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The Agony of Ecstasy: Reconsidering the Punitive Approach to United States Drug Policy

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THE AGONY OF ECSTASY: RECONSIDERING THE PUNITIVE APPROACH TO UNITED STATES DRUG POLICY

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INTRODUCTION

> *People think they can stop the drug traffic by putting people in jail and by having terribly long sentences. But, of course, it doesn't do any good.*[1]
>
> —Judge Whitman Knapp

In the past few years, legislators and judges have become more vocal in their opposition to the "war on drugs"[2] in the United States.[3] However, challenging punitive drug laws is politically diffi-

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1. JAMES P. GRAY, WHY OUR DRUG LAWS HAVE FAILED AND WHAT WE CAN DO ABOUT IT: A JUDICIAL INDICTMENT OF THE WAR ON DRUGS 19 (2001) (quoting Senior Judge Whitman Knapp, United States District Court, Southern District of New York).

2. DAVID SADOFSKY BAGGINS, DRUG HATE AND THE CORRUPTION OF AMERICAN JUSTICE 98-99 (1998) (stating that former President George Bush's Drug Czar, Bob Martinez, declared that the drug war was about stomping out the wrong culture because "drug use is wrong. And the moral argument in the end is the most compelling argument."); ERICH GOODE, *Preface, in* BETWEEN POLITICS AND REASON: THE DRUG LEGALIZATION DEBATE viii (Erich Goode ed., 1997) ("Since 1981, with the administration of President Ronald Reagan, the United States has been waging a 'War on Drugs.'"); GRAY, *supra* note 1, at 27 ("Richard M. Nixon [was] the first U.S. president formally to declare the nation's 'War on Drugs.'"); Mary Thornton, *Administration Attack on Drug's Criticized by DEA Directory*, WASH. POST, May 15, 1984, at A13 (stating that the Reagan administration tried to "wage a war on drugs"). The "war on drugs" describes the United States' drug policy of the past three decades. *Frontline Teachers' Guide – Drug Wars at* http://www.pbs.org/wgbh/pages/frontline/teach/american/drugs (last visited Apr. 25, 2002). It began with Former President Nixon's declaration that illegal drug consumption is public enemy number one, and that an all out war on drugs was necessary. *Id.* After his declaration, the federal government applied a new zeal to the four components of this war: (1) treatment; (2) law enforcement; (3) eradication; and (4) interdiction. President Nixon also established the Drug Enforcement Agency. *Id.*

3. *E.g.*, GRAY, *supra* note 1, at 1 ("I had seen that our drug laws were a failure, and I simply could not keep quiet about it any longer."); Arianna Huffington, *The*

cult; the challenger risks being perceived by the public as someone "weak on crime" who "condones drug use."[4] Tom Campbell, a congressman from California, commented on this phenomenon: "The most common reaction I get from my colleagues is 'You're absolutely right, but, boy, I'm not going to take that risk.'"[5] While the public is decreasingly supportive of punitive laws,[6] many still cling to the belief that such laws will reduce drug use because of fear—fear that drug use among children will increase and that less stringent drug laws will lead to moral decline and empower minority groups.[7]

War On Drugs: Just Say 'No More,' ARIANNA ON LINE, June 1, 2000, *at http://www.ariannaonline.com/columns/files/060100.html* (last visited Apr. 25, 2002) (stating that Representative Jan Schakowsky (D-IL) said, "There is a growing acknowledgment that the drug war hasn't worked," and that Representative Ron Paul (R-TX) declared, "The war on drugs is a total failure. It does more harm than good").

4. *See* GRAY, *supra* note 1, at 28 (stating that our political system rewards politicians who posture as being "tough on drugs"); Nicholas Katzenbach, *Drug Policy and the Rule of Law*, 28 FORDHAM URB. L.J. 172, 173 (2000) ("[T]o a surprising degree, politicians have acted as though . . . the answer to our fear is simply to be 'tough.' Any politician who is viewed as 'soft' on crime is likely to be in trouble."); Andrew Friedman, *A New Day*, VILLAGE VOICE, Nov. 8, 2000, at 59 ("Afraid of being labeled weak on crime, many politicians have been reluctant to push for relaxing the Rockefeller code.").

5. Huffington, *supra* note 3.

6. *Drug War Report*, (The Pew Research Ctr. for the People and the Press, Washington, D.C.), Mar. 21, 2001, *at* http://208.240.91.18/drugs01rpt.htm (last visited May 3, 2002) (noting that in a national opinion poll, seventy-four percent of Americans see the War on Drugs as a losing cause, and fifty-two percent believe that drug use should be treated as a disease).

7. GRAY, *supra* note 1, at 6 (explaining that drug use has been treated as a moral issue in the United States for several decades, and this is why people resist awareness of the damages caused by drug policy itself); DAVID MUSTO, THE AMERICAN DISEASE 294-95 (Oxford University Press, 1999) (1973) (stating that the strongest support for drug prohibition has been associated with fear of a given drug's effect on a minority group as demonstrated by the prohibition of cocaine for fear that it would enable blacks to withstand bullets, the prohibition of opium for fear that it would stimulate sexual contact between Chinese and white Americans, and the prohibition of alcohol for fear that it would encourage immigrants to crowd into large cities); Timothy Lynch, *War No More*, NAT'L REV., Feb. 5, 2001, at 4041 (stating that supporters of the drug war defend their position by claiming that "Drug use is wrong. It is wrong because it is immoral, and it is immoral because it degrades human beings"); Eileen Smith, *Drugs Top Adult Fears for Kids' Well-Being*, USA TODAY, Dec. 9, 1997, at D1 (citing a study conducted by Harvard's School of Public Health and the University of Maryland Survey Research Center showing that Americans believe drug abuse, more than crime or the breakdown of home life, is the biggest danger facing children).

United States drug laws implicate complex matters such as race,[8] gender,[9] class, the national budget,[10] prison overcrowding,[11] civil liberties,[12] and the spread of diseases such as HIV/AIDS and hepatitis.[13] In fact, efforts to reduce drug use may cause more harm than the drugs themselves.[14] For example, increased funding for enforcement of criminal drug laws couple with escalating criminal sentences has led to a rise in drug related convictions and a significant need for prison beds; the war on drugs has created and supported a prison-industrial complex that costs taxpayers over $24 billion per year.[15] Enforcement is often directed at racial minori-

8. Five times as many white people use drugs as black people, yet the majority of drug offenders sent to prison are black. Human Rights Watch, *Racial Disparities in the War on Drugs*, 2000, *at* http://www.hrw.org/campaigns/drugs/war/key-facts.htm (last visited Apr. 25, 2002). Nationwide, one in every twenty black men over the age of eighteen is in prison, as compared to one in every 180 white men. *Id.*

9. From 1986 (the year mandatory sentencing was enacted) to 1996, the number of women sentenced to state prison for drug crimes increased tenfold. *Not Part of My Sentence: Violations of the Human Rights of Women in Custody* (Amnesty Int'l), Mar. 1999, at 39, *at* http://www.amnesty-usa.org/rightsforall/women/ (last visited Apr. 25, 2002). In 1997, a U.S. Justice Department investigation of women's prisons concluded that authorities failed to protect women from sexual misconduct by correctional officers and other staff. *Id.* From 1986 (the year mandatory sentencing was enacted) to 1996, the number of women sentenced to state prison for drug crimes increased tenfold. *Id.*

10. In 1999, the U.S. spent a record $147 billion for police protection, corrections, and judicial and legal activities. This expenditure increased 309% from almost $36 billion in 1982. Discounting inflation, that represents a 145% increase in constant dollars. SIDRA LEA GIFFORD, U.S. DEP'T OF JUSTICE, JUSTICE EXPENDITURE AND EMPLOYMENT IN THE UNITED STATES 1 (1999).

11. The overall U.S. incarceration rate is six times that of its nearest Western counterparts. ELLIOT CURRIE, CRIME AND PUNISHMENT IN AMERICA 61 (1998).

12. A Lexis review of federal court decisions between January 1, 1990 and August 2, 1995, in which drug-courier profiles were used and the race of the suspect was discernible, revealed that of sixty-three such cases, all but three suspects were minorities: thirty-four were black, twenty-five were Hispanic, one was Asian, and three were white. DAVID COLE, NO EQUAL JUSTICE: RACE AND CLASS IN THE AMERICAN CRIMINAL JUSTICE SYSTEM 50 (1999).

13. In 1998, HIV infection became the fifth leading cause of death among persons aged twenty-five to forty-four years. SHERRY L. MURPHY, CTRS. FOR DISEASE CONTROL, DEATHS: FINAL DATA FOR 1998 26 tbl. 8 (2000).

14. Ethan Nadelmann, *Learning to Live With Drugs*, WASH. POST, Nov. 2, 1999, at A21 (stating that many "drug problems" are the results, not of drug use, but of prohibitionist policies: "the violence, the corruption, the vast underground markets, the diversion of ever increasing resources to criminal justice and military agencies, the environmental harms of crop eradication programs and unregulated illicit crop production, the enrichment and empowerment of organized and unorganized criminals, and so much more").

15. *See* PHILLIP BEATTY, BARRY HOLMAN, & VINCENT SCHIRALDI, JUSTICE POLICY INST., POOR PRESCRIPTION: THE COSTS OF IMPRISONING DRUG OFFENDERS IN THE UNITED STATES 2 (2000), *available at* http://www.cjcj.org (estimating that Americans would spend $24 billion to incarcerate non-violent offenders in 2001; the total

ties and lower class communities; civil liberties are sacrificed in cases of racial profiling, illegal searches, and excessive wiretapping.[16] The direct financial cost of the war on drugs is in the billions, with most of the national budget allocated for enforcement.[17] The additional indirect costs are unknown. Yet needle exchange programs aimed at reducing harm by slowing the spread of HIV/AIDS[18] go without funding and often without legal authority to operate.[19] These are merely a few examples of the collateral consequences of the drug war.

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cost spent on incarceration was estimated at $40 billion); Fox Butterfield, *Number of Inmates Reaches Record 1.8 Million*, N.Y. TIMES, Mar. 15, 1999, at A14 (demonstrating the high cost of the increase in prison population that is attributable to an increasing number of drug convictions for longer sentences); Eric Schlosser, *The Prison–Industrial Complex*, THE ATLANTIC, Dec. 1998, at 51 (defining "prison-industrial complex" as "a set of bureaucratic, political, and economic interests that encourage increased spending on imprisonment, regardless of the actual need").

16. GRAY, *supra* note 1, at 97 ("[I]t is widely understood by attorneys and legal commentators that there is a 'drugs exception' to the Bill of Rights."); Ronald J. Ostrow, *Sentencing Study Sees Race Disparity*, L.A. TIMES, Oct. 5, 1995, at A1 (discussing the Sentencing Project's study claiming that public policies ostensibly designed to control crime and drug abuse have contributed to racial disparity in the criminal justice system).

17. *See* OFFICE OF NAT'L DRUG CONTROL POLICY, NATIONAL DRUG CONTROL BUDGET: EXECUTIVE SUMMARY, FISCAL YEAR 2002 (2002) ("In total, funding recommended for FY 2002 is an estimated $19.2 billion, an increase of $1.1 billion over the FY 2001 enacted level of $18.1 billion."). Sixty-seven percent of the drug control budget is spent on supply reduction efforts to reduce the supply and availability of illicit drugs by limiting cultivation, production, trafficking and distribution. RENSSELAER LEE & RAPHAEL PERL, CRS ISSUE BRIEF: DRUG CONTROL: INTERNATIONAL POLICY OPTIONS 2 (2002). In contrast, thirty-three percent is spent on demand reduction efforts to prevent the onset of drug use, help drug users break the habit, and provide treatment through rehabilitation and social reintegration. BUREAU OF WESTERN HEMISPHERE AFFAIRS, UNITED STATES SUPPORT FOR COLUMBIA 1 (2000). The imbalance is even more apparent at the state and local levels, where an estimated eighty percent of spending is devoted to enforcement. DRUG STRATEGIES, CRITICAL CHOICES: MAKING DRUG POLICY AT THE STATE LEVEL 1 (2001).

18. Anne Barnard, *Saving the Sinner from Condoms for Teens to Needles for Addicts, Doctors Try to Lead a Divided Public*, BOSTON GLOBE, Feb. 13, 2001, at E1 ("The American Medical Association, the Centers for Disease Control and Prevention and the Institute of Medicine all endorse needle exchange—when combined with efforts to get people into treatment saying it reduces HIV infections without increasing drug use."); *Syringe Exchange Programs*, IDU/HIV PREVENTION (Academy for Educational Development, Washington, D.C.), June 2000, at 1 (stating that syringe exchange is most cost-effective means of prevention of AIDS).

19. Sandra D. Lane, *The Coming of Age of Needle Exchange: A History Through 1993*, *in* HARM REDUCTION: NATIONAL AND INTERNATIONAL PERSPECTIVES 47, 59-63 (James A. Inciardi & Lana D. Harrison eds., 2000) (discussing the difficulty needle exchange programs meet in securing legal authority to operate due to paraphernalia laws, prescription laws, drug-free zone laws, and the lack of funding for such programs).

An objective cost/benefit analysis of the current drug policy is difficult to ascertain. In 1999, Americans spent an estimated $63.2 billion on illicit drugs.[20] Most of that spending was by hard-core addicts,[21] a group that makes up less than one-quarter of the drug users in this country, but consumes over two-thirds of the illegal drugs.[22] Given that drugs are less expensive and more widely available than ever before,[23] and that punitive drug laws have increasingly negative social consequences,[24] finding advantages of the current approach is a challenge. One commentator believes the important question about any drug control program is whether it "contribute[s] materially to the reduction of drug use and drug-related harms."[25] Whether there is a "material" difference depends on whether "the effect is sizeable and, in particular, whether it is sizeable compared to the costs."[26]

Examining the effects of United States drug policy under this rubric may prove frustrating. For example, more drug convictions could mean a reduction in the number of drug dealers and addicts, but could also mean that more people are using and selling drugs. Fewer drug-related emergency room visits could mean that fewer people are getting sick from using drugs. It could also indicate that fewer people are seeking treatment for drug-related illnesses. Less marijuana use among teenagers than in the past could mean that they are using fewer drugs in general, or it could simply mean they

20. *Frontline, Drug Wars: The Buyers*, *at* http://www.pbs.org/wgbh/pages/frontline/shows/drugs/buyers/whoare.html (last visited Apr. 25, 2002).

21. A hard core addict is commonly understood as a person who uses large quantities of drugs, who is addicted to the point that drug use interferes with the rest of his or her life, and who compulsively uses drugs in the face of tremendous consequences. Interview of Dr. Alan I. Leshner, Director, National Institute on Drug Abuse (Oct. 10, 2000), *at* http://www.mapinc.org/drugnews/v00/n1548/a05.html (last visited Feb. 1, 2002).

22. Frontline, *supra* note 20, *at* http://www.pbs.org/wgbh/pages/frontline/shows/drugs/buyers/whoare.html (last visited Apr. 25, 2002) (reporting that heavy users of cocaine consume seventy percent of all cocaine reported in the NHSDA, and hard core heroin users account for an even larger percentage of heroin sales).

23. *See generally* Judge Rudolph J. Gerber, *On Dispensing Injustice*, 43 ARIZ. L. REV. 135, 155 (2001) ("In 1997, General McCaffrey candidly admitted that 'if measured solely in terms of price and purity, cocaine, heroin, and marijuana prove to be more available than they were a decade ago.'").

24. Nadelmann, *supra* note 14, at A21.

25. JONATHAN P. CAULKINS, DO DRUG PROHIBITION AND ENFORCEMENT WORK? 1 (2000). The intense focus paid to drug-related harms is surprising, given that the Government allows people to harm themselves in many ways without interference. In fact, overeating and lack of exercise kills more people and disables far more people than all illegal drugs. James Ostrowski, *Thinking About Drug Legalization*, POLICY ANALYSIS (the Cato Institute, Washington, D.C.), May 25, 1989, at 71.

26. CAULKINS, *supra* note 25.

are using more of other drugs. Even if the number of drug users were known, that knowledge might not prove an effective measure of the success of drug policy.[27] The effects of the drug war remain open to interpretation, providing fuel for the politics of the debate. Yet, as the drug war enters its thirtieth year,[28] public sentiment is migrating toward frustration and disapproval of the present system; many people claim that the war on drugs has simply failed.[29]

Solutions are proffered by proponents of two traditionally opposed ideologies. On one side of the debate are prohibitionists, those advocating a punitive approach through the criminal justice system, believing that tougher laws will deter new drug dealers and users while removing current ones from society.[30] Their opponents are those advocating harm reduction,[31] who believe that education, prevention, and treatment reduce the harm caused by drug use—harm, that is, to some extent, inevitable.[32] Although legislators have traditionally been on opposing sides of the debate, preserving this dichotomy may no longer be a viable option. A relatively new

27. Peter Reuter, *Drug Use Measures: What Are They Telling Us?*, NAT'L INST. OF JUSTICE J., Apr. 1999, at 12 (asserting that the prevalence of drug abuse cannot be measured by the number of people simply using drugs).

28. GRAY, *supra* note 1, at 27 (noting that Richard Nixon first declared that the nation was engaged in a "War on Drugs" in 1969).

29. Larry D. Hatfield, *Drug War Approach Seen as Utter Failure/Survey Finds Public Favors Treatment*, S.F. CHRON., Mar. 21, 2001, at A1 (discussing results of a study conducted by the Pew Research Center for the People and the Press showing that three-fourths of Americans think the war on drugs is being lost; they also believe, however, that the government should still give top priority to arresting drug dealers and stopping the importation of drugs).

30. The "criminal justice" approach is also known as the "punitive approach" or "prohibition." Richard C. Boldt, *Rehabilitative Punishment and the Drug Treatment Court Movement*, 76 WASH. U. L.Q. 1205, 1217-18 (1998); Christopher Mascharka, *Mandatory Minimum Sentence: Exemplifying the Law of Unintended Consequences*, 28 FLA. ST. U. L. REV. 935, 968 (2001), Norval Morris, *Teenage Violence and Drug Use*, 31 VAL. U. L. REV. 547, 547 (1997). Many refer to advocates of this approach as "drug warriors" because of their endorsement of, and participation in, the war on drugs. *See, e.g.*, Sue Anne Pressley, *Jeb Bush Urged To Reconsider Drug Law View*, WASH. POST, Feb. 1, 2002, at A6. Throughout this Comment, "prohibitionist" and "advocate of the criminal justice approach" will be used interchangeably to refer to a person endorsing the belief that the best approach to drug use is attempting to eradicate it by setting strict penalties and providing the resources to enforce those penalties.

31. James A. Inciardi & Lana D. Harrison, *Introduction: The Concept of Harm Reduction*, *in* HARM REDUCTION: NATIONAL AND INTERNATIONAL PERSPECTIVES, *supra* note 19, at vii-viii (defining harm reduction as a variety of programs and policies that focus on reducing the consequences of psychoactive drug use).

