THE AMERICAN JOURNAL OF BIOETHICS
https://doi.org/10.1080/15265161.2020.1861364

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TARGET ARTICLE

Racial Justice Requires Ending the War on Drugs

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ABSTRACT

Historically, laws and policies to criminalize drug use or possession were rooted in explicit racism, and they continue to wreak havoc on certain racialized communities. We are a group of bioethicists, drug experts, legal scholars, criminal justice researchers, sociologists, psychologists, and other allied professionals who have come together in support of a policy proposal that is evidence-based and ethically recommended. We call for the immediate decriminalization of all so-called recreational drugs and, ultimately, for their timely and appropriate legal regulation. We also call for criminal convictions for nonviolent offenses pertaining to the use or possession of small quantities of such drugs to be expunged, and for those currently serving time for these offenses to be released. In effect, we call for an end to the "war on drugs."

KEYWORDS

race and culture/ethnicity;
health policy;
regulatory issues

A series of prominent killings of unarmed Black people by police in spring 2020 has renewed calls to address systemic racism in the United States and around the world. Among those killed was Breonna Taylor, whose home was wrongfully entered by officers without warning as part of a drug-related search. As we will detail, Black people in the United States are disproportionately targeted, arrested, and incarcerated for crimes related to non-medical drug use, and this is one area where social reform is urgently needed. We are a group of bioethicists, drug experts, legal scholars, criminal justice researchers, sociologists, psychologists, and other allied professionals (see Appendix for details) who have come together in support of a policy proposal that is evidence-based and ethically recommended. We call for the immediate decriminalization of all psychoactive substances currently deemed illicit for personal use or possession,[1] and, ultimately, for their full legalization and careful regulation. In effect, we call for an end to the "war on drugs."

In principle, the "war on drugs" aims to protect people from harm and promote public health. In practice, it has worsened many aspects of public health while inordinately harming certain racialized communities (Mauer and King 2007). In addition, the "war on drugs" has fostered a condescending moralism that conflates drug use with violence or bad character and casts drug users—especially Black and Hispanic drug users—as criminals-in-waiting who deserve to be punished (Mallea 2014). Indeed, the very language of a "war" can work to reinforce "a set of beliefs and values that stress the use of force and domination as appropriate means to solve problems and gain political power" (Kraska and Kappeler 1997). In contrast to this approach, we argue for ending the drug war and investing in the most heavily affected communities. If managed carefully, this shift in policy will not only improve public health, reduce crime and recidivism, lower unemployment and poverty rates, and save governments large sums of money (which could be better spent; see Box 1); it will strike a necessary blow against racial injustice.

The context here is instructive. Historically, drug laws and enforcement have reflected and perpetuated explicit racism, including early legislation against

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[1]By "decriminalization" we mean that all relevant jurisdictions should adopt *de jure* decriminalization so that criminal penalties for the personal possession and use of small amounts of currently illicit drugs are removed by an act of legislation or judicial decision. This is in contrast to merely *de facto* decriminalization, whereby the suspension of criminal penalties depends on local, contingent administrative or law enforcement practices, such as the non-enforcement of the relevant laws and/or referral of offenders to treatment or education programs (Single, Christie, and Ali 2000; Hughes et al. 2016). Thus, although we will argue that individuals struggling with substance-related disorders or other drug-related difficulties should be offered treatment and education, such supportive efforts should be handled through social care institutions that are not tied to the criminal justice system.

Box 1. Saving money and reinvesting in communities.

Drug prohibition harms communities because it is a poor use of limited public resources. For communities that lack sufficient public investment in education, health care, social housing, or infrastructure, drug prohibition diverts public resources away from more socially pressing and worthwhile causes. In the U.S., it is estimated that state and local annual expenditure on drug prohibition amounts to $29 billion, with an additional $18 billion of federal spending (Miron 2018). Meanwhile, drug legalization could yield $58 billion in federal, state, and local tax revenues, with up to $106.7 billion in overall annual budgetary gains for federal, state, and local governments (Miron 2018).

In states that have legalized cannabis, education and public health programs, including substance use disorder treatment and drug use prevention programs, have been the biggest beneficiaries of cannabis tax revenues (DPA 2018). For instance, in Colorado, the state distributed $230 million to its Department of Education between 2015 and 2017 (Colorado Department of Education 2018). In 2019, Washington State collected a total of $390.3 million from cannabis excise and sales tax, with $188.3 million distributed to health care programs and $9.5 million to substance use disorder, education, and prevention initiatives (Washington State Liquor and Cannabis Board 2019). And as a part of California's Adult Use of Marijuana Act (Proposition 64), the California Community Reinvestment Grants ("CalCRG") program has allocated $28.5 million of the revenues from cannabis legalization to support restorative justice projects (with an additional $30 million planned for 2021, $40 million for 2022 and $50 million for 2023), focusing on job placements, mental health treatment, substance use disorder treatment, legal services to address barriers to societal reentry, and access to medical care (California Community Reinvestment Grants Program 2019).

