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HOW THE CLINTON ADMINISTRATION IS ABANDONING THE WAR AGAINST DRUGS

INTRODUCTION

The Clinton Administration is taking a new direction in the drug war. But that new direction will allow more cocaine, heroin, and marijuana to reach American streets, and it will cut federal enforcement personnel. It seeks to pour over $300 million more into a national drug treatment system that has seen federal funding triple since 1988 (to over $2.5 billion annually) yet serves fewer drug-dependent individuals each year and has manifestly failed to reduce the addict population.

President Clinton effectively abandoned leadership of America's anti-drug effort during his first year in office. Now the Administration wants to dismantle crucial parts of this effort despite a rise in teenage drug use during the President's first year in office that reversed more than a decade of steady and rapid decline. Instead of reversing course on a successful strategy, the Clinton Administration should:

- ✔ **Reassert presidential leadership in combatting illegal drug use.** This means more than speaking out against illegal drug use. It means appointing individuals within his Administration who are serious about combatting illegal drugs and dismissing those who are not.
- ✔ **Let state and local officials use federal anti-drug funds for their highest priorities.** This entails consolidating the roughly $3.5 billion in federal drug control programs for states into a block grant that can be used at the local level for purposes ranging from treatment and rehabilitation to prevention and law enforcement.
- ✔ **Use the military and get tough with countries that are the source of illegal drugs.** This means putting the U.S. military in charge of stopping the flow of illegal drugs from abroad, requiring federal law enforcement agencies responsible for drug interdiction to operate under the command and control of the military. It also means insisting that cocaine-source countries reduce their net production of

drugs by at least 10 percent per year and by at least 50 percent in five years or face a loss of aid, as well as trade and diplomatic sanctions.

- ✔ **Mount a serious attack on major drug trafficking organizations.** Require the Attorney General to prepare a report within six months identifying all major drug trafficking organizations known to be operating in the U.S., an enforcement plan for dismantling all those organizations within 18 months, and a plan to repeat this strategic planning process yearly.

Americans have changed their views about drugs. They are more aware than ever of the dangers of drug use. During the 1980s, the federal government led successful efforts to reduce casual drug use, to block shipments of drugs to America, and to reinforce local actions to discourage drug use. But that action by the federal government has already lost momentum under Bill Clinton and seems destined to decline even further. It will be a costly mistake. The failure of national leadership makes a renewal of local anti-drug efforts—prevention, treatment, and enforcement—crucial to the future of the drug war.

THE DRUG WAR AND AMERICAN CULTURE

Between 1977 and the end of the 1980s, a conservative cultural revolution took place in America with respect to drugs. Illegal drug use went from being considered fashionable and liberating to being thought of as unfashionable and stupid. Overall, casual drug use by Americans dropped by more than half between 1977 and 1992. From 1985 to 1992 alone, monthly cocaine use declined by 78 percent. This transformation in cultural attitudes reversed the spread of illegal drug use, and it was carried out by the fundamental institutions of American society. Parents were the first group to mobilize. Initially, parent groups forced the Carter Administration to suspend its drug legalization initiatives. Later, parents gained the vocal support of First Lady Nancy Reagan, who helped make the drug problem a national priority.

The moral injunction not to use drugs swept the nation, conveyed by the core institutions of American society: families, churches, schools, youth organizations, neighborhoods, workplaces, civic groups, and police. Even the media joined in this cultural revolution. In the early 1980s, a *Time* magazine cover portrayed cocaine as the contemporary equivalent to the martini. By 1990, however, the media were contributing an estimated one million dollars a day to the Partnership for a Drug-Free America's anti-drug ads: "This is your brain. This is your brain on drugs."

National leaders helped give momentum to this institutional mobilization against drug use from their "bully pulpit." From the President down, top officials in the Reagan and Bush Administrations visibly supported the effort, and government programs supplemented the institutional mobilization. Federal anti-drug activity and spending were very important, but the contribution of the federal government never approached the magnitude of the effort supplied by citizens, families, and local institutions throughout the nation. In short, the drug war embodied all the elements of successful conservative domestic reform. The American people, recognizing a dangerous threat to the nation and working through its most powerful domestic institutions, changed the cultural attitudes that were the root of the illegal drug problem; drug use—particularly by young people—declined dramatically. The federal government gave strong moral support, and programs

supplemented the efforts of ordinary citizens. Now, under the Clinton Administration, that progress is being reversed.

THE DISMAL CLINTON RECORD ON ILLEGAL DRUGS

When President Bill Clinton took office, the problem of illegal drugs had undergone a sea change in just a little more than a decade. But instead of taking measured steps to address the residual aspects of the drug problem while supporting existing efforts, Clinton Administration officials immediately began undermining existing anti-drug efforts on almost all fronts:

- ✘ For his entire first year in office, President Clinton mentioned the drug issue only rarely and offered no moral or political leadership or encouragement to those in America and abroad fighting the drug war.
- ✘ The Clinton Administration Surgeon General, Joycelyn Elders, has called repeatedly for serious consideration of drug legalization.[1]
- ✘ Just days after the inauguration, President Clinton moved the White House office created to direct national anti-drug efforts to a backwater and slashed its personnel by over 80 percent.[2]
- ✘ One of the first announced goals of Attorney General Janet Reno was to reduce the mandatory minimum sentences for drug trafficking and related federal crimes—sentences that put teeth in drug enforcement and are an important tool for gaining the cooperation of subordinates in bringing major traffickers to justice.[3]
- ✘ The Office of Management and Budget proposed, and House appropriators passed, cuts of $100 million in drug treatment funding and $130 million in prevention education. Fortunately, these cuts later were partially restored in conference action at the insistence of Republican conferees.[4]
- ✘ President Clinton signed a new directive ordering a massive reduction in Defense Department support for the interdiction efforts that have been preventing large quantities of cocaine and other illegal drugs from entering the United States.

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1 See Reuters, "Elders Reiterates Her Support For Study of Drug Legalization," *The Washington Post*, January 15, 1994, p. A8.

2 On February 9, 1993, the White House announced that the Office of National Drug Control Policy (ONDCP) would be cut from 146 staff members to 25. For more detail on drug czardom under the Clinton Administration, see Byron York, "Clinton's Phony Drug War," *The American Spectator*, February 1994, pp. 40-44.

3 See Michael Isikoff, "Reno Has Yet to Make Mark on Crime," *The Washington Post*, November 26, 1993, pp. A1, A10, and A11.

4 See Michael Isikoff, "House Cuts Drug Plan $231 Million: Clinton Lobbyists Tacitly Concurred," *The Washington Post*, July 2, 1993, p. A9.

- ✘ The Administration accepted a 33 percent cut (from $523.4 million in FY 1993 to $351.4 million in FY 1994) in resources to attack the cocaine trade in the source and transit countries of South America.[5]
- ✘ Efforts led by the federal government to eradicate domestic marijuana have been reduced substantially.
- ✘ Most recently, the Clinton Administration has ordered the U.S. military to stop providing radar tracking of cocaine-trafficker aircraft to Colombia and Peru.[6]

While the Clinton Administration spent its first year in office undermining anti-drug efforts, drug use by young people started to rise. The University of Michigan's annual survey of high-school drug use for 1993, released this January, showed that drug use—particularly marijuana use—by 8th, 10th, and 12th-graders rose in 1993 after virtually a decade of steady decline. Even more distressingly, the survey also revealed that student attitudes toward illegal drug use are becoming significantly less hostile, indicating further increases in use are almost certain in 1994.[7]

THE "NEW" CLINTON PLAN

Nine days after the University of Michigan report that teenage drug use was rising, the Clinton Administration presented a "new" drug strategy emphasizing four areas:

- ✔ **Reducing** hardcore drug use through treatment.
- ✔ **Ensuring** safe and drug-free schools by improving prevention efforts.
- ✔ **Empowering** communities to combat drug-related violence and crime.
- ✔ **Increasing** international programs in source countries and reducing interdiction in drug-transit zones.[8]

The new strategy was accompanied by a drug control budget request for fiscal year 1995 totaling $13.2 billion, some $1.1 billion (9 percent) more than the $12.1 billion enacted for FY 1994. The Administration emphasized that it was seeking increased funds in five key areas: drug prevention, up $448 million (28 percent); drug treatment, up $360 million (14 percent); drug-related criminal justice spending, up $227 million (4 percent); international programs, up $76 million (22 percent); and drug-related research, up $27 million (5 percent). The White House requested reductions in two areas: interdiction,

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5 ONDCP, *National Drug Control Strategy: Budget Summary*, February 1994, p. 184.

6 David LaGesse, "Military Stops Helping Nations Track Smugglers," *The Dallas Morning News*, May 14, 1994, pp. A1 and A9.

7 Press release by the University of Michigan's Institute for Social Research on the "Monitoring the Future Study" (also known as the National High School Senior Survey—HSS) for 1993, January 31, 1994.

8 ONDCP, *National Drug Control Strategy: Reclaiming Our Communities From Drugs and Violence*, February 1994, p. 1. An "interim" strategy released last September by Clinton Drug Czar Lee Brown received harsh bipartisan criticism for its superficiality and lack of resources. See ONDCP, *Breaking the Cycle of Drug Abuse: 1993 Interim National Drug Control Strategy*, September 1993.

down $94 million (7 percent), and anti-drug intelligence programs, down $600,000 (0.4 percent).

