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Setting Priorities: Budget and Program Choices for Drug Control

Peter Reuter†

The most visible political battle in drug policy in recent years has been over the allocation of the federal drug control budget. Discussions about what priority to assign to different ways of reducing drug problems have begun and ended with how the federal government spends its money on drug control. For the last decade, the federal drug control budget has been heavily weighted towards programs that are classified as "supply side."1

The first half of this Article argues that this debate has been misguided. First, the federal drug budget is a poor approximation of what the federal government spends to control the drug problem; the debate is about numbers that are not meaningful. Second, the federal drug budget, even if measured correctly, is actually less than half total national drug control expenditures when state and local drug spending are included; thus the debate is focused on the wrong budget. We should be asking about the composition of the national budget rather than the federal budget. Third, budgets are driven by laws and programs; we should debate those laws and programs and not the budgets that result.

The Article's second half attempts to be constructive, inevitably a more difficult task. Setting priorities requires clarity about goals. Thus Part II begins by analyzing the current federal goal of reducing the number of people who use drugs and how this goal affects policy, in particular slighting treatment. Starting from the premise that we seek a set of laws and programs that

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will minimize the total harms from drug use and drug control, the Article asks how we should determine the role of punishment while accepting the current prohibitions on drugs.

In answering this question, I first identify several elements that make up "the drug problem" and then match the major classes of drug control programs to those elements. Because each class of drug control programs helps primarily with only certain drug problem elements, the optimal mix of programs will vary with the nature of the current drug problem, a crucial insight given that the drug problem varies substantially over time and among communities. It is likely that a more punitive approach is more appropriate in the early stages of an epidemic than in later stages. We are very much at the end of an epidemic of drug initiation, so the arguments for a policy focusing primarily on people who are already drug dependent is strong.

I. THE LIMITATION OF BUDGETS FOR DIRECTING POLICY

A. The Federal Drug Budget

Since 1980, recorded federal expenditures on drug control have grown massively, from $1.5 billion in Fiscal Year 1981 to $11.7 billion in Fiscal Year 1992. Even after discounting for inflation, there has been a five-fold growth in these expenditures. Figure 1 presents the growth of the federal drug budget over this period, expressed in constant 1987 dollars.

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2 This section draws heavily on work by my former colleague Patrick Murphy. See Patrick Murphy, Keeping Score: The Frailties of the Federal Drug Budget (RAND, 1994).
3 The term "drug control" is defined in The Anti-Drug Abuse Act of 1988 § 1507(2), Pub L No 100-690, 102 Stat 4181, 4188 (1988), codified at 21 USC § 1507(2). This statute, which established the ONDCP, restricts its mandate to controlled substances. 21 USC § 1507(1). ONDCP budgets reflect this mandate and include only expenditures aimed at reducing the supply of or demand for prohibited psychoactives, or mood-altering substances. Since 1992, the ONDCP has also included modest expenditures aimed at reducing drinking by those under twenty-one. ONDCP, 1992 National Drug Control Strategy 10-11 (1992) ("1992 NDCS") (noting that expenditures for existing programs run by the Department of Education, the Department of Health and Human Services, and the Department of Transportation to stem alcohol abuse by those under twenty-one will now be included as drug abuse treatment expenditures). See also ONDCP, 1992 National Drug Control Strategy Budget Summary 40 n 4 (1992) ("1992 NDCS Budget Summary").
4 Id at 214. The figures here refer to annual appropriations, rather than to requests by the Administration or to obligations. Fiscal Year 1981 represents the last budget of the Carter Administration.
Throughout most of the period, at least two-thirds of the money has been allocated to enforcement programs of various types: source-country control (for example, eradication efforts and military assistance to several Andean countries), interdiction (for example, efforts to seize drugs and drug smugglers on their way into the United States), and domestic enforcement (for example, investigation of high-level dealers and incarceration of convicted dealers and users). As little as one-quarter and never more than one-third of the total budget went to preventing drug use and treating drug abuse or dependency.

As the drug problem intensified during the late 1980s, some senators pushed rhetorically for shifting resources to prevention and treatment programs. Congress, however, has been unable to
accomplish this objective because the federal drug budget is a misleading myth. That budget is not an appropriated budget, decided on by the Administration or Congress, but is instead a complex, after-the-fact calculation of what agencies claim to be spending on drug control. The numbers in the federal drug budget are highly questionable; it is likely that the federal government is spending a good deal less than it claims, and it is possible that it spends roughly equal amounts on supply-side and demand-side efforts. Moreover, the mechanisms for shifting funds from one class of programs to the other are weak.

Of the $12.2 billion in the estimated federal drug budget for 1993, only about $2 billion was appropriated explicitly for drug control.\footnote{This is the sum of the few congressional appropriations that are explicitly and exclusively for drug control: the Drug Enforcement Administration, the Organized Crime Drug Enforcement Task Forces, the National Institute on Drug Abuse, the Office of National Drug Control Policy, and the Department of State’s Bureau of International Narcotics Matters. For Fiscal Year 1993 these totaled $1.81 billion.} Congress could clearly decide to spend more or less on these programs in light of its views on the drug problem and the appropriate roles of the agencies. The remaining $10 billion was hidden in agency budgets.

