Introduction: ***HEALING BEFORE PUNISHMENT***

This is a draft Social Witness Policy statement to guide the study and advocacy of the Presbyterian Church (U.S.A.) on reform of drug policies. Because it would shift the church's emphasis further away from prohibition of illegal substances to legal regulation, and would support shifting resources from the "war on drugs" and mass imprisonment to recovery and rehabilitation, a vote of final approval or disapproval is to follow an opportunity for further discussion and response by members and experts in the field.

The Report is organized with proposed policy and recommendations first (10 pp), followed by a study paper, followed by a study guide and a response form, which may be used by individuals or study groups. We appreciate your help in considering these matters which are literally "life or death" for persons addicted, in prisons, and in danger from drug gangs or military style law enforcement, in the US or supplier countries.

***Healing Before Punishment: Why Presbyterians Seek to End the War on Drugs*—**
*From the Advisory Committee on Social Witness Policy.**

In fulfillment of the assignment from the 221st General Assembly (2014) (*Minutes*, 2014, Part I, pp. 35, 36, 630ff), the Advisory Committee on Social Witness Policy recommends that the 222nd General Assembly (2016) of the Presbyterian Church (U.S.A.):

1. Receive the following affirmation, principles, and recommendations for the reform of drug law and policy for study and discussion across the church prior to final consideration at the 223rd General Assembly (2018), inviting particularly campus ministries, persons in recovery, counselors and related medical personnel, law enforcement, judges, and scholars to contribute comments prior to Sept 15, 2017, for consideration by the Advisory Committee on Social Witness Policy.

2. Receive the supporting study of the consequences of current policies and their needed redirection toward greater public health, harm reduction, and recovery-based approaches in support of the policy being tested.

3. Encourage congregations to host discussions led by persons such as those listed in Recommendation 1 on how Christians and churches should respond to drug use and abuse and the proposals in this report.

4. Direct that the Advisory Committee on Social Witness Policy post online the policy resolution and its component study, "Healing Before Punishment: Why Presbyterians Seek to End the War on Drugs," make available appropriate aids for study and discussion, post all comment publicly for transparent consideration, and, in consultation with legal and medical resource persons, bring a revised report to the 223rd General Assembly (2018) in St. Louis, Missouri.

*The Advisory Committee (ACSWP) is the body of 12 elected persons and staff tasked with helping the church address matters of social justice and Christian conscience. Their reports draw on teams of Presbyterian volunteers with expertise and experience on subjects examined.

In approving the text below for circulation, the 2016 Assembly added this comment:

Comment from the 222nd General Assembly: [A comment is not policy but assists interpretation]. In addition to the other government recommendations, the federal government should reclassify all forms of cannabis from schedule 1 to schedule 2 classification. As it is currently classified, research for medical applications is extremely restricted, which limits the opportunity for new treatments for many conditions, especially for degenerative neurological diseases. Reclassification would open up more possibilities.

PROPOSED CORE AFFIRMATION:

Drug use and abuse are two different things and both affect the spiritual life our nation. In response to overtures from seven presbyteries, this report was requested by the 221st General Assembly (2014) to provide advocacy "for effective drug policies grounded in science, compassion and human rights" (*Minutes*, 2014, Part I, p. 630). The report analyzes the urgent and ongoing tragedies of mass incarceration and drug-related violence in Mexico and elsewhere in Latin America. It presents a Christian framework for reform but is not primarily a study of addiction and recovery, though these necessarily receive attention. The core of the argument is in the title: Healing Before Punishment, which puts evidence-based treatment and racially unbiased regulation to the fore. This initial affirmation condenses the study's findings and provides the logic for the recommendations.

While many congregations and communities are grieving the recent surge in overdose deaths, many linked to legal painkillers, the larger cultural landscape regarding drug use is changing rapidly. Five states and the nation's capital have legalized the recreational use of marijuana. This movement is poised to spread, bringing changes to patterns of behavior, with marijuana possibly joining alcohol and tobacco as drugs of choice in our culture. As the church has in the past, we affirm that humanity was created for joyful service to God and the creation, and that each of us is to be a temple of the Holy Spirit as well as a faithful disciple. With Paul we affirm, "'All things are lawful for me,' but not all things are beneficial. 'All things are lawful for me,' but I will not be dominated by anything" (1 Cor. 6:12). Understanding that our deepest happiness is rooted in loving relationships and meaningful callings, all recreational pursuits involve created goods to be enjoyed mindful of excess, potential harms to oneself, and our responsibilities to others, including those less fortunate.

Despite that goal of moderation, even in healthy families and communities of material abundance people experience psychic, physical, and emotional pain, and attempt to treat or dull such pain with mood- and metabolism-affecting substances. Others seek ecstatic states or an expanded consciousness of transcendence, without apparent health consequences. Yet the scale and scope of the abuse of drugs, including alcohol, and other substances consumed compulsively, reveal a culture-wide spiritual problem. In this context, drug addiction became identified as the chief threat.

In reaction, the United States government adopted a legal prohibition model that relies on punitive policies: the "war on drugs." In practice, this is a war that targets *some* of those who ingest *some of* these substances, or who supply our communities with prohibited substances. Yet this war, fought with mass imprisonment and massive militarization, has become a cure worse than the disease, as documented in the accompanying background findings.

In forwarding this report for consideration, the General Assembly of the Presbyterian Church (U.S.A.) calls for a fundamental shift from a warfare model rooted in fear to a healing model rooted in grace. Simply put, we have been fighting the wrong things with the wrong weapons. The "war on drugs" has targeted communities of color and youth, it has become a gateway to more serious crime, and it has failed to reduce sufficiently addictive behavior in a drug-abundant society. Outside the United States, the war on drugs has corrupted and destabilized governments, poisoned agricultural areas, and led to horrific rates of murder and extortion. Attempts to reduce drug supply overseas and at home have cost billions of dollars, while demand for illicit drugs continues to mark a society that is also awash in alcohol. This is not to deny the serious risks of taking some drugs, whether one is addicted or not, but both pragmatism about reducing harm and trust in the higher power of God call us to support healing rather than punishment.

Thus the "just say no" of total abstinence remains too simple for our whole society. This is recognized in the major social experiment that some states are embarking upon with the regulation of marijuana. This report gives a guarded acceptance to legal regulation of marijuana use, *if* coupled with significant levels of publicly funded research into public health, education, and other impacts of such legalization. Other nations have decriminalized or legalized drug use on a larger scale, using their social service networks to offer treatment and reduce harm based on a public health model. As with marijuana legalization, a goal is to reduce the profitability of underground economies and change behaviors through education and regulation.

Further, following the General Assembly's earlier support for medical uses of marijuana, this report supports the evidence-based revision of the 1970 categorization of drugs upon which the drug war has been based. For some medical conditions, there are currently illicit drugs that—while posing serious risks in other contexts—offer important benefits. At the same time, licit drugs, such as prescription opioids, are being abused extensively. There are also newer synthetic drugs, including drugs related to gene therapies, that require more careful study of potential risks and benefits.

Recognizing that the categorization of 1970 was unscientific and did not provide a proportionate basis for criminal sanctions, it is time to reconsider how drugs are regulated and proscribed. The healing model envisioned here still requires legal regulation (as with cigarettes, alcohol, and pharmaceuticals). This model requires the wise balancing of personal rights and social responsibilities, alert to the fact that

corporate interests are actively seeking to change public policy for their own benefit in this area.

The spiritual nature of addiction leads Christians to call for a framework of healing that is more than simply treatment and therapy, important as these are. If addictions are in part responses to cultural values such as dominance, control, and winning, then recovery approaches should be informed by social psychology, anthropology, and criminal justice. These, in turn, need to inform and be informed by our theologies and communities of grace, repentance, redemption, and reconciliation. Some drug users seeking transcendence and mystical experience may have judged the church's own offerings as lacking.

Most casual drug use does not lead to addiction, and our criminal justice system needs to reflect this more adequately, as proposed below. But, addiction is both a disease and an orientation of life ultimately separate from God as well as others. Theologically, it involves variants of sins we all share, and (sometimes depending on gender) it includes degrees of pride and blaming others, self-loss, and victimization. While many Presbyterians may drink alcohol and come to use marijuana on occasion, we need to be particularly alert to undercurrents of despair or depression. The Gospel does not automatically free us from these things, but it can give us eyes to see that while wine and other substances can "gladden the heart," they may also numb and atrophy our capacity for love and joy in community.

Based on the tenets of our Christian faith, on precedent Presbyterian social policy, and on current research and expert testimony, the following principles offer wisdom to guide our denomination's responses to drug use, addiction, and drug policy. These principles for "Building a House for Health" are followed by specific recommendations for PC(USA) policy and action.

I. Principles for Building a House for Health1

A. Policies on drugs, health, and justice must respond to our theology and ethics. "In sovereign love God created the world good and makes everyone equally in God's image, male and female, of every race and people, to live as one community," says our Brief Statement of Faith (*Book of Confessions*, 10.3, lines 29–32). It further states:

> The Spirit gives us courage to pray without ceasing,
> to witness among all peoples to Christ as Lord and Savior,
> to unmask idolatries in Church and culture,
> to hear the voices of peoples long silenced,
> and to work with others for justice, freedom, and peace. …
> (*Book of Confessions*, 10.4, lines 66–71)

That sovereign love and that Spirit guide our efforts to transform drug policy.

B. Drug and alcohol policy should be evidence-based. Beginning from a place of compassion and desire for fairness, policy should be based on experience and

evidence—in the United States and around the world—of what has effectively protected health and reduced violence. Among relevant considerations:

1. Regulations and social practices that substantially reduced use of tobacco hold important lessons for reducing risks and harms from other drugs, licit and illicit.

2. The U.S. experience with alcohol prohibition—nationwide in the early 20th century and locally to this day—has important lessons about public health gains and unintended consequences.

3. In an environment where media sound bites often misrepresent scientific knowledge, empirical studies help policymakers and the public to evaluate the relative risks and benefits of different drugs, assign resources, and identify best practices for regulations.

4. The experiences of other nations that have implemented harm reduction, public health, and new judicial policies and approaches in response to drug use and addiction are also relevant.

C. Drug addiction functions partly as a disease, and should be diagnosed and treated by health professionals familiar with chemical dependency. People who have suffered trauma as children or adults are more vulnerable to addiction, underlining the value of psychological counseling in many cases. Judicial personnel should not be diagnosing addiction or prescribing treatment, as not all drug use constitutes addiction. Specialized drug courts should offer treatment, restitution, and alternatives to criminalization and incarceration whenever possible.

D. Drug addiction is also a spiritual condition that calls for holistic, communal, and voluntary forms of recovery, to complement medical treatment and therapeutic techniques. The church's ministry is to respond to drug addicts and abusers with compassion and healing, and support alternatives to incarceration whenever possible, while presenting a Gospel that respects the complexity of humans and the mystery of God.

E. Because substance abuse is a public health issue, the bulk of government, church, and private resources that address this problem should be for physical and mental health care and services.

F. Punitive approaches to drug use are generally counterproductive. The criminal justice system should be dedicated to addressing behavior that harms or puts others at serious risk. Adults' right to ingest substances of their choosing holds up to a point where one's individual agency is compromised.2 Particularly when it harms dependents, a responsible community may legislate restrictions and authorize protective intervention on behalf of the common good.

G. Public, cultural, and societal messages concerning drug use can set social expectations and create a climate of prevention and recovery (as in I.B.1. above). Public policy may also learn from traditional societies about social practices that reduce excessive and isolated consumption patterns and addictions.

H. Everyone should have access to essential medicines, including new applications of currently controlled substances and derivatives of traditional plants found to have health benefits. With careful controls and under medical guidance, methadone, morphine, and other pain control medications for cancer, childbirth, and palliative care should be available for people who need them.

I. Good drug policies are equitable with regard to race, income, and gender of the population. Policies and strategies for prosecution that disproportionately harm or benefit some groups relative to others, although their rates of transgressions are substantially the same, should be altered or remedied to ensure fair treatment.

J. Children and adults fleeing violence brought on by our war on drugs are not security threats; they deserve asylum and sanctuary. Just as the church responds compassionately to persons suffering from the effects of addiction, people who have fled criminal organizations and state violence in Mexico and Central America need sustained support.

K. Racially differentiated application and enforcement of drug laws cause deep and pervasive harm. As a predominantly white denomination, PC(USA) members have special opportunities and responsibilities to address the racist structures, processes, and social outcomes that give the war on drugs so disproportionate an impact. The lives and rights of poor people, communities of color, and women in the United States and around the world are no less sacred or valuable than anyone else's lives or rights.

L. Economic causes of involvement in drug production and trafficking need to be addressed. Current drug policy has unacceptable unintended consequences for low-income populations at home and abroad, offering risky opportunities to the unemployed and inflating the costs of living in poorer communities.

M. Police uses of military weaponry, surveillance, and tactics tend to increase violent outcomes and community distrust. In addition to longtime support for community accountability, community policing, and police professionalism, Presbyterians can support movements for the lives of people of color by advocating for a number of practical solutions those movements have developed for ending police violence and militarization.3

N. The increase in gun violence in Latin America attributable to U.S. drug policy and U.S. gun industry exports is inconsistent with the Presbyterian Church (U.S.A.)'s theology of peacemaking. Ending military assistance to often-corrupt police and militaries can reduce the pervasive violations committed by these forces. Restricting the commercial availability of military-grade weaponry, and hence its smuggling by organized crime, can help reduce gun violence in Latin America, in concert with the public health emphasis on harm reduction.4

II. Recommendations Based on Principles for Building a House for Health

Engaging our congregations in our communities. The goal of these recommendations is that each congregation should have a full referral plan for cases of problematic drug use, insight into the structural violence that underpins current drug policies, and an understanding of how to support healing and advocate for constructive change. Developing such capacities can reduce fear and barriers to mutual understanding among church members, drug users, law enforcement, formerly incarcerated people, social activists, immigrants, and health care providers. In the longer term, engagement also supports learning, enabling the church to be a catalyst within our communities, helping reduce harmful behaviors with productive involvement.

A. *Recommendations for PC(USA) Action and Policy*

1. Out of the church's commitment to be a community of healing and justice, each presbytery is encouraged to designate a drug policy facilitator to support congregational engagement and awareness of advocacy and treatment options. The Presbyterian Mission Agency is similarly encouraged to assist presbyteries in identifying facilitators, drawing on earlier Health Ministries contacts, and the Presbyterian Health, Education, and Welfare Association (PHEWA) networks of mutual support.

2. Facilitators are urged to visit congregations in their presbyteries to support their deeper reflection, learning, and engagement, and to assist interested congregations in the following processes:

a. *Education*

(1) Use the Drug Policy Reform Curriculum (see www.pcusa.org/acswp), including its suggestions for dialogue about drug policies and race, adapting it for local needs.

(2) Survey congregation members' experiences (or absence of experiences) of drug use, drug enforcement, incarceration, treatment, and recovery, and determine the best ways for members to learn from their communities and obtain reliable information.

(3) Hold congregation and community fora on changes in drug law that are more just, effective, and compassionate than current punitive approaches. These may include listening processes with churches of people of color to share educational resources and opportunities.

(4) Produce or circulate worship materials that reference the goals and recommendations of this report. These would encourage a celebration of God as healer and source of joy and connection, in contrast to our culture's worship of over-stimulation and unlimited consumption.

b. *Community Service*

(1) Help Presbyterian congregations develop a referral capability for problematic drug use, including non-punitive treatment and recovery facilities, harm reduction programs, and police and non-police options in their communities.

(2) While recognizing the benefits of abstinence-based approaches for many people, promote non-prohibitionist efforts to prevent and reduce the harms from high-risk drug use among both youth and adults.

(3) Support re-entry programs for people released from incarceration.

c. *Engagement and Advocacy*

(1) Encourage churches that host addiction recovery groups to continue that support and to engage in constructive dialogue about treatment, prevention of abuse, and harm reduction. Congregations, 12-step programs, and counselors are also encouraged to explore how both drug use and recovery relate to the quest for meaning and joy in life, found by Christians in the "beloved community" of the church.

(2) Join with other faith communities in advocacy for harm reduction legislation and measures, such as needle exchange and all-night drop-in centers, which shift the paradigm away from the drug war model. To this end, the General Assembly invites other faith groups, including members of National Council of Churches of Christ in the U.S.A., to join us in this endeavor.

(3) In April 2016, the United Nations General Assembly Special Session (UNGASS) on Drugs takes place in New York. While this global event occurs before the PC(USA)'s own General Assembly, we recommend that PC(USA) participate in the UNGASS follow-up process, which is anticipated to generate further actions to reform global drug policy, testing this report in that context.

B. *Public Policy Recommendations*

In addition to congregational engagement in the process of drug policy reform, the PC(USA) recommends the following reforms and actions by federal, state, and local governments. Some reforms may be more realizable at the state and local levels. Other reforms at state and local levels may not be possible without national changes. Presbyterians can advocate these changes with both elected officials and candidates.

