Assessing U.S. Drug Policy

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Summary

The United States has a larger drug problem than any other western nation, whether measured in terms of the prevalence of problematic drug use or the adverse consequences of drugs, including crime and disease (particularly HIV). America's drug problem seems to be declining and is certainly less prominent in the public eye than it was twenty years ago. Nonetheless, cocaine, heroin and methamphetamine continue to cause great harm to the nation, particularly to vulnerable minority communities in the major cities. The declines are probably mostly the natural working out of old epidemics.

U.S. drug policy is comprehensive but unbalanced. Compared to other wealthy nations it spends more money on drug control and a large share of that, perhaps as much as 75%, goes toward enforcement, particularly arresting, prosecuting and imprisoning low level drug dealers. About 500,000 persons are locked up for drug offenses on any one day. Policy measures, whether they involve prevention, treatment or enforcement have met with little success. Prices have fallen and the drugs remain as available as ever. The forces for major change in drug policy seem weak.

America's Drug Problem

Drugs have been part of the landscape of U.S. social problems for at least forty years, from the time of the heroin epidemic of the late 1960s. The principal costs have been the high crime rates and the community consequences of that. HIV associated with injecting drug use, primarily heroin, has been the other large component.

Use

Since 1965, the U.S. has experienced four drug epidemics, in which there have been abrupt increases in new use followed later by sharp declines in new

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use. After the epidemic there has been a relatively large, but slowly declining, population of dependent users. Each drug has had a distinctive social, geographic and ethnic pattern. Each has been strongly associated with crime.

Heroin. The heroin epidemic began around 1967 and was over by 1974, in the sense that few new addicts started each year after that. The problem was concentrated in a few cities and particularly among African-American and Hispanic males. Many heroin addicts have survived for over thirty years with recurring periods of addiction, treatment, imprisonment and occasional abstinence.

Powder cocaine The epidemic here started in the late 1970s and extended over perhaps a decade. The drug was used by a much broader population, in terms of income, ethnicity and education; it was also less concentrated among males.

Crack cocaine The epidemic began in Los Angeles and New York around 1982 and spread to other cities over the next five years. By 1988 rates of new use had declined everywhere. In each city the epidemic lasted about two years and was concentrated among young people in poor minority communities.

Methamphetamine By the early 1980s a small number of cities (most notably San Diego) on the West Cost had substantial methamphetamine dependent communities, primarily in working class neighborhoods, both Hispanic and white. Ten years later the drug spread eastwards and it was the first in which there were substantial problems in rural communities. As of 2008 it remains almost unknown in some major east coast cities such as New York and Boston. Though the number of users dependent on the drug may still be rising, use in the general population is already well below its late 1990s peak.

Marijuana is by far the most widely used drug in the population. About half of every birth cohort since 1960 has tried the drug by age 21. Since the mid-1970s there has been considerable variation in how many teenagers use it. For example, around 1980 about one in four 18-24 year olds reported in a survey that

they had used marijuana in the previous thirty days. The figure fell to one in eight ten years later and since then has risen back to one in six.

In 2000 the federal government estimated that there were about 1 million chronic heroin users, 2.7 million chronic cocaine users and 600,000 chronic methamphetamine users. Much larger numbers, perhaps as many as 5 million, were dependent marijuana users, but this was associated with much more modest problems.

Drug-related Problems

The most conspicuous consequence of drug use in the U.S. has been the crime associated both with its marketing and with the need to obtain money to purchase the substances, which are very expensive. A cocaine or heroin habit in the mid-1990s cost about $15,000 per annum, far more than an alcoholic had to spend for his source of intoxication. Given that regular use of cocaine or heroin made employment difficult, it was hardly surprising that crime was a principal source of earnings to pay for the drugs. Of those arrested in American cities early in this decade, a majority were regular users of expensive drugs, though the drugs varied a great deal by city. See Table 1

Table 1 Percentage of Adult Male Arrestees Testing Positive for Drugs in Five Major Cities, 2002

Primary City	Any NIDA-5 Drug*	Marijuana	Cocaine/ Crack	Opiates	Methamphetamine
Chicago, IL	85.2%	49.4%	47.9%	26.0%	0.3%
Dallas, TX	58.0%	35.3%	30.7%	6.1%	4.0%
Los Angeles, CA	62.3%	36.4%	32.1%	5.8%	14.8%
New York, NY	81.0%	44.3%	49.0%	15.0%	0.5%
Phoenix, AZ	71.1%	41.5%	27.1%	5.0%	31.2%
Median (36 cities)	63.9%	41.5%	30.4%	5.9%	5.3%

* The NIDA-5 drugs are cocaine, opiates, marijuana, methamphetamine, and PCP.