Agency drug budgets are weak approximations. Some agencies simply assign a fixed proportion of their total budget to drug control. For example, the Immigration and Naturalization Service ("INS") assigns 15 percent of its budget to drug-control activities;\footnote{1992 NDCS Budget Summary at 100 (cited in note 3); 1994 NDCS Budget Summary at 96 (cited in note 1) (showing figures from 1993 actual expenditures through 1995 requested expenditures). The detail offered in 1994 was that "[t]he drug percentage reflects estimated work years devoted to INS’s drug mission. The three largest components of the INS drug program are the Border Patrol, the Detention and Deportation and the Investigations activities. INS counts 15 percent of Border Patrol, 25 percent of Detention and Deportation, and 24 percent of Investigations resources as drug related." 1994 NDCS Budget Summary at 96 (cited in note 1).} the only way that Congress could cut the INS drug-control budget by $10 million would be to cut the total agency budget by $66 million. Because its appropriation is not directly affected by its drug control figure, the INS has no incentive to make an effort to get the figure right. Whether 15 percent is the correct figure matters to no one.

These kinds of flat-line agency appropriations account for about $3 billion of the "drug money" in agency budgets.\footnote{Murphy, Keeping Score at 3 (cited in note 2).} The remaining $8 billion is derived from algorithms (often smacking...}
of alchemy) that rival Gramm-Rudman sequestration rules in their complexity. For example, the Department of Veterans Affairs ("VA") estimates how many of its patients are likely to have primary drug problems, how many will have both drug and alcohol problems, and how many will have drug problems and other mental disorders; the VA then uses arbitrary (but possibly reasonable) rules to estimate what percentage of its expenditures on these clients will be classified as drug treatment. When it decides on the VA budget, Congress does not know how it will affect the VA drug budget. Indeed, the VA itself has only a rough idea of what it will spend out of the forthcoming year's appropriation on drug treatment. It is scarcely surprising that the Fiscal Year 1991 figure for the VA in the drug budget, $368 million when appropriated, had risen to $611 million when recalculated in Fiscal Year 1993!

Nor is this a minor matter, as the VA accounts for about one-third of estimated total federal treatment expenditures in recent years.

There are also serious problems in the categorization of programmatic expenditures: the labels "treatment" and "prevention" are not explicitly defined for the budgetary exercise. The federal government labels some funds as "drug prevention" that clearly have additional purposes. For example, the Clinton Administration's 1995 drug budget lists $660 million in prevention expenditures by the Department of Education (requested funds), but in fact the proposed new Safe and Drug-Free Schools and Community programs are clearly multipurpose programs, many

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12 The ONDCP explanation of the VA drug budget estimate 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. 1992 NDCS Budget Summary at 194 (cited in note 3). See also Murphy, Keeping Score at 3 (cited in note 2).

13 Murphy, Keeping Score table 2 at 4 (cited in note 2).

14 In 1993, the federal government spent $2.339 billion dollars on treatment. 1994 NDCS Budget Summary at 11 (cited in note 1). The VA spent $899 million of that amount. Id at 168.
of which are only loosely related to drug prevention. "Funding for this program is being included in the National Drug Control Budget because activities supported with these funds will have an impact on drug prevention as well as violence prevention." Even more questionable is the decision to include as prevention funds the 1995 budget request from the "Crime Control Fund," which requested $284 million for additional police, primarily in community-oriented policing roles. It is perhaps not too cynical to suggest that an administration that claims to be shifting priorities away from enforcement, at a time of budget stringency, is using creative accounting to accomplish that goal.

Treatment funding totals are equally questionable. The ONDCP reports that the Health Care Financing Administration ("HCFA"), which administers Medicaid and Medicare, spent approximately $230 million in Fiscal Year 1993 on drug treatment. This figure represents 0.1 percent of HCFA's total expenditures of over $220 billion. Yet by increasing funding enough to round up to the next tenth of a percent, a larger apparent increase can show up on the books. Indeed, this illusion appears in the 1995 figures, where an 11 percent real increase appears to be a 100 percent increase when converted to percentages. The benefit is twofold. The demand-reduction percentage goes up, but such an "increase" does not involve spending new money and thus has no effect on the deficit. Nor is any money subtracted from another program account that is politically salient.