32. *See* Ethan A. Nadelmann & Jann S. Wenner, *Toward a Sane National Drug Policy*, ROLLING STONE, May 5, 1994, at 24-26 (stating that drug use has been a part of civilization since its inception).

drug that has been gaining popularity among American teenagers demonstrates the impracticality of maintaining this policy divide.[33]

Ecstasy[34] is a psychoactive drug[35] that has both harm reduction advocates and prohibitionists scrambling for a better solution. Ecstasy topped the Government's list of substances "increasing sharply" in 2001.[36] Ecstasy-related emergency room visits increased fifty-eight percent from 1999 to 2000.[37] Most recently, in July 2001, New York police confiscated one million Ecstasy pills in what is reported to be the single largest ecstasy seizure in history.[38]

More alarming than Ecstasy's recent rise in popularity is that it has been classified in the Controlled Substance Act's most restrictive category for over fifteen years.[39] Both state and federal penalties for possession, manufacture, and distribution of the drug have been increasing over the past ten years.[40] Public perception of Ec-

33. The subject matter of this Comment is Ecstasy, but many of the arguments contained herein can be made about other drugs. In many respects this paper is about the drug war.

34. "Ecstasy" is the commonly used street name for 3, 4 Methylenedioxymethamphetamine ("MDMA"). Julie Holland, *Let X-MDMA, in* ECSTASY: A COMPLETE GUIDE 7, 8 (Julie Holland ed., 2001). Throughout this Comment, I will primarily refer to this substance as "Ecstasy" for clarity, even though the term "Ecstasy" often refers to a group of unknown drugs, or to MDMA that has been mixed with other substances. Julie Holland, *Giving MDMA to Human Volunteers in the United States, in* ECSTASY: A COMPLETE GUIDE, *supra*, at 332.

35. A psychoactive drug is one that "has a significant effect on mood or mental state." RANDOM HOUSE WEBSTER'S COLLEGE DICTIONARY 1089 (Random House 1995) (1991).

36. Marsha Rosenbaum, *Telling Our Children What We Know About Ecstasy*, SAN DIEGO UNION-TRIB., Aug. 9, 2001, at B11 (citing NAT'L INST. ON DRUG ABUSE, DEP'T OF HEALTH & HUMAN SERVS., MONITORING THE FUTURE NAT'L RESULTS ON ADOLESCENT DRUG USE: OVERVIEW OF KEY FINDINGS 3 (2001)).

37. *Id.*

38. *Id.*

39. Controlled Substances Act, 21 U.S.C. §§ 801-971 (1996). Temporary Placement of 3, 4-Methylenedioxymethamphetamine (MDMA) Into Schedule I, 53 Fed. Reg. 40061-01 (Oct. 13, 1988). Schedules of Controlled Substances; Scheduling of 3, 4-Methylenedioxymethamphetamine (MDMA) Into Schedule I of the Controlled Substances Act, 51 Fed. Reg. 36552-01 (Oct. 14, 1986) [hereinafter Final Scheduling Rule].

40. U.S. SENTENCING COMM'N, REPORT TO THE CONGRESS: MDMA DRUG OFFENSES: EXPLANATION OF RECENT GUIDELINE AMENDMENTS 6 (2001) (effecting amendment of the Federal Sentencing Guidelines to allow for increased penalties for the possession, manufacture, and trafficking of Ecstasy). In the past ten to fifteen years, Ecstasy has been either explicitly scheduled (categorized in the penal code) in all fifty states, or charged under the states' controlled substance analogue provisions. *See* The Alchemind Society, The Drug Law Library: MDMA Law & Policy, *at* http://www.alchemind.org/DLL/mdmaindex.htm (last visited Apr. 24, 2002). A controlled substance analogue is a substance intended for human consumption that is substantially similar to or is represented as being similar to a Schedule I or Schedule II sub-

stasy's effects varies greatly; some people believe that Ecstasy is a "safe" drug, unlike heroine or cocaine,[41] while others claim that Ecstasy causes brain damage.[42] Driven by fear of health and social consequences, and not believing that other viable solutions exist, lawmakers have attempted to stem Ecstasy use by enacting stricter legal penalties.[43]

The legal quandary is compounded by scientific confusion. Little is actually known about the long-term physical and mental effects of Ecstasy use.[44] Administrative barriers and skepticism about use on human subjects has, until recently, thwarted attempts to conduct private research on humans.[45] Government-sanctioned research on the effects of Ecstasy has been challenged as being neither credible nor thorough.[46] The lack of a neutral, reliable, and comprehensive understanding of Ecstasy's effects has not only affected the decisions of lawmakers, but has contributed to distrust among teenagers of public information campaigns about Ecstasy and other drugs.[47]

This lack of conclusive knowledge of Ecstasy's effects and the increase in use among teenagers has led lawmakers to establish

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stance and is not an approved medication in the United States. 21 U.S.C. § 802(32)(a) (2001).

41. The Alchemind Society, *supra* note 40, at 1.

42. *Id.*

43. *E.g.*, The Ecstasy Anti-Proliferation Act of 2000, Pub. L. No. 106-310, 114 Stat. 1101 (codified as part of the Children's Health Act of 2000, 42 U.S.C. § 290aa-5b (2000)) (explaining in its findings that stricter penalties are needed to counter the growing use and trafficking of Ecstasy).

44. Charles S. Grob, *Deconstructing Ecstasy: The Politics of MDMA Research*, 8 ADDICTION RES. 550, 550 (2000) (discussing the lack of conclusive scientific research on the effects of Ecstasy use).

45. *Id.* at 560. In November 2001, the University of California earned FDA approval to conduct a study wherein twelve people would be given Ecstasy during therapy for posttraumatic stress disorder while eight other people would be given a placebo. Christopher Newton, *FDA Approves Clinical Test*, ASSOCIATED PRESS, Nov. 6, 2001, *at* 2001 WL 29791505. Each person will also undergo sixteen hours of therapy without drugs. *Id.* This is the first human study of Ecstasy's use as a potential aid in treating posttraumatic stress disorder since the drug was made illegal in 1985. *Id.*

46. U.S. SENTENCING COMM'N, *supra* note 40, at 8 n.15 (stating that studies done by George Ricuarte, M.D., one of the biggest contributors to government research on Ecstasy, have been severely criticized by professionals).

47. Rosenbaum, *supra* note 36, at B11 ("This generation of DARE [Drug Abuse Resistance Education] graduates has heard such warnings about a variety of drugs, including Ecstasy, since they were in grade school. Because the messages are inconsistent with their observations and experiences, they feel duped and simply tune them out.").

stricter criminal penalties for Ecstasy use.[48] Their hope is that increasing penalties will "send the message" that Ecstasy should be avoided.[49] Harm reduction advocates argue that knowledge of a drug's effects should precede the establishment of criminal sanctions, and that research which could yield this knowledge should not be prevented by these laws.[50] Harm reduction advocates also promote methods of preventing many of Ecstasy's known immediate side effects like dehydration and overheating, and want to educate users about ways to reduce the risks of their Ecstasy use.[51]

Ecstasy provides a clear example of both the ineffectiveness of the punitive approach to drug policy and the need for mainstream implementation of harm reduction methods. No other drug has incited so much commentary from scientific and medical communities,[52] and its prevalence among youth is rising rapidly. By examining the traditionally discordant approaches to drug policy and their specific application to Ecstasy, a new policy can be crafted that encompasses the best elements of each approach.

Part I of this Comment discusses the history and development of harm reduction and the punitive approach: the two main ideologies on which drug policies are based. It then explains Ecstasy's evolution as a popular recreational drug, its scientific and medical effects, and the legislation that has been drafted specifically in response to its growing popularity in the United States. Part II of this Comment contrasts various policy approaches to Ecstasy, exploring the advantages and disadvantages of each. Part III argues that Ecstasy policy should be revamped to reflect a primarily harm reduction approach. The first and most radical aspect of this new policy would involve legalizing Ecstasy with strict government regulation. In the alternative, Ecstasy should be reclassified as a

48. *See, e.g.*, The Ecstasy Anti-Proliferation Act of 2000, Pub. L. No. 106-310, 114 Stat. 1101 (codified as part of the Children's Health Act of 2000, 42 U.S.C. § 290aa-5b (2000)); The Ecstasy Prevention Act of 2001, S. 1208, 107th Cong. (2001).

49. *E.g.*, *Governor Signs DiGaetano Law Mandating Tougher Sentences for Ecstasy Drug*, DIGAETANO ON THE ISSUES, *at* http://pauldigaetano2001.com/issues.htm (last visited Apr. 17, 2002) (discussing how a new law in New Jersey increasing sentences for Ecstasy "sends a message to New Jersey's young people as well: stay away from Ecstasy.").

50. Grob, *supra* note 44, at 580-81 (discussing the barriers to Ecstasy research).

51. Marsha Rosenbaum, *'Just Say No' Wins Few Points With Ravers*, L.A. TIMES, Jan. 31, 2001, at B9 (explaining, from a parent's perspective, the desire to minimize the harms that can befall teenage Ecstasy users).

52. U.S. SENTENCING COMM'N, *supra* note 40, at 4 (stating that the volume of public comment received on the proposed changes to guidelines for Ecstasy trafficking far exceeds that for any other issue the United States Sentencing Commission has addressed since its inception).

schedule III substance and the Federal Sentencing Guidelines should be amended to repeal recent sentence increases for Ecstasy trafficking. Concurrent with reforming penalty-oriented legislation, Congress should, as its first priority, increase harm reducing measures such as treatment, education, and "safer-use" programs for current users.

I. PROHIBITION, HARM REDUCTION, AND ECSTASY: A HISTORICAL OVERVIEW

A. Prohibition

The United States prohibitionist policy on drug use is rooted in the racial prejudice of the late nineteenth century.[53] Prohibition involves the use of law enforcement and strict penalties to deter and completely eliminate illicit drug use.[54] Although the failings of alcohol prohibition were recognized in the years preceding its repeal, the prohibition, as opposed to regulation, of drug use has remained a cornerstone of United States drug policy.[55]

1. *Early Legislation*

In 1914, Congress enacted the Harrison Narcotics Act, a piece of legislation designed to limit the distribution of cocaine and heroin to health care professionals, as opposed to the free use that had been in effect prior to the statute.[56] In 1919, however, the Supreme Court interpreted the Harrison Narcotics Act as prohibiting any distribution of these drugs and held that such distribution was criminal.[57] Congress then enacted more than fifty pieces of legislation controlling the distribution of drugs that were considered dangerous.[58] By the 1960s, penalties in the United States were generally not related to a drug's inherent danger.[59] The govern-

53. GREY, *supra* note 1, at 20-23.

54. *Id.* at 20.

55. Dana Graham, Comment, *Decriminalization of Marijuana: An Analysis of the Laws in the United States and the Netherlands and Suggestions for Reform*, 23 LOY. L.A. INT'L & COMP. L. REV. 297, 301 (2001).

56. Harrison Narcotics Act, Pub. L. No. 63-223, 38 Stat. 785 (1914) (superseded by § 2567 of the Internal Revenue Code of 1939, 53 Stat. 278). Lisa Scott, *The Pleasure Principle: A Critical Examination of Federal Scheduling of Controlled Substances*, 29 SW. U. L. REV. 447, 451 (2000) (describing the effect of the Harrison Narcotics Act).

57. Webb v. United States, 249 U.S. 96, 99-100 (1919).

58. H.R. REP. NO. 91-1444 (1970), *reprinted in* 1971 U.S.C.C.A.N. 4566, 4601 ("Since 1914 the Congress has enacted more than fifty pieces of legislation relating to control and diversion, from legitimate channels, of those drugs referred to as narcotics and dangerous drugs.").

59. DAVID F. MUSTO, THE AMERICAN DISEASE 255 (1999).

ment sought to correct this imbalance by establishing a reliable process for determining the level of danger posed by any given drug.[60] Congress enacted the Comprehensive Drug Abuse and Prevention Control Act of 1970, which harmonized all federal drug laws into one piece of comprehensive legislation.[61] The part of the Act relevant to this Comment is Title II, now commonly called the Controlled Substances Act (the "Act"), which focuses on strengthening existing law enforcement authority in the field of drug abuse.[62] The Act is the government's legal foundation in its fight against drug abuse.[63]

2. *The Controlled Substances Act*

The Controlled Substances Act authorizes the Attorney General to establish five categories of controlled substances for the purpose of regulating their use, possession, and sale.[64] The categories are known as schedules, and they range from I to V, with schedule I and II substances provoking the strictest controls and most severe criminal penalties.[65] Heroin and marijuana are schedule I substances and cocaine is a schedule II substance.[66] The Attorney General has power to delegate to the Administrator of the Drug Enforcement Administration ("DEA") the responsibility of placing drugs in a schedule, which is how scheduling usually occurs.[67] Proceedings to add, delete, or change the schedule of a drug may be initiated by the DEA, the Department of Health and Human Services ("HHS"), or by petition from any interested party.[68] Once a petition is received by the DEA, the agency begins its own investigation of the drug.[69] The DEA Administrator then asks HHS to complete a scientific and medical evaluation and make a recommendation as to whether the substance should be controlled.[70] To accomplish this task, HHS gathers information from the Food and Drug Administration ("FDA") and the National In-

60. *Id.* at 254-55.
61. Controlled Substances Act, Pub. L. No. 91-513, 84 Stat. 1236 (1970) (codified as part of 21 U.S.C. §§ 801-971). Scott, *supra* note 56, at 451.
62. Controlled Substances Act, 21 U.S.C. §§ 801-971 (1996).
63. *Id.* at 455.
64. Controlled Substances Act, 21 U.S.C. §§ 801-971 (1996).
65. *Id.* § 812.
66. *Id.*
67. *Id.* § 811.
68. Drug Enforcement Admin., Summary of Controlled Substances Act, *at* http://www.dea.gov/agency/csa.htm (last visited Apr. 25, 2002).
69. *Id.*
70. *Id.*

stitute on Drug Abuse ("NIDA").[71] The medical and scientific evaluations by HHS are binding on the DEA only for substances HHS urges not be controlled by the DEA.[72] Whether HHS has ever made such a recommendation against the wishes of the DEA remains unknown, but it is highly unlikely. The Administrator of the DEA then reviews all available data and decides whether a drug should be controlled and if so, into which schedule it should be placed.[73] This decision is final and, for all practical purposes, is not subject to review.[74] Judicial review of an agency decision requires a court of appeals to find an extreme level of error; thus, reversal is unlikely.[75]

If the DEA Administrator determines that a substance should be controlled, the decision as to in which schedule a drug will be placed depends on several factual findings regarding the drug's abuse potential and medicinal properties.[76] Schedule I drugs require the following findings:

1. The drug or other substance has a high potential for abuse;
2. The drug or other substance has no currently accepted medical use in treatment; and
3. There is a lack of accepted safety for use of the drug or other substance under medical supervision.[77]

For schedule II, the required findings are:

1. The drug or other substance has a high potential for abuse;
2. The drug or other substance has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions; and
3. Abuse of the drug or other substances may lead to severe psychological or physical dependence.[78]

Schedule III requires the following:

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71. *Id.*

72. *Id.*

73. *Id.*

74. *See* Grinspoon v. DEA, 828 F.2d 881, 884-85 (1st Cir. 1987) (discussing the standard of review for an agency decision and holding that the DEA's standard for acceptable medical use was not in accordance with the congressional intent of the Act, but that all other claims were invalid or resulted only in harmless error). The Administrative Procedure Act directs that the reviewing court shall set aside agency conclusions found to be arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law. 5 U.S.C. § 706(2)(A) (1996).

75. 5 U.S.C. § 706(2)(a); *see Grinspoon*, 828 F.2d at 884-85.

76. Controlled Substances Act, 21 U.S.C. § 812 (1996).

77. *Id.*

78. *Id.*

1. The drug or other substance has a potential for abuse less than the drugs or other substances in schedules I and II;
2. The drug or other substance has a currently accepted medical use in treatment in the United States; and
3. Abuse of the drug or substance may lead to moderate or low physical dependence or high psychological dependence.[79]

The classification of substances depends on fairly nuanced differences implied by the differing standards of "accepted medical use" and "potential level of dependence," although the Act itself does not contain clear criteria by which the DEA Administrator must measure these properties. In the House Committee Report accompanying the Act, lawmakers attempted to provide some guidance on the "potential for abuse" criterion.[80] The Report states that the Attorney General may find a substance has potential for abuse if individuals are taking the drug in amounts sufficient to create a hazard to their health, or to the safety of other individuals or of the community; there is significant diversion of the drug from legitimate drug channels; individuals are taking the drug on their own initiative rather than on medical advice; or the drug is related to a drug already listed as having a potential for abuse.[81] According to the third prong, any drug used for recreational purposes has a potential for abuse. Furthermore, there is no clear standard for determining an elevation to a "high" potential for abuse, as required for schedule I classification.[82]

The definition of "currently accepted medical use" was a primary issue in the litigation brought to challenge Ecstasy's placement in schedule I.[83] This standard was defined by past DEA Administrator John C. Lawn as "having obtained FDA approval."[84] The benefit of this interpretation is that the detailed scientific research required for FDA approval[85] would likely be nuanced enough to also demonstrate whether a substance has a high potential for abuse. If, however, "currently accepted medical use" is defined

79. *Id.*

80. Scott, *supra* note 56, at 454.

81. H.R. REP. NO. 91-1444 (1970), *reprinted in* 1971 U.S.C.C.A.N. 4566, 4601.

82. 21 U.S.C. §§ 801-971.

83. *See* Schedules of Controlled Substances; Scheduling of 3, 4-Methylenedioxymethamphetamine (MDMA) Into Schedule I of the Controlled Substances Act, 21 C.F.R. § 1308 (1986).

84. *Id.*

85. *See* Julie Holland, *Clinical Experience with MDMA-Assisted Psychotherapy, an Interview with George Greer, M.D., in* ECSTASY: THE COMPLETE GUIDE, *supra* note 34, at 240.

more accurately as "what is actually going on within the health care community,"[86] then assessing a substance's abuse potential would have to depend on other research—research that the DEA neither mandates nor permits. Neither the DEA nor any judicial body has presented a means to measure a substance's abuse potential.[87] The DEA Administrator is therefore given significant discretion without judicial review or substantive congressional guidance.[88] Moreover, the DEA Administrator faces a conflict of interest: the Administrator both classifies drugs and promotes a punitive criminal justice approach to drug abuse. This process may result in substance classifications that are, if not legally arbitrary and capricious,[89] at least lacking in scientific and political merit.

3. *The Creation of Sentencing Guidelines and Subsequent Legislation*

In 1973, the National Institute on Drug Abuse ("NIDA") was established to act as the umbrella organization for most government prevention programs and drug research.[90] Eleven years later, the 1984 Federal Sentencing Reform Act established the United States Sentencing Commission and charged it with creating sentencing guidelines for criminal defendants in federal court.[91] Included in the sentencing guidelines were mandatory minimum sentences for drug offenses committed near schools.[92]

In the 1980s, public sentiment grew increasingly antidrug, as society evaluated the collective damage of drug use in the 1970s and watched as cocaine grew in popularity.[93] In response to the "crack

86. This was the definition found by DEA Administrative Law Judge Francis L. Young. Final Scheduling Rule, *supra* note 39.