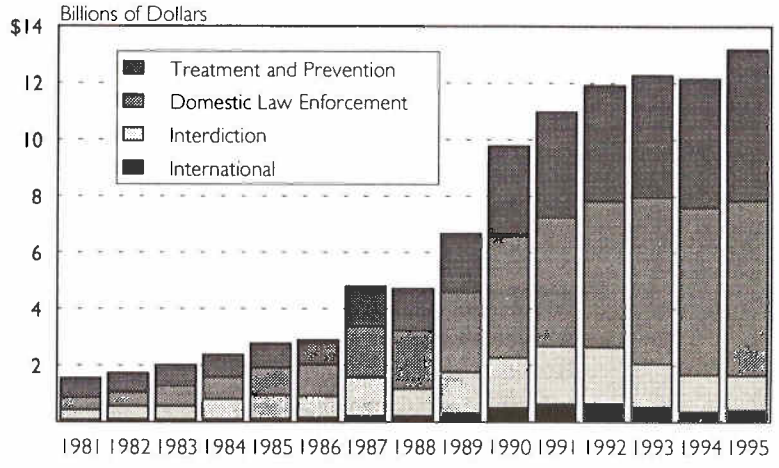
The Administration claims that its budget demonstrates a new emphasis on demand reduction, with 59 percent of the request devoted to supply reduction spending and 41 percent to demand reduction spending as compared with 65 percent and 35 percent, respectively, in FY 1993.

ANALYZING THE CLINTON DRUG CONTROL BUDGET

The Clinton Administration portrays its drug control budget as a sharp increase in spending to combat drugs. But as Chart 1 indicates, this is true only when the budget is compared with the slowdown in spending during the Clinton term so far.[9] Moreover, when the budget is examined more closely, it becomes clear that the spending priorities constitute a step backwards.

Chart 1

National Drug Control Budget



Source: ONDCP.

This chart reflects the fact that the Clinton Administration let federal anti-drug spending drop in FY 1994 by roughly $130 million as compared to FY 1993. The decline is then used as a baseline in some cases to create misleading claims of increases in the FY 1995 budget request, as detailed below.

Specifically, the Clinton budget:

1) Cuts federal drug enforcement personnel.

The new Clinton Administration drug strategy calls for substantial cuts in federal drug enforcement personnel. The principal federal drug enforcement agencies are the Drug Enforcement Administration (DEA), Federal Bureau of Investigation (FBI), Immigration and Naturalization Service (INS), Bureau of Alcohol, Tobacco and Firearms (BATF), U.S. Customs Service, and U.S. Coast Guard. Drug enforcement personnel in these agencies would be cut by a total of 625 positions between FY 1994 and FY 1995.[10] These cuts, moreover, are just in the drug enforcement sectors of the

9 *National Drug Control Strategy: Budget Summary*, February 1994, pp. 2, 184-187.

10 *Ibid.*; see the sections discussing each of the enforcement agencies.

multi-mission agencies (total FBI cuts, for example, will be much greater under the FY 1995 Clinton budget)—and are on top of reductions in many of these same agencies between FY 1993 and FY 1994. Staff inside the enforcement agencies also have complained that the Clinton budget understates the actual reductions in personnel and misrepresents some reductions as limited to non-agent personnel when in fact further agent cuts will be unavoidable at the funding levels requested by the President.

2) **Cuts federal-state-local enforcement task forces.**

The Organized Crime Drug Enforcement Task Forces, which are part of the federal-state-local enforcement task force program, will be cut by 102 positions.[11]

3) **Cuts drug prosecution.**

In addition to cuts in enforcement personnel, the Clinton Administration seeks to cut 102 drug prosecution positions in U.S. Attorneys' offices between FY 1994 and FY 1995.

4) **Contains a phony prevention increase.**

The Administration achieves most of its claimed $1.1 billion increase in funding requested for FY 1995 by counting one-third ($567.6 million) of its community policing request as part of the anti-drug budget; half of this ($283.8 million) is counted as prevention spending.[12]

While most Americans know that law enforcement personnel help prevent crime, the budget portrayal is highly misleading. In all the fanfare about placing greater emphasis on prevention and treatment over enforcement, it turns out that the Administration actually achieved most of its claimed $448 million increase in prevention—which most Americans assume means such things as drug education programs in schools—by counting in funds to pay the salaries of police on patrol. This means the shift in the supply/demand ratio touted by the Clinton Administration is principally the result of a budget trick and a $305.5 million cut in drug interdiction funding between FY 1993 and FY 1995—not of real increases in drug prevention and treatment funding.

5) **Encourages more waste in the drug treatment bureaucracy.**

The principal requested increase in drug treatment funding intended to treat hard-core addicts ($310 million of the claimed $360 million increase over FY 1994) is to be awarded through a program of block grants to the states for alcohol, drug abuse, and mental health services. The Administration claims it will give real focus to the funds, but this has never happened before.[13] The multi-purpose nature of the program

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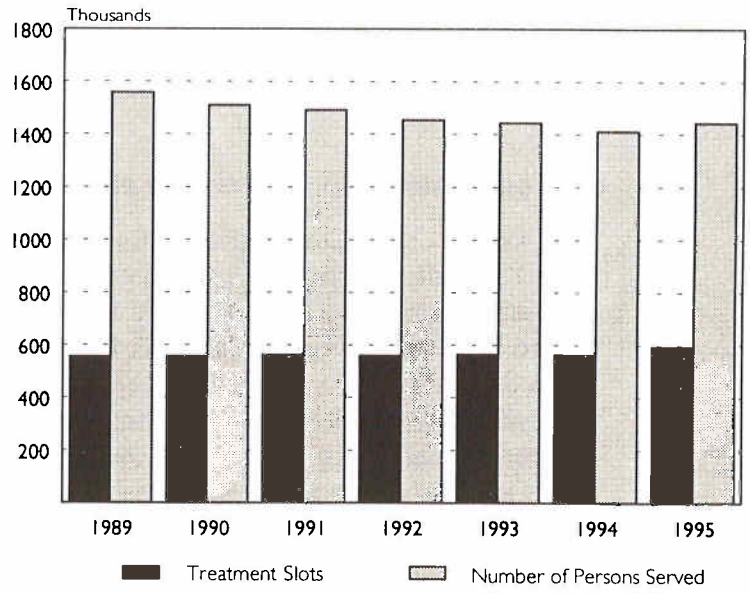
11 These cuts overlap with the federal drug enforcement personnel reductions cited above and the prosecution staff reductions cited subsequently.

12 It should be noted that the FY 1995 Clinton Administration budget includes only a total of $1,720 million for community policing funds, which is much below the amount contained in the pending 1993 crime bill (a five-year $8.9 billion program). Although the President proclaimed his support for the bill—and the community policing provisions in particular—his FY 1995 budget request did not incorporate them.

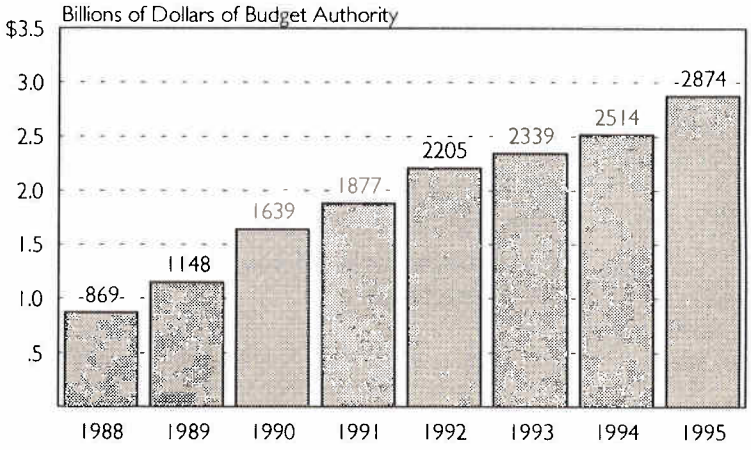
means that three dollars must be spent on the program to achieve an additional one dollar in spending on drug treatment services, but even this ratio is unlikely.[14] The state bureaucracies receiving the funds have resisted efforts by past administrations to "fence" funds, and many of them place a higher priority on alcohol and mental health treatment services than they do on treating hardcore addicts. There are other federal programs specifically designed to focus federal funds on drug treatment, but the Clinton budget chose one program proven not to do so effectively. Moreover, as Chart 2 indicates, the Clinton Administration's claim that it will increase treatment

Chart 2

Drug Treatment Capacity



Federal Drug Treatment Spending



Note: Treatment spending data are for fiscal years.
Sources: HHS, ONDCP.

13 A discussion of this problem is contained in the last Bush Administration Drug Strategy, which proposed (later enacted) the Drug Treatment Capacity Expansion Program (CEP) to earmark funds exclusively for drug treatment where addicts were concentrated most heavily. See ONDCP, *National Drug Control Strategy*, January 1992, pp. 57-61. Congress funded only $15.3 million of the $86 million requested for CEP in FY 1993, however. The Clinton Administration reduced funding to an estimated $10 million in FY 1994 and requests only $6.8 million for CEP in FY 1995.

14 This would reduce the estimated Clinton increase to $103 million and put the total change in treatment funding from FY 1994 to FY 1995 below the rate of inflation—meaning a cut in actual treatment services.

slots for hardcore addicts is hard to believe in light of the budget and data tables provided at the end of its own drug strategy.[15]

Although federal drug treatment spending almost tripled between FY 1988 and FY 1994, the number of treatment slots remained virtually unchanged and the estimated number of persons treated actually declined—from 1,557,000 in 1989 to 1,412,000 in 1994. The Clinton Administration estimates only 1,444,000 would be treated in 1995.[16]

6) Erodes international anti-drug efforts.

