

DRUG CONTROL POLICIES IN THE UNITED STATES: WHAT WORKS AND
WHAT DOESN'T?

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Introduction: Patterns, Prevalence and Problems of Drug Use in the United States

The Bush administration (2001-2009) currently claims that it is "winning" America's decades-long War on Drugs. The latest reports from the Office of National Drug Control Policy (ONDCP) and the State Department point to record seizures of cocaine and crop eradication in Colombia and disruption of criminal smuggling networks in Colombia and Mexico as signs of progress. "Overseas counter drug efforts have slowly constricted the pipeline that brings cocaine to the United States," the ONDCP stated in the 2008 National Drug Control Strategy report. Similar pronouncements about progress in the drug war have been issued repeatedly by virtually every U.S. government since the Nixon administration, which in 1973 claimed the U.S. had "turned the corner" on addiction and drug use. In 1990, then-U.S. drug Czar William Bennett said that the U.S. was on the "road to victory" regarding drug abuse. In early 2007 the ONDCP pointed to a short-term increase in cocaine prices as key evidence of major "success" in the War on Drugs.

But Americans - just 4.5 percent of the world's population - in 2007 consumed some 60 percent of global illicit drug production. Moreover, illicit drugs - including marijuana, cocaine, heroin, and methamphetamines and other synthetic drugs such as ecstasy - are more readily available, more pure and cheaper in the United States in 2007 than they were 25 years

ago when in February 1982 then-President Ronald Reagan declared the contemporary phase of the modern U.S. War on Drugs or in 1969 when then-President Richard Nixon launched Project Intercept along the U.S-Mexican border to halt marijuana smuggling from Mexico into the United States.

In fact, while there has been some decline in overall drug use in the United States in recent years, especially among teenagers (from 11.6 to 9.8 percent since 2002 and a parallel decline in marijuana use from 8.2 to 6.7 percent), the long-term trend is not positive. If the analysis broadened back another 15 years, to 1992 when the rate of teen illicit drug use was just 5.3 percent and marijuana use was at 3.4 percent, it is clear that although use has edged

down somewhat in the last 5 years, teen drug use in the United States is actually almost double what it was 15 years ago.

Nonetheless, American rates of drug use are not exceptionally high in comparison with other advanced capitalist countries. About one in fifteen Americans 12 years of age or over currently uses some illicit drug. This is a much lower rate of drug usage than, for example, that registered in Great Britain and similar to that of Spain. By a considerable margin, prevalence in the United States — as in Europe — is highest among older teenagers and young adults in their early twenties, peaking at about 40 percent using within the last past twelve months for high school seniors. Most Americans who do try drugs use them only a few times and then quit. The "atypical" continuing American user is usually a marijuana smoker who generally ceases to use drugs at some point during his mid- to late twenties.

What such general survey data do not capture well are the negative behaviour patterns that often accompany drug usage and translate into high social costs in the United States — especially drug-related crime, adverse health effects, premature mortality, and loss of economic productivity. These drug-related problems tend to be worse in the United States than they are in most other affluent nations because of the high numbers of U.S. consumers who are dependent on highly addictive and expensive drugs such as cocaine (particularly crack), heroin, and methamphetamines as opposed to marijuana. Marijuana is far and away the most widely used illicit drug in the United States, but it accounts for only about ten percent of the adverse social costs associated with illegal drug use, in large part because marijuana costs are relatively low and its distribution and purchase generate comparatively low levels of drug-related crime and violence.

The compulsive use of relatively expensive and highly addictive drugs in the United States is the legacy of the four major drug "epidemics" that have swept the country over the last five decades. The term "drug epidemic" is employed here to underscore the fact that drug use is a learned behaviour, transmitted from one person to another. Indeed, the available evidence unequivocally indicates that friends or family members, who use drugs, rather than

aggressive drug pushers or dealers, are primarily responsible for initiating new drug users into their first drug experience. In a drug epidemic, rates of initiation in a given area rise sharply as new and highly contagious users of a drug initiate other friends and peers. At least with heroin, cocaine and crack, long-term addicts are not especially contagious. Indeed, they are often socially isolated from new users because they reveal the negative aspects or consequences of addiction. In the subsequent stage of a drug epidemic, usually within a decade or less, initiation declines rapidly as the susceptible population shrinks, either because there are fewer non-users or because the drug's reputation is tarnished as a result of wider knowledge of the adverse consequences associated with prolonged use of a given drug. In the third stage, the number of dependent users stabilizes and then typically declines gradually over the ensuing years.

