DRUG ABUSE AND DRUG ABUSE POLICIES AND LAWS IN MARYLAND

INTRODUCTION

If two 14-year-olds are sent out, one to buy a six-pack of beer, and the other, marijuana, who will have the easier task? "No contest," said a Maryland spokesman for LEAP (Law Enforcement Against Prohibition). The kid seeking the six-pack will need to enlist help from someone age 21 or older to go into a beer store and buy. That's not easy these days. Most people won't do it. The other kid? If he doesn't know someone he can text on his cell phone to meet him outside, he knows exactly where to go, on what corner. And most kids will tell you there are two or three kids in school who deal drugs. Drug dealers don't care how old you are. They don't ask for your driver's license. All you need is cash.

This scenario, along with the increasing use of illegal drugs in our state, our huge drug-related incarceration rates, the millions spent on enforcement and treatment, the sad stories of over-dosing on unregulated products, and the continuing drug-related crime rate, has led the League of Women Voters of Maryland to a study of illegal controlled substances here.

State leagues in Texas, Hawaii and South Carolina, as well as the National Capital Area League and the Baltimore County League, have completed drug studies. Although national and international issues are theoretically not within the scope of state studies, as background are reports about the murderous Mexican drug cartels, poppy growers and the Taliban, cocaine culture in Bolivia and Colombia, and pleas from Mexico, Latin America and elsewhere for the United States to stop providing the super-lucrative illegal market which fuels a planet-wide drug problem have been considered as background.

In approaching this study, the committee has looked at the history of federal as well as Maryland drug laws, the most recent statistics on drug abuse, and current laws and policies governing the sale and use of controlled substances. It has also looked at treatment options, education and prevention programs and at possible alternatives to current policies.

DRUG LAW HISTORY

The first federal law regulating drug use, the Pure Food and Drug Act of 1906, required manufacturers to list ingredients and warnings on labels, but no prohibitions were imposed. The Narcotics Control Act of 1914 was intended to regulate the sale of opium, heroin and cocaine, by taxation not prohibition. The Bureau of Narcotics, established in 1932, took over federal enforcement of opiate and cocaine laws and encouraged states to adopt laws criminalizing the use of marijuana. By 1937 when 46 states had laws against marijuana, most with the same rigorous penalties as those for morphine, heroin and cocaine, the federal government outlawed the non-medicinal possession or sale of pot. Despite testimony from the American Medical Association about its being a recognized medicine in good standing, products containing marijuana were all dropped from the *U.S. Pharmocopeia* by 1941.

The modern war on drugs dates to 1970 when the Comprehensive Drug Abuse Prevention Act put all drugs except alcohol and tobacco under federal control, and to 1972 when Congress created the Drug Enforcement Agency (DEA) to enforce federal drug laws. The Omnibus Drug Act of 1988 created heavier penalties and mandatory sentencing for drug-related felonies and toughened the penalties for users.

MARYLAND DRUG LAWS

Maryland's drug laws, which parallel federal laws, categorize substances into separate penalty groups. Penalties vary, based on the whether a drug is being manufactured, distributed or simply possessed, and on the amount of the drug involved. In addition to substantial fines, a mandatory minimum sentence of not less than five years applies to 50 lbs or more of marijuana

or 448 grams of cocaine. The penalty for simple possession of a controlled substance is imprisonment for up to four years; and for simple possession of marijuana, imprisonment up to one year. A controlled substance within 1,000 feet of a school is punishable by imprisonment of up to 20 years. Any second or subsequent offense may double the sentence for a first offense. Where a mandatory minimum sentence is required by law, a judge has no discretion, no power to lower sentence, regardless of circumstances. A person serving a mandatory minimum sentence on the state or federal level is not eligible for parole.

NATIONAL DRUG USE

The National Survey on Drug Use and Health (NSDUH) is the primary source of information on the prevalence, patterns and consequences of substance abuse among people age 12 and older. Figures released in September, 2010, show 21.8 million Americans (8.7%) were current users of an illicit drug in 2009, a 9% increase over 2008. Of the 21.8 million users, 16.7 million were current users of marijuana, up 8% from the prior year. The average age of initial use dropped from 17.8 to 17.0. Cocaine use among 18- to 25-year-olds declined 18% from 2007, but there were more users of methamphetamines and Ecstasy. No national figures are provided for heroin in the 2010 report.