The FY 1995 Clinton request for international anti-drug programs is $428 million, or $76 million above the amount enacted for FY 1994. However, according to the Administration's own budget, its FY 1995 request is $96 million below FY 1993 funding and $233 million below FY 1992. The claimed "new" attention to working with those nations that are the sources of illegal drugs consumed in the United States is neither new nor a real priority for the Clinton Administration. A partnership with the cocaine-source countries of Bolivia, Colombia, and Peru was launched by President Bush at his summit meeting with their presidents in Cartagena, Colombia, on February 15, 1990.

The results of this partnership have been mixed, and the policy question facing the Clinton Administration should have been whether those results can be improved and, if so, how. But the "new" Clinton approach says little about this issue. It merely raises the possibility of more drug crop eradication—the approach generally relied on in the 1980s with very disappointing results.

Other nations are unlikely to take seriously a "new initiative" that has neither the interest of senior foreign policy makers nor significant resources behind it. It seems the drug problem simply is not a part of the foreign policy agenda of the United States under President Clinton; no carrot and no stick face the countries that are the source of the poison that destroys too many American lives every day. This obvious fact, coupled with the first signs of an erosion of the progress against drug use made over the last decade, fuels calls in other countries for abandoning anti-drug cooperation with the United States.[17]

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15 Treatment funding from *National Drug Control Strategy*, Budget Summary, p. 187. Estimated treatment capacity from *National Drug Control Strategy*, p. 103, Table B-8.

16 Some advocates assert that while the federal government has increased drug treatment spending, state and local governments have cut such spending, but there is no evidence to support this claim nationally. In fact, a study released by ONDCP last year, and undertaken by the U.S. Census Bureau, found that spending by state and local governments on all aspects of anti-drug programming increased between 1990 and 1991 (the two years measured), and treatment spending (under the category health and hospitals) increased 28.1 percent for state governments and 25.2 percent for local governments between 1990 and 1991. See ONDCP, *State and Local Spending on Drug Control Activities: Report from the National Survey of State & Local Governments*, October 1993, p. 5.

17 For example, see "Colombians Press for the Legalization of Cocaine," *The New York Times*, February 20, 1994, p. A6, and Gabriel Garcia Marquez, "The Useless War," *The New York Times*, February 27, 1994, Section 4, p. 15.

7) **Destroys intelligence support for the drug war.**

More and better intelligence on drug trafficking has been, and remains, the key to disrupting and dismantling the drug trade at home and abroad. Sophisticated intelligence is indispensable to identifying and attacking the most important parts of drug organizations and to bringing those at the top of the most powerful organizations to justice.

The Clinton Administration, however, is now dismantling key parts of this intelligence support. Its cut of $600,000 in intelligence funding for FY 1995 (as compared to FY 1994) is just a small fraction of the actual reduction sought in classified and unclassified programs, according to informed sources. Law enforcement, interdiction, money laundering investigations, anti-corruption efforts, and drug-related terrorism prevention all depend on first-rate intelligence. If America is to do more with less in tight budget times, intelligence-gathering becomes even more important. No proposal by President Clinton will do more to weaken America's ability to combat the drug trade than his reduction in intelligence support.

CHANGES IN THE DRUG PROBLEM

America has done a remarkable job.The illegal drug problem the country faces today began as part of the radical political and moral criticism of American culture and the related youthful rebelliousness of the late 1960s and the 1970s. These forces were very different from those that drove the national drug use problem in early 20th century America, when medical and pseudo-medical opinion held that cocaine and other narcotics were harmless health and performance enhancers. The result: these drugs were widely dispensed in elixirs, tonics, prescriptions, and even soft drinks.[18] That crisis was reversed by enforcement and a cultural change in popular attitudes about drugs.

While America's "first" drug crisis (as it is sometimes called) ironically grew out of what might be termed today as a desire for fitness or wellness, America's second drug crisis was driven largely by political forces. Faculty members at elite colleges and universities gave intellectual respectability to drug use at a time when those institutions also were centers of political activity. Themes of revolution, liberation, and drugs were intertwined in popular music, in other parts of the entertainment industry, and in the press. Drug use was "anti-establishment." It was described as liberating and at times even presented as a path to "higher consciousness"—a part of political, moral, and spiritual superiority.

Alarm over the high percentage of U.S. troops returning from the Vietnam War as regular heroin and marijuana users triggered the first phase of the current war on drugs. The Nixon Administration responded quickly with screening and treatment programs for returning military personnel. But to the surprise and relief of many, when most heroin- and opium-using GIs returned home, where drugs then were neither as widely available nor as acceptable as in Vietnam, they ceased using drugs.[19]

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18 See David F. Musto, *The American Disease* (New York: Oxford University Press, 1987).

THE ROOTS OF TODAY'S DRUG WAR

Although a large majority of Americans have always disapproved of drug use, a substantial—and culturally influential—minority stimulated a drift toward the *de facto* legalization of drug consumption during the 1970s. Penalties and enforcement were reduced, use became fashionable, and drug use among the young became more common. When national measurement began in 1975, a majority of high school seniors reported trying an illegal drug at least once prior to graduation. For the next 15 years, the typical high school senior experimented with illegal drugs. The legalization movement perhaps reached its apex in March 1977 when the Special Assistant to the President for Health Issues, Dr. Peter Bourne, testified before the House Select Committee on Narcotics Abuse and Control in favor of the decriminalization of marijuana. Dr. Bourne was joined by officials from the Justice Department, the State Department, the Department of Health, Education, and Welfare, and the U.S. Customs Service. At the time, Bourne and others also considered cocaine a prime candidate for decriminalization.[20]

Shortly thereafter, Bourne resigned following charges he had used cocaine and improperly written a prescription for a controlled substance. Moreover, the Carter Administration suddenly faced growing popular concern that it was leading the country in a dangerous direction on the drug issue. Parents' groups formed to combat drug use by young people and to challenge political efforts at decriminalization. Bourne had brought the matter to a decisive point; and after his departure from the Carter White House, decriminalization effectively was dead as a serious initiative at the federal level. Still, drug use remained at or very near historically high rates, with cocaine use rates rising into the next Administration. In 1974, one of the first national surveys found an estimated five million Americans had used cocaine at least once. By 1982, that number had more than quadrupled to 22 million.[21]

Two sets of events triggered a reverse in the growing acceptance of cocaine. The first was the shocking violence that Colombian cocaine traffickers—"cocaine cowboys"—brought to Florida. Machine-gun shootouts at shopping centers made national news, along with ruthless killings without regard for the lives of innocent bystanders. The cocaine trade created a new type of wealthy and violent criminal gang; and as the use of cocaine spread, it seemed to bring with it levels of violence never before seen in American cities.

Second, cocaine use took an ominous turn with the development of crack cocaine in the early 1980s. Crack was described as the purest, most intense "high" ever available and perhaps the most powerful addictive drug ever encountered. Quite simply, it was too good. Reports of "almost instant addiction" and of crack and cocaine use by adolescents began appearing in the national media. Then, in 1986, Len Bias, on his way to a profes-

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19 *Ibid.*, pp. 258-259. Also see James Q. Wilson, "Against the Legalization of Drugs," *Commentary*, February 1990, p. 22.

20 Musto, *The America Disease*, p. 265.

21 Dana Eser Hunt and William Rhodes, "Characteristics of Heavy Cocaine Users, Including Poly Drug Use, Criminal Activity, and Health Risks," Abt Associates Inc. for ONDCP, Spring 1993, released by ONDCP August 9, 1993, as "Characteristics of Heavy Cocaine Users: A Research Paper," p. 1.

sional basketball career, and professional football player Don Rogers died within days of each other, both from cocaine use. The death of these young men, in outstanding physical condition, shocked America. Young adult users who thought of drugs (cocaine in particular) as exciting and fun started to feel differently. The media now began to describe a crisis: an unprecedented, wealthy, powerful, ruthless, foreign criminal cartel was marketing a deadly addictive substance on a massive scale, with even grade-school children becoming victims. Illegal drug use was portrayed as an enemy within—a cancer threatening all segments of society, particularly the young.

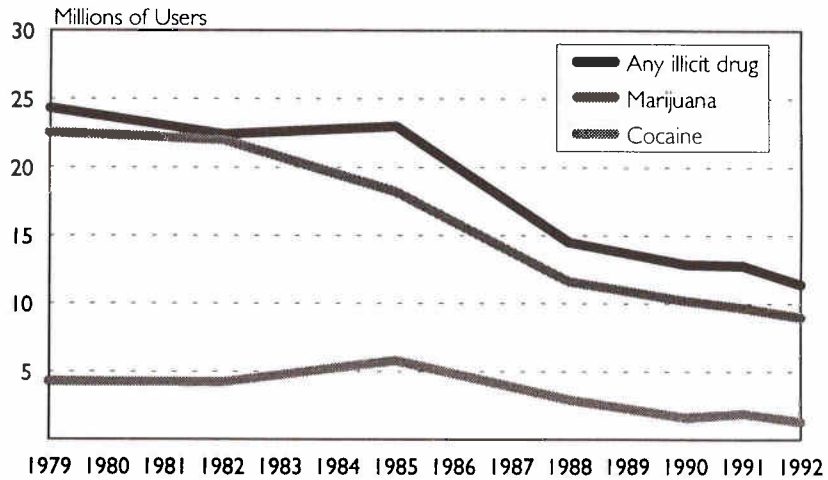
Although a few critics still advocated legalizing drug use, they were relegated to the fringe, and no national political figure even flirted with such a stance—at least not while in office. Instead, there were demands for more criminal sanctions and government spending to combat drugs. In 1988, these demands for a national mobilization culminated in legislation creating a "Drug Czar" who would report directly to the President with the sole job of waging the nation's drug war.[22] The Drug Czar was to take charge and turn the tide. The first person appointed to that post was William J. Bennett, in 1989.