The first modern drug epidemic in the United States involved heroin. It developed with rapid initiation in the late 1960s, mainly in a few big cities and most heavily among poor, Black and Hispanic inner-city minority communities. American soldiers returning from Vietnam, where heroin was widely available, was apparently a contributing factor to this heroin epidemic as well. The annual number of new heroin users in the United States peaked in the early 1970s and then dropped by some fifty percent by the end of the decade and remained low until the mid-1990s when a new heroin epidemic began. For many users, this first epidemic proved highly lethal: for those who survived their addiction was long-lasting,

severely detrimental to their health, and an almost insurmountable impediment to productive employment.

Powder cocaine was the source of America's second drug epidemic. This epidemic lasted longer and peaked more sharply than the prior heroin epidemic. Broadly spread across racial and class lines, cocaine initiation to cocaine peaked in the early 1980s and then fell sharply by almost eighty percent at the end of the decade. Dependence always lags behind initiation, and cocaine use became more prevalent in the mid-1980s as the pool of those who had experimented with the drug expanded. The number of dependent users peaked around 1988 and declined only moderately thereafter through the 1990s and early 2000s.

The third epidemic involved the use of crack. While clearly connected to the powder cocaine epidemic, the crack (a smokable form of cocaine) epidemic was more concentrated among minorities in inner-city communities. The epidemic's starting point varied by city. In Los Angeles and New York, for example, it began around 1982. In Chicago, it began years later in 1988. Nonetheless, in every American city during the 1980s where the crack epidemic hit initiation seems to have peaked within about two years and to have again left population with a chronic and devastating problem of addiction.

The fourth important drug epidemic to strike the United States involved methamphetamine use. This epidemic gradually spread across the United States from west to east over the 1990s and in the early 2000s had affected two-thirds of the country, mainly in areas where cocaine use was less common. It had already peaked and stabilized on the West Coast by the time rapid spread began in the Mississippi and Ohio River valleys in the mid-1990s. As of 2007, it still had not infected most of the East Coast.

There have been other epidemics (for example, ecstasy use), but heroin, cocaine (including crack) and methamphetamines probably account for some ninety percent of the social costs associated with illegal drug use in the United States over the last fifty years. It is important to note that the steep declines in cocaine and heroin street prices in the United States since the late 1970s have not triggered new epidemics involving these drugs. Initiation goes up when prices go down, but once a drug has acquired a bad reputation, it is unlikely that new epidemic outbreaks will take place, even if prices stay low. Information about the

negative consequences of use of a particular drug is a significant protective factor against new explosions, at least for a number of years.

Twenty Five Years of U.S. Drug Control Policies: An American Balance Sheet

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The U. S; government spends billions of dollars every year on drug control. The current American Drug Czar, John Walters, put U.S federal anti-drug expenditures at \$12.5 billion in 2006, but his total excluded key federal costs, such as the expense of federal drug prosecutions and prisoner incarcerations, that most analysts believe should be included. Leaving such costs out effectively permits Washington to claim today that U.S. anti-drug policies roughly balance supply reduction policies (mostly enforcement) and demand reduction policies (mostly prevention and treatment). Inclusion of federal government prosecutorial and prison-related costs does, however, increase the annual U.S. federal antidrug budget to approximately \$17 billion per year. State and local governments in the United States spend even more, so the total costs of the U.S. "War on Drugs" have probably

exceeded \$40 billion annually in recent years. The total spent by all levels of the U.S. government in waging the "War on Drugs" over the last twenty five years is rapidly approaching the astronomical sum of a trillion dollars;

Which kinds of drug control programs work, if any do? Which programs are most cost-effective and which are the least? The following discussion reviews the principal elements or aspects of U.S. drug policies with primary emphasis on demand control within the United States. To establish the context for this evaluation of American demand control strategies, however, it is necessary to begin the review with a brief overview and analysis of

U.S. supply-side control programs, including eradication, crop substitution and interdiction.

