative drug policy model that addresses these ethical and practical issues without neglecting public health. The War on Drugs is predicated upon the claim that recreational drug use and associated issues such as addiction, drug-related crime, overdoses, and drug use by minors cause major damage to individuals, communities, and society as a whole. The scale of harm caused by the recreational use of illegal substances may be relatively small compared to the harms of mass incarceration and structural racism. In fact, the most dangerous substances that cause these harms make up a relatively small portion of drug use in the U.S. and “not that many people use or want to use them” (Fish 163). However, it is undeniable that in some situations, the use of certain drugs can have devastating effects on individuals and communities.

Thus, the remaining puzzle is to determine what, if any, forms of regulation and/or criminalization of currently illicit substances would be most ethical and lead to the most just balance of liberty and health-based harm-reduction. In considering this puzzle, I ask the normative question: What kind of drug enforcement policy model should the United States government follow? I argue that the answer to this question must consider the implications of three theoretical frameworks: progressive versions of democratic theory, structural injustice, and critical race theory. Based on these theories, this thesis will argue that the model should provide
American citizens 1) freedom of choice with regard to the use of relatively low-risk recreational drugs 2) rehabilitation for those seriously endangered or victims of debilitating addiction and 3) sweeping reforms in all policies relating to the monitoring of and intervention into drug use to ensure racial equality in all related practices. These three elements combine to form a new model of drug enforcement, which I call targeted equitable intervention.

I argue that freedom of choice is important to drug policy because, in a democracy, the government has no right or responsibility to control behaviors that do not pose a high risk to its citizens. In fact, doing so only infringes on a person’s individual rights to pursue their desired path and wastes tax-payer money that could be spent improving society through more productive social policies. However, certain drugs are extremely addictive and/or lead to high rates of overdoses; some such drugs will be identified in this paper. For these substances, the government does have a responsibility to take measures that protect citizens and allow them the health and well-being to enjoy the rights and responsibilities of being a citizen of a democracy and a member of their community.

In order to protect Americans from the most dangerous repercussions, treatment is a much more helpful tool than incarceration. Treatment can help individuals regain control of their lives whereas incarceration punishes those individuals further in such a way that takes away their control and worsens structural injustice. Finally, this model calls for reforms that work against this structural injustice that the War on Drugs has worsened. These reforms include, but are not limited to, regulations relating to the strategy and distribution of police in neighborhoods with different demographic make-ups, changes in sentencing and bail policy, and instituting retroactive amnesty for much of the current prison population.
Methodology

In answering its central question, this paper will rely primarily on the support of theoretical frameworks to examine the morality of drug policy options. First, I will examine the three primary existing models for drug enforcement: the prohibitionist model, the public health model, and classical liberalism (Schaler, “Introduction” 12). In analyzing these models, I will argue that, while there are important pieces to each one, none of them can on its own constitute a completely ethical and effective drug policy model for the U.S. The theoretical frameworks of structural justice, critical race theory, and democratic theory will ground this argument. I will then propose my own model, targeted equitable intervention, which incorporates aspects of existing models of drug enforcement and treatment in addition to a focus on anti-racist reforms. Using these grounding theoretical frameworks, I will then show that this policy model fulfills its ethical duties to all its citizens, including those who use drugs recreationally, regardless of race and class. I will also present examples of countries and states that have instituted policies similar to those in this model, which will shed light on possible societal implications of instituting such changes.

While my argument is primarily based on theoretical grounds, I argue that proposing a policy which does not work in practice to support its intended goals is insufficient. For this reason, I use some empirical data, such as figures related to addiction rates, current racial and economic disparities, success rates of existing policies and treatments, and examples from countries and U.S. states which implement similar policies to those in this new model. Although

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1 The words “moral” and “ethical” are subjective terms that can illicit debate about their exact meaning. In this paper, I use these terms in reference to the implications of the theoretical frameworks in which I ground this paper. In the context of U.S. society, “moral” or “ethical” policy recognizes and works against structural injustice and creates a society in which all people are protected and represented equally in democratic society.
it is not the main consideration of this paper, I also take the fiscal sustainability of my model into account in order to determine its potential to reach desired outcomes within the current system. The examination of my model will show that while mainly developed on theoretical grounds, its practicality is also supported via empirical data.

Scope

This thesis addresses the question of how to deal ethically with the recreational use and possession of those drugs that are now illegal in the United States. I will also offer a preliminary response as to how this model would deal with enforcement of the production and sale of illegal drugs. However, this paper will deal primarily with policies relating to drug users rather than dealers. There are many other pressing questions that are interrelated with my central question that will not be addressed, or will only be addressed briefly, within this paper. This includes those relating to topics including but not limited to: mass incarceration for non-drug charges, over-policing and police brutality not related to drug enforcement, and drug trafficking across international borders. While these are all important topics, solutions to these issues fall outside the scope of the targeted equitable intervention model.

Existing Models of Drug Enforcement

The three primary existing models for drug enforcement are 1) prohibitionism, which is in line with current U.S. “War on Drugs” policies, 2) public health, which treats drug use and addiction as a medical issue rather than an ethical or legal one, and 3) classical liberalism, which treats drug use as an ethical issue, concluding that individuals ought to have complete autonomy over their own decisions, including the decision to use potentially dangerous substances (Schaler,
“Introduction” 12). I argue that none of these models can fully answer the question of how to deal ethically and practically with drug use and enforcement in America.

a) Prohibitionist Model

   The prohibitionist argument is based on the idea that prohibiting and strictly punishing the use of these substances is the best way to prevent high rates of addiction, damage to users’ health, deaths caused by drug overdoses, increased drug use by minors, and increased rates of criminal activity perpetrated by people seeking or under the influence of drugs. One leader of the War on Drugs, William Bennett, harshly criticized those who oppose the prohibition of recreational drugs: “like addicts seeking immediate euphoria, the legalizers want peace at any price, even though it means the inevitable proliferation of a practice that degrades, impoverishes, and kills” (Bennet 63). While acknowledging the significant costs and burdens of a war-like approach to combatting illegal drug use, Bennett maintains that the costs of allowing these substances would be much greater, including “hundreds of thousands of lost and broken lives... human potential never realized... time stolen from families and jobs... precious spiritual and economic resources squandered” (64).

   The Office of National Drug Control Policy issued a statement in 1996 which claimed that their “strategy is founded in a firm belief that America can no longer tolerate the negative effects of drug use on the lives of our citizens” (Office of National Drug-Control Policy 41). The statement offers several initiatives that the office had put into place in order to achieve these goals, which range from “a reaffirmation of anti-legalization sentiments” (35) which involved asking American cities to sign a declaration ensuring that they would not legalize any illicit substances to an “initiative to improve community oriented policing services” which put 34,000
additional police officers on the streets to police drug use (37). Proponents of this model argue that the U.S. government is doing the right thing by outlawing the substances that cause these damaging effects and punishing those who break these laws to deter both the supply and demand of these substances.

b) Classical Liberalism

Classical liberalism is based on the philosophy that individuals have the moral right to make their own decisions about drug use and all actions that do not directly harm other people. Thus, this model calls for the total legalization and deregulation of all currently illegal drugs. Although elective treatment could be made available to users, any kind of intervention by the state that takes away individual choice is seen as overly paternalistic and in violation of individual rights under this framework.

One proponent of this philosophy, Douglas Husak, makes the controversial claim that all adults have a moral right to use drugs recreationally. Husak rejects the utilitarian framework of analyzing drug rights based on cost-benefit analyses of legalizing drugs. Instead, he focuses on the principle of what it means for moral rights and autonomy for the government to decide which substances individuals can and cannot use. One method through which he makes this argument is the use of analogies to risky behaviors other than drug use including:

“boxing, mountain climbing, race car driving, skiing, eating fatty foods, playing football, driving a car with or without a seatbelt, riding a motorcycle with or without a helmet, sunbathing, playing ‘Russian roulette,’ consuming saccharin, participating in rodeos, bungee-jumping, and a host of others” (90).
These activities, some of which are legal, provide context through which to consider the potential double-standards that exist within paternalistic laws that are meant to protect citizens from themselves. Under Husak’s theory, it is not only that these activities are often in practice more dangerous than using illicit drugs that shows that the government should not outlaw drug use (although he does make that claim). In addition, this argument is enhanced by the idea that regardless of relative risk, “one would anticipate that the principle of autonomy would allow adults to decide for themselves what extent of risk to assume” (94). Thus, this theorist uses multiple avenues to argue that there is no morally correct reason why marijuana or even heroin should be illegal while consuming sugar, fatty foods, and alcohol is legal.

In “Taking Drugs Seriously: Liberal Paternalism and the Rationality of Preference,” Ann Cudd makes another argument within this model, but with somewhat modified reasons and conclusions. Cudd bases her argument on the concept of liberal paternalism, which says that it is only legitimate for the state to outlaw a behavior when it is clearly irrational. Furthermore, she argues that “the preference of taking drugs is not irrational in every case, and that the society at large is not in the proper position to sort out individual cases” (Cudd 18). This concept grounds her argument that drugs should be legalized. She then uses analogies to support her claim that recreational drug use is often a rational choice. She refutes the argument that drugs are an irrational choice because they make a person “temporarily insane” by pointing out that other choices that are legal and considered rational may also cause a state of temporary insanity (22).