Similarly, the Education Department's claim to be spending $98 million in drug treatment represents at the minimum an expansive definition of treatment, as is its definition of vocational rehabilitation as "those individuals whose disabling condition is

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16 Id at 29 (cited in note 1).
17 Id at 84. No explicit justification is offered for this surprising classification. Presumably the argument is that Community-Oriented Policing is more concerned with "preventing" crime problems than with apprehending criminals; hence this kind of policing, inasmuch as it bears on drugs, is "preventative." See Mark Harrison Moore, Community Policing, in Michael Tonry and Norval Morris, eds, 15 Crime and Justice: A Review of Research 113-14, 136-38 (University of Chicago Press, 1992).
19 See, for example, id at 11 (claiming to raise the percentage of demand-side budget from 35 percent to 41 percent).
20 Id at 41.
21 Id.
22 1994 NDCS at 41 (cited in note 18). The percentage rose to 0.2 percent in the 1995 request due to rounding from .145 percent to .155 percent.
due to drug abuse.\textsuperscript{23} By that rationale, all social service expenditures on those who are harmed by their own drug abuse could be categorized as drug treatment.

The numbers thus are deeply flawed, the result of institutional biases, their detachment from any true budgeting process, and the genuine complexity of measuring drug control efforts in multifunction programs. Though the examples of bias presented have been primarily from demand-side programs, I judge it likely that the overstatement of expenditures (there is a bias against underestimates) is even greater on the supply side than on the demand side. Thus, the true drug budget for recent years may turn out to be substantially smaller than Congress thinks, but may have been split more evenly between demand- and supply-side programs than the budget suggests.

Achieving programmatic balance in the federal budget is made particularly complicated by the "imbedded" nature of so much of the expenditures. It is essentially impossible to reallocate what the Coast Guard spends on drug interdiction to treatment or prevention. Moreover, given the complications introduced by current budget restrictions, intended to produce discipline in both Congress and the White House, it is hard to move money between widely disparate agencies. If Congress wants to expand treatment and prevention, then it will have to appropriate more money for these types of programs, probably by appropriating less for other health and education programs. That battle is not one that treatment and prevention advocates relish, but the legitimacy of such devices as calling community-policing expenditures "prevention" is a poor substitute.

B. State and Local Budgets

The focus on the federal budget is particularly inappropriate because so much money is spent by lower levels of government on drug control out of their own tax revenues, as opposed to federal grants. If budgets matter, then it is important to estimate these non-federal expenditures and to develop ways to change their composition.

The ONDCP recently commissioned the Census Bureau to conduct a detailed study of state and local expenditures on drug control.\textsuperscript{24} That study reported estimates for Fiscal Years 1990-1992.

\textsuperscript{23} Id at 29.

\textsuperscript{24} ONDCP, \textit{State and Local Spending on Drug Control Activities} (1993).
and 1991 but provided little information about how the data were collected. The Census Bureau estimate was incomplete: it did not include expenditures by specialized units of government such as independent school districts. Still, the Census Bureau concluded that state and local governments spent $14.1 billion on drug control in 1990 and $15.9 billion in 1991. When one subtracts the estimated $3.2 billion in federal transfer payments to state and local governments in 1991, this produces a total of $12.7 billion spent on drug control, compared to the $11 billion spent by the federal government that year.

25 Id. The collection task is complicated because most drug control is carried out by multifunction agencies with weak budgeting systems; there is no compelling way to extract the drug function. For example, police agencies do a lot of drug enforcement in the course of routine patrol or detective work; consequently, data on the drug squad budget will grossly underestimate the total going to drug control. The Census Bureau study does not provide detail as to how respondent agencies were instructed to deal with such issues. There are conceptual problems as well: to what extent is the arrest of drug-involved offenders for non-drug offenses appropriately labeled drug control?

26 Most local prevention expenditures are probably made by school districts. Prevention expenditures are extremely difficult to estimate because schools do not split up their budgets on the basis of curriculum content. One crude but appealing method is to estimate what share of class time goes to drug prevention and then to allocate to prevention the same share of the total budget for elementary and secondary education. That still leaves two problems: estimating class time devoted to prevention and estimating the cost of non-school prevention. My estimate is that no more than 1 percent of school time goes to drug prevention, even broadly defined; that would suggest a 1991 expenditure total of less than $2.5 billion of the total $250 billion spent by public elementary and secondary schools. Bureau of the Census, Statistical Abstract of the United States 1994 151 at table 224 at 151 (1994).

27 ONDCP, State and Local Spending at 3 (cited in note 24).

28 Id at ii.
Table 1
Estimated Government Drug Control Expenditures, 1991
(billions of dollars)

<table>
<thead>
<tr>
<th>Govt Level/ Program</th>
<th>Federal</th>
<th>State</th>
<th>Local</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enforcement</td>
<td>7.20</td>
<td>5.65</td>
<td>5.97</td>
</tr>
<tr>
<td>Prevention</td>
<td>1.65</td>
<td>.40</td>
<td>.10</td>
</tr>
<tr>
<td>Treatment</td>
<td>2.07</td>
<td>2.02</td>
<td>.87</td>
</tr>
<tr>
<td>Total</td>
<td>10.92</td>
<td>8.07</td>
<td>6.94</td>
</tr>
</tbody>
</table>

Source: Peter Reuter

When all of these pieces are assembled, it is clear that the total is even more heavily skewed toward enforcement than is the federal allocation; the share going to treatment and prevention at the state and local level is no more than one-quarter and perhaps only one-fifth.

