

C O N G R E S S I O N A L T E S T I M O N Y



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*Drug Policy: Recent Lessons*

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## Testimony before the Senate Committee on the Judiciary

April 29, 1993

My name is Peter Reuter\*. I appreciate the opportunity to testify before this committee. My testimony deals with what experiences of the last four years might teach us about managing the nation's drug problems. The testimony was prepared at short notice and is neither comprehensive nor polished.

### INTRODUCTION

There is little disagreement about the recent history of drug use in the United States. Many fewer persons are using illicit drugs but the numbers using them frequently and suffering severe consequences of that use have not fallen; indeed, the number may have risen somewhat in the last four years and the health and crime consequences of their use are even more likely to be worsening.

There is even some agreement about the proximate (as opposed to ultimate) causes of these changes. Increasing awareness of the adverse health and behavioral consequences of drug use has probably driven the decline in prevalence; not only is it clear that fewer adolescents are experimenting with drugs than was the case a decade ago but a substantial number of non-dependent regular users have desisted. That the numbers of dependent users has not declined is a function of the fact that the dependence is extremely hard to break, particularly for those living in adverse social conditions along with many others suffering from similar problems.

There is much less agreement about what role drug policy has played in reducing drug use. There is not even a shared view of what drug policy has actually been over the last few years. Too much attention is paid to the federal drug control budget, which is neither accurate nor particularly relevant, and too little to what is being done at the state and local level. To make matters worse, there is also too much attention to the wrong indicators of success. More specifically, I will try in this testimony to make the following points.

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\* Co-Director of RAND's Drug Policy Research Center. The views presented here are not necessarily those of RAND or its sponsors.

(1) The second half of the 1980s saw a massive expansion in the toughness of drug enforcement, with state and local governments leading the charge. Perhaps we could be tougher still but I would suggest that we have tried toughness enough to know what it can accomplish *in its current form*. Large numbers of incarcerations has not managed to make cocaine and heroin more expensive or less accessible; the evidence with respect to marijuana is more mixed. A more targeted set of punishments, better linked to coerced treatment, certainly seems worth trying.

(2) U.S. source country control efforts continue to show no sign of success and are structurally flawed. Cutting these programs substantially is one of the few budget-cutting recommendations that has an exemplary basis both in logic and experience.

(3) Finding ways of improving the effectiveness of the publicly funded drug treatment system is probably the most urgent need for demand reduction. Finding ways of integrating drug treatment into the larger system of health and social services that are needed by the drug dependent is an important, and difficult, part of this task.

(4) The focus on punishment by all levels of government reflect the current goals of the federal government. As specified in the annual National Drug Control Strategies the goals are reductions in drug *use* rather than drug *problems*. These goals lead to a slighting of some adverse consequences of the punitive approach and an underemphasis on treatment and prevention. A major change in policy should be signalled by developing a better scorecard for tracking progress in dealing with the harms generated by drug use, not simply the numbers of users.

(5) The final part of my testimony deals with the federal drug budget, which has been the focus of considerable debate, both as to its appropriate size and its allocation among program types. Drawing on work by a former OMB budget examiner, I suggest that the budget is a questionable representation of the federal government's expenditures on drug control. Worse, it focuses attention on a false budget struggle; drug treatment has not been slighted primarily because federal drug policy makers have cared more for enforcement (though they clearly did) but because health officials have given higher priority to other health programs. The drug budget should be de-emphasized; indeed, one might even consider abolishing it as a construct.

### **Enforcement Levels**

I shall focus primarily on federal drug policy but it is important to see federal efforts in the context of the much more pervasive and significant decisions of state and local governments. Since 1985 there has been a massive acceleration in the numbers of persons being arrested for serious drug offenses (i.e. something other than simple

possession of marijuana) and an even more striking increase in the numbers being incarcerated for these offenses.

Figure 1 presents data on arrests for drug offenses from 1979 to 1991. Whereas in 1979 the vast majority of arrests (61 percent) were for simple possession of marijuana, by 1991, the number of arrests for cocaine or heroin possession<sup>1</sup> actually was larger; the latter number rose from 47,000 in 1979 to 331,000 in 1991. The number of arrests for cocaine or heroin distribution also rose by an order of magnitude. The turn-down in 1990 and 1991 for total drug arrests was much less sharp for the more serious distribution offenses.

More striking are figures on the numbers of incarcerations for drug offenders in state prisons. Figure 2 presents those data from 1981 to 1990, the first and last years for which these data are presently available. These figures show an order of magnitude increase in sentences of more than one year, from 11,500 to 118,000. Note that state prison commitments continued to rise sharply in 1990, even after drug arrests had declined. Indeed, the incarceration rate per hundred felony drug arrests continued to rise; from 29 in 1986 to 40 in 1990. The 1990 figure compares with 33 per 100 felony arrests for robbery or 28 per 100 for burglary.