“For example, becoming a psychiatrist, or taking up a competitive and stressful occupation, working hard, moving to a new place, trying new things, taking up a cult
religion, or watching too much TV, all have the potential for making one crazy, even certifiably so” (22)

She further makes the point that exploring art and philosophy, for example, is an activity that can be undertaken with the express purpose of perceiving reality in a new way, similarly to drug use. Additionally, she argues that for some people in difficult stages of life “taking drugs may allow that person an escape from the daily drudgery that nothing else, short of suicide or insanity, could” (23).

Interestingly, Cudd even classifies the use of addictive substances and the subsequent addiction as a potentially rational behavior. She makes this claim by comparing the process of taking drugs despite the risk of addiction to other choices that people would deem rational. In doing so, she makes the point that choices always have opportunity costs. She illustrates this point with the example of choosing to commit oneself monogamously to another person despite the fact that it rules out the possibility of having other partners. She also makes the point that many decisions that people make on a regular basis are likely made without engaging the conscious mind, in a process that is in some ways analogous to addictive behavior (26). An exception that Cudd draws with regard to her claim that drug use can be thought of as a rational choice is the circumstance in which young people, who can easily experience peer pressure, use substances. In this case, she argues that it is reasonable for the government to intervene within the framework of liberal paternalism (29). However, this model includes no foreseeable circumstance in which it would be acceptable for the government to restrict an adult’s substance use.
c) Public Health Model

The third existing model of drug enforcement is the public health/medical framework. The core tenet of this model is replacing punitive measures based on policing and incarceration with those that are based on health-oriented treatment for and prevention of drug use. Within this overarching theme, there is considerable variation among the specific elements of different conceptions of a public health model of drug policy. Unlike models within the framework of classical liberalism, which are based on the ethics of allowing individuals to make their own decisions, the public health model is founded upon the goal of harm-reduction or preventing drug-induced harm to individual and societal health. A key question within varying conceptions of this model is “are legal norms... essential to reinforce prevention efforts, or are they in conflict with them and counter-productive?” (Erickson, “A Public Health” 569).

The use of drug courts is one version of the public health model that still involves legal norms. The National Association of Drug Court Professionals defined drug courts in 1997 using a set of ten key principles:

“1) Drug courts integrate alcohol and other drug treatment services with justice system case processing... 2) Using a nonadversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights... 3) Eligible participants are identified early and promptly placed in the drug court program... 4) Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services... 5) Abstinence is monitored by frequent alcohol and other drug testing... 6) A coordinated strategy governs drug court responses to participants' compliance... 7) Ongoing judicial interaction with each drug court participant is
essential... 8) Monitoring and evaluation measure the achievement of program goals and
gauge effectiveness... 9) Continuing interdisciplinary education promotes effective drug
court planning, implementation, and operations... 10) Forging partnerships among drug
courts, public agencies, and community-based organizations generates local support and
enhances drug court program effectiveness” (Hunter 5)

Individuals can usually only be admitted to drug courts if they are officially deemed substance
dependent by the court’s substance abuse evaluator (Hunter 6). This inherently narrows the scope
of people who can be helped through this institution, and leaves many individuals in the hands of
the traditional court system.

In comparison to traditional courts used in the War on Drugs, drug courts have a much
less punitive orientation. However, their practices still rely on laws prohibiting recreational drug-
use and associated policing measures in order to identify defendants. Drug court participants do
not have autonomy over their situation, which proponents of government paternalism would
support under the conception that the government should step in to protect drug users from
themselves. This is based on the understanding that addiction is a disease that can be treated.
This treatment could be elective, but most iterations of the model involve some form of state
control over the treatment and perhaps “moral indoctrination” of individuals (Schaler,
“Introduction” 13).

Other versions of the public health model have varying levels of entrenchment in the
processes of law and the criminal justice system. Some versions advocate for “the legalization
and medicalization of drug use. They regard addiction as a disease and criminal sanctions as
inhumane and wasteful of taxpayer money” (Schaler, “Introduction” 12). One such framework is
focused on harm-reduction; associated practices “range from basic health care and drug
prescribing to issuing clean needles, but they do not necessarily involve therapeutic change or
reduction of drug use” (Keene 87).

Still other medically-oriented strategies involve legalizing some or all drugs and
regulating, taxing, placing warning labels on them, and educating people on their dangers,
similarly to current policies around alcohol and tobacco. The significant range of conceptions
that exist around the specific purposes and practices that would come with a medical/public
health/harm reduction model leads to a lack of clarity and misuse of some ill-defined terms
(Keene 87). However, the overarching theme of these related models is not only a focus on the
health of individuals, but a practical, perhaps utilitarian, end goal which focuses on maintaining
health, not moral rights or liberty.

**Theoretical Frameworks for Targeted Equitable Intervention**

My proposed policy model is grounded in three theoretical frameworks: structural
injustice, critical race theory, and the progressive interpretation of democracy. I have chosen
these frameworks because they relate to some of the most pressing issues facing the U.S.,
including the prevalence of massive inequality along the lines of race, class, geographic location,
and other identity groups. The first two theories provide helpful explanation of the existence and
implications of these inequalities in society. I chose a model of democracy as my third
framework due to the importance of democracy in this country’s structure and founding
principles. This particular interpretation of democracy is helpful because its application to policy
can address the inequalities explained in the other two theories, while also pointing to the need
for a citizenry that is both free and healthy. These theories are described in the following sections.

a) Structural Injustice

The framework of structural injustice focuses on the role of the structure of society, including its laws and institutions, in creating inequality. Thus, oppression in modern American society is “embedded in unquestioned norms, habits, and symbols, in the assumptions underlying institutional rules and the collective consequences of following those rules” (Young 5). An important element of structural injustice is that not all oppressed groups necessarily have a correlate oppressing group. “While structural oppression involves relations among groups, these relations do not always fit the paradigm of conscious and intentional oppression of one group by another,” although of course in some cases overt prejudice plays a role in this oppression (Young 6). In many cases, instead of purposeful oppressors, oppressed groups exist in relation to relatively privileged groups who benefit from the inequalities that are reproduced within society, regardless of their intentions or actions. Among the inequalities that are embedded in the structure of American society, one of the most large-scale and harmful is the criminal justice system, specifically that of mass incarceration, one of whose major contributors is the War on Drugs. Identity markers that often indicate whether an individual is privileged or disadvantaged by structural injustice include race, class, gender, sexuality, physical and mental ability, and national origin.

b) Critical Race Theory

Critical race theory (CRT) explores structural injustice specifically with regard to race. This theory, created by Professor Derrick Bell, shows the ways in which African Americans and
other racial minorities are disadvantaged in post-civil rights society. This framework challenges the idea that color-blindness can or should exist given the deeply entrenched legacies of slavery, segregation, and other racist policies in American history that still have significant effects on social and legal institutions (Jones 84). Despite the fact that openly discriminating against people based on race is now socially unacceptable and, in most contexts, illegal, this theory points out that race is still a major factor that determines a person’s life experiences and opportunities. It is important to consider critical race theory apart from the more general theory of structural injustice when examining U.S. drug policy since race is so strongly related to the effects of the drug war on different populations.

c) Democratic Theory

Democracy is a core tenet of America’s founding principles, grounded in the idea that a healthy society is one in which, in some form or another, citizens control their own government. “Democracy has been championed as a mechanism that bestows legitimacy on political decisions when they adhere to proper principles, rules and mechanisms of participation, representation and accountability” (Held 297). For this reason, democratic values ought to serve as the basis for the models that ground public policy.

There are multiple conceptions of a democratic government’s ideal practices and results. These conceptions typically fall within the spectrum between the left (who believe in greater governmental power and regulation to protect all citizens) and the right (who believe in fewer regulations). Both ends of the spectrum of democratic theory “share a vision of reducing arbitrary power and regulatory capacity to its lowest possible extent. Both fear the extension of networks of intrusive power into society” (Held 299). However, proponents of different kinds of
democracies disagree about how best to go about structuring the government to reflect these values. The liberal view of democracy is that it is the government’s goal to safeguard the rights of all individuals to make their own decisions according to their own judgments of their best interests, essentially a “free-market” approach to democracy. The socialist or progressive idea of democracy involves a greater role of the government in protecting its citizens. In this framework, the government ought to use democracy to ensure the rights of all people, using accountability to create a society in which people have genuine freedom and equality (299).

This kind of democratic theory, which is typically supported by the left end of the political spectrum, is most often associated with its economic implications, which involve using economic systems to distribute wealth more evenly among the nation’s communities and individuals. In recent U.S. politics, these issues came to the forefront of the public’s attention during Bernie Sanders’s bid for the democratic nomination for president, when he argued for “creating an economy that works for all of us, not just the 1 percent” (White). However, this framework of democracy applies to much more than just redistribution of wealth and has implications for all kinds of policy. This democratic theory supports policies that attempt to prevent all people from being disadvantaged or suffering unnecessary harm due to societal inequalities.

