

THE LEAGUE OF WOMEN VOTERS OF HAWAI‘I

DRUG POLICY STUDY

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League of Women Voters of Hawai‘i

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Executive Summary

The following study was developed by and for the League of Women Voters of Hawai‘i, in an effort to develop an initial analysis of the state’s existing drug policies. It is intended to serve as a basis for policy discussion, positions, and advocacy. The study also presents recommended policy alternatives and proactive steps that may help address the challenges described herein. It is our hope that this study will contribute to a much-needed societal debate around drug-related issues in our state and communities.

The study is grounded in an understanding that the relationship between drug policies and individual and societal wellbeing is complex and clearly bound up with myriad other issues of societal and economic justice and policy. In some cases our policies themselves have proven to have unintended consequences that exacerbate public health challenges and underlying societal inequities. There is no simple panacea that will rid our communities of the difficulties associated with drug abuse and dependency. However, there are many opportunities to develop and implement informed, evidence-based drug policies that can contribute to our community’s economic, physical, mental, and familial health.

The study echoes the call of several other League chapters, including Texas and Seattle, with its recommendation to take a public health approach to drug policy. In particular, the study suggests embracing the approach of harm reduction, which is

a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use to abstinence. Harm reduction strategies meet drug users ‘where they’re at,’ addressing conditions of use along with the use itself.¹

Given this foundation, the study makes several recommendations, presented here in broad thematic categories. Recommendations that could be listed in multiple categories – e.g. treatment of girls is related to both Treatment Capacity and Women & Girls – are listed only once for clarity and brevity’s sake. All recommendations are aimed at reducing the societal, economic and familial costs of drug misuse and dependency (as well as some existing counterproductive policies) for those directly impacted, as well as for the broader community.

Treatment Capacity:

- Increase state and county funding and dedication of other resources to support drug treatment programs. Funding priority should be given to prison-based treatment programs, reentry and halfway houses, drug court programs, and gender-responsive and youth-oriented programs. It would be ideal to generate newly appropriated funds, but existing funding for the criminal justice system could also be redirected.

¹ Harm Reduction Coalition. <http://www.harmreduction.org/article.php?list=type&type=62>

- Devote resources to supporting existing and new gender-responsive treatment and re-entry programs such as the Salvation Army's Women's Way and TJ Mahoney & Associates' community-based reentry program, Ka Hale Ho'āla No Nā Wāhine.
- Develop greater program capacity for girls in need of inpatient and outpatient drug treatment.
- Provide financial and other resources to culturally-based treatment and reentry programs to enable them to offer services to more individuals, measure outcomes, and develop best practices. Examples include the MEO B.E.S.T. program and Ke Ala Lōkahi.

Education & Prevention:

- Create and implement new youth drug education programs that provide accurate and comprehensive information, rather than employing scare tactics.
- Build programs that emphasize education, discussion, counseling and extracurricular activities, and that build trust between students and adults, and continue to eschew student drug testing programs.

Corrections Policy:

- Reduce reliance on mainland correctional facilities and bring offenders home to their own communities. This in turn requires reducing the rate of incarceration in Hawai'i to the point where we can house offenders in the state's facilities.
- Invest in and support family connections for incarcerated persons. This includes expansion and improvement of visitation spaces at correctional facilities themselves, as well as providing financial and human support for programs that enable families to connect with incarcerated members outside of correctional facilities (e.g. the MEO B.E.S.T program).
- Fully enable Act 161 by restoring the law's language from optional to mandatory regarding the diversion of first time nonviolent offenders to treatment rather than incarceration, and by appropriating greater financial resources for the program. According to the state's own assessments, this program could soon 'pay for itself,' as diverting nonviolent offenders to treatment will be extremely cost effective; a conservative estimation for six months of incarceration comes in at \$15,000, while treatment costs \$3,400.²
- Engage in discussion around the potential benefits and pitfalls of decriminalization and legalization of marijuana and other illicit drugs.

² Joint House-Senate Task Force on Ice and Drug Abatement, Final Report. (2003)

- Provide greater financial and human support for the Drug Courts in Hawai‘i, particularly those focusing on families, as well as for measuring their outcomes and developing best practices.
- Improve the state’s administration of the existing medical marijuana program by moving it from the Department of Public Safety to the Department of Health and incorporating other patients’ requests.

Women & Girls:

- Continue to provide state support and funding to the PATH Clinic of the John A. Burns School of Medicine at the University of Hawai‘i for its provision of perinatal services for women with a history of substance abuse.
- Devote resources to further researching women’s pathways to substance abuse and crime, as well as the tools and efficacy of gender-responsive treatment.
- Make permanent the temporary funding for the Girls Court (during the 2009 legislative session) and provide sufficient funding to enable the development of a girl-specific curriculum that would address a variety of life skills, including recovery from and/or avoidance of drug dependency.

In sum, these policy recommendations speak to the need to develop lasting solutions to the problems associated with drug misuse and dependency. They also begin to address the intergenerational cycles of poverty, family disruption, foster care, desperation, drug dependency, crime, and incarceration. This places drug policy within a broader societal, economic and cultural context, and hopefully will enable Hawai‘i to develop policies that have greater impact and are more cost effective than many of those currently in use.

Introduction

The body of federal, state and county policies, laws, and enforcement strategies that together constitute our society's approach to psychoactive substances are of great significance to our community's economic, physical, mental and familial health. Issues related to licit and illicit drug use and distribution impact many facets of our individual and community life. They are particularly salient in the realms of social policy, especially public health and criminal justice, where we grapple with issues such as health care, employment, incarceration, foster care, homelessness, property crime, judiciary costs and education.

In Hawai'i we are sadly well acquainted with the social and economic cost of the abuse of licit and illicit drugs, as well as their distribution and related criminal activities. As evidenced in tragic incidents splashed across our newspapers' front pages, drug use and misuse are directly or indirectly implicated in the 'ice epidemic,' growing rates of incarceration – particularly among the Native Hawaiian community, the growing homeless population, child neglect and abuse, domestic violence, etc. While these costs are felt by our whole community in the form of increasing societal fragmentation and costs to tax payers, the brunt of this burden is borne by our most vulnerable and socio-economically depressed communities.

In Hawai'i we are also aware of a growing national and international consciousness regarding the social and economic costs associated with our drug policies themselves. Careful analyses of existing drug policies and laws increasingly point to the faults of the current system – over reliance on punitive measures and lack of resources for prevention, treatment and reentry into society – and promote alternative approaches to building healthy communities.

Hawai'i has historically been at the forefront of developing progressive social policy to address the health and wellbeing of individuals and communities. In the 1970s Hawai'i was the first state to decriminalize abortion and the first to mandate employer-provided health insurance. In the realm of drug policy, in 1990 Hawai'i was the first to establish a statewide needle exchange program to address the spread of blood-borne diseases. In 2000 Hawai'i was the first state to authorize a medical marijuana program via a legislative act, rather than a voter initiative. Most recently, in 2002, the legislature was one of the first to follow California's lead in establishing a policy of treatment rather than incarceration for first time non-violent drug offenders.

Despite the plethora of drug-related challenges in Hawai'i, and our state's history of progressive social policy, the state has yet to undertake a comprehensive study of drug policy. The League of Women Voters of Hawai'i has therefore elected to develop an initial analysis of the state's existing drug policy and, eschewing total political 'neutrality,' to recommend policy alternatives that may help address the challenges described here. It is our hope that this study will contribute to a much-needed societal debate around drug-related issues in our state and communities.

The League and Drug Policy

The League of Women Voters has taken an interest in drug policy at the local, state and national level since the late 1990s. In 1998 LWV of Albuquerque/Bernalillo County, New Mexico, proposed that the League undertake a national drug policy study. This proposal came before the LWVUS Convention in June of 2000 and the proposed two year study was approved by a voice vote, though it had not been one of the recommended items for study at that convention. However, when Honolulu League member Pearl Johnson returned from the National League Council in 2001 she reported that, upon the LWVUS Board's recommendation, the Council had voted to drop the study due to budgetary constraints. Hawai'i had voted in favor of the study, but the vote of 69-15 met the 60% threshold required to drop the study.

Though the League opted not to undertake a national study, the issue has been pursued with vigor at the local and state level, resulting in drug policy positions in several states, including Washington, Texas, New Mexico, Iowa, and Arkansas. The policy study undertaken by the League in Seattle/King County is of particular depth and has informed the Hawai'i study.

The LWV of Hawai'i became interested in pursuing a local drug policy study primarily through its participation in the Hawai'i Women's Coalition and meeting with groups actively working on drug policy issues. Of particular concern to these groups and our own members are the connections between drug policy and public health and criminal and social justice issues including homelessness, incarceration, health care, employment, foster care, social justice and education.

At its annual meeting in 2007 the LWV of Hawai'i voted to undertake a drug policy study to explore this issue within the context of our Hawai'i community. The following study was researched and written between the fall of 2007 and spring of 2008. As it will form the basis for the League's participation in the public debate regarding drug policy, the study includes a brief history of American drug laws, as well as an examination of drug related policies and issues in Hawai'i. Particular emphasis is placed on the social and economic costs of current policies and possible alternatives to those policies.

Please refer to the glossary at the end of the study for clarification regarding terms and concepts. The appendices provide examples of several organizations' resolutions and positions on drug policy. The bibliography is not intended to represent the comprehensive body of relevant drug-related literature, but merely those research papers, websites and other materials directly cited within the study.

1. A Brief History of American Drug Laws

Until the late 1800s, many drugs that are currently illicit in the United States, including opiates, cocaine and cannabis, were freely available, used in patented medicines and found in commercial products. The first legal prohibition of psychoactive substances originated in the last quarter of the 19th century and was targeted against opium, generally in areas with substantial Chinese immigrant communities. Indeed, many historians suggest that there is a long standing relationship between drug policies and the clash between cultural and racial groups, with drug policies serving to control or oppress minority and subculture groups.

A close examination of the legislative history of America's drug laws reveals a host of uncharitable sentiments that have helped shape public perceptions of disfavored social subgroups and their practices. Any meaningful effort to reform drug policy in the United States must acknowledge this uncomfortable historical nexus between racial animus and American public attitudes toward certain drugs.³

This relationship between drug policy and race, whether direct and intentional and/or reflective of underlying societal and economic inequities drawn along racial lines, surfaces throughout the following study.

Though the nonmedical use of narcotics was rendered illegal in 1914, the United States' first intensive, large-scale experiment with prohibition of a psychoactive substance was the prohibition of alcohol in 1919 via the 18th Amendment to the Constitution. Prohibition failed to curb demand for alcohol, resulted in the emergence of a violent, criminal underground trade, and was finally repealed in 1933, at which point the question of alcohol regulation was left to the individual states. In the following years, efforts to target drug use focused first on marijuana, and then on the growing black market for narcotics.

The use of illicit drugs escalated after World War II, particularly during the turbulent years of the 1960s, from which stemmed the modern 'War on Drugs,' declared by President Nixon. In its early days this 'war' particularly targeted hippies, a group critical of the government and its policies. International drug control efforts were militarized in an attempt to cut off supply. Domestic drug laws focused on developing more punitive measures for drug trafficking and use, including the creation of mandatory minimum sentences for drug possession and sale. These mandatory minimums sentences, fueled by sensational media coverage of the 'crack epidemic' in the 1980s and still in effect, contributed to the United States' swelling incarcerated population, disproportionately made up of young black men. The drug laws themselves contributed to the disproportionate punishment of minorities; for example the mandatory minimum sentence for powder cocaine — generally used by whites — was 100 times lighter than that for crack cocaine — generally used by blacks — despite the lack of any chemical

³ King County Bar Association (2005) *Effective Drug Control: Toward A New Legal Framework*. p. 14

difference in the two substances. (In 2007 the Supreme Court and the United States Sentencing Commission finally addressed this discrepancy, to a limited extent, resulting in reduced sentences and early releases for thousands of incarcerated individuals.)⁴

The societal and economic costs of the ‘War on Drugs’ became increasingly apparent in the 1990s as demand for illicit drugs continued to rise, supply remained steady, price declined, drug purity increased and families and communities suffered the consequences of both addiction and incarceration, despite the millions, and then billions, of dollars spent by the government every year.

In the past twenty years a growing body of practitioners, academics, observers and advocates from the public health, social services and policy realms has come to agree that in the United States,

our laws and social customs for regulating [the nonmedical use of psychoactive substances] incorporated many fundamental scientific errors, such as (1) bad pharmacology – that marijuana is an addictive narcotic and that tobacco does not contain a drug; (2) bad psychology – that repetitive drug use can always be controlled through intentional behaviors; (3) bad sociology – that the drugs used by foreigners and minority groups are the bad drugs, and that criminal laws can effectively reduce psychoactive drug use at a low cost to society; and (4) bad economics – that the increased ‘cost of business’ for selling an illegal product will outweigh the increased profits to be made from selling through illegal markets.⁵

This critique of the War on Drugs has informed some more recent drug policies at the state level, including a greater focus on harm reduction, as embodied in needle exchange programs, treatment rather than incarceration for non-violent offenders, and the legalization of the medical use of marijuana. However, compared to many other developed countries, the United States continues to devote more human and financial resources to criminal justice efforts to eradicate and punish drug use rather than to efforts to educate the population and treat drug users.

⁴ See U.S. Supreme Court opinion in *Kimbrough vs. United States*, 2007
<http://caselaw.lp.findlaw.com/scripts/getcase.pl?court=US&vol=000&invol=06-6330>

⁵ Des Jarlais, D.C. (1995) “Harm Reduction – A Framework for Incorporating Science into Drug Policy.” p.10

Timeline of United States & Hawai'i Drug Policy

- 1874 Kingdom of Hawai'i enacts law outlawing Chinese opium smoking.**
- 1875 First anti-drug law in US enacted; San Francisco Opium Den Ordinance.
- 1914 Harrison Narcotics Act enacted; federal control of narcotics established, nonmedical use of heroin and cocaine made illegal.
- 1919 Eighteenth Amendment to Constitution, establishing national alcohol prohibition.
- 1933 Congress repeals national alcohol prohibition.
- 1937 Marijuana Tax Act removes marijuana from pharmacopeia, in effect criminalizing its use.
- 1970 Comprehensive Drug Abuse and Prevention Act passed by Congress; establishes present framework of five drug 'schedules' and import/export controls.
- 1971 President Nixon declares the 'War on Drugs.'
- 1973 Drug Enforcement Agency (DEA) created.
- 1981 Hawai'i initiates Green Harvest marijuana eradication program**
- 1986 Anti-Drug Abuse Act enacted; creates mandatory minimum sentences for drug offenses; origin of sentencing disparity between crack/powder cocaine.
- 1988 First needle exchange in United States established in Tacoma, WA.
- 1990 Hawai'i state legislature authorizes first state-wide needle exchange program in the United States.**
- 1995 US Sentencing Commission recommends revising mandatory minimum sentencing guidelines to resolve crack/powder cocaine sentencing disparity – Congress overrides commission's recommendation.
- 1996 California passes Proposition 215, legalizing sale and possession of medical marijuana by patients in need. 11 other states follow suit in ensuing decade.
- 2000 Hawai'i becomes the first state to permit the medical use of marijuana via a legislative act.**
- 2000 California passes Proposition 36; people convicted of first or second time non-violent drug offenses to receive drug treatment rather than go to prison.