In the early stages of the crack epidemic there was enormous violence associated with that market. As the users and sellers of crack aged, that violence fell sharply.

Injecting drug use has been a major vector for the spread of HIV, accounting for about one third of the deaths that have occurred from that disease, about 150,000 by 2003. Overdose deaths amount to about 20,000 per annum; this number measures only those who die of acute drug-related causes, not those whose death might result from chronic effects, such as liver failure due to Hepatitis B. It also does not include homicides that might be drug-related; since there were about 15,000 homicides each year in the early part of this decade, it is plausible that a few thousand were related to drug selling.

There are two important effects that are subtler and hard to measure. Inner city neighborhoods have become crime ridden, disorderly and unsightly as a consequence of open-air drug sales. This has immiserated the lives of the residents and driven out investment. The possibility of earning large sums of money as a successful drug dealer may have led many youth in these same communities to abandon education early and enter the drug trade, even though most of them will earn less than minimum wages during the first few years of their career and have a high risk of being imprisoned. The best estimate of total revenues from drug selling, done in 2000, was that it generated about $60 billion, about 60 percent from cocaine sales.

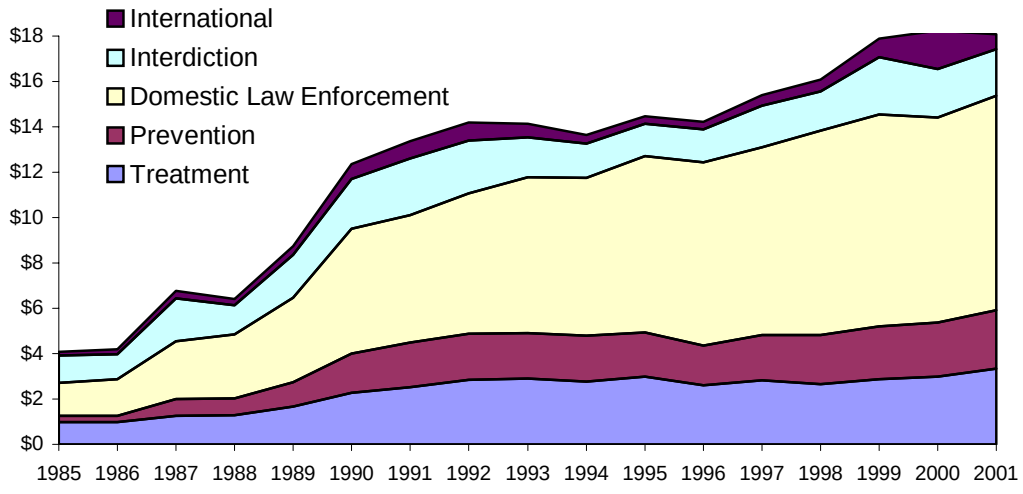
The Policy Response

Though President Richard Nixon was the first president to declare a “war on drugs” in the 1970s, the federal government, under presidents Nixon, Ford and Carter, gave considerable emphasis to treatment, particularly to provision of methadone maintenance for heroin addicts, as a way of combating crime problems. President Carter was notably more liberal on drug policy than any later president, even expressing a view that the punishment for marijuana possession should be no more severe than the consequences of the drug itself.

Since 1981, when Ronald Reagan became president, the response to drug problems has consistently emphasized enforcement, particularly against sellers of cocaine. This emphasis is bipartisan: the Clinton administration was just as tough on drugs as the administrations of Presidents George H.W. Bush or George W. Bush.