1. Congress and the Executive Branch of the Federal government should

a. Revisit the global prohibition regime, through U.S. actions in the United Nations and in bilateral relations, which support or at least do not oppose international initiatives to explore alternatives to drug prohibition and experiment with new approaches tested by realities on the ground.

b. Encourage examination by states of models of legal regulation of the use and possession by adults of some currently illicit drugs for the purposes of public health and safety, such as is underway with marijuana in several states, with rigorous study of social, educational, crime-related, and medical impacts. In order to restrain the size and power of commercial drug interests, it is advisable to separate production and sale, possibly using state-run (not simply licensed) facilities for sale and monitoring of purity and for studying consumption patterns. Appropriate warnings, labels, and other restrictions would apply, and some drugs would necessarily remain prohibited, based on scientific determination.

2. With regard to Public Health:

a. Expand addiction treatment programs so that drug dependent individuals can receive treatment when and where it is needed. Nonprofit and nonresidential programs may be most cost-effective in public planning for healing rather incarceration.

b. Revise, in consultation with the medical community and state-level initiatives, the current outdated scheduling of controlled substances based on scientific and public health criteria.

c. In connection with 2.b. above, increase and shift funding to epidemiological and biomedical research on effects of drugs, patterns of drug use, and impacts of punishment and regulation in order to support best practices in treatment, recovery, and public health.

d. Provide to city and county public health agencies the resources needed to serve as first responders to overdose, problematic drug-induced behavior, and mental illness, so that law enforcement is not the only or primary first responder. Make overdose prevention an integral part of public health, including making the antidote Nalaxone widely available in places where overdoses occur. Promote Good Samaritan legislation that exempts from prosecution persons notifying emergency responders of overdoses.

e. Reevaluate which behavioral health treatments are selected for insurance coverage, based on evidence of effectiveness and a diversity of approaches according to need. In the absence of universal health care, the twenty-two states that have not done so should embrace the Affordable Care Act's expansion of Medicaid coverage to low-income individuals.

f. Lift the ban on federal funding for needle exchange programs and revise laws on drug paraphernalia (including the possession of clean needles), which is consistent with reducing risks of the drugs themselves and associated diseases of HIV/AIDS and Hepatitis C.

3. With regard to the Judicial System and Policing:

a. Condition grants of federal funds to local police and sheriff's departments on ending racially and ethnically discriminatory policing and increasing community trust.

b. Expand the scope of executive orders and group pardons for the release of drug offenders who were sentenced unjustly under the 100-to-1 crack-cocaine and other inequitable and excessive sentencing provisions, in line with efforts at more clemency for nonviolent and over-sentenced prisoners generally.

c. In addition to reforming mandatory sentencing, punitive use of prosecutorial discretion to maintain conviction and incarceration rates (often involving prior, paraphernalia, and possession arrests) should be restrained, especially with defendants who are unable to receive or afford effective counsel. This is to reform the practice of using maximum charges against defendants with limited legal

resources to force plea bargains that incur harsher prison sentences than wealthier defendants usually receive.

d. Eliminate preemptive post-incarceration sanctions for drug offenses that create barriers to recovery and family re-integration, including employment discrimination5 and restrictions on public housing and voting.

e. Social service agencies and community representatives should engage in restorative justice and investment practices together with people who have been harmed by police violence, unjust mandatory minimum sentences,6 and disparate drug law enforcement.7

f. Increase and improve the use of drug courts to deal knowledgably with persons accused of crimes, particularly nonviolent offenses, probation or parole violations, and cases where children are impacted, to facilitate treatment, training, education, and employment, working in concert with medical and social service personnel.

g. End or radically reform asset-forfeiture laws to prevent police seizures of property without due process. Offer people arrested for nonviolent sale of illicit drugs opportunities for training, education, and employment as an alternative to incarceration and a felony record.

4. Economic Policy:

a. Promote sustainable economic development in areas where coca and poppies are grown, centered on local farmer and community input.

b. Promote economic investment in U.S. communities that have been devastated by disinvestment and harmed by discriminatory drug law enforcement and/or drug-related violence. Drug testing of employees should be limited to what is needed to safeguard the person's performance of a job.

5. Foreign and Immigration Policy:

a. Sharply reduce the transfer of weaponry, training, and equipment from the United States to police and militaries in Latin America as part of the war on drugs. Make such transfers of arms and training, in the past and going forward, transparent to the public, to promote accountability. Disclose the extent and general nature of surveillance cooperation and strengthen financial disclosure laws to reduce corruption, money-laundering, and cross-border tax evasion. Advocate for congressional and other public hearings on the human rights and economic development impacts of the war on drugs and any foreign aid linked to it.

b. The president should take executive action to ban the import of assault weapons into the United States, where many are sold and trafficked to criminal drug-trafficking organizations in Mexico and Central America.

c. Provide political asylum and immediate release from detention, pending appropriate process, for those who have fled violence and have a credible fear of violence in their home countries where the war on drugs is occurring.

[The affirmation, principles, and recommendations above would, if approved by the 2018 General Assembly, guide Office of Public Witness and advise members & congregations]

RATIONALE IN THE FORM OF A STUDY PAPER: HEALING BEFORE PUNISHMENT

These (above) recommendations are in response to the following referral: *2014 Referral. Item 09-05. On Calling for a Two-Year Study by the Governing Bodies and Members of the Presbyterian Church (U.S.A.) to Discern How to Advocate for Effective Drug Policies Grounded in Science, Compassion, and Human Rights*—From the 221st General Assembly (2014) (*Minutes*, 2014, Part I, pp. 35, 36, 630ff).

A PDF of the Background study is available online at:
https://pcbiz.s3.amazonaws.com/Uploads/ede12477-ddd4-42ca-898a-493d22e748ab/Healing%20Before%20Punishment.pdf

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Part I: Foundations

Introduction

Our communities experience psychic, physical, and emotional pain, in isolation or in groups. Many members of our communities attempt to treat or dull such pain by repeatedly ingesting mood- and metabolism-affecting substances. The scale and scope of the abuse of drugs, including alcohol, and other substances used compulsively, reveal a culture-wide spiritual problem. In reaction, our nation has chosen to wage a war that targets *some* of those who ingest *some of* these substances, or who supply our communities with prohibited substances. Yet this war, fought with mass imprisonment and massive militarization, has become a cure worse than the disease. In 2014, in response to overtures from seven presbyteries, the General Assembly authorized a study of how Presbyterians might help our society end the war on drugs, an assignment that necessarily led to the consideration of alternatives.

In adopting this report, the General Assembly of the Presbyterian Church (U.S.A.) would call for a fundamental shift from a warfare model rooted in fear to a healing model rooted in grace. Simply put, we have been fighting the wrong things with the wrong weapons. The "war on drugs" has targeted communities of color and youth, it has become a gateway to more serious crime, it has corrupted and de-stabilized governments, and it has failed to eliminate addictive behavior in a drug-abundant society. Attempts to reduce drug supply overseas and at home have cost billions of dollars, while demand for illicit drugs continues to mark a society that is also awash in alcohol.[i] This is not to deny the serious risks of taking some drugs, whether one is addicted or not, but both pragmatism about reducing harm and trust in the higher power of God call us to support healing rather than punishment.

Thus the "just say no" of total abstinence remains too simple for our whole society, despite our reliance on the legal prohibition model for many drugs. This is increasingly recognized in the great social experiment that some states and nations are embarking upon with the decriminalization and regulation of marijuana. This report gives a guarded acceptance to legal regulation of marijuana, coupled with significant levels of publicly-funded research into public health, education, and the impacts of such legalization. Further, following the General Assembly's earlier support for medical uses of marijuana, this report supports the evidence-based revision of the 1970 categorization of drugs upon which the drug war has been based. For some medical conditions, there are currently illicit drugs that – while posing serious risks in other contexts - offer serious benefits. At the same time, licit drugs may be abused.

The healing model here envisioned still requires legal regulation (as with cigarettes, alcohol, and pharmaceuticals), and a wise balancing of personal rights and social responsibilities—we are "our brothers and sisters keepers." The Advisory Committee is particularly concerned with large alcohol, tobacco, or gambling conglomerates becoming involved in marketing and influencing government policy and spending on recovery, treatment, and harm reduction.[ii] But because of the spiritual nature of addiction, as Christians we call for a framework of healing that is more than simply treatment and

therapy, important as these are. If the processes of addiction and recovery are themselves partly cultural and psychological responses to a culture that idealizes dominance, control, and winning, then we need our theology to inform and be informed by our medicine, social science, and criminal justice.

Most casual drug use does not lead to addiction, and some is prompted by a quest for transcendent experiences that are not addictive. But addiction is both a disease and an orientation of life ultimately separate from God as well as others. Theologically, it involves variants of sins we all share, and (often depending on our gender) it includes degrees of pride and blaming others, self-loss and victimization. While many Presbyterians may smoke tobacco and drink alcohol and come to use marijuana on occasion, we need to be particularly alert to undercurrents of despair or depression. The Gospel does not automatically free us from these things, but it can give us eyes to see when wine and other substances that can "gladden the heart," may also numb and atrophy our capacity for love and joy in community.

Addiction has an impact on Christians because it reduces our freedom to regulate when and how much we consume, and stunts our growth and our maturity of relationship with God and other people in our lives. The thing we are addicted to becomes an idol, as our need for the thing holds us captive and takes precedence over God and God's desire for our freedom, health and maturity. Drug policies should, in theory, help us to address all of these problems, but we find that these policies contain their own set of demons.

The war on drugs affects Christian public witness because it affects the healing of *society* as well as of *individuals*. We can compare drug abuse to diseases that involve social ostracization, such as leprosy, or conditions that have been the basis of social exclusion, such as blindness or transexuality. Drug producers, transporters, and sellers face a historical demonization by society that sees them profiting from the self-destruction of others, which helps explain society's punitive policies and practices. Yet in our society, with the highest percentage of persons in prison in the world, punishment has taken on a life of its own, fueled by gun violence, racism, and the prison industry. So healing the individual means addressing also the criminal enterprise and criminal-justice economies that profit from ill-health.

One of our first tasks in constructing a healing and just response to drugs and drug policy is to examine what we believe we know about them. Orlando Fals Borda, a Presbyterian who is known as the father of sociology in Colombia, showed that learning from the social sciences can help mission co-workers be more effective in transforming lives.[1] There is a crucial need to think critically about drugs, and about drug policy and laws. This report thus attempts to deeply inform and to demythologize our understanding of drug use and abuse and drug policy, and we document source evidence that readers can consult for further learning.

[1] Rev. Germán Zárate Durier, "Love your neighbors because they are like you," *Mission Crossroads*, Summer 2015, p. 4.

An understanding of addiction as a disease that actually changes the way the brain works will help us put it into theological context. If we see addiction only in the context of free will, we will understand the choices made by addicts as those of sin – like any other person—which is only part of the story.

Addictive behaviors alter the brain's dopamine receptors, motivation and reward mechanisms, and self-regulation circuits. "Recent studies have shown that repeated drug use leads to long-lasting changes in the brain that undermine voluntary control," according to the director of the National Institute on Drug Abuse, Dr. Nora Volkow.[2] In addition, conditions in the brain before first drug use – created by environmental or genetic influences - can predispose a person to addiction, further diminishing some individuals' capacity to exercise free will in response to substance use.

Moreover, our society is more likely to punish drug addicts for continued self-destructive use than we are to punish, say, a diabetic who does not eat appropriately, though the damage and costs to health may be comparable.[3]

Regarding addiction that does not fit a simple disease model, the late Gerald May, in *Addiction & Grace*, shows how similar addictive behavior is to all kinds of self-defeating attachments that serve to separate us from God, suggesting humility about the presence of temptation in all our lives.[4] True, drugs offer different dimensions of dependency and can require both physical and psychological treatment. Further, scholars like Merrill Singer and J. Bryan Page show some of the ways that modern forms of mass addiction parallel the industrial-scale availability of distilled alcohol and drugs—conditions not foreseen in Biblical and other ancient literature.[5] Yet theologians like Linda A. Mercadante and James B. Nelson illuminate how strongly particular strands of Christian theology shaped Alcoholics Anonymous and how other faith insights available in the church may deepen and build upon the recovery process. While both caution that May generalizes the category of addiction too broadly, Mercadante and Nelson wrestle with the nature of the will in self-destruction, "soul loss," and redemption.[6]

The Church's work with addicted people has aimed to help them, through their focus on God, to stop the use of the substance to which they are addicted. This has been positive for many people. Presbyterian congregations across the country have hosted Alcoholics Anonymous and other 12-step groups. But often the Church has not acknowledged the pain, early exposure to stress and/or trauma, societal reliance on ingesting things to

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[2] Gabor Maté, *In the Realm of the Hungry Ghosts: Close Encounters with Addiction* (Berkeley: North Atlantic Books, 2010), p. 174.
[3] A. Thomas McLellan, et.al., "Drug Dependence, a Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation," *JAMA* (284:13), 4 October 2000, pp. 1689-1695.
[4] Gerald C. May, *Addiction & Grace* (San Francisco: Harper & Row, 1988).
[5] Merrill Singer and J. Bryan Page, *The Social Value of Drug Addicts: Uses of the Useless* (Walnut Creek, CA: Left Coast Press, 2014), chapter two. They observe that the category of "addict" did not exist until the last few centuries.
[6] Linda A. Mercadante, *Victims & Sinners: Spiritual Roots of Addiction and Recovery* (Louisville: Westminster/John Knox, 1996); James B. Nelson, *Thirst: God and the Alcoholic Experience* (Louisville: Westminster/John Knox, 2004).

address discomfort, or chemical imbalances that led addicts to become dependent on those substances.

We are not speaking only about the several kinds of pain experienced by addicts, their families, and communities. This is not an academic exercise of policy analysis. Along with pastoral care, we have a stake in changing policy, because so many people are killed, die early, live in cages, cannot exercise their rights, are humiliated in public, separated from their families, denied care and treatment, or long for education and opportunities enjoyed by others, including by most Presbyterians. Drug policy, like any policy in the Reformed tradition, should be guided by what are traditionally called the three uses of "the Law." The first use is to distinguish right and wrong, the second to maintain a just civil order by force if necessary, and the third use is to be a non-punitive, even nurturing guide for the redeemed. Laws which themselves cause harm or disorder do not lead to grace; nor is the state of grace one of perfection, hence freedom includes the law's continuing guidance and education or formation in what is good.[iii]

We are not above or outside drug-related problems; we are part of them, and when our hearts and minds are open to this reality in our society, we experience the suffering, and know a passion to change the structures that cause it. We conclude this introduction with part of a sermon from the pastor of one of the congregations that initiated this study:

> **"Galatians 5** begins: "For freedom Christ has set us free, stand fast therefore, and do not submit again to the yoke of slavery." Effective drug policy will seek to help people and families be free. Our current drug policy and drug war have failed to decrease drug use and addiction and have contributed further to violence and corruption. But most egregious has been the unequal administration of justice.
>
> It is clear that our current drug laws are not addressing addiction, as many who use illicit drugs are not addicts and there are many things that are not illegal that people are addicted to. In a broad sense, almost anything can be an addiction: sugar, caffeine, food or eating in general, alcohol, tobacco, prescription drugs, many different types of sexual obsessions …, video games, watching TV, messing with our cell phones, nagging at our spouse, shopping, fashion, driving a car, golf, fantasy football, gambling, accumulation of wealth and power, violence, etc. While there are many people addicted to many things, we do not send them to prison for doing them, but instead, there are many marketing strategists trying to make money off our desire to consume them and our desire to stop consuming them."
>
> - Rev. Max Lynn, St. Johns Presbyterian Church, Berkeley, CA[iv]

Some Definitions

Addiction is "any repeated behavior, substance-related or not, in which a person feels compelled to persist, regardless of its negative impacts on the person's life and the lives of others."[7] Addiction can be physical and/or psychological. Gerald May provides a five-part definition that combines both: "(1) tolerance (build-up of resistance, requiring higher

[7] Gabor Maté, *op. cit.*, p. 136.

dosage), (2) withdrawal symptoms, (3) self-deception, (4) loss of willpower, and (5) distortion of attention."[8]

Legal frameworks to address the production, trafficking, supply and possession of drugs range from prohibition to a free market model. *Prohibition* forbids production, trafficking, supply and possession of a particular drug as illegal acts and individuals arrested for any one of these offences are subject to criminal sanctions. In general, the United States has adopted a prohibitionist model at the federal level for drugs such as marijuana, cocaine and heroin. At the other end of the legal framework spectrum, the *free market* approach allows the activities of production, trafficking, supply and possession of a particular drug with no or very few regulations regarding its production or sales. Drugs of sufficiently low risk, such as coffee and tea have such minimal regulation. In the middle of these two poles is a framework of *legal regulation*, such as currently used for alcohol. Legal regulation can be more or less strict depending on the requirements prescribed in law. For example, the requirements often include who can produce, sell and buy the drug, locations where the drug can produced and sold or how much of a drug can be produced or sold at one site, or whether the seller can make a profit.

Also in between the poles of prohibition and the free market legal frameworks is the *decriminalization* of a particular drug. *Decriminalization* "is generally understood to refer to the removal of criminal sanctions for certain offences – usually the possession of small quantities of currently illegal drugs for personal use."[9] For example, during prohibition the manufacture, distribution and sale of alcohol were criminalized; however, the possession, consumption and production of alcohol for oneself was not illegal. Often decriminalization is confused with *legalization* which is the process by which prohibition of a substance is ended or repealed.

