WE ARE BY NOW accustomed to sharply opposing viewpoints and conflicting claims about our national drug policy and its results. A succession of Presidents and Congresses have led the field with calls for a “drug-free” America and “zero tolerance” and have enacted drug prohibitions with ever-harsher criminal penalties and more militant (and more expensive) enforcement tactics. In contrast, libertarian reformers like Nobel Prize winner Milton Friedman or conservatives like William F. Buckley, Jr., call for outright legalization of all drugs. And others (this author among them) call for a public health or “harm reduction” approach, reasoning that dangerous drugs will always be with us and that we had better learn how to live with them in a way that minimizes their adverse health and social consequences.
While this debate rages, we see continued (even rising) drug availability and ever-shifting patterns of drug use: crack and cocaine use are down, but marijuana and heroin use are becoming more popular among young people. And, over the last decade, new and more lethal consequences of illicit drug use have emerged—including infectious disease epidemics (AIDS, TB, hepatitis B, and hepatitis C) linked to unsafe injecting and to the marginal life of the criminalized addict. Meanwhile, of course, huge numbers of people continue to be arrested and imprisoned for drug offenses, the most specific expression of a policy based on prohibition and a punitive approach to drug users.

Yet despite constant appeals for more and better drug treatment, we still see severe shortages in treatment programs as well as limited success in dealing with the severest forms of addiction, that is, to heroin and cocaine. There is new and important Federal support for Methadone (the drug treatment of greatest proven efficacy for heroin addiction), but public opinion remains sharply divided on the use of narcotic maintenance—with New York’s Mayor Guiliani recently calling it “enslavement” and taking steps to end treatment for thousands of patients currently under care in the city.

Further, while AIDS has refocused our attention on drugs as a public health problem, raising the stakes for epidemiologic research and demanding effective interventions to reduce the spread of HIV infection, even massive international documentation of the effectiveness of needle exchange programs has failed to shift a hostile Federal policy that bans funding for such programs because they give the “wrong message,” that is, something other than “zero tolerance.”

What then are our goals in drug policy? And what should they be?
If “winning the war on drugs” was once the battle anthem of national drug policy, that metaphor is now rejected by many, including Gen. Barry R. McCaffery, Director of the White House Office of National Drug Control Policy (ONDCP), as fostering “unrealistic expectations for a speedy victory and a specific end to the campaign.” The General now believes the fight against cancer to be a better analogy—“stressing prevention and treatment.”

Notwithstanding this more health-oriented view and the growth in Federal support for treatment programs, prohibition remains the major strategic goal of our national drug policy, under which treatment continues to be “backed up by a high level of social and legal disapproval” and the strict enforcement of drug laws. This is most evident in the allocation of expenditures in the National Drug Control Budget for fiscal year 1998. Of a $16 billion total, more than $10.7 billion (67%) was devoted to drug law enforcement, interdiction, and supply reduction in the US and abroad. In addition to representing the lion’s share of current Federal funding, enforcement expenditures have shown almost two decades of steady growth—increasing tenfold since 1981. (See Figure 1.) In the same period, Federal support for treatment and prevention has grown by only half that amount.

Even the recent innovation of drug courts, which steer arrested nonviolent users to treatment, represents an extension of Federal enforcement policy and funding priorities. This approach is still based on the continued vigorous prosecution of drug users, while using the criminal justice system to enforce compulsory treatment.

Further, Federal budgets reflect only a small part of all public expenditure for drug control. In this country, most law enforcement occurs at the municipal and state levels, where annual enforcement expenses are estimated at more than $20 billion, compared with approximately $7.6 billion for treatment from all government and private sources.

Thus, as we follow the money for the past 25 years, it is clear that enforcement has been the centerpiece of our drug policy, far outstripping other approaches to the problem. The consequences of disproportionate spending for enforcement are most visible in our society in
the high rates of arrest and incarceration for drug offenses (Figure 2), the increasing proportion of criminal justice activities devoted to drug offenses, and the rise in both over the past 25 years.

TRENDS IN DRUG ARRESTS AND INCARCERATION

While overall crime rates today are at their lowest in the past 25 years, arrests for drug law violations have reached a record high—more than 1.5 million in 1996, the latest year for which complete data are available. State and Federal prisons and local jails today hold more than 400,000 drug law violators—60% of all Federal prisoners and more than 25% of state and local inmates. (See Figure 2.)
Although rates of drug use were already declining rapidly by 1980, between 1980 and 1990 there was a 1055% increase in new commitments to state prisons for drug offenses (from 8800 to 101,600).15 New commitments continued to rise into the 1990s (Table 1).

In 1980 there were 51,950 drug law violators behind bars in state and Federal prisons (8% of all inmates). By 1995 this number had increased more than 700% to 388,000 (25% of all inmates in a prison population now four times as large). This growth represents the clearest expression of a policy based on prohibition and the vigorous application of criminal sanctions for the use and sale of illicit drugs.