A well-accepted example of this kind of democratic model at work is the implementation of laws requiring parents to educate their children and additional laws requiring all citizens to pay taxes that support the public schools in which these children are educated. It is important to note that this still leaves considerable room for individual choice: parents can send their children to public, private, or charter schools or even home-school them, and individuals can choose
whether or not to continue their education when they reach a designated age. This ought to lead to a society in which every citizen is educated and therefore has the tools to make their own decisions in life and participate actively in their democracy if they so choose. Similarly, drug enforcement policy can be organized to allow these same protections and freedoms to citizens of a democracy.

In this paper, I argue that my model of drug enforcement policy is in line with democratic ideals, especially the ideals that ground progressive democratic theory, which advocates for a society in which all people are meaningfully represented and protected under the law. This thesis treats the basic premise of progressive democratic theory as a given and makes normative conclusions about drug policy accordingly; in this paper, I assume that an ideal government is one in which adults not only have individual freedoms but are also protected by the law and social institutions in order to optimize medical and psychological well-being and racial and economic justice so that all citizens have genuine freedom and opportunity.

**Objections to Existing Models**

These theoretical frameworks, when examined in conjunction with one another, show that none of these models can answer the question of how to ethically deal with drug use in the United States. Together, these frameworks point to the idea that drug enforcement policy must be designed to support those populations that are systematically oppressed by the American criminal justice system, namely black and Latino people and the poor, and must generally work toward a society that supports all citizens in having the opportunity to live healthy and free lives. In order to show that no existing policy model has the necessary elements to fully accomplish these goals,
I will critically analyze each model through these frameworks and then explain how these theories combine to support targeted equitable intervention.

a) Objections to the War on Drugs/Prohibitionist Model

Critical race theory, structural injustice, and democratic theory can be easily applied to the War on Drugs in order to show that associated policies create a society that is oppressive to non-white Americans. In contrast to classical liberalism and the public health model which at this point remain primarily theoretical ideas, the prohibitionist model is currently implemented in the U.S. and can thus be more easily and thoroughly critiqued by applying this paper’s grounding theories to empirical data. The government of a progressive democracy would have a responsibility to implement a model of drug policy that supports the liberty and equality of all people. Therefore, supporters of this model of governance could not support the prohibitionist “war” model which worsens structural disadvantage. My objections to the War on Drugs are organized into the following sections which focus on its contributions to economic injustice and racial disparities, and policies that are ineffective or based on misconceptions.

1. Economic Injustice in the War on Drugs

Socialist theories of democracy often focus on economic elements of governance, which are inextricably related to structural racism and classism in the criminal justice system in America. Wealth and income inequality is extreme in the U.S.; in 2011 the poorest quintile of the US population had a median debt of $6,029 while the richest quintile had a median net worth of $630,754 (Amadeo). The War on Drugs and mass incarceration as a whole primarily victimize the poor, worsening structural injustice related to class. Non-incarcerated men ages 27-42 have
52% higher median annual incomes than their incarcerated counterparts, even prior to their incarceration. For women this disparity is almost as high, at 42% (Rabuy, Kopf).

One reason that the poor are more likely to end up in prison is due to the discriminatory bail process. “As commercial bail has grown into a $2 billion industry, bond agents have become the payday lenders of the criminal justice world, offering quick relief to desperate customers at high prices” (Silver-Greenberg). The amount of legal power that bail bondsmen have to determine whether or not an individual is jailed allows them to essentially extort their clients in order to make maximum profits. This leads to poorer defendants going to jail at higher rates than their wealthier counterparts who can afford these payments. Also, according to one criminal court judge, those defendants who do use their limited funds to try to pay the unreasonable costs to bondsmen are “living under constant daily threat that ‘if you don’t bring money, we’re going to put you in jail’” and this pressure “would actually encourage people to go out and commit more crimes” in order to acquire enough money (Silver-Greenberg).

Additionally, there are significant wealth disparities along racial lines. A 2013 study showed that the ratio of median US white household wealth to that of black households was thirteen to one (“Wealth Inequality”). The War on Drugs perpetuates these disparities by damaging already disadvantaged communities by incarcerating a large portion of their citizens. Given that it is especially difficult for incarcerated individuals to become employed even after serving their sentence, mass incarceration leads to a system in which those who are already often living below the poverty line, and their families, struggle even more to earn a living. Ironically, this may increase the chances of previously incarcerated people turning toward alternative sources of income such as drug dealing due to a lack of other viable options, in much the same
way that excessive bail costs can lead people to commit additional crimes. “Some criminal justice research suggests that finding and maintaining a legitimate job can reduce the former prisoners’ chances of reoffending, and the higher the wage, the less likely it is that individuals will return to crime” (Visher 1). Incarcerated individuals often lose work skills during their sentence and typically have little if any access to job training programs. Furthermore, many employers require that applicants disclose whether they have a criminal record, and refuse to hire those who have such a record. For example, one study showed that “a criminal record reduced the likelihood of a callback or job offer by nearly 50 percent” (“Research on Reentry”).

2. Racial Disparities in the War on Drugs

In The New Jim Crow, Michelle Alexander argues the controversial thesis that the current effects of mass incarceration on racial injustice are equivalent to the harms caused by Jim Crow segregation. Alexander points out that the criminal justice system has replaced segregation laws which were explicitly racist with a new strategy of labeling a large percentage of African American people as criminals in order to maintain white supremacy (2). This racial inequality is achieved through a variety of methods. One example is disproportionately policing poor, black neighborhoods, in which residents were clustered demographically due to the legacies of redlining and other historic discriminatory housing policies. Another means of discrimination is through sentencing policy, such as imposing equal penalties for the possession of a quantity of crack cocaine (more common in poor, black neighborhoods) and one hundred times as much powder cocaine (more often owned by white users) despite the physiological effects of the drug being extremely similar. The discriminatory 100:1 ratio in sentencing was reduced in 2010 to 18:1, which is a small step toward equality, but still shows significant bias (139). Not all of these
policies that disproportionately disadvantage black people were created with racist intent; many policymakers thought that reforms that were tough on drug crime would create safer and healthier communities for all people. However, due to the structure of American society, both well-intentioned and intentionally racist policies have combined to create drug policy that affects people of different races unequally.

The U.S. government’s response to the recent opioid epidemic, which is seen as a problem primarily affecting white, middle class people, and the use of illicit drugs in inner cities, which is more often associated with people of color also demonstrates the racial disparities that exist within drug enforcement. One study that analyzed articles about policy responses to opioid use shows this disparity:

“Articles on urban opioid use mostly mentioned arrest or criminal justice involvement, with only one article mentioning methadone and one mentioning treatment. In contrast, articles about suburban and rural prescription drug use mentioned prevention, education, treatment, prescription heroin, drug takeback programs, and cracking down on doctors’ prescribing. Reports on suburban and rural heroin use mentioned treatment drug courts, probation, education, and cracking down on trafficking. Importantly, none of the articles about white drug use suggested incarcerating people for use or possession” (Netherland 677)

The differences in perception of and response to opioid use by people of different race and/or socioeconomic class are yet another result of implicit and explicit bias affecting drug policy in a theoretically colorblind society.
Police brutality and other psychologically and physically violent acts, disproportionately toward black individuals, are also strongly correlated with drug war policing. Policies such as stop-and-frisk which facilitate racial profiling are psychologically violent to those subjected to random searches. “Between 2002 and the third quarter of 2014, 5 million New Yorkers were stopped and frisked; in any given year during this period between 82% and 90% of people stopped had committed no offense and just 9–12% of people stopped were non-Hispanic white, though approximately 33% of New Yorkers were non-Hispanic white in 2010” (Cooper). One study found that “stop and searches could also involve extensive gratuitous physical and sexual violence” and humiliation given the physical nature of inspecting participants’ person while searching for drugs (Cooper). The use of SWAT teams for drug-raids is another example of unnecessary violence in the War on Drugs. SWAT teams are deployed around 40,000 times per year in the U.S., with many of these raids targeting narcotics offenses. The use of heavily armed officers who give families no warning before entering a home has resulted in unnecessary deaths and injuries, and the targets of such violent raids are disproportionately black and Latino households (Cooper).

Mandatory minimum sentencing laws also contribute to mass incarceration and associated inequality. About half “of all federal inmates are drug offenders and three-quarters of those offenders were convicted of a drug offense carrying a mandatory minimum” according to a report issued in October 2017 (“Federal Drug”). This leads to a significantly larger prison population, filled with more drug offenders. As is the case with most aspects of the American criminal justice system, this policy disproportionately affects African Americans; “black and
white offenders convicted of a drug offense carrying a mandatory minimum remained subject to
the mandatory minimum sentences at different rates (64.6% vs. 50.8%)” (“Federal Drug”).