The federal government has allocated about two thirds of its drug control funds to enforcement since 1985; see Figure 1. However this is not a full description of the national drug control budget, since it represents only about half of all drug control expenditures. State and local governments also spend large amounts and their expenditures are even more tilted toward enforcement.

Figure 1. Federal Drug Control Spending by Function, 1985–2001 (billions 2001 $)



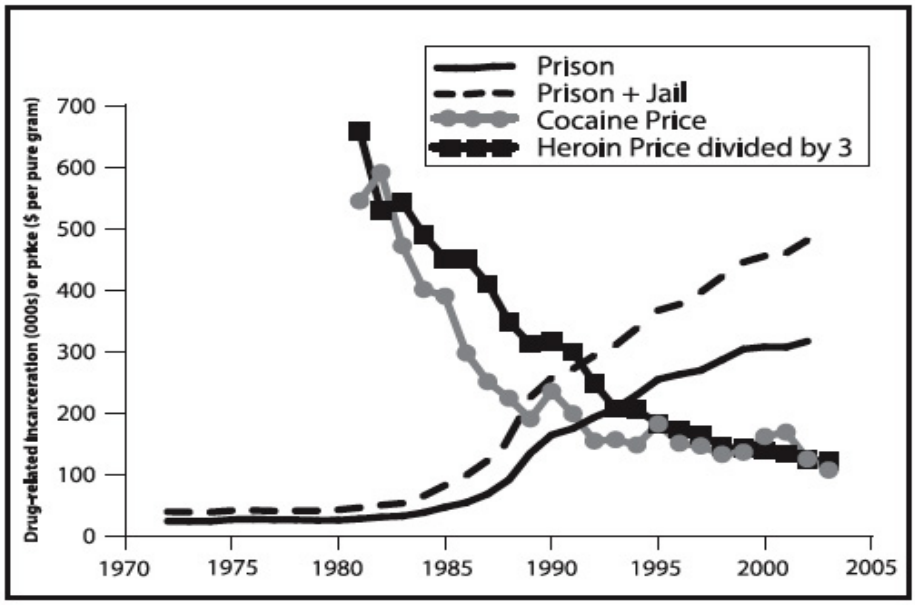
As a result of changes in federal budget procedures, it is impossible to show post 2002 changes consistently but there is good reason to believe that the budget has continued to grow and to increase its emphasis on enforcement. It is likely that total expenditures for drug control, at all levels of government, totaled close to $40 billion in 2007; 70-75% of that went to enforcement. Incarcerating 500,000 inmates for drug offenses would of itself cost about $12-15 billion.

Enforcement The most striking consequence of this emphasis on enforcement is that it has led to a huge number of individuals being incarcerated for drug offenses. Whereas in 1980 fewer than 50,000 were incarcerated, that figure had risen to 500,000 by 2007. The estimated half million (which includes those in local jails as well as federal and state prisons) consists only of those who have been convicted of drug selling or possession, not those whose property or violent crime may have been related to their drug dependence. What is particularly astonishing is that the number has kept on rising even though there is good reason to believe that the scale of drug dealing has been declining modestly for the last fifteen years. Though many are formally in jail or prison for drug possession offenses, most of those are in fact dealers who pled guilty to possession charges in order to avoid a longer sentence.

A major concern has been the racial and ethnic composition of the incarcerated drug dealer population. The probability of going to state prison for a drug offense is about 14 times higher for an African-American male than for a white non-Hispanic male. The ratio for Hispanic males is also high, though probably less than 10. Some of this reflects the greater lengths of statutory sentences for crack cocaine vs powder cocaine; crack cocaine offenses are much more likely to involve black offenders.

In theory tough enforcement should lead to higher prices. As show in Figure 2 that has not happened. Prices for cocaine and heroin have fallen substantially over a long period of time; as compared to the early 1980s prices have fallen by about 80 percent. There is some indication of a price increase in 2007 for cocaine but even that leaves the price well below its 1990s levels and there is some reason to believe that the price increase might be short-lived, probably being related to the current conflict around drug markets in Mexico, just as there was a price spike when the Colombian government tackled the Medellin cartel in 1989-1990. Figure 2 makes the point about the failure by contrasting the decline in prices with the rise in drug prisoners.