We use an operational definition of *racism* as racial prejudice plus power, which can be exhibited by institutions, communities, and individuals. *Institutional racism* does not necessarily involve racist intent, but leads to racially disparate and unjust outcomes. Concepts such as "white privilege", "microaggressions", and "subconscious/internalized racism" help us understand the unconscious dynamics of discrimination. These approaches move us forward from the dictionary's "belief in the superiority of a particular race and prejudice based on this belief."

The Assignment: Why and how this study was organized and conducted

> "In a broken and fearful world the Spirit gives us courage."
> - "Brief Statement of Faith"

The Church needs to take a stand. We need to confess.

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[8] May, op cit., p. 26.

[9] Transform, *How to Regulate Cannabis: A Practical Guide*, May 2014, p. 30, accessed at: http://www.tdpf.org.uk/resources/publications/how-regulate-cannabis-practical-guide. This *Guide* has a useful description of the range of legal frameworks, pp. 28-39.

We are called to understand the present context in which our drug policies and justice system operate. Christ calls us to address situations such as homelessness, joblessness, the welfare system, and poverty in order to "love our neighbors" and care for the whole community. Christ also calls us to partnership with all faith communities and even secular agencies to combat the unhealthy situations that lead to imprisonment, as well as to minister to those in prison. Through these partnerships, we pray that we may develop a society that moves toward both the Old or Hebrew Testament vision of Shalom and Jesus' teaching about the Kingdom of God.

This study draws on the work of the Drug Policy Task Force, which was established by the 221st General Assembly in 2014 to conduct a two-year study "to discern how to advocate for effective drug policies grounded in science, compassion, and human rights." The Task Force was mandated to "promote study, discussion, and engagement among church members and congregants and develop a plan of concrete actions and policy recommendations for the 222nd General Assembly" in 2016.

The Task Force was to serve as a clearinghouse for information and hold four hearings, which occurred in Richmond, California; El Paso, Texas/Ciudad Juarez, Mexico; Denver, Colorado; and Charleston, West Virginia, between February and September 2015. The Overture creating the Task Force also called for engagement with entities such as Presbyterian Women and the Criminal Justice Network, congregants, and Presbyterian Church publications "to learn about the history, development, and implementation of U.S. drug policies." This overall effort to combine both study and interaction with the larger church also included posting an online collection of articles on the Christian justice journal *Unbound* (www.justiceUNBOUND.org), and creating a page of resources on the website of the Advisory Committee on Social Witness Policy.

The set of drug policy issues to be addressed was wide-ranging, including:

- the roles, responsibilities, and limits of the state and citizenry in relation to our bodies;
- what Christian theology suggest[s] about current drug policies;
- our social responsibility to ensure health for members of our communities;
- the spiritual and ethical implications of: massive and disproportionate incarceration of drug offenders, especially people of color, and of the militarization of relations with communities and other nations;
- laws, policies, programs, and treaties [that] currently govern our nation's responses to the production, transit, and use of illicit drugs;
- the consequences of maintaining current punitive drug policies [and] what more effective and humane drug policies [might] look like with regards to the following:

    (1) militarization of law enforcement and the erosion of distinctions between civilian police and military, especially with respect to drug law enforcement;

    (2) relationship between prohibition of drugs and organized crime;

(3) communities' use of illegal drugs and the disparate impact that enforcement of drug prohibition has on poor people and racial minorities;

(4) distinction between harmfulness, addictiveness, and illegality as it relates to use of psychoactive and/or addictive substances;

(5) allocation of public resources required to enforce current drug policies and effectiveness in addressing underlying problems relating to substance abuse and addiction while programs for social needs such as health, education, and community development are underfunded;

(6) rates of illicit drug use, abuse, and addiction; health effects and impacts on special populations—e.g. mentally ill, homeless, 'at-risk' youth, immigrants, victims of sexual violence.

The Task Force was to consist of seven to nine representatives of stakeholders or disciplines, including policy advocacy, addiction science, criminal justice, international relations, formerly incarcerated person, and theologian. Five Task Force members participated throughout the study, while several other stakeholders participated for parts of it. The group did not include a formerly incarcerated person, for example, though several had relatives who had been imprisoned and had worked with prisoners. Even on its small scale the group worked hard to achieve consensus on both principle and strategy.[v]

Previous PC(USA) policy on drug and alcohol use and abuse

Throughout much of its history, the PC(USA) was deeply preoccupied with the effects of alcohol and alcoholism. It was widely involved in the temperance movement in the 19th and early 20th centuries, even to the point of asserting in 1873 that: "the Church is essentially a temperance society and her members should use all their influence for the suppression of the liquor traffic." The 158th General Assembly in 1946 urged reinstating prohibition of alcohol as well as abstinence by PC(USA) members.[10]

In the 1960s and 1970s, the Church increased its emphasis on medical and therapeutic treatment of alcoholism as well as narcotic addiction, to a large extent adopting a "disease model" for understanding them. As early as 1965, the General Assembly called for alternatives to criminalization of drug addiction. The 178th General Assembly in 1966 called narcotic addiction a "medical-social problem arising from many diverse factors, including psychological and physiological dependency on drugs, family instability, cultural conflicts, and social and economic deprivation" which necessitates legal distinctions in the criminal punishment between those who sell to support their habit and those who profiteer from addiction.[11]

In 1992, the PC(USA) published a special issue of its journal, *Church & Society*, on drug abuse, titled "A Body Broken: Substance Abuse and the Church." The following year's 205th General Assembly issued an extensive statement and recommendations on drugs

[10] Minutes, PCUSA, 1946, Part I, pp. 202-7.
[11] Minutes, UPCUSA, 1966, Part I, pp. 381-382.

and drug policy. Much from those statements read as if they could have been written in 2015. A brief review illustrates the similarities. The 1993 statement:

"encourage[d] economic conversion and public investment in need-reduction policies:

- Education concerning the addictions, and prevention programs.
- Public health maintenance programs, which include counseling.
- Rehabilitation of individuals who are addicted, and rehabilitation programs for their families.
- Justice in educational opportunity.
- Justice in economic opportunity."

It also urged "reversal of current U.S. drug supply limiting policies:

- mandatory drug sentencing;
- zero tolerance policy and property confiscation without due process;
- erosion of personal rights and equal protection under the law; and
- decriminalization of possession with judicial focus on drug manufacturers and suppliers."

It called for:

- "the nation to establish 'treatment on demand' for those with chemical dependencies and their families
- the support of innovative, ecumenically sponsored treatment programs and halfway houses, with access to medical support; particularly in economically impoverished regions and neighborhoods; and
- the demilitarization of U.S. drug wars policies in foreign countries, and replace low-intensity conflicts with programs of economic aid and local self-development."

Theological Grounding and Guidance

This section does two things: it argues for dedicated action to end the drug war with its millions of unnecessary casualties as a matter of justice, and it points to some sources of wisdom in our tradition for those facing the chief argument made against drugs and alcohol: that they can cause addiction, particularly for a certain percentage of the population. This section does not provide a theological grounding for the role of government to protect the common good through regulation and the justice system: this can be found in many other Presbyterian resources.

God cares about justice and truth. Equitable relationships between neighbors is of paramount importance to the God of the Bible, trumping even the call to religious observance:

> *"I hate, I despise your festivals, and I take no delight in your solemn assemblies. Even though you offer me your burnt offerings and grain offerings, I will not accept them; and the offerings of well-being of your fatted animals I will not look upon. Take away from*

> *me the noise of your songs; I will not listen to the melody of your harps. But let justice roll down like waters, and righteousness like an everflowing stream" (Amos 5:21-24).*

Jesus Christ instructed his followers to continually make peace and justice with their neighbors, even if it means interrupting a ritual sacrifice at the altar of the temple:

> *"So when you are offering your gift at the altar, if you remember that your brother or sister has something against you, leave your gift there before the altar and go; first be reconciled to your brother or sister, and then come and offer your gift" (Matthew 5:23-24).*

The temple was the most sacred site in the world to first century Jews. In today's world, Jesus' command would be like asking a Roman Catholic believer to interrupt a pontifical mass at St. Peter's Basilica in Vatican City. It would be unthinkable, except under the most dire of circumstances. Yet, this is what Jesus asks of his followers. Religious devotion, in the eyes of God, is meaningless if it is not accompanied by acts of peace, justice, and reconciliation.

This biblical conviction brought the members of our task force together around issues related to the War on Drugs. Our months of research have made it clear to us that current policies are not allowing justice to "roll down like waters" in our local, national, and global communities. Our neighbors are wrongly suffering under the weight of laws that have been written, interpreted, enforced and endorsed by often well-meaning authorities, including members of our church. Yet as it has become more and more clear that our brothers and sisters have something against us, we have not left our gifts before the altar in order to pursue reconciliation. Instead, we have sat comfortably in our churches and sung God's praises while God's children sit in prison cells or lie in morgues because of the lies we chose to believe out of fear and prejudice. The time has come for us to attend to what Jesus calls "the weightier matters of the law: justice and mercy and faith." (Matthew 23:23)

We read in the book of Proverbs that "A false balance is an abomination to the Lord, but an accurate weight is his delight" (Proverbs 11:1). The War on Drugs is disproportionately a war on people of color. Racial disparity in law enforcement and criminal justice is the "false balance" being used against minority racial and ethnic groups. This fact is hardly news to the members of our church. In 1993, the 205th General Assembly of the Presbyterian Church (U.S.A.) acknowledged that

> "In the war on drugs, enemies are the people that the affluent culture projects its fear upon. In this nation, the enemies are predominately people of color… Although four out of five people who use drugs are white, the vast majority of criminal actions are taken against minority men, whose arrest and conviction put them at a disadvantage in the job market for a lifetime" (40.104, 106).

Under this system of unjust oppression that has been disproportionately imposed upon people of color, Christians would do well to remember the biblical promise: "Because the

poor are despoiled, because the needy groan, I will now rise up," says the Lord; "I will place them in the safety for which they long" (Psalm 12:5).

The justification given for the War on Drugs is that drugs and those who use them represent a menace to society that must be controlled by the power of force. The incarceration of drug users and drug sellers has done little or nothing to help those who live with poverty and addiction. The strategy of ministry that Jesus most often employed with people who struggle outside the bounds of legitimate society is one of healing rather than punishment. When chastised by the Pharisees and scribes for his fellowship with so-called "sinners," Jesus replied, "Those who are well have no need of a physician, but those who are sick" (Luke 5:31). The author of Matthew's gospel applies the words of second Isaiah to Jesus as an image of the characteristic tenderness with which Jesus went about his ministry of healing: "He will not break a bruised reed or quench a smoldering wick until he brings justice to victory" (Matthew 12:20). In the same way, people in our time who are chemically dependent need healing, not punishment, in order to find recovery from their addictions. That is why it is now so important for Christians to change the way we think about drugs, addiction, and the War on Drugs.

When we reclaim the fears projected on the addicted and self-destructive, and reflect on our Reformed tradition's strengths and weaknesses, several additional themes must be noted, even if space does not permit their exploration.

1. Our tradition's commitment to reform society as well as individuals was seen vividly in the prohibition movement, a genuine effort to protect families and children before it was a form of moralism. The Temperance movement was partly led by women and early on was allied with abolitionism in a desire to free people from all kinds of bondage. Women's suffrage was seen as key to prohibition. The challenge for us now is to keep that concern to prevent the ravages of addiction through other means, and to understand the limits of legislation and regulation alone.
2. Our theology of the self lifts up the conscience of the individual and this has led to an emphasis on individual rights, as well as a sometimes guilt-producing awareness of one's duty to be of service to God. Despite the Shorter Catechism's chief end: "To glorify God, and to enjoy him forever," joy itself was sometimes in short supply and sensual, bodily pleasure looked down upon. A renewed sense of the Incarnation as a joy-giving fullness of God's Spirit in our bodies, and the psychological awareness that "individuation" requires some positive integration of "the flesh," both suggest that there has been a "one-sidedness" in our tradition. The abundant life in Christ is not the total abandonment to the wine-god Dionysus, but it is important to own the goodness of pleasure and beauty—which even Calvin said were among God's good gifts.
3. Abstinence from alcohol or drugs is a form of freedom and a way of respecting the integrity of our bodies as God has given them to us. As long as the focus is on that freedom being "for" the fullness of life, there should be no implication that Christians or others should "need" to use any intoxicating or psychotropic substance. From a prudential standpoint also, non-essential substances take money away from other uses and place those who partake to excess in vulnerable

states, vulnerable to victimization or abuse. Countless Christians, many children of alcoholics or addicts, abstain based on their awareness of the sometimes-violent consequences of excessive indulgence, and this is to be respected.

4. Anthropologists tell us that a social and ritual context was historically often the only place for taking drugs or alcohol, and this includes the supervised use of psychedelic plants in pursuit of visions. Current folk wisdom about not drinking alone may carry the awareness that drinking only at family meals can limit alcoholism, and similar practices of emphasizing a communal context may carry over with recreational drug use.
5. The Christian ritual of communion in most Presbyterian congregations is done with grape juice out of a fear for tipping persons in recovery back into addiction. Other congregations provide both wine and grape juice. This deserves serious attention, aware that Christ's presence is the main thing for us to experience, and knowing that the Reformation was first of all a reform of worship to give more freedom to God's Spirit.
6. Depth psychology in the tradition of Carl Jung often sees dependence on drugs or alcohol as a failed initiation process, repeatedly putting one in a transformed state, but without leading to a new and awakened person. Adapted to Christian insights (and arguably dependent on them), this perspective appreciates that the desire for deeper meaning and transcendence in life may lead through disorientation and breakdown of the self-controlling "ego" to access unconscious patterns and greater unity. David Dan, a Jungian therapist, points to the double meaning of "getting to the bottom of things" and hitting bottom, and sees the 12-step program as a more complete initiation and transformation process.[12]
7. The basic Christian pattern of death and resurrection can be seen in the spiritual life of those who do suffer and survive the "demonic possession" of addiction, who live the paradox that by choosing powerlessness they gain freedom from addiction's power. In losing their lives as they knew them, they save their lives for a higher purpose.

We, the members of Christ's church, are invited to assist Jesus in this ministry of healing. We know it is a complex social and cultural task that touches most of our families and many of our own lives. We pray to be open to God's joyful energy even as we are wise about the almost infinite human capacities for self-deception and exploitation. We are called to not break the bruised reeds nor quench the smoldering wicks, but open the floodgates of justice and pursue healing and reconciliation, so that we might participate in the coming of God's kingdom and the doing of God's will, on earth as in heaven.

Part II: Where We Are Today

Changes Since 1993

How is current drug use and drug policy different from use and policy in 1993 when the last substantial PC(USA) social witness policy on this problem was written?

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[12] David Dan, "Beyond the Gingerbread House: Addiction, Recovery, and Esoteric Thought, *Quadrant*, 1991 (24:2), pp. 41-56.

Much damage has been done. The rate and number of people dying from overdoses has more than tripled. The number of overdose deaths from opioids has skyrocketed, first from prescription painkillers, and since 2010 from heroin in the wake of a crackdown on 'pill mills' and lowered price of heroin.[13] The increase in heroin deaths has been almost entirely among White people, while heroin-related deaths and emergency room visits among Black and Hispanic people have remained stable.[14] Some states, such as West Virginia and New Mexico, have had the highest rates of drug overdose for several years.[15]

In 1992, *Church & Society* reported, "With more than a million persons behind bars at a cost of $16 billion a year, the U.S. has the world's highest documented rate of incarceration."[16] By 2012, twenty years later, the United States had 2.2 million incarcerated in jails and state and federal prisons.[17] The 1990s saw an explosion of arrests for marijuana, what two authors called "the transformation of the war on drugs"; while a low proportion of these arrests resulted in felony convictions, they pushed millions of Americans into the criminal justice system.[18]

'Drug Wars' in Latin America

The militarized approach to U.S. drug control efforts in Latin America described in the 1993 policy has continued and deepened the history of U.S. military intervention in the region, contributed to a growth in serious human rights abuses, undermined civilian governance, militarized police forces, and blurred the distinction between military and civilian police functions. The military and police focus has diverted scarce public resources and foreign aid from unfulfilled basic human needs to unproductive counter-narcotics efforts. While U.S. policy in Central America has focused on narcotics, the region suffers the highest homicide rate in the world. In Mexico, an estimated 100,000 men, women, and children have lost their lives to the war on drugs in the past eight years.[19] The war in Colombia, fueled in part by more than $8 billion in U.S. counter-narcotics aid, has displaced more than five million Colombians.[20]

Because such military policies have brought such negative consequences while failing to achieve their stated aims, there is also more global support for changing drug policies

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[13] Lenny Bernstein, "Heroin deaths have quadrupled in the last decade," *The Washington Post*, 7 July 2015.
[14] John Tozzi, "Whites Account for the Entire Jump in Heroin Deaths," *Bloomberg News*, 14 July 2014.
[15] CDC, "Unintentional Drug Poisoning in the United States," July 2010; Trust for Americans' Health, *The Facts Hurt: A State-by-State Injury Prevention Policy Report 2015*, June 2015, p. 14.
[16] Eva Bertram and Robin Crawford, "Is the Drug War a Just War?" *Church & Society* 1992 (82:5), 55.
[17] The Sentencing Project, "Facts about Prisons and People in Prison."
[18] New York City, for example, saw a 2,461% increase in marijuana possession offenses between 1990 and 2002. Ryan S. King and Mark Mauer, "The War on Marijuana: The Transformation of the War on Drugs in the 1990s," *Harm Reduction Journal* (3:6), April 2006.
[19] Amnesty International, *Mexico: Confronting a Nightmare: Disappearances in Mexico*, June 2013, AMR 41/025/2013.
[20] The United States has spent more than $8 billion since 2000, mostly to strengthen the Colombian military, which during this period has killed more than 5,000 civilians. More than 95% of these killings remain in impunity. See Fellowship of Reconciliation, *The Rise and Fall of 'False Positive' Killings in Colombia*, 2014, at: forusa.org/colombia-report-2015.

than existed in 1993. International reforms that show alternatives to prohibition have proliferated during the last 22 years. Some of these changes have achieved remarkable success, which we will explore below.