Focusing on the federal budget's overemphasis on enforcement misses the primary budgetary target. If we as a nation are too punitive, this result is the consequence of state and local decisions; these levels of government are responsible for most of the enforcement expenditures and most of the resulting imprisonments on drug offenses.

Properly analyzing the federal budget as a component of the national budget can lead to some strikingly different conclusions. For example, expenditures on drug interdiction have been frequently cited as too high a share of federal drug control expenditures, given the evidence of interdiction's limited effectiveness in either raising the price or reducing the availability of cocaine and heroin.

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29 The figures here are pieced together from the tables in the 1992 NDCS Budget Summary and from State and Local Spending on Drug Control Activities. They include some judgments about how federal payments to state and local governments are divided among treatment, prevention, and enforcement. Federal prevention and treatment expenditures include research expenditures in these activities.

30 Data on correctional populations and drug enforcement expenditures, broken down by level of government, are presented in Drugs, Crime and the Justice System at 148-51, 195 (cited in note 7).

31 See Peter Reuter, Gordon Crawford, and Jonathan Cave, Sealing the Borders: The Effect of Increased Military Participation in Drug Interdiction (RAND, 1988).
that only the federal government can carry out interdiction and that the national enforcement budget is at least twice as large as the federal budget, interdiction's recent share (less than 5 percent of the consolidated total)\(^3\) may not be unreasonable.\(^3\) Moreover, the focus on federal budgets distracts attention from where the most important decisions are being made, namely at the state and local levels.

C. Programs, Not Budgets

The final element of my trilogy of errors is that because budgets reflect policy, priorities should be discussed in terms of policy rather than budgets. The primary determinant of federal prison expenditures, to pick an easy example, is the law providing high mandatory minimum sentences for drug offenders convicted of federal drug crimes.\(^4\) If Congress wishes to spend less on incarcerating drug offenders, it will have to cut those minimum sentences and/or direct the Department of Justice to cut its investigation or prosecution of drug offenders. Cutting the prison budget will only mean that those who are sentenced will either have to be let out earlier or that they will spend their sentences in more crowded and ill-serviced facilities. Letting offenders out earlier is difficult at the federal level because there is no longer a federal parole board.\(^5\)

A focus on budgets also tends to obscure important differences among programs. The broadest labels, supply-side and demand-side, are admittedly crude ones, but the slightly more re-

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\(^3\) Interdiction in Fiscal Year 1994 was 10.7 percent of the federal budget. 1994 NDCS Budget Summary at 11 (cited in note 1). If state and local expenditures are greater than those of the federal government, then the share will be below 5.35 percent.

\(^4\) The process for justifying the interdiction expenditure involves some rough analytic and empirical heuristics. The cost of smuggling is seen as primarily determined by interdiction-related activities; after all, the cost of sending a kilogram of cocaine by Federal Express from Colombia is less than $100. Smugglers in fact charge roughly $10,000 per kilogram for their services, accounting for between 7 and 10 percent of the street price of a kilogram. This estimate of smuggling costs is based on the margin between import and export prices of cocaine. See David Anders Boyum, Reflections on Economic Theory and Drug Enforcement table 6.7 at 272 (Ph.D. Diss, Harvard University, 1992) (on file with the University of Chicago Legal Forum). If enforcement is seen as primarily working by raising the price of drugs, one crude measure of a program's effectiveness is its contribution to that price.

\(^5\) The minimum sentences for drug offenders have been raised in a series of acts since 1984. See, for example, the Sentencing Reform Act, Pub L No 98-473, 98 Stat 1987 (1984).

\(^5\) The United States Parole Board was phased out in the 1984 Sentencing Reform Act (cited in note 34).
fined categorization (enforcement, treatment, and prevention) is also basically flawed. William Bennett, in his eloquent "Introduction" to the first National Drug Control Strategy, objected to the demand-side/supply-side split, arguing that enforcement could directly reduce demand. After all, effective enforcement should raise the price and reduce the availability of illicit drugs and thus reduce consumption. Bennett equated consumption with demand, a misconception that is common in the drug policy field but that misses the central point of the distinction between demand and supply. A decrease in consumption resulting from higher prices rather than lower demand merely shifts the point on the demand curve at which supply equals consumption, and is likely to increase the revenues of drug sellers. Demand for drugs is believed to be inelastic. Therefore, reduced consumption without reduced demand, with its corresponding higher revenues for drug sellers, will generally worsen various aspects of the drug problem. A reduction in demand, on the other hand, will lower consumption without generating these highly undesirable side effects.