87. *See id.*

88. *See id.*

89. *See* Motor Vehicle Mfrs. Ass'n of United States, Inc. v. State Farm Mut. Auto Ins. Co., 463 U.S. 29, 43 (1983) ("Normally, an agency rule would be arbitrary and capricious if the agency relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or was so implausible that it could not be ascribed to a difference in view or the product of agency expertise.").

90. MUSTO, *supra* note 59, at 257.

91. Federal Sentencing Reform Act, Pub. L. No. 98-473, 98 Stat. 1837 (1984) (codified at 18 U.S.C. 3551); MUSTO, *supra* note 59, at 273-74.

92. MUSTO, *supra* note 59, at 274.

93. Drug use among young people was at a near-epidemic level in the late 1970s. OFFICE OF NAT'L DRUG CONTROL POLICY, NATIONAL DRUG CONTROL BUDGET: EXECUTIVE SUMMARY, FISCAL YEAR 2002 (2002); Abbie Crites-Leoni, *Medicinal Use of Marijuana: Is the Debate a Smoke Screen for Movement Toward Legalization?*, 19 J. LEGAL MED. 273, 276 (1998) (discussing the antidrug sentiment of the mid-1980s).

epidemic,"[94] Congress enacted the Anti-Drug Abuse Act of 1986.[95] It set forth a spectrum of mandatory minimum sentences for criminal offenses where crack cocaine was found in a defendant's possession.[96] Two years later, the Anti-Drug Abuse Act of 1988 was enacted.[97] Under this statute, alcohol was included with other drugs, and states were encouraged to adopt heightened penalties for drunk driving in exchange for grant money.[98] Later that year, this act was amended to include The Drug-Free Schools and Communities Act Amendments of 1986.[99] Educational institutions were required to establish a means of maintaining drug-free campuses, informing students and employees at the beginning of each school year of the penalties for drug use or sale, and providing information on available treatment.[100]

In addition to implementing legislation generally addressing drug abuse, Congress has taken new measures to stem Ecstasy use and trafficking. Two bills specifically addressing Ecstasy and other club drugs[101] have been introduced in the past three years: the Ecstasy Anti-Proliferation Act of 2000 and the Ecstasy Prevention Act of 2001.[102] The DEA has also unsuccessfully attempted to use legislation commonly known as the "crack house" statutes[103] to

94. Crack is a smokable, rapidly reacting form of cocaine base. Soon after crack first appeared, in the early to mid-1980s, crack abuse swept through the country. Philip B. Heyman, *The New Policing*, 28 FORDHAM URB. L.J. 407, 409 (2000).

95. Anti Drug Abuse Act of 1986, Pub. L. No. 99-570, 100 Stat. 3207 (codified at 21 U.S.C. 801 (1999)).

96. *Id.*; MUSTO, *supra* note 59, at 274. The Anti-Drug Abuse Act of 1986 established mandatory minimums for persons convicted of trafficking controlled substances, and it established a 100-to-1 quantity ratio between crack and powder cocaine. *Id.* That means that it takes 100 times as much powder cocaine to trigger the same mandatory penalties as for a given amount of crack. *Id.* In 1987, the United States Sentencing Commission used the same ratio to set penalties under the Sentencing Guidelines. U.S. SENTENCING COMM'N, SPECIAL REPORT TO THE CONGRESS: COCAINE AND FEDERAL SENTENCING POLICY iv (1995).

97. Anti-Drug Abuse Act of 1986, Pub. L. No. 99-570, 100 Stat. 3207 (codified as 21 U.S.C. 801 (1999)).

98. *Id.* at Title I, Subchapter T.

99. Drug-Free Schools and Communities Act of 1986, Pub. L. No. 100-297, 102 Stat. 252 (codified as part of 20 U.S.C. 3171 (1994)).

100. *Id.*

101. Club drugs are those typically used by young adults at bars, clubs, and raves, including Ecstasy, GHB, Rohypnol, Ketamine, Methamphetamine, and LSD. Nat'l Inst. on Drug Abuse, *Club Drugs*, *at* http://www.clubdrugs.org (last visited Apr. 23, 2002).

102. The Ecstasy Anti-Proliferation Act of 2000, Pub. L. No. 106-310, 114 Stat. 1101 (codified as part of the Children's Health Act of 2000, 42 U.S.C. § 200aa-5b (2000)); The Ecstasy Prevention Act of 2001, S. 1208, 107th Cong. (2001).

103. 21 U.S.C. § 856(a)(2) (2000). The statute declares it unlawful to knowingly open or maintain any place for the purpose of manufacturing, distributing, or using

prosecute club owners and rave[104] promoters in federal courts.[105] In *United States v. Barbecue of New Orleans*,[106] the DEA and club owners charged under the "crack house" statutes reached a settlement wherein the DEA required the club owners to ban rave culture accoutrements such as glow sticks and pacifiers.[107] However, New Orleans Federal District Judge Thomas Porteous permanently enjoined such a ban, finding that the government cannot ban inherently legal objects that are used in expressive communication simply because they may also be used to enhance the effects of an illegal substance.[108] He further held that "[W]hen [a] First Amendment right . . . is violated by the government in the name of the War on Drugs . . . it is the duty of the courts to enjoin the government from violating the rights of innocent people."[109]

B. Harm Reduction

Harm reduction[110] rests on two premises: first, that psychoactive drug use has been a part of every culture since the beginning of

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any controlled substance or to manage or control any building, room, or enclosure, either as an owner, lessee, agent, employee, or mortgagee, and knowingly and intentionally rent, lease, or make available for use, with or without compensation, the building, room, or enclosure for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance. *Id.*

104. Raves are large, incandescent dance parties where electronic music is played. Gwen Filosa, *Sponsor's Guilty Plea Brings Rave New World*, TIMES-PICAYUNE, Jun. 14, 2001, at 1.

105. *Federal Judge Throws Out Glow Stick, Pacifier Ban in New Orleans Rave Case*, THE WEEK ONLINE WITH DCRNET, Feb. 8, 2002, *at* http://www.drcnet.org/wol/223.html (last visited Apr. 23, 2002) [hereinafter Pacifier Ban]. The DEA attempted to stretch the meaning of the "crack house" statutes to allow for the prosecution of anyone who operates a business where drug use occurs, and where the building management are aware of the drug use; United States v. Brunet, No. 01-010 (E.D. La. Mar. 7, 2001).

106. United States v. Barbecue of New Orleans, Inc., No. 01-153 (E.D. La. Aug. 23, 2001).

107. Pacifier Ban, *supra* note 105. Pacifiers and light sticks are sometimes used at raves or large clubs by people using Ecstasy and other club drugs to enhance the effects of the drugs. Stacy St. Clair, *Why Image Could Doom Teen Club*, CHI. DAILY HERALD, May 2, 2002, at A1.

108. McClure v. Ashcroft, No, 01-2573 (E.D. La. Feb. 1, 2002).

109. *Id.*

110. Harm reduction is a term of art intended to encompass a spectrum of approaches to drug use. Inciardi & Harrison, *supra* note 31, at vii-viii. The more traditional understanding of the ideology allows a person to use drugs, even to the point of causing harm to herself, without interference from the government. *Id.* A more recent understanding of harm reduction includes the goal of reducing drug use. *Id.* (describing one theory of harm reduction that supports prohibition but seeks to minimize its negative effects). For the purpose of this Comment, harm reduction is a hybrid of these approaches: it is a method to minimize drug related harm and the harm caused

civilization, rendering eradication unrealistic and probably impossible, and second, that drug use is primarily a social and public health issue as opposed to a penal issue.[111] In practice, harm reduction encompasses programs that attempt to make drug use as safe as possible for both the users and the community.[112] Examples of specific programs include syringe exchanges for intravenous drug users; treatment programs; "safer-use" educational campaigns that offer objective, factual information to drug users; and treatment as an alternative to incarceration for convicted drug offenders.[113] Harm reduction advocates recognize that drug use can never be completely safe, and some acknowledge the need for law enforcement in certain circumstances.[114]

Harm reduction is often confused with legalization. Legalization involves removing criminal penalties for possession of some or all illicit drugs and usually involves implementing a system of regulated distribution similar to that which is in place for alcohol and cigarettes, with state-run sales, quality and price control, and a ban on advertising.[115] Legalization advocates often point to crime caused by prohibitive drug laws themselves as support for legalization.[116] Although many harm reduction advocates support legali-

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by the punitive criminal justice approach. Although this Comment includes prevention and treatment measures under the umbrella of harm reduction, the traditional harm reductionist would advocate only treatment, and only for voluntary and willing participants. *See* Harm Reduction Coalition, *Harm Reduction Principles*, *at* http://www.harmreduction.org/prince.html (last visited Apr. 23, 2002) (stating that drug treatment should be noncoercive).

111. *See* Nadelmann & Wenner, *supra* note 32, at 24-26 (elaborating on the role that drug use has played in societies through history); Inciardi & Harrison, *supra* note 31, at vii-viii (describing one definition of harm reduction as accepting the reality of drug use and the harms caused by such use while preserving the choice of individuals to engage in drug use or to forego drug use); Telephone Interview with Ethan Nadelmann, Director, Drug Policy Alliance (Feb. 13, 2002).

112. *See* JEROME BECK & MARSHA ROSENBAUM, PURSUIT OF ECSTASY: THE MDMA EXPERIENCE 136 (1994); Inciardi & Harrison, *supra* note 31, at vii. This understanding of harm reduction has also been referred to as "Safety First." Telephone interview with Marsha Rosenbaum, West Coast Director, Drug Policy Alliance (Nov. 12, 2001).

113. *See* Robert J. MacCoun, *Toward a Psychology of Harm Reduction*, 53 AM. PSYCH. 1199, 1199-1208 (1998) (discussing the many programs that can fall into the category of harm reduction).

114. *See id.* (proposing a policy incorporating harm reduction and law enforcement).

115. *See* GRAY, *supra* note 1, at 213-14 (discussing regulated distribution and legalization generally).

116. *See* WILLIAM WEIR, IN THE SHADOW OF THE DOPE FIEND: AMERICA'S WAR ON DRUGS 253 (1995) (stating that twenty to forty percent of the murders in America take place because of the black market drug business); David R. Henderson, *A Humane Economist's Case for Drug Legalization*, 24 U. CAL. DAVIS L. REV. 655, 659

zation to some extent, legalization is a broader approach to drug policy that is not necessarily informed by the social and medical concerns underlying harm reduction.[117] In fact, most legalization arguments are economic.[118]

Decriminalization may be a component of harm reduction, but it is a distinct approach advocating that selected laws not be enforced and that penalties for possession be substantially reduced.[119] In practice, decriminalization directs law enforcement efforts away from minor possession of less harmful drugs and toward larger distribution networks involving more dangerous drugs.[120] By altering the manner in which criminal drug laws are enforced, decriminalization aims to reduce harms to drug users arising from the criminal justice system itself, while more efficiently utilizing government resources.[121] Examining the development of harm reduction in the Netherlands and its subsequent migration to the United Kingdom and North America enables a complete understanding of this approach and its various applications.[122]

(1991) (discussing the phenomenon of drug users committing other crimes to afford drugs, which are made more expensive because of prohibitive laws).

117. Although legalization is generally proposed for its efficiency, it would probably not result in increased drug use. Using cigarettes as a model, even if self-reports of alcohol and tobacco consumption underreport actual consumption by as much as thirty to fifty percent, at least seventy percent of Americans are resistant to the temptations and risks posed by the easy availability of cigarettes. Further, more than ninety percent of the population either refrains from powerful drugs altogether or else consumes them responsibly and in moderation. Nadelmann, *supra* note 14.

118. Joshua C. LaGrange, Note, *Law, Economics, and Drugs: Problems with Legalization Under a Federal System*, 100 COLUM. L. REV. 505, 505 (2000) ("Proponents of drug legalization often find support for their position in neo- classical economic theories that demonstrate the inefficiency of supply- restricting drug control policies like those traditionally used in the United States.").

119. GRAY, *supra* note 1, at 7; *Hearing Before the House Gov't Reform and Oversight Comm., Subcomm. on Criminal Justice, Drug Policy, and Human Res.*, 106th Cong. 1 (1999) (statement of Robert J. MacCoun & Peter Reuter). For the purpose of this Comment, discussion of harm reduction will not include decriminalization except where explicitly mentioned as part of a multi-faceted approach to drug policy.

120. *See* Graham, *supra* note 55, at 320 (explaining the predominant argument for decriminalization of marijuana as removing penalties for personal use by adults while arresting commercial sellers).

121. *See* Stephen B. Duke, *Drug Prohibition: An Unnatural Disaster*, 27 CONN. L. REV. 571, 611 (1995) (discussing the reallocation of government resources that could take place if some drugs were decriminalized). *See generally* SAM STALEY, DRUG POLICY AND THE DECLINE OF AMERICAN CITIES (1992) (arguing that decriminalization is an important step toward addressing the economic and social needs of cities).

122. *See* Diane Riley & Pat O'Hare, *Harm Reduction: History, Definition, and Practice*, *in* HARM REDUCTION: NATIONAL AND INTERNATIONAL PERSPECTIVES, *supra* note 19, at 3 (stating that harm reduction developed in the Netherlands, the United Kingdom, and North America).

1. *The Netherlands*

The Dutch established a drug policy guided by harm reduction ideology with the development of three innovative concepts.[123] The first concept is that different drugs carry different risks, some acceptable and some not.[124] This concept was developed as a response to the increase in drug use in the 1960s.[125] This increase led to broad public concern about the operation of the criminal justice system.[126] Specific concerns about the effect of drug laws on personal choice, the consequences of criminalization, and the risks to the user, led the Dutch government to create an official commission (the "Commission") to study the increased use of narcotics and issue a report proposing possible solutions.[127] The Commission's thorough report proposed that the bases for all future drug policy be "risk-criteria," principles for legislation and policy-making that would take into account the relative risks of illegal drugs.[128] In 1972, the emergence and rapid spread of heroin put pressure on the government to seriously discuss the Commission's report and consider legal reforms.[129] Applying risk criteria, legislators decided that the law should distinguish between "drugs presenting unacceptable risks," such as heroin, cocaine, LSD, and amphetamines, and drugs presenting acceptable risks, such as hashish and marijuana.[130] This concept, that "hard" and "soft" drugs should be separated both legally and in the public's perception, is one of the most significant and effective elements of Dutch harm reduction.[131] In 1976, the Dutch codified this policy by creating two classes of drugs, schedule I and schedule II, which reflect the respective risks of the drugs.[132]

Prevention, treatment, and risk minimization comprise the second aspect of Dutch harm reduction.[133] By preventing nonusers

123. BECK & ROSENBAUM, *supra* note 112, at 136.

124. Henk Jan van Vliet, *The Uneasy Decriminalization: A Perspective on Dutch Drug Policy*, 18 HOFSTRA L. REV. 717, 720 (1990).

125. *Id.*

126. *Id.* at 720-21.

127. *See id.* at 722 (describing the creation, goals, and function of the Commission, officially called the Baan Working Party).

128. *Id.* at 722.

129. *Id.* at 723.

130. *Id.* at 724.

131. *See* Dirk K. Korf & Ernst C. Buning, *Coffee Shops, Low-Threshold Methadone, and Needle Exchange: Controlling Illicit Drug Use in the Netherlands, in* HARM REDUCTION: NATIONAL AND INTERNATIONAL PERSPECTIVES, *supra* note 19, at 116.

132. *Id.* at 118.

133. van Vliet, *supra* note 124, at 725.

from trying "hard" drugs and helping current users abstain, the Dutch believed they could reduce risks both to drug users and society.[134] Professionals in the field soon realized that abstinence-only methods were inadequate; relying solely on treatment and prevention left the majority of drug users, who were not seeking abstinence, without a range of necessary services.[135] These professionals began providing medical and social assistance to injection drug users who were not seeking abstinence, allowing them to monitor and influence the health, social, and legal status of the users while reducing damage to society.[136]

The third and most widely known element of Dutch drug policy is decriminalization. Decriminalization is based on the "normalization"[137] or "cultural integration"[138] that the state reaches when the public believes the eradication of drugs is unattainable.[139] The Dutch enacted a policy of pragmatic nonenforcement for violations involving the sale or possession of up to approximately one-fifth of an ounce of marijuana.[140] Marijuana's decriminalization keeps transactions public to prevent a health issue from becoming a crime problem.[141]

2. *The United Kingdom*

The United Kingdom instituted a program of regulated distribution of certain drugs for addiction maintenance in the 1980s, and instituted other harm reduction tactics derived from the Dutch approach.[142] In response to epidemic levels of heroin use, the city of

134. *Id.* at 725.

135. *Id.* at 725 n.40.

136. *Id.* at 726.

137. van Vliet, *supra* note 124, at 727; *see* Rodney Skager, *Education, Prevention, and Treatment*, 28 FORDHAM URB. L.J. 130, 131 (2000) (explaining normalization as what occurs when users, as well as many nonusers, accept some amount of drug use as normal).

138. van Vliet, *supra* note 124, at 727.

139. *Id.* at 726-27.

140. GRAY, *supra* note 1, at 217-18 (noting that the amount of marijuana allowed under this policy was reduced from one ounce to one-fifth of one ounce in 1995 because of political pressure); TIM BOEKHOUT VAN SOLINGE, DRUGS AND DECISION-MAKING IN THE EUROPEAN UNION 124 (2002) (stating that the Dutch amended their marijuana policy in response to pressure from its European Union neighbors).

141. GRAY, supra note 1, at 218.

142. Inciardi & Harrison, *supra* note 31, at ix (detailing the beginning of the United Kingdom's first comprehensive harm reduction program); Norbert Gilmore, *Drug Use and Human Rights: Privacy, Vulnerability, Disability, and Human Rights Infringements*, 12 J. CONTEMP. HEALTH L. & POL'Y 355, 405 (1996), *available at* http://www.drugtext.org (last visited Apr. 22, 2002) (stating that the United Kingdom has steadily favored a regulatory approach to control drug use, which has resulted in the

Merseyside, England adopted a harm reduction program known as the "Mersey model."[143] This program served three separate functions. The first component of the Mersey model, maintenance, was instituted after a committee concluded that maintenance on drugs is necessary for some drug-addicted persons to lead useful lives.[144] The second element was the creation of one of the first syringe exchange programs in the United Kingdom.[145] The third component was informal decriminalization. In lieu of arrest, local police began to refer drug users to drug services, a practice known as "cautioning."[146] The Mersey model grew to include counseling, prescription of drugs (including heroin), and employment and housing services.[147]

United Kingdom drug policy has evolved significantly over time. In 1971, Britain's drug policy became primarily prohibition-based,[148] with the Mersey model developing as an exception; some of those harm reduction tactics continue to be applied in certain areas.[149] International treaty obligations have kept British drug policy grounded mainly in the punitive-based criminal justice approach.[150] A number of British lawmakers and law enforcement leaders have recently expressed disfavor with this prohibitionist

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medical availability of heroin and methadone, an emphasis on medical, rather than criminal justice, definitions of harmful use, and the implementation of innovative harm reduction approaches).

