Case Study Series:

Drug policy, harm reduction and young people

UNITED STATES of AMERICA

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Introduction

While the United States of America (USA) has become infamous for having the largest prison population in the world as a result of its regressive drug policy, the impacts of its drug policy towards young people who use drugs are rarely discussed. This case study offers an overview of some of the main drug policy issues facing young people in the USA, looking at the impacts of the drug policy and harm reduction on young people, drawing data and evidence from official national statistics and experiences of young people who use drugs themselves. This paper then concludes with a series of recommendations for potential reform areas.

Drug use prevalence and initiation

The USA has among the highest rates of both licit and illicit drug use in the world.[1] The 2010 population census found that over 22 million people over the age of 12 years old use drugs (approximately 9 per cent of the population), with cannabis being the most widely used drug. For those aged 12 to 17 years old, 10.1 per cent currently use drugs.[2] For young people in the age cohort of 18 to 25, the prevalence rate reached 18.5 per cent for cannabis, 5.9 per cent for non-medical use of psychotherapeutic drugs, 2 per cent for hallucinogens, and 1.5 per cent for cocaine. Furthermore, a majority of US adolescents (60.2 per cent) reported having been offered drugs, suggesting drug availability is also particularly high.[3]

The National Institute on Drug Abuse (NIDA) conducts a school-based survey called 'Monitoring the future',[4] providing data on young people's drug use below the age of 18. While school-based surveys certainly lack validity and are not necessarily the most accurate snapshot of drug use among young people, its latest figures are certainly worth highlighting. Figures show that over the last five years there has been a significant decrease in alcohol use, while there have been large increases in the illicit use of **cannabis, prescription stimulants and amphetamines.**[5]

Youth RISE and the Joint United Nations Programme on HIV and AIDS (UNAIDS) recently conducted a community consultation project among young Americans in San Francisco who inject drugs that aimed to understand the context of injecting drug use amongst young people in the country. During the consultation, the participants highlighted the drugs which were most accessible. Cannabis, prescription pain killers such as Vicodin and OxyContin, benzodiazepines such as Xanax and Valium, and stimulants like ecstasy, speed, cocaine and crack. Many young people also reported being able to easily access heroin and psychedelic drugs.

> ***The way I started doing drugs was through prescription drugs. My friends were taking pills and smoking weed, so I went into my mom's medicine cabinet and found some pills. I tried it and liked it. I was 11 years old. I imagine a lot of people start like that probably.***

Most estimates suggest that the initial age of drug use is 14 years old, and that the earlier the age of initiation, the greater the potential for young people to experience drug dependence. According to statistics published by the National Institute on Drug Abuse (NIDA),[6] 12.8 per cent of those who first tried cannabis at the age of 14 or younger experienced drug dependence, while only 2.6 per cent of those who had first used cannabis aged 18 or older did so.

In San Francisco, the participants at the Youth RISE/ UNAIDS consultation highlighted that 13 years old tended to be the most common age of initiation of first drug use. The age of initiation into injection drug use was slightly older, and tended to average in the late teens to early twenties. As is often the case with transitions to injecting use, initiation to injecting drugs tended to be based on the rational need to get the most effective use out of young people's drugs, with other methods being considered as leading to unnecessary wastage for young people with little money. They wanted to *'get as high as possible'*. Anecdotal evidence showed that when drugs are strong enough, young people often preferred to smoke them; however when they are low quality, injecting would often be the preferred method.

Other factors leading young people to begin injecting drugs included an intense life event such as relationship break ups, pain relief and rebellion. For those who become dependent, the act of injecting drugs was also reported to be a ritualistic and almost religious experience.

Drug policy framework

The roots of contemporary US drug policy undeniably lie in former President Nixon's *'war on drugs'* rationale. The *'war on drugs'* discourse that emerged in the 1970s can be seen as a response to the social events of the 1960s, a time characterized by widespread political dissent and social upheaval. The response to that new social climate saw a dramatic increase in the size and scope of the federal drug control institutions throughout the 1970s. This process was further entrenched under President Reagan in the 1980s – and it is there that the roots of today's over-incarceration can be found. Throughout that decade, media sensationalism perpetuated the persecution of drug use and people who use drugs. Sensationalism around crack cocaine and the vast anti-drugs *'Just say no'* prevention campaign targeting young people and school children are two of the most well-known examples characterizing this period. The dominant anti-drugs discourse of the moment also meant that access to harm reduction was significantly impacted upon, at a time when such services were fast expanding in Europe. While seeds of reform began to develop in the 1990s, it was not until the 2000s that drug policy reform really began to gather momentum.