3. Misconceptions and Ineffective Policy in the War on Drugs

Proponents of the War on Drugs often argue that the use of illicit substances inevitably
leads to additional, potentially violent, crimes. However, this assumption is not necessarily
correct, even with regard to some of those drugs that are considered particularly dangerous. One
study of cocaine users in Toronto showed that for many people who use this substance, crime
is neither necessary to pay for drugs nor an unavoidable bi-product of their drug use.

“The most common means of getting cocaine, by far, were to buy it with their own
money or be given it. The next most frequent ways, for about half the respondents, were
to borrow money from family or friends or to sell cocaine... Criminal activity, other than
drug sales, was resorted to rarely. Fewer than 10 percent of respondents had ever
shoplifted, broken into a building or car, or engaged in prostitution in order to obtain
money to buy cocaine” (Erickson, “Cocaine Careers” 303)

This evidence does not show that there is no correlation between illicit drug use and crime.
However, it does suggest that this correlation is often overstated and does not warrant
incarcerating those who use drugs due to an assumption that they are not law-abiding citizens
other than using, and in some cases selling, drugs. Law enforcement should deal with more
serious crimes when they are actually committed instead of locking people up preemptively
based on shaky assumptions about people who use drugs.

Another issue within the War on Drugs is that most associated educational efforts,
including public service announcements and school curricula, demonize drugs and portray the
results of using drugs as unrealistically harmful. This portrayal can actually cause target audiences, often children and teenagers, to realize that they are being misinformed and thus not believe that any of the purported risks of drugs are real. “They see their friends and others using drugs with consequences different from the ones they’re taught to expect. As a result of this misinformation, adults’ credibility with children is diminished, with dangerous results” including the possibility that they will infer “that people cannot hurt themselves with drugs” (Schaler, “Thinking about Drinking” 348).

Specifically, many of the anti-drug television commercials that the government has spent hundreds of millions producing since the 1980s were likely counterproductive in their goal of reducing teenage recreational drug use. One researcher demonstrated that “for some kids, seeing anti-drug ads made them curious about what doing drugs would be like, even if they had never had that curiosity before” or it can make them want to rebel against adults in these advertisements, who may appear patronizing (Ferro). Some later adds which used fewer scare tactics and were more relatable to young people, such as the “Above the Influence” campaign had somewhat more success (Ferro). The ineffective earlier adds which demonized drugs represent another facet of War on Drugs policy that did not support a healthy citizenry with the power to make educated decisions.

The list of discriminatory and/or ineffective policies and structures within laws, policing, sentencing, jury selection, profiling, drug education, bail, and other aspects of drug enforcement and the criminal justice system is too long to recount in this paper. This is due to the legacies of explicitly racist structures and the continued prejudice and racist attitudes that exist either consciously or unconsciously in the minds of those who hold power in the criminal justice
system. These inequalities show the relationship between structural injustice to the criminal justice system and specifically drug-enforcement policies. Therefore, major reforms, specifically aimed at working toward racial and economic justice in drug policy, are necessary for the government to fulfill its responsibilities to citizens. Additionally, due to the enduring structural injustice that affects the sociopolitical environment of drug use, treatment, and enforcement, even the classical liberal or public health approach would perpetuate racial inequality without a specific emphasis on implementing policies that support racial justice.

b) Objections to Classical Liberalism

Proponents of the “liberal”\textsuperscript{2} or free market understanding of democracy would logically support the model of classical liberalism with regard to drug policy. Under this framework, it would follow that the use and sale of all drugs would be legalized and every individual would have the opportunity to decide whether or not it is in their best interest to use a given drug. However, when examined in conjunction with CRT and theories of structural injustice it becomes clear that the current structure of society is such that certain populations are privileged by a free-market system while others are disadvantaged. Thus, with regard to drug policy, simply legalizing the use of all recreational drugs would not be sufficient to reduce drug-related harms. The legacies and current realities of racist and classist policies that put certain groups more at-risk of drug-related harms would remain without additional reforms. The effects of the use of some drugs are devastating enough that they may prevent individuals from having a meaningful version of the autonomy that democracy is meant to provide. Unlike liberal democratic theory, the more progressive democratic model would not support a classical liberal model of drug

\textsuperscript{2} In this case “liberal” refers to its meaning associated with classical liberalism, and is similar to the ideology known as libertarianism (not to be confused with the term liberal’s connotation in American politics as the left end of the political spectrum).
legalization. This is due to the extent to which allowing the use of all substances, even those that have proven to be especially dangerous and addictive, is harmful to creating a society of free and equal citizens.

Proponents of classical liberalism claim that individuals have the right to make their own decisions about which drug-related risks they want to take. However, there are reasons other than rational choice that people may use drugs, such as lack of education about the risks of some drugs or insufficient access to mental healthcare and other alternatives to drug use as a way of dealing with hardship, especially given that a culture of using very dangerous drugs is ingrained in some communities. Of course, drug use is also common among people from more privileged backgrounds who may have better access to education and medical or psychological care. Dangerous drug use and addiction within both privileged and marginalized communities can also begin with using substances that are legitimately prescribed, mental illness, peer pressure especially in the case of teenagers, or simple human curiosity leading to unintended consequences.

Within the framework of a progressive democracy, people should have autonomy over their own decisions to the extent that this is feasible while still supporting a society that promotes opportunity, health, and freedom for all people. Although allowing the use of many of the less dangerous drugs is conducive to achieving the goals of this kind of democracy, fully legalizing the use of substances which are highly addictive and dangerous may take away more autonomy than it provides to citizens. In addition, this model does not do enough to combat those inequalities which are ingrained in American society along the lines of class and race, failing to adequately address the implications of structural injustice and critical race theory.
c) Objections to the Public Health Model

A progressive democracy may fit best with the general framework of public health-based models of drug policy than any other existing model. Its goal is to improve the health of individuals, which ought to help them regain the autonomy and well-being needed to participate on an equal playing field within democratic society. A drug court system is less punitive than incarceration and thus does not systematically disadvantage users to the same extent as traditional courts nor would it allow for the harm that could come to users by simply allowing drug use. However, it is not a full solution to ethical problems. Policing, arrests, and mandatory treatment for the users of recreational drugs still exist in most versions of this model. For this reason, without significant modifications, this policy model does not entirely fit with democratic values and does not take sufficient steps to undo societal inequalities.

Furthermore, even other versions of the public health/harm reduction model which place little to no emphasis on the role of law fail to meet the full needs of a democracy’s citizenry. First, these methods may not do enough to distinguish between the uses of different illicit substances. Given the vast range of effects of different drugs, any standardization of regulations for all drugs would likely be too strict for the least harmful drugs, which have minor enough risks that adults should have complete autonomy over their usage choices. In fact, there is the potential for intrusive moral indoctrination that undermines democratic rights of individuals. Conversely, for the most dangerous drugs these regulations may not be enough to fulfill the responsibility to support a healthy citizenry. A version of the public health/medical model which focuses exclusively on intervening only the necessary amount to protect individuals’ ability to be autonomous would be the most in line with the theoretical frameworks which ground this paper.
However, even a medical model with perfect balance of intervention and liberalism to support a citizenry healthy enough to access their share of liberty and opportunity would be missing a crucial consideration: creating policies that work against structural injustice. A clear step in this process would involve working to eliminate disparities in the methods, policing based or otherwise, of monitoring and treating drug use. Although somewhat outside the direct scope of drug policy, an important element of solving drug-related harms would involve improving access to quality healthcare, mental healthcare, and education in marginalized communities in order to provide options that decrease the extent to which people are left with drug use and sales as the preferable course of action.

**Targeted Equitable Intervention Model**

Given the implications of the frameworks of critical race theory, structural injustice, and democratic theory, I propose a new model of drug policy which I call the targeted equitable intervention model. This model allows freedom of choice to individuals with regard to recreational drug use as much as possible while still protecting individuals and communities from suffering serious negative consequences of drug use. Additionally, this model involves implementing reforms that offer rehabilitation instead of punitive measures for those who use drugs that are deemed by scientists and medical professionals to be most harmful. Finally, it is key to this model that the legacies of racial injustice are addressed through reforms that affect all aspects of monitoring and intervention in recreational drug use.

**a) Individual Freedom in Targeted Equitable Intervention**

A key piece of this model is that any and all intervention is specifically “targeted” at substances that have been deemed extremely debilitating due to their addictiveness or associated
risk of overdose and other negative health effects. For this reason, although the recreational use of all drugs would be decriminalized within this model, not all drugs would be legalized. As I will discuss more in the next section, protecting health and well-being by intervening when these most dangerous substances are used is an important part of targeted equitable intervention. Conversely, for those substances that are not deemed particularly dangerous, this model allows for significant individual freedom of choice. The legalization of the recreational use of many currently illicit drugs would work toward a society in which adults have greater freedom and fewer unnecessary restrictions on their behavior. This constitutes the “targeted” element of targeted equitable intervention; legal and non-elective medical mediation can be aimed specifically at the most dangerous drugs, allowing for the legalization, regulation, and taxation of all others.