In the United States, public opinion has shifted, especially in relation to punitive marijuana laws. In 1995, one in four Americans favored making marijuana possession legal; twenty years later, a majority favor making it legal. An even larger majority thinks the federal government should not enforce marijuana laws in states that have made it legal.[21] Public opinion favoring reform of laws on other drugs probably lags behind sentiment on marijuana, but even there, 63% favor states reducing mandatory minimums for nonviolent drug offenses of any kind.[22] New science also allows the disease model of addiction to be better understood.[23]

One of the success stories for addressing addiction occurred in the United States: reduced tobacco use, especially among young people. This trend was already well underway at the time of the 205th General Assembly, which encouraged Presbyterians to abstain from tobacco products and urged the elimination of tobacco export subsidies. Tobacco use by adults in the U.S. had fallen from 42% in 1965 to 25% by 1993. It was reduced further to 19% by 2011.[24] Regulatory controls are one part of this story: restrictions on advertising, health warnings, and enforcement of prohibition of sales to minors[25] have been important. But so have other social forces that have made tobacco smoking decidedly less "cool."[26]

Nevertheless, this tale of success is tempered by a devastating reality: tobacco smoking still causes more deaths in the United States than *all other substance use combined*, by a factor of *seven*.

The time since 1993 has also seen dramatic changes in health care in the United States, which has become increasingly costly. This has important consequences for the treatment of addiction. The Mental Health Parity and Addiction Equity Act, implemented in 2010, requires health insurers to extend the same conditions and benefits for persons seeking treatment for a substance use disorder as they do for people with other medical conditions, and these provisions were folded into the Affordable Care Act that mandates

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[21] "Illegal Drugs," *Gallup*, accessed at: http://www.gallup.com/poll/1657/illegal-drugs.aspx.
[22] Drew Desilver, "Feds may be rethinking the drug war, but states have been leading the way," *Pew Research Center*, 2 April 2014, at: http://www.pewresearch.org/fact-tank/2014/04/02/feds-may-be-rethinking-the-drug-war-but-states-have-been-leading-the-way/.
[23] The number and breadth of scientific articles are too many to be cited here. For a useful introduction to much of this science, see Gabor Maté, *op. cit.*
[24] Centers for Disease Control and Prevention, "Trends in Current Cigarette Smoking Among High School Students and Adults, United States, 1965–2011," accessed at: http://www.cdc.gov/tobacco/data_statistics/tables/trends/cig_smoking/index.htm.
[25] E. Feighery, et.al., "The effects of combining education and enforcement to reduce tobacco sales to minors. A study of four northern California communities," *JAMA*, 11 December 1991 (266: 22), 3168-71; L. Jason, et.al., "Reducing the illegal sales of cigarettes to minors: analysis of alternative enforcement schedules," *Journal of Applied Behavior Analysis*, 1996 (29:3), 333-344.
[26] Source for effects of social pressure on falling tobacco use?

health coverage for all individuals.[27] But the lack of coverage in the 22 states that have declined to extend Medicaid affects some four million people, who are disproportionately poor and people of color.[28]

The costs of current drug policy and changing attitudes affect the Church. As the Church recognized over time, not all uses of alcohol are sinful or constitute abuse. Similarly, not all uses of illicit substances, although they may imply risks, constitute abuse or sin, which has profound implications for how we respond to persons who possess or use illegal drugs, as well as to those who make or supply those drugs.

In 2003, the Church affirmed that:

> "Our vision is of a society where there is education and health care for all, drug treatment for all who require it, jobs for all who need them, and a sense of belonging to a community. With this vision of community, we can begin to develop a criminal justice system that is truly just."[29]

At the Task Force's hearing in Richmond, California, we heard a painful reflection on the Church from Sam Vaughn, who works on behalf of the city with youth who are at risk of committing violence. Asked what churches can do, Vaughn said:

> The Church is absolutely irrelevant, at least in Richmond, and I hate to say that. Someone can get shot out in front of the church, literally, bullet holes in the walls of the church, and the church won't even let that person have their funeral there, because, 'You know what, you're bringing danger onto us. It's unsafe. We don't like you all coming in my church smelling like weed.' So the community has come to an understanding that the church is for healthy people. The church is a hospital, the pastor is supposed to be a doctor, and the folks in the congregation should be sick. What folks have done, they feel like they're better than everyone out on the streets. And the people out on the street recognize that difference, recognize that I'm not welcome there.

These issues are literally at our doors. In March 2014, police in North Little Rock, Arkansas responding to reports of a disturbance on a bus removed Robert Storay, a 52-year-old African American Army veteran, from a bus, during which he allegedly hit the officer with a cane. The officer then shot and killed Storay, who had earlier filed a lawsuit for police abuse. The killing occurred at the front steps of First Presbyterian Church in North Little Rock.[30]

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[27] "The Mental Health Parity and Addiction Equity Act," Centers for Medicare and Medicaid Services, at www.cms.gov.
[28] Rachel Garfield, et.al., "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update," *Health Reform*, 17 April 2015, accessed at: http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/.
[29] Resolution Calling for the Abolition for For-Profit Prisons, approved by the 215th General Assembly of the Presbyterian Church USA (2003),
[30] "NLR officer involved in Wednesday shooting identified," *Arkansas Online*, 7 March 2014, at: http://www.arkansasonline.com/news/2014/mar/07/nlr-officer-involved-wednesday-shooting-identified/; and www.mappingpoliceviolence.org/unarmed

The Black Lives Matter movement, building on growing efforts to end mass incarceration, has further challenged the Church. "This movement is … challenging the church to live into its calling, to risk stability for faithful action, and to both follow and lead," according to David Wigger, who recently graduated from Louisville Presbyterian Theological Seminary. "It is challenging the church to be a witness in the world and to live beyond the four walls or a Sunday service. It is challenging the church to be better."[31] Writer and activist Ryan Herring puts it more directly. "If our theology renders us silent and docile in the face of oppression, then it is quite frankly toxic to our faith. What good are we to society and to God's kingdom if we are sitting in pews while the world around us suffers and burns?"[32]

The church's moments of silence on injustices related to the drug war may be a contributing cause to another worldly phenomenon: the rapid loss of young members participating in Presbyterian life. For every PC(USA) congregation worshipper aged 18 to 25, there are now more than six worshippers older than 65, and worshippers' median age is increasing – a change that predates and is separate from the departure of conservative congregations.[33]

More than with most subjects, people offer opinions about drugs and drug abuse based not on their own experience, but on what they have heard. For example, two out of three Americans believe the problem of drugs is very or extremely serious *in the country*, but less than a third of those same people in a representative survey describe it as very or extremely serious in the area *where they live*.[34] The problem, in other words, is somewhere else in the country. This makes the importance of *evidence-based policy* all the greater, both because direct experience of the problems is highly uneven in our society, and because many people form opinions about the problem or policies not based on direct experience.

What, then, can we do differently? What do our deepest religious tenets of faith call us to do? That drug prohibition and its militarized and racist enforcement have generated so much damage calls on us not only to act to reform those policies, but to inquire why such harmful policies were adopted. This, in turn, requires us to understand current drug use and drug policy. We'll then turn to the roots of those policies in our history of racism within the United States, and in a drive for domination in international relations.

Drug Use and Policies Today

About 24 million Americans – or 9.4% - used illicit drugs in the last month. Of these, the majority used marijuana. In contrast, 136 million Americans used alcohol, and nearly half

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[31] Ryan Herring, "Now is a Time for Theology to Thrive," *Sojourners*, September / October 2015, accessed at: https://sojo.net/magazine/septemberoctober-2015/now-time-theology-thrive.
[32] *Ibid.*
[33] Deborah Bruce and Cynthia Woolever, "Looking inside Presbyterian congregations," 29 March 2011, at: https://www.pcusa.org/news/2011/3/29/looking-inside-presbyterian-congregations/.
[34] "Illegal Drugs," *Gallup*, op. cit.

of those who use alcohol - about one in four Americans - reported binge alcohol drinking.[35]

In 2014, the U.S. Surgeon General estimated that tobacco use leads to at least 480,000 deaths each year in the United States.[36] By comparison, there were 25,692 deaths from alcohol-induced causes in the United States in 2010, and 16,235 deaths from poisoning by opioid analgesics in 2013, which represented a near quadrupling of the rate of deaths since 1999.[37]

According to child abuse pediatrician Dr. Kathryn Wells, "We know alcohol is the worst substance of abuse you can use during pregnancy, most damaging to the fetus, without a doubt based on the information and research we have now."[38] Neonatal and breast milk exposure to heroin and cocaine also poses significant risks, including infant withdrawal syndrome from opiate exposure. Risks from fetal exposure to marijuana by the mother are not well studied.

Table 1. Illicit drug use in the past month among individuals aged 12 or older: 2013

	Aged 12 or older		Aged 12 to 17		Aged 18 or older	
Substance	Number (in thousands)	Percent	Number (in thousands)	Percent	Number (in thousands)	Percent
Illicit drug use	24,573	9.4%	2,197	8.8%	22,376	9.4%
Marijuana and hashish	19,810	7.5%	1,762	7.1%	18,048	7.6%
Cocaine	1,549	0.6%	43	0.2%	1,505	0.6%
Inhalants	496	0.2%	121	0.5%	375	0.2%
Hallucinogens	1,333	0.5%	154	0.6%	1,179	0.5%
Heroin	289	0.1%	13	0.1%	277	0.1%
Nonmedical use of prescription-type drugs	6,484	2.5%	549	2.2%	5,935	2.5%
Pain relievers	4,521	1.7%	425	1.7%	4,096	1.7%

NOTE: Numbers and percentages do not sum to the illicit drug use estimate as individuals may have used more than one illicit drug.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2013.

Evidence since 2002 suggests that cracking down on non-prescription opioid use correlates to an increased use of heroin and associated risky behaviors. This is occurring especially among whites, according to one study. The study authors recommended that,

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[35] "Binge drinking" is usually defined as four or more drinks in one occasion.
[36] Brian D. Carter, M.P.H., Christian C. Abnet, Ph.D., et al., "Smoking and Mortality — Beyond Established Causes," *New England Journal of Medicine*, 12 February 2015; 372: 631-40.
[37] LH Chen, H Hedegaard, and M Warner, "Drug-poisoning deaths involving opioid analgesics: United States, 1999–2011," *NCHS data brief no. 166*. US Department of Health and Human Services, CDC, 2014, p. 1.
[38] Testimony to Drug Policy Task Force, Denver, CO, 19 June 2015.

"frequent nonmedical users of prescription opioids, regardless of race/ethnicity, should be the focus of novel public health efforts to prevent and mitigate the harms of heroin use."[39]

Demographics of use and dependency: Rates of drug use are remarkably consistent across race within the United States. Drug use by White and Hispanic teenagers is higher than for Black teenagers: "For nearly all drugs, black seniors report lifetime, annual, 30-day, and daily prevalence rates that are lower than those for their white and Hispanic counterparts," according to Centers for Disease Control and Prevention data.[40] More recent government data indicates that while illicit drug dependence among African Americans is slightly higher than for Whites, the rate of binge alcohol drinking is higher for whites.[41] There is evidence that White youth in fact engage in more retail *drug selling* than Black youth, according to representative survey of 9,000 teenagers on their behavior.[42]

Criminal Penalties

About half a million people are incarcerated for drug offenses in the United States. Mandatory minimum sentences legislated in 1986 dramatically increased federal sentences for sale, transport, as well as possession of drugs, varying according to the type and weight of the drug and prior convictions. For example, someone convicted for a second time for possessing a single ounce of crack cocaine, though no serious injury results, leads to a mandatory ten years in prison.[43] Most states have adopted similar approaches. There are nearly four times as many people in state prisons and jails for drug offenses as there are in federal prisons.[44] Many of those incarcerated for drug offenses have not been sentenced; they are in jail awaiting trial.

People convicted of drug offenses who have served prison time also confront extensive post-incarceration penalties. These vary from state to state, and include losing the right to vote, the right to serve on a jury, the right to run for public office, the ability to live in publicly-subsidized housing, and the right to employment (because of discrimination based a felony conviction).

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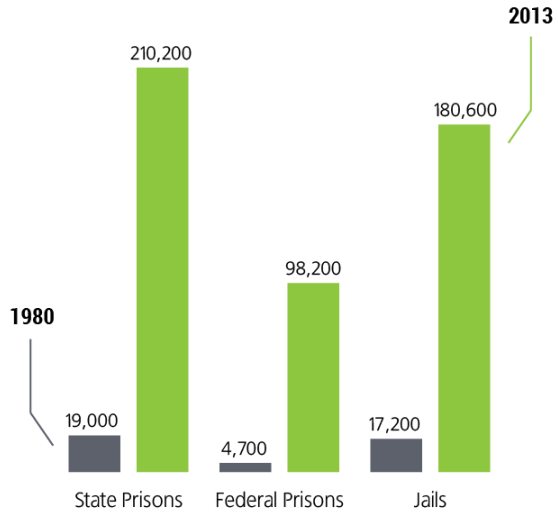
[39] Silvia S. Martins, et.al., "Racial/ethnic differences in trends in heroin use and heroin-related risk behaviors among nonmedical prescription opioid users," *Drug and Alcohol Dependence*, 1 June 2015 (151), pp. 278-283.
[40] Melissa Sickmund and Charles Puzzanchera (eds.), *Juvenile Victims and Offenders: 2014 National Report*, Office of Juvenile Justice and Delinquency Prevention, December 2014, p. 65.
[41] http://www.drugwarfacts.org/cms/Drug_Usage#Demographic
[42] From 1997 to 2001, 17% of Whites reported having sold illegal drugs by age 17, compared to 13% of Blacks and 16% of Hispanics. The survey was not repeated in later years. Howard Snyder and Melissa Sickmund, *Juvenile Victims and Offenders: 2006 National Report*, Office of Juvenile Justice and Delinquency Prevention, March 2006, p. 70.
[43] Chart of all federal mandatory minimums, at: www.famm.org.
[44] The Sentencing Project, at http://www.sentencingproject.org/template/page.cfm?id=128.

Number of People in Prisons and Jails for Drug Offenses, 1980 and 2013



Sources: Carson, E.A. (2014). *Prisoners in 2013*. Washington, D.C.: Bureau of Justice Statistics; Mauer, M. and King, R. (2007). *A 25-Year Quagmire: The War on Drugs and its Impact on American Society*. Washington, D.C.: The Sentencing Project; Glaze, L. E. and Herberman, E.J. (2014). *Correctional Populations in the United States, 2013*. Washington, D.C.: Bureau of Justice Statistics.

THE SENTENCING PROJECT

The war on drugs has been an important driver of the 'school to prison pipeline,' described by the ACLU as "policies and practices that push our nation's schoolchildren, especially our most at-risk children, out of classrooms and into the juvenile and criminal justice systems," and prioritizes incarceration over education. The pipeline operates through under-resourced schools, zero-tolerance discipline policies (modeled on drug policy), reliance on police in schools for discipline, private disciplinary schools, poor legal representation for minors, and lack of educational services in juvenile facilities.[45]

The war on drugs has also impacted property rights, including those of working class people. Civil asset forfeiture allows police to seize assets from anyone if they believe they were involved in a crime, without charging them or showing evidence that they were.[46] Since 2008, police have seized cash and property worth $3 billion in more than 55,000 seizures on highways and elsewhere, according to a *Washington Post* investigation. Some police training companies have specialized in instructing police how to aggressively carry out forfeitures. Hundreds of local drug task forces rely on seized cash to pay for more than 20% of their budgets. There is evidence that the seizures disproportionately impact people of color.[47] The United States also promotes asset

[45] ACLU, "What Is the School-to-Prison Pipeline?" at: https://www.aclu.org/fact-sheet/what-school-prison-pipeline#3.
[46] For an informative and entertaining, if sobering, report on civil forfeiture, see John Oliver's *Last Week Tonight*, 5 October 2014, at: https://www.youtube.com/watch?v=3kEpZWGgJks.
[47] Michael Sallah, et.al., "Stop and Seize," *The Washington Post*, 6 September 2014.

forfeiture procedures internationally.[48] The leader of Texas narcotics agents, Gilbert Gonzalez, told the Task Force he believes seized assets should be directed to drug treatment and drug courts rather than law enforcement. In January 2015, then-Attorney General Eric Holder issued a directive prohibiting the use of federal law to seize assets without warrants or criminal charges, although agents may still use many existing state forfeiture laws to seize assets.[49]

The federal government projected to spend more than $25 billion on drug control in 2015. While the amount spent on treatment and education has increased from previous years, about 57% of the federal drug budget is still spent to control illicit drug supply: law enforcement, interdiction, and international programs. State and local governments also spend on drug control, with an even greater proportion focused on law enforcement.[50] Besides the federal Drug Enforcement Administration, many state, local, and international agencies are involved in drug law enforcement.

