Drug Use, Consequences and Social Policies

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During the twentieth century, the United States has experienced an enormous amount of social policy in the area of substance abuse. Although some would argue that both ideologies and policies have fluctuated significantly over time (e.g., from the punitive law enforcement policies during World War II to the more public health approach of the Kennedy administration), the more punitive approach has clearly dominated. It currently characterizes today's policies and promises to do so in the near future (Office of National Drug Control Policy IONDCP 1998). Coined more than a decade ago, "war on drugs" policies have defined U.S. drug control for at least 70 years of this past century: the early 1900s through 1950s, 1980 through 1999. Today, both Republicans and Democrats typically embrace the punitive approach. Challenges come instead from the academic, medical, and philanthropic communities. These communities push for a more humane approach that favors prevention, treatment, decriminalization, and alternative sentencing. Below are reviewed some of the costs and consequences of drug abuse and the impact of drug-related social policies on society and the individual. Also discussed are other social policies having relevance to the problem (e.g., welfare reform).

SOCIAL AND ECONOMIC COSTS OF DRUG ABUSE

Most people know that illicit drug abuse contributes to crime in our society. Fewer, however, know that drug abuse also creates considerable public health and medical problems as well, including tuberculosis, hepatitis, endocarditis, overdose, and HIV to name a few. Among other illnesses, alcohol dependence often results in liver and pancreatic disorders, immune system impairment, and fetal alcohol syndrome. These health-related problems pose ominous threats to our health care system. Therefore, drug abuse and alcoholism are a major drain on our criminal justice, health care, and social welfare systems.

Although we may never be able to fully ascertain the exact social and economic costs of drug abuse and alcoholism on individuals and our society, estimates have been offered that reveal a grim reality and rocky road for the twenty-first century. In one of the most comprehensive reports, the National Institute on Drug Abuse (NIDA) and National Institute on Alcohol Abuse and Alcoholism (NIAAA 1992) calculated that alcohol and drug abuse cost approximately $246 billion in 1992 (alcohol $148 billion and drug abuse $98 billion). Some of these costs include $18.8 billion for health care services, $10 billion for specialized services for drug and alcohol treatment, and $18.7 billion for health problems attributed to alcohol and drug abuse. More than 132,000 persons died as a consequence of alcohol and drug problems in 1992. Of these deaths, 107,400 were related to alcohol abuse and 25500 to drug abuse. NIDA and NIAAA (1992) estimated $82 billion in lost work potential and productivity to alcohol and drug abuse in 1992 ($67.7 billion and $14.2 billion, respectively).

Among the working-age population, an estimated 4.6 million persons met the criteria of drug dependence, while 24.5 million did so for alcohol dependence. The Lewin Group (1997) found that
the combination of drug and alcohol disorders were negatively associated with employment opportunities and wages for males and females. Alcohol seemed to have a bigger impact than drugs. Alcohol dependence decreased the likelihood of full-time work and educational accomplishment, while drug dependence showed insignificant results. Finally, the Lewin Group figured costs related to crimes involving illicit drug abuse were about $59.1 billion, while those for alcohol abuse were estimated at $519.7 billion. More discussion on crime and drug use consequences is offered below.

Clearly the scope of these drug-related problems demand priority for U.S. domestic and foreign policy. We know today that the consequences of drug abuse and alcoholism spill over into many areas of life and that no individual is exempt from them. A crucial question for our society, therefore, is whether existing and future-oriented drug control policies will succeed in reducing these consequences or, if in attempting to do so, they exacerbate them or generate new ones. The paragraphs below review information regarding this quandary.

WAR ON DRUGS POLICIES

Our government’s chosen approach to deal with the “drug problem” is to adopt a punitive policy orientation that levies heavy criminal sanctions against drug users, abusers, and drug sellers. The approach is called the war on drugs and currently has a general in the U.S Army—General Barry McCaffery—as its leader. The hope is that tough punishment will outweigh the benefits associated with the drug trade and that people will rationally chose not to use or sell drugs.

Using this ideology, the ONDCP (1998) has formulated five major goals for drug control policy for the years 1998 to 2008 and will allocate close to $20 billion a year to achieve them. For fiscal year 1999, Congress appropriated $17.8 billion to meet its war on drugs goal. A breakdown of the fiscal year 1999 by budget reveals the following: (1) educate and enable youth to refuse illegal drugs, alcohol, and tobacco - $2 billion, (2) increase public safety by reducing drug related crime and violence - $7.5 billion, (3) reduce the health and social cost of illegal drug use - $3.4 billion, (4) preserve US soil from the drug threat - $2.68 billion, and (5) disrupt foreign and domestic sources of drug supply - $2.28 billion. One can quickly see that three (goals two, four, and five) of the five goals, and about $12.5 billion (or 70 percent) of the budget, are punitive law enforcement objectives offered to control drug supplies and those involved in it.