These states have shown that they are able and willing not only to allocate large percentages of the saved funds toward social goods including schools, health care, and infrastructure (DPA 2018), but also to invest in community-building projects for communities that have been disproportionately affected by the "war on drugs," mass supervision, and mass incarceration. But we need to be clear. To fully rebuild those communities that struggle with the greatest concentration of substance use disorders, and which suffer from the cumulative, collateral effects of unjust drug enforcement will require public and charitable expenditures that significantly exceed the potential savings from ending prohibition in any given municipality or state.[2] Responsibly reinvesting these savings is a minimum first step, not a final answer.

Chinese "opium dens" and Mexican "reefer madness" (Musto 1999; Manderson 1999; Vagins and McCurdy 2006; Provine 2007; Fellner 2009; Campos 2012; Lopez 2014; Luna 2016; Netherland and Hansen 2016; Rosino and Hughey 2018). As we will discuss, the harmful effects of prohibition continue to be especially burdensome for certain racialized groups. Black and Hispanic men, in particular, are subject to heightened scrutiny in relation to suspected drug-related activities, for example, during "investigatory" traffic stops (Weitzer and Brunson 2015; Epp et al. 2017). They are more often met with police use of force, controlling for potentially confounding variables (see Fryer Jr. 2019). They are more likely to face arrest, prosecution, conviction, and incarceration (Mauer and King 2007; Fellner 2009; Mitchell and Caudy 2015; Koch, Lee, and Lee 2016; Nellis 2016; Omori 2019). Moreover, when convicted, they face harsher criminal penalties (Turner and Dawkar 2014; TSP 2018; Lynch 2019).

These discriminatory practices exacerbate vulnerabilities within affected communities, including those mired in structural disadvantages tracing back to slavery and Jim Crow—with persisting inequities that are still widely underestimated (Small 2001; Nunn 2002; Clear 2007; Alexander 2010; Del Toro et al. 2019; Onyeador et al. 2020). It has become evident that piecemeal reforms are not enough to address these problems. Rather, what is needed is a paradigm shift in how we think about drugs in society. As we will argue, even if racial discrimination in drug arrests, prosecutions, and sentencing could somehow be eliminated, drug prohibition itself would remain unjust and harmful on balance (Huemer 2007; Fellner 2009).

Our proposal to decriminalize and subsequently legalize non-medical drug use applies especially to cannabis, as the benefits and risks of this drug and associated policy options have been the most exhaustively researched. Cannabis is, on the whole, much less harmful to users and others than alcohol, tobacco, and a range of prescription medications that are not prohibited despite the greater potential for dependence and abuse (Nutt, King, and Phillips 2010; Anomaly 2013). But changing the policy on cannabis does not go far enough. In our view, the deep-seated racial injustices associated with current drug laws and their biased enforcement, the harms associated with illegal drug markets that thrive under prohibition, and the violence both within and between communities that such markets engender, call for a more comprehensive approach. Accordingly, we are in favor of the ultimate legalization and careful regulation of MDMA (ecstasy), psychedelic drugs such as LSD and psilocybin, heroin and other opioids, methamphetamine, and powder and crack cocaine—that is, all drugs used for non-medical purposes that are currently deemed illicit (for related discussions, see e.g., Abbott et al. 2020; Hoss 2019; Marlan 2020).

The personal use and possession of small quantities of these substances, we argue, should be entirely

[2]Potential federal enforcement savings are unlikely to result in a significant reduction in the size or budgets of the many agencies involved that are not exclusively focused on drug enforcement, and specialized drug enforcement agency funding is likely to be reprogrammed to regulatory enforcement.

excluded from the purview of criminal law (see footnote 1 for details). Policymakers should pursue this first step—decriminalization—without delay. Although this step alone would, at least in principle, mitigate some of the harms and injustices we have mentioned, the shift away from prohibition would of course need to be accompanied by supportive policies and initiatives to minimize the risks and potential negative externalities that might be associated with such a transition. In particular, while the groundwork for a fully legalized and regulated system is being developed, a combination of decriminalization and harm reduction akin to the Portugal model (see below) is strongly advised.

The bottom line, however, is that if and when problems with substance use or misuse arise, these should be approached through healthcare programs and social support, not prison time. Moreover, once the groundwork for legalization has been laid, the production, storage, handling, distribution, sale, and supply of drugs currently deemed to be illicit should be legally regulated like other drugs in the U.S. and the Anglosphere in general, such as alcohol, nicotine, and prescription medications.[3]

As a part of this process, policymakers should directly involve current and former drug users and their social networks in the revision of relevant policy, while implementing community-building programs based on coherent, long-term strategies that meet the needs of those affected (for details and further discussion, see Zigon 2019). We suggest that policymakers also develop racial and ethnic impact statements for any new regulations or changes to existing laws (DPA 2015).