Police forces in the United States have become increasingly militarized since the onset of the drug war. U.S. foreign counter-drug assistance has also contributed to a blurring between military and police functions and operations.

Harms versus Legal Classification

The U.S. Congress and President Obama took bipartisan action in 2010 to address a gross inequity in drug policy: the 100-to-1 sentencing disparities between crack and powder cocaine. The 1986 Anti-Drug Abuse Act established mandatory minimum prison sentences that made five grams of crack cocaine an equivalent crime to possession 500 grams of powder cocaine. This disparity in sentencing guidelines contributed significantly to more severe impacts on African Americans, not only because Whites and Blacks were likely to consume cocaine in different forms, but because it incentivized law enforcement not to arrest people possessing powder cocaine, since the penalties were negligible. The Fair Sentencing Act did not entirely eliminate this injustice, since the law was not retroactively applied to those sentenced under the 1986 law, and it still applied a disparity of 18-to-1 for sentences for crack and cocaine.[51] However, the Congress and executive branch recognized an important principle: relative severity of criminal sanctions for possession, sale or production of a substance should correspond to the pharmacology and medical risks of the substance's uses. Proposed legislation would

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[48] The United States established an asset forfeiture agreement with Panama in 2013 that will share with Panama the takings from seizures, giving Panamanian agencies greater incentive to participate in asset seizure operations. See U.S. Department of State, International Narcotics Control Strategy Report, March 2014, accessed at: http://www.state.gov/j/inl/rls/nrcrpt/2014/vol1/index.htm.
[49] Robert O'Harrow, Jr., et.al, "Holder limits seize-asset sharing process that split billions with local, state police," *Washington Post*, 16 January 2015.
[50] Office of National Drug Control Policy, "National Drug Control Budget: FY2015 Highlights," March 2014; John Walsh, "Just How 'New' is the 2012 National Drug Control Strategy," 8 May 2012, at http://www.wola.org/commentary/just_how_new_is_the_2012_national_drug_control_strategy.
[51] Families Against Mandatory Minimums, "Crack Cocaine Mandatory Minimum Sentences," at: http://famm.org/projects/federal/us-congress/crack-cocaine-mandatory-minimum-sentences/.

make this principle retroactive and eliminate the differential between crack and powder cocaine sentences.[52]

Reforms should account for the relative risks of harm of different substances. A 2007 study in *The Lancet* used a survey of medical, psychiatric, forensic, legal, chemistry, pharmacology and police experts to assess the risks of physical dependence, and social harm from using 20 substances. They then compared these risks to the legal classification of the substances in British law. [53] U.S. drug classifications are even more skewed: they classify cocaine, methamphetamine, and oxycodone as having *less abuse potential* than marijuana and hallucinogenic drugs such as LSD and Ecstasy.[54]

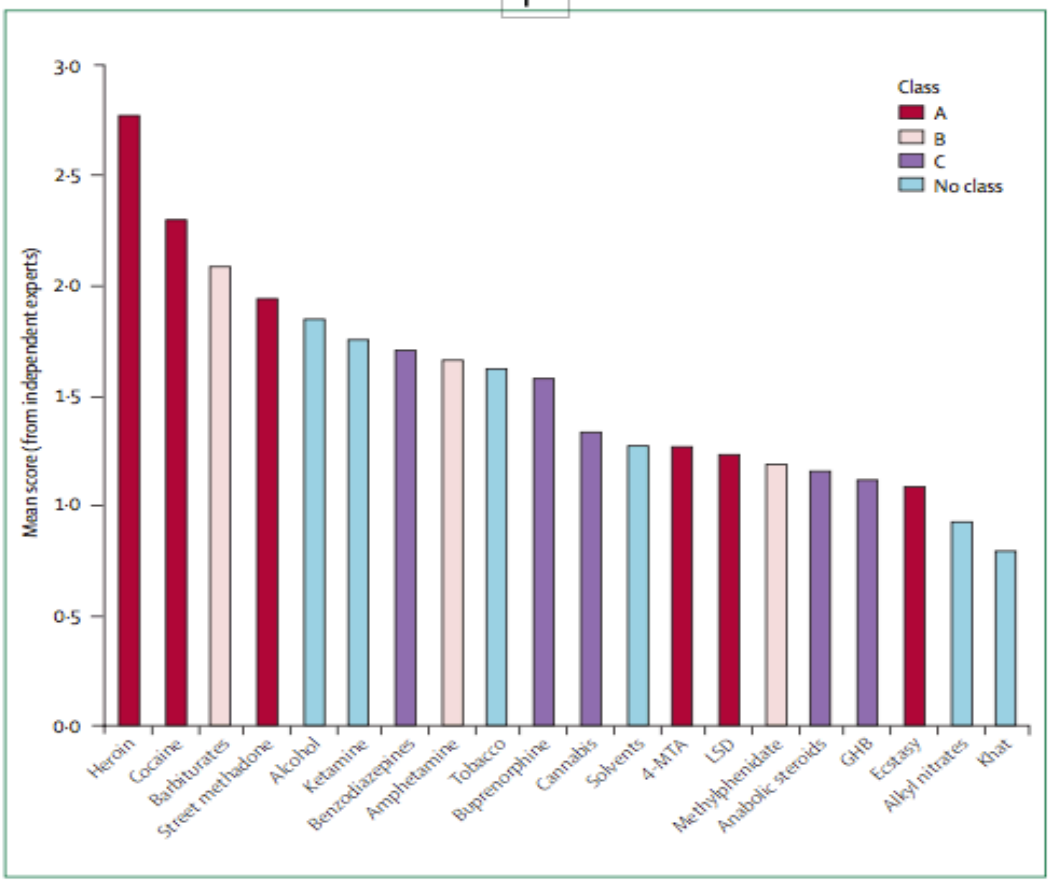

Figure 1: **Mean harm scores for 20 substances**
Classification under the Misuse of Drugs Act, where appropriate, is shown by the colour of each bar.

What is evident in this classification of harms is that the risks and legal classifications bear little, or at best an uneven, relationship to each other.

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[52] This is **H.R. 1255, Fairness in Cocaine Sentencing Act**, introduced by Rep. Bobby Scott (D-VA).
[53] David Nutt, et. al. "Development of a rational scale to assess the harm of drugs of potential misuse," *The Lancet* 2007 (369): 1047-1053.
[54] Drug Enforcement Administration, "Drug Schedules," at: http://www.dea.gov/druginfo/ds.shtml.

An important aspect of the risk of harm is addictiveness. While research shows that many other factors besides the substance contribute to risks for a person becoming addicted,[55] there is also substantial difference between substances in the risk of addiction (either a physical or psychological dependence).

The estimated portion of people who use substances who develop a dependence on them is as follows: for tobacco, 31.9%; heroin, 23.1%; cocaine, 16.7%; alcohol, 15.4%; anxiolytics (including sedatives and hypnotic drugs), 9.2%; cannabis, 9.1%; analgesics, 7.5%; psychedelics, 4.9%; inhalants, 3.7%.[56]

This means that most people who at one time use what are commonly considered addictive substances, including heroin and cocaine, do not develop addictions to them. When people are detained or arrested for possession of these substances, then, there is substantial possibility they are not dependent and do not need treatment, even if they used poor judgment during their use of the substance. This has implications for drug courts, as we will see.

"The United States already spends about $35 billion a year on alcohol - and substance-abuse treatment," notes author Gabrielle Glaser. "With the Affordable Care Act's expansion of coverage, it's time to ask some important questions: Which treatments should we be willing to pay for? Have they been proved effective? And for whom—only those at the extreme end of the spectrum?"[57] A "one size fits all" type of approach to treatment may be simple to grasp and seemingly easy to implement (Just Say No!). But it doesn't reflect reality. A more realistic manner to assess the potential for problematic substance use is along a continuum rather than in a binary fashion. An important step to making treatment fit patients' needs is the development of standards and training for addiction treatment. Casa Columbia recommends establishing evidence-based accreditation standards for treatment programs.[58]

A public health approach to drug policy must address the risks of both substance use by and incarceration of children and adolescents. Considerable research indicates that because the brains of adolescents are still in formation, they are more at risk of developing unhealthy dependence when they use drugs and alcohol.

> During adolescence, when the reward pathways in the brain are continuing to develop, they are readily influenced by external experiences and stimuli, including exposure to addictive substances. A growing body of evidence suggests that due to this increased sensitivity, addictive substances physically alter the reward centers of the brain faster and

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[55] See Carl Hart, *High Price: A Neuroscientist's Journey of Self-Discovery that Challenges Everything You Know about Drugs and Society* (New York: Harper, 2013) and Gabor Maté, *op.cit.*

[56] The margin of error for developing dependence on heroin was much higher than for other substances – 5.6%, so the probability of developing heroin dependence among users actually ranged from 17.5% to 28.7%. JC Anthony, LA Warner, RC Kessler, "Comparative Epidemiology of Dependence on Tobacco, Alcohol, Controlled Substances, and Inhalants: Basic Findings From the National Comorbidity Survey," *Experimental and Clinical Psychopharmacology*, 1994 (2:3), 244-268.

[57] Gabrielle Glaser, "Alcoholics Anonymous," *The Atlantic*, April 2015.

[58] Casa Columbia, *Addiction Medicine: Closing the Gap Between Science and Practice*, June 2012.

more intensely in adolescents than in adults, heightening their vulnerability to addiction.[59]

At the same time, adolescence is a time of individual experimentation and, frequently, of rebellion against authority. Research also indicates that adolescents who are arrested and pulled into the criminal justice system face serious life disruption and costs to health.[60]

It is important to clarify whether by prevention we mean to prevent first-time use or problematic use. In either case, an effective prevention strategy means investing in health care, in neighborhood development, and in monitoring health. "Primary prevention is making little kids careful about what they put in their bodies," says Dr. Bryan Page. "'Education' is different from 'prevention.'"[61] A cognitive-behavioral approach works better at prevention than education.

Part III: Historical Roots and Dynamics of Drug Policies

Historical Roots of Punitive Drug Policy

While the United States has historically been the global leader of drug prohibition policies, such prohibition was instituted first overseas, in U.S. and British colonial possessions, before it was established within the United States. Protestant Church leaders played an important part in such global prohibition. Among them, Rev. Charles Henry Brent served on the commission recommending prohibition of opium, chaired the first international Opium Conference in Shanghai in 1909, and headed the American delegation to international opium conferences in the Hague.[62]

A century ago, opiates and cocaine were freely available, and used both medicinally and recreationally by people throughout the United States. Scores of patent medicines, elixirs and liquid concoctions contained substantial amounts of opium or cocaine – including potions used to treat conditions particular to women. Opiate dependence peaked in the United States near the turn of the twentieth century, when the number of addicts was estimated at close to 250,000 in a population of 76 million – representing a drug addiction rate far higher than that of today's society.[63] The prevailing attitude was that drug addiction was a health problem, best treated by physicians and pharmacists.

Public attitudes about drug use began to change as perceptions about drug users shifted. Even though white Americans consumed their own fair share of opium in liquid, powder, or pill form in concoctions such as laudanum and other widely available tonics and elixirs, societal prejudice against opiates grew with the arrival of large numbers of Chinese in the United States, whose custom of smoking opium was perceived as strange and foreign. In 1875 San Francisco passed the nation's first drug law, banning only the

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[59] Guerri, C., & Pascual, M. (2010). Mechanisms involved in the neurotoxic, cognitive, and neurobehavioral effects of alcohol consumption during adolescence. *Alcohol, 44*(1), 15- 26.
[60] Seth Ammerman, et.al., "The Impact of Marijuana Policies on Youth: Clinical, Research and Legal Update," *Pediatrics* (135:3), March 2015, pp. 769-785.
[61] Dr. Bryan Page, discussion with Drug Policy Task Force, 19 June 2015.
[62] David F. Musto, *The American Disease: Origins of Narcotic Control* (New York: Oxford University Press, 1999), pp. 25-28.
[63] Ibid., pp. 303-304.

smoking of opium in opium dens, the form of opium use most commonly associated with the Chinese. The motivations underlying the birth of the nation's drug policy are clear: in 1902, the Committee on the Acquirement of the Drug Habit of the American Pharmaceutical Association declared: "If the 'Chinaman' cannot get along without his 'dope,' we can get along without him."[64] The first state drug prohibition law was passed in 1909, when California outlawed the importation of smoked opium.

In 1910, Dr. Hamilton Wright, considered by some to be the progenitor of anti-narcotics laws in the United States, reported that contractors were giving cocaine to their black employees in an effort to get more work out of them. A few years later, stories began to proliferate about "cocaine-crazed Negroes" in the South running dangerously amuck. One article in *The New York Times* went so far as to state that cocaine made blacks shoot better, and would "increase, rather than interfere with good marksmanship." Another reported that some southern police departments had switched to .38 caliber revolvers, believing that cocaine made blacks impervious to smaller .32 caliber bullets. Evoking highly racially- and gender-charged imagery, an article in *Literary Digest*, a popular magazine of the era, claimed that, "most of the attacks upon white women of the South are the direct result of the cocaine-crazed Negro brain."[65]

The impact of these and other racialized representations of drug users were profound – indeed, when Coca-Cola removed cocaine from their popular soft drink, they did so not only out of concern for their customers' health, but also to appease their southern market, which "feared blacks getting cocaine in any form." The proliferation of media stories linking cocaine with violence by African-Americans may have been motivated in part by a desire to persuade southern members of Congress to support the proposed Harrison Narcotics Act, which greatly expanded the federal government's regulatory powers with respect to illegal drugs, ostensibly to fight crime. The sensationalism, gross distortion, and appeal to racism inherent in these media stories may have been necessary to garner support for these new laws, given that drug users were actually committing very little crime.

As use of marijuana became popular on the American jazz scene in the 1920s and 30s, blacks and whites increasingly began socializing as equals and smoking the drug together. The anti-marijuana propaganda of the time cited this breach of racial barriers as exemplifying the social degradation caused by marijuana. For instance, officials in New Orleans attributed many of the region's crimes to marijuana, which they claimed was also a dangerous sexual stimulant. Harry Anslinger, head of the newly formed federal narcotics division, warned political and community leaders about blacks and whites dancing together in "teahouses," using racial prejudice to sell prohibition.[66]

The first federal law targeting marijuana possession and use, the Marijuana Tax Act of 1937, was enacted during the Great Depression, and its proponents once again used racist rhetoric as their chief selling point. It was said that Mexican immigrants, who were vying

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[64] *Ibid.*, p. 17.
[65] *Ibid.,* pp. 6-8, 304-305.
[66] Ibid., p. 221; Johan Hari, "The War on Billie Holiday," *In These Times*, 16 January 2015.

with out-of-work White Americans for the few agricultural jobs available, engaged in marijuana-induced violence against these whites. The American Coalition, an anti-immigrant group, claimed:

> "Marihuana, perhaps now the most insidious of our narcotics, is a direct by-product of unrestricted Mexican immigration. … Mexican peddlers have been caught distributing sample marihuana cigarettes to school children. Bills for our quota against Mexico have been blocked mysteriously in every Congress since the 1924 Quota Act. Our nation has more than enough laborers."[67]

Illicit and licit economies

The illicit drug industry is an illustration of what we could call capitalism on steroids, as it seeks profit at all costs. It mimics legal profit-making industries in several important ways: the lowest income is found among workers in the production of raw materials (growing coca and poppies) and in the retail sector (street selling), while much more profit is made in wholesale, transport (traffickers) and financial services (money laundering).

The illegality of drugs is an important driver of violence by traffickers. Susie Byrd, former City Council member in El Paso, explained to the Task Force the terrible spike in Ciudad Juarez, El Paso's sister city along border, which suffered more than 3,000 homicides in 2010:

> It used to be that independent smugglers could carry drugs through Juarez. That was allowed; you would maybe pay a little bit of a fee, but the rules changed. The Juarez cartel said, 'Now we're the only ones that can carry marijuana through this marketplace.' But the Sinaloans had all the marijuana and the Juarez cartel didn't. It created this very combustible violence in Juarez. That's what happens in a black market when there's tension, the way you resolve those tensions is through violence - that's the way you control the marketplace.