THE REAGAN-BUSH COUNTERATTACK: FIGHTING ILLEGAL DRUG USE

Parents' groups already had mobilized to fight illegal drug use by young people at the end of the Carter years; but they received a powerful boost when First Lady Nancy Reagan made their cause her own. Many in the media ridiculed the effort, but it began to build strength as evidence of the danger mounted and prevention activities, endorsed by the President and his wife, began to have an effect. And not only the young got the message.[23]

Chart 3

Trends in Current Drug Use for Ages 12 and Older



Source: NHSDA.

Drug use began to decline during

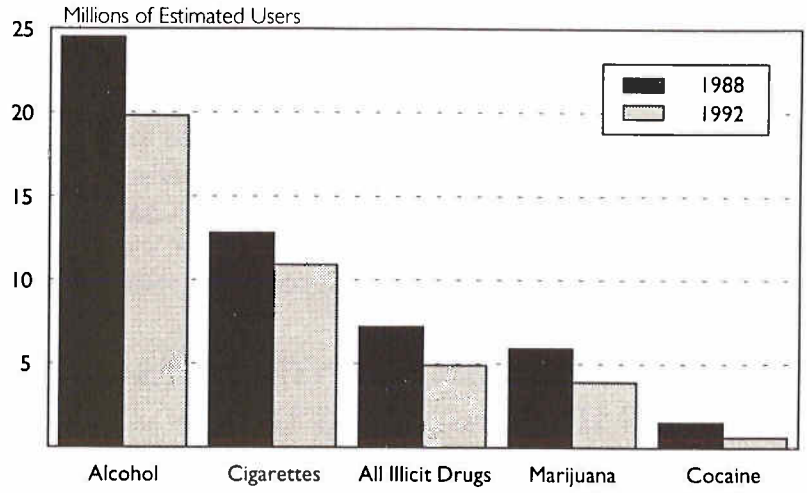
22 The official name of the position was Director of the Office of National Drug Control Policy.

23 Unless otherwise noted, all the following charts and data on drug use are from the Office of Applied Studies, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, "Preliminary Estimates From the 1992 National Household Survey on Drug Abuse (NHSDA)," Advance Report Number 3, June 1993.

the mid-1980s and by 1992, overall illegal drug use was less than half the peak level in 1979. The decline in cocaine use lagged behind the general trend, fueled by the availability of crack, but cocaine use then also fell, with current or monthly (usually referred to as "casual" or "non-addicted") use dropping almost 80 percent between 1985 and 1992. This was important because casual use is the most common way drug use spreads—from friend to friend. While not every casual user goes on to become an addict, virtually every addict starts as a casual user.

Chart 4

Current use of Illicit Drugs, Cigarettes and Alcohol, Ages 12-25

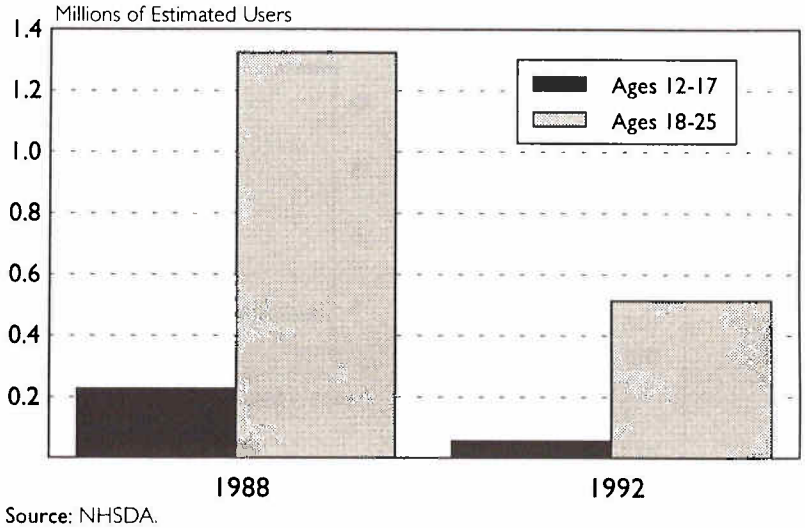


Source: NHSDA.

Even more important were the dramatic reductions in drug use by young people during the 1980s and early 1990s. Annual use of any illicit drug by high school seniors dropped from 54.2 percent in 1979 to 27.1 percent in 1992, and cocaine use fell from an annual rate of 13.1 percent at its peak in 1985 to 3.1 percent in 1992.[24] This means not only fewer young people exposed to the dangers of drugs, but also fewer adults using drugs in the future. As a detailed study of responses to the National Household Survey on Drug Abuse

Chart 5

Current Cocaine Users, Ages 12-17 and 18-25



Source: NHSDA.

24 Press release, "Monitoring the Future Study," January 31, 1994, Table 3.

found: "Regardless of the time (be it the 1970s, 1980s, or 1990s), respondents who have not tried a drug by the time they reach their mid-twenties are unlikely to ever do so."[25]

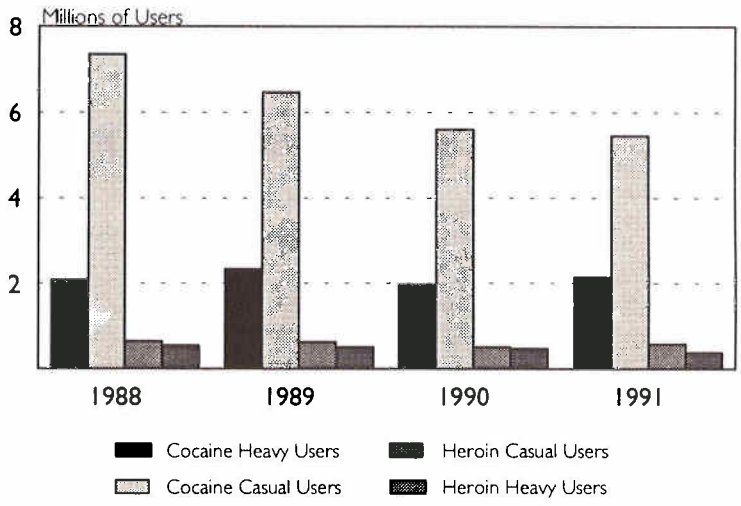
The data in Chart 4, taken from the NHSDA Survey, are instructive for three reasons. First, they show the extent of illegal drug use and its decline between 1988 and 1992 for the age group 12-25. Second, they make clear that the decline in drug use was comprehensive and did not involve merely a shift from one drug to another, or from illegal drugs to cigarettes and alcohol (as sometimes is assumed). Finally, the data show that illegal drug use fell at a greater proportionate rate than did cigarette and alcohol use—this despite the extensive education campaigns against tobacco and alcohol use by the young. Although it is often difficult to dissect cause and effect in human behavior with scientific precision, it seems clear that the categorical legal prohibitions against drugs—actively enforced—played an important part in keeping drug use smaller and making it decline more rapidly. Significantly, where the greatest concern—cocaine use by young people—was brought to bear, the greatest results were produced.

SAVING THE ADDICTED: IS TREATMENT THE ANSWER?

The most obvious casualties of the fad of drug use in the 1960s, 1970s, and 1980s are today's drug addicts. Chart 6 reveals that the drop in casual cocaine use between 1988 and 1991 was rapid (and thus the source of potential new addicts) even though the heavily-addicted cocaine and heroin user populations remained roughly the same size.[26]

Chart 6

Estimated Number of Heavy and Casual Users of Cocaine and Heroin



Sources: ONDCP, Abt Associates.

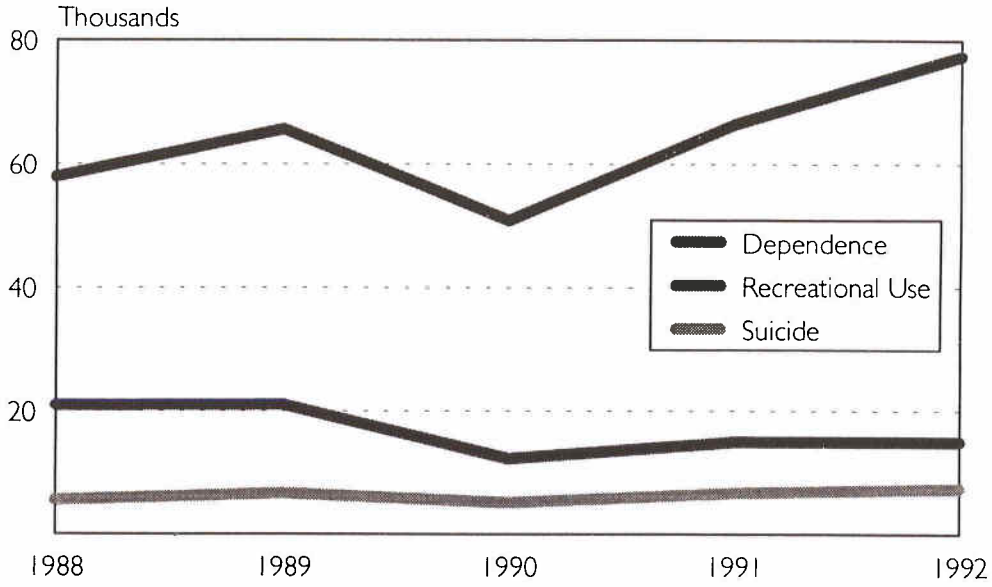
During this period, drug use became confined increasingly to addicts who have been on drugs for years, with fewer additions to the addict group as a result of the decline in casual use. The demographics of the cocaine-

25 Christine Smith and William Rhodes, "Drug Use by Age Cohorts Over Time," Abt Associates, Inc., unpublished, quoted draft, August 11, 1992, p. 3. This is one of several contracted studies done for ONDCP. Some, like this one, have not been released by ONDCP, but the office now wants them to be available to interested individuals.

