

America's drug policy: time for another commission?

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The author was associate director of the National Commission on Marijuana and Drug Abuse (1971-73) and principal author of the two commission reports. He participated in national drug policy making thereafter as consultant to the Special Action Office for Drug Abuse Prevention in the White House (1973-75), special assistant to the attorney general (1975-76), and member and secretary of the National Advisory Council on Drug Abuse (1975-80). These activities spanned three presidential administrations from both political parties.

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I.

The time has come for establishing a national commission to examine the causes of the demand for drugs in the United States and to assess the efficacy of the nation's current policies for reducing this demand. I am a veteran of a national commission on this same subject, established by the Congress some 20 years ago. Chaired by former Governor Raymond P. Shafer of Pennsylvania, the National Commission on Marijuana and Drug Abuse was established in 1970 with a bifurcated statutory mandate—first to study marijuana and then to examine broader issues relating to the causes and consequences of drug use. The commission's report on marijuana, entitled *Marihuana: A Signal of Misunderstanding*,¹ was issued in March 1972, and its final report, entitled *Drug Use in America: Problem in Perspective*,² was issued a year later.

At the time the Shafer Commission was established, the nation was fighting two wars: one against the Vietcong in Southeast Asia and another against illicit drugs at home. It often seemed that the two wars were related because of the salient links between illicit drug use and antiwar protests, and the Nixon administration's interest in suppressing both. Not surprisingly, for the first time in the history of U.S. drug policy, the nation's response to illicit drug use was being directed from the White House.

Public discourse about the nation's drug policy had become very discordant. On the one hand, the war against drugs was high on the Nixon administration's agenda of domestic political issues. Critics of the administration's initiatives were said to be soft on crime and soft on drugs. In response, the administration's opponents charged that illicit drug use continued to escalate, notwithstanding increased expenditures on law enforcement and rising numbers of seizures and arrests, and they urged increased spending for prevention and treatment—what we now call the “demand side.” The critics pointed to

the high human costs of prevailing policy and claimed that it was time to focus on the underlying causes of the problem rather than on its symptoms.

The debate became increasingly polarized. Defenders of the administration's policy argued that a law enforcement approach would work if only it were given a fair test, such as by prescribing harsher criminal penalties for drug traffickers, including death. At the same time, others were arguing for radical changes in course, including outright legalization.

In retrospect, I think the Congress established the Shafer Commission because it recognized that American society was confronting a fundamentally new phenomenon that was unlikely to be responsive to the measures in place since 1914, when the first federal antinarcotic legislation was enacted. I think the Congress also concluded that when public discourse has become so polarized and the prevailing approach has become so controversial, it is time for a careful review of the current strategy, even if such a review is not expected to produce a fundamental change in course.

I am not an unbiased witness about the Shafer Commission's work. I believe the commission provided the type of sober assessment of current policy that Congress envisioned. Before summarizing several key features of the commission's reports and commenting on the continued relevance of some of its recommendations, I want to emphasize the obvious parallels between the situation that existed in 1971 and the situation that exists today, 21 years later. Echoes of the 1971 public debate can clearly be heard in current public discourse. Critics assail prevailing national policy because it is too repressive, because it ignores the demand side in favor of the supply side, because it does more harm than good, and because it neglects the underlying causes of the problem. In August 1991, at the annual meeting of the American Bar Association, the administration's war on drugs was assailed in one panel as a "war on the Constitution" and in another as

a "war on minorities." We hear the same proposals for radical changes in policy, ranging from the death penalty for drug sellers to legalization of all drugs.

The time has come again for an independent, nonpartisan assessment of our current strategies. I say this not as a critic of the prevailing approach, though in some respects I am, but rather as a proponent of prudent policy development. Periodic review of "the way things are" is a sound strategy in government, just as it is in industry and in academic life. The intensity of the current debate is reason enough to consider establishing a commission. However, I think much more can be said, in concrete terms, about the things that we need to know in order to resolve the ongoing controversies about our nation's drug policy. Much has been learned in the last 21 years. But much has also been forgotten, or perhaps even ignored, in the years since the Shafer Commission produced its two reports.

II.

In my opinion, the Shafer Commission's primary contribution lies in its ideas about how we should think about nonmedical use of drugs. Most importantly, the commission emphasized that America's drug problem is not one problem but many problems, encompassing licit as well as illicit substances. The commission suggested a typology of drug-using behavior that has become more or less a standard in the field—ranging from experimental use through compulsive use.³ Only by disaggregating the problem, the commission found, is it possible to isolate pertinent causal influences and to design sensible intervention strategies.