Supply-side Control and Interdiction Programs

Most U.S anti-drug programs focus on enforcing American drug laws, predominantly against drug dealers or trafficker. Interestingly, a similar emphasis is also commonly found in the anti-drug campaigns of countries with less prohibitionist and punitive policy approaches to drug issues, including the Netherlands. While eradication and crop substitution programs in source countries outside the U.S. territorial boundaries, especially in the Andean republics of Colombia, Peru and Bolivia, receive the lion's share of media coverage, in fact they account for a relatively limited share of the U.S. federal government's drug budget - approximately one billion dollars per year in 2006. Interdiction efforts - the seizure of drug shipments and the arrest of drug "mules" or couriers on the way into the United States - receive substantially more funds - approximately three billion dollars per year in 2006.

In practice, neither source-country eradication and crop substitution programs nor interdiction efforts have demonstrated over the past twenty five years any real capacity to bring about more than transitory reductions in drug consumption in the United States (or Europe, for that matter). Nor do they hold promise for greater effectiveness in the foreseeable future. Such policies concentrate on disrupting the initial phases of the production and distribution chains in which illicit drugs are still relatively cheap and easily replaced because there are plenty of land, labour, and alternative routes available to allow for trafficker

adaptations to state-directed anti-drug policies and tactics. In effect, such disruptions cause only marginal increases in the costs of cultivation, refining and smuggling of illicit drugs and, hence, do not make drug production and trafficking sufficiently less profitable to discourage the transnational criminal organizations involved in drug smuggling activities.

Law Enforcement and Incarceration

The bulk of all U.S. drug control resources go into the enforcement of America's prohibitionist drug laws. Between 1980 and 1990, dependent drug use and violent drug markets and trafficking organizations expanded rapidly while the number drug-related incarcerations rose by 210,000. Between 1990 and 2000 drug-related problems began to ease, but drug imprisonments increased by another 200,000. Since 2000 drug arrests and incarcerations have continued to rise in the United States despite further declines in rates of drug use, drug addiction and drug-related violent crime. As of 2007, the total U.S. prison

population stood at some 2.2 million inmates with almost half jailed for some sort of drug related (mostly non-violent) offences.

The basic justification for aggressive punishment of drug-related crimes is that high rates of incarceration will reduce drug use and associated problems. The theory is that tough enforcement raises the risks of drug trafficking and, thus, will lead some traffickers to drop out of the business and prompt the remainder to demand higher prices for taking higher risks. In this logic, the price of illicit drugs should go up accordingly. In fact, however, the general price trends over the last twenty five years have gone in the opposite direction ù down. Of course, it is possible that prices may have fallen even further had it not been for the massive expansion in U.S. drug law enforcement, as many U.S. drug officials have tended to argue. Nonetheless, even granting this counterfactual hypothesis, in light of the huge costs involved in incarcerating so many Americans for drug related, non-violent crimes (between 30 and 40 thousand dollars per inmate per year, depending on the state where they are imprisoned) it is abundantly clear to most analysts that expanded incarceration was not a cost-effective policy for controlling drug use in the United States.

Moreover, there is absolutely no evidence to support the idea that tougher enforcement has made cocaine or any other illicit drug harder for Americans to obtain. The fraction of high-school seniors who reported that cocaine is available or readily available has remained steady at fifty percent for the past twenty five years. Eighty five percent of high-school respondents have consistently said the same about the availability of marijuana.

Why then, in the face of overwhelming evidence that heavy emphasis on law enforcement, especially imprisonment of non-violent drug offenders, does not work well and is not cost-effective have U.S. federal government authorities consistently pursued such a policy strategy? Any adequate explanation of this policy puzzle requires the analyst to delve into the òintermesticö dynamics of drug policy-making in the contemporary United States. Summarized briefly, at least four different levels of explanation inevitably come into play. First, it is obvious that there is a high degree of òpath-dependencyö present in U.S; drug

policy; that is, decisions made in the past clearly shape present policy and make modifications or deviations from the current prohibitionist and punitive strategy and tactics difficult, if not impossible, in American governmental decision-making circles.

While quite possibly valid, the path dependency explanation nonetheless, effectively begs the questions of why the U.S. government got started down this particular path in the first place and why it is so hard to change now in the face of considerable empirical evidence that current policy is not succeeding in the goal of preventing or substantially reducing drug use and abuse in American society. A first approximation to a more comprehensive explanation involves understanding the puritan and religious backdrop to American rejection of drug use; The U.S. remains a highly religious society; All Protestant sects, especially the born-again Christian Evangelical groups, the Catholics, the Jews, and the Muslims unanimously condemn and reject drug use. Their moral condemnation of drugs weighs heavily against changes away from the currently dominant policy approach rooted in prohibition and punishment.