- 2002 Hawai'i passes Act 161; mandating treatment rather than incarceration for first time nonviolent drug offenders, echoing California's Proposition 36.**
- 2007 US Supreme Court decides two cases regarding mandatory minimum sentences: in *Kimbrough v. United States*, the Court decided, 7-2, that judges may consider the unfairness of the 100-to-1 ratio between crack cocaine and powder cocaine sentences and may impose a sentence below the guideline in cases where the guideline sentence is too severe. In *Gall v. U.S.*, the Court, again voting 7-2, found that judges can impose sentences that are shorter than the applicable guideline range and need not justify them with "extraordinary circumstances."
- 2007 The United States Sentencing Commission unanimously voted to give retroactive effect to a recent amendment to the Federal Sentencing Guidelines that reduces penalties for crack cocaine offenses. Federal sentencing judges will make the final determination of whether an offender is eligible for a lower sentence and how much that sentence should be lowered. Some prisoners will receive lowered sentences and some are eligible for early release, beginning March 3, 2008.

2. Hawai‘i Context – Drug Policies & Issues

Drug policy in Hawai‘i is currently officially described as a three-prong approach consisting of prevention, treatment and law enforcement solutions. However, approximately 2/3 of public resources dedicated to drug-related issues are committed to the criminal justice system and law enforcement. In practice this results in a generally punitive approach to mitigating the damage to our community caused by illicit drug use, abuse, addiction and distribution, with several exceptions for public health-oriented programs. This chapter describes the body of Hawai‘i’s drug-related policies, laws and programs.

Syringe Exchange

The first syringe exchange program in Hawai‘i was initiated in 1990, and the statewide, state-funded system came online in 1993. This landmark program was the first statewide one in the country. Hawai‘i provides all funding for the syringe exchange program, as the federal government prohibits the use of federal funds for needle exchange activities. The Hawai‘i State Department of Health describes the program as follows:

“Sterile syringe exchange is a public health program for injection drug users. It is an important component of a comprehensive set of programs designed to reduce the spread of HIV/AIDS and other blood-borne infections among injection drug users, their families and communities.”⁶

It is a particularly important public health program because over half of all new HIV infections in the country stem from injection drug users - two-thirds of these from sharing needles, and the rest either from unprotected sex with an injection drug user or transmission from an infected mother to her fetus or newborn child.⁷ This public health measure has proven tremendously effective according to the Hawai‘i State Department of Health.

“Most cities that responded early in the epidemic by implementing comprehensive syringe exchange programs have kept infection rates among drug injectors below 5%, while rates of infection in cities like New York and Miami (where syringe exchange began late or not at all) are between 40% and 60.”

Indeed, in Hawai‘i HIV infection rates among intravenous drug users are extremely low, ranging from 0.3% to 1.3%, which can be directly attributed to political support and state funding for harm reduction activities, notably the syringe exchange program.⁸

The program has also proven very effective in engaging drug users in holistic education and treatment services, resulting in many successful referrals to methadone and other treatment services.

⁶ <http://hawaii.gov/health/healthy-lifestyles/std-aids/reducing-harm/index.html>

⁷ <http://hawaii.gov/health/healthy-lifestyles/std-aids/reducing-harm/syringe-exchange.html>

⁸ Marten, L.R., Qiu, Y., Borthakur, P.B., & Whitticar, P.M. (2005) “Two Decades of HIV/AIDS in Hawai‘i: Contrast with National Trends.”

Methadone programs

Hawai‘i state funds were first dedicated to methadone treatment in 1976, with a grant to the nonprofit entity Drug Addiction Services of Hawai‘i (DASH). The organization, which changed its name to Ku Aloha Ola Mau in 2006, continues to provide outpatient methadone maintenance and detoxification and other substance abuse treatment in Honolulu, Hilo, and Puna. Methadone maintenance and detoxification is also provided by the Comprehensive Health and Attitude Management Program (CHAMP) in Honolulu and Maui.

Methadone treatment (also called agonist maintenance treatment) is a broadly accepted form of harm reduction for heroin users that uses a long-acting synthetic opiate medication administered over a sustained period at a dosage that prevents opiate withdrawal, blocks the effects of opiate use, and decreases opiate craving. It allows patients to stabilize and function normally, including return to employment. It also reduces the spread of HIV and Hepatitis C by eliminating injection drug use. To successfully tackle drug addiction, patients must generally engage in counseling and/or other behavioral intervention as a component of methadone treatment.

Medical Marijuana

In 1999 Governor Cayetano proposed that Hawai‘i permit the medical use of marijuana, and in 2000 he signed Hawai‘i’s Act 228 into law, making Hawai‘i the first state to permit such use via an act of the state legislature. Others had achieved the same result via ballot initiatives, and the medical use of marijuana is currently legal in 11 additional states. A poll conducted in 2000 found that 77% of Hawai‘i voters were in favor of the passage of the law.⁹ Majority support was found to be universal across major demographic segments in the state, including ethnicity and political party affiliation. Supporters cited their interest in easing pain or suffering and allowing doctors rather than the government to determine whether marijuana is an appropriate medication to treat certain illnesses.

In 2001 the medical marijuana program came into effect under administrative rules developed by the Hawai‘i Department of Public Safety. The program, administered by the Narcotics Enforcement Division, ensures that patients and their caregivers meet specific criteria, that physicians are protected from prosecution at the state and local level, and defines parameters for recommending and growing medical marijuana. Since the Supreme Court let stand the decision in *Conant v. Walters* in 2003, physicians are also free from federal prosecution for recommending medical use of marijuana to patients. However, patients in possession of marijuana for medical use may still be subject to federal prosecution, as marijuana remains a Schedule I drug (those substances deemed to be without acceptable medical uses and with a high potential for misuse) under federal classification. Forty-two hundred patients are currently registered in Hawai‘i.

⁹ Drug Policy Forum of Hawai‘i commissioned poll conducted by QMark Research & Polling

Green Harvest

The state's federally funded marijuana eradication program is generally referred to as Operation Green Harvest. The program was initiated in 1981, which, according to a National Institute of Justice research brief, coincided with the arrival of methamphetamine ('ice') into Hawai'i.¹⁰ There is much debate as to whether there is a direct causal relationship or merely a correlation between Green Harvest (and the reduced availability of marijuana) and the increased incidence of methamphetamine use. While Green Harvest has reduced the supply of locally grown marijuana, it has not eradicated it. According to a 2006 report, *Marijuana Production in the United States*, Hawai'i annually produces 2.38 million pounds of marijuana worth \$3.82 billion dollars, making it the fourth greatest producing state in the US.¹¹ The crop is grown primarily for export, with about 22 times more being consumed outside the state than in.

Weed & Seed

Operation 'Weed and Seed' is a multi-agency strategy sponsored by the United States Department of Justice since 1991 that "weeds out' violent crime, gang activity, and drug trafficking in high crime neighborhoods, then 'seeds' the target area with social programs, neighborhood restoration projects and economic development."¹² The Weed and Seed program in Hawai'i is run by the US Attorney's Office. The first site in Hawai'i was established in Chinatown-Kalihi-Palama in 1998 and was expanded westward into Kalihi Valley and eastward to the Waikīkī Convention Center in 2003. A second site was created in Waipahu in 2000, and a third site in 'Ewa/'Ewa Beach in 2002.

Hawai'i state criminal prosecutions for offenders arrested within the Honolulu Weed and Seed sites are governed by the following approach:

- Using a dedicated Weed and Seed Court
- Fast tracking – accelerated intake and charging of offenders
- Removal of offenders from the site – high bail/pretrial detention, geographic bans and incarceration
- Intensive monitoring of probationers
- Accommodation by the Drug Court

In pursuit of the program's 'weeding' goal, the Department of the Prosecuting Attorney instituted new legal procedures to ensure that anyone committing a crime within the Hawai'i sites is immediately arrested and charged, then banned from the area or incarcerated. 'Quality of life' crimes such as drinking in public, disorderly conduct and criminal littering are also aggressively prosecuted. According to the Department, "the results are phenomenal," with crime dropping 50% in the Chinatown-Kalihi-Palama site since the program's inception.¹³

¹⁰ Chaiken, M.R. 1993. "The Rise of Crack and Ice: Experiences in Three Locales."

¹¹ Gettman, J. 2006. *Marijuana Production in the United States*. p.11-12

¹² Department of The Prosecuting Attorney. <http://www.co.honolulu.hi.us/prosecuting/weedandseed.htm>

¹³ Department of The Prosecuting Attorney. <http://www.co.honolulu.hi.us/prosecuting/weedandseed.htm>

Some observers suggest that the Weed and Seed program focuses on ‘weeding’ efforts such as prosecution and incarceration at the expense of ‘seeding’ projects such as drug treatment and neighborhood restoration programs. Additionally, critics point out that individuals who are prosecuted under the program are sent to federal prison in California, which contributes to the problems caused by out of state incarceration (see page 36).

Ice Taskforce & Omnibus Bill

In the early 2000s, Hawai‘i’s elected officials focused their attention on the ‘ice epidemic’ sweeping through Hawai‘i’s communities. The Legislature created a Joint House-Senate Task Force on Ice and Drug Abatement, which issued its Final Report in 2003. This Report in turn led to an Omnibus ice bill in 2004, which included HB2003 (the statutes) and HB2004 (the funding). The Report emphasized the importance of improving prevention and treatment services, but the current situation (five years later) is little different – resources are still primarily directed toward the criminal justice system and treatment services are woefully insufficient to meet the demand.

Prison Overcrowding

Hawai‘i’s prisons and jails are chronically overcrowded, with all individual facilities facing severe overcrowding and ever greater numbers of Hawai‘i inmates housed at facilities on the mainland. In 1985 a federal court decision known as the Spear Consent Decree required that the state of Hawai‘i address conditions at overcrowded prisons that were deemed unconstitutional. In 1999 all conditions of the Decree were deemed to have been met. While conditions have improved since the 1980s, overcrowding is problematic and growing worse, as is the primary means of addressing that issue – sending inmates to facilities on the mainland. (See page 36 for details.)

In 2005 there were 521 arrests for drug manufacture or sale and 2,214 arrests for drug possession in the state of Hawai‘i.¹⁴ The Department of the Attorney General only maintains records for drug manufacture, sale and possession, but not for other offenses that may be drug related, such as property crime. This is partly because it is difficult to determine with certainty which offenses are indirectly related to drugs, and to characterize that relationship.

First Time Nonviolent Drug Offenders

In 2002 the Hawai‘i state legislature passed Act 161 to divert first time nonviolent drug offenders from prison to substance abuse treatment. Though the bill was passed, it lacked sufficient funding for effective implementation. In 2004, the Hawai‘i state legislature passed HB 2003 to allocate funds to a range of substance abuse treatment programs, including Act 161. Though Governor Lingle vetoed the bill, she was overridden by the legislature, and the bill passed to become Act 44. This act allocated \$14.7 million for a range of substance abuse treatment programs. However, it also changed the language regarding the diversion of first time offenders to probation and treatment rather than

¹⁴ Department of the Attorney General. (2007) Crime in Hawai‘i: Uniform Crime Report.

incarceration from mandatory to optional. In practice this has undermined the intent of providing treatment rather than incarceration for first time nonviolent drug offenders.

Hawai'i's Act 161 was based on California's 2000 Substance Abuse and Crime Prevention Act, also known as Proposition 36. Prop 36 changed California state law to allow first- and second-time nonviolent, simple drug possession offenders the opportunity to receive substance abuse treatment instead of incarceration. See below (page 38) for a detailed description of Prop 36.

Drug Court

Like drug courts across the United States (1,621 operational in December 2004), the Hawai'i Drug Courts hear cases involving offenders who are charged with non-violent, drug-related crimes. Drug courts thus relieve crowded court dockets, and focus on providing an environment for treatment and counseling, rather than incarceration and punishment. During the typically two-year long program of comprehensive drug treatment, participants are required to submit to frequent and random drug testing, make regular appearances before the judge, and are monitored for compliance with the program. Noncompliance leads to graduated sanctions, including jail time.

The country's first drug court was established in Miami in 1989. In Hawai'i, the State Judiciary began the program in 1996 with the creation of the O'ahu Adult Drug Court. Since then, the Hawai'i State Judiciary has initiated drug court programs statewide; including the Maui and Kaua'i Adult Drug Courts and Family and Juvenile Drug Courts on O'ahu.

The Hawai'i State Judiciary is pleased with the success of the drug courts, which they believe successfully tackle drug addiction, prevent recidivism, and avoid the costs to the state of incarceration. According to a 2005 Hawai'i State Judiciary press release, "since it began in 1996, O'ahu's Adult Drug Court Program has an overall recidivism rate of five percent. This is indeed significant when compared to the national drug court recidivism average of 16.4 percent. The recidivism rate for adult drug courts on Maui and the Big Island are also below the national average."¹⁵

Some observers are concerned about the broader efficacy of Hawai'i's Drug Courts, as they address only a small number of cases and are perceived to 'cherry pick' individuals that will most likely be successful and therefore may not represent an accurate picture of the challenges associated with developing a broader treatment program.

Family Drug Court

Family Drug Courts emerged in the 1980s along with the broader trend toward drug courts, largely in response to an increase in the number of children in foster care, as well

¹⁵ Hawai'i State Judiciary press release April 27, 2005. "Hawai'i Celebrates 'National Drug Court Month' With Graduation Ceremony, Proclamations."
http://www.courts.state.hi.us/page_server/News/PressReleases/Articles/30689C512C697EA410384C85737.html

as increased drug abuse, homelessness and poverty. They are designed to address the needs of abused and neglected children by focusing on substance issues among parents, all within the context of family court child-protection cases. By 2003 there were 86 Family Drug Courts in operation throughout the United States.¹⁶

In Hawai‘i, there are currently two Family Drug Courts, one in the First Judicial Circuit in Honolulu (established in 2002) and one in the Second Judicial Court on Maui (established in 2005). The connection between alcohol and illicit drugs and child well-being in Hawai‘i is clear; approximately 85% of all child welfare cases in Hawai‘i involve substance abuse on the part of the parents or caretakers.¹⁷

In a 2006 evaluation of the Honolulu Family Drug Court (FDC), Dr. Meda Chesney-Lind of the University of Hawai‘i concludes that parental participation in the program for 30 days or more contributes significantly to reunification between adults and their children. Reunification is dependent on improvement in several areas including abstinence from drugs and alcohol, improved parenting skills, decreased reliance on welfare, improved educational attainment or job skills, and the ability to secure housing. The increased rate of family reunification among FDC participants therefore indicates overall progress for clients and their families. Chesney-Lind’s study concludes that the Honolulu FDC’s success is partly due to its multi-pronged approach to intervention, focus on gender-specific and culturally sensitive treatment, and a strong residential service component. The study roughly calculates that the Honolulu FDC provides cost savings (by avoiding foster care) of \$114,264 to \$324,000 per child.¹⁸

Juvenile Drug Court

Established in 2001, the Hawai‘i Juvenile Drug Court provides a treatment-based program of no less than eight months for substance abusing juvenile offenders aged 12-17 who are referred to the Family Court for nonviolent offenses. It is available only for juveniles living on O‘ahu and under the jurisdiction of the Family Court of the First Judicial Circuit.