Two final points of clarification. First, it is not our aim to argue either for or against the prudence or permissibility of personal use of drugs for non-medical purposes. Thus, in advocating for the proposed policy changes, we are not making any specific normative commitment as to whether individuals should or should not use any of the aforementioned drugs. More importantly, we do not suggest that all currently illicit drugs should be readily available to any potential consumer: the precise modes of access, and barriers to accessibility, must depend on the drug and its particular profile of benefits and risks as it would realistically be used under different conditions.[4] Accordingly, it is possible that some drugs should be heavily regulated, with their sale or administration requiring, for example, a special license, and/or some individuals who are at an especially high risk of harm being dissuaded by appropriate means (e.g., a person with severe psychosis seeking access to a high dose of psilocybin; see Smith and Sisti 2020). The question of how to devise and implement such regulatory policies in order to minimize harms and achieve successful compliance is beyond the scope of this paper. Nevertheless, we maintain that many, if not most, of the negative outcomes that are associated with so-called recreational drug use and dissemination in society are either produced or made worse through prohibition (Ostrowski 1991; Barnett 2009; Hart 2013; Todd 2018; Hart 2020).

Second, our paper should not be read as a general defense of the rights of adults to access, possess, and/or use drugs currently deemed illicit nor is it an attempt to argue for the constitutional protection of such rights enforced by the judiciary. Although we are not, in principle, opposed to a rights-based approach (for example, see Flanigan 2017), we intend our proposals to be considered within the domain of democratic politics. This is, therefore, a call for citizens to lobby their elective representatives, and for policymakers at state and federal levels to act by drawing up and passing appropriate legislation, and/or ensuring that these ideas are put on the ballot.[5]

DRUG PROHIBITION HARMS USERS

The standard case for drug prohibition is that it protects people from using certain drugs, which are thought to be harmful and inherently addictive. However, the "war on drugs" is based on a misunderstanding of the science of addiction (for example, it discounts contextual factors contributing to harmful

[3]Criminal penalties could still apply to certain activities, of course, such as the unlawful sale or manufacture of certain drugs, even under a legalized system. However, such a system would ensure that individuals are not targeted with offenses relating to personal possession and use.

[4]Obviously, further painstaking scientific research into such benefits and risks will be necessary to inform relevant policies. Also note: the case of heroin-assisted treatment in the Netherlands offers an example of the ways in which different regulatory standards can be operationalized for different substances (Blanken et al. 2010).

[5]Recent events have proved encouraging. While our article was under review in November of 2020, ballot measures were passed in the U.S. state of Oregon simultaneously decriminalizing the possession of all currently illicit drugs for personal use, legalizing the therapeutic use of psilocybin, and expanding access to evidence-informed drug treatment, peer support, housing, and harm reduction services. During the same time period, voters in Arizona, Montana, New Jersey, and South Dakota opted to legalize cannabis use, bringing the total to 15 U.S. states plus the District of Columbia that have legalized cannabis. Non-medical cannabis use is decriminalized in a further 15 U.S. states, as are all so-called recreational drugs in Portugal as of 2001 (Greenwald 2009; Hughes and Stevens 2010; Kreit 2010; Silvestri 2015).

drug use; see more generally Hart 2020; Pickard 2020), and it undermines the wellbeing of people who use drugs (Barnett 2009; Room and Reuter 2012; Csete et al. 2016), especially low-income racial and ethnic minorities (Clifford 1992; Provine 2007). Prohibition has not met its explicit aim of substantially lowering the overall rate of drug use, partly because severity-based deterrence, enforced by criminalization of drug possession and use, has historically been counterproductive (MacCoun 1993). Indeed, there has been an increase in global consumption of illicit substances over the last half century (Hall 2018).[6] Drug prohibition, like alcohol prohibition, is criminogenic and can therefore be harmful to both users and non-users; it can motivate users to commit burglaries and robberies in order to purchase drugs; it contributes to systemic violence; it is associated with corruption in the criminal justice system; it diverts law enforcement efforts away from solving predatory crimes and arresting their perpetrators; and it can contribute to a cycle of ongoing criminal behavior for those who hold criminal records for trivial drug-related offenses (Duke 2009).

When combined with criminalization, prohibition harms users by exposing them to criminal sanction, making them more vulnerable to arrest and incarceration—which itself poses health risks, including lower life expectancy and inadequate access to treatment for substance use disorders (Mauer and King 2007; Barnett 2009; Csete et al. 2016). In addition, prison conditions as normally found in the U.S. isolate people from their friends and family, deprive them of education and employment opportunities, exacerbate mental health problems, and may make people more prone to aggression (Petteruti and Walsh 2008; Raphael and Stoll 2009; Harding 2019). These experiences can generate lifelong personal, economic, and social obstacles (including for those who only experience community supervision), such as barriers to housing, employment, and welfare, as well as the denial of voting rights (Western 2002; Clear 2007; Petersilia 2009; Western and Pettit 2010; Natapoff 2020). Even the knowledge that one is subject to surveillance and the heightened risk of incarceration can be highly distressing (Miller and Stuart 2017; Del Toro et al. 2019).