The black market has a large impact on drug prices as well. "You can buy in the Golden Triangle [in Mexico] a pound of marijuana for $23 and you can go up and sell it in Chicago for $770. So the markup is extraordinary," Byrd testified.[68]

Money laundering[69] in its most basic form is making money that comes from a "dirty" or illegal source appear like it comes from a "clean" or legal source, so as to not raise suspicions of law enforcement. If law enforcement discovers that money is connected to criminal activity, it can be seized. But by hiding the illegal origins of the money, say drug sales, the money can be used freely in the formal financial system. Another reason that drug traffickers need to launder money is that drugs are primarily paid for with cash,

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[67] *The New York Times,* 15 September 1935, cited in Musto, *op. cit.,* p. 220.
[68] Susie Byrd, testimony before Drug Policy Task Force, El Paso, TX, 2 May 2015.
[69] This section is indebted to a draft paper by Ben Leiter of the Latin America Working Group. See also Celina B. Realuyo, *It's All About the Money: Advancing Anti-Money Laundering Efforts in the U.S. and Mexico to Combat Transnational Organized Crime* (Woodrow Wilson Center), 2012.

which in large amount is not only heavy and bulky, but also draws the attention of law enforcement.

Drug trafficking organizations have used diverse methods to launder money, several of which have involved participation of large banks. Since 2010 federal investigators have accused Wachovia Bank (subsequently taken over by Wells Fargo) and banking giant HSBC of violations of banking regulations that facilitated moving some $420 billion and more than $679 billion, respectively, through their accounts on behalf of Mexican drug cartels. According to prosecutors, Wachovia "willfully" overlooked the suspicious nature of this probable drug money and knowingly failed to institute standard anti-money laundering mechanisms, ignoring persistent and urgent warnings from a London whistleblower and others. When the investigation of Wachovia began, money laundering activities simply shifted to banking giant HSBC.

For both banks, no charges were brought against any individual bankers involved and the banks themselves avoided prosecution. Instead, Wachovia made a $160 million federal payment, less than one twentieth of one percent of the amount it helped to launder, while HSBC paid a much larger forfeiture and fine amounting to $1.9 billion.[70]

Monetary interests also explain why Mexican authorities have not acted effectively against drug traffickers, according to Edgardo Buscaglia, a research scholar in law and economics at Columbia University. "The Mexican authorities fear that if they begin to attack and dismantle these fortunes, it will damage the formal economy… There's no easy way out for the political and entrepreneurial elite: they would have to fight corruption in their own milieus, to stop the laundering that fuels the murder of ordinary people in this country."[71]

Geographically Spreading the Problem of Drug Production and Trafficking

An important effect of drug enforcement has been "geographical displacement… often called the *balloon effect* because squeezing (by tighter controls) one place produces a swelling (namely an increase) in another place."[72] Apparent victories in eliminating one source, trafficking organization or transit route are reliably negated by the emergence of other sources, traffickers and routes. U.S. supply reduction and interdiction approaches result in geographical displacement and the spreading of the illicit drug trade into more regions and countries. "While the arrests of kingpins make for splashy headlines," *The New York Times* noted, "the result has been a fragmenting of the cartels and spikes in violence… as smaller groups fight for control. Like a hydra, it seems that each time the government cuts down a cartel, multiple other groups, sometimes even more vicious,

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[70] Christie Smythe, "HSBC Judge Approves $1.9B Drug-Money Laundering Accord," *Bloomberg*, 3 July 2013.
[71] Anabel Hernández, *Narco Land: The Mexican Drug Lords and Their Godfathers* (New York: Verso, 2014), pp. 293-295.
[72] Antonio Maria Costa, UN Office on Drugs and Crime, "Making drug control 'fit for purpose,': Building on the UNGASS decade," p. 10.

spring up to take its place."[73] The history of recent drug interdiction and crop eradication efforts in Bolivia, Colombia, Peru, Caribbean countries, and most recently Mexico and Honduras demonstrate the 'balloon effect' in action.

Experience in many countries shows the futility and suffering generated by strategies that target low-level producers, transporters, and sellers of illicit drugs. People in such roles not only receive few benefits from drug trafficking, while facing enormous risks from the State's enforcement and the criminal organizations' regulatory tactics (in the absence of State regulation). Typically individuals with few economic options and experiencing structural poverty, they also are easily replaced.

But the strategy of going after high-level traffickers also usually serves only to shift the locus of criminal leaders, and often generates violent battles for succession of leaders who are killed or arrested. The drug war in Mexico "has been a copy of the American antiterrorism strategy of high-value targets," according to Raúl Benítez Manaut, a professor at the National Autonomous University of Mexico. "What we have seen with the strategy of high-value targets is that Al Qaeda has been diminished, but a monster appeared called the Islamic State. With the cartels, it has been similar."[74]

Part IV: Analysis of Drug War Impacts

Abstinence is a necessary goal for many drug-dependent individuals. For society as a whole, however, total abstinence is a chimera that has led to disaster. Even career drug agent Gilbert Gonzalez, who as the director of the Texas Narcotics Officers Association is heavily invested in the drug prohibition paradigm, told the Task Force: "We're not going to solve the drug issue; we're going to manage it."

The criminal justice system is pervaded with racial discrimination at every phase of the process, as documented by Michelle Alexander in her seminal book *The New Jim Crow: Mass Incarceration in the Age of Colorblindness*. The magazine *Slate* combed studies of racial disparities, which found that:

- Black Americans are more likely to have their cars searched.
- Black Americans are more likely to be arrested for drug use.
- Black Americans are more likely to be jailed while awaiting trial.
- Black Americans are more likely to be offered a plea deal that includes prison time.
- Black Americans may be excluded from juries because of their race.
- Black Americans are more likely to serve longer sentences than white Americans for the same offense.
- Black Americans are more likely to be disenfranchised because of a felony conviction.

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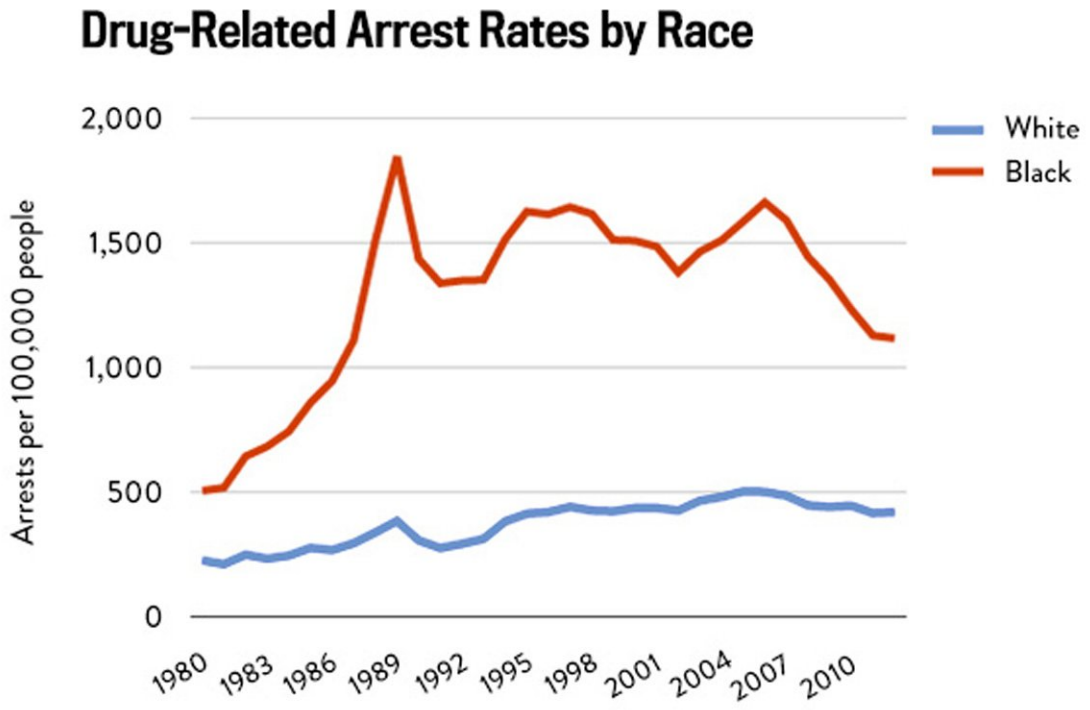
[73] William Neuman, "As Mexico Arrests Kingpins, Cartels Splinter and Violence Spikes," *The New York Times*, 12 August 2015.
[74] Neuman, *New York Times*, op.cit.

- Black Americans are more likely to have their probation revoked.[75]

One in four young Black men has experienced what he thought was unfair treatment by police in the last 30 days.[76]

Many of these inequities are not a direct result of drug policy, but racial inequalities in drug laws and enforcement force Black people into the criminal justice system where these broader injustices exercise themselves onto Black people. This is especially the case because, as the graph below illustrates, arrest rates for drug offenses bring Black people into jails and prisons at two to four times the rate of White people. Note that this was already the case in the early 1980s, before the drug war began in earnest. Drug arrest rates for Whites also doubled since the 1980s. It is also important to note that the abuse of legally available alcohol and prescription opioids is higher among Whites than among Blacks or Hispanics.[77]



Source: Bureau of Justice Statistics

[75] Andrew Kahn and Chris Kirk, *Slate*, 9 August 2015, at http://www.businessinsider.com/theres-blatant-inequality-at-nearly-every-phase-of-the-criminal-justice-system-2015-8#ixzz3iZOgfi7F
[76] Frank Newport, "In U.S., 24% of Young Black Men say Police Dealings Unfair," 16 July 2013, at: http://www.gallup.com/poll/163523/one-four-young-black-men-say-police-dealings-unfair.aspx.
[77] Substance Abuse and Mental Health Services Administration, *Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings*, p. 34; Li Hui Chen et.al., "Drug-poisoning Deaths Involving Opioid Analgesics: United States, 1999–2011," *NCHS Data Brief No. 166*, September 2014.

When Baltimore residents responded to the killing of Freddie Gray by police in April 2015 with an uprising, one drug policy reformer tweeted: "I'm just trying to imagine what police/community relations might be like today if there'd never been a war on drugs."[78]

The war on drugs has been characterized by racial and age disparities in enforcement and broader resource inequities even in progressive communities. Many consider San Francisco to be a center of enlightened drug policy reforms. Yet a 2012 study by the Center on Juvenile & Criminal Justice (CJCJ) showed that African Americans experienced felony drug arrests at rates 19 times more than other races in San Francisco, and 7.3 times more than African Americans elsewhere in California. While African Americans as a whole had higher death rates from illegal drug use than other races – an approximate measure for illegal drug use – these rates could not account for the high arrest rates of African Americans, especially among teenagers, who had lower drug death rates than other races. "When the city conducted a periodic crackdown on drugs, arrest increases nearly always focused wholly or overwhelmingly on African Americans – a pattern not found elsewhere in the state," the study authors noted.[79]

CJCJ presented their study results at a remarkable public hearing organized in April 2012 by the San Francisco Human Rights Commission on the "Human Rights Impact of the War on Drugs," which led to a set of recommendations for city policy. The hearing is a strong example of positive action that local human rights or civil rights commissions can take in other localities.[80]

One recovering addict who testified at the hearing, David Moss, recounted going to jail 14 times for being under the influence of a narcotic, and not once was he offered treatment. He said he never robbed or assaulted anyone, but he was treated like a criminal. "Having a disease is not a crime," Moss said. He emphasized that drugs and alcohol are symptoms of a deeper problem. "So rather than building more beds, building bigger prisons, give people a chance to find out what's beneath the alcohol and drugs, so they can be moms, dads, brothers, sisters, and husbands and wives again."[81]

Though Moss never sold drugs, his comments highlight ways that drug policy does not address the broader needs that lead people to sell illicit drugs, including lack of funds for education and jobs in low-income communities, and the devastation of housing capital for families of color. The foreclosure crisis hit African American communities particularly hard, compounding long-standing inequities generated successively by slavery, Jim Crow segregation, unequal benefits from New Deal programs and the GI Bill

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[78] Sanho Tree, 27 April 2015, at http://t.co/2NR7580mb2.
[79] Mike Males and William Armaline, *San Francisco's Arrest Rates of African Americans for Drug Felonies Worsens,* Center on Juvenile & Criminal Justice, April 2012, accessed at cjcj.org.
[80] The Task Force met with the organizer of the hearing, Zoe Polk.
[81] *Community Voices: The Human Rights Impact of the War on Drugs*, San Francisco Human Rights Commission, April 2012, accessed at: http://sf-hrc.org/sites/sf-hrc.org/files/community%20voices%20report%2011%2017%2014.pdf. See also a 30-minute video of hearing highlights at https://www.youtube.com/watch?v=EnIfIWtxK7k.

of Rights,[82] and "redlining" bank loan practices.

During the housing bubble in the 2000s, for example, Wells Fargo targeted Black churches for subprime mortgage loans "because it figured church leaders had a lot of influence and could convince congregants to take out subprime loans," according to one bank officer.[83] From 2005 to 2009, the net worth of black households declined by 53%, while the net worth of white households declined by 16% . The bank's discriminatory practices led the City of Baltimore to sue Wells Fargo, which settled for $175 million in 2012, but that "was hardly a fix for the loss of family wealth suffered by those who lost their homes."[84]

Impacts on Diverse Sectors
We have examined how drug policies affect communities of color and addicted individuals. Other sectors are affected as well.

Women: The vast majority of women who are incarcerated around the world for drug-related offenses are mothers. Women are particularly vulnerable to prosecution and incarceration based on their relationships with men who are involved in the illegal drug trade, rather than their own leadership or conduct in that trade. Whether or not formal penalties are imposed, drug policies encourage social stigma, shame, and discrimination. Research demonstrates that women who are themselves arrested or who live in communities with high incarceration rates for non-violent drug offenses have greater likelihood of economic instability.[85] Women also face significant barriers to accessing appropriate drug treatment.[86] Numerous state policies still permit the shackling of pregnant inmates during delivery and early bonding with their infants.

Poor people: The criminal justice system disproportionately punishes poor people for most offenses, including drug possession, growing, and sales. Moreover, drug testing has become a standard requirement to receive public benefits, representing additional state coercion of poor people not applied to people with more resources.

Impacts on immigrants: The growth in Mexico and Central America of organized crime founded on transporting drugs to the U.S. market has made hundreds of communities in these countries dangerous, especially for young men. Most do not report crimes to law

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[82] Ira Katznelson, *When Affirmative Action Was White: An Untold History of Racial Inequality in Twentieth-Century America* (New York: W.W. Norton, 2005).
[83] Michael Powell, "Bank Accused of Pushing Mortgage Deals on Blacks," *The New York Times*, 6 June 2009.
[84] Nathalie Baptiste, "Them That's Got Shall Get," *American Prospect*, 13 October 2014, accessed at: http://prospect.org/article/staggering-loss-black-wealth-due-subprime-scandal-continues-unabated.
[85] Kerwin Kofi Charles and Ming Ching Luoh, "Male Incarceration, the Marriage Market, and Female Outcomes," *Review of Economics and Statistics*, 2010 (92:3) 614-627.
[86] Office of Applied Studies, Substance Abuse & Mental Health Services Administration, *Facilities Offering Special Programs or Groups for Women: 2005*, DASIS REP., 15 May 2008, accessed at http://www.oas.samhsa.gov/2k6/womenTx/womenTX.htm.

enforcement because they are widely perceived (and often documented) to be part of or collaborating with criminal groups. As Kelly Wells testified to the Task Force in El Paso:

> This has very serious implications for the US strategy for the war on drugs. Up to this point it has focused on giving more resources, more money, more arms, training, etc., to law enforcement in Central America, which overwhelming evidence suggests is often implicated in the crime itself. So we're basically giving money and arms and training to the criminals. Directly.[87]

In the past two to three decades, the policies, rhetoric, and enforcement agencies that address illegal drugs and immigrants have become increasingly of one fabric. The backdrop for this merging of drug, counter-terrorism and immigration policies is the *threat narrative*, which blends the policies through fear. "The dominant public narrative conceives of and portrays immigration as criminals, an economic, social, cultural, and political threat," observes the National Alliance of Latin American and Caribbean Communities.[88] A recent example of this narrative is use of the word "surge" – commonly used to describe military offensives - to describe the large number of Central America children fleeing violence to the United States.

As a result, drug laws are applied even more punitively and arbitrarily to immigrants than to U.S. citizens. For example, a U.S. resident with a green card can be deported for a single minor offense occurring decades before. Noncitizens in deportation proceedings who have been convicted of a drug offense (with few exceptions) are also ineligible for bail, and will face mandatory imprisonment until their hearing. "Drug trafficking" in immigration law does not distinguish between drug cartel leaders and someone who sells a small amount of marijuana to a neighbor; both are classified as "aggravated felonies," with the harshest immigration consequences. The Department of Homeland Security can deport someone if it has "reason to believe" the person sold drugs, even without a conviction.[89]

<u>Policing in the United States</u>

We believe law enforcement in our country has been delegated with and permitted to exercise an increasingly repressive function, illustrated by the number of police shootings of unarmed people, use of SWAT teams to serve drug warrants, and acquisition of equipment for war and mass surveillance. Drug control has served as a foundational rationale (prior to fears of terrorism) for much of this repressive function, such that reforming drug policy is linked to rethinking the role and operational foundation of U.S. policing.

<u>International Impacts</u>

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[87] Testimony by Kelly Wells, Staff Attorney, Diocesan Migrant and Refugee Services, El Paso, TX, 2 May 2015.

[88] "What is Wrong with Current Immigration Policy and How Can We Get It Right?" unpublished paper, NALACC, January 2013.

[89] Raha Jorhani, Office of the Alameda County Public Defender, testimony before the Drug Policy Task Force, Richmond, California, 18 February 2015.