143. Riley & O'Hare, *supra* note 122, at 4.

144. *Id.*

145. *Id.* This was called the Mersey Regional Drug Training and Information Centre. *Id.*

146. *Id.*

147. *Id.*

148. In 1971 the United Kingdom enacted the Misuse of Drugs Act, a piece of legislation based on the prohibitionist approach to drug policy. VISCOUNTESS RUNCIMAN DBE, DRUGS & THE LAW: REPORT OF THE INDEPENDENT INQUIRY INTO THE MISUSE IF DRUGS ACT 1971 1 (1999).

149. Riley, *supra* note 122, at 4 (listing elements of the Mersey model); Harold Seymour & Gail Eaton, *The Liverpool Model: A Population Based Approach to Harm Reduction*, March 1997, *at* http://www.drugtext.org/articles/97844.htm (last visited Apr. 25, 2002) (discussing the elements of the Mersey Model that were still in use in 1997).

150. *See, e.g.*, GRAY, *supra* note 1, at 147 (discussing the creation of the United Nation's International Narcotics Drug Control Board which, in 1997, issued a report that essentially called for criminalizing any opposition to the war on drugs); United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, U.N. ESCOR, U.N. Doc. E/CONF 82/15 (1988), *reprinted in* 28 I.L.M. 493; United Nations Convention on Psychotropic Substances, Feb. 21, 1971, 1019 U.N.T.S. 175, *reprinted in* 10 I.L.M. 261.

scheme.[151] A member of the Liberal Democratic Party recently stated, "The current position is one that is completely out of control. The status quo is no longer an option."[152] The Association of Chief Police Officers, a group comprised of the country's police chiefs, called for the free, regulated, and legal distribution of heroin to addicts because it believed that the current approach was not working.[153] As Chief Constable Barry Straw observed, "If there is indeed a war on drugs, it is not being won; drugs are demonstrably cheaper and more readily available than ever before."[154] In March 2002, the British Government announced a plan to ignore personal use of Ecstasy and other club drugs while focusing enforcement efforts on dealers and the impact of "hard drugs" such as heroin and cocaine.[155] In a new set of Home Office guidelines, the Government demonstrates its acceptance that drug-taking is a part of youth culture that cannot be eradicated.[156] The guidelines "give clubs advice on how to prevent dealing and how to make the venues safer for drug-using club goers," including the provision of water and better ventilation.[157]

3. *The United States*

Harm reduction methods in the United States have traditionally been proposed and implemented only by public health professionals or grass roots organizations.[158] While the United States has not utilized many of the harm reduction practices that originated in the Netherlands and the United Kingdom, it has fostered one significant harm reduction strategy, methadone maintenance.[159] Imple-

151. *Top British Cops Call for Legal Heroin for Addicts, Liberal Democrats Join Growing Ecstasy Rescheduling Chorus*, THE WEEK ONLINE WITH DRCNET, Dec. 14, 2001, *at* http://www.drcnet.org/wol/215.html (last visited Apr. 25, 2002) (statement of Baroness Walmsley, head of the Liberal Democratic Party panel that produced a report calling for the downward classification of both cannabis and Ecstasy).

152. *Id.*

153. *Id.*

154. *Id. See generally* Gerber, *supra* note 23 (discussing the ineffectiveness of the current drug policy).

155. Richard Ford, *Dance Clubs Given a License to Go Soft on Drugs*, TIMES OF LONDON, Mar. 8, 2002, at 3.

156. *Id.*

157. *Id.*

158. *See* Riley & O'Hare, *supra* note 122, at 11 (discussing the United States' resistance to the harm reduction practice of needle exchange and the endorsement of the program by two national AIDS commissions and the National Academy of Science).

159. *Id.* at 5. Methadone maintenance is the administration of methadone, a synthetic opiate, to a heroin addict to take away the addict's craving for heroin. GRAY, *supra* note 1, at 195.

mented in Canada in the late 1950s and in the United States in the early 1960s, methadone maintenance was seen as a way to reduce the societal harm resulting from crimes related to heroin addiction.[160] In the past forty years, methadone maintenance programs have gained increased political and scientific support in the United States.[161] The Office of National Drug Control Policy has expressed support for such programs,[162] and a 2000 study conducted by the National Institute on Drug Abuse ("NIDA") found that "methadone maintenance is an effective treatment for heroin addiction."[163]

While United States drug policy has remained entrenched in the criminal justice model,[164] some aspects of harm reduction in its broadest meaning have seeped into the criminal justice system. Two notable programs comingle treatment with law enforcement, Treatment Alternatives to Street Crime and the Therapeutic Community.

Treatment Alternatives to Street Crime ("TASC") is a private business operating in more than 100 jurisdictions in the United States, and acting as a bridge between the criminal justice system and drug treatment communities.[165] Once contracted, TASC identifies, assesses, and refers drug-involved offenders to community treatment services as an alternative or supplement to existing criminal sanctions.[166] After making the referral, TASC monitors the offender's progress and compliance and reports back to the referring justice system agency.[167] Offenders who violate any of the conditions of participation with TASC are sent back to the criminal

160. Riley & O'Hare, *supra* note 122, at 5.

161. Edward Jurith, *Is Our Drug Policy Effective?*, 28 FORDHAM URB. L.J. 4, 44 (2000) ("The federal government is also undertaking a review of the methadone maintenance program. Our aim is to have methadone programs and methadone treatment outcomes accredited by health care standards, and not just by regulatory standards, as has been done in the past."); Press Release, NIDA, New Study Underscores Effectiveness of Methadone Maintenance as Treatment for Heroin Addiction (Mar. 7, 2000) (on file with author).

162. Jurith, *supra* note 161, at 44.

163. NIDA NEWS RELEASE, *supra* note 161.

164. Kal Raustiala, *Law, Liberalization, & International Narcotics Trafficking*, 32 N.Y.U. J. INT'L L. & POL. 89, 137 (1999) (discussing the focus of U.S. drug policy on criminal justice).

165. James A. Inciardi, *The Harm Reduction Roles of the American Criminal Justice System, in* HARM REDUCTION: NATIONAL AND INTERNATIONAL PERSPECTIVES, *supra* note 19, at 199.

166. *Id.*

167. *Id.* at 200.

justice system.[168] Some data suggests that TASC-referred clients remain in treatment longer than non-TASC clients and that they have better post-treatment success.[169]

Therapeutic Communities ("TCs") are used increasingly in correctional facilities, where the facility isolates a community from the rest of the prison population to separate them from the drugs, violence, and prison subculture that could interfere with rehabilitation.[170] The overall goal of a TC is to change a person's patterns of behavior and thinking to foster a responsible, drug-free lifestyle.[171] In the late 1990s, studies documented the effectiveness of treatment programs designed for drug-involved offenders and resulted in the allocation of more federal funds to corrections-based treatment.[172]

Several nonprofit organizations promoting harm reduction have also developed in the past few years.[173] They often focus on disseminating "safer-use" information to people who choose to use drugs in spite of the known risks.[174] In 1999, a nonprofit organization called DanceSafe was founded to provide harm reduction services to the growing club and rave populations.[175] One of DanceSafe's primary functions is providing adulterant testing[176] of

168. *Id.*

169. *Id.*

170. *Id.* Programs such as TCs indicate recognition by lawmakers and prison officials that the drug culture pervades American prisons despite their failure to openly acknowledge this fact or refer to TCs as a form of harm reduction.

171. *Id.*

172. *Id.* at 201; *see, e.g.,* M. DOUGLAS ANGLIN, ET. AL., STUDIES OF THE FUNCTIONING AND EFFECTIVENESS OF TREATMENT ALTERNATIVES TO STREET CRIME (TASC) PROGRAMS (1996); James A. Inciardi et. al., *An Effective Model of Prison-Based Treatment for Drug-Involved Offenders*, 27 J. DRUG ISSUES 261 (1997); SANDRA TUNIS ET. AL., EVALUATION OF DRUG TREATMENT IN LOCAL CORRECTIONS, (1996).

173. *See, e.g.*, DanceSafe, *at* http://www.dancesafe.org (last visited Apr. 16, 2002); Harm Reduction Coalition, *at* http://www.harmreduction.org (last visited Apr. 16, 2002); The Lindesmith Center, *at* http://www.drugpolicy.org (last visited Apr. 16, 2002).

174. *See, e.g.,* Diane Riley, Canadian Centre on Substance Abuse, *The Harm Reduction Model: Pragmatic Approaches to Drug Use from the Area Between Intolerance and Neglect* (1993) (claiming that research has shown that users will change their behavior in response to information about safer use); Harm Reduction Coalition, *Principles of Harm Reduction*, *at* http://www.harmreduction.org/prince.html (last visited Apr. 16, 2002) (discussing the need for accurate information about drugs and drug use, including their adverse and harmful effects).

175. *See* DanceSafe, *supra* note 173.

176. Adulterant testing or pill testing is conducted in one of three ways: onsite at clubs and raves, in a lab, or with testing kits that can be ordered from DanceSafe. *Id.* Through the onsite program, users who are unsure of the authenticity of a pill they possess can bring it to a booth where trained harm reduction volunteers will test it for adulterants using a reliable, liquid reagent. *Id.*

pills sold in clubs as Ecstasy.[177] In this capacity, DanceSafe either distributes test kits through the mail, tests pills in a California lab sanctioned by the DEA for this purpose, or provides on-site testing to determine if a pill contains substances other than Ecstasy.[178] In an on-site testing situation, if an adulterant is found, the DanceSafe tester provides the user with information about the specific risks of the actual substances in the pill.[179] DanceSafe's target audience is comprised primarily of nonaddicted, recreational drug users who realize there are risks involved in drug experimentation, but often are not aware of all of the risks.[180]

Prevention education has long been considered an integral part of a comprehensive drug policy, but how to use it most effectively is a subject of great debate.[181] The national prevention program, Drug Abuse Resistance Education ("DARE"), advocates abstinence and is taught in eighty percent of the nation's school districts.[182] However, extensive research during the past two decades has identified a number of other prevention strategies that measurably reduce drug use.[183] These strategies share a common goal: strengthening "protective factors" (i.e., well-developed social skills, strong family bonds, attachment to school, and active involvement in the community and religious organizations), while reducing "risk factors" that increase vulnerability to drug abuse (i.e., substance abuse by a parent, lack of parental guidance, disruptive, abusive family relationships, school failure, early experimentation with drugs, and living in a community where substance abuse and dealing are pervasive).[184] Harm reduction education efforts usually en-

177. *See id.* ("Adulterant screening or 'pill testing' is an important harm reduction service for Ecstasy users. Many tablets sold on the illicit market as 'Ecstasy' actually contain substances far more dangerous than MDMA.").

178. *Id.*

179. Interview with Tim Santamour, Executive Director of DanceSafe in New York, N.Y. (Sept. 17, 2001).

180. *Id.*

181. *See* GRAY, *supra* note 1, at 165 (posing questions about the effectiveness and purposes of drug education); Jacob Sullum, *Quit War, Legalize Drugs*, USA TODAY, Feb. 27, 1992, at 10A (discussing former drug czar William Bennet's view that there is very little evidence that conventional antidrug education is effective).

182. DARE America, *at* http://www.dare.com/index2.htm (last visited Jan. 8, 2002).

183. *See generally,* CTR. FOR SUBSTANCE ABUSE PREVENTION, UNDERSTANDING SUBSTANCE ABUSE PREVENTION, TOWARD THE 21ST CENTURY: A PRIMER ON EFFECTIVE PROGRAMS (1999).

184. *Id.* The reasons adolescents begin using drugs vary, depending on individual history, social influences, family dynamics and environmental influences. DRUG STRATEGIES, KEEPING SCORE 8 (1997).

compass "safer-use" campaigns meant to inform current users of accurate risks.[185]

C. "Ecstasy"

1. *Development and Use*

The drug commonly known as Ecstasy is actually the chemical compound 3,4-methylenedioxymethamphetamine.[186] It was first patented by the German pharmaceutical company Merck in 1914 as an intermediate chemical used in the process of synthesizing a medicine intended to stop bleeding.[187] Until 1953, Ecstasy appeared only twice in scientific literature, as a side product of chemical reactions.[188] The Army Chemical Center then funded secret testing on animals of various psychotropic chemicals, including Ecstasy, for their potential as brainwashing weapons.[189] This research yielded no significant results and the use of Ecstasy for such purposes was abandoned.[190] In 1976, therapists started using small quantities of Ecstasy to augment their patients' psychotherapy, claiming it heightened self-insight and empathy.[191] The therapists called the drug "Adam"[192] and found it to be particularly beneficial in facilitating communication, acceptance, and fear reduction.[193] None of their research was officially documented or published, however, because they feared that publishing preliminary findings would ensure criminalization of this still legal drug, thereby blocking further research.[194] Later, a lack of documented research

185. *See* Harm Reduction Coalition, *Principles of Harm Reduction*, *at* http://www.harmreduction.org/prince.html (last visited Apr. 17, 2002) (discussing the need for accurate information about drugs and drug use, including their adverse and harmful effects); DIANE RILEY, CANADIAN CTR. ON SUBSTANCE ABUSE, THE HARM REDUCTION MODEL: PRAGMATIC APPROACHES TO DRUG USE FROM THE AREA BETWEEN INTOLERANCE AND NEGLECT 1 (1993) (claiming that research has shown that users will change their behavior in response to information about safer use).

186. BECK & ROSENBAUM, *supra* note 112, at 9.

187. Julie Holland, *The History of MDMA*, *in* ECSTASY: THE COMPLETE GUIDE, *supra* note 34, at 11, 11.

188. *See id.*

189. *See id.*

190. *See id.*

191. *See* BECK & ROSENBAUM, *supra* note 112, at 14.

192. *See* Holland, *supra* note 187, at 11, 13 (explaining that therapists nicknamed MDMA "Adam" because of the state of emotion and empathy of the user, likened to that of Adam in the Garden of Eden).

193. *Id.* at 14; Charles S. Grob & Russell E. Poland, *MDMA in* SUBSTANCE ABUSE: A COMPREHENSIVE TEXTBOOK 269-75 (1997) (discussing Ecstasy-augmented psychotherapy that improved self-esteem, communication ability, and capacity for empathy).

194. *See* BECK & ROSENBAUM, *supra* note 112, at 15.

would be a factor in Ecstasy's classification as a schedule I substance.[195]

The first published human study of Ecstasy was released in 1978.[196] Two chemists described its effects as "an easily controlled altered state of consciousness with emotional and sensual overtones."[197] One of the scientists introduced Ecstasy to some therapists because of its promise in the psychotherapeutic process; thus contributing to Ecstasy's underground therapeutic use.[198] Recreational use of the drug grew in the mid-1980s, due in part to media attention directed at this new "miracle drug."[199] Although Ecstasy was gaining popularity in Boston and Washington, D.C., the first major hub of Ecstasy use in the United States was Dallas, Texas.[200] As the DEA became aware of the rampant use and distribution of Ecstasy in Texas, it became concerned with the growing use of this new, and somewhat unknown drug.[201] In 1984, the DEA initiated its first investigation into Ecstasy to decide whether it should be treated as a controlled substance.[202] Ironically, the media attention given to the DEA's investigation spurred savvy drug dealers to get involved with Ecstasy's black market distribution.[203]

Possibly in response to the DEA's actions, therapists who had been using Ecstasy in their practices sponsored a meeting on Ecstasy in California in 1985.[204] The professionals in attendance had used Ecstasy in more than 1000 therapy sessions.[205] Several professionals who later challenged the DEA's classification of Ecstasy as a controlled substance participated in this meeting.[206] Nevertheless, the federal government classified Ecstasy as an illegal sched-

195. *See* Final Scheduling Rule, *supra* note 39.

196. Holland, *supra* note 187, at 12.

197. *Id.*

198. *Id.*

199. *See* BECK & ROSENBAUM, *supra* note 112, at 15; Marsha Rosenbaum & Rick Doblin, *Why MDMA Should Not Have Been Made Illegal, in* BETWEEN POLITICS AND REASON: THE DRUG LEGALIZATION DEBATE, *supra* note 2, at 135, 140-41 (describing the effect of a surge in media coverage of Ecstasy on its popularity for recreational use).

200. *See* BECK & ROSENBAUM, *supra* note 112, at 18-19, 21.

201. Holland, *supra* note 34, at 8.

202. Final Scheduling Rule, *supra* note 39.

203. *See* Grob, *supra* note 44, at 554.

204. Holland, *supra* note 187, at 13.

205. *Id.* at 13.

206. *See* Julie Holland, *Clinical Experience with MDMA-Assisted Psychotherapy, An Interview with George Greer, M.D., in* ECSTASY: THE COMPLETE GUIDE, *supra* note 34, at 227; *see also* BECK & ROSENBAUM, *supra* note 112, at 22.

ule I substance in 1985.[207] That year marked the beginning of an era aimed at stringent attempts to both understand and penalize Ecstasy use.

2. *The Science of Ecstasy*

Ecstasy is 3,4-methylenedioxymethamphetamine, a semisynthetic drug taken in pill form, that is related to amphetamines and mescaline.[208] Ecstasy's attractive effects include "euphoria, increased physical and emotional energy, and heightened sensual awareness."[209] Immediate, short-term, adverse effects may include jaw tension, rapid heartbeat, teeth grinding, and dry mouth.[210] Frequent use may also result in muscle tension, anxiety, dysphoria, and almost a total loss of the desired effects of the drug.[211] Unlike classic, physically addictive drugs, increasing the dosage of Ecstasy after a tolerance has been established will not result in increased euphoric sensation.[212] Therefore, although some individuals use Ecstasy frequently in the beginning, they eventually taper their use to achieve maximum benefits.[213] The number of deaths caused by Ecstasy to date is unknown. A *60 Minutes* special that aired in 2000 claimed that over 1100 people have died from the ingestion of Ecstasy over the past few years, but this figure was later disproved.[214] Approximately fifteen fatalities per year have been reported, and in each case death was caused by the overheating of the Ecstasy user.[215]

Most proposals to use Ecstasy in controlled treatment protocols from the mid-1980s to the present have been denied approval.[216] The Swiss government, however, granted permission to a group of clinical psychiatrists to treat their patients with Ecstasy from 1988 to 1993.[217] Scientists eventually conducted a retrospective analysis of results from the treatment, and the Ecstasy-augmented psycho-

207. Controlled Substances Act, 21 U.S.C. § 811 (1996).
208. Holland, *supra* note 201, at 8.
209. Gary L. Bravo, *What Does MDMA Feel Like?*, *in* ECSTASY: THE COMPLETE GUIDE, *supra* note 34, at 21, 24.
210. *Id.*
211. Marsha Rosenbaum & Rick Doblin, *Why MDMA Should Not Have Been Made Illegal*, *in* THE DRUG LEGALIZATION DEBATE, *supra* note 2, at 135, 143.
212. *Id.*; Bravo, *supra* note 209, at 27.
213. Rosenbaum & Doblin, *supra* note 211.
214. Marc Savlov, *Countdown to Ecstasy: A New Drug for a New Millennium*, AUSTIN CHRON., Jun. 9, 2000, at C1.
215. Grob, *supra* note 44, at 557.
216. *Id.* at 560.
217. *Id.*

therapy of 121 patients indicated a high degree of treatment response within acceptable safety parameters: most of the treated patients had improved "clinical status" as a result of the Ecstasy-assisted treatment.[218] The majority of Ecstasy research in the United States has been conducted on animals and those humans who have previously engaged in recreational use of Ecstasy.[219] Many claim that such research has been incomplete.[220]

Policy decisions hinge on whether Ecstasy is a neurotoxic substance, that is, one that poisons nerve tissue.[221] Ecstasy operates in the brain through three main neurochemical mechanisms: blockage of serotonin reuptake,[222] induction of serotonin release,[223] and induction of dopamine release.[224] The major concern is that in performing these functions, Ecstasy causes damage to serotonin nerve cells, resulting in the brain's inability to properly produce serotonin long after the effects of the drug have faded.[225] Serotonin neurons are "thought to play a role in regulating mood, memory, sleep, and appetite."[226] Congressional findings in two recent Ecstasy bills and the Drug Enforcement Agency's Final Rules regarding Ecstasy's classification in the CSA all mentioned its potential for causing brain damage as a critical factor.[227]

The validity of this concern is hotly debated among members of the scientific community. One report found an absence of certain chemical markers that are indicative of neurotoxicity.[228] In an-

218. *Id.*

219. *Id.* at 568, 573, 580 (explaining that recreational use of Ecstasy by the test subject impacts the validity of the study because the quantity and quality of Ecstasy used by these subjects cannot be determined, and many such test subjects have likely engaged in recreational use of other substances).