From a wider public health perspective, prohibition undermines programs to reduce disease transmission within drug-using communities (Bertram et al. 1996; Rhodes and Hedrich 2010; WHO 2014; Csete et al. 2016; UN 2019), perpetuates unhelpful stigma surrounding drug use (Ahern, Stuber, and Galea 2007; Csete et al. 2016; Buchman, Leece, and Orkin 2017; UN 2019), and discourages users from seeking medical and non-medical help and support when needed (Bertram et al. 1996; Ahern, Stuber, and Galea 2007; Csete et al. 2016; Buchman, Leece, and Orkin 2017; UN 2019). As such, drug prohibition imposes a multitude of health-related costs. As we will discuss, it leads to unsafe drug use and inadequate knowledge of the real effects of drugs; it provides barriers to treatment for substance-related disorders; it diverts funds away from health organizations; it can threaten or block access to the therapeutic benefits of certain drugs; and it precludes the existence of "safe supply" programs and health and safety regulations relating to presently illegal drugs.

DRUG PROHIBITION HARMS COMMUNITIES AND FEEDS SYSTEMIC RACISM

As we noted, drug prohibition and criminalization reflect and perpetuate racial injustice in many contexts (Musto 1999; Vagins and McCurdy 2006; Provine 2007; Fellner 2009; Campos 2012; Lopez 2014; Csete et al. 2016; Luna 2016; Netherland and Hansen 2016; Rosino and Hughey 2018). These policies have been directly linked to police militarization and brutality (ACLU 2014) and are among the important contributing factors to mass incarceration and mass supervision, especially of Black and Hispanic men (Sterling 2004; Alexander 2010; Pfaff 2017).

One of the most significant problems with prohibition is that it leads to illicit markets: specifically, unregulated markets that result in the production of drugs of unknown and inconsistent purity, and, in many cases, dangerous bulking agents and toxic additives, thus increasing rather than reducing the potential for harm (Barnett 2009; Csete et al. 2016; Veit 2018). It has also contributed to the production of novel psychoactive substances in an attempt to circumvent existing laws. Accordingly, some jurisdictions have responded with "catch all" laws against all psychoactive substances, including those not currently

[6]Note: even if decriminalization did lead to an increase in the rate of non-medical drug use among certain subgroups, it would still be an effective policy if it reduced the overall harm to drug users and to society at large (e.g., by reducing violence associated with illegal drug markets). In this context, it should be noted that U.S. government drug policy has primarily sought to undermine the capacity of drug suppliers to meet, grow, and benefit financially from drug demand, so as to drive up drug prices and lower drug purity. These measures were intended to make it prohibitive to start using drugs while incentivizing treatment efforts by making it harder for users to sustain their habits. However, drug prohibition and enforcement have not achieved these ends. Rather, drug prices have generally fallen or remained stable, drug potency has increased, and drug use has steadily risen (Sterling 2006).

prohibited, but these laws have a number of problems (see, for example, Thorne Harbour Health 2017).

Prohibition also fails to deal with the background conditions, such as deep-rooted economic deprivation, that sustain illegal industries (Thoumi 2003), and the associated exploitation of structurally vulnerable individuals by criminal gangs and drug cartels (Wainwright 2016). Prohibition thus expands opportunities for crimes against drug users (Barnett 2009) and sets the stage for violence within and between criminal organizations, as well as violence against state officials and innocent parties (Reuter 2009; Thoumi 2010; Csete et al. 2016).[7] Furthermore, reductions in community safety and cohesion are exacerbated by increased exposure to state-backed violence and law enforcement, including dangerous raids by SWAT teams and other forms of policing that disproportionately target Black neighborhoods (Beckett, Nyrop, and Pfingst 2006; ACLU 2014; Ghandnoosh 2015).

In the U.S., overall rates of illicit drug use and opioid misuse among Black people are very similar to those among White people (Figure 1). However, Black people are more likely to be arrested, prosecuted, convicted, and incarcerated—with longer sentences—for drug offenses (Vagins and McCurdy 2006; Mauer and King 2007; Fellner 2009; Turner and Dawkar 2014; Mitchell and Caudy 2015; Csete et al. 2016; Koch, Lee, and Lee 2016; Nellis 2016; Lynch 2019; Omori 2019). Notably, sentencing disparities persist even after accounting for baseline differences in criminal history and crime severity (see, e.g., Steffensmeier and Demuth 2000, 2001; Spohn 2000). Moreover, the possession or distribution of drugs that are perceived to be more commonly used by Black people (e.g., crack cocaine) than by Whites people (e.g., powder cocaine) have been associated with harsher sentences,[8] despite approximately similar harm/benefit profiles and chemical constitutions (Vagins and McCurdy 2006; Lynch and Omori 2018).