The United States exercises peerless leadership in the world. Some of this leadership is due to the country's economic, technological and military power, as well as its willingness to use force – to serve as the "world's policeman." Yet it also leads through the definition of global ideals and norms – the norms it is policing. Global drug policy is a primary example of the way that the United States has both promoted the enactment of drug prohibition laws through international agreements, national legislation, and coercive pressure, and selectively enforced those laws through military and police intervention and economic and diplomatic sanctions.[90]

The United States has implemented coercive measures against other nations' programs for drug harm reduction. U.S. political pressure, for example, contributed to the curtailment or cancellation of opiate maintenance programs in Canada, United Kingdom and Australia.[91]

The United States also has exported its incarceration policies, for example through funding of prisons in countries such as Colombia and Honduras.[92] The export of incarceration occurs although, as President Obama has said:

> Over the last few decades, we've also locked up more and more nonviolent drug offenders than ever before, for longer than ever before. For nonviolent drug crimes, we need to lower long mandatory minimum sentences -- or get rid of them entirely.[93]

In this context, the United States' promotion and in many cases imposition of its own drug policies in other nations, some of them with already very weak judicial systems, exacerbates the harms of that model.

U.S. military training of poorly paid young men with few work options plays directly into the game of drug traffickers. The criminal organizations known as 'drug cartels' function by controlling the territories through which their illicit commerce passes. Some territories, such as those on the border with the United States, their largest market, are especially valuable. The organizations' income comes not just from drug profits, but by taxing all licit and illicit commercial activity in the territory that they control. Those who don't pay the cartels' "tax" face their terrible and certain wrath. The cartels draw on their military training and access to high-powered weapons to enforce such territorial advances.

A core problem of combating drug cartels through military assistance to Latin American armed forces is that the assistance consists of goods and capacities that the cartels need to control territory – and the cartels can always pay soldiers and police more than the State

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[90] Peter Andreas and Ethan Nadelmann, *Policing the Globe: Criminalization and Crime Control in International Relations* (New York: Oxford University Press, 2008).
[91] Maté, *op. cit.*, pp. 338-341.
[92] James Jordan, "Empire of Prisons," *Counterpunch*, 5 June 2014, accessed at: http://www.counterpunch.org/2014/06/05/empire-of-prisons; US Agency for International Development, "The Future of CARSI in Honduras," March 2012.
[93] https://www.whitehouse.gov/the-press-office/2015/07/14/remarks-president-naacp-conference.

can. The United States thus trained most of the inaugural members of the feared Zetas cartel, when they were members of an elite Mexican special forces unit, the GAFEs. Similarly, as part of counter-drug programs, the United States Southern Command has been assisting Guatemalan special forces troops known as Kaibiles, former members of which participated in the Guatemalan genocide in the 1980s. The Zetas, in turn, have recruited Kaibiles for their military skills, as trainers, and set up operations in the small jungle town where the U.S. has helped build the Kaibiles training base.[94]

Most weapons used by drug trafficking organizations in Mexico do not come from U.S.-assisted government forces, but most do originate in the United States. The United States provides an open market for military-style weapons that are highly desired by criminal organizations in Mexico. Although personal possession of guns of any kind is illegal for most persons in Mexico, it is extremely easy to bring guns over the border. In the Rio Grande Valley of Texas alone, more than 20,000 trucks and cars cross over the border into Mexico every day, 365 days a year.[95] The huge volume of legal commercial traffic, where controls are focused on movement into the United States, makes the border structurally porous in the North-South direction.

As a result, more than two thirds of the guns seized in Mexico and traced between 2008 and 2013 were sold in the United States.[96] A study by the Trans-Border Institute estimated that, from 2010 to 2012, people purchased 253,000 firearms each year in the United States to be trafficked into Mexico.[97] The United States is thus arming both sides in the drug war in Mexico. The leader of a group of Mexicans in exile told the Task Force that their members fled Mexico because of drug trafficking *and* weapons trafficking.[98] Imported assault weapons could be banned from the United States without Congressional action. There is precedent for executive action to do so. Guns are normally considered primarily a domestic issue within the United States. Yet it is also very much a foreign policy and international human rights problem.

The military approach to U.S. drug control efforts in Latin America also has continued and deepened the history of U.S. military intervention in the region, contributed to a growth in serious human rights abuses, undermined civilian governance, militarized police forces, and blurred the distinction between military and civilian police functions.[99] The Drug Enforcement Administration (DEA) has the largest presence overseas of any U.S. law enforcement agency, operating in 65 countries, but Congress exercises little

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[94] John Lindsay-Poland, "The Military Logic of the Drug Business," September 2011, forusa.org. For an in-depth expose of the Mexican state's persistent and deep penetration by drug traffickers, see Anabel Hernández, *Narcoland*.

[95] "Going South: Numbers show international bridge traffic dropping," *Valley Morning Star*, 10 June 2013.

[96] "Mexico," Department of Alcohol, Tobacco, Firearms and Explosives, Firearms Trace Data, as of March 10, 2014.

[97] Topher McDougal, et.al., *The Way of the Gun: Estimating Firearms Traffic Across the U.S.-Mexico Border*, University of San Diego Trans-Border Institute, March 2013, p. 2.

[98] Testimony of Alredo Holguin, Mexicanos en Exilio, El Paso, TX, 2 May 2015.

[99] Mesoamerican Working Group (MAWG), *Rethinking the Drug War in Central America and Mexico*, 21 January 2014, at: www.cipamericas.org/archives/11315.

oversight, allowing its actions to remain in shadow.[100] A recent study of DEA in Central America and the Caribbean concluded that "the DEA's coordinated drug enforcement operations contribute to increasing the level of violent and property crimes in the region."[101]

The focus has diverted scarce public resources and foreign aid from unfulfilled basic human needs to unproductive counter-narcotics efforts. While U.S. policy in Central America has focused on narcotics, the region suffers the highest homicide rate in the world. Perhaps the starkest example of a breakdown of democratic institutions today is Honduras. After a coup d'etat forced the elected president into exile in 2009, the rule of law disintegrated and violence and impunity soared with a resurgence of death squad tactics and targeted killings of land rights advocates, journalists, LGBT persons, lawyers and political activists. Both military and police are allegedly involved in abuses and killings but are almost never brought to justice.[102]

In Mexico, an estimated 100,000 men, women, and children have lost their lives to the war on drugs since 2007, when President Felipe Calderón declared the war. In addition, more than 26,000 Mexicans have been disappeared,[103] and countless numbers have been wounded and traumatized. The massive deployments of military forces across the country have led to increases in enforced disappearances, extrajudicial killings, and torture.[104]

The war in Colombia, fueled in part by more than $8 billion in U.S. counter-narcotics aid, most of it military, has displaced nearly five million Colombians, with reports of more than 4,700 extrajudicial killings by the armed forces. More than 95% of these killings remain in impunity.[105] In response to these catastrophic outcomes, a growing number of Latin American leaders are calling for formal reconsideration of global prohibition and militarized drug control policies.[106] Such a call from leaders who have themselves promoted and carried out military approaches to production of illicit drugs presents an unprecedented opportunity to engage in a broad evidence-based approach to drugs, not only in the Americas, but globally.

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[100] A study of DEA in Central America and the Caribbean concluded that "the DEA's coordinated drug enforcement operations contribute to increasing the level of violent and property crimes in the region." Horace A. Bartilow and Kihong Eom, "Busting Drugs While Paying with Crime: The Collateral Damage of U.S. Drug Enforcement in Foreign Countries," *Foreign Policy Analysis* (2009) 5, 93-116.
[101] DEA Administrator Michele Leonhart, statement before House Subcommittee on Crime, Terrorism and Homeland Security, June 20, 2012; Horace A. Bartilow and Kihong Eom, op. cit.
[102] Associated Press, "US Aids Honduran Police Despite Death Squad Fears," March 23, 2013.
[103] To "disappear" a person an act, typically by state authorities, in which a person is taken and never seen again, though they were presumably killed.
[104] Valeria Espinosa and Donald B. Rubin (2015), "Did the Military Interventions in the Mexican Drug War Increase Violence?" *The American Statistician*, 69:1, 17-27.
[105] Washington Office on Latin America, *Don't Call it a Model*, July 3, 2010; *Report of the United Nations High Commissioner for Human Rights on the situation of human rights in Colombia,* January 7, 2013.
[106] Edward Fox, "Guatemala, Colombia, Mexico Urge UN to Review Global Drug Policy," *Insight Crime*, October 4, 2012, http://www.insightcrime.org/news-analysis/guatemala-colombia-mexico-urge-un-review-global-drug-policy.

In Brazil, "In the context of the so-called 'war on drugs,' military police forces have unnecessarily and excessively used lethal force, resulting in the deaths of thousands of people over the past decade," according to a report by Amnesty International.[107]

The futility of military approaches to reduce or control drug production is perhaps best illustrated by U.S. involvement in Afghanistan since 2001. The United States has spent an estimated $750 billion on military and police assistance and operations.[108] Much attention has been focused on the human toll and errors in military strategy there. Yet the country also remains the world's number-one grower and exporter, by far, of poppies used to produce heroin – as it was before 2001 – and poppy production has more than doubled during the period of U.S. war and occupation.[109]

Meanwhile, drug crop "eradication campaigns have had devastating consequences for the environment" around the world, according to the UN Development Program.[110]

Part V: Alternatives and Changes to Come

Changes to Come: Marijuana

Social attitudes toward marijuana use have changed dramatically in the United States. A majority of people who are surveyed favors its legalization, and given generational differences on the topic, this majority is likely to grow. Four states and the District of Columbia have made marijuana use legal; another 16 states have decriminalized possession of moderate amounts of marijuana. In the next two years, referenda and legislative campaigns may hold referenda to consider legal regulation of marijuana will occur in another ten states.[111] Marijuana is also popular around the world: globally, 180 million use marijuana each year.[112] Its possession and use are decriminalized in many countries, cities, and U.S. states, and in 2012, Uruguay became the first nation to legalize and regulate production and sales as well as use of marijuana.

Health effects: Marijuana has been used for medical, spiritual, and recreational purposes for thousands of years, and it was prescribed by doctors in the United States for a variety of conditions from the mid-1800s until the 1930s. Marijuana use has been shown to have beneficial impacts for pain, nausea, multiple sclerosis, HIV-related conditions, and other illnesses.[113]

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[107] Amnesty International, *Brazil: You Killed My Son: Homicides by Military Police in the City of Rio de Janeiro*, August 2015, at https://www.amnesty.org/en/documents/amr19/2068/2015/en/.
[108] Neta C. Crawford, "U.S. Costs of Wars Through 2014: $4.4 Trillion and Counting," 25 June 2014.
[109] UN Office on Drugs and Crime, "Illicit crop cultivation," at: https://www.unodc.org/unodc/en/alternative-development/illicit-crop-cultivation.html.
[110] UNDP, *Addressing the Development Dimensions of Drug Policy*, June 2015, p. 27.
[111] Marijuana Policy Project, at https://www.mpp.org/states/.
[112] United Nations Office of Drug Control (2013), *2013 World Drug Report*, at: www.unodc.org/unodc/secured/wdr/wdr2013/World_Drug_ Report_2013.pdf
[113] J. Michael Bostwick, "Blurred Boundaries: The Therapeutics and Politics of Medical Marijuana," *Mayo Clinic Proceedings,* February 2012 (87:2), 172-186.

Nevertheless, "[t]hose who consume large doses of [marijuana] on a regular basis are likely to have lower educational achievement and lower income, and may suffer physical damage to the airways," according to a peer-reviewed survey of studies. "They also run a significant risk of becoming dependent upon continuing use of the drug. There is little evidence, however, that these adverse effects persist after drug use stops or that any direct cause and effect relationships are involved."[114]

More studies are needed to fully understand cannabis' medical properties and effects. But federal barriers to such research are considerable as long as it is classified as having no medical use. Existing critical studies may be confirmed or disconfirmed with larger data sets.[vi] A co-linear use of nicotine may indicate that marijuana use may reinforce tobacco use for some part of the population, and the effects of "vaping" may also deserve study in this connection.

Addictiveness: An estimated 9% of those who use marijuana develop a dependence on its use. "In regular cannabis users, abstinence leads to a withdrawal syndrome characterized by negative mood (irritability, anxiety, misery), muscle pain, chills, sleep disturbance, and decreased appetite."[115]

Violence and mortality: Laboratory studies find no link between marijuana use and violence. There are no recorded cases of marijuana use by itself causing cancer or inducing a death, which is remarkable when we consider how many innocuous activities lead to death.[116]

Adolescent use: As with alcohol, nicotine, and other drugs, the potential for developing marijuana dependency is substantially greater when an individual's first exposure occurs during adolescence than in adulthood.

Marijuana is already readily available to a high percentage of young people – high school students are more likely to have tried marijuana than cigarettes,[117] and more than 80% of 12th graders say marijuana is available to them, which has been true consistently since the 1970s.[118] Its illegality has not thwarted this wide availability.

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[114] Iversen, Leslie L., PhD, FRS, "Long-Term Effects of Exposure to Cannabis," *Current Opinion in Pharmacology*, February 2005, (5: 1), p. 71, at http://www.ncbi.nlm.nih.gov/pubmed/15661628.
[115] *Ibid.* Iversen, Leslie L.
[116] Carter, Gregory T.; Earleywine, Mitchell; McGill, Jason T., "Exhibit B: Statement of Grounds," Rulemaking petition to reclassify cannabis for medical use from a Schedule I controlled substance to a Schedule II (Office of Lincoln D. Chafee, Governor Rhode Island and Office of Christine O. Gregoire, Governor of Washington: Letter to Michelle Leonhard, Administrator of the Drug Enforcement Administration, 30 November 2011), p. 38.

[117] QEV Analytics, LTD., "National Survey of American Attitudes on Substance Abuse XVII: Teens," (New York, NY: National Center on Addiction and Substance Abuse at Columbia University, August 2012), p. 30.
[118] University of Michigan, *2014 Monitoring the Future Survey*, at: monitoringthefuture.org/data/14data.html, Figure 6, Marijuana Trends.

Gateway drug?: There is a clear association between the use of marijuana among teenagers and higher use of other illicit drugs. There is also a strong association between use of tobacco and alcohol with use of other drugs, including marijuana. But in the words of one study:

> "The causal significance of this sequence of initiation into drug use remains controversial. The hypothesis that it represents a direct effect of cannabis use upon the use of the later drugs in the sequence is the least compelling. There is better support for two other hypotheses which are not mutually exclusive: that there is a selective recruitment into cannabis use of nonconforming adolescents who have a propensity to use other illicit drugs; and that once recruited to cannabis use, the social interaction with other drug using peers, and exposure to other drugs when purchasing cannabis on the black-market, increases the opportunity to use other illicit drugs."[119]

In other words, where marijuana use is a gateway, it is primarily a gateway to other parts of the illegal or underground market. Taking it out of that market can separate availability of marijuana from illicit drugs. "You don't go to the liquor store and get offered cocaine," noted Mason Tvert at the Drug Reform Task Force hearing in Denver.

Alternatives: Learning from Positive Experiences

As individuals we all have much to learn from other people's experiences, practices, traditions, and innovations, in spiritual as well as material matters. As a nation, too, we benefit from learning what other countries as well as state and local governments within the United States have done in response to drug use, production, and sales. [120] Several examples follow of some promising approaches to drugs.

After a long period as a dictatorship and closed society, Portugal opened its borders in the 1970s, and by the 1980s, had a high rate of heroin use, which in turn led to a high incidence of AIDS. The country's location facilitates its role as a gateway for drug trafficking. When law enforcement was not effective, Portugal in 2001 decriminalized the possession of all drugs and dedicated significant resources to outreach, treatment, and other services. "The big effect of decriminalization was to make it possible to develop all the other policies" of services, according to Joao Goulao, director of treatment programs in Portugal.[121] While interpretation of data has been disputed, a careful comparison of claims and data shows that current and recent use of illicit drugs remained stable in

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[119] Hall, W., Room, R. and Bondy, S., WHO Project on Health Implications of Cannabis Use: A Comparative Appraisal of the Health and Psychological Consequences of Alcohol, Cannabis, Nicotine and Opiate Use, August 28, 1995 (Geneva, Switzerland: World Health Organization, March 1998).

[120] Staff of the Colorado Department of Public Health and Environment, for example, have described lessons learned from the legalization of marijuana in Colorado that should be useful for policy makers in other states. Tista Ghosh, MD, MPH, Mike Van Dyke, PhD, Ali Maffey, MSW, Elizabeth Whitley, RN, PhD, Laura Gillim-Ross, PhD, and Larry Wolk, MD, MSPH, "The Public Health Framework of Legalized Marijuana in Colorado," *American Journal of Public Health* (106), January 2016, pp. 21-27.

[121] Johan Hari, *Chasing the Scream: The First and Last Days of the War on Drugs* (New York: Bloomsbury, 2014), p. 162.