Student Drug Testing

The Hawai‘i State Legislature has considered and rejected (most recently in February 2003) bills that would allow schools to randomly drug test students enrolled in athletics or ‘physically strenuous’ extracurricular activities. No public schools in Hawai‘i currently have a random drug testing policy. Mid-Pacific Institute (a private school on O‘ahu) implemented a program of voluntary drug testing beginning in the 2005-2006 school year. In the Mid-Pac program parents and their children choose whether or not to sign up for random drug testing over the course of the school year. Test results are shared only with parents, and the school receives no information about positive or negative results. Positive results do not result in punitive action such as removal from

¹⁶ Chesney-Lind, M. (2006) Family Drug Court of the First Judicial Court Evaluation Project: Final Report.

¹⁷ Chesney-Lind, M. (2006) Family Drug Court of the First Judicial Court Evaluation Project: Final Report.

¹⁸ Chesney-Lind, M. (2006) Family Drug Court of the First Judicial Court Evaluation Project: Final Report.

athletic teams or suspension.¹⁹ Reportedly approximately one-third of the students and their parents have opted to participate in the voluntary program.

The Board of Education has also tentatively approved the use of dog and locker searches, with or without cause, at public schools. Pilot dog-sniffing programs have been undertaken at Lahainaluna High School, Lahaina Intermediate School and Lāna‘i High and Elementary Schools. State funding has been approved for expanding the program, but not allocated.

Teacher Drug Testing

The state of Hawai‘i is moving forward with a plan to institute random drug testing of school employees, including teachers, librarians and counselors. The policy emerged primarily in response to the recent arrest of four teachers within the Hawai‘i state public school system for use and distribution of illicit drugs. No drugs were found on school grounds and there is no evidence that children were in any danger in connection with the recent cases.

In 2007 the random testing policy was approved by Bargaining Unit 5 of the Hawai‘i State Teachers Association (HSTA) during contract negotiations with the state. The state made random and reasonable-suspicion drug testing a non-negotiable item of the contract, which also included a 4% pay raise. Members of Bargaining Unit 5 ratified the two-year contract by 61%, marking this as a controversial contract in comparison with that of 2005, which received support from 93% of members.²⁰ Hawai‘i is the first state in the nation to develop a blanket policy of random drug testing for teachers.

In January 2008, however, the state Board of Education (BOE) voted unanimously not to fund the teacher drug testing program from the Department of Education budget, citing their preference to fund educational programs. The BOE suggested that the Governor or Legislature allocate additional funds if the drug testing program is to go ahead.

At this writing, July 2008, the HSTA has stated its opinion that random drug testing violates both the state and federal constitutions. The policy may also be challenged in the courts by the ACLU in a class action lawsuit. The ACLU argues that random drug testing contravenes adults’ constitutional rights to privacy, does not contribute to public safety, and is “ineffective, expensive and, often times, illegal.”²¹ Other critics of the policy suggest that suspicionless drug testing may erode student respect for their teachers and undermine trust-based relationships, as well as draw inappropriately upon the already limited resources available to the public education system.

¹⁹ Mid-Pacific Institute. http://midpac.edu/campuslife/drug_testing.php

²⁰ *Honolulu Advertiser* (2007)
<http://the.honoluluadvertiser.com/article/2007/May/02/br/br0948375126.html>

²¹ ACLU. (2008) <http://www.aclu.org/drugpolicy/testing/31358res20070917.html>

Facts & Issues

The following section of the report provides background information regarding current national and state drug issues and policies and explores some alternatives to those policies. This information is intended to assist the members of LWV Hawai'i in their consideration of the desirability and direction of drug policy reform at both the state and national level.

3. Public Health Approach

A pivotal question in the drug policy debate is whether substance abuse and drug addiction should be housed primarily in the province of the criminal justice system, or in the domain of public health. A transition toward the latter emphasis would require the evolution of policies and the channeling of resources not only for incarceration-based responses to drug related issues, but also for responses focused on lessening the harm associated with drug abuse (and even existing drug policies) by reducing associated rates of death, disease, crime and suffering. Currently in the United States and in Hawai‘i, approximately two-thirds of resources targeting drug-related issues are dedicated to the criminal justice system.

The public health oriented approach is commonly referred to as ‘harm reduction,’ which the Harm Reduction Coalition describes as:

*a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use to abstinence. Harm reduction strategies meet drug users ‘where they’re at,’ addressing conditions of use along with the use itself.*²²

See Appendix B for a full description of the principles of harm reduction. Well known examples of harm reduction policies include regulation of smoking in public places, the use of nicotine replacement patches, designated driver initiatives, Mothers Against Drunk Driving, and ‘safe sex’ campaigns promoting the use of condoms.

A common misconception regarding harm reduction is the confusion of this approach with the libertarian perspective that everyone has the right to take whatever drugs he or she desires. In fact, proponents of the harm reduction approach recognize that “government and public health authorities have a definite responsibility for formulating policies to reduce the health and social harm associated with the nonmedical use of psychoactive drugs.”²³ Other opponents of harm reduction equate it with legalization, despite the fact that many harm reduction approaches, such as methadone treatment, function within the existing legal framework.

Many developed and developing countries around the world, however, have embraced harm reduction and the public health approach to drug policy. According to Dr. Alex Wodak, past President of the International Harm Reduction Coalition, “harm reduction is now the mainstream approach to drug problems in all countries in Western Europe (except Sweden) and will soon be the mainstream in Asia. Many United Nations organizations are now declaring unambiguous support for harm reduction.”²⁴

²² Harm Reduction Coalition. <http://www.harmreduction.org/article.php?list=type&type=62>

²³ Des Jarlais, D.C. (1995) “Harm Reduction – A Framework for Incorporating Science into Drug Policy.” p.10

²⁴ Wodak, A. (2004) http://www.drugpolicy.org/library/05_07_04wodaknih.cfm

The United States, however, has been slow to embrace harm reduction policies for illicit drugs, primarily due to the concerns cited above. For example, the most widely practiced harm reduction programs in the US, syringe exchange and methadone programs, are embraced by the medical community, but remain controversial within national policy discussions and continue to receive insufficient financial and human resources. Federal dollars can still not be used to fund syringe exchange activities, despite the fact that at least seven US government agency and commissioned studies published between 1993 and 2001 conclude that syringe exchange programs effectively reduce HIV infection among drug users and that they do not increase illicit drug use.²⁵

Despite this tradition of ambivalence, as evidence builds that the practical interventions of harm reduction are effective, national and local political and regulatory bodies are beginning to support harm reduction policies. For example, in 2007 the US Conference of Mayors resolved to take a public health approach to drug issues (see Appendix C for full resolution). In conclusion, the resolution states:

*the United States Conference of Mayors believes the war on drugs has failed and calls for a New Bottom Line in U.S. drug policy, a public health approach that concentrates more fully on reducing the negative consequences associated with drug abuse, while ensuring that our policies do not exacerbate these problems or create new social problems of their own; establishes quantifiable, short- and long-term objectives for drug policy; saves taxpayer money; and holds state and federal agencies accountable.*²⁶

Several chapters of the League of Women Voters, including Texas and Seattle, have embraced this approach and consider substance abuse and drug addiction to be public health issues. In Hawai'i, many public policy groups such as the Joint Senate-House Task Force on Ice and Drug Abatement and social service providers have come to the same conclusion.

²⁵ Wodak, A. (2004) http://www.drugpolicy.org/library/05_07_04wodaknih.cfm

²⁶ United States Conference of Mayors (2007)
http://www.usmayors.org/75thAnnualMeeting/resolutions_full.pdf

Public Health - Policy Alternatives for Hawai‘i

Applying the Public Health Approach

There are many ways in which the public health approach and harm reduction principles can be integrated into existing and new drug-related policies and programs. Some of these possibilities are mentioned immediately below and others are found in the policy alternatives presented at the conclusion of the following chapters. They share a commitment to practical, evidence-based steps that reduce the harm associated with drug abuse and dependency.

Hawai‘i’s Medical Marijuana Program

Since Hawai‘i first established the medical marijuana program in 2000, it has grown to encompass 4,200 patients. There are several improvements that could make the program more accessible to patients, increase the participation of physicians, and enable it to effectively address patients’ medical needs while respecting their rights as law abiding citizens. Changes sought by patients include:

- increasing the amount of marijuana patients can grow and/or keep on hand;
- increasing the caregiver : patient ratio from 1:1 and thereby enable caregivers to care for more patients;
- establishing reciprocity with other states with medical marijuana programs; and
- making the program more approachable and user-friendly.

Many patients and advocates suggest that, in addition to these substantive changes within the program itself, its administration should be shifted from the Department of Public Safety’s Narcotics Enforcement Division (NED) to the Department of Health (DOH).

In 2007, LWV Hawai‘i participated (via the Hawai‘i Women’s Coalition) in a concerted, albeit unsuccessful, legislative effort to move administration of the program under the jurisdiction of the DOH. This policy change is sought primarily to address patients’ fear and the stigma associated with registering with a narcotics enforcement agency. These concerns were exacerbated by a security breach in July 2008, when the patient database was mistakenly released to a Big Island newspaper. The administrative move to the DOH would assuage the fears of people with qualifying medical conditions who are currently intimidated by the idea of registering with NED and therefore either forgo the benefits of the medication, or use marijuana without registering and therefore face the possibility of arrest by state or local authorities. It would also mitigate the reluctance of some physicians to certify patients, which is the biggest barrier for patients seeking certification. Such a change would better reflect the legislative intent of this program and enable the program to take advantage of the outreach and education capacity of the DOH, as is the case in most of the states that permit the medical use of marijuana.

4. Prevention & Education

Prevention and education are the foundational elements to all drug policies. However, rising rates of drug use and addiction demonstrate the lack of success achieved by the past thirty years of prevention and education efforts. This chapter discusses prevention and education, explores the weaknesses of existing approaches, and proposes several alternatives.

Prevention

The Office of National Drug Control Policy has developed a list of 15 ‘evidence-based principles for substance abuse prevention’ programs, which are presented below in an abbreviated fashion:²⁷

1. Define a population – e.g. age, sex, geography, race, etc.
2. Assess levels of risk, protection, and substance abuse for that population.
3. Focus on all levels of risk, with special attention to those exposed to high risk and low protection. Prevention programs and policies should focus on all levels of risk, but special attention must be given to the most important risk factors, protective factors, psychoactive substances, individuals, and groups exposed to high risk and low protection in a defined population.
4. Reduce the availability of illicit drugs, and of alcohol and tobacco for the under-aged.
5. Strengthen environmental support for anti-drug-use attitudes by sharing accurate information about substance abuse, encouraging drug-free activities, and enforcing laws, and policies related to illicit substances.
6. Teach life skills and drug refusal skills, using interactive techniques that focus on critical thinking, communication, and social competency.
7. Reduce risk and enhance protection in families. Strengthen family skills by setting rules, clarifying expectations, monitoring behavior, communicating regularly, providing social support, and modeling positive behaviors.
8. Strengthen social bonding and caring relationships with people holding strong standards against substance abuse in families, schools, peer groups, mentoring programs, religious and spiritual contexts, and structured recreational activities.
9. Ensure that interventions are appropriate for the populations being addressed. Make sure that prevention interventions, including programs and policies, are acceptable to and appropriate for the needs and motivations of the populations and cultures being addressed.
10. Intervene early and at developmental stages and life transitions that predict later substance abuse. Such developmental stages and life transitions can involve

²⁷ ONDCP. <http://www.whitehousedrugpolicy.gov/prevent/practice.html>

biological, psychological, or social circumstances that can increase the risk of substance abuse.

11. Reinforce interventions over time. Repeated exposure to scientifically accurate and age-appropriate anti-drug-use messages and other interventions-especially in later developmental stages and life transitions that may increase the risk of substance abuse-can ensure that skills, norms, expectations, and behaviors learned earlier are reinforced over time.
12. Intervene in settings and domains that most affect risk and protection for substance abuse, including homes, social services, schools, peer groups, workplaces, recreational settings, religious and spiritual settings, and communities.
13. Ensure consistency and coverage of programs and policies.
14. Train staff and volunteers. To ensure that prevention programs and messages are continually delivered as intended, training should be provided regularly to staff and volunteers.
15. Monitor and evaluate programs.

In practice, most prevention programs are targeted to young people, and are generally delivered to students as a component of their schooling. Few embody all the principles listed above, and indeed some of them actively undermine one or more of them, as described below.

Youth Education

D.A.R.E. (Drug Abuse Resistance Education) is the most ubiquitous and well-known drug education program for children in the public school system. Founded in Los Angeles in 1983, the program is a self-described “police officer-led series of classroom lessons that teaches children from kindergarten through 12th grade how to resist peer pressure and live productive drug and violence-free lives.”²⁸ D.A.R.E. remains popular, despite numerous studies disproving its efficacy, and its failure to appear on the list of federally recognized programs for drug prevention. For these reasons a growing number of school districts including some in Colorado, Minnesota and Utah no longer use D.A.R.E. Nonetheless D.A.R.E. is still in use in 75% of the US’s school districts, and in more than 43 countries around the world. In Hawai‘i, 95% of elementary and public schools use a non-federally recognized program, some in tandem with a federally recognized program. At these schools D.A.R.E. is by far the most popular program, and is implemented by 70% of them.²⁹

Despite their exposure to D.A.R.E. and similar programs, many students have chosen to try illicit drugs (48% of high school seniors) and alcohol (73%).³⁰ This failure is

²⁸ D.A.R.E. (2008) http://www.dare.com/home/about_dare.asp

²⁹ Ishida-Ho, A., Kunstman, W., Shoda-Sutherland, C., & Wilson, M. (2004) “A Survey of Substance Abuse Prevention Education Programs in Hawai‘i Schools.”