26 William Rhodes, Paul Scheiman, and Kenneth Carlson, "What America's Users Spend on Illegal Drugs, 1988-1991," Abt Associates, Inc., February 23, 1993, released by ONDCP, August 23, 1993, p. 10, Table 1. This study contains the most recent analysis of the size of the drug using population and of the volume and cost of the drugs they consume.

Chart 7

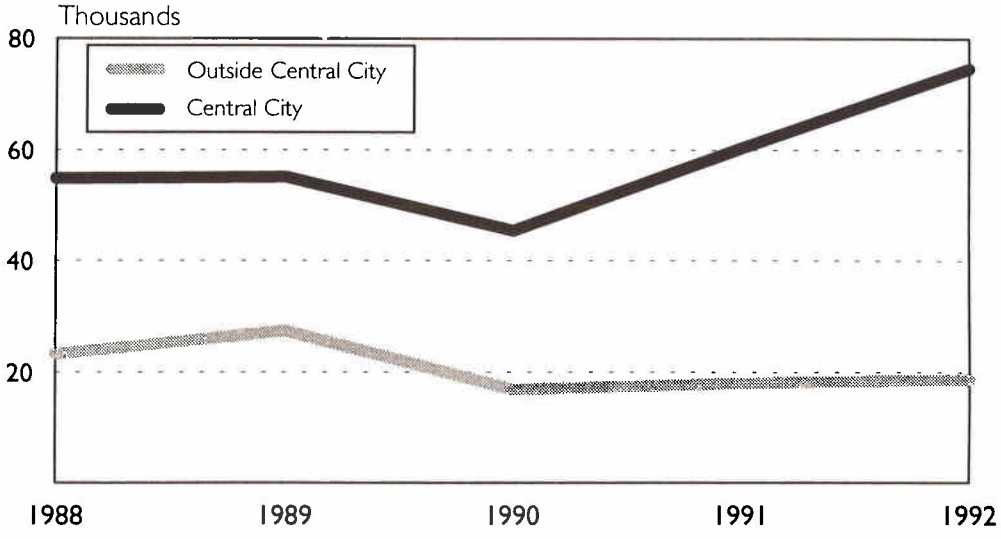
Cocaine Emergency Room Cases by Nature of Use



Source: DAWN.

Chart 8

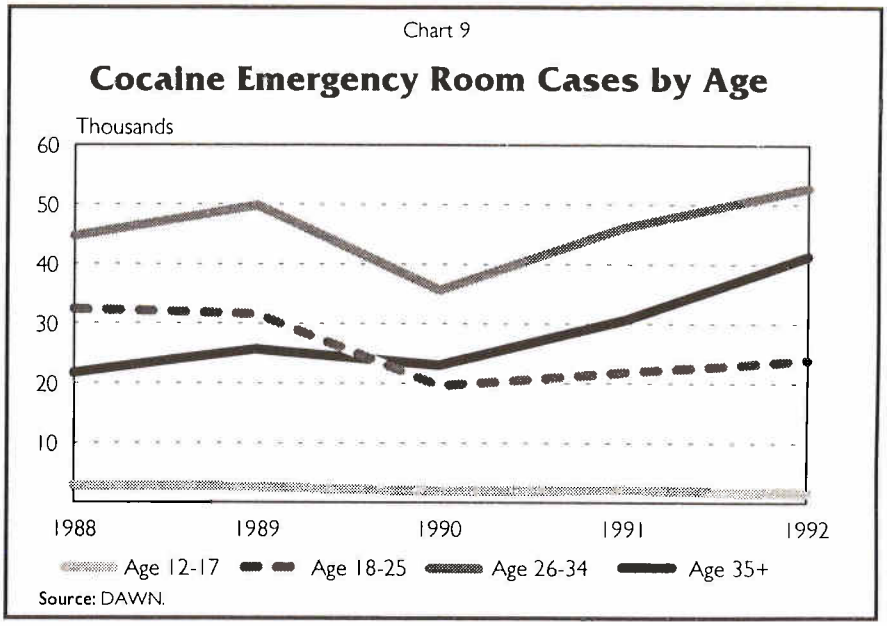
Cocaine Emergency Room Cases by Location



Source: DAWN.

addicted population are difficult to specify precisely, but one useful indicator is the network of hospital emergency rooms that report emergency cases involving drugs. The Drug Abuse Warning Network (DAWN) is managed by the U.S. Department of Health and Human Services. Data from hospitals throughout the nation are compiled on a quarterly basis and annual summaries are made, presenting a statistically representative picture of emergency room cases for the nation as a whole.

Chart 9



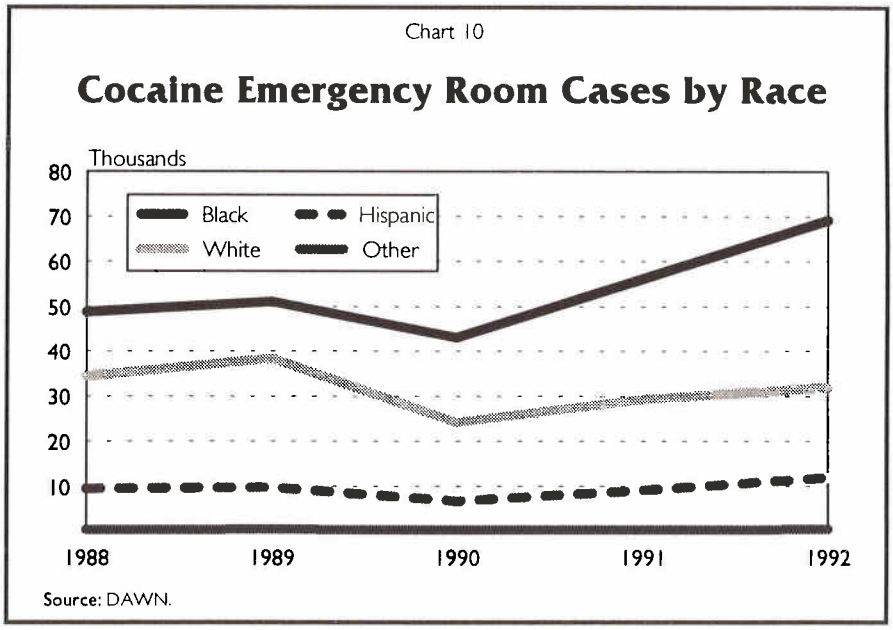
DAWN reports reveal that increasing numbers of emergency room cocaine cases are related to addictive use rather than to recreational use.[27]

These cases are focused increasingly in the nation's central cities (see Chart 8).

The population entering emergency rooms for cocaine-related problems is aging (see Chart 9).

Moreover, the DAWN data reveal that cocaine-related emergency room cases are becoming more and more concentrated among black Americans (see Chart 10).

Chart 10



27 The data cited below are from Office of Applied Studies, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, "Estimates From the Drug Abuse Warning Network: 1992 Estimates of Drug-Related Emergency Room Episodes," Advance Report Number 4, September 1993, p. 45.

Similar demographic trends are reflected in the data on heroin emergency room cases.[28]

Heavy cocaine users also tend to use a variety of other drugs (such as marijuana, heroin, and sedatives) and alcohol.[29] Heavy cocaine and heroin users are predominantly male and unmarried (most have never married), and most commit crimes and are frequently involved in the criminal justice system. They commit crimes, including selling drugs, to get money to purchase drugs; but heavy cocaine users, in particular, also commit crimes as a result of "the effects of the drug itself (they become disinhibited and commit crimes), or because of a life-style choice (they participate in both drug use and criminal activity)."[30]

This heavy user group is the population the Clinton Administration proposes to reduce by a 14 percent increase in federal drug treatment spending and a diminished emphasis on reducing the supply of drugs to which they are addicted. As noted earlier, however, while federal spending on drug treatment increased threefold between FY 1988 and FY 1994, estimated treatment capacity declined; and that capacity, measured in terms of persons served per year, is equivalent to more than half the total estimated number of cocaine and heroin addicts. Since the number of people being treated has changed little, it is reasonable to ask: Why hasn't the system reduced the number of addicts, and how will the Clinton strategy do so?

Most addicts have been through treatment more than once. The harsh fact is that drug addicts like using drugs (even though most of them also dislike some aspects and consequences of their drug use). They sometimes admit themselves to treatment programs, not to stop using drugs, but to regain greater control over their drug use; but the overwhelming majority of addicts entering treatment with the goal of ending their drug use are coerced to do so by the courts, family members, or employers. That is why the liberals who discuss treatment as if it were the opposite of enforcement show a profound ignorance of the reality of drug treatment.[31]

It is also important to understand that some treatment programs simply are not effective, yet are able to remain in business. Sometimes addicts and programs are not matched properly.[32] When the cocaine epidemic started, for instance, there were many unused her-

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28 *Ibid.*, pp. 46-47.

29 Hunt and Rhodes, "Characteristics of Heavy Cocaine Users," p. 7.

30 *Ibid.*, p. 10.