Second, the past almost five decades of cyclical drug epidemics have strongly reinforce middle America's religiously-based rejection of drugs; Middle class voting patterns in American politics have continually reflected and reinforced rigidly prohibitionist attitudes and policy preferences among the majority of U.S. voters. In short, middle class parents in the

United States fear that their children will be caught up in the next U.S. drug epidemic and their use their vote to support prohibitionist policies in the hope that their families can be insulated from such dangers.

Third, and finally, the institutional-electoral arrangements in the American political system, in which the entirety of the U.S. House of Representatives (435 members) must stand for election (or re-election) every two years makes experimentation with alternatives to current prohibitionist and punitive U.S. policies all but impossible. Any U.S. Representative who publicly calls for non-punitive policies is virtually guaranteed to lose his or her next election, thereby truncating any real possibility to obtain and incorporate policy feedback into the congressional policy-making process. The fact that one third of the U.S. Senate (one hundred members, each serving a six year term) must stand for election is similarly, although slightly less, limiting. The end result is that drug policy innovation at the federal or national level in the United States is virtually frozen in place and largely impervious to empirically-based evaluations that conclude that current policies are not working.

In contrast, drug policy at the state level of government in the United States is presently far more inclined toward innovation; This is due largely to the fact that the states, rather than the federal government, must bear most of the administrative burdens and costs of executing current federal anti-drug laws, such as imprisonment. The upshot is that states like California, New York and Florida have begun to experiment with harm-reduction rather than more punitive policies, especially with regard to youthful and non-violent offenders. The relatively new youth drug courts that have emerged in several states over the last decade or so and California's Proposition 36 (imposing treatment rather than jail time for non-violent drug crimes) seem to promise drug policy reform at the state rather than the national level in coming years. Some of these newer state programs are discussed briefly in the following section.

Prevention and Education

Rand Corporation studies of prevention programs in the United States have

found that prevention programs are at least twelve times more cost effective per dollar spent than supply-side or interdiction programs in reducing drug use among American primary and secondary students. Despite that positive finding, however, it is nonetheless true that the most widely used prevention programs in American schools (e.g., the DARE program) have never been proven in empirical evaluations to have significant, long-term impacts on lowering drug use among American youth. Indeed, even the most sophisticated model prevention programs appear to produce only modest and largely temporary reductions in drug use among adolescents that tend to dissipate by the end of secondary school or soon after high school graduation.

Given that most such school-based prevention programs involve only some thirty or so contact hours with students, it is not surprising that they are relative ineffective in countering the pro-drug use effects of ongoing socialization from with relatives, friends and peers, movies, and television that are known to stimulate initiation. Even when the inherent limitations of such programs are recognized, however, the budgetary costs per pupil involved in classroom prevention programs are so reduced that they still appear to be modestly cost-effective.

To improve the overall effectiveness of school-based prevention, many experts argue that it is necessary that they begin at very early ages in primary school and continue throughout secondary school, that they be dynamic and interactive rather than simply preachy and passive, and that the number of contact hours be increased substantially. In addition, many experts maintain that such programs should be extended beyond high-school as continuing public education programs for young adults.

Such beyond-school recommendations in favour of continuing drug prevention education notwithstanding, in practice media-centered anti-drug campaigns have never been shown through empirical research to have any effect on American patterns of drug use at all. Data-based assessments of mass media campaigns against drug use are, of course, inherently difficult and problematic, because it is virtually impossible to isolate a control group unaffected by other factors against which the impacts of such campaigns might be measured accurately. Even so, the evaluations of mass media campaigns that have been done (e.g., the Westat and the Annenberg School of Communications studies of the U.S. federal government's expensive and widely-viewed anti-drug television campaign) indicate that such advertising efforts have no discernable effects whatsoever on drug use in America.