220. *Id.*

221. RANDOM HOUSE WEBSTER'S COLLEGE DICTIONARY 909 (3rd ed. 1995) (1991).

222. Serotonin is a vasoconstrictor that is present in high concentrations in some areas of the central nervous system; reuptake is the process by which serotonin is reabsorbed. STEDMAN'S MEDICAL DICTIONARY 1516 (24th ed. 1992) (defining "uptake").

223. *Id.* at 1277 (defining "serotonin").

224. *Id.* at 421; Holland, *supra* note 187, at 29.

225. *USSC Report*, *supra* note 40, at 8-9.

226. *Vermont Legislative Research Shop: Ecstasy (MDMA)* (The University of Vermont, Burlington, VT), Apr. 23, 2001 *at* http://www.uvm.edu/~vlrs/doc/ecstacy.htm (last visited Apr. 25, 2002).

227. *See generally* The Ecstasy Anti-Proliferation Act of 2000, Pub. L. No. 106-310, 114 Stat. 1101 (codified as part of the Children's Health Act of 2000, 42 U.S.C. § 290aa-5b (2000)); The Ecstasy Prevention Act of 2001, S. 1208, 107th Cong. (2001); Final Scheduling Rule, *supra* note 195; U.S. SENTENCING COMM'N, *supra* note 40.

228. JAMES P. O'CALLAGHAN, Ctr. for Disease Control and Prevention, Defining Neurotoxicity: Lessons from MDMA and Other Amphetamines 1 (2001).

other study, Ecstasy users demonstrated impairments in visual and verbal memory.[229] However, some studies indicate that, even if Ecstasy does cause such brain damage, the brain's elasticity and redundancy render the damage only temporary and insignificant.[230] In contrast, one animal study showed that some damage persisted after seven years, but it did not specify the quantity or quality of such damage.[231] Critics of this study cite the large quantities of Ecstasy given to the test subject animals.[232] If Ecstasy does produce neurotoxicity, researchers and therapists may be able to take measures to reduce any damage.[233] Some researchers have found that using the doses that most people use results in slightly reduced sleep, less impulsive behavior, and less hostility.[234] In contrast to most of the studies conducted involving large doses of Ecstasy, a 1993 study involved administering a low dose of Ecstasy to monkeys every two weeks for four months; the Ecstasy produced no effect on the subjects.[235] This study was never published in mainstream media.[236]

Prevention education and media reports documenting the consequences of Ecstasy use are often misleading. During a special program aired on MTV, a SPECT scan[237] of an Ecstasy user's brain was shown.[238] The areas of low blood flow were displayed as blank spaces, while the areas of normal blood flow were shown as brain tissue.[239] This was misleading to many viewers because the areas of

229. *"Ecstasy" Damages the Brain and Impairs Memory in Humans*, NIDA NOTES (NIDA, Washington, D.C.), Nov. 1999, at 10-11 (discussing a study wherein the performance on standardized memory tests of Ecstasy users was measured against nonusers and both groups performed within a normal range).

230. *Id.* at 10 (citing George Battaglia, et. al., *MDMA Induced Neurotoxicity: Parameters of Degeneration and Recovery of Brain Serotonin Neurons*, 19 PHARMACOLOGY, BIOCHEMISTRY, & BEHAV. 269, 269 (1988)).

231. *Id.*

232. Holland, *supra* note 187, at 19.

233. Matthew Baggott & John Mendelson, *Does MDMA Cause Brain Damage?*, *in* ECSTASY: THE COMPLETE GUIDE, *supra* note 34, at 142 (claiming that, because the possible long-term consequences of neurotoxicity are unknown, researchers and therapists can reduce the risk of neurotoxicity by maintaining low temperatures and humidity, and by keeping frequency and quantity of Ecstasy doses at a minimum).

234. *Better Than Well: Society's Moral Confusion Over Drugs Is Neatly Illustrated by Its Differing Reactions to Prozac and Ecstasy*, THE ECONOMIST, Apr. 6, 1996, at 87.

235. Grob, *supra* note 44, at 563.

236. *Id.* at 563.

237. *True Life: I'm on Ecstasy* (MTV television broadcast, Nov. 30, 2000); Julie Holland, *MDMA Myths and Rumors Dispelled*, *in* ECSTASY: THE COMPLETE GUIDE, *supra* note 34, at 54, 56-57 (defining a SPECT scan as a single positron emission computed tomography scan).

238. *Id.*

239. *Id.*

low flow looked like patches of missing tissue.[240] In reality, Ecstasy does not destroy brain tissue.[241] While one study has shown that single doses of Ecstasy do cause decreased blood flow in certain areas of the brain, any decrease is temporary.[242]

NIDA held a conference in July 2001 on the current state of Ecstasy research.[243] At the conference, a University of Minnesota study was presented which found that "Preliminary data analyses suggest that ecstasy use may not be as detrimental to cognitive function as has been previously reported."[244] Therapists claim that Ecstasy can be used to treat depression, schizophrenia, and post-traumatic stress disorder.[245] Charles Grob, a physician at the Harbor-UCLA Medical Center, summarized the current state of scientific research on Ecstasy: "In spite of substantial media coverage and millions of federal dollars for basic science research on neural mechanisms for possible brain injury caused by Ecstasy, full understanding of both its medical consequences and cultural impact has remained elusive."[246]

3. *Ecstasy and Federal Laws*

On July 27, 1984, the DEA published in the Federal Register its intention to classify Ecstasy as a schedule I drug.[247] In response, a group of therapists, psychiatrists, and researchers secured legal counsel and filed a letter requesting hearings on the matter.[248] Five hearing sessions were conducted before the DEA's administrative law judge, Francis L. Young, over a period of eight months.[249] The

240. *Id.*

241. *Id.*

242. *Id.* at 57.

243. *MDMA/Ecstasy Research: Advances, Challenges, Future Directions: A Scientific Conference* (July 2001), *at* http://www.nida.nih.gov/meetings/mdma/mdmaposters1.html (last visited Apr. 24, 2002).

244. Karen L. Hanson & Monica Luciana, Neurocognitive Function in Recreational Users of MDMA (July 19, 2000) (unpublished study on file with the Department of Psychology, University of Minnesota).

245. *See, e.g.*, Jose Carlos Bouso, *Using MDMA in the Treatment of Post-Traumatic Stress Disorder*, *in* ECSTASY: THE COMPLETE GUIDE, *supra* note 34, at 248; Julie Holland, *Using MDMA in the Treatment of Schizophrenia*, *in* ECSTASY: THE COMPLETE GUIDE, *supra*, at 273; June Reidlinger & Michael Montagne, *Using MDMA in the Treatment of Depression*, *in* ECSTASY: THE COMPLETE GUIDE *supra*, at 261.

246. Grob, *supra* note 44, at 550.

247. Schedules of Controlled Substances Proposed Placement of 3, 4-Methylenedioxymethamphetamine Into Schedule I, 49 Fed. Reg. 30210-01 (July 27, 1984).

248. *Id.*

249. Final Scheduling Rule, *supra* note 195.

Administrative Law Judge ("ALJ") heard testimony from thirty-three witnesses and received ninety-five exhibits into evidence.[250]

On July 1, 1985, during the course of the hearing, the DEA Administrator placed Ecstasy into schedule I pursuant to recently enacted emergency scheduling provisions.[251] It is no coincidence that this legislation was passed just months before the DEA published its intent to control Ecstasy in the Federal Register.[252] Emergency scheduling "is intended [ ] to apply to what have been called 'designer drugs,' new chemical analogs [sic] or variations of existing controlled substances, or other new substances, which have a psychedelic, stimulant or depressant effect and have a high potential for abuse."[253] The Final Report on temporary placement stated that "the temporary placement is not meant to interfere with the hearing."[254] At that point, however, the findings of the ALJ became essentially meaningless because the DEA Administrator independently determined that Ecstasy posed such a threat to public safety that leaving it unscheduled for six more months would be objectionable.[255] The DEA Administrator had already concluded that this relatively new drug would be placed in schedule I, regardless of the ALJ's recommendation.[256]

On May 22, 1986, the ALJ issued his Opinion and Recommendations regarding the scheduling of Ecstasy.[257] He recommended that it be placed in schedule III after finding that Ecstasy:

1. has a currently accepted medical use in the U.S.;
2. has an accepted level of safety under medical supervision; and
3. has less than a high potential for abuse.[258]

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250. *Id.*

251. 21 U.S.C. § 811(h)(1) (1996).

252. The Comprehensive Crime Control Act of 1984 amended the Controlled Substances Act to allow the Administrator of DEA to place a substance, on a temporary basis, into Schedule I when necessary to avoid an imminent hazard to the public safety. Comprehensive Crime Control Act of 1984, Pub. L. No. 98-473, 98 Stat. 1976 (1984) (codified as amended at 42 U.S.C. §§ 10601-10604 and scattered sections of 18 U.S.C. (1996)); United States Department of Justice, *Drugs of Abuse*, *at* http://www.usdoj.gov/dea/concern/abuse/chap1/control/emerge.htm (last visited Apr. 25, 2002).

253. Final Scheduling Rule, *supra* note 195.

254. *Id.*

255. *See generally* Final Scheduling Rule, *supra* note 195.

256. *See generally id.*

257. *Id.*

258. *Id.*

The ALJ found that "accepted medical use" is determined by what is "actually going on within the health care community," not by a substance's FDA approval status.[259] In addition, the ALJ found that the DEA did not meet its burden in establishing that Ecstasy has a high potential for abuse.[260]

Although this ruling was issued almost two years after the DEA's initial publication in the Federal Register, and after a prolonged series of hearings lasting for most of that time period, the DEA Administrator reviewed the record and declined to accept the recommendations of the ALJ.[261] The Administrator claimed there was substantial evidence to support the classification of Ecstasy in schedule I.[262] His main point of contention with the ALJ's ruling was the definition of "approved medical use."[263] The Administrator reasoned that FDA approval was dispositive of "accepted medical use," and any other meaning would make the FDA application and approval process a sham.[264] "The fact that a handful of physicians are of the opinion that a substance may have therapeutic value is not an acceptable alternative to the thorough clinical and preclinical evaluation which precedes approval of a [new drug application]."[265] The Administrator was also persuaded by the scientific research demonstrating Ecstasy's potential for neurotoxicity, in spite of the conflict among scientists on this issue.[266] The 1983 World Health Organization recommendation that Ecstasy be placed in schedule I of the Convention on Psychotropic Substances.[267] The subsequent placement of Ecstasy into schedule I by the United Nations Commission on Narcotics Drugs also influenced the Administrator's decision.[268]

Lester Grinspoon, one of the psychiatrists who originally requested the DEA hearings, petitioned the United States Court of Appeals for the First Circuit to review the DEA's final rule.[269] The Court of Appeals only seriously considered the first claim of the suit, that the Administrator applied the wrong legal standards for

259. *Id.*
260. *Id.*
261. *Id.*
262. *Id.*
263. *Id.*
264. *Id.*
265. *Id.*
266. *Id.*
267. *Id.*
268. *Id.*
269. Grinspoon v. DEA, 828 F.2d 881, 881 (1st Cir. 1987).

"currently accepted medical use."[270] The court employed a standard of review based on congressional intent.[271] Where that intent is not unambiguously expressed in a statute, the court reviews an agency's actions to determine if they are based on a "permissible construction of the statute."[272] The Court held that the DEA Administrator's finding was in direct conflict with the intent of the Administrative Procedure Act and vacated the Administrator's determination that Ecstasy be placed in schedule I.[273] This served little purpose, however, because the court merely instructed the Administrator to reconsider the classification of Ecstasy without treating the absence of FDA approval as conclusive evidence that Ecstasy has no accepted medical use.[274] Therefore, the Administrator merely had to find another reason to hold that Ecstasy lacked "acceptable medical use."[275] Ecstasy was permanently placed in schedule I on March 23, 1988.[276]

In the last two years, Congress has attempted to deal with increased use of Ecstasy among young people with a "tough on crime" approach led by Senator Bob Graham (D-Fla).[277] He introduced the first bill to specifically address Ecstasy: the Ecstasy Anti-Proliferation Act of 2000.[278] This bill was enacted in September 2000 as a provision of the Children's Health Act of 2000.[279] In a version that was ultimately not enacted, the bill would have punished anyone who disseminated information about drugs if that person had reason to believe that the information would be used to commit an illegal act.[280] This section was not adopted in the final version, and the main function of the bill as amended is to mandate that the United States Sentencing Commission prepare a report on

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270. *Id.*

271. *Id.* at 884-85.

272. *Id.* at 885.

273. *Id.* at 898 (citing the Administrative Procedure Act, 5 U.S.C. §§ 551-559 (1996))

274. *Grinspoon*, 828 F.2d at 881, 891.

275. *Id.* at 898 ("[O]n remand, the Administrator will not be able to rely on lack of FDA approval to demonstrate the absence of an accepted medical use.").

276. Schedules of Controlled Substances; Scheduling of 3, 4-Methylenedioxymethamphetamine (MDMA) Into Schedule I of the Controlled Substances Act; Remand, 53 Fed. Reg. 5156-01 (Feb. 22, 1988).

277. *See* The Ecstasy Anti-Proliferation Act of 2000, 42 U.S.C. § 201 (2000); The Ecstasy Prevention Act of 2001, S. 1208, 107th Cong. (2001).

278. The Ecstasy Anti-Proliferation Act of 2000, Pub. L. No. 106-310, 114 Stat. 1101 (codified as part of the Children's Health Act of 2000, 42 U.S.C. § 201).

279. *Id.*

280. The Ecstasy Anti-Proliferation Act of 2000, 106 S. 1208, § 6 (2000) (codified as amended as part of the Children's Health Act of 2000, 42 U.S.C. § 201 (2000)).

Ecstasy with the ultimate end of increasing penalties so they are "comparable with the sentences for other drugs of abuse."[281] The bill also appropriates ten million dollars for enforcement and prevention activities, although ninety-five percent of this money will likely be used for enforcement alone.[282]

Consequently, the United States Sentencing Commission amended the Federal Sentencing Guidelines (the "Guidelines") in May 2001 to reflect an increase in sentencing for Ecstasy related crimes.[283] In order to set penalties in cases involving multiple drugs with different penalties, the Federal Sentencing Commission has established the concept of "marijuana equivalency."[284] In this scheme, the Guidelines use marijuana penalties as the common standard to which all other drugs are related mathematically.[285] For example, one gram of powder cocaine has a marijuana equivalency of 200 grams.[286] Twenty grams of powder cocaine would be equivalent to 4000 grams of marijuana.[287]

The Commission issued a report explaining how its findings about Ecstasy led to its decision to increase penalties significantly.[288] After considering more public commentary than had ever been received by the Commission,[289] it decided against promulgating the published proposal to equate the penalties for Ecstasy trafficking with the penalties for heroin trafficking.[290] Instead, the Commission voted for a penalty structure that is, gram for gram, somewhat more severe than for powder cocaine.[291] The Commission chose a greater penalty structure for Ecstasy than for powder cocaine because it found that:

1. unlike Ecstasy, powder cocaine is not neurotoxic;
2. powder cocaine is not aggressively marketed to youth in the same manner as Ecstasy; and

281. The Ecstasy Anti-Proliferation Act of 2000, Pub. L. No. 106-310, 114 Stat. 1101 (codified as part of the Children's Health Act of 2000, 42 U.S.C. § 201 (2000)).

282. *See id.* It is worth noting that while the text of the bill alludes to prevention as a priority, only $500,000 of the $10 million is specifically allocated for prevention activities. *Id.*

283. *See id.*

284. *See* U.S. Sentencing Comm'n, *supra* note 46, at 5 n.1 (explaining the marijuana equivalency chart located in U.S.S.G. § 2D1.1).

285. *Id.*

286. *Id.*

287. *Id.*

288. *Id.* at 2-3 (explaining the purpose and statutory directive prompting the Report).

289. *Id.* at 4.

290. *Id.*

291. *See id.* at 4-5.

3. powder cocaine is only a stimulant, but Ecstasy acts as both a stimulant and a hallucinogen.[292]

The amended Guidelines increased sentences for Ecstasy trafficking offenders by 115%, from an average of thirty-four months to seventy-three months imprisonment.[293] In its prison impact model, the Sentencing Commission noted that 372 prison beds would be required ten years after implementation, with 270 beds required within five years.[294] However, the prison impact model admittedly understated the actual impact of the amendment; the estimates reflected only sentence increases of an assumed constant number of convicted offenders and no changes in law enforcement activity or prevalence of use were factored into the impact analysis.[295]

Senator Bob Graham introduced The Ecstasy Prevention Act of 2001 in the Senate on July 19, 2001 and Congress has not yet enacted the bill.[296] This act aims to "combat the trafficking, distribution, and abuse of Ecstasy (and other "club drugs") in the United States."[297] The Act proposes to add a section to the Public Health Service Act that would give monetary incentives to state and local governments to target club drug use.[298] States and municipalities could earn incentives by "passing ordinances restricting rave clubs, increasing law enforcement on Ecstasy, and seizing lands under nuisance abatement laws to make new restrictions on an establishment's use."[299] The act also appropriates funds to various aspects of Ecstasy interdiction and treatment.[300] In total, the Act allocates $24.5 million for law enforcement efforts directed at Ecstasy and other club drugs.[301] Despite the Act's title, only $2.5 million of this

292. *See id.* at 5.

293. Ecstasy Prevention Act of 2001, S. 1208, 107th Cong. (2001).

294. *See id.* at 16.