Figure 2 also includes the two observations that are available on jail time for drug offenses. In 1983 a single day count found 22,000 inmates (both sentenced and unsentenced) in local jails on drug charges; in 1989 that figure had risen to 87,000.

The federal court numbers show the same patterns; namely significant increases in arrests but much larger increases in prison commitments. Table 1 shows that whereas the number of federal defendants (drug charges only) rose three fold between 1980 and 1990, the number of commitments to federal prisons rose five fold, from 2,266 to 11,972. The guidelines and mandatory sentences amplified that dramatically; whereas in 1985 the expected time served for drug offender inmates was probably only 22 months, that figure had tripled to 66 months in 1990.

One way to summarize all this expansion in punishment is to estimate the number of "cell-years" handed out for drug offenses in 1980 and 1990; i.e. the number of years which individuals are likely to spend incarcerated for drug offenses as a result

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<sup>1</sup>The Uniform Crime Reports has traditionally combined heroin and cocaine arrests; what the FBI has put together, no man shall pull asunder. Studies of individual cities confirm the conventional wisdom that the vast bulk of the increase is in cocaine arrests.

of court activities in that year<sup>2</sup>. The estimates involve a number of assumptions about time served and backward extrapolations for jail times but a reasonable estimate for 1980 is 45,000; for 1990 we can more confidently estimate the figure to be about 340,000. By this measure the federal government accounts for only about 20 percent of the total number of cell years; of course federal arrests are an even smaller share of total drug arrests.

What have been the consequences of this burgeoning of punishment? The logical basis of the punitive approach is that it will raise the price of drugs and reduce their availability<sup>3</sup>; secondarily, it may reduce the demand for drugs by signaling society's concern about illicit drugs. The available data do not suggest that toughness has had the hoped for primary consequences. The long-term decline in cocaine prices was interrupted in 1989 but appears to have resumed since 1990. Heroin prices fell sharply in the late 1980s, reflecting either the expansion of Burmese production or, more likely, the development of more efficient importation and wholesaling operations within the United States. Only marijuana appears to be a success story in terms of price. The little data on availability, from Monitoring the Future, showed finally a decline in cocaine availability in schools after 1989 but this may well reflect the sharp decline in demand in the relevant age groups rather than the effects of tougher enforcement.

The state numbers are also a useful reminder of how much is missed when the discussion of the balance between supply side and demand side programs is focused on the federal drug budget. I have prepared estimates, really back-of-the envelope calculations, of the level of expenditures by different levels of government on the major classes of programs in 1990; see Table 2. These estimates suggest that not only do state and local governments spend more on drug control than does the federal government, but that their expenditures are even more skewed toward enforcement than those of the federal government.

Of course enforcement, particularly at the federal level, involves more than just arrests and incarcerations. It also involves seizures of drugs and drug-related assets. Over the last four years it appears that the quantity of seizures, of both cocaine and

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<sup>2</sup>Some of the jail time is for pretrial detention. It constitutes punishment, though not necessarily the result of judicial actions.

<sup>3</sup>This refers to enforcement aimed against producers and sellers; the logical structure of users sanctions, which are not a primary element of current enforcement, is different.

heroin, has increased substantially; moreover, there is reason to believe that these seizures represent an increasing proportion of imports to the U.S. . What is striking is the apparent lack of impact of these accomplishments on the price or availability of either cocaine or heroin. For cocaine, that may reflect the continuing decline in export price of the drugs from their Andean countries; smugglers have shifted to modes of smuggling that put cheaper drugs at more risk and expensive labor at less risk. For example, there may be more use of containerized cargoes and less of dedicated small planes. A higher percentage of shipments will then be seized but costs to smugglers will not rise.

### **Overseas Programs**

The last administration emphasized programs aimed at reducing exports from source countries, particularly in the form of the Andean Initiative. Funding for overseas programs has risen from \$220 million in FY 87 to \$760 million in FY 92, with further substantial increases built into the existing legislation. A large share of this money goes to helping the Andean (Bolivia, Colombia and Peru) military and police combat refining and trafficking in the region. Eradication programs now get little funding, reflecting the unwillingness of Bolivia and Peru (the major coca leaf producers) to allow aerial spraying; instead, the emphasis apart from support of military and enforcement programs is on alternative economic development.