³⁰ Rosenbaum, M. (2007) “Safety First.”

increasingly understood to stem from flaws within our prevention and education programs themselves. The three gravest flaws of these programs are: (1) the failure to distinguish between drug use and abuse and the associated claim that all use is abuse; (2) the reliance on misinformation regarding the danger of certain drugs, which is used as a scare tactic; and (3) the failure to provide sufficient information that would allow those who do use drugs to reduce associated danger and harm.³¹

Taken together, this lack of sufficient and accurate information has led young people to become cynical and to mistrust *all* messages regarding drugs, a dangerous outcome indeed. In light of the failure of existing drug education programs, public health practitioners and academics are creating and implementing new forms of drug education based upon the principles of harm reduction (see page 29).

School-Based Drug Testing

Perhaps the most controversial means of preventing drug use by youth is school-based drug testing, and indeed many experts dispute whether this is, in fact, a method of prevention. As mentioned above (see page 18 for details), no public schools in Hawai‘i currently employ random drug testing. Mid-Pacific Institute (a private school on O‘ahu) implemented a program of voluntary drug testing beginning in the 2005-2006 school year.

In 1995 the US Supreme Court ruled that school-based drug testing of students involved in athletics is not a violation of their rights. Another decision in 2002 expanded this ruling to include all students involved in any extracurricular activity. Though frequently touted by proponents as an effective ‘get tough’ policy, school-based drug testing is not supported by the majority of the medical community or youth and family-oriented service organizations. The National Association of Social Workers (NASW) states that school-based drug testing is “both invasive and counterproductive to combating drug and alcohol abuse in schools.”³² The Association for Addiction Professionals (NAADAC) questions the benefits and efficacy of school-based drug testing, stating that “the challenges are manifold in determining whom to test, what to test for, what safeguards there are against false-testing processes, how the privacy of a student’s health status is protected, and whether drop-out rates would soar as a result of this testing.”³³

According to the American Association of Pediatrics (AAP), a national survey of physicians specializing in pediatrics, family medicine, and adolescent medicine found that 83% of those surveyed disagreed with drug testing in public schools.³⁴

³¹ Rosenbaum, M. (2007) “Safety First.”

³² National Association of Social Workers (NASW). (2002) “Social Workers Disagree with Supreme Court Decision to Test Students for Drug Use.” <http://www.socialworkers.org/pressroom/2002/062702.asp>

³³ Association for Addiction Professionals (NAADAC). (2008) *Position Statement: Adolescent Drug Testing.* <http://naadac.org/documents/display.php?DocumentID=102>

³⁴ American Academy of Pediatrics Committee on Substance Abuse and Council on School Health. (2007) “Testing for Drugs of Abuse in Children and Adolescents: Addendum – Testing in Schools and at Home.” (Policy Statement.) *Pediatrics*. Vol. 119 No. 3.

The AAP itself suggests that “school- and home-based drug testing poses a number potential benefits and risks.” Benefits include offering the potential for early intervention and treatment, and possible support for adolescents’ refusal to use drugs (the latter has yet to be proven). However, “drug testing poses substantial risks – in particular the risk of harming parent-child and school-child relationships by creating an environment of distrust and suspicion.”³⁵ NASW agrees that school-based drug testing “breaks down the walls of trust between student and school—a bond which time and again proves to decrease the likelihood of students participating in risky behaviors.”³⁶

Many organizations point to the unintended consequences of conducting school-based drug tests for illicit drugs. For example, the AAP points out that:

*Widespread implementation of drug testing may, therefore, inadvertently encourage more students to abuse alcohol, which is associated with more adolescent deaths than any illicit drug but is not included in many standard testing panels. Mandatory drug testing may also motivate some drug-involved adolescents to change from using drugs with relatively less associated morbidity and mortality, such as marijuana, to those that pose greater danger (eg, inhalants) but are not detected by screening tests. No studies have yet been conducted on this important issue. Safety of randomly testing adolescents for the use of drugs should be scientifically established before it is widely implemented.*³⁷

Similarly, in its response to the 2002 Supreme Court ruling, NASW discussed the perverse impact of focusing on students involved in extracurricular activities:

*Thousands of social workers nationwide devote their lives to understanding, preventing, and treating substance abuse. School social workers focus primarily on helping students succeed; creating a safe and supportive learning environment for students to get the education they deserve and need. Policies such as this one deny participation in a broad range of extra-curricular activities for those students who refuse to submit to “suspicionless” drug testing—regardless of whether that decision was based on principle or modesty. They are, in essence, guilty until proven innocent. Empirical evidence, however, continues to show that students who participate in extra-curricular activities are least likely to be involved with alcohol and drugs, or any other “risky behaviors.”*³⁸

³⁵ American Academy of Pediatrics Committee on Substance Abuse and Council on School Health. (2007) “Testing for Drugs of Abuse in Children and Adolescents: Addendum – Testing in Schools and at Home.” (Policy Statement.) *Pediatrics*. Vol. 119 No. 3.

³⁶ National Association of Social Workers (NASW). (2002) “Social Workers Disagree with Supreme Court Decision to Test Students for Drug Use.” <http://www.socialworkers.org/pressroom/2002/062702.asp>

³⁷ American Academy of Pediatrics Committee on Substance Abuse and Council on School Health. (2007) “Testing for Drugs of Abuse in Children and Adolescents: Addendum – Testing in Schools and at Home.” (Policy Statement.) *Pediatrics*. Vol. 119 No. 3.

³⁸ National Association of Social Workers (NASW). (2002) “Social Workers Disagree with Supreme Court Decision to Test Students for Drug Use.” <http://www.socialworkers.org/pressroom/2002/062702.asp>

Public health and social service organizations are particularly worried about the paucity of developmentally appropriate adolescent substance abuse and mental health treatment services. The AAP worries that students who test positively for drug use are unlikely to receive appropriate or effective treatment. NAADAC echoes the concern that there is a shortage of adolescent prevention and treatment workforce training for additional professionals and therefore “feels strongly that if a community does adopt a school drug testing program, stakeholders should first ensure that sufficient resources are available to address students who test positive.”³⁹

³⁹ Association for Addiction Professionals (NAADAC). (2008) Position Statement: Adolescent Drug Testing. <http://naadac.org/documents/display.php?DocumentID=102>

Prevention & Education - Policy Alternatives for Hawai'i

Youth Education

The most important policy improvement we can make in the area of youth drug education is the creation of new programs that provide accurate and comprehensive information. As Elizabeth Clark, Executive Director of the National Association of Social Workers, states, "what is most effective in keeping kids away from drugs and alcohol are substance abuse prevention programs based on scientific research."⁴⁰

Dr. Marsha Rosenbaum of the Drug Policy Alliance (a former research grantee of the National Institute on Drug Abuse) has developed such an approach, called 'Safety First: a reality-based approach to teens and drugs.'⁴¹ Embodying the principles of harm reduction, the foundational tenets of this program are:

- Provide honest, science-based information.
- Encourage moderation if youthful experimentation persists.
- Promote an understanding of the legal and social consequences of drug use.
- Prioritize safety through personal responsibility and knowledge.

More information is available at www.safety1st.org.

Dr. Rodney Skager, Professor Emeritus UCLA Graduate School of Education & Information Studies, has also developed an approach, called "Beyond Zero Tolerance: a reality-based approach to drug education and student assistance."⁴² In this method the basic tenets are:

- Drug education should be honest, balanced, interactive, and delivered in a way that involves full participation of students.
- Intervention for students who need assistance should be an integral part of drug education.
- A restorative process, in which offenders identify harms they have caused and then make amends, should replace most suspensions and expulsions.

The Oakland, California school district has been successfully using the UpFront program based on these principles for almost a decade.

⁴⁰ National Association of Social Workers (NASW). (2002) "Social Workers Disagree with Supreme Court Decision to Test Students for Drug Use." <http://www.socialworkers.org/pressroom/2002/062702.asp>

⁴¹ Rosenbaum, M. (2007) "Safety First."

⁴² Skager, R. (2005) "Beyond Zero Tolerance."

Student Drug Testing

As explained above, the medical community and social services generally wish to avoid student drug testing, as it is deemed ineffective, expensive and counterproductive. In its place, they suggest alternative programs that emphasize education, discussion, counseling and extracurricular activities, and that build trust between students and adults. After school programs, in particular, have been found to be an effective preventative measure.

If drug testing is to be further explored, this endeavor should follow the Association of American Pediatrics relevant policy:⁴³

- The AAP supports rigorous scientific study of both the safety and efficacy of school- and home-based drug testing of adolescents.
- The AAP recommends that school- and home-based drug testing not be implemented before its safety and efficacy are established and adequate substance abuse assessment and treatment services are available.
- The AAP encourages parents who are concerned that their child may be using drugs or alcohol to consult their child's primary care physician or other health professional rather than rely on school-based drug screening or use home drug-testing products.
- The AAP recommends that health care professionals who obtain drug tests or assist others in interpreting the results of drug tests be knowledgeable about the relevant technical aspects and limitations of the procedures.

⁴³ Association for Addiction Professionals (NAADAC). (2008) Position Statement: Adolescent Drug Testing. <http://naadac.org/documents/display.php?DocumentID=102>

5. Treatment

It is widely agreed that substance abuse treatment is a cost-effective way to reduce the economic, societal and public health costs associated with drug abuse. Effective treatment enables those with drug dependencies to return to their normal lives, with positive impacts on families, communities and the economy. The National Institute on Drug Abuse (NIDA, part of the National Institutes on Health) estimates that for every dollar spent on treatment, there is a \$4 to \$7 reduction in the cost of drug-related crimes, and in some outpatient programs, the ratio of total savings to costs can exceed 12:1.⁴⁴

However, the vast majority of those in the United States who need treatment for drug dependencies do not receive it. According to the National Survey on Drug Use and Health, of the 22.5 million Americans aged 12 or older who needed treatment for substance (both alcohol and illicit drug) abuse and addiction in 2004, only 2.33 million people (10% of those in need) received treatment at a specialty facility.⁴⁵ The high cost of untreated abuse and addiction for families and communities includes increased violence and crime, prison expenses, court and criminal costs, healthcare utilization, child abuse and neglect, foster care, welfare costs and unemployment.

Drug Addiction Treatment

Drug dependency is regarded by the medical community as a disease responsive to treatment. The medical community does not differentiate between the treatment required for licit drugs (e.g. alcohol) and illicit drugs (e.g. heroin). The American Medical Association has developed several policies relating to drug treatment, including the following:

“The AMA has stated repeatedly that drug dependencies, including alcoholism, are diseases and that their treatment is a legitimate part of medical practice (Policy 95.983, AMA Policy Compendium). Although illicit drug use is a criminal action, drug addiction is a disease amenable to treatment (Policy 420.970). Government and other public and private organizations are urged to base their policies on the recognition that drug dependencies are diseases (Policy 95.983).”⁴⁶

NIDA elaborates further, identifying drug addiction as a “complex but treatable brain disease” characterized by relapses “at rates similar to those for other well-characterized, chronic medical illnesses such as diabetes, hypertension, and asthma.”⁴⁷ Multiple sessions of treatment may therefore be necessary to achieve success. This has become increasingly problematic as insurers have limited the length of treatment or number of treatment episodes to rein in costs.

⁴⁴ NIDA. <http://www.nida.nih.gov/Infofacts/treatmeth.html>

⁴⁵ National Survey on Drug Use and Health (2004).

<http://www.oas.samhsa.gov/NSDUH/2k4NSDUH/2k4results/2k4results.htm#7.2>

⁴⁶AMA (1997) <http://www.ama-assn.org/ama/pub/category/13636.html>

⁴⁷ NIDA. <http://www.nida.nih.gov/Infofacts/treatmeth.html>

There are many types of drug treatment, including medical detoxification, short and long term residential programs, ongoing medical and maintenance treatment, and outpatient services. Research demonstrates that it is important to offer a wide array of drug treatment modalities. Treatment programs may include elements of pharmacotherapy, psychotherapy, behavior therapy, cognitive therapy, skills training, counseling, and other rehabilitative therapies. While the ultimate goal of many drug addiction treatment programs is lasting abstinence, the intermediate goal is always harm reduction, including reducing drug abuse, improving the patient's ability to function, and minimizing medical and social complications of drug abuse and addiction. Some common forms of treatment include:

- **Medical detoxification** is most appropriately understood as a precursor of treatment, rather than a treatment modality in and of itself. Provided in an inpatient or outpatient setting, detoxification treats the physiological effects of discontinuing drug use, sometimes through the use of medications. It does not address psychological, social, or behavioral problems associated with addiction. To achieve lasting success, it should therefore be followed by one of the following modes of treatment.
- **Long-term residential treatment** requires patients to reside in the place of treatment, often a nonhospital setting, where they receive 24 hour care. Programs generally last six to twelve months. Treatment models include the therapeutic community and cognitive-behavioral therapy. Many programs include additional services, such as employment training and broader support services.
- **Short-term residential programs** provide a relatively brief residential treatment program generally lasting three to six weeks, followed by ongoing outpatient therapy or participation in group counseling or a self-help organization. These programs reflect the 12-step approach to treating alcohol addiction. According to the White House Office of National Drug Control Policy (ONDCP), since this approach was popularized in the mid-1980s, "reduced health care coverage for substance abuse treatment has resulted in a diminished number of these programs, and the average length of stay under managed care review is much shorter than in early programs."⁴⁸
- **Outpatient drug-free treatment** encompasses a spectrum of programs of varying intensity that do not require patients to 'live-in.' Programs often include an element of group counseling.
- **Agonist maintenance treatment** for heroin addicts, commonly referred to as methadone treatment, consists of synthetic opiate medication, usually provided in an outpatient setting. Patients on sustained methadone treatment can often reintegrate successfully into society.
- **Narcotic antagonist treatment** (Naltrexone) for opiate addicts is also conducted in an outpatient setting. This treatment can be administered by a patient's own physician, which lowers perceived and actual barriers to receiving treatment.

⁴⁸ ONDP. <http://www.whitehousedrugpolicy.gov/treat/treatment.html>

Patients on sustained narcotic treatment can often reintegrate successfully into society, though patient noncompliance is a common problem and can undermine the treatment.

In Hawai‘i, several state and county agencies and private entities provide drug treatment services to the general population, the incarcerated population and those reentering society. Many of these services are underwritten by, contracted by, or receive funding from the Hawai‘i Department of Health’s Alcohol and Drug Abuse Division (ADAD). These services are of great assistance to those in need and are widely appreciated. They are, however, insufficient to meet the state’s growing demand for treatment services especially on the Neighbor Islands where there are far fewer facilities. The largest treatment facility in Hawai‘i, Hina Mauka, which includes a 48-bed residential facility in Kāne‘ohe, recently opened a new outpatient services facility. It is expected that this new facility will reduce Hina Mauka’s usual waiting list, which stands at 30 to 40 people.⁴⁹ While this new addition will help address pressure at Hina Mauka, demand throughout the state continues to greatly outstrip the availability of treatment services.