Further evidence of the punitive trend in drug policy can be found when breaking the budget out by function and department. Fiscal year monies for 1999 will go to the following functions: (1) the criminal justice system-$8.5 billion, (2) treatment programs-$3 billion, (3) prevention-$2.2 billion, (4) international programs-$796 million, (5) interdiction-$2.4 billion, (6) research-$797 million, and (7) intelligence-$270 million. The criminal justice function’s budget is 2.8 times higher than the treatment budget and 3.9 times higher than the prevention budget.

In fiscal year 1999, the Department of Defense will receive $937 million to combat drug use and abuse. There is no further breakdown provided to the public regarding how that money will be spent. The Department of Health and Human Services will receive $2.9 billion. About $1.5 billion will go to the Substance abuse and Mental Health Services Agency for drug treatment and related activities, $143 million to the Centers for Disease Control (CDC), $56.5 million to children and families, and $400 million for health care financing. The Department of justice gets the biggest pot of money for fiscal year 1999-$7.7 billion. The largest portion will go to the Bureau of Prisons-$2 billion. For most law-enforcement-related programs, Congress appropriated significantly more money than the President requested. The Department of Defense, the Drug Enforcement Administration, the Bureau of International Narcotics and Law Enforcement, Customs, and the Coast Guard were such beneficiaries.

There currently are no plans for these budget proportions to fluctuate dramatically during the first part of the twenty-first century. They clearly show our government’s current and future investment in punitive war on drugs policies. However, the scope of this punitive ideology extends well beyond these goals and finances. It also reaches into civil and criminal laws and rights, including constitutional protections.

Today, there are approximately 100 separate federal mandatory minimum provisions located in 60 different criminal statutes. Most of these were codified during the Reagan-Bush years when the war on drugs rose to prominence. Four statutes for drug and weapons offenses account for nearly 94 percent of all mandatory minimum cases (U.S. Sentencing Commission 1995). Sentences are unequal and racially biased. Current sentencing policy contains a 100-to-1 ratio between crack and cocaine sanctions. Established by Congress, crack mandatory minimums stipulate that simple possession
receives five years incarceration, whereas simple possession of any other drug, including powder cocaine, gets one year.

**IMPACT OF WAR DRUG POLICIES**

Bertram, Blachman, Sharpe, and Andreas (1996) have carefully argued that the war on drugs damages the United States and its citizens in three main ways. First, it exacerbates crime and health problems. Consider recent legislation on pregnant women who use drugs. New war on drugs policies require physicians to test for illicit drugs and report positive patients to law enforcement. Arrest and incarceration are possible outcomes. Consequently, many pregnant drug users are often reluctant to get prenatal care.

Second, war on drugs policies tend to increase race and class inequality. Although Whites make up the majority of illicit drugs users and are more likely to be dealers, Blacks were four times more likely to be arrested on drug charges than Whites in 1991 (U.S. Sentencing Commission 1992). Blacks are the minority of drug users and sellers, yet they constitute the majority of those arrested, convicted, and harshly sentenced for drug-related offenses. According to the U. S. Sentencing Commission (1992), one-half of the federal court districts that handled crack cases in 1992 prosecuted only minorities.

Third, legislation and policies of the war on drugs often undermine democracy, particularly the Fourth (e.g., drug testing) and Eighth Amendments (e.g., harsh sentencing policies). These policies also challenge various civil rights such as voting, ownership (asset forfeiture), residence rights (eviction programs for drug-using tenants), and receipt of state welfare payments (i.e., denial or termination of benefits for drug offenders).

**HIV AND AIDS**

Researchers have observed that during this current and second wave of HIV in the United States, intravenous drug use has become a main route of transmission. The Centers for Disease Control reported nearly nine years ago that intravenous drug users accounted for 21 percent of all AIDS cases. By 1997, 24 percent of men with AIDS were intravenous drug users, while 47 percent of women with AIDS used intravenous drugs (CDC 1997). Because possession of syringes is illegal in many states, transmission rates remain high. Although needle exchange programs have shown great success in reducing HIV transmission, widespread implementation is controversial and at odds with war on drugs policies.

Given the rapid escalation of drug offender sanctioning, HIV in prisons has become an increasingly important topic for policy makers as we start the twenty-first century. Between 1991 and 1995, the number of HIV positive (38 percent) inmates grew at approximately the same rate as the overall prison population (36 percent). Approximately, 2.3 percent of state and federal prison inmates were HIV positive in 1995, with females reporting a higher rate than males: 4 percent to 2.3 percent. In state prisons, 21 percent of HIV prison inmates had AIDS, and 16 percent in federal prison. In 1995, 1,010 state inmates died of AIDS related causes, up from 955 in 1994 (Bureau of Justice Statistics [BJS] 1995). Only 60 percent of inmates surveyed in local jails reported ever being tested for HIV. This suggests the published rates could be significantly higher, especially since such a large percentage of federal, state, and local inmates are convicted drug offenders. The costs associated with addressing HIV in prison are prohibitive.