Figure 2: U.S. Drug-Related Incarceration and Retail Heroin and Cocaine Prices



Note: prices are adjusted for inflation

Treatment Each year about 1 million persons are treated for substance abuse (not including alcohol alone). Large as that number seems, it is small in comparison with estimates of the total number of persons in need of treatment. Not including those in prison or jail, there may be as many as 4 million persons who have abuse problems with cocaine, heroin and methamphetamine. Need for treatment does not always lead an addict to seek treatment; pressure from family, friends, employers or the criminal justice system is frequently required to get the addict into treatment. So it might not just be lack of expenditures that lead to a large "treatment gap". However the low share of addicts in treatment in the U.S. contrasts with other rich Western nations. For example in the Netherlands, Switzerland the United Kingdom, about half of those with heroin problems are in treatment programs; in the U.S. the fraction may be as little as one sixth.

Treatment is not only inadequate in terms of the number of available slots, it is also of low average quality. Drug treatment, particularly the provision of

methadone maintenance, is separated from the mainstream of health care. Wages are very low, many of the workers are not well trained and the turn-over of the workforce is high. Despite this, there is abundant evidence that treatment, even not very good treatment, is both effective and cost-effective. Over 80 percent of those who enter treatment for the first time will either drop out or relapse, so that treatment is itself a career, like drug use. Nonetheless, the reductions in drug use generate large declines in crime and various health risk behaviors; these in turn yield large benefits both to the user and to society.

Prevention There is universal enthusiasm for prevention programs in concept. By international standards the U.S. spends large amounts on prevention per capita and as a share of the drug control budget. Unfortunately much of that money is wasted on ineffective programs. In recent years the Office of National Drug Control Policy has funded a mass media campaign that repeated evaluations have found to have no effect on youthful drug use. The most popular program in schools, Drug Abuse Resistance Education (DARE) has been evaluated a number of times and found ineffective; in face of negative findings the DARE program has agreed to redesign its efforts, though still using police officers as the messengers. Other prevention expenditures have gone to programs that have no plausible basis for making a difference.

International Programs

Expenditures on source country programs (eradication, alternative development, police training, equipment etc.) constitute a tiny share of U.S. drug control expenditures. Even with Plan Colombia at its height, the U.S. was spending less than $1.5 billion on these programs, less than 10% of federal drug control expenditures and less than 5% of total governmental drug control expenditures. The vast majority of that money was spent in the Andean region. Though Afghanistan dominates world heroin production, the United States

imports most of its heroin from Colombia and Mexico. Indeed, these two countries account for almost all of the U.S. drug imports, with Mexico serving as the transit point for most cocaine and also producing much of the imported marijuana and methamphetamine.

Interdiction programs, which aim to seize drugs and couriers on their way into the United States, account for more money. Though most interdiction money is spent inside the U.S.. some does go to maintaining ships and planes in the Caribbean and Central American waters, so it has an international component.

There is good reason to doubt the effectiveness of moneys spent against the growers of coca leaf, the source country refiners and even the smugglers. The basic argument is reflected by the numbers in Table 2. These figures show that the vast majority of the retail price of cocaine is accounted for by transactions in the United States, almost all of that in the form of compensation to U.S. resident dealers for incurring the risks of being imprisoned or injured in the course of the business.

Table x Cocaine Prices Through the Distribution System

Product	Market Level	Effective Price/kg.
Coca leaves	Farmgate/Colombia	$300
Coca base	Farmgate/Colombia	$900
Cocaine hydrochloride	Export/Colombia	$1,500
Cocaine hydrochloride	Import/U.S.	$15,000
Cocaine (67% pure)	Dealer/U.S.	$40,000
Cocaine (67% pure)	Retail/U.S.	$150,000

The 1985 torture and murder of DEA agent Enrique Camarena in Mexico by drug traffickers tied to Mexican police agencies led to a strong reaction from Congress. Starting in 1986 the president was required each year to certify which nations were “co-operating fully” with the United States in suppressing drugs.