Treatment & Criminal Behavior

The strong connection between the use and abuse of drugs, criminal behavior and incarceration is explored at length below (see Chapter 6). Many studies show that treatment for substance abuse and addiction substantially reduces criminal behavior and arrests. According to NIDA, “treatment offers the best alternative for interrupting the drug abuse/criminal justice cycle for offenders with drug abuse problems.”⁵⁰ A US Department of Health and Human Services National Treatment Improvement Evaluation Study compared criminal behavior and arrests during the 12-month period before and after treatment and found that treatment reduced arrests by 64% and self-reported criminal activities by 80%.⁵¹

Unfortunately, most drug abusing offenders do not receive treatment. In 1997 the Bureau of Justice Statistics reported that less than 20% of incarcerated offenders with drug problems received treatment while in prison.⁵² Some observers suggest that in Hawai‘i less than 7% of incarcerated people in need of treatment receive it.

Untreated offenders are much more likely to relapse into drug abuse and to repeat criminal behavior, resulting in re-arrest and reincarceration while simultaneously jeopardizing public health and safety and requiring the expenditure of further public resources. Research demonstrates that continuing drug treatment for drug offenders *after* returning to the community significantly lowers relapse to drug use and recidivism to crime.⁵³

⁴⁹ *Honolulu Star Bulletin*. (2008) “Services Expand at Hina Mauka.”

⁵⁰ NIDA. <http://www.nida.nih.gov/Infofacts/CJtreatment.html>

⁵¹ NTIES. <http://ncadi.samhsa.gov/govstudy/f027/crime.aspx>

⁵² NIDA. <http://www.nida.nih.gov/Infofacts/CJtreatment.html>

⁵³ ONDP. <http://www.whitehousedrugpolicy.gov/treat/treatment.html>

Treatment - Policy Alternatives for Hawai‘i

Drug Treatment

Drug treatment programs, both public and private, are in great need of increased financial and human resources. The American Medical Association (AMA) “urges federal, state, and local governments to increase funding for drug treatment so that drug abusers can have immediate access to appropriate care, regardless of ability to pay.” The AMA adds that “this is the most important step that can be taken to reduce the spread of human immunodeficiency virus (HIV) infection among intravenous drug abusers (Policy 20.977).”⁵⁴

The need for increased funding is universal, encompassing prison-based treatment programs, reentry and halfway houses, drug court programs, and gender-responsive and youth-oriented programs. Another specific need is for treatment programs that enable the participation of women with children, for example programs like Women’s Way in Honolulu that permit clients’ youngest children to reside with their mothers for the duration of the services.

In Hawai‘i, as elsewhere, approximately two-thirds of drug-related funding is dedicated to the criminal justice realm, leaving prevention and treatment chronically underfunded. Given sufficient political will, state legislation can address this need by appropriating further funds, or reprioritizing funds currently deployed in the criminal justice system, to support existing programs and creating new ones where needed. See below (pages 37 and 39) for an assessment of the cost savings associated with pursuing treatment rather than incarceration.

Age-appropriate treatment

Public health and social service organizations are particularly worried about the paucity of developmentally appropriate adolescent substance abuse and mental health treatment services. The AAP worries that students who test positively for drug use are unlikely to receive appropriate or effective treatment. NAADAC echoes the concern that there is a shortage of adolescent prevention and treatment workforce training for additional professionals and therefore “feels strongly that if a community does adopt a school drug testing program, stakeholders should first ensure that sufficient resources are available to address students who test positive.”⁵⁵ There is an appalling lack of resources for Hawai‘i’s youth who are grappling with drug use and abuse. Further resources should be devoted to age-appropriate treatment services.

⁵⁴AMA (1997) <http://www.ama-assn.org/ama/pub/category/13636.html>

⁵⁵ Association for Addiction Professionals (NAADAC). (2008) Position Statement: Adolescent Drug Testing. <http://naadac.org/documents/display.php?DocumentID=102>

6. Drugs & Incarceration

The relationship between crime and the use and abuse of drugs, particularly illicit drugs, is obvious but complicated. At the most basic level, most psychoactive substances are generally understood to be *non-criminogenic*, meaning they do not inherently cause criminal behavior. (An important exception is alcohol, which *is* deemed to have a criminogenic influence.) Despite this, illicit drug use and abuse is clearly associated with criminal offenses and resulting incarceration. The National Institute on Drug Abuse (NIDA) identifies three connections between illicit substances and criminal activity; simple possession or sale of drugs, stealing to get money for drugs, and offenses that stem from a lifestyle that predisposes drug abusers to engage in illegal activities, for example through participation in illicit markets. It follows that drug use and abuse is closely related to incarceration, though this relationship is shaped by the policies and laws that govern drug offenses. For example, in 1986 sentencing for drug offenders was substantially revised by the Anti-Drug Abuse Act, which imposed mandatory minimum sentences for drug-related offenses. These federal regulations were followed in many cases by further state-level minimum sentences, for example for crystal methamphetamine-related offenses in Hawai‘i. This increased the terms of incarceration and eliminated the chances for probation or parole for most drug related offenses. This in turn has contributed to tremendous growth of the incarcerated population, especially non-violent offenders, in Hawai‘i and throughout the United States.

It would be too simplistic to suggest that drug possession or use alone can account for the growing incarcerated population in the United States or in Hawai‘i, and this study only suggests that it is a significant contributing factor. In Hawai‘i the Department of the Attorney General tracks the number of offenses related to drug manufacture, sale or possession. In 2006 there were 521 arrests for drug manufacture or sale and 2,214 arrests for drug possession across the state.⁵⁶ But the Department does not maintain records regarding the number of offenses that are drug-related. This is partly because it is difficult to determine with certainty which offenses are drug-related. It is even more difficult to determine the nature of the relationship between drug issues and criminal activity – which precedes the other; are they merely correlated; or is there a direct causal link? The answer likely varies for each individual offender and his or her set of circumstances. While the exact relationship between drug issues and criminal activity is not fully understood, the connection between the two is explored below.

Incarceration & Drug Use

The incarcerated population and those on parole are much more likely to exhibit substance dependence or abuse drugs than the general population, and are unlikely to receive treatment for their addiction. In 2004 the rate of substance dependence or abuse among American adults who were on parole or a supervised release from jail during the past year was 40.8%, compared with 9.2% of the general population. Similarly, the rate of substance dependence or abuse among probationers in 2004 was 38.5%, compared to

⁵⁶ Department of the Attorney General. (2007) Crime in Hawai‘i: Uniform Crime Report.

8.8% of adults not on probation.⁵⁷ The high rate of dependency among the currently or formerly incarcerated population feeds into high rates of recidivism, perpetuating an on-going cycle of crime and punishment.

Hawai‘i’s Swelling Incarcerated Population

In Hawai‘i the incarcerated population has risen from 926 people in 1980 to 6,251 people in 2006. As a result, Hawai‘i’s prisons and jails are chronically overcrowded, with all individual facilities housing substantially more inmates than originally intended. In 1985 a federal court decision known as the Spear Consent Decree deemed that the conditions in Hawai‘i’s overcrowded prisons were unconstitutional, and required that they be addressed. While conditions have improved in the intervening 23 years (the conditions of the Decree were all met by 1999), overcrowding is still problematic. For example, in 2006 the head count at Hālawā Correctional Facility, the state’s largest facility, was 1,144, which is nearly double its designed capacity of 586.⁵⁸

Since 1996 the state has responded to overcrowding by sending ever greater numbers of Hawai‘i inmates to facilities on the mainland. The out-of-state inmate population grew from 300 to 1,844 between 1996 and 2006, with legislative approval and funding to send an additional 676 inmates to the mainland in 2007. Over 150 female inmates are currently at a Kentucky facility, while male inmates are housed at contracted facilities in Arizona.

The direct financial cost of Hawai‘i’s prison and jail system is reflected in the annual budget of \$118 million for the state’s correctional facilities and a total of \$194 million for the Department of Public Safety (with only \$2 million coming from federal sources and the rest from state and county resources). The Narcotics Enforcement Division receives \$1.5 million a year.⁵⁹ According to the Department of Public Safety, in 2006 the state paid over \$47 million to house our prisoners in mainland facilities.⁶⁰

In 2000 ADAD identified the gap in treatment needs for Hawai‘i’s offender population and found that the following were not receiving needed treatment: 12,537 individuals on probation; 2,036 individuals incarcerated in prison; 1,083 individuals on parole; 893 individuals incarcerated in jail; and 411 individuals on supervised release.⁶¹

Family Connections and Societal Impact

Clearly the societal impact of incarceration extends beyond the individual directly involved to encompass families and the broader community, contributing to the multi-generational cycle of incarceration and the disproportionate representation of certain ethnic and socioeconomic groups in Hawai‘i’s correctional facilities. A recent study for

⁵⁷ National Survey on Drug Use and Health (2004).

<http://www.oas.samhsa.gov/NSDUH/2k4NSDUH/2k4results/2k4results.htm#7.2>

⁵⁸ PSD Annual Report. p. 30

⁵⁹ PSD Annual Report p. 64

⁶⁰ PSD Report to the 2007 Legislature. (2006)

<http://www.state.hi.us/psd/documents/reports/LEG%20RPT%20-%20Mainland%20Corr%20Fac.pdf>

⁶¹ Joint House-Senate Task Force on Ice and Drug Abatement, Final Report. (2003) p.79

the Hawai‘i Attorney General found that 50% of those in the juvenile justice system have had a parent involved in the criminal justice system and 25% have been placed in a foster home (not *hānai* or extended family).⁶² This jibes with the observation of social workers in the field that when compared with youth elsewhere in the US, juvenile drug use in Hawai‘i is influenced more by family members than by peers.

In some cases a parent’s criminal behavior, particularly if violent, may render a parent unfit to assume responsibility for his or her children and warrant the removal of those children from the home. This study takes a similar position to the Vera Institute of Justice, whose studies of New York families impacted by incarceration concludes in support of maintaining family ties, but clearly states that this should not “be interpreted as a recommendation that children be returned to parents found guilty of a violent felony, or that the children in the study group should not have been removed from their homes. The first responsibility of child welfare officials must be to ensure that a child is safe.”⁶³

However, in many cases the severing of family connections due to incarceration causes even more damage to both incarcerated individuals and their family members, particularly children. According to the Vera Institute of Justice studies:

*the evidence that substance abuse problems often underlie the child welfare and criminal justice problems of these families is compelling. The efforts to arrange visits and maintain parental contact for these children are an important and necessary step in addressing the problems of children with incarcerated parents.*⁶⁴

Sustaining family ties, partially achieved through visitation, contributes to the well being of both the offender and his or her family. From the offender’s perspective, it has been found to reduce rates of recidivism, ease reintegration, and increase the chances of find post-incarceration employment. While the reasons for reoffending are complex and should not be reduced to the single factor of loss of family ties, the connection between the two is apparent and it is suggested that family ties result in a decline in recidivism of around 50%.⁶⁵ From this perspective, “family preservation efforts may function as a crime reduction tool. Successful efforts to avert placement not only keep families together and children out of foster care, but can also prevent the increase in maternal criminal activity that can take place following a child’s removal.”⁶⁶

⁶² Pasko, L. “Profiles of Female and Serious Juvenile Offenders in Hawai‘i.” http://hawaii.gov/ag/cpja/main/rs/sp_reports_0306/pfsjoh-7112006.ppt#256,1, Profiles of Female and Serious Juvenile Offenders in Hawaii

⁶³ Ross, T., Khashu, A. & Wamsley, M. (2004) “Hard Data on Hard Times: Empirical Analysis of Maternal Incarceration, Foster Care, and Visitation.”

⁶⁴ *ibid*

⁶⁵ Brookes, M. (2005) “Investing in family ties: Reoffending and family visits to prisoners.”

⁶⁶ Ross, T., Khashu, A. & Wamsley, M. (2004) “Hard Data on Hard Times: Empirical Analysis of Maternal Incarceration, Foster Care, and Visitation.”

The familial impacts of incarceration are particularly pronounced when women are imprisoned. This often results in the loss of a child's primary caregiver and placement with the foster care system, with negative consequences for both mothers and children.

Since the passage of the federal 1997 Adoption and Safe Families Act, the state is required to terminate the parental rights of children who have been in foster care for 15 of the last 22 months. In practice, incarcerated mothers can therefore lose the rights to their children, who are permanently placed in the foster care system or adopted, which can result in the displacement of Hawai'i children to the mainland. Given the disproportionate representation of Native Hawaiians in the criminal justice system, this is particularly devastating for Native Hawaiian children who may lose the opportunity to grow up within their cultural community.

Hawai'i faces a particular challenge with regard to maintaining family connections for those offenders incarcerated in mainland facilities. This situation clearly deprives offenders of the opportunity to maintain familial connections through visitation. Again, the Vera Institute of Justice explains:

Without visitation, the government imposes a double punishment on convicted parents: in addition to a loss of liberty, lack of contact may further strain parent-child relationships. In the worst case, lengthy separation without visits leads to the permanent dissolution of the family.⁶⁷

Non-violent Drug Offenders

One increasingly popular means of reducing the incarcerated population and addressing the connection between drugs and criminal behavior is the diversion of nonviolent drug offenders from the criminal justice system to treatment programs. This strategy is cost effective and reflects the principles of harm reduction and a commitment to a public health approach to drug problems. According to a study by the Open Society Institute, two thirds of Americans describe drug abuse as a medical problem that should be handled mainly through counseling and treatment (63%) rather than a serious crime that should be handled mainly by the courts and prison system (31%).⁶⁸ Several states have embraced this approach, as described below.

In 1996 Arizonans voted in favor of the Drug Medicalization Prevention and Control Act (Proposition 200), which sends first and second time nonviolent drug offenders to treatment rather than incarceration. In 2004 Maryland enacted a new law that gives prosecutors discretion to divert nonviolent drug offenders into treatment instead of prosecution and prison, allows judges more discretion at sentencing, enables persons already serving prison time for drug offenses to be paroled for treatment purposes, and appropriates more funds for treatment.

⁶⁷ Ross, T., Khashu, A. & Wamsley, M. (2004) "Hard Data on Hard Times: Empirical Analysis of Maternal Incarceration, Foster Care, and Visitation."

⁶⁸ Open Society Institute.

http://www.soros.org/initiatives/justice/articles_publications/publications/hartpoll_20020201

Perhaps the best documented law is California's 2000 Substance Abuse and Crime Prevention Act (Proposition 36). Passed by 61% of California voters, Prop 36 changed state law to require first- and second-time nonviolent, simple drug possession offenders the opportunity to receive substance abuse treatment instead of incarceration. Proposition 36 went into effect on July 1, 2001, with \$120 million for treatment services allocated annually for five years. Over 36,000 Californians enter treatment each year through Prop 36.