295. *See id.* at 6.

296. Ecstasy Prevention Act of 2001, S. 1208, 107th Cong. (2001). As of April 2002, this Act has not been signed into law.

297. *Id.*

298. *Id.* § 506.

299. *Id.*

300. *Id.*

301. *Id.* $15 million is allocated for the director of the Office of National Drug Control Policy to combat trafficking in high-intensity drug trafficking areas, including assistance for investigative costs, intelligence enhancements, technology improvements, and training. *Id.* $7 million is allocated for the director of the Office of National Drug Control Policy to carry out the Free Media Campaign Act of 1998, ensuring that the campaign addresses the reduction and prevention of abuse of Ecstasy and other club drugs. *Id.* $1.5 million is allocated for the National Institute on Drug Abuse to conduct research and produce a report by January 2003 that evaluates

amount is directed at treatment and education, which are the two primary modes of prevention.[302] Currently, The Ecstasy Prevention Act is pending before the Senate Judiciary Committee.

II. THE SPECTRUM BETWEEN PROHIBITION AND LEGALIZATION: OPTIONS FOR ECSTASY POLICY

Since the repeal of alcohol prohibition, United States drug policy has ironically been grounded in the belief that outlawing illicit drugs and punishing their use with severe criminal penalties will prevent their use.[303] Government-sponsored harm reduction programs, such as abstinence-based prevention and treatment, have accompanied criminal sanctions to varying degrees.[304] Grass roots efforts have also incorporated safer-use programs in some communities.[305] Nonetheless, the application and effectiveness of these approaches to Ecstasy are still in flux. The current combination of tactics, including increasingly severe penalties, private pill-testing, and prevention, is failing.[306] Although Ecstasy use accounts for only a small percentage of all drug use in the United States, it is the fastest growing substance of choice among teenagers.[307] Ecstasy-related emergency room visits have been increasing and Ecstasy is more readily available than ever before.[308] No solution will eliminate Ecstasy use, but the Government can aim to more effectively and efficiently reduce Ecstasy use and related harms. An examination of how alternative approaches to drug policy are or could be applied to Ecstasy, and the associated benefits and criticisms of

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the effects that Ecstasy has on an individual's health. *Id.* $1 million is allocated to the establishment and function of an Interagency Ecstasy/Club Drug Task Force that will design, implement, and evaluate the education, prevention, and treatment strategies of the federal government. *Id.*

302. *Id.*

303. *See supra* note 30 and accompanying text (explaining the punitive criminal justice approach to drug policy that parallels alcohol prohibition).

304. For a complete discussion of the application of harm reduction programs in the United States, see *supra* notes 158-85 and accompanying text.

305. For a complete discussion of the application of harm reduction programs in the United States, see *supra* notes 158-85 and accompanying text.

306. *Supra* notes 36-38 and accompanying text.

307. *Supra* note 37 and accompanying text.

308. *See* Holland, *supra* note 187, at 19 (explaining that at a July 2000 DEA conference on club drugs, it was estimated that two million hits of Ecstasy were coming into the United States each week, and that according to the 2000 Monitoring the Future study, eleven percent of high school seniors had tried Ecstasy at some time); *supra* note 37 and accompanying text (citing statistics for the increase in emergency room visits related to Ecstasy use).

such approaches, may prove useful in determining what, if any, changes should be effected.

A. Prohibition and Federal Laws

1. *Ecstasy's Placement In Schedule I*

Since 1985, Ecstasy has been categorized as a schedule I substance in the Controlled Substances Act, the classification typically reserved for the most dangerous drugs.[309] One of the most significant effects of a drug's placement in schedule I is the limit placed on its research, especially studies involving human subjects.[310] A scientist wishing to conduct research on a schedule I substance must register with the Attorney General and then obtain approval from HHS and the FDA.[311] HHS approval is based on the competency of the practitioner and the merits of the research protocol,[312] while FDA approval often depends on designing a protocol that has concrete measurable outcomes.[313]

Opponents of Ecstasy's schedule I classification argue that the contradicting outcomes of current scientific research about the effects of Ecstasy should instigate more, not less, research.[314] The current challenge in obtaining FDA approval for a study wherein Ecstasy is administered to human subjects is in constructing a protocol with outcome measures that are concrete enough to be acceptable to the FDA.[315] This requirement is difficult to meet because the results of psychotherapy are often difficult to quantify.[316] The problem with the available Ecstasy research on human subjects is that it was conducted only on subjects who have used Ecstasy recreationally in an uncontrolled setting.[317] Given the unreliable purity level of street Ecstasy,[318] and the number of study

309. *Supra* notes 251-76 and accompanying text (explaining the process by which Ecstasy was placed into schedule I).

310. Julie Holland, *MDMA Research: Introduction*, *in* ECSTASY: THE COMPLETE GUIDE, *supra* note 34, at 295.

311. 21 C.F.R. § 1301.18 (1997).

312. Controlled Substances Act, 21 U.S.C. § 823 (1996).

313. *See* Holland, *supra* note 206, at 240.

314. BECK & ROSENBAUM, *supra* note 112, at 145.

315. *See* Holland, *supra* note 206, at 40.

316. *Id.* at 40.

317. *See id.* at 40.

318. Judith Holland, *Minimizing Risk in the Dance Community: An Interview with Emanuel Sferios*, *in* ECSTASY: A COMPLETE GUIDE, *supra* note 34, at 163 ("[A] large percentage of the pills being sold as Ecstasy . . . do not contain MDMA.").

participants who may be poly-drug users,[319] current study results are neither accurate nor indicative of the damage, or lack thereof, of low level use in a controlled setting.[320] Moreover, the research conducted by NIDA, some argue, is biased either in its content or distribution.[321] For example, in the Sentencing Commission's Report, which was mandated by Congress, the United States Sentencing Commission ("USSC" or the "Commission") stated at several points that it was instructed to report on the damage and danger caused by Ecstasy use, regardless of evidence to the contrary.[322] One example was the instruction by Congress that the Commission report on the danger of the high concentration of Ecstasy in each pill; the Commission found no evidence to support this claim.[323]

2. *Amendment of the Federal Sentencing Guidelines for Ecstasy*

In May 2001, the Federal Sentencing Guidelines were amended to increase the federal penalties for trafficking in Ecstasy.[324] The amendment made the penalties for trafficking Ecstasy higher than those for trafficking cocaine and only slightly lower than those for heroin. Supporters of the increase believe that the changes gave law enforcement another weapon with which to battle Ecstasy.[325] The Department of Justice contends that additional punishment is needed to curb the dramatic increase in the drug's use in recent years.[326] As the DEA remarked,

> [T]hese new sentencing enhancements . . . will arm federal drug law enforcement with a valuable tool against Ecstasy traffickers by increasing the likelihood of federal prosecution, allowing more appropriate terms of imprisonment for mid and high level

319. Judith Holland, *Giving MDMA to Human Volunteers in the United States: An Interview with Charles Grob*, *in* ECSTASY: THE COMPLETE GUIDE, *supra* note 34, at 333 (noting that Ecstasy research subjects often have extensive histories of multidrug use).

320. *See* Holland, *supra* note 206, at 40.

321. *See* Grob, *supra*, note 44, at 563-79 (raising questions about several government-sponsored studies of Ecstasy, and the dissemination of those studies showing harm to the exclusion of at least one study demonstrating no negative effects following low dose administration of Ecstasy).

322. *See* U.S. SENTENCING COMM'N, *supra* note 40, at 9.

323. *Id.* at 9.

324. Ecstasy Prevention Act of 2001, S. 1208, 107th Cong. (2001); 42 U.S.C. § 201 (2000).

325. Press Release, U.S. Senator Bob Graham, Graham Hails New Ecstasy Guidelines, Which Go Into Effect Tomorrow (Apr. 30, 2001) (on file with author).

326. Peter Slevin, *Sentencing Guidelines Toughened for Ecstasy*, WASH. POST, Mar. 21, 2001, at A17 (discussing the contention that stricter punishment is necessary to curb drug use).

> dealers, and providing more effective leverage in turning low level distributors to assist in apprehending and prosecuting the top level violators in Ecstasy trafficking organizations.[327]

During the U.S. Sentencing Commission's public comment period, many critics openly opposed the increase.[328] The Federation of American Scientists issued a statement concluding that there is "no justification, either pharmacologically or in policy terms" for increased Ecstasy penalties.[329] Scientists also fear that harsher penalties will lead to increased production of counterfeit substances sold as Ecstasy in an attempt to meet the demand for Ecstasy without risking harsher sentences.[330] This poses a serious health risk to users.[331] The new Guidelines also raise the concern that young, first-time offenders engaged in Ecstasy trafficking will spend more time in prison than violent criminals despite the fact that over eighty-five percent of federal Ecstasy offenders have little or no criminal history.[332] Senator Bill Graham, sponsor of the sentence-increasing Ecstasy Anti-Proliferation Act,[333] stated that "The new guidelines are aimed at punishing profiteers, not young people who make a bad choice."[334] These groups, however, may be one and the same. According to the USSC, over one-third of the federal offenders sentenced for Ecstasy offenses in 2000 were between the ages of twenty-one and twenty-five; the average age of all federal Ecstasy offenders is twenty-seven.[335]

Increased penalties have also been critiqued from an economic perspective. Strict enforcement advocates attack the supply side of the drug trade with two goals: stopping the flow of drugs and re-

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327. Joseph D. Keefe, Statement Before the Senate Governmental Affairs Committee, (July 30, 2001), *at* http://www.usdoj.gov/dea/pubs/cngrtest/ct073001.htm (last visited Apr. 21, 2002) [hereinafter Statement of Keefe].

328. *See* U.S. SENTENCING COMM'N, *supra* note 40, at 4 (stating that the USSC received hundreds of submissions during its public comment period opposing the increased penalties).

329. Press Release, Drug Policy Alliance, Harsh New Federal Penalties for Ecstasy Take Effect (Apr. 30, 2001) (on file with author).

330. *Id.*

331. *Id.*

332. *Id.*; *see infra* note 347 and accompanying text (comparing the average sentence for a nonviolent drug with that of a charge for manslaughter).

333. The Ecstasy Anti-Proliferation Act of 2000, Pub. L. No. 106-310, 114 Stat. 1101 (codified as part of the Children's Health Act of 2000, 42 U.S.C. § 201 (2000)).

334. Bob Graham, *Tuesday: A New Tool to Combat Ecstasy Epidemic,* ORLANDO SENTINEL, Apr. 30, 2001, at A17.

335. U.S. SENTENCING COMM'N, *supra* note 40, at 13 (noting that the average age of a heroin or methamphetamine trafficker is thirty-three years old, while the heaviest use of Ecstasy occurs among people ages eighteen to twenty-five).

ducing supply to drive up prices.[336] Proponents of strict enforcement as a means of reducing drug use argue that current interdiction efforts work because they increase the consumer cost.[337] In many cases, the consumer costs are raised ten to one hundred times the manufacturing cost.[338] However, strict enforcement may actually fail to drive up the cost of Ecstasy. The profit margin for Ecstasy is enormous; each pill costs two to twenty-five cents to produce, and sells for ten to forty-five dollars on the street.[339] Ecstasy trafficking and dealing is enormously profitable.[340] Yet, the price increase does not affect the typically middle-class Ecstasy purchaser.[341] A California magistrate judge commented that arrests and incarcerations may simply clear the way for newer, smarter Ecstasy traffickers.[342] The competing financial cost to society is also a concern. The increased number of prison beds,[343] the cost of housing prisoners for longer periods,[344] and the

336. CAULKINS, *supra* note 25.

337. *Id.*

338. *Id.*

339. PBS, *Ecstasy Discussion Guide* (2001), *at* http://www.pbs.org/inthemix/educators/ecstasy_guide.html (last visited Jan. 20, 2002); *see also* Press Release, U.S. Customs Service, U.S. Customs Service Commissioner Announces New Steps to Combat "ECSTASY" Abuse and Trafficking (Mar. 13, 2000) (on file with author) (quoting customs officials saying that "Profit is one of the driving forces behind the surge in Ecstasy traffic. In Europe, Ecstasy tablets cost just a few pennies apiece to make. Once the tablets reach a nightclub in the U.S., they can be sold for $20—$40 a piece"); Luke Johnson, *Increase in Use of "Club Drug" Ecstasy Poses Growing Risk*, WASHINGTON FILE, Jul. 27, 2000, at 1 (quoting the United States Department of State as saying, "[T]he tablets—produced at very low cost, and sold to users for anywhere between $20 and $40—offer a very high profit margin.").

340. *See Ecstasy Spreads: Many Users Think It Is Safe. Not So, Say Scientists and Police. Permanent Brain Damage?*, Partnership for a Drug-Free America, Ecstasy and Club Drugs Information Center, Dec. 1, 2001, *at* http://www.drugfreeamerica.org (last visited Jan. 20, 2002) ("At one former Ecstasy factory [there was] a machine that can produce 300 Ecstasy pills a minute. Assuming that it operates ten hours a day, seven days a week, it can produce more than 1.2 million pills a week. The cost per pill for manufacturers: 20 cents. On the street that pill is worth $20.").

341. NIDA Infofax, *MDMA (Ecstasy), at* http://www.nida.nih.gov/Infofax/ecstasy.html (last visited Jan. 20, 2002) (stating that Ecstasy use has spread to other social settings and has become the drug of choice among white middle-class young adults in Washington, D.C.); Statement of Keefe, supra note 327.

342. *See* GRAY, *supra* note 1, at 211 (quoting Magistrate Judge Ronald Rose as saying, "There is just so much money to be made that the slim chance of being caught is always worth the risk. Believe me, after 20 years as a prosecutor and judge, I can assure you that we only catch the stupid ones.").

343. *Supra* notes 11, 14-15 and accompanying text.

344. GRAY, *supra* note 1, at 37. ("[I]t costs taxpayers between $20,000 and $30,000 to keep just one inmate confined for a year.").

societal costs of mixing drug users and violent criminals in prison[345] are all criticisms of the enhanced sentences for Ecstasy trafficking. Families Against Mandatory Minimums, a nonprofit organization, also criticizes such sentences for the harm families suffer when a member is imprisoned for a lengthy period of time.[346] The average federal sentence for a drug offense is seventy-eight months, over twice the average sentence for manslaughter.[347] Disproportionate sentencing for nonviolent drug offenses and violent offenses troubles many, especially when it has yet to be proven that the substance in question causes serious harm.[348]

B. Harm Reduction

The harm reduction view, that drug use should be addressed as a social and public health concern,[349] has gained public support in recent years.[350] This is likely due in part to the fact that 86.9 million Americans over age twelve have used an illicit drug at least once in their lifetime.[351] This is not to say, however, that law enforcement is not necessary in some circumstances. According to Kurt Schmoke, the former mayor of Baltimore, Maryland, "Our goal must be defined as finding the right balance of law enforcement and public health strategy to achieve the goals that we hold in common: safer communities, healthier individuals, reduced sub-

345. *See id.* at 29-30 (discussing the growing number of drug prisoners in the United States and the unintended effects of forcing drug users to associate with criminals, prison overcrowding, early release of violent offenders to make room for nonviolent drug offenders serving mandatory minimum sentences, court docket backlog, and loss of deterrent effect).

346. *See* Families Against Mandatory Minimums, *at* http://www.famm.org (last visited Jan. 20, 2002).

347. *See* Arianna Huffington, *Bush's Drug Policy: "The Thing With Two Heads,"* ARIANNA ON LINE, May 17, 2001, *at* http://www.ariannaonline.com (last visited Jan. 20, 2002).

348. *Supra* notes 228-35 and accompanying text (discussing conflict among scientists regarding the damage caused by Ecstasy).

349. *Supra* note 110 (defining harm reduction).

350. *E.g.*, Diane Riley & Pat O'Hare, *Harm Reduction: History, Definition, and Practice*, *in* HARM REDUCTION: NATIONAL AND INTERNATIONAL PERSPECTIVES, *supra* note 19, at 9 (stating that harm reduction seeks to minimize harms to the individual, the community, and society as a whole by approaching drug use as a public health issue, while respecting individuals' choices); Jefferson Fish, *Rethinking Our Drug Policy*, 28 FORDHAM URB. L.J. 48, 49-50 (2000) (explaining that harm reduction, or medicalization, treats drug use primarily as a public health issue).

351. SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH AND HUMAN SERVS., SUMMARY OF FINDINGS FROM THE 2000 NATIONAL SURVEY ON DRUG ABUSE 131 (2001).

stance abuse, and the elimination of AIDS."[352] While many harm reduction advocates would agree with these goals, they would not support the balance Schmoke proposes.[353] In fact, many harm reduction advocates believe that the primary use of the criminal justice system as a method to deal with drug use should be eliminated entirely.[354] Others claim that as long as drug use is treated through the punitive criminal justice system, harm reduction methods should be used to humanize the system itself.[355] The advantages and disadvantages of such methods—treatment, prevention, and safer-use programs—can be most clearly evaluated individually.

1. *Treatment*

Treatment is the "use of any planned, intentional intervention in the health, behavior, or personal life of an individual suffering from alcoholism or from another drug dependency to enable the individual to achieve and maintain sobriety and physical and mental health.[356] Drug treatment is seven times more cost effective than domestic law enforcement in addressing drug abuse.[357] There are approximately 800,000 prison inmates nationally who have drug and alcohol abuse problems, but only one in six receives any kind of drug treatment at all.[358]

Treatment is widely accepted as a viable and effective solution to the problem of substance abuse.[359] The few critics of this solution mainly question the validity of the "disease model" of addiction.[360]

352. Fish, *supra* note 350, at 48.

353. Harm Reduction Coalition, *Principles of Harm Reduction*, http://www.harmreduction.org/prince.html (last visited Apr. 10, 2002) (discussing the negative results of the drug control strategy that prioritizes criminalization).

354. *Id.*

355. James A. Inciardi, *The Harm Reduction Roles of the American Criminal Justice System*, *in* HARM REDUCTION: NATIONAL AND INTERNATIONAL PERSPECTIVES, *supra* note 19, at 199.

356. Am. Soc'y for Addiction Med., *Public Policy Statement, Treatment for Alcoholism and Other Drug Dependencies, at* http://www.asam.org/ppol/treatment.htm (last visited Jan. 20, 2002).

357. *A Cheaper Way to Fight Cocaine*, S.F. CHRON., June 14, 1994, at A7.

358. GRAY, *supra* note 1, at 185.

359. *See, e.g.*, Steven Belenko, *The Challenges of Integrating Drug Treatment into the Criminal Justice Process*, 63 Albany L. Rev. 833, 837 (2000) (discussing the research demonstrating that drug treatment can significantly reduce drug use and related crime); Bernadette Pelissier et. al., *Triad Drug Treatment Evaluation Project*, 65 FED. PROBATION 3 (2001) (stating that drug treatment provided to incarcerated offenders reduces the likelihood of future criminal conduct and drug use).

360. For a general discussion of the disease model of addiction, see Bruce K. Alexander, *The Disease and Adaptive Models of Addiction: A Framework of Evaluation*, *in* VISIONS OF ADDICTION 45 (Stanton Peele ed., 1988).