In light of what is known about past cycles of drug epidemics in the United States, especially with regard to the dynamics of initiation, stabilization and gradual decline in use, there is little question that information about the negative consequences of drug abuse is of fundamental importance to effective reduction of drug use in American society. Armed with that knowledge and awareness, it would seem that permanent, widely distributed, public informational campaigns (not the expensive, high-profile, thirty second TV spot advertisements apparently preferred by U.S. authorities) might be more effective over time. Reaching diverse ethnic, racial, age and class groupings with appropriate anti-drug messages tailored to communicate accurate, factual information to specific segments of the American population (in a language and vocabulary they will understand and relate to) promises, at very least, to shorten the time frame of future drug epidemic cycles in the United States (and probably in other countries too). Given that the learning curve of each succeeding generation

(or sub-generation) of new drug users poses different and complex problems of effective communication, anti-drug campaigns must not only be permanent and ongoing, but they must also be constantly updated and modified to deal with new drugs and patterns of youth drug use.

Treatment and Rehabilitation

Treatment programs have been subjected to extensive, data-based evaluations over the last two decade or more in the United States. In 2004, for example, some 1.1 million American drug users underwent some type of drug treatment. U.S. federal government expenditures on such treatment programs totalled \$ 2.4 billion and the fifty state-level governments in the country spent at least as much for an overall treatment budget of almost 6 billion dollars. American heroin addicts usually receive methadone (a synthetic heroin substitute). All other drug users in treatment programs in the United States get some form of counselling. The majority of drug users in such programs quit the program before finishing their treatment. Among the minority who do complete their treatment programs, more than half relapse into drug usage within five years or less.

Nonetheless, drug treatment programs are consistently evaluated as cost-effective. This is because most who enter such programs, especially for heroin or cocaine use, are serious criminal offenders. At least while they are enrolled in treatment, their rates of drug use tend to decline along with their proclivity to engage in criminal activities. These crime reduction benefits of treatment programs help the communities in which they live as well as the drug patients themselves.

In view of the positive, cost-effective results of treatment programs, it is confounding to observe that there is only limited availability of treatment programs in the United States. In an average year only some 850,000 to one million American drug users gain access to treatment programs out of the three to four million who are dependent on heroin, cocaine or methamphetamines.

Even more perplexing and worrisome, in Fiscal Year (FY) 2008, the Bush administration, after two decades of consistent increases, reduced total federal resources for prevention from \$1.86 billion in FY 2007 to \$1.57 billion in FY 2008, a \$283.9 million decrease. Since FY 2002, total federal resources for drug prevention programs have declined by twenty one percent or some \$421.3 million dollars. Since FY 2002, total federal government resources for demand reduction have declined by \$163.2 million. Over the same period, resources intended to halt drugs from entering the United States and to disrupt local drug markets abroad increased by a total of \$2.48 billion. Since 2002, interdiction expenditures alone increased the most to the tune of \$1.38 billion. Interdiction resources now comprise twenty five percent of the total U.S. federal drug budgets for FY 2008.

Drug treatment as an alternative to incarceration has become a standard response, more talked about than actually implemented. Drug courts that use judges to persuade and legally compel drug offenders to enter and remain in treatment programs do offer some promise of greater compliance, but they offer only modest and incremental solutions because the screening criteria for entering such programs are restrictive and often exclude violent and repeat offenders. Proposition 67 in California, which allowed most of those arrested on drug possession charges (not trafficking) for the first time would not be

incarcerated (but rather sent to treatment) has achieved some success, particularly in reducing the number of first-time drug offenders sent to jail without a parallel rise in crime rates. But such programs only deal with the least serious, non-violent offenders, and, thus, only address a limited spectrum of drug-related crimes.

Some analysts in the United States presently advocate shorter sentences and the imposition of what has been termed "coerced abstinence" from drugs via drug testing imposed and monitored by the courts once drug offenders are released from prison on parole. Sanctions, including a return to prison, would flow whenever a probationer or parolee tested positive. Such programs, however, if they were expanded significantly might be both difficult and expensive to administer and to monitor.

Conclusions

Initial promises made by then-candidate George W. Bush — as yet unfulfilled and unlikely to be fulfilled in the final year of his second presidential term — bring America to

ineffective net result in the nation's so-called War on Drugs; The current U.S. government drug policy priorities are similar to those that prevailed two decades ago during the Reagan administration (1981-1989), when the key U.S. strategy was to limit drug supply. No matter how the FY 2008 federal drug budget is interpreted or spun, the current U.S. Drug Czar clearly continues to emphasize interdiction and international programs to control supply as the chief tools to address the nation's drug problems. Nonetheless, no federal drug budget, from either party, can afford to ignore the overwhelming body of research that shows that only a balanced approach between supply- and demand-reduction programs will have any real effect on America's drug consumption patterns and the attendant societal costs.