For example, patterns of adolescent experimentation tend to be particularly responsive to the ebb and flow of prevailing cross-currents in the culture, which shape adolescent behavior in general. Twenty-one years ago, the upsurge in experi-

mental drug use was very much associated with political disaffection and dissident behavior largely related to the war in Vietnam. In contrast, the recent decline in experimentation seems related to the emergence of health consciousness in the adolescent population; this trend is related to the AIDS epidemic and is reflected in changing attitudes toward cigarette smoking, a behavior that has long been a precursor to illicit drug use.

Lying beneath these evanescent influences on adolescent experimentation are the factors that determine whether experimentation ceases or persists and, if it does persist, whether it escalates into what the commission called "intensified" and "compulsive" use patterns. These use patterns tend to be more deeply rooted in either social pathology or psychopathology. Obviously, a differentiated understanding of the factors that predict escalated-use patterns will suggest different strategies of preventive intervention among adolescents and young adults. And the different levels of risk among different target populations should also help us set our priorities for allocating resources. Further differentiation is required, of course, among repetitive users, who vary widely in their ability to control their drug use and avoid dysfunctional consequences.

Improved understanding of the diverse correlates of, and influences on, various patterns of drug-using behavior do not, of course, tell us what to do about them. But this effort to disaggregate the problem does help policy makers identify factors that might be most amenable to (or resistant to) particular strategies of intervention. Most importantly, of course, it helps us to set priorities when choices need to be made.

The Schafer Commission also developed a road map for formulating a coherent social response to drug use in a modern society. Its plan was predicated on a model of risk management. The key idea was that drug use is, to some extent,

endemic in contemporary society and that a sensible social policy would be a stable and integrated one rather than one constantly being reshaped by transient political forces. A good analogy for what the commission had in mind is the modern approach to highway safety. In this context, an entire range of risk-reduction strategies has been used, including road engineering, vehicle engineering, and interventions targeted at what injury control specialists call the "human factor," including increases in the minimum drinking age.

By curtailing the supply of illicit drugs and counteracting social and psychological factors associated with experimentation, we can aim to reduce the exposed population. By targeting other interventions on high-risk populations, we can aim to reduce the intensity of consumption and its adverse consequences. This is not a battle plan for war, but rather a blueprint for containment. In public health, the most apt analogy is not polio, but heart disease. An important corollary of this way of thinking about drug policy is reliance on cost-benefit assessments. In the commission's view, one of the main shortcomings of American drug policy was a failure to take the costs of repressive measures into account.

In sum, the Shafer Commission presented a series of ideas designed to shape the way we think about drug-control policy: disaggregate the problem, use highway safety rather than a military mission as the model for policy making, and assess the utility of all interventions within a cost-benefit framework. Against this backdrop, the commission made a variety of specific recommendations concerning federal strategy in the 1970s. I will mention five key proposals.

First, the commission proposed a balanced and coordinated use of what we now call supply-side and demand-side strategies. The commission even went so far as to recommend that they be managed by the same governmental agency. The merger of demand-side and supply-side activities under one administrative structure was never a realistic proposal. But

better coordination of demand-side activities, particularly at the state and local levels, was essential, in the commission's view, because sound management requires stability for long-term planning and the flexibility to respond immediately to changing conditions.

Second, the commission recommended the development of sophisticated information systems to monitor patterns of drug-using behavior, including changes in incidence and prevalence. The commission itself funded the first national surveys of drug use among the general population and helped inspire the high school student surveys that have been conducted by the University of Michigan. The commission also worked with the relevant federal agencies to conceptualize the appropriate methodologies for what became the DAWN system (the Drug Abuse Warning Network).⁴

Third, the commission strongly endorsed the voluntary-treatment strategy codified by Congress in the Drug Abuse Office and Treatment Act of 1972. This was a major shift in strategy—away from coercion and toward the creation of incentives for voluntary treatment. One important corollary of this approach was a cloak of confidentiality. Another was the need to establish a stable treatment capacity that would be available to respond to changing needs in the community and also would be available to implement developing treatment technologies as they came on line. (Another corollary, and perhaps the most controversial aspect of the commission's approach, was that criminal sanctions should be deployed against drug users mainly for therapeutic leverage, and not as means of punishment.)

Fourth, the commission wanted to harness the process of policy making to a developing knowledge base. One of the first actions that the commission undertook was to recommend a moratorium on drug education programs; none of the existing approaches had been evaluated, and the commission was seriously concerned that they were doing more harm than good.

The commission envisioned that a single action-oriented agency would be able to sponsor a directed research program to provide an ongoing basis for sensible policy development and implementation. (Basic research, on the other hand, must be insulated from direct programmatic control so that it can remain responsive primarily to scientific considerations.)