The past decade has been a transitional period, in particular over the past few years. While 14 states have some degree of decriminalization of cannabis,[7] Colorado and Washington State have gone even further and created two different types of regulated cannabis markets, although this has had a less significant effect in the lives of young people. Within these states, cannabis use, possession or sale for people under 21 remains illegal, along with driving under the influence of marijuana and smoking in public spaces. In Colorado, it is therefore still illegal to possess and use marijuana for people aged under 21, but possession remains decriminalized for people between ages 18 and 21. Although young people can still be fined, the threat of a prison sentence has been removed for those caught with an ounce or less of cannabis. Young people aged under 18 can also be sent to a juvenile assessment center instead of prison. Measures in Washington State have also been undertaken to deter underage use with retail outlets not being allowed within 1,000 feet of schools. There will also be tight restrictions on marijuana advertising.

Other efforts have also begun to take place to address over-incarceration, with successive National Drug Control Strategies since 2009 increasingly emphasizing public health approaches, rather than simply criminal justice ones. The latest drug strategy[8] from the Obama Administration is clear in indicating that a comprehensive strategy must include a range of prevention, treatment, in addition to law enforcement elements – ranging from strengthening international partnerships to focusing on intervention and treatment efforts in health care – aimed at reducing both illicit drug use and its negative consequences. An example of this new focus in practice has been the development and growth of drug courts, although this practice remains highly controversial. As of 2013, there were over 2,800 drug courts operating throughout the country, over 450 of them being juvenile drug courts, imposing coercive abstinence-based rehabilitation programs. Although drug courts can be considered as a positive move to address over-incarceration, much concern has been raised around the practice – for example, methadone is not accessible as a substitution treatment through the drug courts system, and this practice continues to process people who use drugs through a criminal lens, rather than a health one.[9]

Another key issue in the USA relates to the fact that the non-white population continues to be disproportionately affected by decades of punitive drug policies, despite rates of drug use being similar across racial and ethnic lines. Black and Hispanic people are far more likely to be criminalized for non-violent drug offences than white people, some states incarcerating black men on drug charges at 20 to 50 times the rate of white men. According to the 2012 Bureau of Justice Statistics, 1 in 108 adult Americans incarcerated, 1 in 35 adult Americans are on probation, under parole, or in jail/prison, with Black people up 38 per cent of the prison population despite only making up 13 per cent of the population. This has led to 1 in every 15 black men behind bars – or 1 in every 8 Black men in their twenties being put into prison on any given day.[10]

Non-violent drug offenders make up 21 per cent of state prison and 50 per cent of the federal prison population. This has contributed to the USA imprisoning a larger percentage of its black population than South Africa did at height of apartheid. As a result of mass incarceration, around 2.7 million children under the age of 18 have a parent in prison or jail – with two thirds of incarcerated parents being imprisoned for non-violent drug offences. The impact upon young black children has been even worse, with 1 in 9 black children having an imprisoned parent, four times as many 25 years ago. This process has led to more than 14,000 children enter foster care every year because of the incarceration of their patent(s).[11]

A range of other policies have also had a significant impact upon young people. Most high-schools in the USA address student drug use with a zero tolerance policy that may include expulsion, suspension and exclusion from extracurricular activities. The 1998 amendment to the Higher Education Act denies federal financial aid to any student with a drug conviction, so one drug offence can permanently damage a student's prospects of attending higher education, or ability to gain long-term employment. The law creates an unjust environment where a drug conviction for an economically disadvantaged student carries much more serious consequences than a drug conviction for a student who does not receive financial aid.