These programs offer almost no prospect of helping reduce the United States drug problem. The cost of growing coca leaves and refining them into cocaine constitute an absolutely trivial share of the cost of cocaine to American consumers. A kilogram of cocaine costs less than \$5,000 (indeed maybe less than \$2,000) in Colombia and sells on the U.S. retail market (in dilute one gram units) for more than \$100,000. Even if the source countries were willing to implement the control programs that the U.S. government is pushing, they could do no more than make growing, refining and exporting somewhat more expensive; there is too much usable land, too many willing peasants, competent smugglers and corrupt officials to actually limit the total amount of cocaine produced. As someone observed in 1980, it is rather like trying to make steak at the Palm more expensive by rustling cattle in Montana. Crop substitution schemes, while without the potentially bad political effects of eradication, will make peasants better off by raising the price of coca leaf but will not shift labor and land out of the coca sector.

Even if the programs doubled the export price of cocaine, the retail price would rise by no more than 5 percent and probably much less<sup>4</sup>. Needless to say, it is highly unlikely that the governments could effectively implement the control programs on a continuing basis and accomplish such a price increase.

The historical evidence for the failure of these programs is overwhelming. Only the Mexican spraying programs of the mid-1970s constitute an exception and there were special circumstances that account for that success. The small expert community is essentially unanimous that the programs will not be well implemented in the Andean countries, whose interests are very different from those of the U.S., whatever their rhetoric on the subject. The smaller analytic community is equally unanimous that the programs, even if implemented, cannot accomplish their goal of lowering the availability of cocaine in the United States.

### **Federal Demand Reduction Efforts**

While it is important to maintain drug prevention effort, the primary focus of demand reduction now should be on creating an effective treatment system. The drug problem of this nation is primarily the result of harms caused by a relatively small number of persons (2-3 million) who are already drug dependent. It appears that the current treatment system fails to provide the right kinds of services to help them deal with their dependency.

I am certainly not an expert on the nature of the appropriate treatment services. However, it appears that a significant part of the current weakness of the treatment system lies in its isolation from the broader health and social services systems to which the drug dependent need access. For example, most programs are not funded or even permitted to provide primary health care, though their patients are very much in need of treatment for a whole range of medical problems that pose threats to the broader community. Moreover, those patients are not competent at following up on referrals provided by the treatment providers.

The isolation of treatment programs has many dimensions; physical, occupational and regulatory. It also has many sources though a reluctance to deal with a very difficult patient population on the part of other providers seems to be particularly important. But at the heart seems to lie the block grant system, which provides a

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<sup>4</sup>A technical exposition of these arguments is contained in Kennedy, Reuter and Riley, 1993.



separate funding stream that prevents the integration of services. In turn, the block grants represent the political weakness of drug treatment professionals and organizations in their battle for resources against other service providers. The fear is that without a separate funding flow, drug treatment would receive even less than it currently does. But the separation of financing lowers the effectiveness of treatment.

I do not have a solution to this problem. But it does point to the difficulty of raising the quality of treatment services through the present mechanisms.

### **The Goals of Drug Policy<sup>5</sup>**

The focus on punishment as the principal instrument for drug control has many sources, such as American beliefs about what constitutes the drug problem itself, as well as the well established and strengthening association between drug abuse and crime. But the federal government's choice of goals is also an important influence.

In 1989, with the creation of the Office of National Drug Control Policy (ONDCP), the executive branch of the federal government was required to develop a strategy, along with explicit quantitative goals. The 1988 Anti-Drug Omnibus Control Act specified that the strategy should include "long range goals for reducing drug abuse in the United States" and "short-term measurable objectives which the Director determines may be realistically achieved in the two-year period beginning on the date of the submission of the Strategy." The strategy was to be formulated annually.

The first *NDCS* made a clear statement as to goals: "The highest priority of our drug policy must be a stubborn determination further to reduce the overall level of drug use nationwide – experimental first use, "casual" use, regular use and addiction alike." (p.8) This is reflected in the specific goals, which are heavily reliant on the National Household Survey on Drug Abuse (NHSDA), and to a lesser extent on the annual survey of high school seniors (called Monitoring the Future [MTF]) and the Drug Abuse Warning Network (DAWN). As enunciated in the first *NDCS* and confirmed by its three successors the goals are to reduce the following by specified fractions (usually 10 percent in 2 years and 50 percent in 10 years):

1. NHSDA-measured last month drug use.
2. MTF measured adolescent last month drug use
3. NHSDA-measured last year cocaine use

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<sup>5</sup>This section reflects research being conducted jointly with Robert MacCoun.

4. NHSDA-measured last week cocaine use
5. NHSDA-measured last month cocaine use among those aged 12-17
6. NHSDA-measured last month alcohol use among adolescents.
7. DAWN ER (Drug Abuse Warning Network Emergency Room) mentions of cocaine, marijuana, heroin and dangerous drugs.
8. (a) Amounts of cocaine, marijuana, heroin and dangerous drugs entering the U.S.
- (b) NHSDA-measured availability of cocaine, marijuana, heroin and dangerous drugs.
9. Domestic marijuana production.
10. MTF-measured approval of drug use.