The surge in incarcerated populations in the 1980s was due to harsher enforcement policies and longer mandatory sentences for possession of smaller quantities of drugs, including disproportionate penalties for possession of crack cocaine. This resulted in progressively longer prison terms for drug offenses and a widening gap in sentence length between drug offenders and those convicted of violent crimes16—which has helped increase the proportion of the prison population behind bars for drug offenses (Figure 2). And while some individuals are in prison for major trafficking offenses or violent crimes, more than 90% of drug offenders are arrested for possession or for low-level drug deals to support their personal use.16

It is clear from these data that we have practiced what we preach, literally with a vengeance. There are more drug offenders behind bars today than the total incarcerated population of 1970.17 Indeed, drug enforcement has accounted for such a large increase in our prison population that the US is now the Western democracy with the highest per capita rate of imprisonment.18

What have been the effects on the patterns of drug use of this vast natural experiment in drug control policy?

Figure 4. Percentage of US household residents ages 12 to 17 self reporting past-month use of illicit drugs, by type of drug, selected years, 1979-1995

TRENDS IN THE PREVALENCE OF DRUG USE

Proponents of a drug policy based on prohibition and its rigorous enforcement claim that their approach is working. See, for example, Figure 3, reprinted here from the ONDCP's 1998 National Drug Control Strategy,1 which is used to support this contention. It shows that self-reported past month use of any illicit (that is, illegal) drug, and specifically of cocaine and marijuana, have declined sharply since 1985.

While Federal drug control officials admit that the problem is still serious, costing at least 14,000 lives and $110 billion a year,1 they assert that our approach has increased societal disapproval of drug use and lessened the extent and severity of the drug problem. Citing reductions in "casual use" of all illegal drugs by 50% (and of cocaine by 75%) since 1979,1 in its 1998 National Drug Control Strategy, the ONDCP claims that we will do even better in the future and sets a new 10-year goal of a 50% reduction in overall drug use in America, to a level below the lowest point attained in the last 30 years.1

These claims are greeted with some skepticism given the growing world market in illicit drugs. We are seeing greater availability of higher purity drugs at lower prices; from 1981 to 1996 the average price per pure gram of cocaine fell by 66% and the average purity of street heroin rose from 6.7% to 41.5%.1 Increased crop acreage and expanded international traffic have driven a steady rise in the number of consumer and producer nations to at least 140 countries and a $500 billion world market, as has been well documented by the ONDCP, the US Drug Enforcement Agency, Interpol, and the United Nations Drug Control Program.1

In a world awash in drugs, with widespread economic hardship and social dislocation to motivate their continued production and distribution, can we succeed in protecting our nation from drugs and their dangers by the application of our current policies?

Apparently not.

Despite reductions in adult use, the latest data from national surveys19 show a sharp climb since 1991 in the prevalence of illicit drug use among American high school students—despite decades of intense enforcement and powerful anti-drug messages. (See Figure 4.) This primarily reflects increased use of marijuana, but use of the harder drugs also appears on the increase.19 These climbing rates of teen use are a sentinel for the failure of our current policies to reduce the number of new users of prohibited drugs. And, interestingly, they are echoed in teen use of legal drugs—tobacco (despite the anti-tobacco crusades of the last few years) and alcohol—neither of which may be legally sold to people in this age group.19

Are there other ways in which our drug policies are failing us? What do the data show?
While overall population trends in the use of any illegal drug are informative, individuals use specific drugs. Figure 6 shows 1979–1996 trends for each drug category (age, sex, ”race”) and for each of the illicit drugs (as well as for tobacco and alcohol use). The NHSDA collects data on use in the respondent’s lifetime (“ever used”), in the past year, and in the past month (“current use”). But, despite these shortcomings, data from large, ongoing, national surveys are very useful in this population over time. They also permit us to see the demographic profile of drug users and to identify changes that may have used drugs a single time or who are experimental or casual users. Figure 4 shows the national data in a generation despite changes in prevalence.21 These data show that most illicit drug users are not “hard core” addicts and that most experimental or casual use does not eventuate in continued or regular use.
consensus/cons/108/108_statement.htm

Substance Abuse and Mental Health Services Administration (US). Historical estimates from 1996.


Institution; 1996.


clear that the most negative health consequences of drug use are not evenly distributed—they are at least as dangerous. These laws have spawned a lethal biosocial ecology in which the images of young black men being arrested and imprisoned for drug offenses continue to fill the news media. While all the data suggest little systematic difference in the prevalence of drug use across racial groups, there is a notable pattern of rising drug deaths for blacks but a 129% increase for whites and others (Figure 11).

In 1996, African Americans, who represent only 12% of the US adult population and a similar proportion of the drug treatment population, accounted for 24% of drug-related deaths. The almost 30% higher rate of drug deaths among blacks was among those over the age of 25. As Figure 12 shows, the death rate for intentional drug-related injuries (primarily overdose deaths) is 3.5 per 100,000 individuals. For non-drug-related injuries, the rate is 4.8 per 100,000 individuals. This is comparable to the rate for whites, who have a death rate of 3.9 per 100,000 individuals.

Table 3. Drug-related emergency department visits, United States, 1994

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<th>Drug-related emergency department deaths</th>
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<tr>
<td>White</td>
<td>4272</td>
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<tr>
<td>Black</td>
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<td>12.3</td>
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<tr>
<td>Black/White</td>
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Table 2. Drug-related deaths, African Americans and others, United States, 1988–1995

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<td>1988</td>
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<td>1990</td>
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</tr>
<tr>
<td>1992</td>
<td>400</td>
</tr>
<tr>
<td>1995</td>
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Table 1. Drug-related deaths, deaths, and emergency department visits, United States, 1994

<table>
<thead>
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