Several states in the United States have already legalized the use of recreational marijuana for adults, and this is a first step toward offering individuals more freedom of choice. Marijuana is consistently ranked by scientists as less dangerous and addictive than alcohol and tobacco, which are already sold and used legally. In fact, according to the Drug Enforcement Agency, there have never been any reported deaths due to an overdose of marijuana (“Drug Fact Sheet”). Tobacco, alcohol, and marijuana (in those states where its use has been legalized) are also currently regulated and taxed. These tax funds can be used to pay for positive social reforms.

Regulation allows the government to ensure that people only use drugs in the safest possible conditions, with full and accurate knowledge of what they are putting into their bodies. Regulations allow the government to control who produces drugs and monitor their production
and ingredients in the same way that the Food and Drug Administration and the Department of the Treasury’s Alcohol and Tobacco Tax and Trade Bureau currently do for many substances (Office of the Commissioner). This process can ensure that drugs do not contain harmful additives and that every substance’s packaging contains a full list of ingredients. Along with a list of ingredients, warning labels about possible health effects help individuals make informed decisions about substance use. Government agencies can also restrict the strength and dosage that people can purchase, making it much less likely that people use dangerous amounts of a substance. Regulations can also prevent children and teenagers from gaining access to drugs by requiring that they are only sold to adults with valid identification.

In addition to federally legalizing the use of recreational marijuana, this model of drug policy also calls for the legalization and regulation of other currently illegal drugs. Leaders in the medical and scientific communities are in the most knowledgeable position to make specific judgments as to which drugs are safe enough to legalize. Based on current rankings of danger, I propose that heroin, cocaine, and street methadone are among the substances that should not be legalized for recreational use (Bowcott), although their use should be decriminalized. Whereas many hallucinogenic substances, such as LSD, ecstasy, and hallucinogenic mushrooms are among those that should be considered for complete legalization when used by consenting adults due to their relatively low danger compared to other substances, including alcohol.

As is already the case with legal substances such as alcohol, individuals would remain responsible for their actions under the influence of any newly legalized substances. Just as driving under the influence of alcohol is now a serious offense, operating a vehicle or engaging in any kind of illegal activity while under the influence of any mind-altering substance would
remain punishable under the law. Although addiction is a genuine struggle that can affect behavior, the fact of being under the influence of or addicted to a mind-altering substance is not a legal defense for criminal activity. “There is no medical foundation for adopting the general proposition... that addictive conduct is involuntary” (Fingarette 321).

Those who use and/or are addicted to drugs are still subject to the law, but corresponding sentences for crimes can still take into account the drug-related factors that led to their actions and what will be productive for the individual’s future. “Undoubtedly there are those who regard possible legal approaches to addiction in polar terms: Either we inflict harsh, punitive, and degrading measures on the addict, or we declare the person sick and therefore not responsible for his conduct. What is needed here is the abandonment of such extreme and fixed positions” (322). There are serious concerns about the ethical implications of incarceration and other elements of punitive legal action in the United States, and the theoretical frameworks discussed in this paper show that these should be re-examined by policy-makers for all crimes. However, the corresponding sentences for any crimes other than the isolated use, possession, or sale of a drug for recreational purposes fall outside the scope of this thesis.

For those who are identified as using or in possession of a small amount of substances that remain illegal, but do not show evidence of addiction, minor penalties such as fines (or mandated community service for those without the financial resources to pay a fine) would be deemed appropriate. While the aim of the targeted equitable intervention model is not to impose punitive measures, it is necessary to have some deterrent for using or owning substances that come with such serious risks. However, incarceration would not be an appropriate deterrent for these infractions under this model due to its dehumanizing effects on individuals and the societal
impacts of locking up so many citizens. Punitive and deterrent methods of drug enforcement ought to be kept to a minimum, and to this end drug use should be decriminalized. However, in the interest of keeping citizens healthy, some minor penalties would become necessary to control those substances that harm individuals and communities most, but these penalties can be reduced “to the level of a parking ticket-or a speeding ticket” in order to “cease packing our prisons with non-criminals” (Fish 169).

b) Treatment, Health-Oriented Policy in Targeted Equitable Intervention

Another core tenet of my model is attention to protecting health and well-being which allows individuals to lead meaningful lives and engage with society and democratic practices. Policies that work toward this goal of protecting health and well-being primarily constitute the “intervention” piece of Targeted Equitable Intervention. Both elective and mandatory health-oriented policy generally fall into two categories: harm minimization and treatment. “Harm minimization involves health-related interventions to reduce health-related harm and treatment involves therapeutic interventions to control or stop drug dependence” (Keene 87). Both of these policy categories are important to the goals and methods of this model given that they can each play an important role in improving health outcomes.

Many policies geared toward harm minimization for drug users’ health involve measures meant to prevent the drug-related spread of infections and communicable diseases such as HIV, hepatitis B and C, and tuberculosis (Keene 96). This harm can be reduced by policies that involve distributing clean equipment such as needles and syringes and providing information and counseling to populations who are at-risk of spreading these diseases (95). Policies such as handing out clean needles knowing that they will be used to take illicit drugs may seem
paradoxical or contrary to the intent of this drug enforcement policy. However, it is possible to attempt to control a substance while still implementing policies that reduce its related harms. If drug users already have access to an illicit substance that they want to inject, they likely already have access to needles with which to do so; making sure that they have access to clean needles will reduce the spread of communicable diseases and will be unlikely to increase drug use. Other policies focus on preventing other societal problems associated with drug use, such as driving under the influence. Designated driver programs (Des Jarlais 11) and education about alternatives to driving while under the effects of mind-altering substances also have the power to save lives. While this kind of policy does not prevent the effects of the use of recreational drugs themselves, it does help to avoid additional unintended negative consequences that are often associated with drug use. Therefore, it is an important step in working towards a healthier society.

Treatment oriented policies in targeted equitable intervention can be broken down categorically into elective and mandatory treatments. In order to improve health outcomes while also encouraging personal freedom, elective medical treatment must be available to all individuals who would like to work toward their own sobriety. Elective treatments need not be targeted toward only extremely dangerous drugs because all individuals who identify that their well-being is compromised by substance use deserve help in ending their reliance on the drug. Elective treatments do not infringe on personal freedom in any way, and thus should be made available indiscriminately. Within this model, nobody would be penalized for admitting to the use an illegal substance in the context of seeking out treatment or choosing to go to the hospital because of a dangerous medical situation caused by the use of an illegal drug.
In addition to elective drug treatments, this model calls for mandatory treatment for users who are identified as dependent on the most harmful drugs. For both mandatory and elective treatments, the government would increase access to clinics and rehabilitation centers which help individuals reduce their reliance on drugs that harm their health and ability to lead productive and happy lives. Cognitive behavioral therapies have been shown to be effective in reducing addiction to both currently legal and illegal substances including alcohol, marijuana, cocaine, methamphetamine, and nicotine (National Institute). Additionally, methadone clinics can be effective as what is known as “replacement therapy” for those who are “addicted to opioid-based drugs, such as heroin or prescription painkillers” (“What is a Methadone Clinic”). Methadone and some other substances “induce physiological dependence in the same way as heroin” (Keene 42). Therefore, it is not a complete solution to the problem of dependence. However, this kind of therapy serves the purpose of easing users off of heroin and other drugs with mind-altering effects associated with greater rates of criminal activity and negative health outcomes. This method can be used in conjunction with other types of therapy and counseling.

While there is cost associated with providing both elective and mandatory treatment, significant government funds can be saved due to decreased costs associated with incarceration and policing and increased tax revenue. Studies show that treatment is both cheaper and more effective than incarceration.

“incarceration costs more than $19,000 per inmate, while treatment programs - such as the drug court program - cost only about $5,400 per participant. The re-arrest rate of drug court participants is 23.5 percent, compared to 54 percent of those incarcerated... Those
receiving treatment had high rates of employment, higher monthly incomes and were more likely to be taking care of their own children" (Carter)

Therefore, not only are the immediate costs of incarceration higher than those of treatment, but the relative long-term success of treatment saves taxpayers even more money going forward.

With regard to implementing mandatory treatment, some version of the drug court systems already in place can play a major role in this endeavor. One criticism of mandatory treatment is that the integrity of the therapeutic process is compromised by the coercion of a participant. This argument is founded upon the idea that those receiving mandatory treatment may simply do what is necessary in order to fulfill their legal obligation without putting genuine effort into fighting their addiction or that they will perceive the need to “pretend to participate in therapy in order to avoid punishment” (Fish 170). However,

“most studies suggest that outcomes for those who are legally pressured to enter treatment are as good as or better than outcomes for those who entered treatment without legal pressure. Individuals under legal pressure also tend to have higher attendance rates and remain in treatment for longer periods, which can also have a positive impact on treatment outcomes” (“Is Legally Mandated”).