Two of the goals have not been monitored, simply because it turns out that there are no acceptable measures available; amounts of cocaine, marijuana, heroin and dangerous drugs entering the U.S. (8a) and domestic marijuana production (9). That leaves 9 actual goals, of which 6 use the household survey, two the high school senior survey and one the DAWN figures. The loss of the consumption measure is a major one, since a small number of frequent users accounts for the bulk of consumption; thus consumption might serve as a surrogate for the number of frequent users (and perhaps the average harms they incur).

Before considering the consequences of these goals, note what is missing from this list; deaths related to either the acute or chronic effects of drug use; babies born damaged as the result of maternal drug use during pregnancy; crimes caused by drug use or distribution; disease (particularly AIDS) attributable to drug use; or the illicit incomes generated by drug selling. These are the harms that are mentioned most frequently in descriptions of the drug problems of this nation. Nor, as it turns out, are DAWN ER mentions a good surrogate for the adverse health consequences of drug abuse, since an increasing share of those showing up at Emergency Rooms are seeking entry into treatment rather than reporting acute harms from drug use.

I suggest that one major reason for the absence of these harms from the "measurable goals" for the Strategy is simply that no compelling measures exist. DAWN obtains data on the number of Medical Examiner reports of deaths in which illicit drugs are one of the causal factors, which might be seen as a potential measure of a major harm. However these data come from MEs in only about 25 major metropolitan areas and there is no systematic way of extrapolating those figures to the nation as a

whole<sup>6</sup>. There are enormous conceptual as well as practical difficulties in estimating the number of "drug related" crimes<sup>7</sup>. No basis currently exists for estimation of the frequency or severity of drug affected infants; see Besharov (1989). The first systematic estimate of incomes from drug selling was developed only in 1991 (ONDCP, 1991) and has such a broad confidence interval that measurement of trends is more than can reasonably be expected, given the weak statistical systems underlying it.

The Congressional requirement for objective measurement is another instance of the American faith in the power of measurement, now taken to be a hallmark of good public policy. I have written elsewhere about some of the negative consequences of this passion for numbers (Reuter, 1984; 1986). It also consistent with the American dedication to due process and transparency in public policy. Requiring specification of goals in advance means that claims of success in a partisan setting can be subject to reasonable scrutiny. The measures should be seen to derive from systematic and credible sources so as to facilitate that scrutiny. Alas, in a situation where such measures are not available for the appropriate goals, the result is "lamppost" measurement; like the drunk in the story, we are left to look for the keys under the lamppost, a notoriously difficult task.

### **The Consequences of Goals**

I believe that the specification of goals has affected policy. The evidence for such a proposition lies in the rhetoric of actors and logic of the goals rather than hard quantitative analysis; the evidence is certainly capable of multiple interpretations.

Prevalence goals are likely to reinforce the pre-existing American emphasis on enforcement rather than prevention and treatment. The limitation of prevention is that it

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<sup>6</sup>One plausible approach for estimating the number of DAWN defined deaths for a single drug nationally would be to take the ratio of DAWN deaths to DAWN ER mentions in cities where both ME and ER data are collected and then apply that ratio to the national DAWN ER estimate. However, Jonathan Caulkins of Carnegie Mellon University has examined the ratio of ME to ER mentions across cities and has found the figure to range from about 0.5 to 50, without any strong central clustering. We appear to be without any convincing means of estimating either the number, or trends in numbers, of drug related deaths.

<sup>7</sup>Goldstein, Brownstein and Ryan . (1992) attempted to estimate the number of drug related homicides in New York State in 1984 using detailed retrospective data. Almost twenty percent of the cases could not be classified. Yet the data available on individual homicides is far better than for other crimes.

affects prevalence with a long lag. Programs aimed at 7th graders, the group most commonly targeted by school-based prevention, will affect prevalence measures substantially only with a long lag, since drug use rates peak at ages 18-22. Though three of the goals are specific to the age group (drug use and drug approval measured in the MTF, adolescent drug use in the NHSDA), these have received secondary billing in the public debates.

Treatment programs have even less attraction as a means for reducing prevalence because they operate on the very tail of the distribution. Indeed the 1992 *NDCS* in commenting on the significance of the goals established in 1989 stated that "[f]or the first time, the Federal government committed itself to measure progress by the actual reduction in drug use instead of the amount of drugs seized, or the number of arrests made, *or the number of addicts treated.*" (p.2, emphasis added) Even if treatment programs were completely effective, i.e. every patient entering the system in 1992 became drug free thereafter, they would reduce the total number of monthly users of illicit drugs by less than 800,000, only 7 percent of the NHSDA monthly total.