When we take into account the harms of incarceration to individuals that have already been mentioned, initial race disparities in arrests, convictions, and sentencing can lead to and maintain long-term vulnerabilities and widening socio-economic disparities (Chin 2002; Clear 2007; Alexander 2010). In turn, differences in socio-economic status can contribute to disparities in the effectiveness of substance abuse treatment programs. Specifically, Black and Hispanic people, who make up approximately 40 percent of the admissions to such programs in the U.S., are roughly 4 to 8 percentage points less likely than White people to complete treatment for substance-related disorders largely due to socio-economic reasons (Saloner and Lê Cook 2013). Relatedly, because substance abuse treatment programs in the U.S. are linked to the criminal justice system (Kreit 2010), Black and Hispanic adolescents are more likely, compared to White adolescents, to be discharged from treatment due in part to incarceration (Marotta et al. 2020).[9]

The incarceration of a parent can also have profoundly adverse effects on children (Murphey and Cooper 2015), effects that have clear racial implications given that Black children are far more likely than children from other racial groups to have a parent involved in the criminal justice system (Raphael and Stoll 2009; TSP 2019). But public officials are rarely held accountable for unjust enforcement tactics—let alone the enforcement of unjust laws—because they are protected by indemnification provisions and the legal doctrine of civil immunity.

To address these more specific racial injustices, we call for criminal convictions for nonviolent offenses pertaining to drug use or possession of small quantities of non-medical drugs to be expunged, and for those currently serving time for these specific offenses, including those with drug-related parole and probation revocations, to be released. Failing that, criminal records for these offenses should be, at the very least, protected from judicial access in future criminal proceedings and decoupled from a person's rights and entitlements as a citizen. Furthermore, those who would continue to hold a conviction on their record for these offenses should receive retroactive ameliorative relief under new decriminalization and/or legalization laws (Yuen Thompson 2017).

Taking a wider perspective, we note that the U.S. commitment to drug prohibition has not only influenced drug policy worldwide (Csete et al. 2016; Coyne

[7]Indeed, violence driven by conflicts within and among gangs and drug-selling crews has, historically, constituted the majority of urban homicide problems (Block and Block 1993; Kennedy, Piehl and Braga 1996; Papachristos 2009), the bulk of which are intraracial (Braga and Brunson 2015). This suggests that the illegal drug market is a major contributing factor to violence within Black communities.

[8]The well-known federal sentencing disparity between powder and crack cocaine offenses has only recently and partially been addressed by the Fair Sentencing Act (FSA) of 2010, which reduced the statutory ratio from 100:1 to 18:1, respectively. In 2018, the First Step Act made this reform retroactive.

[9]The findings of Marotta and colleagues (2020) suggest that Black and Hispanic adolescents were less likely to be discharged when they had been referred by schools and other social institutions, indicating that racial and ethnic disparities in treatment attrition could be mitigated by a combination of *de jure* decriminalization and the enhancement of links between substance abuse treatment programs and social institutions (see footnote 1).

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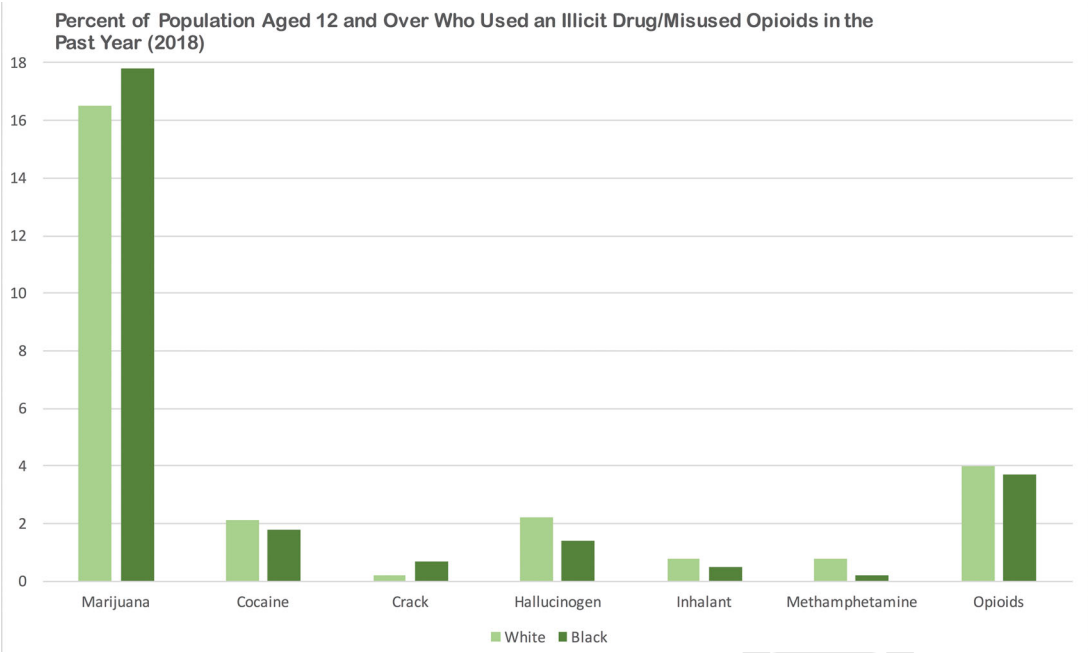