The University of California, Los Angeles (UCLA) is charged with carrying out ongoing analyses of the impact and efficacy of Prop 36. In 2006 UCLA published a cost-benefit analysis of Prop 36 from the 'taxpayer perspective,' in which the focus is on costs to state and local governments. The study found that Prop 36 has a cost-benefit ratio of nearly 2.5 to 1, meaning that for every \$1 allocated to fund the law, approximately \$2.50 is saved. In sum, the program led to a total cost savings of \$2,861 per offender over the 30 month follow-up period, resulting in a net savings to the Californian government of \$173.3 million (after subtracting \$3 million for state administrative costs). Cost savings were achieved through substantial reduction of incarceration costs, with savings increasing in step with the duration of offenders' participation and success in treatment programs.⁶⁹ The experience with Prop 36 is particularly relevant to Hawai'i, as over half of offenders entering the program's treatment services are identified as users of methamphetamine. In fact, contrary to popular opinion that methamphetamine addiction is 'untreatable,' these individuals have a greater success rate (35%) than users of either crack/cocaine (32%) or heroin (29%).⁷⁰

In November 2008 Californians will vote on a ballot initiative that builds upon the success of Prop 36. If passed, NORA, or the Nonviolent Offender Rehabilitation Act, will increase funding and oversight for individualized drug treatment for nonviolent drug offenders and parolees; reduce criminal consequences of drug offenses; shorten parole for most drug offenses; develop further oversight and reporting resources for drug treatment; and change certain marijuana misdemeanors to infractions.

Hawai'i's Act 161 (see page 16) is based on California's Prop 36 and currently allows the diversion of first time nonviolent drug offenders from prison to substance abuse treatment. However, in 2004 the language of the law regarding the diversion of first time offenders to probation and treatment rather than incarceration was changed from mandatory to optional. In practice this has undermined the intent of providing treatment rather than incarceration for first time nonviolent drug offenders. Changes that would enable this law to be effective are discussed below in the policy alternatives section.

⁶⁹ Longshore, D. et al. (2006) "Evaluation of the Substance Abuse and Crime Prevention Act."

⁷⁰ http://www.prop36.org/meth_day_2006.html

Drugs & Incarceration – Policy Alternatives for Hawai‘i

There are many policies that could contribute to the overarching goal of reducing rates of drug-related crime, incarceration and recidivism. This section addresses several of those policies.

Reducing Usage of Mainland Correctional Facilities

The direct economic cost of maintaining Hawai‘i offenders in mainland correctional facilities (over \$47 million in 2006) is compounded by societal and familial costs that contribute to recidivism (again more tax payer costs) and the self-perpetuating negative cycle of incarceration across generations and within certain socioeconomic groups. Reducing reliance on these facilities and bringing offenders home to their own communities would begin to address these challenges. This in turn requires reducing the rate of incarceration in Hawai‘i to the point where we can house offenders in the state’s facilities. The following strategies are aimed at achieving this reduction.

Investing in Family Connections

The reduction in recidivism among offenders who maintain family ties while incarcerated (see above) suggests that investment in family connections is economically and socially sound. This could include expansion and improvement of visitation spaces at correctional facilities themselves. Perhaps even more important is providing financial and human support for those programs that enable families to connect with incarcerated members *outside* of correctional facilities. The Maui Economic Opportunity B.E.S.T. (Being Empowered and Safe Together) program provides a stellar example of this approach, connecting families in activities that are of cultural and community significance. For example, the B.E.S.T. program provides

family reunification programs, giving inmate-clients more activities that will allow them to spend time with their loved ones and to reestablish important connections with their ‘ohana. ...[This includes] opportunities for clients and their family members to spend hours together engaged in Hawaiian cultural practices. Whether working in a taro lo‘i, paddling a canoe, or improving life skills, clients will be learning or relearning cultural practices and values that reconnect them with their ‘ohana and guide them on the righteous path to rebuild their lives.⁷¹

Non-violent First Time Drug Offenders

Fully enabling Act 161 could result in an overall reduction of Hawai‘i’s nonviolent incarcerated population, potentially relieving the need to send prisoners to the mainland and mitigating the difficulties associated with long distance incarceration for individuals and their families. Funding the associated treatment services could substantially reduce recidivism rates, further contributing to decreasing the incarcerated population and

⁷¹ <http://meoinc.charityfinders.org/BEST>

enabling people to become constructive family members and productive members of society.

To achieve this potential, the law's language should be changed from optional back to mandatory regarding the diversion of first time offenders to treatment rather than incarceration. Further funding for treatment should also be appropriated to ensure success. According to the state's own assessments, diverting nonviolent offenders to treatment will be extremely cost effective; a conservative estimation for six months of incarceration comes in at \$15,000, while treatment costs \$3,400.⁷² Treatment will not only provide this immediate cost savings, but by addressing the underlying substance abuse problem, is likely to prevent the financial (and societal) costs associated with otherwise likely recidivism.

Drug Courts

Drug courts, which substitute mandatory treatment for incarceration are "popular, widely praised, and rapidly expanding alternative approaches of dealing with drug offenders and people charged with nonviolent crimes who are drug users."⁷³ Studies regarding the effectiveness of drug courts, however, remain generally incomplete and inconclusive.

Drug courts are seen as a positive alternative to the criminal justice system and incarceration because they focus directly on addressing underlying problems of drug addiction and avoid the social and economic costs associated with incarceration. However, there are some concerns regarding the fairness and effectiveness of drug courts. Several examples of these concerns are:⁷⁴

- The needs for voluntary drug treatment are far from being met, which creates a perverse situation in which a person needs to be arrested to receive (coerced) treatment through a drug court.
- Arrest is not necessarily the best way to determine who needs treatment, as people who are arrested and found to be using drugs may be doing so in a non-problematic way.
- Drug courts rely upon a system of justice for drug offenders in which the defense, prosecution and judge work as team to require that the offender enter into a treatment program. In this approach the offender may lose the dedicated advocate otherwise guaranteed in our judicial system.
- Drug courts often monitor and measure success by relying heavily upon urine testing rather than addressing more complex indicators such as success in employment, education or family relationships.
- Drug courts generally rely upon abstinence-based treatment that may, for example, withhold methadone for heroin addicts.

⁷² Joint House-Senate Task Force on Ice and Drug Abatement, Final Report. (2003)

⁷³ Drug War Facts. (2006) p.25

⁷⁴ Drawn from Drug War Facts. (2006) p.25

- Drug courts invade the relationship of confidentiality between patient and healthcare provider.

Despite these concerns, experience with Drug Courts in Hawai‘i, particularly those focusing on families, suggests a generally positive outcome for participants in terms of reduced substance abuse, lower rates of recidivism, family reunification, employment. These programs warrant greater financial support, both for delivering services and measuring outcomes.

Discretionary Sentencing

The national level policy regarding mandatory minimum sentences for drug related charges, long noted as problematic and racially charged (see page 9), has very recently been addressed by the US Supreme Court. In December 2007 the Court and the United States Sentencing Commission addressed the discrepancy between sentences for crack and powder cocaine, which had resulted in much heavier sentences for the possession and distribution of crack cocaine (generally by black Americans) than for powder cocaine (generally by white Americans). This has resulted in reduced sentences and early releases for thousands of incarcerated individuals, beginning in March 2008.

Decriminalization and/or Legalization

One of the most direct means of severing the connection between drugs and incarceration is to decriminalize or legalize some or all illicit drugs. Public opinion regarding decriminalization and legalization is difficult to judge, as polling results are clearly linked to the wording of questions. For example, when asked if they favor legalization of marijuana, the majority of respondents answer ‘no.’ However, when asked if they believe that marijuana users should go to jail, they likewise answer ‘no.’

Decriminalization would reduce the punishment for possession of a drug to a civil fine rather than criminal penalties or potential jail time, while distributing to minors, trafficking, and selling would remain subject to standard criminal punishment. Decriminalization still signifies societal disapproval, whereas legalization denotes more general acceptance. In a legalized system, control over the distribution of drugs would be accomplished through a regulatory model of taxes, minimum age requirements, and licensing such as that currently employed in the case of alcohol and tobacco. Legalization would eliminate criminal and civil penalties for both the possession and sale of a drug.

It is important to keep in mind that, while either decriminalization or legalization would prevent incarceration for simple drug possession and distribution (within certain parameters), they would *not* prevent incarceration for criminal behavior associated with drug use or abuse. For example, while drinking alcohol is legal (within certain parameters), driving while under the influence of alcohol or alcohol-induced violence is illegal and may result in incarceration.

Many observers and practitioners remain opposed to decriminalization or legalization of (currently illicit) drugs. They are concerned that such a policy shift would result in increased drug use and dependence, as well as more incidences of drug-related violence and crime. The majority of US and Hawai‘i policymakers who privately express interest in pursuing this approach do not do so in public, often for fear of appearing ‘soft on crime.’

Decriminalization and/or Legalization of Marijuana in Hawai‘i

Marijuana possession has been decriminalized in 13 states, as well as in European countries such as Spain, Portugal, Luxembourg, Belgium and Austria.

In a 2006 economic analysis of Hawai‘i’s current public policy regarding marijuana, Dr. Lawrence W. Boyd of University of Hawai‘i, West O‘ahu finds that annual statewide law enforcement expenditures of \$10 million have failed to reduce marijuana availability in Hawai‘i. He asserts that the state’s current low prosecution levels and small penalties for marijuana possession (a petty misdemeanor for possession of less than one ounce) amount to *de facto* decriminalization. It is therefore doubtful that *de jure* (legally enacted) decriminalization would have much effect on marijuana use in Hawai‘i. Decriminalization of marijuana possession in Hawai‘i would also save state and county governments approximately \$5 million per year. Legalizing, taxing and controlling marijuana would save an additional \$5 million per year and would create tax revenues of between \$4 million and \$23 million.⁷⁵

Bills to decriminalize marijuana have been introduced in Hawai‘i repeatedly over the last decade, but have never gained traction in the state legislature.

⁷⁵ Boyd, L.W. (2006) “The Budgetary Implications of Marijuana Decriminalization and Legalization for Hawai‘i.”

7. Women, Girls & Drugs

Women and Drugs

Women's experiences with drugs are now widely understood to be very different than those of men. For example, "women's use of and relationship to drugs is often affected by their experiences with domestic violence and their responsibilities for family and children. Women are also disproportionately affected by laws and regulations regarding drug use and welfare reform."⁷⁶ However, because most public health and criminal justice research has focused on men (until recently), we are only beginning to understand the differences between men's and women's relationship to drugs. The National Institute on Drug Abuse (NIDA) has begun promoting research focusing on gender differences with regard to drugs. According to NIDA, "data from laboratory, field and clinical research is beginning to show gender differences in biological factors in drug abuse, the progression and initiation to drug use and abuse, the antecedents and consequences of drug use and abuse, and prevention and treatment."⁷⁷ It is also increasingly apparent that the majority of women in need of drug treatment also need treatment as victims of violence and sexual abuse.

Many social service organizations and advocacy groups suggest that women face unique stigmatization for their drug use. This is due in part to the perception of drug abusing women's 'double deviance' – their violation of the law *and* their failure to meet the traditional expectations of women as nurturing wives and mothers. This perspective has been clearly evident in the Hawai'i media coverage of the 'ice epidemic.'

Incarcerated Women

It is generally agreed that women have different 'pathways to crime' than do men, with many women finding their way to drug possession, use and distribution through relationships with men involved with drugs, out of economic desperation, or as a form of self-medication. During the past twenty years more and more women have found themselves too far down this path, which ends in incarceration for many.

Since 1986 the number of women incarcerated in the US has increased 400%; for women of color the rise is 800%.⁷⁸ This dramatic rise is directly connected to the enactment of mandatory minimum sentencing in 1986, since which time the number of women sentenced for drug offenses has increased ten-fold.⁷⁹ A 1999 Bureau of Justice Statistics report found that about half of women offenders incarcerated in state prisons were using alcohol, drugs, or both at the time of their offense, that approximately 60% of them described themselves as using drugs in the month before the offense, and that 50% described themselves as a daily user of drugs.⁸⁰ The same report found that nearly one-

⁷⁶ Paltrow, L. (2000) <http://www.drugpolicy.org/communities/women/>

⁷⁷ NIDA. <http://www.nida.nih.gov/WHGD/WHGDIntro.html>

⁷⁸ Paltrow, L. (2000) <http://www.drugpolicy.org/communities/women/>

⁷⁹ *Drug War Facts*. (2006) p.222

⁸⁰ ONDCP. <http://www.whitehousedrugpolicy.gov/drugfact/women/>

third of women in state prisons said they had committed the offense for which they were incarcerated in order to obtain money to support their need for drugs.

By 2006, 85% of women offenders were incarcerated for nonviolent offenses, making women both the fastest growing and the least violent segment of prison and jail populations.⁸¹ Indeed, women often serve longer sentences than do men “precisely because they refuse, or are unable, to give prosecutors evidence about their husband’s or boyfriend’s crimes and connections,” whereas men are more likely to provide incriminating evidence about their wives or girlfriends.⁸²

The impact of incarcerating women extends far beyond the individual, with a particularly heavy burden placed on families and children. (See page 36 for discussion of societal and familial impacts of incarceration.)

Incarcerated Women in Hawai‘i

The statistics regarding women incarcerated in Hawai‘i are staggering, even compared to the already worrying national trends. In 1972 one woman was imprisoned in the state; in 1982 there were 43; and by 2006 there were 778. This represents an *18 fold increase* between 1982 and 2006, compared to a 6.75 fold increase for the state’s entire (male and female) incarcerated population between 1980 and 2006. According to a 2008 Hawai‘i Senate Concurrent Resolution, of the 120 Hawai‘i women incarcerated at a single facility on the mainland, 95% are mothers.⁸³

Treating Women

Treatment programs have generally been designed with men’s needs in mind, largely because of the greater incarcerated male population. Women also continue to face more barriers to finding effective treatment than do men, including basic access to programs (just not enough beds or slots), transportation needs, lack of childcare options, etc. Just as women arrive at substance abuse and dependency in their own way, it is increasingly apparent that they need gender-responsive treatment to successfully break this dependency and associated cycles of crime. Such programs address the particular challenges women face reducing their dependency on drugs, maintaining or rebuilding relationships with their children and families, and reentering society after incarceration.