Moreover, there is a considerable concern that the NHSDA simply does not include many of those who are likely to be treated. The survey omits those housed in prison or jail and the homeless. It also has a non-response rate of about 20 percent. Estimates of the number and characteristics of frequent users of cocaine derived from the NHSDA are not consistent with the characteristics of the treated population<sup>8</sup>. Nor does the NHSDA provide the basis for estimating the number of heroin addicts. Indeed, it is worth noting that heroin is not listed among the specific drugs for which prevalence reduction is a stated goal; given its importance in the spread of AIDS, through sharing of needles, this is a startling omission, explained (I suggest) by the lack of credible measures of the size of the populations. Since 1980 only one such estimate has been published (Cooley et al., 1990) and it relies on highly speculative city level estimates (Reuter, 1993).

A possible defense for the choice of goals is that the level of harms is a simple function of the number of drug users. I.e. it might be claimed that a reduction in prevalence will lead to a corresponding, if not proportionate, reduction in harms. Not only does that turn out to be highly implausible (as shown in the next section) but the

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<sup>8</sup>On the numbers of cocaine users see Wish (1990). The treated population has a much higher share of African-Americans than does the population of recent cocaine users identified in the NHSDA.

focus on prevalence turns policy away from nuances of drug control that are extremely important. It also leads to a dismissal of one of the most important of all propositions about drug policy, namely that aggressive enforcement can increase drug related harms.

### **The Federal Drug Budget**

I would like to conclude my testimony with a discussion of the federal drug budget, since it has become a primary battle ground for policy discussions. The federal drug budget is of questionable accuracy. As the Committee knows better than I, it is an artificial construct, created after the fact, not an appropriation or authorization by the Congress. Its frailty may be illustrated by some examples developed by Patrick Murphy, former budget examiner for ONDCP, in a forthcoming RAND paper:

"For a few agencies, the drug budget calculation methodology can produce estimating algorithms that rival the rules that governed the Gramm-Rudman-Hollings sequester formula. The Department of Veterans Affairs (VA) is one such example. ONDCP's explanation of how VA estimates its drug budget is as follows:

The drug percentage represents the drug treatment costs for all primary and secondary drug diagnoses in all hospital bed sections, including costs of specialized drug dependence treatment units which account for approximately one-third of total treatment costs. The drug portion of medical care costs is broken down into four general components: 100 percent of the medical costs of patients participating in drug treatment programs; 100 percent of the medical costs of patients with a primary diagnosis of drug abuse but who are not participating in drug treatment programs; 50 percent of the costs of patients with a secondary diagnosis of drug abuse; 25 percent of the costs of patients with a secondary diagnosis of substance abuse. Costs for drug treatment programs are counted at 100 percent. The percentage of costs attributable to the treatment of patients with drug use disorders in other specialized treatment programs was calculated to be 33.5 percent (ONDCP, 1992: 194).

As should be clear from this example, there is a great deal of room for judgement in the allocation of funds in [this type of] programs....."

"A second important implication stemming from the complexity of these calculations is the opportunity they present for manipulation. A simple example illustrates the potential and incentive to resort to drug budget "smoke and mirrors." ONDCP reports that the Health Care Financing Administration (HCFA) which administers Medicaid and Medicare, will spend approximately \$200 million dollars in FY 1992 (1992: 53). This figure represents 0.1 percent of HCFA's total expenditures of over \$190 billion. If a rationale could be developed to raise the estimate to 0.2 percent, the administration could claim an addition \$200 million for treatment programs--an 11 percent increase over the FY 1992 level for the federal treatment budget total. The benefit is twofold. The demand reduction percentage goes up, but such an "increase" does not involve the spending of new money, thus having no effect on the deficit. Nor is any money subtracted from another program account with political salience."

"Evidence of methodological shifts appears in Table 2. This table gives, for three successive years of publication, the estimated drug control expenditures for selected departments for the same year, FY 1991. Each column represents a different annual publication by the ONDCP.<sup>9</sup> The timing of this change, occurring when the administration was under increasing pressure to increase treatment and prevention funding, can give rise to some skepticism.

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<sup>9</sup>Table 2 also suggests that the VA underwent a similar methodology shift. It is unclear what the rationale was for this change.