Fifth, the commission recommended that alcohol and tobacco be brought within the range of vision of drug abuse policy, not only because of the astounding social costs of these problems, but also because of the ways in which improved understanding of these behaviors can contribute to our understanding of the use of illicit substances.

III.

The Shafer Commission issued its final report in 1973. It is not uncommon for a commission of this nature to be forgotten almost immediately after its report has been issued. Commission reports seem to be taken less seriously as prescriptions for policy than as period pieces for political and social historians or as targets for revisionist commissions. I'm reminded in this connection of the Commission on Obscenity and Pornography,⁵ whose 1970 report was largely ignored until Ed Meese appointed his own commission⁶ to take another (more conservative) look at the problem.

Contrary to customary experience, however, the Shafer Commission's two reports had an immediate impact on national policy. During the Nixon, Ford and Carter administrations many of the elements of the system envisioned by the commission were carried out. Information systems were established; federal expenditures on both the supply and the demand side were maintained at satisfactory levels; the voluntary-treatment strategy was put in place; a network of treatment slots was established throughout the country; substantial block grants were distributed to the states to be

administered by "single state agencies" responsible for both prevention and treatment programs; NIDA's research budget was increased; and courts and prosecutors initiated diversion programs to refocus the purposes of the criminal process in cases involving drug users.

The federal strategies on drug abuse prevention marked the progress of these changes over the decade,⁷ and the Ford administration issued a valuable White Paper on the subject in 1975.⁸

Major steps were also taken to bring alcohol, tobacco and nonmedical use of controlled substances within a common frame of reference. Closer coordination was established between NIAAA and NIDA in the arena of prevention. The NIDA Advisory Council formally recommended to NIDA that cigarettes be regarded as within the research mission of NIDA. Major initiatives were undertaken also at the secretarial level within HEW (and then HHS) to promote a public health approach toward alcohol and tobacco.⁹

Unfortunately, most of these positive developments came to an end in the 1980s. I do not mean to suggest, I hasten to add, that all of the policy initiatives undertaken during the past 11 years have failed. Unfortunately, however, the central elements of the strategy envisioned by the Shafer Commission were forgotten or ignored, and the nation is now paying a heavy price for this sudden reversal of course. I will mention four major areas of concern.

For example, the commission had strongly emphasized the need for continuity in government programming, and especially for a stable investment in demand reduction. These lessons were forgotten in the anti-government climate of the 1980s. The main problem was that the single state agencies funded under the block grant program disappeared practically overnight. The nation's substantial investment in expertise to manage the nation's drug program was squandered, and all

that remained, at least on the demand side, was a shell. I should note in passing that the commission itself was concerned about the emergence of a self-perpetuating bureaucracy—a so-called “drug abuse industrial complex”—as a result of the infusion of public monies in the 1970s. However, legitimate concerns about the growth of big government led, unfortunately, to drastic—and destructive—cuts in the nation’s capacity to monitor, reduce and manage the nation’s drug abuse problems.

A national treatment capacity that had been so wisely established in the 1970s, largely during the Nixon administration, was severely reduced during the 1980s. Thus, when the nation was hit, almost simultaneously, by AIDS and the crack epidemic, it wasn’t ready to provide the needed outreach services and ameliorative treatment. Unfortunately, we are still playing catch-up.

The growth in employee substance abuse assistance programs and in private health insurance coverage for substance abuse treatment have helped to establish an accessible system of voluntary treatment for citizens who are fortunate enough to be employed and to be covered by these programs. Needless to say, however, these programs are not accessible to the population at greatest risk. By allowing the nation’s publicly funded treatment capacity to shrink, the government missed an opportunity to contain the new epidemics. Unfortunately, the erosion of drug abuse prevention and treatment services is part of a larger pattern of social neglect, which continues to degrade the quality of life among our nation’s impoverished minority populations.

The Shafer Commission emphatically recommended a differentiated response to various aspects of illicit drug use, based on careful cost-benefit assessment. Unfortunately, “zero tolerance,” as it has been proclaimed and implemented, is the very antithesis of the approach the commission had in mind. Occasional marijuana use is simply not equivalent—socially,

morally or clinically—to a compulsive crack habit. Repressive measures are costly in human terms and can cause more harm to the user's life than the drugs themselves.

Even proponents of “zero tolerance” and the “war on drugs” recognize that their rhetoric is more sweeping in its implications than the prevailing strategy. But the Shafer Commission had condemned exaggerated antidrug slogans because the rhetoric itself has harmful consequences: it misleads the public—no one really wants to be intolerant of friends, neighbors or family members who have used drugs and who may need support and assistance; it inevitably leads to distorted priorities; and it polarizes public discourse.