31 The criminal justice system is probably the single greatest cause of addicts entering treatment today. "Drug courts" and so-called diversion programs give less violent addicts a choice of entering and completing treatment or going to jail for an extended period. Former Washington, D.C., mayor Marion Barry may be the best-known example of this practice.

32 In remarks before "The 1993 National Summit on U.S. Drug Policy," May 7, 1993, Dr. Mitchell S. Rosenthal, president of Phoenix House and one of the nation's foremost drug treatment authorities, noted that what he called "disordered drug abusers" (others might call them "hardcore addicts") require long-term, drug-free, residential treatment. This means 18 to 24 months of treatment within a therapeutic community. There are only an estimated 11,000 such slots nationwide, and they cost an estimated $17,000 to $22,000 per year. President Clinton's drug strategy completely ignores this problem and points to the proposed "Health Security Act" as the ultimate solution to the nation's treatment needs (*National Drug Control Strategy*, p. 25). That plan explicitly excludes coverage for such long-term treatment, however, and what coverage it would provide is promised for the year 2001!

oin treatment slots but not enough slots for those needing treatment tailored for cocaine addiction. It is vital that the government insist that programs receiving federal funds demonstrate they are effective and increase service capacity in target areas. But the federal government is a very blunt and rather slow instrument with which to accomplish this. The federally funded portion of the treatment system is estimated to be less than half the total national spending on drug treatment, and federal measures for accountability and targeting must attempt to reach through multiple layers of bureaucracy in the federal government and in state and local governments.

The Administration's goal of increasing the success rate of treatment also is likely to prove too optimistic because a growing proportion of the addict population is older, with a long history of addiction from early adulthood. Many of these so-called "hardcore" addicts are addicted to a variety of drugs and suffer from a range of pathologies, including severe mental disorders. The best treatment programs can offer some hope of recovery; but for a substantial percentage of the most severely addicted, there may be no effective treatment today.

A recent study of heroin addicts highlights this problem in stark terms. Five hundred eighty-one narcotics addicts (most of them heroin addicts) were studied at intervals over 24 years. The group originally entered treatment through a criminal justice program, the California Civil Addict Program, between 1962 and 1964. The 1985-1986 follow-up study found only 25 percent of the group tested free of opiates; another 6.9 percent were in a program of methadone maintenance (receiving the drug methadone to block the "high" resulting from heroin use and thus remove the strongest reason for such use); and 27.7 percent (now in their late 40s) had died—and the mortality rate was accelerating. The researchers warn: "The results suggest that the eventual cessation of narcotics use is a very slow process, unlikely to occur for some addicts, especially if they have not ceased use by their late 30s."[33]

In August of last year, the Clinton Administration's Drug Policy Director, Lee Brown, released a research paper, "Characteristics of Heavy Cocaine Users," which contains a similar, sobering conclusion regarding the success rates of treatment programs for cocaine addicts:

> ... while many users benefit from treatment, compulsive use is most frequently a chronic condition. The Treatment Outcome Prospectives Study (TOPS) showed that for every 10 clients who used cocaine regularly during the year prior to treatment, six clients had returned to heavy use one year after treatment, and eight clients had relapsed into heavy use within three to five years after treatment. These statistics do not accurately reflect the success of treatment outcomes. (The TOPS study is the most recent large-scale study of treatment outcomes. Many smaller scale treatment studies show results with better long-term outcomes.) Nevertheless, the TOPS data suggest that *treated cocaine users are more likely than not to return to drug use.*[34]

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33 Yih-ing Hser, M. Douglas Anglin, and Keiko Powers, "A 24-Year Follow-up of California Narcotics Addicts," *The Archives of General Psychiatry*, Vol. 50 (July 1993), pp. 577-584. Quotation from p. 577.

34 Hunt and Rhodes, "Characteristics of Heavy Cocaine Users." Emphasis added.

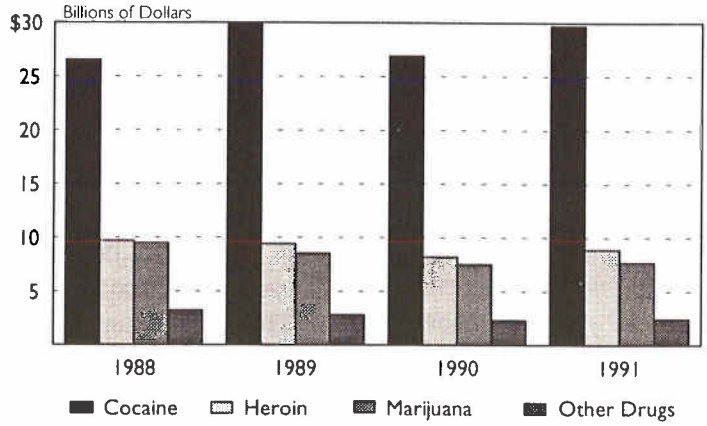
Those who assert today that "treatment is the answer," and those who advocate legalizing drugs and retrieving those who become addicted by expanding drug treatment, never confront the fact that a significant portion of those currently addicted to cocaine and heroin will die of that addiction and that treatment alone cannot save them.

THE SUCCESS OF INTERDICTION

What is increasingly an addict-driven trade today is dominated by cocaine. Three-fifths of the total spent on illegal drugs is spent on cocaine — and today that means crack. The irony is that actual reductions in the population of heavy cocaine users seem to have come not from treatment programs, but from efforts to reduce supply—efforts which President Clinton is now dismantling.

Chart 11

Estimated U.S. Expenditures on Illicit Drugs

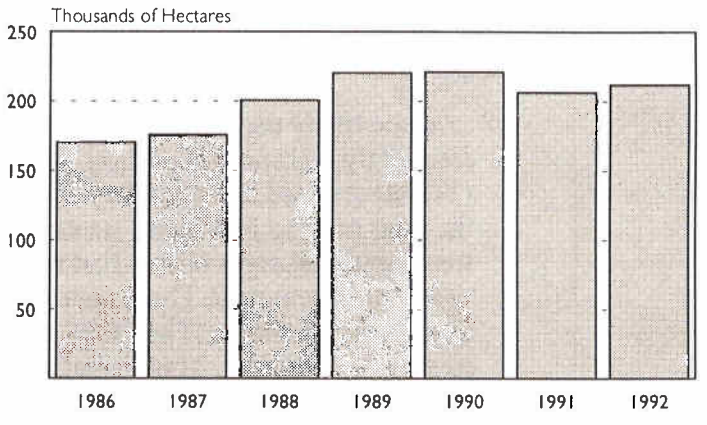


Sources: ONDCP, Abt Associates.

Working from 1989 to 1992 with cocaine source countries (Bolivia, Colombia, and Peru) to reduce coca[35] crops did stop the increase in cultivation that occurred during the 1980s but did not substantially reduce the total crop size.[36]

Chart 12

Total Coca Cultivation



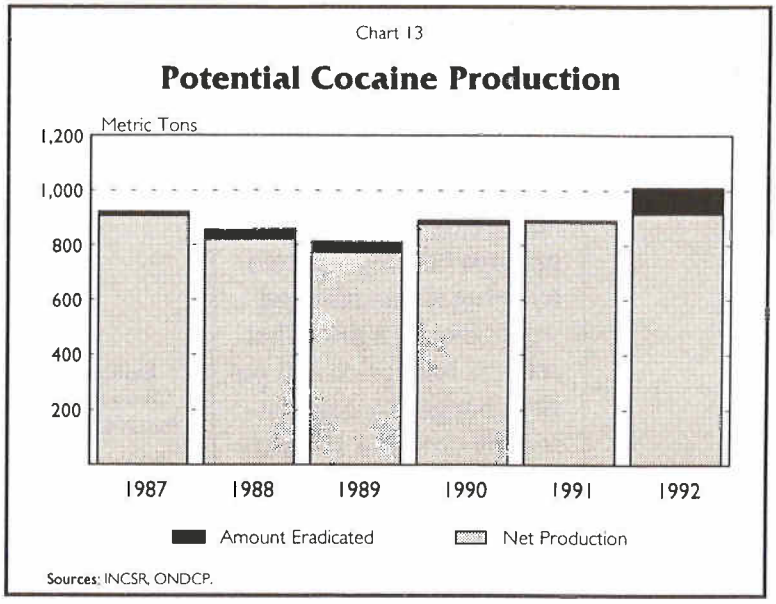
Source: INCSR

Eradication of plants under cultivation had been a principal emphasis of U.S. anti-drug policy in the 1980s, but it produced very poor results. It continued, where feasible, during the Bush Administration, even as interdiction and attacks on traffickers' organizations and infrastructure were made the highest priority. Since 1987, eradication ef-

35 Coca is a bush whose leaves are processed to extract cocaine.

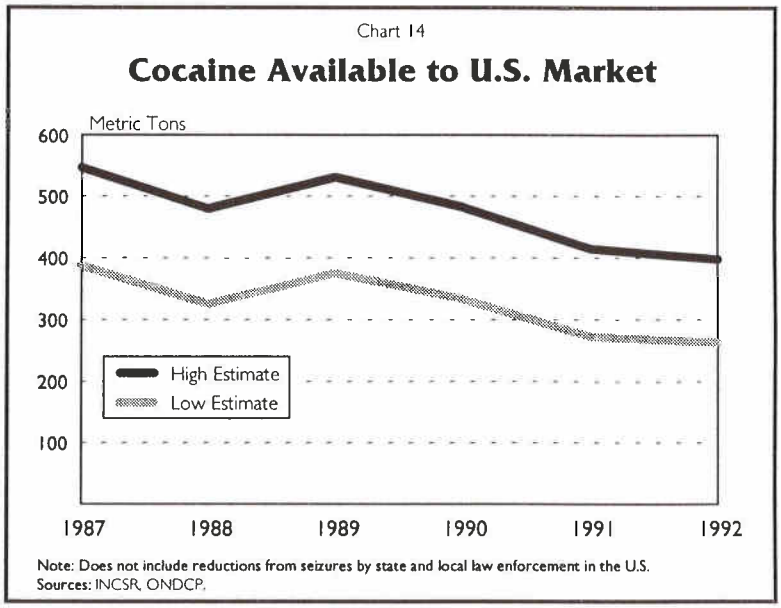
36 U.S. Department of State, *International Narcotics Control Strategy Report (INCSR)*, April 1993, pp. 15 and 16. This chart and the next four charts are based on the INCSR data and on unpublished analyses by the staff of ONDCP's Office of Research undertaken during the Bush Administration.

forts in cocaine source countries have produced a less than 10 percent reduction in estimated potential cocaine production; this reduction came close to 10 percent only in 1992.