The current "drug czar," John Walters, supports treatment as a companion to increased enforcement and longer periods of incarceration, but has also accused treatment advocates of being dogmatic and has questioned the concept of addiction as a disease.[361] Treatment is sometimes encouraged or mandated in criminal possession cases in which the defendant engaged in only casual or recreational use.[362] Moreover, court-ordered treatment rests on the premise that every illicit substance user is addicted and in need of abstinence-based treatment.[363] However, treatment professionals point out that "Everyone who uses a drug is not an addict, at least not yet."[364]

Ecstasy is a nonaddictive substance, but repeated use can lead to psychological dependence.[365] Psychological dependence is characterized by a desire to engage in repeated use, without the compulsive nature of physical addiction.[366] Treatment for nonaddictive substances like Ecstasy is very different from treatment for physically addictive substances such as cocaine, alcohol, and heroin.[367] In contrast to these substances, Ecstasy dependency occurs because of the mental and physical euphoria felt when under its influence.[368] Consequently, treatment professionals face a challenge in determining how to appropriately handle Ecstasy users, and have not accepted any single protocol.

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361. *See* John P. Walters, *Just Say No . . . To Treatment Without Law Enforcement*, WKLY. STANDARD, Mar. 6, 2001, at 19 ("The therapy-only lobby is alive and well and more dogmatic than ever. If it weren't for the ideology associated with treatment—addiction is a disease, not a pattern of behavior for which people can be held responsible—law enforcement and punishment would be natural partners of the treatment providers (remember Marion Barry, whose treatment followed his arrest).").

362. DAVID A. PETERS, THE PROBABILITY OF ADDICTION 6 (1997).

363. *Id.*

364. *Id.*

365. *Supra* notes 212-13 and accompanying text (explaining how abuse of Ecstasy might occur and correct itself, rendering Ecstasy only psychologically addictive). *Contra Facts about MDMA (Ecstasy)*, NIDA NOTES (NIDA, Washington, D.C.), 2000, at 1 (stating that Ecstasy is addictive).

366. Psychological dependence, or habituation, is the result of repeated consumption of a drug that produces psychological but no physical dependence. U.S. Dep't of Labor, Working Partners Substance Abuse Database, Glossary of Terms, *at* http://www.notes.dol.gov/said.nsf (last visited Apr. 24, 2002). The psychological dependence produces a desire (not a compulsion) to continue taking drugs for the sense of improved well-being. *Id.*

367. Physical addiction occurs when a person's chemical usage causes repeated harmful consequences and the person is unable to stop using the drug of choice; the term implies that withdrawal will take place when the mood changing chemical is removed from the body. *Id.*

368. Alcohol Drug Treatment Referral, *Drug Information: Ecstasy, at* http://www.nationalhotline.org/ecstasy.html (last visited Apr. 24, 2002).

In September 2001, the Maryland legislature issued an action plan that incorporated treatment methods into its efforts to counteract the increasing number of teenagers using Ecstasy.[369] This plan includes training county treatment providers and prevention educators, educating hospital and emergency room personnel to ensure that an Ecstasy episode is properly treated, and issuing alerts to increase awareness of Ecstasy's effects within the medical and treatment communities.[370] One researcher recommends psychotherapy and a careful examination to determine if a user took Ecstasy to self-medicate an underlying disorder, such as depression or anxiety, which should be treated separately.[371] Treatment for Ecstasy would include the same elements used to treat addiction or dependence on other substances; it is a generally accepted notion among treatment professionals that the overall addiction, whether physical or psychological, is the problem, not the specific substance.[372] It should be noted, however, that not all drug users become addicts, and addiction treatment may prove unnecessary within this population.[373]

2. *Prevention*

Advocates of almost every approach to drug policy respect prevention education, but selection of specific prevention methods engenders great disagreement. Preventing alcohol, tobacco, and other drug use among the nation's children was the first of five goals outlined last year in the National Drug Control Strategy.[374] However, the Federal government allocated only thirteen percent of its drug budget to prevention programs and research.[375] Prevention spending lags at the state level as well, where only twenty per-

369. MD. CABINET COUNCIL ON CRIMINAL AND JUVENILE JUSTICE, STATE ECSTASY ACTION PLAN (2001).

370. *Id.*

371. Karl L.R. Jansen, *Mental Health Problems Associated with MDMA Use*, *in* ECSTASY: THE COMPLETE GUIDE, *supra* note 34, at 106-07.

372. *Ecstasy* (DrugAbuse.com), *at* http://www.drugabuse.com/drugs/ecstasy/ (last visited Apr. 24, 2002).

373. Robert Curley, *Addiction Insights*, ALCOHOLISM AND DRUG ABUSE WKLY., Apr. 3, 1995, at 3 (stating that only a small percentage of drug users need addiction treatment).

374. OFFICE OF NAT'L DRUG CONTROL POLICY, NATIONAL DRUG CONTROL STRATEGY: 2001 ANNUAL REPORT 6-7 (2001).

375. *Id.*

cent of state drug budgets address both prevention and treatment.[376]

a. Traditional Prevention Programs

There are two prominent abstinence-only prevention programs in the United States: Drug Abuse Resistance Education ("DARE") and Life Skills Training ("LST").[377] A study found DARE to be ineffective in February 2001, yet eighty percent of the nation's school districts still utilize the DARE program.[378] More than one dozen experts describe this drug education movement as dysfunctional and highly politicized.[379] They also describe it as a program that does not stand up to scientific scrutiny.[380] These experts believe that the abstinence-based model of drug prevention education used in America's schools is as likely to have no effect on minors' drug use, or even the unwanted effect of inciting curiosity, as it is to persuade them not to use drugs.[381]

A popular alternative to DARE is LST, a program consisting of a three-year curriculum beginning in sixth or seventh grade.[382] The program covers three general topics: the effects of drugs on the body, the development of personal or self-management skills, and the honing of students' social and resistance skills.[383] LST statistics show a reduction in the use of alcohol, tobacco, and marijuana among program participants by as much as seventy-five percent, and a significant decrease in the use of narcotics and hallucinogens.[384] The Department of Education, NIDA, and the Center

376. *Id.*; M. A. R. Kleiman, *Drugs and Drug Policy: The Case for a Slow Fix*, 15 ISSUES IN SCI. AND TECH. 1 (1998).

377. DARE is a police officer-led series of classroom lessons for children from kindergarten through twelfth grade. DARE, http://www.dare.com (last visited May 11, 2002); LST targets middle and junior high school students and consists of a three-year curriculum comprising fifteen sessions in the first year, ten sessions in the second year, and five to eight sessions in the third year. DRUG STRATEGIES, CRITICAL CHOICES: MAKING DRUG POLICY AT THE STATE LEVEL 1 (2001).

378. Donald R. Lynam & Richard Milich, *Project DARE: No Effects at 10-Year Follow-Up*, 67 J. OF CONSULTING & CLINICAL PSYCHOL. 590, 592 (1999) ("[T]here appear to be no reliable short-term, long-term, early adolescent, or young adult positive outcomes associated with receiving the DARE intervention."); DARE, http://www.dare.com/index2.htm (last visited Apr. 23, 2002) (stating that DARE is still taught in the majority of school districts in the country).

379. Lyman & Milich, *supra* note 378, at 592.

380. *Id.*

381. *Id.*

382. DRUG STRATEGIES, CRITICAL CHOICES: MAKING DRUG POLICY AT THE STATE LEVEL 1 (2001).

383. *Id.*

384. *Id.*

for Substance Abuse Prevention have all deemed DARE exemplary.[385] The program is taught in approximately 3000 schools, and has produced over 800,000 alumni.[386]

The Center for Educational Research conducted a study in 2001 that criticized LST's data and methods for calculating effectiveness, finding that students who did not complete the entire three-year curriculum had higher drug use rates than those who never encountered the program.[387] A former researcher on one LST study found that students who went through LST were more likely to drink alcohol than students who were not exposed to the program.[388]

Abstinence-only prevention programs have drawn sharp criticism from many in the scientific community and the national government. The General Accounting Office, which evaluates how effectively federal money is spent, reported that "There is no evidence that the no use approach is more successful than alternative approaches, or even successful in its own right."[389] A more general criticism of widely used prevention programs such as DARE and LST is that drug education researchers often evaluate their own programs, and, with few exceptions, tend to parse out their data so programs appear more successful than they actually are.[390] While "Just Say No" programs may work for very young children, they are largely ineffective for teenagers and young adults.[391]

b. Alternative Prevention Programs

An alternative prevention education program called "resilience education" focuses on young people's ability to adapt and thrive within the current drug culture, without teaching that abstinence is the only response.[392] As many as seven million children between the ages of ten and seventeen are at particularly high risk because of personal, family, or community factors.[393] As such, supporters of this program hail it as a more realistic approach than no-use programs. Marsha Rosenbaum, West Coast director of the Drug

385. Jason Cohn, *Drug Education: The Triumph of Bad Science*, ROLLING STONE, May 24, 2001, at 41.

386. *Id.*

387. Center for Educational and Resource Development, http://www.cerd.org/current/jde2001.html (last visited Apr. 23, 2002).

388. Cohn, *supra* note 385, at 41.

389. *Id.*

390. *Id.*

391. Rosenbaum, *supra* note 36, at B9.

392. *Id.*

393. DRUG STRATEGIES, KEEPING SCORE 8 (1997).

Policy Alliance, notes, "What's missing from 'drug education' is education. For the kids who don't say no, where can they go for honest, realistic information about drugs in a life-or-death situation? They sure can't go to the so-called educator in a no-use prevention program."[394]

Another alternative prevention program is New York's Student Assistance Program ("SAP"), which encourages young people to seek counseling for anything that might lead to alcohol or drug use.[395] This program, in place since 1979, offers confidential assistance for all students, regardless of whether or not they have begun experimenting with drugs.[396] While offered to all students, the program most often benefits at-risk students.[397] Evaluations since 1983 indicate that SAP reduces teenage use of alcohol and other drugs by up to fifty percent.[398] The positive results are attributed to individualization of the program at each participating school.[399]

Prevention programs specifically targeting Ecstasy use have been initiated by NIDA, but many educators still cannot determine which efforts will be most effective at reducing use.[400] The National Clearinghouse for Alcohol and Drug Information simply writes, "In developing prevention efforts that target young people, prevention managers must design strategies to counter the increasing use and widespread availability of the club drug Ecstasy."[401] The strategies that can counter the growing Ecstasy use are likely the same ones used to counter other drugs. In an in-depth study of prevention programs, NIDA found that the most effective prevention programs enhance "protective factors" such as positive family relationships, community involvement, and success in school, while

394. *Id.*

395. *Id.*

396. *Id.*

397. Behavioral Health Services North, *School-Based Services*, *at* http://www.bhsn.org/bhsn8.htm (last visited Apr. 24, 2002).

398. DRUG STRATEGIES, *supra* note 393.

399. *Id.*

400. For example, on its website, NIDA shows the image of a brain and describes one half as being a normal brain (with the correct serotonin production), and the other half being damaged by repeated Ecstasy use. NIDA, http://nida.nih.gov. This image has been widely criticized because people generally vary in their serotonin production, and the Ecstasy user may have used other drugs prior to the scan. Club Drugs.org, http://165.112.79.54/ (last visited Apr. 24, 2002). NIDA also attempts to educate elementary school students on the effects of various drugs, including Ecstasy, on the brain and body with cartoon images and simple-to-read text. NIDA, http://165.112.78.61/MOM/HALL/MOMHALL1.html (last visited Apr. 24, 2002).

401. *Prevention Works!*, The National Clearinghouse on Alcohol and Drug Abuse *at* http://www.health.org/govpubs/prevalert/v3i25.htm (last visited Apr. 24, 2002).

moving toward reversing or reducing known "risk factors" such as chaotic home environments, lack of mutual attachments, lack of nurturing, and poor social coping skills.[402]

3. *Safer-Use Programs*

Part of a comprehensive harm reduction plan to address the increase in Ecstasy use should include safer-use programs that educate the public on the risks of using Ecstasy and provide information about how to use it more safely.[403] In the early 1990s, the rave community began its own safer-use campaign by developing a code of conduct for rave organizers.[404] This campaign includes emphasizing the provision of "chill out" rooms,[405] easy access to cold water, and the distribution of drug risk information.[406] Harm reduction advocates willingly acknowledge that Ecstasy, like any other drug, is not safe,[407] but claim that "young people are clamoring for, and listening to, recommendations for reducing immediate harm."[408] Such recommendations include the following: resting periodically to prevent overheating; drinking water; testing pills to be sure they do not contain dangerous adulterants; avoiding combining Ecstasy with other drugs; and moderating dose levels and frequency of use.[409] DanceSafe,[410] for example, disseminates drug risk information and provides an extra service, adulterant testing, at clubs and raves or by mail.[411]

Advocates claim that adulterant testing is an important component of the safer use of Ecstasy.[412] By the mid-1990s, only an esti-

402. *NIDA Infofax, Lessons from Prevention Research*, *at* http://165.112.78.61/Infofax/lessons.html (last visited Apr. 24, 2002).

403. *Supra* note 174 and accompanying text.

404. Gwen Filosa, *Rave Promoters Feel the Heat*, NEWHOUSE NEWS SERVICE, Mar. 13, 2001, at 1.

405. "Chill out" rooms are rooms provided at raves or clubs where patrons can go to cool down. *Id.*

406. Grob, *supra* note 44, at 558.

407. *See* P'ship for a Drug-Free Am., Ecstasy and Club Drugs Info. Ctr., Ecstasy Spreads: Many Users Think It Is Safe. Not So, Say Scientists and Police. Permanent Brain Damage?, Dec. 1, 2001, *at* http://www.drugfreeamerica.org (last visited Apr. 23, 2002) (quoting Emanuel Sferios, the founder of DanceSafe, stating: "No drug use is safe").

408. Rosenbaum, *supra* note 36, at B11 (emphasis added).

409. *Id.*

410. *Supra* notes 175-80 and accompanying text (explaining the establishment and purpose of DanceSafe).

411. *Promoting Health and Safety in the Rave Community* (DanceSafe), *at* http://www.dancesafe.org (last visited Apr. 24, 2002); *see also supra* notes 175-180 and accompanying text.

412. *Promoting Health and Safety*, *supra* note 411.

mated forty percent of pills sold as Ecstasy were actually Ecstasy.[413] Although statistics have not yet been compiled, DanceSafe offers anecdotal evidence of the effectiveness of its efforts.[414] In the summer of 1999, DanceSafe discovered through its pill-testing program that tablets containing dangerously high doses of DXM[415] were causing the majority of medical emergencies in the Oakland rave community, as well in many other cities across the U.S.[416] DanceSafe was able to warn users about this increased risk.[417] Another dangerous adulterant is PMA.[418] PMA precursor chemicals are easier to obtain and are not strictly controlled by the government like those for Ecstasy; as such, someone can produce PMA without taking the risks of producing real Ecstasy.[419] Although DanceSafe's standard testing cannot identify PMA, the organization's website provides a picture of a PMA pill and warns readers to avoid it because of its danger.[420]

Despite evidence that safer-use campaigns actually reduce harm, many critics still oppose them because of their potential message: that Ecstasy use is acceptable and safe under certain circumstances.[421] Dr. Alan I. Leshner, director of the National Institute on Drug Abuse, has said, "I'm against anything that sends a message that if you do it well it is O.K., because it is not O.K."[422] A legislative aide to Senator Bob Graham, who authored the two

413. Grob, *supra* note 44, at 558.

414. Interview with Tim Santamour, Executive Director of DanceSafe in New York, N.Y. (Sept. 17, 2001).

415. DXM is the abbreviation for dextromethorphan, a legal cough suppressant that in high doses can prevent sweating. DanceSafe, http://www.dancesafe.org (last visited Apr. 24, 2002).

416. Filosa, *supra* note 104, at 1.

417. *Id.*

418. *See* The Nat'l Clearinghouse for Alcohol and Drug Info., *The Hallucinogen PMA: Dancing With Death*, Oct. 2000, *at* http://www.health.org/nongovpubs/pma-dea/ (last visited Apr. 24, 2002) (stating that paramethoxyamphetamine (PMA), is an illicit, synthetic hallucinogen that has stimulant effects similar to other clandestinely manufactured amphetamine derivatives like MDMA. Since May 2000, PMA ingestion has been associated with three deaths in Chicago, Illinois, and seven deaths in central Florida).

419. *See, e.g.*, DanceSafe, *PMA Warning, at* http://www.dancesafe.org/pma_faq.html#intro (last visited Apr. 24, 2002).

420. *Id.*

421. *Id.* In addition, one toxicology expert criticized DanceSafe's on-site testing because such testing is not conducted in a sterile environment and the testers do not have the relevant specialized degrees. *Party Drug, Fatal Drug* (CBSNews broadcast, Jul. 26, 2001), *at* http://www.cbsnews.com/stories/2000/11/29/48hours/main253290.shtml (last visited Apr. 24, 2002).

422. Jeff Stryker, *For Partygoers Who Can't Say No, Experts Try To Reduce the Risks*, N.Y. TIMES, Sept. 25, 2001, at F5.

congressional bills targeting Ecstasy,[423] claims that "Arguably, organizations such as DanceSafe promote Ecstasy use. These organizations are giving a mixed message, a very dangerous message to people who use this drug."[424]

C. Decriminalization

Some consider decriminalization a lesser form of legalization where criminal sanctions for users are removed while those for manufacturers and sellers remain intact.[425] "Decriminalization" typically means that a person can legally possess a small quantity (enough for personal use only) of a given drug, or that penalties for drug possession are reduced.[426] A primary concern about decriminalization is that it will lead to increased usage.[427] However, the decriminalization of marijuana by eleven states in the United States during the mid-1970s does not appear to have caused increases in marijuana consumption.[428]

Some decriminalization of Ecstasy has already occurred in the United States.[429] At the state and local level, low-level Ecstasy possession has not been enforced consistently.[430] DanceSafe negotiates with local police to give volunteer testers and Ecstasy users amnesty from arrest.[431] This reprieve allows DanceSafe to perform services that could otherwise lead to massive arrests.[432] Further decriminalization of Ecstasy could involve reducing penalties for possession and entering into formal agreements with law enforcement agencies not to enforce low-level possession violations.

D. Legalization with Regulation

Legalization is often misunderstood. As most advocates define it, legalization involves the repeal of laws prohibiting drug use and the implementation of regulated system of Ecstasy distribution

423. *See supra* notes 278-302 and accompanying text (discussing The Ecstasy Prevention Act of 2001 and The Ecstasy Anti-Proliferation Act of 2000).

424. Stryker, *supra* note 422, at F5.

425. Ethan A. Nadelmann, *Drug Prohibition in the United States: Costs, Consequences, and Alternatives*, 245 SCIENCE 939, 939-47 (1989).

426. For a complete definition of decriminalization, see *supra* note 119 and accompanying text.

427. Nadelmann, *supra* note 425, at 939-47 (citing L. D. Johnston, J. G. Bachman & P.M. O'Malley, Marijuana Decriminalization: The Impact on Youth 1975-1989 (1981).