DRUGS IN MARYLAND

A report on Maryland from the U.S. Drug Enforcement Administration (DEA), dated October 26, 2010, points out that Maryland is situated on the north end of the mid-Atlantic region and is bisected by Interstate 95. Drugs, weapons and illicit proceeds destined for New York City routinely transit the state through Baltimore. Maryland's drug situation is complicated by the presence of two major metropolitan areas: Baltimore and its surrounding counties in the north, and the suburban counties of Washington, D.C. in the south. Baltimore is deeply affected by the heroin trade, having carried the dubious distinction as one of the most heroin-plagued cities in the nation for several decades, the report says.

Marijuana is the most widely abused drug in Maryland and is readily available in every part of the state, the report says. Low levels of marijuana cultivation occur primarily in western Maryland and along the Eastern Shore, where private farmland and public parkland allow for grower anonymity. In addition more than 2,000 indoor marijuana plants were eradicated in Maryland in 2009. Most of the marijuana that is trafficked in Maryland is, however, imported from the southwestern U.S., Mexico, and Canada.

Cocaine and crack pose a significant threat throughout Maryland, particularly in the Washington suburbs. Law enforcement sources in communities on the Eastern Shore and Western Maryland also cite crack cocaine as the primary drug threat in their areas. Violence continues to accompany the cocaine trade in the state. Wholesale levels of cocaine normally are readily available via suppliers in New York City, the southwestern United States and Atlanta. Hispanic drug traffickers are increasingly present in Baltimore and other parts of the state, the report says.

Heroin is abused throughout Maryland, but is centered in and around Baltimore, where high-purity heroin is readily available. Baltimore is home to higher numbers of heroin addicts and heroin-related crime than almost any other city in the United States. These problems tend to spill over into adjoining counties where many heroin distributors maintain residences. Since the first half of 2009, the western Maryland area that includes Frederick, Washington, Allegany and Garrett Counties has seen a significant increase in heroin distribution and use. Although New York City has traditionally been the principal source for heroin sold in Baltimore, much of the heroin now available is increasingly supplied by sources on the U.S. southwest border to high-level distributors in the city.

Methamphetamine, synthetics like Ecstasy and pharmaceutical diversions have a small presence in Maryland but are not included as part of this study.

The Baltimore-Washington corridor has been designated a High Intensity Drug Trafficking Area. It includes Baltimore City and Anne Arundel, Baltimore, Howard, Montgomery, Prince George's and Charles Counties. The DEA currently maintains a district office in Baltimore, plus offices in Hagerstown and Salisbury. The Tactical Diversion Squad in Baltimore is staffed by diversion investigators, special agents and intelligence analysts.

As of October, 2006, (most recent available figure), there were 20,097 full-time law enforcement employees in Maryland. During 2006, 36.1% of federally-sentenced defendants in Maryland had committed drug offenses. For Fiscal Year 2010 there were approximately 22,000 state-court offenders in Maryland correctional institutions of which 20.5%, or 4,518 were incarcerated for drug related offenses. Of that number there were six prisoners for marijuana distribution and 192 for marijuana possession. The annual cost per prisoner in Maryland is $35,040. Based on these figures the cost to Maryland taxpayers for all drug related crimes in 2010 was $15.8 million and for marijuana alone, $6.9 million. During 2006, (most recent figure available) there were 788 drug-induced deaths reported in Maryland.

TREATMENT IN MARYLAND

The most recent available figures (2006) show that there were over 65,000 admissions to drug/alcohol treatment in Maryland, while approximately 109,000 Marylanders reported needing, but not receiving, treatment for illicit drug use. In addition to Boards of Health in each subdivision there are over 300 treatment centers. Programs range from education, referrals, support groups, community outreach, substance abuse and crisis intervention to outpatient counseling and in-patient residential programs. Currently, according to a directory of Maryland drug and alcohol rehabilitation programs, there are 327 treatment centers in Maryland. Several of the centers operate in more than one locality and some have more than one program running in the same geographical area. The number of centers range from one each in Caroline and Garrett Counties to 103 in Baltimore City. The programs themselves vary from out-patient counseling to residential. Some of the counties, such as Anne Arundel, have separate funds to help low-income users access the programs. Other programs rely on insurance.

The 2010 Federal Health Care Law appears to make no distinction that would limit treatment of drug abuse patients. The prohibition against denying coverage for pre-existing conditions makes no exception and there is no provision for insurance companies to charge a higher rate due to a history of drug abuse. The Law does appear to provide some grant-funding opportunities for community services and training for medical professionals in the field.

INCARCERATION AND COSTS

According to the U.S. Bureau of Justice Statistics, reported in the Winter 2011 issue of *The Wilson Quarterly,* drug offenders now account for 20% of inmates in federal and state prisons and local jails, up from only 6% in 1980, with the average state prison sentences being 2.5 years. About 38% are African-American and 20% are Hispanic. Roughly two-thirds lack a high school diploma. The rate of incarceration has increased by a factor of seven in the last generation with America now locking up one percent of its population. Moreover, it is estimated that a "chronic offender may cost more than $7 million in the course of his criminal career."