While crop eradication has not generally been a success, however, interdiction of cocaine within the source countries and in transit to the U.S. has substantially reduced the potential supply of cocaine that could arrive on American streets.

Thanks to seizures, the amount of the crop that reached the United States declined sharply between 1989 and 1992. In 1992, half or more of potential cocaine production was seized. The biggest area of increased seizures has been in South America, including the Colombian government's war against the drug cartels. Assistance from the United States, particularly military detection and tracking help, supported interdiction throughout the hemisphere and even contributed to forced losses in the face of imminent apprehension by authorities. Interdiction stopped almost twice as much cocaine as was actually consumed. Moreover, efforts to reduce the supply of cocaine seem to have contributed to a reduction in emergency room cases and in the addict population.



Reductions in the supply of cocaine could be expected to lead to an increase in street prices, a decline in purity, or both, or to scarcity if the disruption is large and sudden enough. During the disruption of South American supplies in 1989 and 1991, there were periodic reports by law enforcement agencies that cocaine trafficking groups they had under investigation were experiencing problems securing cocaine or securing it in a timely manner, even at a higher price. These reports could not be rendered as precise empirical data, but the Drug Enforcement Administration does compile data on cocaine prices throughout the nation and reports them on a quarterly and yearly basis. These data reveal that the

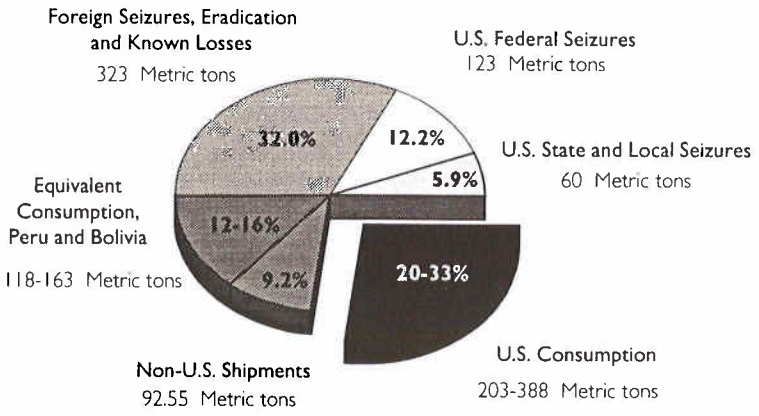
downward trend in prices and upward trend in purity through early 1989 were abruptly reversed.[37]

The magnitude of this change in availability is perhaps best represented by using a standardized price; that is, a price that reflects both price and purity changes by calculating the cost of a 100 percent-pure gram of cocaine at each point of measurement.[38] This reduction in the availability of cocaine —driving the price up and the purity down—coincided with a 27 percent reduction in cocaine emergency room mentions between 1989 and 1990.[39]

Medical examiner reports of deaths related to cocaine use during this period also declined. Analysis initiated by the Drug Czar's office found cocaine price increases, reductions in purity, and declines in cocaine emergency room cases, deaths, and cocaine use among arrestees for all the more than 20 largest U.S. cities for which data are available.[40]

Chart 15

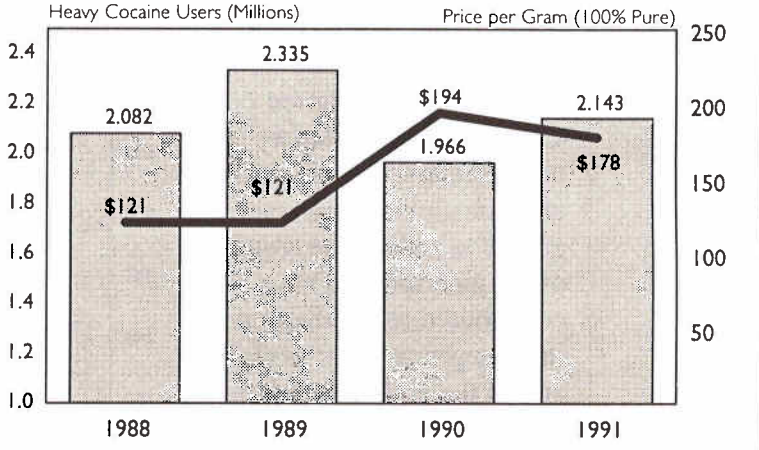
Estimated Distribution of Cocaine Supply: 1992



Note: Chart uses midpoints where estimates employ a range.
Sources: INCSR, EPIC, ONDCP.

Chart 16

Standardized Retail Cocaine Price and Estimated Number of Heavy Cocaine Users



Sources: ONDCP, Abt Associates.

37 Unpublished results of an ONDCP-funded analysis of data from DEA's System to Retrieve Information from Drug Evidence (STRIDE), conducted by Abt Associates, Inc., and presented in an ONDCP briefing, "Domestic Cocaine Situation," January 27, 1993.

38 *Ibid.*

39 Office of Applied Studies, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, "Estimates From the Drug Abuse Warning Network: 1992 Estimates of Drug-Related Emergency Room Episodes," Advance Report Number 4, September 1993, p. 45.

Significantly, as Chart 16 shows, this supply reduction and price change coincides with the decline in the number of heavy cocaine users mentioned earlier.

Several points must be emphasized in interpreting these data. Among them:

Any analysis is limited by the available data. Despite the limitations of the data, the reduction in cocaine availability seems beyond question, and that it was a key causal factor of the decline in cocaine use, particularly heavy use, is the most obvious and reasonable conclusion in light of the data. But this cannot be "proven" with the same degree of certainty that would be the case if the available data were more extensive.

It should be remembered that cocaine price and purity are affected by both supply and demand. The National Household Survey on Drug Abuse indicates that casual or non-addictive use of cocaine was dropping dramatically immediately prior to and during the period of stepped-up interdiction. While non-addictive users consume a much smaller quantity of cocaine than heavy or addicted users, an almost 80 percent drop in non-addictive users between 1985 and 1992 certainly reduced demand in a significant, if limited, extent (which cannot be measured with precision by existing surveys and analyses). In order to increase cocaine retail prices and reduce purity, supply reduction efforts would have to cut supply beyond the amount that would have satisfied the reduced demand.[41]

Do most prominent cocaine traffickers have sufficient market control to manipulate prices by controlling supply? If they do, price and purity reports cannot be used to indicate market disruption directly and may be of no use at all for this purpose. There is no definitive knowledge of the extent of traffickers' ability to manipulate the cocaine market, but the available evidence suggests they are not able to manipulate prices. In smaller transactions and at the wholesale level in particular areas, law enforcement investigators have reported efforts by particular groups to influence prices by withholding supply, but these have been limited in both scope and duration. Moreover, there is no evidence either of large-scale efforts to manipulate availability or of the ability to do so.

The cost of the entire international drug control effort for programs and assistance to foreign countries rose from $209 million in fiscal year 1988 to $660 million in 1992 (its peak). It rose from 4.4 percent to 5.6 percent of the federal drug control budget. Interdiction costs increased between 1988 and 1992, but almost that entire increase involved the estimated cost of Department of Defense (DOD) activities in support of the anti-drug ef-

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40 ONDCP, "Price and Purity of Cocaine: The Relationship to Emergency Room Visits and Deaths, and to Drug Use Among Arrestees," October 1992.

41 The decline in heavy cocaine use in the face of increased price indicates an important difference between casual and addictive use. As long as cocaine is easily obtainable, it seems that casual users not deterred by prevention efforts are unlikely to be deterred by even moderate increases in street prices. This is probably because they are paying so little of their disposable income for the drug that price increases do not affect their ability to obtain it. Many heavy users, on the other hand, are using most of their disposable income to purchase cocaine (especially crack). When the price goes up, they generally have to make due with less. This leads some of them to enter detox and treatment and apparently reduces the rate at which those who continue using suffer the health problems that cause them to appear at emergency rooms.

fort. Even with this increase, interdiction costs as a percentage of the federal drug control budget actually declined between FY 1989 and FY 1992.

Measured strictly by results, national prevention efforts produced outstanding results, especially dramatic declines in casual cocaine use; and contrary to conventional opinion, interdiction and cocaine source country programs seem to have been the crucial cause of the only reductions in heavy or addictive cocaine use.

Why did the reduction in cocaine supply not continue throughout 1991 and beyond? One reason is that beginning in the summer of 1991, the movement of U.S. military resources to the Persian Gulf for Desert Shield and Desert Storm reduced interdiction coverage. Those resources were never returned to previous levels; and although there were plans within the Drug Czar's office to make this a major policy issue for presidential decision in connection with the FY 1994 strategy, the Bush Administration ended before that strategy could be crafted.