428. Nadelmann, *supra* note 425, at 939-47.

429. Stryker, *supra* note 422, at F5.

430. *Id.*

431. *Id.*

432. *Id.*

similar to that which currently exists for alcohol and cigarettes, with state-run sales, quality and price control, and regulated advertising.[433] The goal of such legalization is to undercut the criminal element.[434] Advocates claim that legalization would reduce health risks to users because pills would be tested as part of the regulation process; only a set strength and purity level would be available for purchase.[435] Advocates also cite the high financial cost and ineffectiveness of the drug war as reasons for legalization. In addition to the Office of Drug Control Policy's annual budget, "It costs approximately $8.6 billion per year to keep drug law violators behind bars."[436] Drug-related criminal and medical costs total over $67 billion, and almost seventy percent of that is attributable to drug-related crime.[437] While legalization may initially drive drug use up, proponents argue that any such increase would taper off and the net result would be less harm than exists under the current prohibition-based drug policy.[438] Some argue that legalization would reduce crimes committed indirectly because of drug use, such as those related to the black market for drug sales which has developed in response to drug prohibition.[439]

However, legalization is not considered a viable solution by most advocates of the punitive criminal justice approach.[440] This is best expressed in the Anti-Drug Abuse Act of 1988: "The Congress finds that legalization of illegal drugs, on the federal or state level, is an unconscionable surrender in a war which, for the future of our

433. *See* GRAY, *supra* note 1, at 213-14 (discussing regulated distribution and legalization); *see generally* DIRK CHASE ELDREDGE, ENDING THE WAR ON DRUGS (1998) (explaining how regulated distribution would function).

434. *Id.*

435. *See* Ethan Nadelmann, *How to Legalize: An Interview with Emily Yoffe*, MOTHER JONES (Feb./Mar. 1990), at 18-19, *available at* http://www.lindesmith.org/library/tlchowto.html (last visited Apr. 22, 2002) (discussing how a substance like cocaine might be regulated in a legalization framework).

436. Bureau of Justice Statistics, Prisoners in 1996, 1997, at 10-11, *at* http://www.drugwarfacts.org/economi.htm (last visited Apr. 22, 2002).

437. *National Drug Control Strategy 2000 Annual Report* (Office of National Drug Control Policy 2000), at 66, http://www.drugwarfacts.org/economi.htm (last visited Apr. 25, 2002).

438. *See* Nadelmann, *supra* note 435, at 18.

439. William Raspberry, *The Delusional Drug War*, WASH. POST, May 4, 2001, at A25 ("[M]uch of the harm we attribute to drugs–including gang warfare, police corruption and murder–results not from the drugs themselves but from our efforts to prohibit drugs."). In 1993, then Surgeon General Joycelyn Elders said, "I do feel that we would markedly reduce our crime if drugs were legalized." MUSTO, *supra* note 59, at 282.

440. *See supra* notes 4-5 and accompanying text; *see also* The Anti-Drug Abuse Act of 1988, PL No. 100-690, 102 Stat 4181, § 5011 (codified as 21 U.S.C. 1501).

own country and the lives of our children, there can be no substitute for total victory."[441] The DEA opposes legalization because it would likely (1) "reduce the perception of the risks and costs of drug use; (2) increase availability of and access to harmful drugs; (3) increase demand, use, abuse, and addiction; and (4) remove the social sanction against drug abuse that is reinforced in legislation."[442] A pamphlet published by The Partnership for a Drug-Free America warns that even considering or discussing legalization as a viable option may contribute to higher drug use among young teenagers.[443]

Opponents to legalization also include within their ranks some advocates of decriminalization. Two public policy professors at the University of California acknowledge that many of the harms currently associated with drugs are due to their illegality, but they maintain that legalization would increase drug use.[444] This increase would result from price reductions following elimination of the black market inflationary impact on the price of drugs; even incorporating taxes and transaction costs into the regulated price would result in a significant price reduction.[445]

III. A HYBRID PLAN FOR ECSTASY POLICY

The United States' "war on drugs" has fostered a fear-based Ecstasy policy that is ineffective, costly, and dangerous.[446] Ecstasy use continues to increase and its long-term harms are clearly known, yet lawmakers continue to respond with increasing punish-

441. The Anti-Drug Abuse Act of 1988, PL No. 100-690, 102 Stat 4181, § 5011 (codified as 21 U.S.C. 1501).

442. UNITED STATES DEPARTMENT OF JUSTICE, DRUG ENFORCEMENT AGENCY, DEA's POSITION: SPEAKING OUT AGAINST DRUG LEGALIZATION (2000), *at* http://www.usdoj.gov/dea/demand/druglegal/02dl.htm (last visited Jan. 20, 2002).

443. P'SHIP FOR A DRUG-FREE AM., The Wrong Message Of Legalizing Illicit Drugs 1 (Aug. 18, 1994), *at* http://www.druglibrary.org/schaffer/GOVPUBS/wrong1.htm (last visited Apr. 24, 2002).

444. Subcommittee on Criminal Justice, Drug Policy and Harm Resources, Committee on Government Reform, Testimony Before the House Government Reform and Oversight Committee (Jul. 13, 1999), *at* http://www.house.gov/reform/cj/hearings/99.7.13/maccoun.htm (last visited Jan. 20, 2002) (hypothesizing about the results of legalization of cocaine and heroin).

445. *Id.*

446. *Supra* note 7 and accompanying text (exploring the fears that drive the current drug policy); *supra* notes 14-17 and accompanying text (discussing the economic and social costs of the war on drugs); *see also supra* notes 34-51 and accompanying text (summarizing Ecstasy facts and policy).

ment.[447] The harms caused by Ecstasy, like other drugs, are social and public health harms that should be addressed primarily by medical and scientific professionals.[448] Prominent scientists and physicians have cautioned against implementing strict penalties for Ecstasy since the scheduling hearings in 1984.[449] Yet, legislators have unsuccessfully attempted to control Ecstasy use and trafficking for the past fifteen years through the punitive criminal justice approach. After years of failed attempts, legislators should realize that Ecstasy policy is complex and calls for a nuanced approach.[450] A hybrid plan, combining several elements of the various approaches that have been explored in this Comment, will more effectively address health, safety, and crime reduction goals.

First, Ecstasy should be reclassified as a schedule III substance so that research and medical use will be permitted. Second, the federal penalties for Ecstasy trafficking should be reduced. Third, Ecstasy should be decriminalized nationally to encourage users to seek out harm reduction services without fear of arrest. Finally, the national drug control budget should be revised to allocate significantly more drug control funding to government and private sponsored harm reduction methods, including various types of prevention education, treatment, and safer-use programs.

A. Ecstasy Should Be Reclassified as a Schedule III Substance

Reclassifying Ecstasy as a schedule III substance would allow for research on humans that could further illuminate potential medical

447. *Supra* notes 36-38 and accompanying text (citing statistics demonstrating the increase in use of Ecstasy); *supra* notes 43-47 and accompanying text (discussing the increase in penalties by legislators and the scientific confusion about the effects of Ecstasy).

448. *Supra* note 350 and accompanying text (presenting the view that drug use is a public health issue that should be addressed by public health professionals).

449. *Supra* notes 247-50 and accompanying text (describing the hearing process and the large number of witnesses and submissions from the medical and scientific communities).

450. Although this Comment has focused on federal laws, drug offenses are often treated differently from state-to-state. *See* ImpacTeen Illicit Drug Team, *Illicit Drug Policies: Selected Laws from the 50 States* (Andrews University 2002), *at* http://www.andrews.edu/BHSC/inpacteen-illicitdrugteam/index.php (last visited Apr. 24, 2002). States play an important role in the war on drugs. *New Study Provides First Comprehensive Report on Drug Laws in All 50 States and DC, Variations Abound*, The Week Online with DRCNet, Feb, 22, 2002, *at* http://www.drcnet.org/wol/225.html (quoting Dr. Jamie Chriqui, lead author of the report) (last visited Apr. 24, 2002). Since states play such an important role, federal reform as advocated in this Comment may be most effective if also accompanied by vast state reform in the same vein.

uses and the dangers of Ecstasy use.[451] The reasons the DEA's ALJ recommended schedule III placement are still compelling: Ecstasy has an accepted medical use; under medical supervision, Ecstasy administration meets acceptable safety parameters; and Ecstasy has less than a high potential for abuse.[452] As the First Circuit Court of Appeals held, FDA approval is not dispositive of a substance having an "accepted medical use."[453] However, the therapists who used Ecstasy on their patients reported great benefits when it was used within acceptable safety standards.[454] In fact, the serotonin damage reported in some studies is almost identical to that done by the once widely used appetite suppressant, fenfluramine, yet that drug earned FDA approval.[455] Recent studies support the finding that Ecstasy's potential addictive power is only psychological, which should place the drug in schedule III.[456]

Reclassification of Ecstasy as a schedule III substance would be advantageous from a health and safety perspective because it would ease the restrictions on human research that perpetuate the confusion over Ecstasy's medical effects.[457] The dispute among scientists over the long-term effects of Ecstasy, together with the increasing number of younger users, illustrate the need for further research that is objective and thorough.[458] While the abstinence-only approach to prevention touting the dangers of Ecstasy use drives the reported results of government-sanctioned research,[459] objective research will lead to a more effective, reality-based policy that will likely result in more young people paying attention to risk

451. *Supra* notes 310-20 and accompanying text (discussing the administrative barriers to research as a result of Ecstasy's schedule I placement and the need for objective research).

452. *Supra* notes 257-59 and accompanying text (explaining the ALJ's ruling that Ecstasy should be classified as a schedule III substance).

453. Grinspoon v. DEA, 828 F.2d 881, 891 (1st Cir. 1987).

454. Grob, *supra* note 218, at 560 (discussing the positive results obtained in controlled therapeutic settings).

455. *See id.* at 564 ("Fenfluramine has also been known for years to have virtually identical long-term effects as Ecstasy on serotonin neurochemistry and neuronal architecture.").

456. *See* BECK & ROSENBAUM, *supra* note 112, at 113-29 (stating that the abuse potential of Ecstasy is low and discussing factors that contribute to abuse among users).

457. *See* Grob, *supra* note 44, at 580-81 (discussing the obstacles to a controlled MDMA study on humans and the need for objective data).

458. *Supra* notes 228-36 and accompanying text (discussing contradictory Ecstasy research).

459. *Supra* notes 46-47 and accompanying text.

warnings.[460] Such research can be conducted only if Ecstasy is reclassified as a schedule III substance.

B. Federal Sentences For Ecstasy Trafficking Should Be Reduced

The sentencing requirements for Ecstasy under the Federal Sentencing Guidelines should be reduced to preamendment levels,[461] which were lower than the sentences for cocaine.[462] Although the Commission has cited certain findings as the bases for its decision to increase Ecstasy sentences, it considered a significant amount of conflicting information when making the decision and has not explained why it chose to find only certain facts persuasive. For example, Ecstasy's neurotoxicity is unresolved within the scientific community.[463] Many experts have commented that Ecstasy is generally less dangerous than other drugs;[464] however, the Commission found conclusively that Ecstasy is neurotoxic.[465] The Commission also failed to find any evidence to suggest that Ecstasy causes the same harms as other regularly abused drugs.[466] Moreover, this failure was apparently not factored into the decision to increase Ecstasy sentences.[467] In making its decision, the Commission also considered legislative history indicating that there was congressional concern over the dramatic surge in the use of Ecstasy.[468] It is highly likely that congressional influence affected the Commission's findings, and this effect demonstrates the conflict of interests in federal drug policy implementation.

The economic costs and societal harms that will result from increased sentences outweigh the dubious deterrent effect they may

460. *Supra* notes 46-47 and accompanying text (discussing teenagers' mistrust of abstinence-only advertisements); *see also supra* notes 228-42 and accompanying text (discussing contradictory Ecstasy research and a misleading scare-tactic television special).

461. *Supra* notes 283-87 and accompanying text (explaining the 2001 sentencing increases).

462. *Supra* notes 283-91 and accompanying text (discussing the evidence considered in the process of increasing Ecstasy sentences).

463. *Supra* notes 221-36 and accompanying text (discussing the scientific dispute about Ecstasy's neurotoxicity).

464. U.S. SENTENCING COMM'N, *supra* note 46, at 18.

465. *Id.*

466. *Id.*

467. *Id.* at 18-19. This fact could have been considered in the decision not to increase penalties to be equal to those for heroin trafficking.

468. *Id.* at 16 ("Congressional activity indicates that Congress is concerned over the surge in use of Ecstasy and other club drugs.").

offer, especially given the potential profits of Ecstasy trafficking.[469] When the Federation of American Scientists finds there is "no justification, either pharmacologically or in policy terms" for increased Ecstasy penalties, lawmakers should listen.[470] The disregard by Congress and the DEA of all but a few Government scientists indicates the level of bias in the formation of Ecstasy policy.

C. Ecstasy Should be Further Decriminalized

Ecstasy decriminalization, already occurring at the local level, should be clarified and broadened nationally.[471] Absent the fear of arrest, more people will take advantage of safer-use[472] programs.[473] The argument that decriminalization is tacit approval of illicit drug use can be countered with the assertion that "Penalties for possession of a drug should not be more harmful to the individual than the use of the drug itself."[474] Authorities still debate what harm is caused by Ecstasy[475] and have not assessed the harm if safer-use programs are followed.[476] Given that the harm caused by strict criminal sanctions is severe,[477] enforcement of Ecstasy possession laws may cause more harm than does the use of Ecstasy.

D. The Drug Control Budget Should Prioritize Harm Reduction Methods

The national drug control budget should be revised to allocate significantly more drug control funding to government and private-sponsored harm reduction methods, including effective prevention education, treatment, and safer-use programs. More of the funding that is currently earmarked for enforcement efforts should be allocated to these programmatic harm reduction solutions.[478] If the

469. *Supra* notes 339-45 and accompanying text (discussing the U.S. Sentencing Commission's prison impact model and the other societal harms of the increased Ecstasy penalties).

470. Press Release, The Lindesmith Center, Harsh New Federal Penalties for Ecstasy Take Effect (Apr. 30, 2001) (on file with author).

471. *Supra* notes 426-32 and accompanying text (discussing decriminalization as applied to Ecstasy).

472. *Supra* notes 403-20 and accompanying text.

473. *Supra* note 431 and accompanying text.

474. GRAY, *supra* note 1, at 219 (quoting former President Jimmy Carter).

475. For a complete discussion of the potential harms caused by Ecstasy use, see *supra* notes 214-246 and accompanying text.

476. *Supra* notes 403-20 and accompanying text.

477. *Supra* notes 14-19 and accompanying text.

478. For an explanation of the current drug control budget, see *supra* note 17.

Administration's main concern is the safety of those using Ecstasy, primarily young people, then funds should be allocated to efforts that will improve their safety and health.

Most of the current budget allotted to prevention efforts goes to either DARE or LST,[479] despite the demonstrated ineffectiveness of abstinence-only education.[480] Such programs should be discontinued and replaced with a combination of resilience education and student assistance programs.[481] This combination would meet the goals set forth by NIDA: enhancing protective factors and reducing risk factors.[482]

Funds should also be allocated to treatment programs because the field of Ecstasy treatment is in its infancy.[483] Treatment should involve the continuing education of hospital and emergency room personnel to ensure that patients under the influence of Ecstasy are treated properly and that they provide only voluntary counseling and/or abstinence treatment.[484] Although Ecstasy addiction is not a physical condition requiring medical attention,[485] dependency and abuse can still occur, and some abusive Ecstasy users may want to achieve abstinence.[486] Given the cost-effectiveness of treatment programs, allocating funding for Ecstasy treatment simply makes sense.[487]

If protecting public health is a priority, then safer-use programs[488] should also be an integral part of Ecstasy policy. Substantial anecdotal evidence establishes young people's need for both

479. *Supra* notes 378-91 and accompanying text (describing DARE and LST).

480. *Supra* notes 385-91 (explaining DARE and LST, their respective advantages and disadvantages, and the general criticisms of abstinence-only prevention education).

481. *Supra* notes 392-99 (discussing both resilience education and the Student Assistance Program).

482. *Supra* note 402 and accompanying text (explaining a NIDA study of several prevention programs that found the qualities that make a prevention program most effective).

483. *Supra* notes 367-73 and accompanying text (tracing the development of treatment programs directed at Ecstasy users and how they differ from those for people using traditionally addictive substances such as heroin and cocaine).

484. *Supra* notes 365-72 and accompanying text (discussing treatment options for Ecstasy).

485. *Supra* note 365 and accompanying text (discussing the nonaddictive nature of Ecstasy).

486. *Supra* notes 212-13 and accompanying text (explaining that Ecstasy has the potential to become only psychologically, not physically, addictive).

487. *Supra* note 357 and accompanying text (explaining that treatment is seven times more cost-effective at reducing drug use than incarceration).

488. *Supra* notes 403-24 and accompanying text (exploring options for Ecstasy-specific safer-use programs).

objective information and recommendations for reducing the immediate harms caused by Ecstasy use.[489] DanceSafe's success in preventing users from unknowingly taking pills adulterated with substances more dangerous than Ecstasy, with the cooperation of the police, demonstrates the need for funding of these programs.[490] The fear that pill-testing and the dissemination of drug-risk information implicitly condone Ecstasy use must be abandoned for the sake of public health.[491] In fact, most of the Ecstasy-related emergency room visits and deaths have been the result of consumption of adulterated pills or heat exhaustion; both of which can be easily prevented by safer-use programs.[492]

CONCLUSION

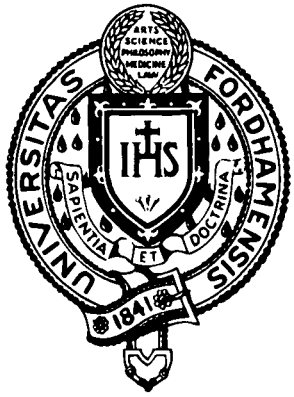
The war on drugs and its latest battle on Ecstasy will be lost as long as it is waged with prohibitionist tactics. While no solution to Ecstasy-related problems will be flawless, a public health approach will reduce the immediate harms that can lead to death, and will likely resolve many of the long-term risks. At the very least, implementing an approach focused on public health will allow more research to be conducted, overall Ecstasy education and awareness to increase significantly, and resources to be allocated more efficiently. The price of this new approach is abandonment of the idealistic belief that Ecstasy can be eradicated as a recreational drug. Accepting that Ecstasy will be used recreationally is not surrender, it is compromise. The time for a peaceful resolution of this war is long overdue.

489. *Supra* notes 403-20 and accompanying text (discussing the need among Ecstasy users for safer-use information and the specific risk information that is provided).

490. *Supra* notes 175-77, 431-32 and accompanying text (explaining DanceSafe's functions); *supra* notes 415-20 (providing examples of DanceSafe's success in warning Ecstasy users about the risks of adulterated Ecstasy).

491. *Supra* notes 421-24 and accompanying text.

492. *Supra* note 418 and accompanying text (discussing deaths attributed to adulterant PMA).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