Portugal.[122] The most important health outcomes have been a decline in overdose deaths and HIV and AIDS cases, while the drug user population has aged, indicating fewer people starting to use.[123]

Switzerland, the United Kingdom, and Canada treat some heroin addiction through supplying safe places and supplies of the drug, part of programs to wean addicts from using as well as to reduce collateral crime and harms from heroin use such as theft to supply their habits. In Switzerland, less than 15% of program participants relapsed into daily use after three years, while crimes committed by those in the group fell by more than two thirds. "Some make a virtually complete recovery," according to a researcher of a similar program in Britain, "but others, we get them from a bad place to a less bad place."[124]

Some heroin addicts will inject no matter what it takes, often with devastating health and social consequences. When someone has such a chronic addiction, administering the drug in ideal circumstances minimizes the risk of harm to self and others. In Vancouver, British Columbia, a trial of controlled heroin administration in a clean environment led to improved family relations, employment, and mental health, and to lower use of other drugs compared to patients receiving methadone, according to a study in the *New England Journal of Medicine.*[125]

In Bolivia, indigenous people for millennia have grown and used coca leaves, which they chew as a social connector similar to the way Westerners use tea and coffee, to ward off fatigue, and counter altitude sickness. Coca leaves, which grow only in the Andean region, are also processed with kerosene and other chemicals to make cocaine. When cocaine became a major illicit export product in the 1970s, Bolivia and Peru grew a majority of coca leaves in the world. The United States sponsored programs of forced eradication of coca leaves, which were opposed by organized coca growers, including current president Evo Morales, elected in 2006. Bolivia under Morales temporarily left the United Nations drug convention and re-acceded with a reservation to permit coca growing. The country kicked out the Drug Enforcement Administration in 2008 and established its own drug control strategy, which supports economic development in rural coca-producing areas, and limits coca growing to what will be used for licit products.[126]

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[122] Caitlin Elizabeth Hughes and Alex Stephens, "A resounding success or a disastrous failure: Re-examining the interpretation of evidence on the Portuguese decriminalization of illicit drugs," *Drug and Alcohol Review* (31), January 2012, pp. 101-113.
[123] Caitlin Elizabeth Hughes and Alex Stephens, "What Can We Learn from the Portuguese Decriminalization of Illicit Drugs?" *British Journal of Criminology* (50), 2010, pp. 999-1022.
[124] Gaelle Faure, "Why Doctors Are Giving Heroin to Heroin Addicts," *TIME*, 28 September 2009, at: http://content.time.com/time/health/article/0,8599,1926160,00.html; Gabor Maté, *In the Realm of the Hungry Ghosts*.
[125] E. Oviedo-Joekes, et.al. *NEJM* (361:8),2009, pp. 777-786.
[126] UN Office of Drug Control, "Bolivia to re-accede to UN drug convention, while making exception on coca leaf chewing," January 2013.

Coca cultivation in Bolivia has fallen by 35 percent since 2010, showing that repressive measures are not needed to control crops that can be used to produce narcotics.[127]

These countries have undertaken policy change not only without support from the United States, but with Washington actively discouraging such innovations. In light of the deep, persistent, and varied harms that punitive drug policies have generated worldwide, it is critical that the United States allow other nations – and exercise its considerable influence in the United Nations - to implement approaches that are democratic and responsive to their values and situations.

There is a similar imperative within the United States, where the federal government should encourage states to be flexible and innovative, especially in efforts to remedy racially disparate sentencing, reduce and prevent health harms for drug users, and invest in treatment and other public health programs.[128] [129] [130]

Needle exchange programs are an example of local grassroots initiatives to address health harms from IV drug injection, in which the federal government has lagged behind. Although extensive evidence shows that needle exchange programs have dramatically reduced the incidence of HIV and Hepatitis C among drug users, the federal government bans the use of federal funding for such programs. In areas facing increased heroin use, communities and states must fund their own programs. (When needles are considered drug "paraphernalia," addicts do not carry their own for fear of arrest, and then often share needles in "shooting galleries," spreading infection).

Alternatives for those who sell

If our aim with respect to selling of high-risk drugs is to change behaviors that bring the most harm to communities, then cycling low-level street sellers into and out of prison is often ineffective, and very costly to those individuals, their families, and society. But some focused approaches have had more success. This is how it worked in High Point, North Carolina, where an initiative combined "focused deterrence" with dialogue on racial conflict:

> A particular drug market is identified; violent dealers are arrested; and nonviolent dealers are brought to a "call-in" where they face a roomful of law enforcement officers, social service providers, community figures, ex-offenders and "influentials" — parents, relatives and others with close, important relationships with particular dealers. The drug

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[127] Coletta Youngers and Kathryn Ledebur, *Building on Progress: Bolivia Consolidates Achievements in Reducing Coca and Looks to Reform Decades-Old Drug Law*, (Washington Office on Latin America), August 2015; Tim Rogers, "How Bolivia became a drug war success story – after ousting Uncle Sam," *Fusion*, 19 August 2015, at: http://fusion.net/story/185398/how-bolivia-became-a-drug-war-success-story-after-ousting-uncle-sam/.

[128] American Public Health Association Policy Statement Number 8817. A Public Health Response to the War on Drugs: Reducing Alcohol, Tobacco and Other Drug Problems Among the Nation's Youth. Adopted January, 1988.

[129] American Public Health Association Policy Statement Number 201312. Defining and Implementing a Public Health Response to Drug Use and Misuse. Adopted November 2013.

[130] American Public Health Association Policy Statement Number 201410. Regulating Commercially Legalized Marijuana as a Public Health Priority. Adopted November 2014.

> dealers are told that (1) they are valuable to the community, and (2) the dealing must stop. They are offered social services. They are informed that local law enforcement has worked up cases on them, but that these cases will be "banked" (temporarily suspended). Then they are given an ultimatum: If you continue to deal, the banked cases against you will be activated.[131]

This strategy focused on open-air drug markets, which brought with them activities that the community found especially harmful, such as shootings. It was built on programs to address gun violence and other violent crimes. And its success required blunt conversations about race and power between the community and law enforcement, in order to work together for the focused objective. After four years of this model, violent crime declined an average of 39% and drug crime dropped by 30%.[132] Comparable impacts were documented after a similar intervention in Providence, RI.[133]

For such a model to function over time and to actually turn around the lives of dealers, it is critical that people selling on the street have adequate legal employment options, education, and services. In San Francisco, the city's district attorney established the "Back on Track" program that offers alternatives to criminal prosecution to young adults (ages 18 to 30) who are arrested for a first felony of a low-level drug sale. Candidates participate in an intensive community service program, appear in a special court three times a month, and must enroll in school and find employment, often with participating employer Goodwill Industries. Upon completion of the program, charges are dismissed. While incarcerating such low-level offenders costs $50,000 a year, this program costs just one tenth of that for each participant.[134]

Drug courts

Drugs courts in the U.S. have been an alternative outcome for persons arrested for drug offences. The purpose of these specialized courts is to offer treatment options to drug-dependent people in order to reduce substance abuse and reduce crime. Begun in 1989, there are now more than 2,700 such courts in the U.S.[135] Drug courts operate in a variety of ways to divert persons arrested for drug, alcohol, and related offenses from incarceration to treatment and social programs, typically resorting to incarceration if the arrested persons decline or fail in treatment.[136] They can also function for persons who commit non-drug crimes where it is credibly claimed they did so as a result of drug use.

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131 David Kennedy, "Drugs, Race and Common Ground: Reflections on the High Point Intervention," *NIJ Journal* (March 2009), No. 262, pp. 12-17.
132 *Ibid.*
133 David M. Kennedy and Sue-Lin Wong, *The High Point Drug Market Intervention Strategy*, National Network for Safe Communities, 2012, pp. 33-41.
134 Jacquelyn Rivers and Lenore Anderson, *Back on Track: A Problem-Solving Reentry Court*, U.S. Department of Justice, Bureau of Justice Assistance, September 2009.
135 National Association of Drug Court Professionals: nadcp.org/learn/what-are-drug-courts/types-drug-courts.
136 Justice Policy Institute, *Addicted to Courts: How a Growing Dependence on Drug Courts Impacts People and Communities*, March 2011, accessed at: justicepolicy.org/uploads/justicepolicy/documents/addicted_to_courts_final.pdf.

While there are diverse views about the efficacy and ethics of involuntary treatment for addicted persons, meta-analyses of drug court evaluations conclude there is evidence that this alternative strategy reduces criminal recidivism and substance abuse.[vii] The evaluative findings also indicate drug courts can be a cost-effective alternative.[viii] Important as well for the mission of our church, drug courts can call upon high quality performance from faith-based organizations that are called to minister to persons struggling to end their drug addiction.

There are several important issues, however, that should be understood regarding drug policy reform and the use of drug courts:

- In some jurisdictions people who are not drug dependent and do not need treatment are arrested for possession of a drug and have their cases placed into drug courts. The rehabiliative purpose and effort of a drug court in these cases is inappropriate.
- By using drug courts as an alternative strategy, the preference for not arresting people for personal drug consumption confronts the imperative of providing publicly-funded treatment to persons with addictions and preventing crime. A strategy that de-criminalizes or establishes legal regulation (such as tickets or fines) of certain types of personal drug possession and use could unclog both the courts and the jails.
- A hybrid reform strategy is possible that combines legal regulation for low risk substances such as marijuana and drug court use targeted to persons who are addicted to or commit crimes related to drugs that remain illegal.
- At times prosecutors do not cooperate with judicial officers. When this conflict occurs, it often undermines the drug court's purpose of offering treatment options to drug-dependent people coming into the judicial system.

Based on the information provided to the Task Force and analysis of the information through the lens of Christian faith, principles to guide the PC(USA) response to drug use, addiction and drug policy were developed and presented at the beginning of this report. Congruent with these "Principles for Building a House of Health" are specific recommendations which are also listed in the front section of the report.

Acknowledgements
We are deeply grateful to all those who collaborated and gave of their time for the Drug Policy Task Force's hearings and meetings. We were graciously hosted by Sojourner Truth Presbyterian Church in Richmond, California; the Denver Presbytery in Denver, Colorado; Grace Presbyterian Church and Annunciation House in El Paso, Texas; and First Presbyterian Church, Bream Memorial Church and Presbytery of West Virginia in Charleston, West Virginia. For reasons of economy, each meeting was preceded by a hearing in the same location.

Dozens of people generously gave deeply informed and meaningful testimony to the Task Force. They are listed in Appendix B.

Appendix A Task Force members

Rev. Gordon Edwards, Chair; Acting General Presbyter, Cimarron Presbytery; former pastor, Stillwater, OK; member of Drug Court panels.
Rev. Barrett Lee, Pastor, substance abuse counselor, Kalamazoo, MI
Hon. James Rowe, Esq. Judge in Charleston, WVA.
Deborah Small, Esq. Director, Break the Chains (education and advocacy), Richmond, CA.
Matt Stafford, MSW, Substance abuse social worker, Austin, TX.
Gail Tyree (through May 2015); Organizer, Planned Parenthood; Memphis, TN. (Also active in the Presbyterian Criminal Justice Network)
Consultant: John Lindsay-Poland, Oakland, CA, Wage Peace Coordinator, American Friends Service Committee
Advisor: Dr. J. Bryan Page, Professor of Anthropology, University of Miami, Coral Gables, FL.
Liaison to the Advisory Committee: Dr. Jean Demmler, sociologist, Denver, CO.
Staff: Rev. Chris Iosso, Ph.D. Coordinator, Advisory Committee on Social Witness Policy, Louisville, KY

Appendix B
List of those who gave testimony to the Drug Policy Task Force

Richmond, California
James Anthony, Law Enforcement Against Prohibition
Dr. Davida Coady, Options Recovery
Rev. Kamal Hassan, Sojourner Truth Presbyterian Church
Raha Jorjani, Alameda Public Defender's Office
Marilyn Langlois, Richmond Planning Commission
Ted Lewis, Global Exchange
Rev. Max Lynn, St. Johns Presbyterian Church
Eduardo Martinez, Richmond City Council
David McPhail, St. Johns Presbyterian Church
Dorsey Nunn, Legal Services for Children
Robert Rooks, Californians for Safety and Justice
Andrés Soto, Richmond Progressive Alliance
Laura Thomas, Drug Policy Alliance
Sam Vaughn, Office of Neighborhood Safety
Tamisha Walker, Safe Return Project

El Paso, Texas / Ciudad Juárez, Chihuahua, Mexico
Susie Byrd, El Paso school trustee
Judge Patrick M. Garcia, 384th District Court
Guillermo Ceballos, Jay Nye, Mike Alvarado, El Paso Drug Court counselors
Omar Sanchez, probation officer
Rubén García, Annunciation House
Gilberto González, Texas Narcotics Officers Association
Alfredo Holguín, Mexicanos en Exilio
Mark Lusk, University of Texas at El Paso

Oscar Martínez, University of Arizona
Roger Martinez, Chief Juvenile Probation Officer
Zulma Méndez, University of Ciudad Juarez
Richard Newton, Law Enforcement Against Prohibition
Marisela Reyes, victim of political violence from Juarez Valley
Jeremy Slack, University of Texas at El Paso
Kathy Staudt, University of Texas at El Paso
Kelly Wells, Diocesan Migrant and Refugee Services
Dr. Leticia Chavarría, Ciudad Juarez Security Roundtable
Maria Elena Ramos Rodríguez, Maria Luisa González, Programa Compañeros, Ciudad Juárez
Veronica Corchado, Juárez Strategic Plan
Emilia Gonzalez, Commission for Solidarity and Defense of Human Rights
Rebecca Alarcon, Hector Raul Ríos, Jorge Eduardo Ramirez, Gustavo Martinez Medina, Catarina Cantillo Castañeda, Organización Popular Independiente (Independent Grassroots Organization)

Denver, Colorado
Roger Goodman, Washington State Representative (by phone)
Lewis Koski, Marijuana Enforcement Division, State of Colorado
Dr. Christian Thurstone, Smart Approaches to Marijuana
Mason Tvert, Marijuana Policy Project
Art Way, Drug Policy Alliance
Dr. Kathryn Wells, Children's Hospital Denver

Charleston, West Virginia
Darryl Cannady, South Central Educational Development (Bluefield, WV)
Andrea Darr, West Virginia Center for Children's Justice
Dr. Dan Foster
Bob Hansen, Recovery Point of Huntington
Rev. Dr. Linda Mercadante, Methodist Theological School, Ohio
Lt. Chad Napier, Kanawha Valley Metro Drug Unit
Dr. Robert Newman, President Emeritus, Beth Israel Medical Center (New York)
Prof. J. Bryan Page, University of Miami (Florida)
Robert Wilkinson, Chief Public Defender, Huntington
Michael Mills, West Virginia Bureau for Public Health

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[i] Clearly there are societies with a zero tolerance approach to drugs and official alcohol bans, with drug traffickers subject to capital punishment. Malaysia, Iran, and China, are among those nations with strict controls over drug use and other areas of life. Even in these societies, some drug use is reported, however draconian the punishments. In the US context, the danger is more that legal and illegal business combinations form to dominate markets, controlling supply and price, and potentially influencing law enforcement.

[ii] The Ohio vote against marijuana legalization in 2015 was related partly to the role of self-interested businesses: https://www.washingtonpost.com/news/wonk/wp/2015/11/03/ohio-rejected-legalizing-marijuana-what-that-means-for-the-future-of-pot/

[iii] There are many accounts of the three uses of the law, among them Calvin's in the *Instruction in Faith* (Louisville: Westminster/JohnKnox, 1992, re-issue of Fuhrmann translation with Leith forward) especially chapter 17's discussion of sanctification and the law being written on the heart, and in the answers to questions 93-97 in the Westminster Larger Catechism.

[iv] For the full sermon: http://justiceunbound.org/carousel/a-biblical-and-theological-reflection-on-consumption-addiction-and-prejudicial-drug-policy/

[v] As in the church at large, members differed on how complete a transition away from the "prohibition" model should be, how closely it links to a punitive approach, how much the team should consider addiction as well as its primary focus on the "drug war," and how these differences are affected by participation in a denomination which is 90% White, disproportionately affluent[v], and largely separated from poor communities of color that are adversely and disproportionately impacted by drug policies.

[vi] This study does not deny health threats from all drugs, though it notes the history of how dangers have been magnified for reasons of prejudice and profit. An overview of marijuana science can be found here: http://www.nytimes.com/2014/07/31/opinion/what-science-says-about-marijuana.html?opinion-series More negative views, generally with limited data samples, can be found through these links: http://www.currentpsychiatry.com/view-pdf.html?file=fileadmin/cp_archive/pdf/0602/0602CP_Article2, http://www.medscape.com/viewarticle/766633, http://www.psych.ox.ac.uk/publications/139772, http://www.bmj.com/content/342/bmj.d738.

[vii] For a review of drug court data from 2004-2011, see study the Government Accounting Office performed for the Department of Justice: http://www.gao.gov/assets/590/586794.html For adults, recidivism was generally lowered, but for juvenile drug courts, there were less clear outcomes. Low recidivism is one measurement of success, although low incarceration rates could also be a measure.

[viii] http://www.courtinnovation.org/sites/default/files/documents/Assessing_Efectiveness.pdf A different perspective is more critical: https://www.drugpolicy.org/docUploads/Drug_Courts_Are_Not_the_Answer_Final2.pdf

The Study Guide and the Response Form are separate documents also available from acswp@pcusa.org, or The Advisory Committee on Social Witness Policy (ACSWP) at (502) 569-5827