This shows that although there may be issues with court-ordered treatment, these efforts in practice do lead to positive results for patients. In addition, given the cruel, unproductive, and costly nature of incarceration, mandatory treatment may be the only ethical response to situations in which an individual’s health and well-being is seriously compromised by addiction.

The process for identifying defendants in the drug court system would have to change dramatically so that only those addicted to the most dangerous drugs would be required to attend.
Drug courts, while coercive for participants, are not meant to be punitive in nature and could form an important piece of effective and ethical drug policy if used correctly and in conjunction with other structural changes. These courts would sentence those who are deemed to be reliant on remaining illicit drugs to the kinds of treatments and therapies previously listed. Variables such as the extent of the addiction, the substance in question, and whether or not the individual has undergone treatment before would determine whether they would be required to live in a residential treatment center or can remain living in their homes while receiving an appropriate treatment or therapy.

Accurate information and education geared toward people of all ages about the risks and safest practices associated with using drugs recreationally is another step toward protecting public health. In contrast to ineffective scare tactics, accurate education about the potential risks of drug use and safest ways to use drugs (such as how to reduce the chances of infections or overdose) is an important piece of targeted equitable intervention. Just as advertisements for alcoholic beverages now include the message that consumers should “drink responsibly,” users of other newly legalized drugs should receive the message that they can make their own decisions about substance use while continuing to look out for their own safety and the safety of others.

This model would also put stricter and more consistently enforced controls on pharmaceutical companies who supply opioids and doctors who prescribe them. “As a result of limited science, external pressures, physician behavior, and pharmacologic development, we have seen the significant consequences of opioid overprescribing, misuse, diversion, and dependence” (“Chronic Pain”). Research suggests that prescribing opioids for non-cancer
chronic pain may come with more risks than benefits. In fact, “a growing body of evidence is suggesting that opioids may in many cases actually worsen chronic pain” although they do seem to be an effective treatment for certain types of pain (Compton).

There is a clear correlation between the rate at which opioids are prescribed and the rate at which they are used recreationally and abused, and therefore they should only be prescribed when it is clear that they will improve patient health outcomes. “The bottom line is that measures must be taken to reduce the prescribing of these drugs. A crucial part of this strategy is to better educate physicians in pain management and to develop better, evidence-informed prescribing guidelines for them to follow” (Compton). For this reason, efforts to improve public health through drug policy should include clearer, evidence-based guidelines and regulations for physicians who prescribe potentially dangerous drugs. It is also important that patients who receive these drugs are well-informed about the proper dosage for their condition and possible risks of exceeding that dosage or otherwise misusing their prescription.

c) Anti-Racist/Classist Reforms in Targeted Equitable Intervention Model

The “equitable” aspect of this model is essential to reducing the harms that stem from a long history of policies that disproportionately harm African American people and the poor. Given that this model would significantly reduce the number of substances that would be controlled through coercive means by law and eliminate incarceration as a response to the use of even the most dangerous drugs, dangers of mass incarceration and other forms of structural injustice would automatically be significantly reduced. Decriminalizing all drugs helps to solve problems related to mandatory sentencing, discriminatory bail policies, and the effects of incarceration on the prison population and their families and communities.
However, given that some form of policing, a drug court system, and minor penalties such as fines would continue to exist for some illicit drugs, additional reforms would still be necessary to work toward structural justice. A first step in the reform process would be to put in place regulations that prevent police from having a disproportionately large presence in black communities, at least for the purpose of drug enforcement. In fact, police presence focused on combatting recreational drug use, even of the most dangerous substances, should be kept to an absolute minimum. Given that societal factors other than drug enforcement policy lead to a disproportionate police presence in different communities, some of these policing disparities fall outside the scope of drug policy. However, to the extent possible, targeted equitable intervention would work to prevent these disparities in the context of drug enforcement and reduce this policing generally.

In addition to the legalization of many substances and decriminalization of all others, “people who use psychoactive substances in the privacy of their own homes should be of no interest to the police” (Fish 169). Instead, police can focus their efforts on more serious violent crimes and only intervene when drug use takes place in public or causes a disturbance. In contrast to War on Drug policies such as discriminatory stop-and-frisk practices, this model acknowledges that proactively seeking out illicit drug use for punitive purposes is more harmful than helpful to communities affected by drug use. This change in strategy and attitude for policing would eliminate many of the opportunities for implicit and explicit bias to impact policing and arrest rates for different demographic groups. It also generally works toward a society in which policing is reserved for necessary circumstances. The disparities between responses to the opioid epidemic in rural and suburban America and the use of opioids and other
illicit drugs associated with black and Latino people in urban contexts would also be eliminated. Targeted equitable intervention’s drug enforcement policies apply the same way to middle class Americans who use opioids for which they do not have a prescription as they do to all other drug users.

Additionally, disparities such as those which exist between legal ramifications of using crack cocaine and powder cocaine would be eliminated completely; although this disparity was reduced in 2010, complete eradication of this disparity is necessary in a just system. Efforts to undo the harms of mass incarceration should also involve providing amnesty to the hundreds of thousands of individuals who are currently in prison for drug-related offenses. The portion of the prison population made up of those who are incarcerated simply for the use or possession of drugs such as marijuana or other drugs that would be legalized in the targeted equitable intervention model should be released. These newly released individuals and other people formerly incarcerated on this kind of charge should also have their records expunged. Those incarcerated for the use of more dangerous substances can have their cases reexamined using this model’s procedures. Many of these individuals would receive mandated treatment while others who are not deemed dependent on any substance can be released, having already spent time incarcerated for a minor infraction.

Another piece of this model involves trying to change public perception about people who use drugs recreationally and live in communities affected by drug use. It is important to note that although it is unclear what percent of Americans would support the radical changes within this proposed model, there is evidence that American society is moving away from the prohibitionist mindset with regard to recreational drug use. Current drug policy in the U.S. does
not reflect changing public opinion. According to a 2014 national study, 67% of respondents said drug policy should focus on providing treatment, whereas only 26% said that it should focus more on prosecuting drug users (7% said they did not know). This study also showed that 63% of respondents think it is a good thing that some states were moving away from mandatory minimum prison sentences for non-violent drug crimes. In 2001, only 47% felt this way, indicating a significant change in public perception (Motel).

Furthermore, as of the beginning of 2018, 61% of Americans believed that marijuana should be legalized. There is a significant generational gap in opinions on this issue:

“Majorities of Millennials (70%), Gen Xers (66%) and Baby Boomers (56%) say the use of marijuana should be legal. Only among the Silent Generation\(^3\) does a greater share oppose (58%) than favor (35%) marijuana legalization” (Geiger)

This suggests that if this pattern continues then society will move further toward legalization sentiments in future generations. These evolving attitudes toward recreational drug use and the goals of drug enforcement policy can lay the groundwork for work which continues to raise awareness about the humanity of those who use drugs and their communities, the cruelty of incarceration, and the effectiveness of alternative models of drug policy.

Strategies improving societal education about drugs can include changing the message and tone of information disseminated through media such as speeches, public service announcements, and public education. Even seemingly small changes in semantics, such as avoiding dehumanizing labels such as “addict” and “ex-con” in government discourse and policy can make an important difference in the perception of these individuals (Davies). Instead,

\(^3\) The Silent Generation refers to those born between 1925-1942 (Sansburn).
language such as “person suffering from addiction” and “previously incarcerated person” is more respectful. An example of a similar movement to change public perception of a marginalized group of people is the switch that some politicians and media outlets made from using the term “illegal” to the term “undocumented” when referring to immigrants who live in the United States without the official paperwork to do so. When this seemingly minor change in language is used it sends the message to the American public that a person is still worthwhile regardless of immigration status (Demby). A similar goal can be achieved by changing the way that the government and the public represent people who use drugs recreationally. The previous section discussed ways that accurate public service announcements and improved curricula of health classes can be beneficial to helping those who use drugs make healthy decisions. Similarly, portraying those who use drugs in a respectful, accurate, and humane manner can help to reduce harmful prejudices and stereotypes. This change in public perception will make equitable drug enforcement policy easier to implement and more effective due to increased community support.