As a result of the Higher Education Act, over 200,000 students have been denied access to federal financial aid because of a drug charge on their record.[12] Furthermore, the application for federal financial aid does not ask about any other types of conviction, thus someone with a much more serious offence unrelated to drugs could receive student aid while someone with a minor, non-violent drug conviction (including for simple drug possession) would not be able to. With employers now being legally allowed to drug test and ask about previous convictions on job applications,[13] the long-term impacts of the practice on young people can be severe. Other negative impacts of drug convictions include restrictions around voting, public housing, child custody and other public assistance such as loans.

HIV/AIDS and hepatitis C

While the HIV prevalence rate among young people who inject drugs is unknown, the HIV prevalence among the total population of people who inject drugs is approximately 1,855,000, a prevalence of 15.57 per cent.[14] As of 2010, people who inject drugs are estimated to make up about 8 to 10 per cent of the total number of people living with HIV.[15] Just over 80,000 young people aged between 13 and 29 are living with HIV, and approximately a quarter of all new infections occur among young people aged 13 to 24.[16] Estimates suggest that 48 per cent of young people living with HIV are unaware that they are infected.[17] As such, it can be inferred that a majority of young people living with HIV are not accessing treatment and are further increasing the potential for transmission. Consequently, from 2007 to 2010, the only age cohort with increasing rates of newly diagnosed HIV cases was among young people between the ages of 15 to 24.

While data on hepatitis C is limited, especially among young people, estimates suggest that as many as 3.9 million people in the USA are living with chronic hepatitis C, and in 2007, the number of deaths associated with hepatitis C surpassed those from HIV for the first time. Hepatitis C prevalence rate among people who inject drugs is particularly high, at 73.4 per cent.[18]

Overdose

Another critical health issue is the high overdose mortality rate, which is a particularly important issue for young people. Recent estimates suggest that around 70,000 children annually experience drug overdoses, most commonly from prescription drug use.[19] Furthermore, in just over a decade from 1999 to 2010, the Centres for Disease Control and Prevention recorded a rise from 16,849 to 38,329 in fatal drug overdoses.[20,21] Every day in the USA, 113 people die as a result of a drug overdose, and another 6,748 are treated in emergency departments specialised in dealing with issues related to drug use,[22] largely prescription painkillers (particularly oxycodone, hydrocodone and methadone) rather than illicit drugs. Despite accidental overdose deaths now being the leading cause of accidental deaths in the USA among people ages 25 to 64,[23] only fourteen[24] states and the District of Columbia have enacted policies to provide limited immunity from arrest or prosecution for minor drug law violations for people who summon help at the scene of an overdose[25].

Harm reduction services

Harm reduction services have struggled to remain open in the USA. Differing federal, state and municipal legislations have caused a web of uncertainty and contradictory policies, making it impossible to establish a uniform policy that either condones or condemns harm reduction initiatives across the country. Varying degrees of harm reduction interventions developed at state level are being challenged at the federal level, where the government does not fully support such services and has re-instated a federal ban on syringe exchange funding. Whilst many harm reduction interventions – including needle and syringe programs (NSP) and opioid substitution therapy (OST) are available in parts of the country, coverage for both NSPs and OST programs remains inexistent in huge areas of the country. Where services do exist and are supported, access to harm reduction services greatly differs in urban or rural settings. While some states and cities have a long history and established services where accessibility and attitudes to young people are very good, as is the case in San Francisco, many other states and cities suffer from a severe lack of funding, political support and accessibility.

> ***We were not allowed to serve anyone under the age of 18. I definitely did because, like we said, you're not checking IDs. If some of them lie, I'm not going to turn them away from services, but there was definitely a "do not tell me that you are under 18".***

Drug prevention vs. harm reduction?

Harm reduction services and education programs aimed at young people are limited to urban areas and have been restricted by the historical emphasis towards school-based drug prevention programs, most notably the extensive 'D.A.R.E.' (Drug Abuse Resistance Education) program. D.A.R.E. was established in 1983 and has been implemented in 75 per cent of the nation's schools,[26] and was *'…a collaborative program in which local law enforcement and local schools join together to educate students about the personal and social consequences of substance abuse and violence'.*[27] A vast majority of academic studies have shown it to be direly ineffective in preventing drug use among young people, let alone preventing related harms.[28] Despite the program's extraordinarily large budget, the USA has consistently had one of the highest rates of drug use among young people.