This certification procedure became the source of great tension between the U.S. and various Latin American governments in the 1980s and 1990s, even though in all these years the U.S. has failed to certify the major producing and trafficking countries only a handful of times. Since President Bush in 2001 stated that "the main reason why drugs are shipped through Mexico to the United States is because United States citizens use drugs", there has been a great deal less interest in the certification process either in the U.S. or Latin America, though the annual International Narcotics Control Strategy Report continues to be published each year, with its assessment of each country's efforts at drug control.

The United States government has also been very aggressive in its dealings with the United Nations, whether it be in the Commission on Narcotic Drugs (CND), International Narcotics Control Board (INCB) or United Nations Office on Drugs and Crime (UNODC). Harm reduction, the claim that it might be possible to reduce the total damage that prohibited drugs do to society by lowering the harmfulness of drug use, has become widely accepted in Europe (with Sweden as an important exception). However the U.S. has consistently pressed for stands by the UN agencies against harm reduction, in particular against the iconic program of syringe exchange, in face of a strong scientific consensus that such programs do no harm and sometimes do substantial good. The United States is committed to the view that only by reducing the number of users can drug problems be reduced and has been highly critical of other approaches, aided by a number of Asian and African countries that share these broad views. The INCB critique of drug consumption rooms, heroin maintenance programs and decriminalization of marijuana use are believed to reflect U.S. pressure.

Politics and Public Opinion

From about 1985 to 1995 drug policy was a major issue in U.S. politics, frequently mentioned in campaign speeches and the subject of a great deal of

legislation. Since the late 1990s the topic has become invisible. For example, there has been almost no discussion of drug policy in the presidential elections post-1996. The most sophisticated recent study of public opinion on the matter showed a general pessimism both about the problem (seen to be getting worse) and about the effectiveness of different programs. Though support for tough sentencing, particularly of drug users was not strong, there was also little support for any major changes in policy, even including the removal of criminal penalties for possession of small amounts of marijuana.

There have been some modest changes that suggest a tiring with the "war on drugs" approach. The most significant is the passage (by referendum) of Proposition 36 in California in 2000. Under Prop 36 first or second time arrestees for drug possession were to be evaluated for treatment and were not at risk of being sent to jail or prison. Drug courts, of which there were more than 1,500 by 2007, also represent an effort to deal with drug offenders less harshly by offering treatment rather than incarceration, typically to non-violent offenders. However no other statement has adopted a Prop 36 type regime and drug courts, though large in number, still account for less than 5 percent of criminal offenders because they have tight restrictions on who is eligible for the program. An experience heroin addict with numerous convictions for violent offenses would be excluded in most jurisdictions.

No prominent members of Congress have made drug policy an important issue in recent years, so there is little momentum for change at the federal level. A recent effort (2007-2008) to lessen the notorious disparity between cocaine powder and crack sentences in the federal system is instructive of how much resistance there is to lessening the harshness of the regime. Even though the reform proposal from the U.S. Sentencing Commission would still have ensured that any offender convicted of selling crack faced a sentence of multiple years, there was strong protest against making the change, particularly to applying it to those who were already sentenced under the old regime. The Attorney General

spoke out against it as resulting in the release of dangerous offenders, with no reference to any principal of justice.

My own judgment is that there has been a lessening of pressure for aggressive action in other countries. President Bush in 2001, at a meeting with President Vincente Fox, stated that so long as the U.S. had a large demand for drugs, Mexico would have a major drug problem. Perhaps as a consequence, the Congressional theatrics around the annual release of the drug certification report has almost disappeared. The recently announced Merida agreement, under which the U.S. offers about $450 million a year to support Mexico's efforts to control drug trafficking represents probably less an expectation that it will much help the United States with its problems than the hope that it will help Mexico deal with the drug trafficking problems that the U.S. demand has created. Though there is some pressure on the fragile government of Afghanistan to eradicate opium poppies, Secretary of State Rice has been careful to acknowledge that any reductions in heroin production there will only occur over a long period of time.

The future of U.S. drug policy is likely to be very similar to the recent past. Even if the extent of drug dependence and related harms continues to moderate, there is little effective pressure for relaxation of the intense enforcement of the last two decades. Drug treatment may receive more support than in the past but that, of itself, will make only a moderate difference. Major legal change is extremely unlikely.