In addition, efforts to improve social conditions in marginalized communities are essential to creating a society in which fewer people are left with drug use or sale as their only apparent option to improve quality of life. This would not curb all use of dangerous drugs, given that many people use substances for reasons such as curiosity or simply because it is an activity that they enjoy. However, for the populations that do use drugs due to a lack of other accessible resources, these efforts are key. Thus, improved public housing, neighborhood development, public education, and medical facilities in neighborhoods highly affected by drug use are key to supporting the model for drug policy I have presented. Improving access and quality of all these elements of society may seem like a large and difficult goal. However, given the funds from tax
revenue gathered from the sale of regulated drugs and the money saved by not incarcerating
hundreds of thousands of non-violent individuals, this model supplies the funds to at least begin
serious efforts toward improving these institutions and aspects of neighborhood life.
Furthermore, examining society through critical race theory and with a focus on creating a
healthy democracy in which all people are meaningfully represented, one will find that these
reforms are ethically necessary and ought to be the U.S. government’s priority despite the fact
that it may be a long and costly road to achieving a more equitable society.

d) Drug Dealers in Targeted Equitable Intervention

Given that this model decriminalizes all drugs and legalizes many, the black market for
recreational drug use would shrink considerably. Interestingly, there is also evidence that the
minimization of law enforcement practices that actively seek out and punish non-violent drug
users and dealers can also lead to “fewer, older, less violent sellers” in the remaining black
market (Cleveland 190). This is because frequent police raids and unduly long sentences for drug
dealers lead to a market in which dealers live in constant fear and frequently turn each other in as
part of deals to reduce their own sentences. At first glance, this fear of harsh drug enforcement
may seem like it would lead to the positive result of deterring the sale of drugs and thus reducing
drug use and its negative consequences. However, highly punitive policy mainly deters drug
dealers who have other, safer options, leaving room for another group to take over this market:
namely, “low-income user-dealers who need to pay for their habits and young, ill-educated,
vViolent teenagers, kids who need to trade their very limited futures, even their lives, for a few
hundred dollars” (191). Although it is in some ways counterintuitive to implement policies that
make it safer for individuals to break the law, this may be the key to reducing “the presence of
large numbers of ill-educated, violent juveniles” that make the American illicit drug market so much more dangerous and problematic than this market’s equivalent in Europe and Australia (190). Therefore, targeted equitable intervention not only decreases illicit drug sale by legalizing many drugs but also reduces violence and the presence of minors in remaining drug sale; however, to the extent that the sale of illicit substances would still exist, some model for intervention is necessary.

Although this model focuses primarily on responses to recreational drug use, this section will comment on the basic approach that targeted equitable intervention would take with regard to those who create and distribute illegal substances. Dealing potentially dangerous drugs for a profit has different ethical implications than using those drugs oneself due to the potential to harm others. However, the same societal conditions and injustices that leave certain people in positions where drug use feels like the only viable option can apply to those illegally selling drugs to others in order to support themselves and their loved ones. Also, assuming that drug dealers are selling their products to consenting adults who know what they are purchasing, ethical implications are unclear and subject to debate. Due to harsh laws that impose lengthy mandatory minimum sentences on drug dealers, those caught in this moral grey area often fall victim to the many harmful and even cruel trappings of incarceration and its lifelong effects. For this reason, I propose that within the targeted equitable intervention model, incarceration should not be the first response to most sale of illicit drugs. In fact, discrete, non-violent drug sale should not be actively sought out by law enforcement at all. However, when such behavior is identified because it takes place in public spaces or is noticed by concerned citizens, fines,
community service, and referrals to social workers and job training programs ought to be the first response for those who are caught selling or producing illicit substances.

This approach involves shifting away from highly punitive measures such as incarceration as much as possible. As stated earlier, I argue that the current American criminal justice system and its propensity for incarcerating the population at an alarming rate should be overhauled in favor of a more just solution. At the very least, prisons should have better living conditions and more opportunities for education and job training. However, given that these changes fall outside the scope of this paper, the model for dealing with those drug dealers who cause the most persistent harm to others would have to rely on minimal use of incarceration as that is perhaps the only option for which the current system allows.

This model calls for minor fines, community service, and/or appropriate therapies for those who sell illicit substances to consenting adults and are identified by law enforcement without any active intrusion in private spaces. For those who repeat this offense in public several times, sell dangerous substances to minors, sell substances with additional dangerous additives that consumers are unaware of, or engage in other violent illegal activity while dealing drugs, incarceration would be an appropriate response. However, sentences should be relatively short even for these individuals compared to current sentence lengths. Both while serving their sentence and after their release, people should have ample access to counseling and job training. Furthermore, the same protections that this model includes to protect people of different race and class who use drugs must exist for those who deal these substances as well.
Theoretical Frameworks and Targeted Equitable Intervention

In previous sections, I argued that none of the existing models of drug policy fulfill the ethical requisites set out by the theoretical frameworks of critical race theory, structural injustice, and progressive democratic theory. However, these theories can be used to support the policy model of targeted equitable intervention. The combination of liberalism with minimal intervention in the name of protecting safety and well-being while reforming systems to avoid reproducing a structurally unjust society is in line with the implications of each of these frameworks.

The theories of structural injustice and critical race theory both highlight the extent to which societal systems disadvantage African American people and other marginalized groups even in the post civil-rights era when laws do not explicitly give different rights based on race. The implication of these theories is that simply creating a superficially “colorblind” legal system is not enough to prevent the mistreatment of people based on race within that system. This is why targeted equitable intervention places an emphasis on creating policies that actively work against this oppression, something which none of the three major existing frameworks do. The model includes policies that work to eliminate sentencing disparities and processes that make it easy for individuals with power in the criminal justice system and legal system to act on conscious or unconscious biases, such as ending stop-and-frisk and regulating the police presence in different areas. Thus, this model acknowledges and addresses the injustices explained by critical race theory and theories of structural injustice. Furthermore, the elimination of purely punitive responses to drug offenses and the drastic reduction of drugs that are outlawed
is supported by these frameworks as well due to the extent to which they cut down mass incarceration and policing which are key areas in which racial injustices are perpetrated.

This model is supported by progressive democratic theory due to its balance between liberalism and policies that use necessary means to protect the health and general welfare of citizens. In order to have a democracy in which all people are meaningfully able to participate in their government and enjoy the same rights as their fellow citizens, it is important to give consenting adults as much freedom as is possible while still putting policies in place that prevent them from danger. This theory of democracy supports the idea that laws and regulations should afford people the means to lead healthy lives free from substances that can lead to addiction and the risk of a drug overdose. Certain substances can take away freedom and prosperity by causing these harmful effects; therefore, laws prohibiting their use (without imposing excessive punishments for those who break these laws) actually protect more individual freedoms than they take away. Just as our democracy is healthier when a certain degree of education for children is required by law, the same is true when policies are put in place to protect people from losing their autonomy, health, and possibly their lives to dependence on drugs or overdoses.

Mandatory treatment and rehabilitation help mitigate these harms and put power back in the hands of citizens. However, this is not the case for substances such as marijuana and other drugs which are relatively safe and do not prevent individuals from participating and benefitting from democratic society. In a healthy democracy, all people should have genuine freedom and opportunities to pursue their chosen path, as opposed to a complete lack of regulation which gives the appearance of freedom but actually affords little choice to marginalized or at-risk individuals and communities. The targeted equitable intervention model of drug enforcement is
designed to maximize both individual freedom of choice and regulations that protect well-being and opportunity.

Targeted equitable intervention’s response to the production and sale of drugs is based on these same values. The balance between relatively minor consequences for most people caught dealing drugs and more serious consequences for people who deal drugs in ways that are especially dangerous to society minimizes incarceration to the extent possible while still protecting minors and other citizens. This works towards realizing the competing rights and needs of different members of democratic society.

**Examples of Alternative Drug Policy**

Elements of targeted equitable intervention are already incorporated into policy in other countries and certain state and local initiatives and laws within the U.S. Examining the results of such policies can help shed light on how they affect society, and whether or not this policy model would accomplish its goals. None of these examples are meant to show how the entire model of Targeted Equitable Intervention would work when implemented on a nationwide basis in the United States; the model’s specific combination of policies has yet to be tested in any country, and even if it had, the unique historical and sociopolitical context of the U.S. would include added variables that could affect policy results. However, these studies are useful indicators of the kinds of effects that would result from implementing elements of the targeted equitable intervention model. Additionally, it is important to note that the models in these examples are not the grounding frameworks for the model suggested in this paper, but rather tools for examining how elements of this model may affect society.
a) Portugal

In 2001, Portugal decriminalized the use and possession of all drugs. “Rather than being arrested, those caught with a personal supply might be given a warning, a small fine, or told to appear before a local commission – a doctor, a lawyer and a social worker – about treatment, harm reduction, and the support services that were available to them” (Ferreira). The European country, which had been using a prohibitionist model similar to the U.S. War on Drugs to fight its heroin epidemic, saw a drastic reduction in drug-related deaths, incarceration, and infections soon after implementing this policy. In fact, Portugal now has around six drug overdose deaths per million citizens, whereas the European Union average is 17.3 per million and the U.S. average is 185 per million (McCarthy).

Portugal’s successful methods are evidence that decriminalization of all drugs should be a key part of American drug policy as well. It is also important to consider the connections between decriminalization and legalization of drugs with other policies and societal attitudes.