Adoption of needle exchange programs has the potential to significantly reduce the spread of HIV and the costs associated with treating HIV positive individuals. For instance, a University of California team of researchers estimates that it costs about $119,000 to treat a person with HIV over his or her lifetime. But a clean needle program would only average between $1,000 and $12,000 for each HIV infection averted over a five year period (DCRNet 1999).

**INCARCERATION AND DEPENDENCY**

According to the BJS (1999), 1.1 million men and women were incarcerated in state and federal prisons in 1996, while another 510,400 were serving time in our nation’s jails. Between 1986 and 1996, the correctional population grew an average of 8.4 percent per year. For the third year in a row, drug offenders surpassed property, public-order, and violent
offenders for entry into state prisons. All indicators at the federal, state, and local levels show that drug offenders compose the majority of our correctional population.

The increased incarceration of fathers and, especially, mothers for drug offenses has generated a new danger for future generations of U.S. citizens. A recent study has revealed that there are approximately 1.5 million children of prisoners and at least 3.5 million children of offenders on probation or parole (Gabel and Johnston 1995). Typically, care for these children is assumed by maternal grandmothers with little or no state assistance. Incarceration of parents produces many troubling consequences for children such as an increased threat of poverty, emotional, psychological, and behavioral disorders, developmental delays, disrupted family bonding, shame and stigma, and distrust and hatred of law enforcement (Gabel and Johnston 1995). Furthermore, children of incarcerated parents are at a much greater risk of ending up in the criminal justice system themselves (Barnhill and Dressel 1991).

EMPLOYMENT

In 1986, President Reagan enacted Executive Order No. 12564, which made it a condition of employment for all federal employees to refrain from using drugs. This order required every federal agency to develop a comprehensive drug-free workplace program. Commonly referred to as the Drug Free Workplace Act of 1986, it required random testing of contract workers where public safety and national security were concerned. Surveys of Fortune 500 companies have found that from the mid-1980s to 1991 companies' drug testing increased from 18 percent to 40 percent (Shepard and Clifton 1998). According to the American Civil Liberties Union (ACLU 1999), drug testing is up 277 percent from 1987. In 1992, an estimated 22 million tests were administered to people at their place of employment, with a 5 percent (1.1 million) false positive rate. Shepard and Clifton (1998) recently made a compelling case that drug testing actually reduces workplace productivity rather than increasing it. Drug tests are estimated to cost $1 billion annually or 20 million tests at $50 per test. College students are not exempt from war on drugs policies either. The Higher Education Act of 1998 denies or delays eligibility for federal financial aid for any student convicted of a drug offense, no matter how minor (DCRNet 1999).

OTHER DRUG RELATED SOCIAL POLICIES

The federal Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) programs are administered by the Social Security Administration. These programs provide cash benefits and Medicaid eligibility to those deemed disabled. Drug addiction and alcoholism (DA&A) had been considered a form of mental disorder entitling an afflicted person to SSI or SSDI benefits since the inception of these programs in the 1970s. As a result of Congressional legislation (i.e., the Contract with America Advancement Act of 1996), effective December 31, 1996, the DA&A disability ceased to exist. This social policy change affected over 209,000 people nationwide (Gresenz, Watkins, and Podus 1998). Congress predicted that about 75 percent of all DA&A recipients would retain benefits for redetermination with another disability. However, the Lewin Group (199,) has preliminarily stated that about 64 percent have lost all benefits.

The loss of SSI/SSDI DA&A benefits may affect recipients' ability or desire to access substance abuse treatment or other medical services, as well as their housing situations, nutritional status, criminality, and so on. Additional impacts might be expected on these persons' families and communities. The full impact of this policy change will soon be available for study; however, preliminary reports suggest worsening health, housing, and crime problems since termination of the disability program (Gresenz et al. 1998: Lewin Group 1997).

CONCLUSION

The paragraphs above have discussed the dilemma our nation faces concerning the use and abuse of drugs and alcohol. It is clear to many that current policies are very expensive and largely ineffective in solving the drug problem. The leading indicators of drug use and abuse show small fluctuations in youth drug use since the 1980s war on drugs, with some decline in the early part of the 1990s but escalation by the decade's end. Adult drug abuse has remained relatively constant, with a small dip in crack cocaine use and abuse in the late 1990s (ONDCP 1998). It is, perhaps, time to
consider an alternative approach that would not only address the incidence of drug use and abuse directly, but also the parallel health, medical, and social consequences it wreaks on individuals and our society. Perhaps those who endorse such an alternative, harm-reduction approach will elevate their efforts in challenging extant political ideology and action in the twenty-first century. And, it is hoped, political parties will listen and act accordingly.

REFERENCES