Figure 1. Percentage of White vs. Black US population to use an illicit drug/misuse opioids in the past year. Note that use/misuse is similar between the racial groups, with two main exceptions: crack, which has a higher rate of use among Black people, and hallucinogens and methamphetamine, which have higher rates of use among Whites people. Data source: SAMHSA (2018).

and Hall 2017; Koram 2019; Piaggio and Vidwans 2019), but also contributed to human rights abuses and other harms in countries along the illegal drug supply chain (Villar and Cottle 2011; Paley 2014; Piaggio and Vidwans 2019) while providing a powerful mechanism for increased U.S. "dominance" over poorer countries of the Global South (Telles 2019). There are also implications for gender equity in these countries, as noted by a United Nations task force on women: "Even when women may not directly participate in drug use or the drug trade, they are often responsible for mitigating the associated risks for themselves and for their families, and they are forced to carry the double and triple burden of care when families break apart and community life deteriorates" (UN Women 2014).

Finally, the same harms and racial disparities in U.S. drug enforcement persist in other countries. For example, in England and Wales in 2016/2017, Black people were almost nine times more likely than White people to be stopped and searched for drugs (Shiner et al. 2018, p. 15). They were more likely to be arrested following a stop and search than White people and more likely to be prosecuted (*ibid.*, p. 35). In addition, Black people were convicted of cannabis possession at almost twelve times the rate of White people, despite lower rates of self-reported use (*ibid.*, p. 44), and they were over nine times more likely than White people to be sentenced to immediate custody for drug offenses (*ibid.*, p. 45).

DRUG PROHIBITION VIOLATES RIGHTS

Drug prohibition and criminalization not only negatively impact individual users and communities, they may also violate people's rights (Barnett 2009; Fellner 2009). Although some voters and public officials may disapprove of others' personal drug use, people generally have rights over their own bodies that allow them to make decisions not only about their health, but also about the substances they choose to consume, including those drugs that have been legalized in the U.S. and elsewhere, such as alcohol and tobacco. For example, people may use drugs to examine their consciousness, to explore their character, to access and respond to their values, motivations, and desires, and to engage in self-development and self-understanding (Fadiman 2011; Kaelen et al. 2015; Schmid et al. 2015; Liechti, Dolder, and Schmid 2017; Preller et al. 2017; Griffiths et al. 2018; Veit 2018; Earp 2018; Lewis 2020; Earp and Savulescu, in press). Although most drugs,

including alcohol, can be used in ways that harm the user, the potential for self-harm does not normally provide adequate grounds for outright prohibition. In general, prohibition conflicts with one's right to control what substances one can put into one's body for one's own enjoyment or self-exploration (Huemer 2007; Barnett 2009).[10] Moreover, people who freely choose to use drugs for personal purposes do not (as such) violate the equal liberty of others and are, therefore, not presumptively liable to civil penalties. As Ostrowski (1990) noted decades ago:

> Drug prohibition is [the] initiation of physical force against persons engaging in non-violent actions and voluntary transactions involving prohibited drugs. By definition, drug suspects and drug convicts have not been arrested or convicted for having initiated force against the police or private citizens. They would be suspected or convicted of robbery, rape, murder, etc., if they had initiated force against others. (p. 609)

In addition to directly violating some rights, prohibition with criminalization indirectly weakens other rights (Barnett 2009). As demonstrated by the case of Breonna Taylor, for instance, it makes some people more vulnerable to violations not just of their civil liberties but also of their right to life, even when they are not engaged in illegal activity (Husak 1992). For example, drug laws can be used as a pretext for privacy-invading police actions that violate constitutional prohibitions against unreasonable searches (e.g., no-knock raids), unreasonable seizures (e.g., civil asset forfeiture) and excessive force (Bertram et al. 1996; Barnett 2009). Finally, to the extent that drug prohibition is enforced in ways that discriminate on the basis of race, it also undermines rights to equal protection of the law, as guaranteed by the Fourteenth Amendment to the U.S. Constitution (Fellner 2009).

[10]The right to health may also sometimes be at stake. For some people, prohibited substances such as marijuana, psilocybin, MDMA, LSD, or Ketamine, may be used to treat conditions or manage symptoms in light of the limitations or side-effects associated with conventional medications, or to augment existing therapies (Fadiman and Korb 2015; Griffiths et al. 2016; Mithoefer, Grob and Brewerton 2016; Polito and Stevenson 2019). Although participation in "medical marijuana" ("MMJ") programs varies considerably by state, registry estimates in 2016 suggest that there were around 650,000 registered MMJ users in the U.S. (Fairman 2016), with the majority of participants reported to be in their 40s and 50s (Ilgen et al. 2013; Zaller et al. 2015). However, for those who, for example, cannot access MMJ programs, or whose optimum therapeutic drug is not approved for medical use, drug prohibition impedes their right to access beneficial medical treatment. This problem has been exacerbated by a hostile regulatory and funding climate that has, historically, inhibited research into "illicit" drug treatments and novel drug-assisted therapies, especially those involving MDMA, LSD, or psilocybin (Mithoefer, Grob, and Brewerton 2016; Abbott et al. 2020).