IV.

The nation's current policy either overlooks or ignores some key recommendations of the Shafer Commission. Perhaps this is reason enough to favor a new commission—to update and reinforce the Shafer Commission's findings and recommendations. But I think a stronger case can be made. Social conditions and patterns of drug use have changed significantly since 1973, and responses different from the ones recommended by the commission may be in order. I want to close by mentioning a few features of the current situation that merit sustained examination by a new commission.

First, the connection between severe mental disorder and patterns of intensified drug use needs to be explored. A major epidemiological shift has occurred in the past 16 years, largely relating to a growing population of chronically mentally ill, young adult males who also are repetitive users of many different drugs. The emergence of this population is clearly related to deinstitutionalization and appears to be associated with increased rates of violence and other types of social dysfunction. This phenomenon has been observed clinically and documented epidemiologically. But the causal

links connecting drug use, mental illness and dysfunctional behavior are not well understood. This is a problem that will be with us for years to come, and we clearly need to understand it better in order to know how to intervene both preventively and therapeutically.

A second and important difference in the contours of drug abuse in the past 21 years is that the drug culture—and the various economic and social factors that tend to be associated with it—has swallowed many communities in this country. Unfortunately, of course, many of these decaying communities are minority communities. This fact accounts for the most vehement criticisms of existing policy. On the one hand, repressive policies are said to constitute a “war on minorities,” because minorities are disproportionately represented among the users and dealers of illicit drugs. On the other hand, minority communities are most heavily victimized by the drug problem and have the largest stake in efforts to ameliorate it.

Clearly, serious and sustained attention to this problem is required. Drug abuse is both symptom and cause of the deepening social pathology of our inner-city communities. This problem cannot be ignored. Indeed, I am tempted to say that what is needed in this respect is not another Shafer Commission, but rather another Kerner Commission.¹⁰

This leads to my closing thoughts. The Shafer Commission was created because the social reality of illicit drug use in America had suddenly and significantly changed in the 1960s. The problem of addiction among under-class and other outsider populations had persisted since the turn of the 20th century, worsening perceptibly in the 1950s, and an “elite” class had always used illicit drugs, particularly cocaine. What was new in the 1960s was that illicit drug use penetrated the middle class of American society. This phenomenon clearly required different responses.

Today illicit drug use persists in all strata of American life and has become even more deeply rooted. It is time for a thorough study of the roots of the persistent demand for drugs in this country and of the efficacy of our current policies.

- Notes
1. National Commission on Marihuana and Drug Abuse, *Marihuana: A Signal of Misunderstanding*, First Report (Washington, DC: U.S. Government Printing Office, 1972).
 2. National Commission on Marihuana and Drug Abuse, *Drug Use in America: Problem in Perspective*, Final Report (Washington, DC: U.S. Government Printing Office, 1973).
 3. One of the patterns described by the Shafer Commission was "recreational" use—a term that was entirely sensible from a scientific standpoint but that proved objectionable from a political standpoint due to a supposedly implicit hint of approval. This was somewhat ironic in light of the fact that one of the main targets of the commission's work was political distortion of straightforward thinking about drug use.
 4. DAWN is jointly funded and operated by the Department of Health and Human Services (through NIDA) and the Department of Justice (through DEA). For an early critique, see Medicine and the Public Interest, Inc., *Drug Abuse, Data Systems and Regulatory Decisions* (Washington, DC, 1977).
 5. Commission on Obscenity and Pornography, *The Report of the Commission on Obscenity and Pornography* (Washington, DC: U.S. Government Printing Office, 1970).
 6. Attorney General's Commission on Pornography, U.S. Department of Justice, Final Report (Washington, DC: U.S. Government Printing Office, 1986).
 7. *Federal Strategy for Drug Abuse and Drug Traffic Prevention* (Washington, DC: U.S. Government Printing Office, 1973 and subsequent years).
 8. Domestic Council Drug Abuse Task Force, *White Paper on Drug Abuse* (Washington, DC: U.S. Government Printing Office, 1975).
 9. Some of these initiatives are reviewed in R. J. Bonnie, "Discouraging Unhealthy Personal Choices: Reflections on New Directions in Substance Abuse Policy," *J. Drug Issues* 8 (1978): 199-219; R. J. Bonnie, "Discouraging the Use of Alcohol, Tobacco and Other Drugs" in N. Mello (ed.), *Advances in Substance Abuse* 2 (1981): 145-184.

10. National Advisory Commission on Civil Disorders, *Report of the National Advisory Commission on Civil Disorders* (Washington, DC: U.S. Government Printing Office, 1968).