It is true that enforcement against drug retailers can reduce demand. Mark Moore noted in 1973 that only enforcement that raises the non-monetary costs of purchasing drugs, by making them riskier or harder to find, shifts the demand curve; street-level enforcement can, in theory, accomplish this. Because the federal government attempts to confine itself to higher-level enforcement, rather than street-level transactions, however, the usual categorization of supply-and-demand programs is correct for the federal budget (except perhaps for pass-throughs to local governments for policing), but not for the "national" budget that was discussed in the previous section.

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37 No credible estimates of the elasticity of demand for illegal drugs, either singly or as a group, have been published. An analogy is often drawn to cigarettes, for which studies have established that the elasticity of demand at current prices is substantially less than one. See Edwin Mansfield, Applied Microeconomics 88 (W. W. Norton & Co., 6th ed 1994) (stating that many studies have found the price elasticity of demand is about 0.4). Michael D. White and William A. Luksetich, Heroin: Price Elasticity and Enforcement Strategies, 21 Economic Inquiry 557, 557-63 (1983) (arguing that dependency-creating drugs have a price elasticity of demand of less than one).
38 A higher price for a drug will in theory generate more violence in the trade because it increases the incentive to steal or defraud and because court protections are not available for illegal contracts. As with most statements about the economics of the drug trade, this is a reasonable speculation without any empirical testing.
Enforcement aimed at users, such as "sell-and-bust" in street markets, may be categorized as demand side, albeit not of the kind that liberal advocates of treatment are likely to be happy about. Yet enforcement aimed at users may indeed be effective in preventing drug use; lack of easy access to highly visible markets may do as much to deter those adolescents who are at moderate risk of becoming regular drug users as any existing secondary prevention program. However, it is difficult to distinguish user-oriented enforcement from other kinds of local drug enforcement, certainly in budgetary terms.

A discussion of priorities, then, must go to the content of programs. Expanding efforts at enforced abstinence for probationers, parolees, and those out on pretrial release programs will result in increased enforcement budgets but is substantially a demand-side program. Its goal is to reduce the demand for drugs, but it uses the threat of penalties, aimed at those users whose behavior causes the greatest harm, to accomplish that goal.

Moreover, there are more dimensions to policy than the current budget splits suggest. Treatment for criminal justice referrals has very different consequences for drug-related harms than does treatment for pregnant women. The former provides large gains to the community, through reductions in crime; the latter’s gains will primarily go to the infants of those women. Comparing those gains is complex, but the latter is likely to appear more congruent with the "public health" approach that has become a popular slogan for drug policy reformers than is treatment of high-rate criminal offenders. However, if one takes a broad view of public health, in which violence is seen as a major cause of health harms, then the former might be the preferred program.

Indeed, drug policy theoretically might best be divided not by characteristics of program instruments (enforcement, treatment, etc.) but by the nature of the harms reduced; unfortunately, that is neither empirically nor politically feasible. But a realization that different programs confer very different benefits, very differ-

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41 Id at 192-96.
ently distributed across various beneficiary groups, helps point to the weakness of the current classification.

II. A FRAMEWORK FOR POLICY CHOICES

Although the federal budget is a poor indicator of current drug policy, it is still too oriented toward law enforcement. This bias stems from the goal of reducing drug use rather than reducing net harm. This Part thus begins by considering the objectives of drug policy as embodied in the Bush Administration’s annual editions of the National Drug Control Strategy. This is followed by an effort to develop an alternative set of goals that reflects the harms with which drug policy should be concerned but that accepts that most programs will only help alleviate certain harms and may actually exacerbate others. Finally, I suggest some guiding principles for both budget allocations and decisions about punitiveness.

A. Goals for Drug Policy

In 1989, with the creation of the ONDCP, Congress imposed on the Executive Branch of the federal government a requirement that it develop a strategy and explicit quantitative goals for dealing with the drug problem.43 The 1988 Anti-Drug Omnibus Control Act specified that the strategy, to be published annually, should include “long-range goals for reducing drug abuse in the United States”44 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.”45

This marked an innovation for drug policy. Though other administrations had issued drug-policy strategy documents,46 not one had defined its goals, either analytically or quantitatively. Given the increasing governmental emphasis on quantitative objectives,47 the 1988 requirement that explicit quantitative

45 21 USC § 1504(a)(2)(B).
47 See Michael A. Stoto, Ruth Behrens, and Connie Rosemont, eds, Healthy People 2000 1-2 (National Academy Press, 1991) (“prepared as a record of the public hearings and other activities designed to gather and organize information for the United States
goals be developed can be seen as helping to move drug policy from a principally moralistic domain toward the mainstream of public policy.