THE BENEFITS OF DECRIMINALIZATION AND LEGAL REGULATION

Decriminalizing drug consumption and possession of small amounts of drugs currently deemed to be illicit would not, on the whole, undermine public health or public safety. Rather, decriminalization makes drug use safer and eliminates the harms and injustices associated with arresting and incarcerating drug users. For example, in Portugal, the decriminalization of all recreational drugs in 2001, together with preventive, treatment, and other harm-reduction efforts plus social reintegration, reduced the harmful effects of arresting and incarcerating drug users, freed up scarce resources in the criminal justice system, and lowered the rates of reported substance use disorders, overdoses, and drug-related HIV and hepatitis (Greenwald 2009; Hughes and Stevens 2010; Kreit 2010; Silvestri 2015; DPA 2019).

By 2017, Portugal's drug-induced mortality rate among adults was substantially lower than the European average (4 deaths per million compared to 22 deaths per million) (EMCDDA 2019). Although the rate of cannabis use in the overall population over a twelve-month period increased from 3.3% in 2001 to 5.1% in 2017, use of all other previously illicit drugs (over a twelve-month period) has fallen below 2001 levels (Balsa, Vital, and Urbano 2017; DPA 2019; EMCDDA 2019). In addition, since the introduction of these policies, drug offenses, including trafficking and related crimes, have not spiraled upwards (Hughes and Stevens 2010; DPA 2019; SICAD 2019).

As the Portugal example shows, when drug users do not fear criminal charges, they are able to seek out medical treatment, mental health care, and social support programs, and can access government-approved public information about the harms involved in drug use. In Portugal, the social institutions that focused on harm reduction instead of punishment were also able to engage and help more young people than the criminal system (Silvestri 2015). Additionally, drug decriminalization enabled officials to more effectively deliver housing, health, and employment assistance to populations that would have been more difficult to reach under a prohibitive regime (Kreit 2010; Silvestri 2015; DPA 2019).

Decriminalization alone, however, does not remove the harms associated with illicit markets (Ostrowski 1990). Such markets do not prioritize consumer safety, and sellers may not be concerned with the age, medical history, or vulnerability of their customers. In addition, decriminalization without legalization would continue to subject people who use drugs to civil

penalties, including fines, which, in the case of a fine default, could still lead to imprisonment (Hall 1997). Consequently, as we have said, while the first and immediate step should be to decriminalize the personal use and possession of small amounts of all drugs currently deemed to be illicit, subsequent steps should find ways to safely and legally regulate the production, storage, distribution, handling, sale, supply, and use of such drugs.

Legal regulation offers several advantages over mere decriminalization. It would allow governments to introduce "safe supply" programs for cannabis, opioids such as heroin, stimulants such as cocaine and crystal meth, empathogens such as MDMA, and psychedelics such as psilocybin and LSD in order to curtail the harms associated with illegal markets, end the stigmatization of drug use and drug users, and increase the benefits of responsible drug use and treatment options for substance use disorders (CAPUD 2019). If the drug industry were a regulated business, governments could provide drug safety-and-hygiene regulations, expanding upon those measures already known to be cost-effective and efficient at reducing harms associated with drug use, such as needle exchange programs (in combination with medication-assisted therapy where appropriate) (Rhodes and Hedrich 2010; Kimber et al. 2010). Accordingly, they would be able to tax drugs according to proper assessment of their respective harms (e.g. Nutt, King, and Phillips 2010), and regulate production, storage, handling, and distribution. In collaboration with scientists, regulators, and local authorities, governments could enforce drug safety laws, with qualified officials inspecting production and distribution premises in order to ensure compliance.

In addition, state and local authorities could provide drug consumption rooms, in which people can use a range of substances through different routes of administration (EMCDDA 2018), as well as clinical-like settings for injection drug use. They could provide government-approved health information and guidelines relating to safe use, potential harms, and potential benefits. They could also restrict advertising, set appropriate age limits, ban sales to intoxicated people, ensure that public health information is clearly displayed on all packaging, and facilitate and enforce appropriate licensing laws. Such laws could not only limit purchase amounts and purchasing times, but also require special licenses for the purchase of certain drugs deemed to be higher-risk. Of course, we recognize that whether, and to what extent, these suggested features of a possible regulatory regime will lead to a reduction in relevant harms in practice will, ultimately, depend on the types of enforcement strategies that policymakers adopt to ensure compliance and the rigor with which these strategies are carried out.

All told, we consider a policy of legal regulation to be preferable to decriminalization on its own, which in turn is preferable to criminalization.