A second reason is that pressure on the Colombian traffickers declined. In part this was because a significant portion of police and military forces had to be diverted to providing security for a national election and a constitutional referendum. Later, in 1991, after the surrender of several major traffickers, security forces focused on a manhunt for Pablo Escobar (before his first surrender and after his escape). This is not to say that all pressure on the cocaine trade in Colombia ended in 1991. It did not.

Today, all source country governments are reducing their activities against the cocaine trade, and there is no visible effort by the Clinton Administration to prevent the utter disintegration of the most effective international anti-drug partnership of the last decade. If President Clinton lets that partnership collapse, Americans face the prospect of foreign countries permitting the unchallenged production and shipment of illegal drugs to the United States and elsewhere: In short, uncontrolled supplies of illegal drugs.

WHAT IT WILL TAKE TO FIGHT A REAL DRUG WAR TODAY

President Clinton's effective abandonment of the drug war creates a formidable obstacle to building on what has been achieved in the anti-drug effort and to dealing with the remaining problem. Unfortunately, there seems very little likelihood that the federal government will offer the leadership and support that existed in the last two administrations.

If the federal government were serious about finishing the drug war, it would undertake several measures. Among them:

✔ Reassert presidential leadership.

Applying direct presidential leadership is crucial for the renewal of prevention efforts, especially to discourage drug use among young Americans.

✔ **Focus anti-drug spending at the state and local level.**

Congress should combine existing federal anti-drug support to states and localities, which will total over $3.5 billion for FY 1994,[42] into a single anti-drug block grant that communities can use for their own anti-drug priorities, from prevention programs to prison construction, from treatment programs to security enhancements in schools and public housing.[43]

✔ **Use the military.**

To step up interdiction efforts, the federal government must replace the forces that were diverted during the Gulf War. This means putting the U.S. military back in charge of stopping the flow of illegal drugs from abroad and requiring federal law enforcement agencies responsible for drug interdiction to operate under the overall command and control of the military.

✔ **Get tough with drug-exporting countries.**

The United States must insist that cocaine-source countries reduce their net production of drugs by at least 10 percent per year, and by at least 50 percent in five years, or face a loss of aid and the imposition of trade and diplomatic sanctions.

✔ **Combat criminal networks.**

The Attorney General should prepare a report within six months identifying all major drug trafficking organizations known to be operating in the United States. The Justice Department also should develop a plan to deploy federal enforcement personnel to dismantle these organizations within 18 months,[44] and such strategic planning should be required on a regular basis thereafter.

✔ **Target drug dealers.**

The Administration should launch a nationwide advertising campaign highlighting the existing federal mandatory minimum sentences for such offenses as selling drugs within 1,000 feet of a school, involving a minor in drug selling, possession of drugs with intent to distribute, possession of a firearm while involved in drug sales, and committing acts of violence in connection with drug trafficking. These laws are a powerful deterrent, and the wider the knowledge of them, the more powerful their deterrent effect.

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42 Approximately $599 million in the Department of Education, over $1.8 billion in the Department of Health and Human Services, and over $1.1 billion in enforcement and demand-reduction program funding in a variety of other programs.

43 The new program could avoid feeding government bureaucracies by forbidding the use of any funds for administrative purposes and requiring that at least half of all non-law-enforcement expenditures be spent on activities operated by private sector organizations, fully open to religiously affiliated groups (many of which have outstanding programs for young people and the rehabilitation of addicts).

44 Attorney General Richard Thornburgh prepared such a report (*Drug Trafficking: A Report to the President of the United States*, August 3, 1989), but it was not turned into a battle plan for federal drug enforcement.

Of course, it is probably unrealistic to expect President Clinton or the current Attorney General to support any of these initiatives, but it is also irresponsible to take the position that nothing can be done as long as the Clinton Administration turns its back on the drug problem. Citizens and local governments throughout the nation can take decisive steps to reduce today's drug problem dramatically.

✔ Renew efforts to prevent drug use by young people.

Drug prevention must be the cornerstone of all anti-drug efforts. With the decline in use by teenagers, general recognition of the importance of effective prevention measures has diminished. Last year's increase in teenage use is a reminder that each generation must be taught that illegal drug use is wrong and harmful. This lesson must be taught by all institutions in the community.

Educators sometimes complain that they lack tested and proven anti-drug curricula that will discourage young people from using drugs when they are exposed to them, but depending on formal lessons and a curriculum misses the point. Children learn about drug use from what the adults around them say and do. Parents teach by example and by what they consistently and seriously portray as right and wrong. The same is true of schools and the communities in which children are raised. If drug use and sale are not seen as aggressively opposed and prevented, children learn they are acceptable despite what some adults may tell them occasionally as a formal lesson.

Teaching drug prevention must be a part of the basic task of teaching children right from wrong. It will always fall mainly to parents to provide that education in the home and to act to ensure that schools and their communities are teaching the same lesson effectively. This is made much easier if national leaders and other adults in positions of responsibility set the right example and speak visibly in support of parents. Since that national support has largely evaporated, parents, churches, schools, youth organizations, and communities are even more crucial as teachers of drug prevention.

✔ End the *de facto* legalization of drugs in American cities by closing open-air drug markets.

Open-air drug markets feed addiction and are a visible sign of the toleration of the drug trade in every major city in this country. It is time to end this national disgrace. Reuben M. Greenberg, the chief of police of Charleston, South Carolina, has explained how drug markets can be closed with aggressive, committed leadership and within the current resources of most local law enforcement agencies.[45] He has demonstrated that the view that drug pushers cannot be driven from city streets without prohibitive costs is simply false. Drug pushers cannot operate effectively when law enforcement personnel are present, and forcing drug deals from open spaces makes them more difficult, dangerous, and less numerous. The Charleston example and others like

45 Reuben M. Greenberg, "Less Bang-Bang for the Buck: A Market Approach to Crime Control," *Policy Review*, Winter 1992, pp. 56-60.

it on a smaller scale conducted by neighborhood patrols in communities throughout the nation point to what can be achieved. Creating the necessary presence and maintaining it in response to relocation efforts by drug dealers is doable if closing drug markets is made a priority. Chief Greenberg did not use massive arrests, and he did not violate civil liberties. What he did do is get pushers off the streets of his community, free poor neighborhoods from criminal siege, and restore a climate that promoted economic renewal.

This approach should be repeated in every city. Mayors, city councils, and police chiefs should pledge to close all open-air drug markets in their communities within one year. Citizens should demand such a pledge and make clear that they intend to insist that those officials who do not keep it are removed from office. It is time to stop claiming that the crime and drug problem in communities can be fixed only by the federal government. Decisive action can and must be taken by local officials and community members.

✔ Use drug testing in treatment programs.

Drug testing is a proven tool to discourage drug use by individuals in treatment and those in the criminal justice system. Good treatment programs require testing regularly and apply sanctions against individuals who are caught returning to drug use. Testing arrestees provides a basis for using bail, sentencing, release conditions, and other aspects of the criminal justice system to compel individuals to stop using drugs. Including an extended period of regular testing after convicted drug-using offenders complete their sentences discourages a return to drug use and crime.

Positive drug tests must involve steadily escalating penalties (starting with a one or two-day return to jail or a half-way house and moving to reincarceration for an extended period). Most heavy drug users pass through the criminal justice system, and any short-term costs of creating temporary detention facilities for the enforcement of a drug testing program will save larger costs to the community in repeated criminal justice expenditures on the same individuals and the damage their crimes do to the innocent.

✔ Challenge the local media.

The news media brought home to Americans the dangers of illegal drugs in the latter part of the 1980s. They also provided hundreds of millions of dollars in public service messages designed to discourage drug use. The local media can play a crucial part in helping communities do what needs to be done today.

Local media should bring public attention to bear on open-air drug markets. Journalists should help their communities better understand the elements of effective drug prevention programs for young people, where such efforts are being done well, and where they are being done poorly in their cities and towns. Is teenage drug use going up or down? How are the drugs that threaten children entering the community and what can be done to stop them? How can parents get reliable drug prevention information for their children? Which programs have a proven record of success and which are wasting resources? Where can people go to get help?

Many communities have created partnerships between the media and police to publicize wanted criminals and receive tips from citizens that help in their apprehension. These partnerships should be expanded to deal more effectively with drug use. Investigative reports are needed on the major groups or gangs supporting the local drug trade, including the identities of gang members. Such action in the media can stimulate vital community support for effective enforcement. Reporting also is vital in providing citizens with the information they need to hold their local officials accountable for curtailing the drug trade in their communities.

CONCLUSION

The Clinton Administration has turned its back on the drug problem and taken actions that have undermined achievements in prevention, interdiction, and enforcement. The Administration's promise to reduce drug addiction utterly fails to address the problems in the drug treatment bureaucracy that have brought fewer and fewer results despite more and more spending. If America is to prevent a return to the levels of drug use of years past, local communities must take the necessary steps to drive the drug problem from their neighborhoods: make sure children are taught by word and example that drug use is wrong and harmful; close open-air drug markets; and make drug testing a cornerstone of drug treatment and of sanctions on drug users entering the criminal justice system. In addition, local media should systematically, and regularly, report on the state of the local drug war, informing citizens on what needs to be done—and how—to overcome drug use and drug trafficking. Only by taking such decisive actions will America successfully finish the war against drugs.

Prepared for The Heritage Foundation
By John P. Walters

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