**Table 2**  
 ONDCP Reported FY 1991 Drug Budgets  
 for Selected Departments  
 (millions of dollars)

	<u>Year Published</u>		
	<u>1990</u>	<u>1991</u>	<u>1992</u>
Justice	3,825	3,821	3,842
Health & Human Svcs.	1,672	1,697	1,925
Treasury	779	900	978
Transportation	773	755	750
Defense	1,208	1,105	1,043
Education	618	679	683
Veterans Affairs	300	368	473

Source: ONDCP

Murphy's analysis suggests that we should look with considerable skepticism at the existing budget figures even as a representation of what the federal government spends. The federal government may be spending much less<sup>10</sup> than is claimed in the ONDCP budget statement (this year issued by the "OMB budget team") and the allocation across classes of programs may be quite different from the official figures.

But even more important, the federal drug budget construct poses a false competition between enforcement expenditures and those for treatment and prevention. Because Congress does not appropriate a drug budget (nor receives the drug budget from ONDCP as an item for debate) but instead scatters its components into the 13 other appropriation bills, drug treatment agencies have to contend with other health programs for funding. Cuts in the Customs or DEA budget will not, in a politically or budgetarily meaningful way, free up resources for expanding drug treatment; instead, SAMHSA will have to convince HHS that it deserves a larger share of the health budget than it currently can obtain.

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<sup>10</sup>In principle, the figure could be higher. However, Murphy's analysis points to incentives for overstatement and nothing in the other direction.

For that purpose it will be necessary to put more effort into showing the public health consequences of dealing with the drug dependent population. Intravenous Drug Use (IVDU) is the primary risk factor for about one third of all AIDS cases. Hepatitis C is spreading among the IVDU population. The increase in TB cases in the last few years seems to have its origins primarily in the worsening condition of drug abusers. If drug treatment can reduce the extent of drug abuse among the 2 to 3 million dependent users of cocaine and heroin, then it may lower mortality and morbidity for other population groups as well. This may turn out to be the most publicly compelling case for increased drug treatment.

I welcome questions.



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Figure 1: Composition of Drug Arrests Changing: 1979-1991