Perinatal Issues

Women who use and misuse illicit drugs during pregnancy are presented with particular challenges in their efforts to receive both drug treatment and prenatal and postpartum care. Concern about ‘getting caught’ for illicit drug use and subsequently being prosecuted and/or losing custody of one’s child serves as a great barrier for pregnant women seeking regular prenatal care, as well as drug treatment. This in turn leads to higher infant mortality and abandonment of babies. The case of Cornelia Whitner in South Carolina brought this dilemma to light. Without her knowledge or consent, Ms.

⁸¹ Drug War Facts. (2006) p.222

⁸² Paltrow, L. (2000) <http://www.drugpolicy.org/communities/women/>

⁸³ Hawai‘i Senate Concurrent Resolution 156. (2008)

Whitner was tested for crack cocaine during her pregnancy, and after testing positive she was prosecuted. The US Supreme Court subsequently upheld the South Carolina ruling that it was mandatory to report suspected drug abuse in pregnant women.

“After implementation of the mandatory reporting laws and the prosecution of Cornelia Whitner, there was a precipitous drop in admissions to drug treatment programs for pregnant women and a subsequent increase in infant mortality as well as a twenty per cent increase in the number of abandoned babies.”⁸⁴

This illustrates the challenge of developing sound drug policies that achieve the desired intent of protecting individuals and society. In particular, it highlights the difficulty of relying solely on law enforcement strategies and suggests that a public health approach that focuses on the health of both mother and child, rather than on punishment, would be more effective.

Just such an approach is embodied in the Perinatal Addiction Treatment of Hawai‘i (PATH) Clinic of the John A. Burns School of Medicine at the University of Hawai‘i. The PATH Clinic is located on the Salvation Army Family Treatment Services grounds in Honolulu. The clinic provides prenatal and postpartum care for women on O‘ahu with a history of substance abuse. Holistic services provided at the clinic include substance abuse counseling, pediatric care, psychiatric care for those with dual diagnoses, and case management that addresses social services and coordinates with child welfare services to ensure the safety of the child and to keep families intact as much as possible.⁸⁵ Though established only in April 2007, the clinic’s initial reports are very promising. Director Dr. Tricia Wright reports that the clinic has served over 60 women to date, and that of the 16 women who have given birth at the clinic, all have delivered healthy infants and all but one were drug free at the time of birth. The woman who continued to struggle with drug use during her pregnancy, has since entered residential drug treatment with her infant and is currently drug free.

Girls, Drugs and Crime

Girls’ involvement in the juvenile justice system has increased dramatically over the past 30 years, with the proportion of national female juvenile arrestees growing from 15% of all juvenile arrests in 1975 to 19% in 1990 and 29% in 2004. In Hawai‘i girls represent an even greater percentage of juvenile offenders; in 2003, females accounted for 41% of the total juvenile arrests on O‘ahu, compared to the 29% national average.⁸⁶ The connection between girls, drugs and crime is complex and multi-faceted. It includes personal drug use, abuse and addiction, as well as the impact of drug use, abuse and addiction by family members, peers and sexual partners that can result in domestic violence and neglect. According to the Hawai‘i Department of the Attorney General,

⁸⁴ Hawai‘i HB No 2881 (2008)

⁸⁵ Hawai‘i HB No 2881 (2008)

⁸⁶ <http://www.girlscourt.org/faq.html>

36% of the girls (and 43% of the boys) in the juvenile justice system are frequent drug users, while 75% report some form of drug use.⁸⁷

Hawai‘i currently has grossly insufficient resources to effectively address juvenile crime and substance abuse among girls. There are only *eight* beds for residential, in-patient drug treatment for girls *statewide*, located at the Bobby Benson Center on O‘ahu. Outpatient care is generally offered through schools, but many girls in the juvenile justice system are no longer in school and therefore cannot access these services. There are no gender-specific treatment programs for girls.

In 2004 the Hawai‘i State Judiciary created the Hawai‘i Girls Court in an attempt to address the growing problem of female delinquency in Hawai‘i. The Girls Court is intended to “develop and expand gender-specific programming that addresses the special needs of adolescent girls in the juvenile justice system.” In particular, the Girls Court treats girls who appear before the court not only as *offenders*, but acknowledges their status as *victims* of physical or sexual abuse or domestic violence. To participate in Girls Court, girls must be accompanied by a family member or other adult who commits a considerable amount of their own time and energy to the program.

The Hawai‘i Girls Court focuses on reducing recidivism, decreasing runaways, reintegrating girls into society, and building family relationships. According to the Court, it has reduced recidivism by 47%, including a 60% reduction in the number of runaways and a 62% reduction in arrests.⁸⁸ The Court also leans away from using the Judiciary’s secure Detention Home and favors less restrictive non-secure shelter facilities.

⁸⁷ Pasko, L. “Profiles of Female and Serious Juvenile Offenders in Hawai‘i.”
[http://hawaii.gov/ag/cpja/main/rs/sp_reports_0306/pfsjoh-7112006.ppt#256,1,Profiles of Female and Serious Juvenile Offenders in Hawaii](http://hawaii.gov/ag/cpja/main/rs/sp_reports_0306/pfsjoh-7112006.ppt#256,1,Profiles%20of%20Female%20and%20Serious%20Juvenile%20Offenders%20in%20Hawaii)

⁸⁸ <http://www.girlscourt.org/faq.html>

Women, Girls & Drugs ---- Policy Alternatives for Hawai‘i

Gender-responsive Approach

Resources should be committed to further research regarding women’s pathways to substance abuse and crime, as well as the tools and efficacy of gender-responsive treatment.

In Hawai‘i more resources should be devoted to supporting existing and new gender-responsive treatment and re-entry programs. Two stellar examples of this approach are the Salvation Army’s Women’s Way where women can enter residential treatment with their youngest child and TJ Mahoney & Associates’ community-based reentry program, Ka Hale Ho‘āla No Nā Wāhine. This program assists approximately 100 women transition from prison to the community each year. Women live on-site for a minimum of six months, during which time they participate in a community-based work release program in which individual women progress at their own pace, participating in activities, classes, interventions and services based on their own particular stage of transition rather than prescribed ‘milestone’ moments. While the program does not offer treatment services for drug dependence (this must be completed prior to going into the work furlough program), it does help participants develop the life skills that indirectly help recovery by helping women to manage their lives. As the program’s website states,

Because the majority of female offenders are mothers, increasing their odds for successful reentry also helps prevent their children from entering the same cycle of abuse, addiction, crime and incarceration. Our entire society has everything to gain from the humane and compassionate treatment of female offenders.⁸⁹

In addition to programs for women, Hawai‘i must develop greater capacity – beyond the existing eight beds – for girls in need of drug treatment.

Hawai‘i Girls Court

The Girls Court has proven to be an effective way of addressing girls in the juvenile justice system. To further enable the program, its temporary state funding should be made permanent during the 2009 legislative session, when it comes up for review. The Girls Court also hopes to secure funding to develop a girl-specific curriculum for girls in the juvenile system. The curriculum would be comprehensive, including a variety of life skills, as well as addressing drug issues.

⁸⁹ TJ Mahoney & Associates. <http://reawakeningforwomen.org/index.php?view=3.0>

8. Drugs & Racism

It is clear that race has long played a role in national drug policy. Recall from the introduction that many American drug policies have targeted specific racial or ethnic groups; including anti-opiate laws against Chinese immigrants, anti-marijuana laws against Mexican immigrants, and crack sentencing guidelines against African Americans.

While the connections between race, drugs, and incarceration are evident, they are also difficult to fully understand, partly because they are interwoven with and compounded by socioeconomic disparities, lack of representation or voice, etc. It is also challenging to identify causal relationships among these issues, as they tend to create negative, self-perpetuating cycles.

Native Hawaiian Incarceration

In Hawai‘i, the Native Hawaiian community is that most disproportionately affected by drug use and incarceration. According to the Office of Hawaiian Affairs Native Hawaiian Data Book, in 2005, 37% of incarcerated males and 44% of incarcerated females in Hawai‘i correctional facilities were Native Hawaiian, while 41% of incarcerated males and 47% of incarcerated females in out of state correctional facilities were Native Hawaiians.⁹⁰ Correctional facility workers estimate that Native Hawaiians make up closer to 60% of the inmate population.⁹¹ Recall that Native Hawaiians compose only 9.1% - 20% of the state’s population, depending on whether the census methods allow for selection of multiple ethnicities.⁹² This disproportionate representation of Native Hawaiians in the correctional system is also reflected in the juvenile justice system, with Hawaiians accounting for 36% of all juvenile arrests.

University of Hawai‘i Professor Emeritus Gene Kassebaum explains that while Caucasians and Hawaiians are arrested at comparable rates, Hawaiians are more likely to be imprisoned.⁹³ Some argue that this “stratification of the carceral landscape” is a legacy of Hawai‘i’s colonial history.⁹⁴ The disproportionately high rate of incarceration among Native Hawaiians certainly has a legacy of its own. Perhaps most worrying is its impact on Native Hawaiian children, who make up 53% of children in foster care in the state.⁹⁵ Recall that time in foster care is strongly correlated to youths’ drug abuse, participation in the juvenile justice system and eventual incarceration. (See page 36.)

⁹⁰ Reynolds, A. (2006) *Native Hawaiian Data Book*. p.169-175

⁹¹ Hawai‘i Senate Concurrent Resolution 156. (2008)

⁹² US Census Bureau. <http://quickfacts.census.gov/qfd/states/15/15001.html>

⁹³ Kassebaum, G. cited in Keahiolalo-Karasuda, R. (2007) “Hawaiians (Ethnic) and Incarceration.”

⁹⁴ Keahiolalo-Karasuda, R. (2007) “Hawaiians (Ethnic) and Incarceration.”

⁹⁵ Keahiolalo-Karasuda, R. (2007) “Hawaiians (Ethnic) and Incarceration.”

Drugs & Racism ---- Policy Alternatives for Hawai‘i

At the national level, specific drug policies can and are being changed to redress historic, racially charged injustices. The recent Supreme Court decisions regarding sentencing guidelines for crack and powder cocaine are a promising example of this trend. In Hawai‘i, while the connection between drugs – and therefore incarceration – and race is obvious, related intergenerational cycles of poverty, poor health and lack of education have stymied efforts to enact meaningful change at the political level. Progressive efforts therefore remain largely the purview of community based organizations.

Because Native Hawaiians compose more than a third of the state’s incarcerated population, any programs developed and implemented to reduce the rates of incarceration for non-violent offences, to keep inmates in Hawai‘i, and to help with reentry to society will be of assistance to this community. An example is the ‘Restorative Circles’ program that eases the reentry of Hawai‘i inmates to their communities through a family-based process of restorative justice. This program focuses on helping individuals and families to heal from experiences of crime, violence, and separation.⁹⁶ To learn more visit http://www.uscourts.gov/fedprob/June_2006/circles.html.

Culturally-based Programs

In addition to traditional treatment and reentry programs, researchers and practitioners are discovering the value and efficacy of culturally-based programs. A pioneer in this area is Dr. Val Kalei Kanuha, of the University of Hawai‘i, whose program, Ke Ala Lōkahi pursues Native Hawaiian cultural interventions for Native Hawaiian batterers and battered women, exploring indigenous, community-based approaches to addressing violence against women and children. Such culturally-based programs have also proven their value in drug treatment and facilitating reentry to society after incarceration.

There are several such programs already operating in Hawai‘i. Ho‘omau Ke Ola is a culturally based drug treatment program in Wai‘anae, O‘ahu that integrates traditional drug treatment and Hawaiian culture in residential and outpatient drug treatment programs open to patients of all ethnicities. The Maui Economic Opportunity B.E.S.T. program (see above, page 40) also builds upon Hawaiian cultural traditions as it supports participants in defeating drug addictions, building strong relationships with their families, and reentering society.

These programs merit funding and other support to offer services to more individuals, to measure outcomes, and to develop best practices for replication.

⁹⁶ Walker, L. Sakai, T. & Brady, K. (2006) “Restorative Circles: A Reentry Planning Process for Hawai‘i Inmates.”

9. Conclusion

The relationship between drug policies and individual and societal health is complex and clearly bound up with myriad other issues of societal and economic justice and policy. It has additionally become highly politicized, particularly since the 1980s, resulting in polarized perspectives that do not lend themselves to developing effective solutions. In some cases our policies themselves have proven to have unintended consequences that exacerbate public health challenges and underlying societal inequities.

There is no panacea that will rid our communities of the difficulties associated with drug abuse and dependency. However, there are many opportunities to develop and implement informed, evidence-based drug policies that can contribute to our community's economic, physical, mental and familial health. In addition to these positive results, public health approaches are far more cost effective than a punitive approach. This combination of societal and economic benefits has motivated many jurisdictions, including states as diverse as California, Alabama, and Texas, to develop new policies and reprioritize the allocation of resources.

In Hawai'i we are unfortunately well versed in the social and economic cost of the abuse of licit and illicit drugs, their distribution, and related criminal activity. We are also increasingly aware of the costs associated with the very policies intended to tackle these challenges. In both cases, the brunt of the cost is born by our most vulnerable communities who are grossly over-represented in the criminal justice and foster care systems, and are subject to inter-generational cycles of poverty and desperation. These costs are also felt by the entire community, as ever greater societal fragmentation and as higher economic costs to tax payers who fund our law enforcement and social services.

This report suggests that the current national and state level policies exhibit an over-reliance on punitive measures and a lack of resources for prevention, treatment and reentry into society. The policy alternatives presented above focus on redressing that imbalance and redirecting existing and new resources to support evidence-based public health programs that reduce the harm associated with both substance abuse itself and the unintended consequences of current drug policies.

It is our hope that this study and its recommendations will contribute to a much-needed societal debate around drug-related issues, policies and laws in Hawai'i.

Appendix A

Glossary

Decriminalization

A policy that reduces the punishment for possession of the drug(s) in question to a civil fine, rather than criminal penalties or potential jail time. Distributing to minors, trafficking, and selling would remain subject to standard criminal punishment.

Drugs

Legal and illegal psychoactive substances such as alcohol, tobacco, marijuana, crystal methamphetamine, cocaine and heroin that act primarily upon the central nervous system, where they alter brain function, resulting in temporary changes in perception, mood, consciousness, and behavior.