Calling the "war on drugs a dismal failure", columnist Nicholas Kristoff in a 2009 *New York Times* op-ed piece, said the war has had three results: First, it has vastly increased the proportion of population in prisons, nearly five times the world average, from roughly 41,000 in 1980 to 500,000 in 2009. Second, it has empowered criminals at home and abroad. And third, it has squandered our resources. Citing figures by Harvard Economist Jeffrey Miron, Kristoff said federal, state and local governments have spent $44.1 billion annually enforcing drug prohibitions; and that we spend seven times as much on interdiction, policing and imprisonment as we do on drug treatment.

Kristoff also pointed out that these figures do not include "the collateral damage everywhere… the devastated neighborhoods, broken or distressed families and children left without support."

MARYLAND DRUG COURTS

As of July, 2009, Maryland had 40 drug courts. Twenty are for adults, 13 are for juveniles, four are family dependency courts, and three are DUI (alcohol and substance abuse) courts. No drug courts exist in Allegheny, Kent, Calvert, Garrett and Queen Anne Counties, while Baltimore City has four. These courts evaluate individuals who have been arrested for using drugs and are interested in drug treatment instead of incarceration. When candidates are accepted for treatment, the drug court presents its recommendation to designated judges in the district court (generally for juveniles) or circuit court (generally adults) who put the candidates on probation and who periodically review their treatment progress. The drug court assumes the responsibility for overseeing and evaluating the progress of these individuals. Funding consists of state and local government support with periodic federal government grants. A 2009 evaluation, coordinated by the Maryland Office of Problem Solving, indicates a success rate of 70% based on urinalysis tests of individuals in the drug court programs. A 2005 report from the U.S. Government Accountability Office (GAO) found significant savings to taxpayers in drug court jurisdictions.

DRUG EDUCATION IN MARYLAND

Two major drug programs are used in public and some independent schools: a federal program entitled Safe and Drug Free Schools, and local initiatives, the most common of which is Drug Abuse Resistance Education (DARE). The aim of the now defunded federal program has been to deter violence, promote school safety, discourage drug use, and to encourage meaningful conversations with parents. School authorities applied for money following federal guidelines which included special needs assessment, measurable goals and periodic progress evaluations. While the money was available, 80% went to schools and 20% went to the governor's office which was allocated to support community-based substance abuse and violence prevention activities. The federal money was distributed to the states in 2009 to cover costs through June, 2011. It is not known whether the program will be refunded or whether the participating schools will choose to continue the programs on their own.

The DARE program, designed for grades K-7, consists of lessons taught by trained police officers at no cost. This program is now used in 19 Baltimore City schools and in 14 Maryland counties. Schools may offer their own programs, such as Project Alert in Anne Arundel, which includes 11 sessions on the dangers of substance abuse. All high schools in Maryland cover alcohol, tobacco and drugs in their required semester of health education. In 2004 the Maryland General Assembly mandated participation in a Youth Risk Behavior Surveillance Study developed by the Center for Disease Control.

CURRENT GOVERNMENTAL POLICIES

Although there seems to be a growing nationwide consensus that we are not winning the "war on drugs" and that there should be more efforts at education and treatment, both federal and state government policies and expenditures appear aimed primarily at heavier penalties, more enforcement and more incarceration.

The Obama Administration's national drug policy, like the Bush Administration policy before it, includes a broad range of initiatives for reducing drug abuse by partnering with communities across the nation to prevent drug use from starting in the first place; intervening during the first sign of trouble; treating those with serious addictions; partnering with law enforcement; supporting those in recovery; attacking the economic basis of the drug trade; and building international partnerships To further these goals the Obama Administration has been asking for

budgetary increases of some 13.4% to be directed at the drug problem. As of February 2011, the Federal government has granted 209 researchers the ability to conduct research with marijuana, marijuana extracts and THC.

Maryland Policies mirror the federal policies, with the possible exception of marijuana, where there have been efforts toward passage of a medical marijuana law.

MARIJUANA – A SPECIAL CASE?

On the federal level whatever efforts there may have been to change marijuana laws have attracted little attention. The National Survey on Drug Use and Health, cited above, says the increase in marijuana use is "fueled by discussions of legalization, so-called 'medical' marijuana and a proliferation of pro-drug messages in the media and popular culture (such that) young people are misinformed about a drug whose potency has tripled in the past 20 years and sends more youth to treatment than any other drug." NSDUH says further that "because marijuana is consistently linked with lower grades, higher dropout rates, higher rates of illness and increasing emergency room and treatment admissions, the Administration is determined to reverse this trend." But, despite this stated position of the Obama Administration, the United States Supreme Court has ruled that federal law does not preempt state medical marijuana laws. A recent Gallup poll shows that 44% of Americans support making marijuana legal.