The 1989 National Drug Control Strategy ("1989 NDCS") clearly states the Administration's goals:

[T]he 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. 48

This was reflected in its specific goals, which were heavily reliant on the National Household Survey on Drug Abuse ("NHSDA"), 49 and to a much lesser extent on the annual survey of high school seniors conducted by the University of Michigan (Monitoring the Future or "MTF") 50 and the Drug Abuse Warning Network ("DAWN"). 51 As enunciated in the 1989 NDCS and reiterated by its three Bush Administration successors, the goals were to reduce the following by specified percentages (almost always 10 percent in two years and 50 percent in ten years):

- NHSDA-measured last-month drug use;
- MTF-measured adolescent last-month drug use;
- NHSDA-measured last-year cocaine use;
- NHSDA-measured last-week cocaine use;
- NHSDA-measured last-month cocaine use among those aged twelve to seventeen;
- NHSDA-measured last-month alcohol use among adolescents;

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48 1989 NDCS at 8 (cited in note 36).
49 The NHSDA is an annual general population survey. Its results are published by the Department of Health and Human Services under the title National Household Survey on Drug Abuse: Main Findings.
51 Published annually by the Department of Health and Human Services as Data from the Drug Abuse Warning Network (DAWN).
• Drug Abuse Warning Network-Emergency Room ("DAWN-ER") mentions of cocaine, marijuana, heroin and dangerous drugs;

• (a) Amounts of cocaine, marijuana, heroin, and dangerous drugs entering the United States;
  
  (b) NHSDA-measured availability of cocaine, marijuana, heroin, and dangerous drugs;

• Domestic marijuana production; and

• MTF-measured approval of drug use.\(^{52}\)

Two of the goals—amounts of cocaine, marijuana, heroin, and dangerous drugs entering the United States (8a), and domestic marijuana production (9)—have not been monitored simply because no acceptable measures are available.\(^{53}\) That leaves nine implemented goals, of which six use NHSDA data, two MTF data, and one DAWN data.

The loss of the import and domestic marijuana production measures is a major one. These would have served as surrogates for total consumption of each drug. Because a small number of frequent users account for the bulk of consumption, consumption itself might serve as a surrogate for the number of frequent users (and perhaps the average harms they produce).\(^{54}\) That is, as

\(^{52}\) See 1989 NDCS at 93-97 (cited in note 36); ONDCP, 1990 National Drug Control Strategy 117-121 (1990); ONDCP, 1991 National Drug Control Strategy 3-18 (1991); 1992 NDCS at 13-29 (cited in note 3). The Clinton Administration has issued one complete National Drug Control Strategy, the 1994 NDCS (cited in note 18). This does contain a more complete set of goals and may signal a strategy which is less punitive in orientation, but the policy consequences of which cannot yet be assessed. 1994 NDCS at 61-72 (cited in note 18).

\(^{53}\) 1992 NDCS at 25-27 (cited in note 3) (stating that current measures were not adequate to determine progress toward these goals). The ability to develop estimates of imports and domestic consumption is likely to be developed slowly at best. For a pessimistic view on this topic, see Peter Reuter, Prevalence Estimation and Policy Formulation, 23 J Drug Issues 167 (1993).

\(^{54}\) For cocaine it is estimated that 22 percent of most frequent users account for 70 percent of total consumption. See Susan S. Everingham and C. Peter Rydell, Modeling the Demand for Cocaine table 3.2 at 15; table 4.2 at 16 (RAND, 1994). For marijuana, somewhat dated figures are given in Peter Reuter, The Economic Significance of Illegal Markets in the United States: Some Observations (in French translation), in E. Archambault and X. Greffe, eds, Les économies non officielles (Le Decouverte, 1984). I have updated these estimates of the concentration of marijuana use in unpublished tabulations from Monitoring the Future. For heroin the concentration is much lower, since occasional use has become a rare phenomenon; a large percentage of those who use heroin in a given year are heroin dependent. I know of no study that has attempted to analyze variation in
compared to any available prevalence estimate, annual increases in the total quantity consumed would provide a better indicator of changes in the severity of drug harms because it is the drug use of the most frequent users that drives this figure and the related harms. As it is, we are left with measures of the numbers of users, crudely categorized into frequency of use and/or age.

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; and the illicit incomes generated by drug selling. These are the harms that are mentioned most frequently in descriptions of the nation’s drug problems. Nor, as it turns out, are DAWN-ER mentions a good surrogate for the adverse health consequences of drug abuse. A substantial share of those showing up at emergency rooms are seeking entry into detoxification rather than reporting acute harms from drug use; thus the availability of detoxification and other treatment may be an important factor in determining DAWN-ER totals.

As enunciated here, the principal goal of federal policy has been the reduction of use and not of harms. But since there would be no harms if there were no use, might the two not be synonymous? The answer is that this is indeed a possibility, but an unlikely one; use reduction and harm reduction are likely to clash, at least in the medium term. For example, as already mentioned, enforcement that reduces the number of users by raising prices will probably increase drug expenditures and related harms in the short run.

I suggest that one major reason for the absence of harms from the “measurable goals” for the NDCS is simply that no compelling measures exist. DAWN obtains data on the number of annual heroin use among the heroin dependent.


For example, in 1991, 25 percent of those showing up at emergency rooms because of cocaine were seeking detoxification. Department of Health and Human Services, Annual Emergency Room Data 1991, Data From the Drug Abuse Warning Network 43 (1992).