Drug Addiction

According to the National Institute on Drug Abuse (NIDA), addiction is a “chronic, often relapsing brain disease that causes compulsive drug seeking and use despite harmful consequences to the individual that is addicted and to those around them.” Other examples of chronic, relapsing diseases include diabetes, asthma, and heart disease. Like these diseases, drug addiction can be managed successfully, though, as with other chronic diseases, it is not uncommon for a person to relapse and begin abusing drugs again.⁹⁷

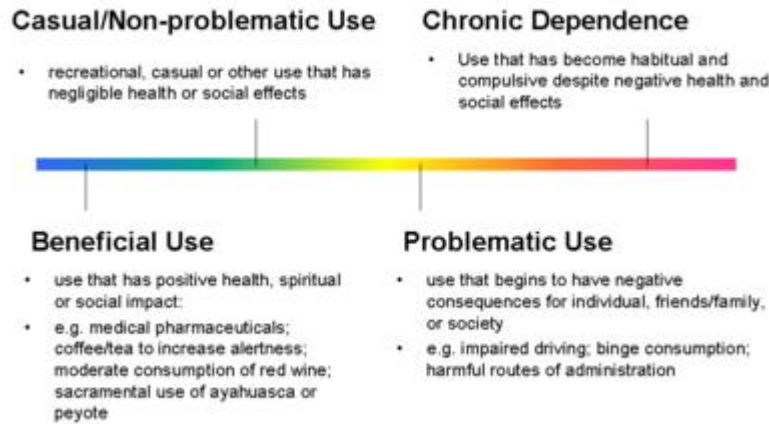
Drug Use -- Abuse

The terms ‘drug use’ and ‘drug abuse’ are considered by many to be overly simplistic and generally unhelpful as medical or societal descriptions. From a public health perspective, drug use is most usefully seen within a spectrum along which medical and social impacts are measured (see chart below).⁹⁸

⁹⁷ National Institute of Drug Abuse (NIDA). <http://www.nida.nih.gov/Infofacts/understand.html>

⁹⁸ “A Public Health Approach to Drug Control in Canada, Health Officers Council of British Columbia” (2005) <http://www.cfdp.ca/bchoc.pdf>

Spectrum of Psychoactive Substance Use



Source: A Public Health Approach to Drug Control in Canada, Health Officers Council of British Columbia, 2005 <http://www.cfdp.ca/bchoc.pdf>

Harm Reduction

The Harm Reduction Coalition describes harm reduction as “a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use to abstinence. Harm reduction strategies meet drug users ‘where they’re at,’ addressing conditions of use along with the use itself.”⁹⁹

Jail

Incarceration facility used to confine people serving sentences of generally less than one year for misdemeanors, persons awaiting trial or sentencing on felony or misdemeanor charges, and persons confined for civil matters.

Legalization

A policy that would eliminate criminal and civil penalties for both possession and sale of the drug(s) in question and may include a system of regulation, which could include restrictions use similar to those applicable to alcohol and tobacco. The regulation model uses taxes, minimum age requirements, and licensing to control distribution.

Parole

Period of conditional supervised release which sometimes follows a term of incarceration. There has been no parole for any offenses in the federal system since the mid 1980s.

⁹⁹ Harm Reduction Coalition. <http://www.harmreduction.org/article.php?list=type&type=62>

Prison

Incarceration facility typically used to hold more serious offenders (generally convicted of a felony) sentenced to terms of more than one year.

Probation

Period of correctional supervision in the community to which criminal offenders may be sentenced in place of incarceration.

Recidivism

The tendency to relapse into a previous condition or mode of behavior, especially a relapse into criminal behavior or substance abuse, after a person has either experienced negative consequences of that behavior, or has been treated or trained to extinguish that behavior.

Appendix B

Principles of Harm Reduction

The principles of harm reduction, as defined by the Harm Reduction Coalition, emphasize the importance of taking a pragmatic and compassionate approach to minimizing the harm associated with drug use, abuse and addiction. A harm reduction approach therefore:

- Accepts, for better and for worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
- Establishes quality of individual and community life and well-being--not necessarily cessation of all drug use--as the criteria for successful interventions and policies.
- Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
- Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.
- Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.
- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.
- Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.

* Principles taken from the Harm Reduction Coalition
<http://www.harmreduction.org/article.php?list=type&type=62>

Appendix C

US Conference of Mayors Resolution: “A New Bottom Line in Reducing the Harms of Substance Abuse”

WHEREAS, the United States Conference of Mayors has long been concerned about substance abuse and its impacts on cities of all sizes; and

WHEREAS, this Conference recognizes that addiction is a chronic medical illness that is treatable, and drug treatment success rates exceed those of many cancer therapies; and

WHEREAS, according to the 2005 National Survey on Drug Use and Health, an estimated 112,085,000 Americans aged 12 or over (46.1% of the US population aged 12 and over) have used an illicit drug at least once; and

WHEREAS, the United States has 5% of the world’s population, but 25% of the world’s prisoners, incarcerating more than 2.3 million citizens in its prisons and jails, at a rate of one in every 136 U.S. residents—the highest rate of incarceration in the world; and

WHEREAS, 55% of all federal and over 20% of all state prisoners are convicted of drug law violations, many serving mandatory minimum sentences for simple possession offenses; and

WHEREAS, the U.S. Conference of Mayors adopted a resolution at its 74th Annual Meeting opposing mandatory minimum sentencing on both the state and federal levels and urging the creation of fair and effective sentencing policies; and

WHEREAS, drug treatment is cost-effective: a study by the RAND Corporation found that every additional dollar invested in substance abuse treatment saves taxpayers \$7.46 in societal costs, a reduction that would cost 15 times as much in law enforcement expenditure to achieve; and

WHEREAS, the National Treatment Improvement Evaluation Study shows substantial reductions in criminal behavior, with a 64% decrease in all arrests after treatment, making public safety a primary beneficiary of effective drug treatment programs; and

WHEREAS, the U.S. Conference of Mayors adopted a “Comprehensive National Substance Abuse Strategy” at its 69th Annual Meeting, and a “Comprehensive Drug Prevention and Treatment Policy” at its 66th Annual Meeting, both of which called for treatment to be made available to any American who struggles with drug abuse; and

WHEREAS, federal, state, and local costs of the war on drugs exceed \$40 billion annually, yet drugs are still widely available in every community, drug use and demand have not decreased, and most drug prices have fallen while purity levels have increased dramatically; and

WHEREAS, according to the Office of National Drug Control Policy (ONDCP), only 35% percent of the federal drug control budget is spent on education, prevention and treatment combined, with the remaining 65% devoted to law enforcement efforts; and

WHEREAS, over one-third of all HIV/AIDS cases and nearly two-thirds of all new cases of hepatitis C in the U.S. are linked to injection drug use with contaminated syringes, now the single largest factor in the spread of HIV/AIDS in the U.S.; and

WHEREAS, the U.S. Conference of Mayors has, on three separate occasions, adopted resolutions in support of expanded access to sterile syringes by people who inject drugs as a public health strategy to decrease the transmission of blood-borne diseases and provide links to treatment without increasing drug use; and

WHEREAS, virtually all independent analyses have found ONDCP's drug prevention programs to be costly and ineffective: the Government Accountability Office (GAO) recently found that both the National Youth Anti-Drug Media campaign and the Drug Abuse Resistance Education (DARE) program have not only failed to reduce drug use, but instead might lead to unintended negative consequences; and

WHEREAS, blacks, Latinos and other minorities use drugs at rates comparable to whites, yet face disproportionate rates of arrest and incarceration for drug law violations: among persons convicted of drug felonies in state courts, 33% of convicted white defendants received a prison sentence, while 51% of black defendants received prison sentences; and

WHEREAS, women are the fastest growing prison population in the U.S., increasing by over 700% since 1977, to 98,600 at the end of 2005. Drug law violations now account for nearly one-third of incarcerated women, compared to one-fifth of men; and

WHEREAS, at year end 2005, over 7 million U.S. residents—about 3.2% of the adult population, or 1 in every 32 adults—were incarcerated or on probation or parole, of whom 28% were under correctional supervision for a drug law violation; and

WHEREAS, at its 73rd and 72nd Annual Meetings, the U.S. Conference of Mayors adopted a resolution to promote the successful reentry of people leaving prison or jail, through job training, transitional housing, family reunification, drug abuse and mental health treatment, and the restoration of voting rights; and

WHEREAS, the cost of local law enforcement and of providing services to formerly incarcerated residents is borne primarily by local governments; and

WHEREAS, cities across the country have experienced a rise in violent crime and must prioritize scarce law enforcement resources, yet the nation's police arrested a record 786,545 individuals on marijuana related charges in 2005—almost 90% for simple possession alone—far exceeding the total number of arrests for all violent crimes combined; and

WHEREAS, there is no easy, “one-size-fits-all” solution to substance abuse and drug-related harms: individual cities, counties, and states face unique challenges and therefore require local flexibility to pursue those policies that best meet their specific needs;

NOW, THEREFORE, BE IT RESOLVED that the United States Conference of Mayors believes the war on drugs has failed and calls for a New Bottom Line in U.S. drug policy, a public health approach that concentrates more fully on reducing the negative consequences associated with drug abuse, while ensuring that our policies do not exacerbate these problems or create new social problems of their own; establishes quantifiable, short- and long-term objectives for drug policy; saves taxpayer money; and holds state and federal agencies accountable; and

BE IT FURTHER RESOLVED that U.S. policy should not be measured solely on drug use levels or number of people imprisoned, but rather on the amount of drug-related harm reduced. At a minimum, this includes: reducing drug overdose fatalities, the spread of HIV/AIDS and Hepatitis, the number of nonviolent drug law offenders behind bars, and the racial disparities created or exacerbated by the criminal justice system; and

BE IT FURTHER RESOLVED that short- and long-term goals should be set for reducing the problems associated with both drugs and the war on drugs; and federal, state, and local drug agencies should be judged – and funded – according to their ability to meet specific performance indicators, with targets linked to local conditions. A greater percentage of drug war funding should be spent evaluating the efficacy of various strategies for reducing drug related-harm; and

BE IT FURTHER RESOLVED that a wide range of effective drug abuse treatment options and supporting services must be made available to all who need them, including: greater access to methadone and other maintenance therapies; specially-tailored, integrated services for families, minorities, rural communities and individuals suffering from co-occurring disorders; and effective, community-based drug treatment and other alternatives to incarceration for nonviolent drug law offenders, policies that reduce public spending while improving public safety; and

BE IT FURTHER RESOLVED that the Conference supports preventing the spread of HIV/AIDS, hepatitis and other infectious diseases by eliminating the federal ban on funding of sterile syringe exchange programs and encourages the adoption of local overdose prevention strategies to reduce the harms of drug abuse; and

BE IT FURTHER RESOLVED the impact of drug use and drug policies is most acutely felt on the local communities, and therefore local needs and priorities of drug policy can be best identified, implemented and assessed at the local level. A successful national strategy to reduce substance abuse and related harms must invest in the health of our cities and give cities, counties, and states the flexibility they need to find the most effective way to deal with drugs, save taxpayer dollars and keep their communities safe.

* United States Conference of Mayors Adopted Resolution June 2007.
http://www.usmayors.org/75thAnnualMeeting/resolutions_full.pdf

Appendix D

O‘ahu County Committee of the Democratic Party of Hawai‘i: Resolution 06-31 Urging Hawai‘i to Adopt a Public Health Approach to Drug Policy*

Whereas, the Women’s Caucus of the Democratic Party considers substance abuse and drug addiction public health issues; and

Whereas, our state has continued to attempt to resolve drug abuse problems through the criminal justice system, resulting in severe prison overcrowding of inmates and warehousing of Hawai‘i prisoners on the U.S. continent; and

Whereas, current drug policies, as applied and enforced, have taken a particularly hard toll on economically disadvantaged communities through the disproportionate incarceration of Native Hawaiians and other persons of color, and the poor, disrupting families and interfering with or denying educational, employment and housing opportunities, thereby exacerbating the social conditions that gave rise the drug abuse in the first place; and

Whereas, criminal prosecutions of substance-using pregnant women have deterrent effects on women seeking prenatal care; and such lack of prenatal care increases infant mortality; and

Whereas, research clearly demonstrates that shifting public resources into education, prevention, treatment, and research programs is significantly more effective in reducing drug abuse than the use of criminal sancations, but two thirds of Hawai‘i’s spending on drug policy is nonetheless allocated to law enforcement approaches while only one third is spent on prevention and treatment combined; now therefore

Be It Resolved that the O‘ahu County Committee of the Democratic Party calls upon the state and county governments to adopt a public health approach to Hawai‘i’s drug problems; and

Be It Further Resolved that Hawai‘i focus limited resources on making quality drug abuse education and state of the art treatment for those already addicted widely available; and

Be It Further Resolved that pregnant women who have a history of substance abuse have ready access to programs and facilities equipped to provide comprehensive prenatal, delivery, and postpartum care; and

July 22, 2008

Be It Further Resolved that certified copies of this resolution is transmitted to each elected Democrats in the state and county governments in Hawai'i and the Resolution Committee of the State Democratic Convention

*Resolution passed in 2006 and subsequently ratified by the statewide Democratic Party.

Appendix E

National Organization for Women Resolution: Women's Rights – Another Casualty of the “War on Drugs”*

WHEREAS, the incarceration rate of women convicted of low-level drug-related offenses has increased dramatically in the past decade as a result of our nation's relentless "War on Drugs," and poor women and women of color have been disproportionately targeted for drug law enforcement and receive long mandatory prison sentences that have little relationship to their actions or culpability; and

WHEREAS, two thirds of women in prison have at least two children who are displaced as a result of their incarceration, often forced to live in the care of family, friends, or state-sponsored foster care where they may be at increased risk of emotional, physical, or sexual abuse; and

WHEREAS, women's unique patterns of drug abuse and addiction and special treatment needs are inadequately addressed, as women often turn to drugs to cope with undiagnosed or untreated mental illness, and/or the trauma of physical or sexual abuse or other stresses particular to women; and

WHEREAS, the intersection of substance use and pregnancy are increasingly the focus of drug law enforcement; and

WHEREAS, violence against women and other circumstances specific to women's involvement in drug-related activities are often overlooked or ignored in sentencing, such as situations in which women who have been emotionally, physically, or sexually abused by partners involved in drug operations are dependent on them and unlikely to turn to the authorities; and

WHEREAS, after incarceration, women continue to bear the stigma and burden of post-conviction sanctions that constitute collateral consequences of incarceration impeding their reintegration into society, including denial of access to public housing, public assistance and food stamps, higher education aid and civic participation, effectively rendering them second-class citizens;

THEREFORE BE IT RESOLVED, that the National Organization for Women (NOW) iterate its opposition to the "War on Drugs" and in its stead support an approach to drug use and addiction that promotes compassion, public health and human rights; and

THEREFORE BE IT FURTHER RESOLVED, that NOW educate its membership about the harms the "War on Drugs" inflicts on women, using the NOW web site, NOW materials and literature and regular NOW legislative updates including pending legislation that would negatively impact women; and

BE IT FINALLY RESOLVED, that an ad-hoc committee be created to research current drug policy that has a particular impact on women and report back to the leadership and membership at the next national conference on a potential action plan to be implemented locally and nationally in conjunction with other organizations currently working toward the same objectives.

* 2005 NOW Conference Resolution

<http://www.now.org/organization/conference/resolutions/2005.html#drugs>

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