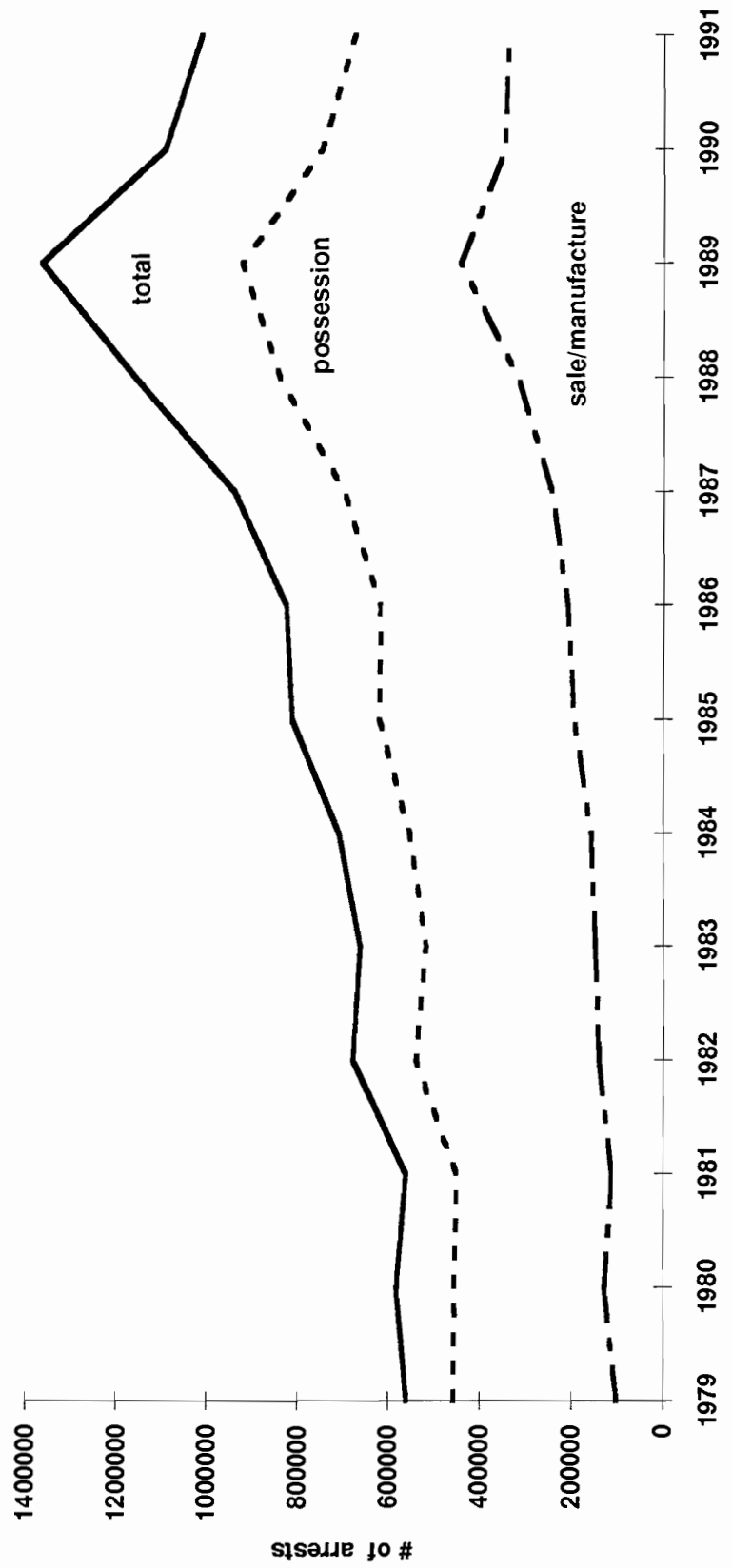
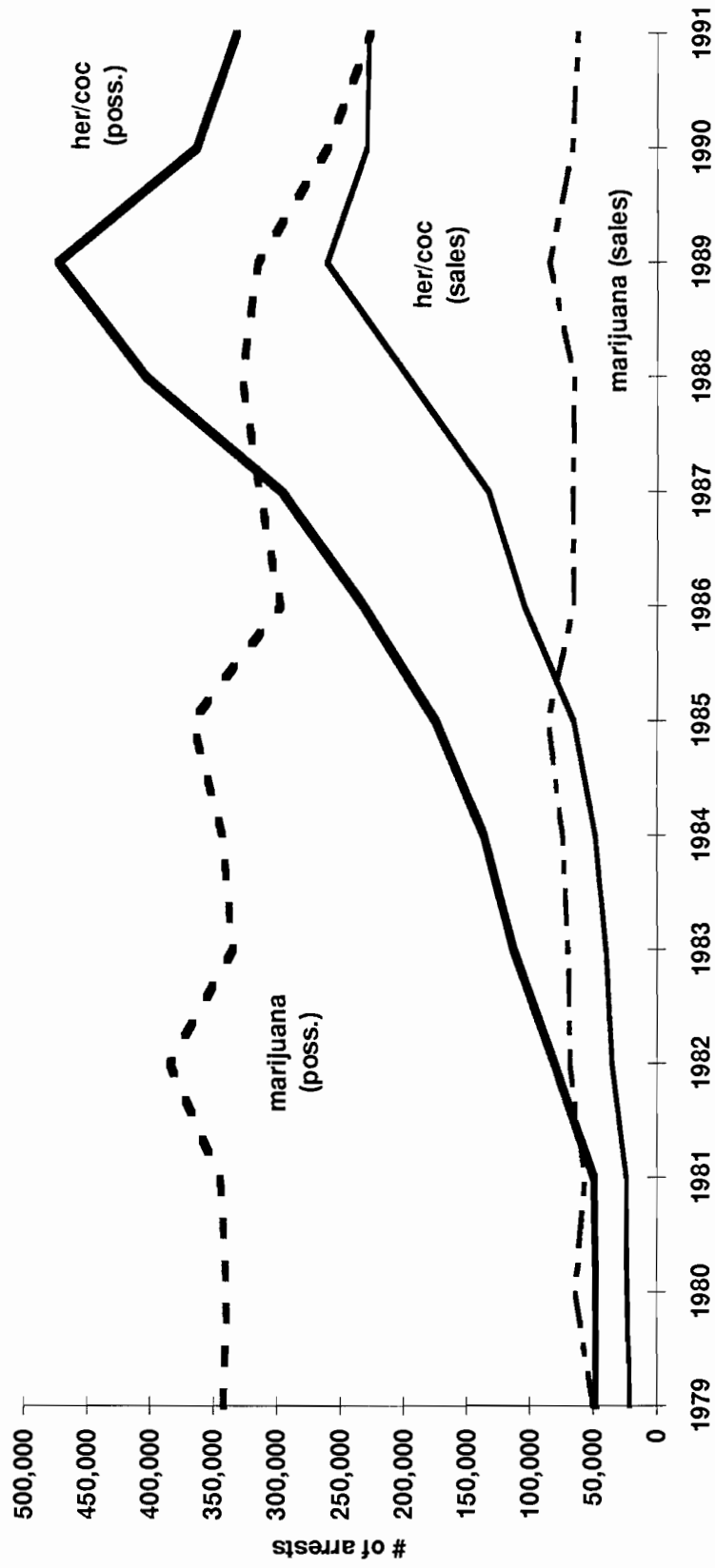
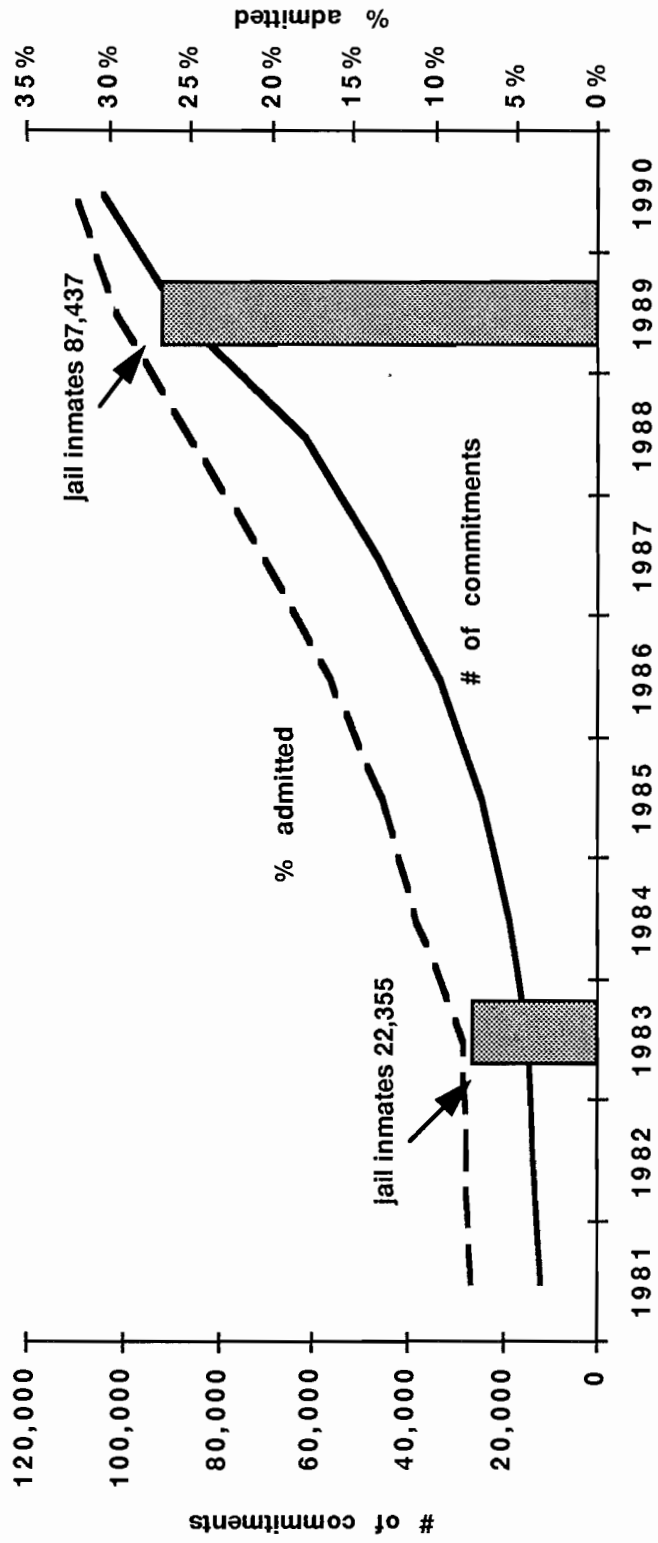