On the state level, 15 states and the District of Columbia currently have legal medical marijuana, while 12 more are working toward legalizing it for medical purposes. The 2011 Maryland General Assembly refused to legalize medical marijuana but authorized a study on how to distribute it to medical patients. The 2011 General Assembly also passed legislation allowing sick people who are arrested for marijuana possession to be found not guilty if they are able to present a doctor's note.

Medical marijuana has been used to treat glaucoma, diabetes, high blood pressure multiple sclerosis and chronic-illness pain. It is said to calm the stomach of chemotherapy and AIDS patients. The downside is that it can impede short-term memory, coordination, reasoning and the respiratory system. The American Medical Association meanwhile wants further well-controlled studies of marijuana to determine its efficacy, a goal inhibited by the federal classification of marijuana as a Schedule One controlled substance. Without endorsing either medical marijuana or legalization, the AMA is asking that marijuana's controlled substance status be reviewed so that the National Institutes of Health may facilitate grant applications for well-designed clinical research.

WHAT OTHER LEAGUES STUDIES FOUND

The League studies in Baltimore County, the National Capital Area, in Texas, South Carolina and Hawaii all strongly emphasized the focusing of government budgets on education and treatment instead of enforcement and incarceration. Although all resulted in positions favoring medical marijuana, only the Baltimore County study advocated legalizing all drugs with various degrees of regulation, decriminalizing drugs as a first step, and allowing addicts to obtain their drugs from licensed medical professionals. And only the Baltimore County study addressed the issue of mandatory minimum sentencing, at least to the extent of allowing judicial discretion for first time offenders. The LWV of the National Capital Area is the only League supporting heroin as well as marijuana for medicinal purposes. It calls for a public funding priority for detoxification and self-help programs, outpatient care, therapeutic communities and aftercare, but stresses that the financial responsibility for drug treatment should fall, to some extent, on insurance, patients, patients' families, employers and labor unions, as well as the local, state and national governments.

The Hawaii League supports a mandate that all first-time offenders shall receive treatment, not prison time, and wants its now-legal medical marijuana program moved from the Department of Public Safety to the Department of Public Health. The Texas League advocates

education programs for adults, aimed at keeping children from using drugs. The Texas position also calls for sterile needle and syringe programs to prevent blood-borne diseases. The South Carolina study resulted in a June 2011 consensus that "illegal drug use should be considered a public health issue. Drug use and drug addiction should be addressed by substance abuse treatment programs and education instead of incarceration."

WHAT OTHERS ARE SAYING ABOUT ALTERNATIVES TO THE STATUS QUO

LEAP (LAW ENFORCEMENT AGAINST PROHIBITION) says all drugs should be legal and regulated. Composed of retired judges, corrections and police officers, prosecutors and wardens, LEAP says most of those active in law enforcement agree with legalization but don't speak out in fear of losing their jobs. Executive Director Neill Franklin said most arrests are of non-violent drug offenders with issues which should be dealt with from a health not a criminal perspective. According to LEAP, the Maryland State Police had 70 to 80 agents for the whole state in the 1970s. That number has grown to over 300 at tremendous cost, both human and economic. If the war on drugs were a success, there would be a decline in the purity and production of drugs and expenditures for law enforcement, arrests, drug seizures and consumption would go down. Instead purity, production, costs, arrests and consumption are "way up", he said. Citing Department of Justice figures, he said between 1973 and today, drug enforcement staffing nationwide has almost quadrupled, from about 2,900 to over 10,750 today. The budget has grown from $75.9 million to $2.35 billion. Prison costs have tripled since 1980. Noting that alcohol is still the U.S drug of choice, alcohol arrests (for driving under the influence, drunkenness, etc.) still exist, but they have stabilized since the end of Prohibition.

MARYLAND's ABELL FOUNDATION in January 2009 published a study calling for heroin maintenance treatment for those who have failed in other treatment, including methadone maintenance. Since tougher enforcement and greater treatment provisions have failed to decrease the harm heroin causes in Baltimore City, the study proposes that heroin be provided in a medically supervised facility, so users would no longer have to commit numerous property crimes or sell to other users in order to finance their extremely expensive habits. Heroin maintenance is now a routine treatment option in several European countries.