The backing given to the D.A.R.E. program and its *'just say no'* underlining message has limited the support for harm reduction services aimed at young people. Nevertheless, harm reduction programs and services catering for young people who use drugs do exist in a number of places and are generally well received by the community and health services.

Needle and syringe programs

The reinstatement of the US federal funding ban for NSP in December 2011 came just two years after the 21 year old ban was repealed by President Obama. While the lifting of the ban in 2009 mobilized non-governmental donors to fill the gap left by the federal government, the recent move to reinstate the ban has severely undermined and marginalized existing programs away from mainstream health services.[29] Access to NSPs also remains unavailable for those incarcerated.

Due to the issues around accessibility to services in many of the remote regions of the country, it is very common for young people to repeatedly use the same needle. The Youth RISE/UNAIDS consultation reported that sharing needles with peers, buying them from older users, or even picking up discarded needles and reusing them was common. Many NSPs also operate a 'one-for-one' policy, where a new syringe can only be received when a used one is being returned. This policy has been widely criticized with many users not getting the amount of needles they need, an issue particularly concerning to young people who use in groups of friends. Certain states require a prescription in order to receive syringes at pharmacies, which has also had a severe impact on accessibility for young people. Young people are also particularly stigmatized for injecting drugs, even by their older counterparts, and this stigma often presents itself as a key factor in preventing them from accessing services on their own.

> ***There was one needle exchange. It was a van that was around for three or four days of the week and it was at a different place every time. It was always hard to find regular services."***
>
> ***"I've had experiences at pharmacies where state law says it should be completely legal for me to go buy a syringe, but they will refuse to sell you one. It's completely illegal for them to do that. It's up to the pharmacist's discretion whether they want to actually serve you or not. And I try and be actually as honest as possible as to why I'm getting syringes, I tell them straight up that I'm a drug user and that I need syringes and if they don't give them to me, there's a possibility that I'll get HIV.***

Opiate substitution therapy

Like NSPs, methadone has also been restricted and undermined by government regulations and misinformation. Methadone remains one of the most tightly regulated drugs in the USA and costs from US$50 to US$100 per week, which may be covered by private insurance or Medicaid. Buprenorphine can be prescribed by physicians who have gone through special training. In the 42 states (plus the District of Columbia) where methadone services exist, the age at which young people can access methadone maintenance programs is restricted to those aged at least 18 years old. They have to have been dependent on opiates for at least a year in order to be considered. In many circumstances, young people between the age of 16 and 18 can only access a methadone treatment program if they have had two prior unsuccessful detoxification attempts and are granted parental consent.

Financial cost is another significant factor that excludes young people from OST. Most OST programs are run from private clinics, often deterring young people who do not want to be seen accessing drug services and do not want to be attending the same services as older people who use drugs. Other factors such as issues around health insurance and failing to understand paperwork also makes accessing OST programs difficult for young people. OST is rarely accessible for those incarcerated.

Conclusion and recommendations

While there has certainly been a rhetorical shift in US drug policy with the adoption of a discourse more focused on public health, in reality there has been little extensive change, in particular for young people. Major issues need to be urgently addressed for young people who use drugs. In this regard, some key recommendations focusing on young people can be made:

- **Repeal the federal ban on NSPs funding in order to scale up services, and ensure that there is sufficient funding to create specific services catered for young people who use drugs where needed.**
- **Access to methadone and buprenorphine through improved government-supported welfare services needs to be scaled up, clearer guidelines created to ensure young people can access services and age restrictions removed to ensure those under 18 who needs services can access them.**
- **End policies that exclude people with a drug conviction from key rights and opportunities, including obtaining financial support in order to attend higher education or having prospective employers alerted of such convictions.**
- **Support the expansion of 'Good Samaritan' laws to all states and colleges as they have been shown to be effective at reducing overdose deaths, especially among young people who use drugs.**
- **Address the disproportionate sentencing for non-violent drug offences which are both discriminatory, unjust and potentially life destroying.**
- **Re-distribute the extensive funding for the D.A.R.E. drug awareness campaigns and reallocate it towards a more effective drug education programmes fit for young people in the 21st century, which should include comprehensive sex education and education focusing on HIV, hepatitis C and how to reduce drug-related harms.**

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Notes

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