The term “harm reduction” is commonly used in Western Europe but has had little circulation in the United States. Inasmuch as it has been used in the United States, it has been associated with legalization and thus has acquired a more controversial connotation than is warranted. Use reduction is a transparent term coined by Robert MacCoun.
SETTING PRIORITIES

medical examiner reports of deaths in which illicit drugs are one of the causal factors. These data, however, only come from medical examiners in about twenty-five major metropolitan areas, and there is no systematic way to extrapolate these figures to the nation as a whole.\(^{58}\) There are enormous conceptual as well as practical difficulties in estimating the number of "drug-related" crimes.\(^{59}\) No basis currently exists for estimating the frequency or severity of harms suffered by drug-affected infants. The first systematic estimate of incomes from drug selling was only developed in 1991, and it has such a broad confidence interval\(^{60}\) that measuring trends will be exceptionally difficult.\(^{61}\)

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. It is also consistent with the American dedication to due process and transparency in public policy. Requiring that goals be specified in advance means that claims of success in a partisan setting can be subject to reasonable scrutiny. If the measurements are seen as deriving from systematic and credible sources, then the measurements will facilitate such scrutiny. Alas, in situations where 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 unrewarding task.

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\(^{58}\) 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 medical examiner and emergency room data are collected and then to apply that ratio to the national DAWN-ER estimate. However, Jonathan Caulkins, Assistant Professor of Public Policy at Carnegie-Mellon University and Co-Director of the Drug Policy Research Center at RAND, has examined the ratio of emergency room to medical examiner mentions across cities and has found the figure to range from about 0.5 to 50, without any strong central clustering. Personal communication with Jonathan Caulkins, 1993. We appear to be without any convincing means of estimating either the number, or trends in numbers, of drug-related deaths. Vital-statistics-based estimates lack credibility; when vital-statistics estimates are compared with those from DAWN, the latter are substantially higher.


\(^{60}\) A confidence interval is a statistical margin of error. Webster's Ninth New Collegiate Dictionary 275 (Merriam-Webster Inc., 1986).

\(^{61}\) ONDCP, What America's Users Spend on Illegal Drugs 1, 12-16 (1991).
B. The Logical Consequences of Goals

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 real and increasing association between drug abuse and crime. But the federal government's choice of goals is also an important factor. The evidence for this proposition lies in the rhetoric of actors and the logic of the goals rather than in 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 treatment and prevention. Treatment programs have little attraction as a means for reducing prevalence because they operate on the tail of distribution. Indeed, the 1992 NDCS, in commenting on the significance of the goals established in 1989, stated that "for 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." Even if treatment programs were completely effective, that is, if every patient entering the system in 1992 became drug-free thereafter, such programs would reduce the total number of monthly users of illicit drugs by less than 700,000—less than 7 percent of the NHSDA monthly total.

Taking a narrow scoring point of view, the situation is even worse. There is a considerable concern that the NHSDA simply does not include many of those who are likely to be treated. The survey omits incarcerated persons and the homeless, many of whom have substantial drug problems. It also has a non-response rate of about 20 percent. Nor does the

62 "Prevalence goals" refers to focus on numbers of users rather than harms.
64 There were approximately 700,000 new treatment admissions in 1989. National Drug and Alcoholism treatment United Survey: 1989 Main Findings Report table 4 at 12 (Department of Health and Human Services, 1990) 351,000 clients were reported to have either drug problems or alcohol and drug problems. This is a one day count. I assume that six months is approximately the average treatment time, resulting in approximately 700,000 for the year.
65 A "narrow scoring" point of view considers only how a program affects use as measured by surveys.
68 The 1991 response rate was 81.3 percent. Lana Harrison and Joseph Gfroerer, The
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NHSDA provide the basis for estimating the number of heroin addicts. Indeed, heroin is not listed among the specific drugs for which prevalence reduction is a stated goal, given the role that heroin use plays in the spread of AIDS (through the sharing of needles), this is a startling omission, explained (I suggest) by the lack of credible measures of the size of the population. Since 1980, only one such national estimate has been published, and it relies on highly speculative city-level estimates. Thus successful treatment is unlikely to produce lower NHSDA prevalence estimates.

The limitation of prevention is that a long lag occurs before such efforts affect prevalence. Programs aimed at seventh graders (aged thirteen to fourteen), the group most commonly targeted by school-based prevention, will only substantially affect prevalence measures five or six years later, as drug use rates peak at ages eighteen to twenty-two. Though three of the goals are specific to the younger age group (drug use and drug approval measured in the MTF, and adolescent drug use in the NHSDA), these have received secondary billing in the public debates.

Use reduction is presented as a pragmatic rather than an ideological or moral policy, though the immorality of drug use is a fundamental tenet of its expression in the 1989 NDCS. Under this view, the extraordinary drug problem that the United States had during the late 1980s is the consequence of permissive or tolerant attitudes, particularly in the 1960s. Large segments of the youthful population came to believe that drugs were not harmful. Governments did not take sufficient action to punish those who broke the law by using drugs; enforcement was lax and the media mocked those concerned with the dangers of drugs. The best way, perhaps the only way, to diminish the drug problem is for the government expressly, and aggressively, to disapprove of all drug use. There are no goals that should be sacrificed in the quest to minimize the number of persons using drugs.