IMPLEMENTING DRUG POLICY REFORM

Those seeking to implement drug policy reform need to be aware of the complexities of international law and associated policies. For example, they need to be aware of the U.N.'s international drug control treaties, which have been ratified by the majority of member states, and of the U.N.-based international drug control system, which has been partially responsible for the rise of the "global drug prohibition regime" built around its multi-lateral conventions (Nadelmann 1990). Several U.N. treaties[11] prohibit the non-medical use of many of the drugs currently deemed to be illicit, and have been criticized for the very same reasons discussed in this paper (Hall 2018). Given the legalization policies that have come into effect in certain jurisdictions (see footnote 5), the future of these treaties is uncertain (*ibid.*). However, the question is how to justify domestic policy shifts in light of preexisting international commitments, especially as the global drug prohibition regime has—at least historically—generated a substantial amount of compliance (Finnemore and Sikkink 1998). As Bewley-Taylor (2018) suggests, one option might be to modify certain treaty provisions by means of a "special agreement" among a group of like-minded nations.[12] For instance, if the U.S. sets a precedent for the legalization of the personal possession and use of all drugs deemed to be illicit (plus their regulation as described), and if other influential nations follow suit,

[11]See: Single Convention on Narcotic Drugs (1961), Convention on Psychotropic Substances (1971), and Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988).

[12]Another option, one that was pursued by the Obama administration in response to the legalization of cannabis in Washington State and Colorado, is to highlight the "flexibility" reserved to signatory parties in seeking to achieve the treaties' aims (Bennett and Walsh 2014; Bewley-Taylor, Jelsma, and Barrett 2015). With the 2018 proposal of the Strengthening the Tenth Amendment Through Entrusting States ("STATES") Act, which seeks to continue to class cannabis as a Schedule I drug while prohibiting federal law enforcement from prosecuting those in compliance with state law, it seems that the U.S. still considers the "flexibility" approach to treaty compliance to be a politically attractive option (e.g., see Firestone 2019). Given that we call for the legalization and regulation of cannabis as the first of a series of policy changes, the "flexibility" approach could support the implementation of our proposals in the short term.

then the treaties in question would likely become "dead letter[s]" (Hall 2018).

Although it is not our aim to defend a particular solution for how a given jurisdiction should navigate the tension between (a) implementing drug policy reform at a local/national level and (b) responding to the demands of international law, we do suggest that if the U.S. is to set a standard for other countries to follow, its reforms must be both evidence-based and ethical—and driven by a firm commitment to racial justice. Indeed, responsible drug policy is about more than just drugs: it is about the flourishing of entire communities. And in this context, it is most especially about the flourishing of Black and Hispanic communities that have been disproportionately harmed by the "war on drugs." Thus, while we ultimately call for the adoption of *de jure* decriminalization (as qualified above), one way to mitigate racial disparities in prosecution, conviction, and sentencing rates in the short term is by immediately shifting the focus away from the criminal justice system to a civil "drug court" model (Kreit 2010). This shift would ameliorate harms caused by criminal proceedings and provide less punitive points of contact to treatment and social services. Such a shift is already widely supported among public health and policy experts (*ibid.*).

But we need to be upfront. A full recovery from the failed "war on drugs" will require more than minor shifts and tinkering. Rather, it will require a domestic, postwar "Marshall Plan" consisting of (1) community-building programs focused on poverty alleviation, job creation, improved schooling and housing, and social mobility, thereby reducing the systemic harms that are either caused or made worse by the "war on drugs," mass supervision, and mass incarceration; (2) adequately expanded healthcare, social support programs, and rehabilitation efforts for those who struggle with addiction or other harms associated with drug use or misuse; and (3) realistic, evidence-based educational programs oriented around dissuading minors from drug use, promoting safety among adults who choose to use drugs, and honestly informing the public, policymakers, and other stakeholders about the benefits and risks of using different drugs in different settings.

CONCLUSION

Little of what we argue here is new. The ideas regarding decriminalization, at least, have been the consensus or near consensus of people who use drugs, drug policy experts, harm reduction advocates, criminal justice reformers, and others for decades (Bennett 1974; Maloff 1981; Farr 1990; Duke 1995; Kerr et al. 2006; Stimson 2007; WHO 2014, 2017; UN 2019). Here, we simply add our support as bioethicists and allied professionals to this long-proposed policy change while calling for its extension through to legal regulation of *all* drugs currently deemed to be illicit, and highlighting the implications for systemic racism (Danis, Wilson, and White 2016). As we have observed, the "war on drugs" has disproportionately targeted historically vulnerable communities. In particular, Black and Hispanic communities have borne the brunt of this misguided "war" with its unjust drug laws coupled with discriminatory policing, prosecution, conviction, and sentencing. The moral imperative now is for policymakers to act. Drug prohibition and criminalization have been costly and ineffective since their inception (Miron and Zwiebel 1995; Sterling 2006; Miron 2018): it is time for these failed policies to end. The first step is to decriminalize the personal use and possession of small amounts of all drugs currently deemed to be illicit and to legalize and regulate cannabis. Policymakers should pursue these changes without further delay.

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