MICHELLE ALEXANDER, in her 2010 book entitled *The New Jim Crow***,** explores in depth the institutionalized racism of poverty-stricken inner cities, where selling drugs may be the only "employment" available to survive. According to a survey by the Department of Health and Human Services, there are four times as many white drug users as black users, but blacks represent more than half of those imprisoned on drug charges Absurd sentencing rates, combined with laws making it legal to discriminate against even nonviolent former felons in hiring, housing and education, constitute nothing less than a new racial caste system, Alexander says.

A JUSTICE POLICY INSTITUTE study, entitled *Maryland's Mandatory Minimum Sentencing Laws: Their Impact on Incarceration, State Resources and Communities of Color,* observes that Maryland is one of just 11 states to see a reduction in its prison population since 2003. It credits both government and local agencies with working to increase drug treatment for those in the criminal justice system and with improving access to drug treatment for the public at large. "But Maryland still spends the lion's share of its correctional resources on the incarceration of drug-involved individuals," the study says. For every dollar spent on drug imprisonment the state invests 26 cents in the treatment of drug abusers referred by the criminal justice system. Maryland has spent $123 million annually to incarcerate drug prisoners, compared with $31 million for treatment. Overall the study showed that mandatory minimum sentencing presents a barrier to achieving a goal of treatment, has a racially disparate impact, costs the

state millions in corrections costs, and is not the most effective public safety investment for the state.

THE *WALL STREET JOURNAL* in April 2009, featured a debate between writers Steven B. Duke and John P. Walters. Pointing out that the drug-fueled murders and mayhem in Mexico bring to mind the Prohibition-era killings in Chicago, Duke says the only long-term solution is to legalize the drugs we overlooked when we repealed Prohibition in 1933. "We cannot destroy the appetite for psychotropic drugs. What we can do is eliminate the black market for drugs by regulating and taxing them as we do our two most harmful recreational drugs, tobacco and alcohol." Noting that marijuana, now 70% distributed by Mexican cartels, can be grown anywhere, he said the entire American demand could be met by growing it at home. If we taxed the marijuana agribusiness at rates similar to those for tobacco and alcohol, we could raise about $10 billion in taxes per year, and save another $10 billion we now spend on law enforcement and imprisonment. And after we have reaped the rewards of legalizing marijuana, we could move on to hard drugs, he suggests. Cocaine, heroin and amphetamines can be highly addictive and harmful, but prohibition makes those dangers worse, unleashing on vulnerable users chemicals of unknown content and potency, and deterring addicts from seeking help for their dependency.

In the opposing *Wall Street Journal* article, Walters maintains that progress in Colombia shows the war on drugs is "winnable", and that relaxed restrictions will lead to more drug use and abuse. He cites successful crackdowns on cocaine and methamphetamine epidemics in "the American heartland" that were stopped only by targeted prevention and law enforcement. He points out that cocaine has had a terrible effect on urban poor, that child abuse and neglect is 80% due to drugs, and that more than 50% of those arrested today for violent and property crimes test positive for illegal drug use when arrested. Calling for more drug courts, more treatment through schools, places of worship and the workplace, he says legalization would rob us of court-sanctioned supervised treatment.

A CALL FOR A MAJOR STUDY appeared in July 2010 as an op-ed commentary in the *Baltimore Sun.* In it, Kurt Schmoke, former Baltimore mayor and current Howard Law School Dean, and Irving Taylor, a psychiatrist in Ellicott City, proposed the creation of an impartial study commission to provide a cost/benefit analysis of Maryland's current drug control policies. Appointed by the governor and approved by the General Assembly, the commission would be made up of health and mental health providers, addiction researchers and advocates, law enforcement personnel, elected officials, and individuals with expertise in microeconomics and macroeconomics. Their focus would be on factual analysis, not philosophical debate.

BIBLIOGRAPHY: References upon request

Serving regularly on the Maryland League Drug Study Committee have been Anne Lee, Anne Libis, Wilma Rosenberg, Millie Tyssowski and Marcia Reinke (chair) plus Melpi Jeffries, State coordinator. Also contributing information by email were most of Maryland's local Leagues.

DRUG STUDY CONSENSUS QUESTIONS

1. Should the use of marijuana be legalized?
   a. For medicinal use
   b. For any use
   c. Subject to restrictions on production
   d. Subject to restrictions on distribution
2. Should the use of non-prescription illegal drugs classified as controlled substances, e.g. heroin, cocaine, be legalized?
   a. For medicinal use
   b. For any use
   c. Subject to restrictions on production
   d. Subject to restrictions on distribution
3. Should mandatory minimum sentencing procedures be changed to allow for judicial discretion in connection with drug cases?