“Portugal’s remarkable recovery... could not have happened without... a change in how the country viewed drugs, addiction. In many ways, the law was merely a reflection of transformations that were already happening in clinics, in pharmacies and around kitchen tables across the country. The official policy of decriminalization made it far easier for a broad range of services (health, psychiatry, employment, housing etc.) that had been struggling to pool their resources and expertise, to work together more effectively to serve their communities” (Ferreira)

This shows the connection between policy, social perceptions, and results. Of course, changes to drug enforcement policy do not exist in a vacuum; they must be accompanied by other social
changes as well. It is for this reason that targeted equitable intervention not only includes changes in the law but also social policies that work toward improved conditions in neighborhoods affected by drug use and drug enforcement. A policy model unfortunately cannot on its own change the attitudes and perceptions of the public; however, educational efforts and other policies can reflect values and influence society away from demonizing drug users and their communities and toward working toward these populations’ health and wellbeing. These efforts and the fact that American society is increasingly accepting toward drugs and those who use them suggest that the implementation of targeted equitable intervention in the U.S. could have similar success to Portugal’s policy changes.

b) The Netherlands

The Netherlands is another example of a country with drug policy that has seen success by steering away from the prohibitionist model. This country’s policy model involves distinguishing between what are considered List I drugs (including heroin, cocaine, ecstasy, amphetamines) and List II drugs (including cannabis and hallucinogenic mushrooms). Laws regarding List II drugs are more lenient than others, but these substances are still highly regulated. The Netherlands is famous for allowing the use of marijuana in some settings, but this use is only allowed under highly controlled conditions in which “coffee shops” can sell small amounts of the drug. Outside of these conditions, neither List I nor List II drugs are fully legalized, but the use and possession of small amounts of substances is not criminalized. “Anyone found in possession of less than 0.5 g of List I drugs will generally not be prosecuted, though the police will confiscate the drugs and refer the individual to a care
agency” (“Netherlands”). However, there are more serious consequences for cultivating or supplying these substances, which can lead to incarceration.

These policies have been relatively successful, with a rate of around 16 overdoses per million citizens (“Drug Laws”), which, while not as low as Portugal’s rate, is still significantly lower than the European average and orders of magnitude lower than the U.S. average. Additionally, the availability of recreational marijuana does not appear to have acted as a “gateway” toward more dangerous drugs for users. In fact, “only 22% of those [in Amsterdam] aged 12 and over who have ever used cannabis have also used cocaine … This compares to a figure of 33% for the United States” (Grund 4). One takeaway from the Netherlands’s drug model is that less punitive measures aimed at the users of recreational drugs “result in fewer criminal records, less social exclusion and more controlled consumption” (Grund 60).

The Netherlands model shares significant similarities with targeted equitable intervention. They both include a distinction between drugs based on their level of danger, although the line is drawn at different points; for example, ecstasy is a drug that would most likely be fully legalized within targeted equitable intervention but is a List I drug in the Netherlands. Like Portugal, the results of the Netherlands’s drug policy show that countries that give users of recreational drugs relative freedom of choice have fewer rates of drug related harms, such as overdose and far fewer individuals incarcerated for drug-related crimes.

c) Switzerland

From 1987 and 1992, Swiss officials engaged in a novel experiment by allowing people to legally use heroin and other drugs exclusively in Zurich’s Platzspitz Park. At the same time, national policy continued to strictly prohibit the possession and sale of these substances in all
other locations. This experiment spiraled out of control, leading to a population of 20,000 or so people, many of whom came from outside the country, using drugs within the park (Duke 203). Zurich’s chief medical officer explained that the city’s doctors "were having to resuscitate an average of 12 people a day, with peaks of 40 a day on some days" (Cohen). The park became overrun with crime, litter, destruction of property, and public indecency by 1992 to an extent that Zurich City Council found it necessary to entirely rescind the right to use drugs in this location (Duke 203).

Although this policy was unsuccessful and harmful to many people, the intentions behind this effort were to make positive change.

“The city characterized its approach as an enlightened effort to isolate the drug problem in an area away from residential neighborhoods, curb AIDS and foster rehabilitation. Its policy reflected a strong current of feeling among some European experts that it is the illegal and clandestine nature of the drug business, rather than the drugs themselves, that causes many of the associated problems” (Cohen)

The ideas guiding the Platzspitz Park initiative were conducive with creating a healthy and equal society, but its execution led to harm and chaos for the populations that it meant to protect. The results of this experiment suggest that regulation and legal and medical control must accompany the legalization and/or decriminalization of drugs. There is a middle ground between allowing the unrestrained use of drugs in a public space and declaring a harmful “war” on these substances, and by extension on those who use them. Another lesson from this experiment is that drug policy should be consistent in different areas in order to avoid clustering dangerous drug use. Platzspitz Park became so overrun with drug use and associated problems because, as the
only location with such permissive drug policy, it attracted users from all over Switzerland and other countries.

While the story of Platspitz Park is somewhat of a cautionary tale, other elements of contemporary Swiss drug policy, such as its focus on harm reduction and providing treatment to those addicted to drugs, have had more promising results. The current Swiss policy model is based on four pillars: prevention, therapy, risk reduction, and enforcement. The model is similar to the medical model, but still relies on legal norms and law enforcement given that the recreational use of drugs is not legalized in the country. A particularly novel policy implemented in Switzerland involves prescriptions for controlled amounts of heroin itself as treatment for opioid addicts who react poorly to replacement drugs such as methadone. This treatment has been shown to be effective in reducing overdoses by ensuring that people recovering from addiction only take small dosages of the drug in a clean and safe environment while using other treatments and therapies to reduce their dependence ("Prescription Heroin"). As long as heroin is prescribed responsibly and sparingly, only to those who are already suffering from opioid addictions, then this policy can help recovering drug users without causing the kinds of negative results seen from over-prescription of opioids in the U.S.

d) Colorado and Washington

While it is still quite early, and findings are preliminary, the results of initial studies of the effects of marijuana legalization in Colorado and Washington point in a positive direction. Findings include no change in marijuana use by teenagers, very little change in rates of traffic fatalities, a large reduction in marijuana arrests, and tax revenues have gone up. However, the decline in arrests for marijuana possession, sale, and cultivation, the legalization of marijuana did nothing to reduce racial disparities in remaining arrest rates. For example, "black people account
for 3.8% of the population in Colorado, but comprise 9.4% of marijuana possession arrests” even after legalization (Gettman 7). These arrests, which took place either due to marijuana possession on federal land or other violations of the new marijuana policy, show that working toward more legalization without additional reforms that focus on reducing structural injustice in remaining drug enforcement practices does not solve problems associated with racial injustice.

Although there have also been some negative consequences such as a small increase in marijuana poisonings among both children and adults, (for adults this was “mostly attributable to... tourists who had come to the state and had a negative experience with marijuana”) (Ingraham, “Here’s how Legal Pot”), the overall results of legalization in these states seem to point to more benefits than harm for citizens. This supports the idea that working toward more individual freedom of choice for recreational drug users is a step toward a healthier, more free society. However, legalizing substances such as marijuana should come along with health-related policies, such as harm reduction strategies, and anti-racist reforms to more fully address the needs of the American citizenry.

Conclusion

It has been widely acknowledged that the current War on Drugs has been unsuccessful in its goals and that its results are ethically unacceptable. Given America’s state of mass incarceration of disproportionately African American people and the continued use and sale of illicit drugs all over the country, it is clear that this country’s model for drug-enforcement should be overhauled. However, given the tension between allowing for individual freedoms and protecting people from the dangers of drugs, there remains significant debate about how the government should go about this overhaul. Basing my argument on the progressive conception of
democratic theory, critical race theory, and structural justice, I conclude that the U.S. government should provide communities affected by drug use with a model of drug enforcement that provides individual rights, medical and social service intervention that protects health and well-being, and anti-racist reforms that work against the legacies of racist policies and practices. In order to achieve this goal, I propose implementing the targeted equitable intervention model, which works toward a more just society in which people are given meaningful freedom and supported in living healthy lives that allow for greater engagement with their democracy, community, and personal aspirations.

The policy model recommended challenges policymakers to consider how best to implement those laws and programs that fit this framework. There are many remaining questions regarding practices associated with this model at both local and national levels. Determining the specifics of the laws related to taxation and regulation of newly legalized substances, health-based treatments and harm reduction policies, and reforms that keep those working within the criminal justice system from acting in ways that harm people based on race or class is no easy task. This is especially difficult considering the messy realities of politics, public perception, bureaucracy, and the many intersecting issues that interact with drug policy and its enforcement.

Further economic analysis of this policy model is necessary to determine how best to allocate government resources within drug enforcement, treatment, and related social improvements. In addition, there is a need for more research on best practices for both elective and mandatory therapies for those struggling with drug dependence. This research should take into account issues associated with both illicit drugs and the medically-prescribed opioids that can cause dependence and lead to dangerous drug misuse. Another area for further research is
alternatives to incarceration for non-drug related criminal activity and reforms that would make prisons more humane and focused on successful reentry. Targeted equitable intervention aims to provide guiding principles that can ground policy and the direction for further research on how to make drug policy that works for all Americans.
Works Cited


Gettman, Jon. Marijuana Arrests in Colorado After the Passage of Amendment 64. http://www.drugpolicy.org/sites/default/files/Colorado_Marijuana_Arrests_After_Amendmendment_64.pdf


AboutFDA/Transparency/Basics/ucm194879.htm.


“What is a Methadone Clinic & How Does It Work?” American Addiction Centers, americanaddictioncenters.org/methadone-addiction/clinic-facts/.