Figure 1a: Composition of Drug Arrests Changing: 1979-1991



**Figure 2: Drug Offenses: Commitments to State Prison and Number of Jail Inmates**



**Table 1: Defendants in U.S. District Courts**

	<u>1980</u>	<u>1985</u>	<u>1990</u>	<u>1992</u>
<b>Total Number of Defendants</b>	6,343	11,208	19,271	22,023
<b>Number of Convicted</b>	4,479	9,231	16,188	18,319
<b>(% of Defendants)</b>	75%	83%	84%	83%
<b>Number Sentenced to One Year or More</b>	2,266	4,818	11,972	14,170
<b>(% of Convicted)</b>	51%	52%	62%	77%
<b>Avg. Sentence Length (mos.)</b>	55	65	79	87
<b>Expected Time Served (mos.)</b>	22	22	66	74

**Table 2: Structure of Drug Policy**

	<b>Enforcement</b>	<b>Treatment</b>	<b>Prevention</b>	<b>\$B</b>
<b>Federal</b>	Interdiction Source Country	Fund ↓	Fund ↓	10
<b>State</b>	Prisons	Fund ↓	Fund ↓	8.5
<b>Local</b>	Police Prosecutors Jails	Deliver	Deliver	10
<b>Billions</b>	22	3.5	3.0	28.5