See, for example, 1989 NDCS at 2-3 (cited in note 36).

Mark Kleiman correctly observes that use reduction could refer to either prev-
A possible defense for focusing on use rather than harms is that the level of harms is a simple function of the number of drug users. Therefore, 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, but the 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 American drug policy, namely that aggressive enforcement can actually increase drug-related harms.

C. A More General Approach to Policy Consequences

1. Elements of the drug problem.

Table 2 presents a list of eight phenomena that I take to constitute some of the major components of "the drug problem." All of them have many elements themselves; for example, the health consequences of drug dependence include an array of problems that affect users and the rest of the community, such as HIV, tuberculosis, and hepatitis C. Crime by users includes both "economic-compulsive crime" and crime induced by the psychoactive properties of the drugs themselves, to use Paul Goldstein’s distinction. The list could be expanded, but I believe each item of a larger list could be associated with one of the four categories of sources used here: initiation, dependence, distribution, and production.

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74 See notes 82-84 and accompanying text.
Table 2

Elements of the Drug Problem

<table>
<thead>
<tr>
<th>Elements</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescents dropping out of school</td>
<td>Initiation</td>
</tr>
<tr>
<td>Gateway to other behavioral problems</td>
<td></td>
</tr>
<tr>
<td>High mortality and morbidity among users and</td>
<td>Drug Dependence</td>
</tr>
<tr>
<td>their intimates</td>
<td></td>
</tr>
<tr>
<td>Crime by users</td>
<td></td>
</tr>
<tr>
<td>Large criminal incomes</td>
<td>Drug Distribution</td>
</tr>
<tr>
<td>Violence in competition</td>
<td></td>
</tr>
<tr>
<td>Distortion of source country societies</td>
<td>Drug Production</td>
</tr>
<tr>
<td>Strains on U.S. foreign policy</td>
<td></td>
</tr>
</tbody>
</table>

Some of the problems in the list are related not so much to the consequences of drug use itself as to initiation of the young into drug use. Young people's involvement in the subculture surrounding illicit drugs, their routine violation of the law, and their possible progression to drug dependence are the central concerns associated with initiation. Another set of problems is caused by the dependence or abuse of drugs; these include the spread of AIDS and crimes committed to support expensive drug use. Cocaine sells in illegal markets for about eight times its legal price, which helps explain the high level of property crime associated with dependence on cocaine. Sharing of dirty needles in commercial shooting galleries by heroin addicts is largely a function of the prohibition on unauthorized possession of hypodermic needles.

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76 Cocaine is a Schedule II drug, occasionally used by dentists as a local anaesthetic. On the ratio of legal to illegal prices, see Moore, 15 Crime and Justice: A Review of Research 124 (cited in note 17).


78 The influence of legal availability of syringes on needle sharing is surprisingly weak. For example, syringes are readily available at low prices from pharmacies in Italy.
Other problem elements, such as killings of rival drug dealers, are not directly related to drug use but rather to the distribution of drugs. Even if drugs did not adversely affect behavior, the struggle for markets and contract disputes in an illegal setting would generate (at least in the United States) a great deal of violence. Still other problem elements—for example, the distorted social and political institutions in Bolivia, Colombia, and Peru—are a function of the production of the drugs themselves.

If it were possible to eliminate illicit drug use altogether, all of these problems would either vanish or would be much ameliorated. But because different elements of the problems have different sources, lowering drug consumption does not necessarily have the desired effect on all elements of the drug problem. Initiation may decline sharply, as suggested above, even while dependence is worsening. There are also policy trade-offs among these components. For example, we may be able to reduce cocaine use with more stringent enforcement against dealers, but we might suffer, at least in the short run, a worsening of related crime and health problems. Indeed, drug-related homicide appeared to rise in 1990, just as there was mounting evidence of reduced drug consumption.79

Breaking up the drug problem into its component elements helps clarify the programmatic consequences of the harm-reduction and use-reduction approaches.80 The following subsection identifies the relationship between particular programs and individual elements of the problem and then examines how the choice of goals affects program emphasis.

2. Matching programs and problems.

The traditional classification of programs dealing with drug problems has been enforcement, treatment, and prevention. If we further divide enforcement into the categories of source-country control (for example, crop eradication and refinery destruction)
and domestic enforcement (including interdiction of smuggled drugs), we can match program types with the dimensions of the drug problem schematized in Table 2. That matching is presented in Table 3.

Table 3
Matching Programs and Problem Elements

<table>
<thead>
<tr>
<th>Program Targets</th>
<th>Problem Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention</td>
<td>Initiation</td>
</tr>
<tr>
<td>Treatment</td>
<td>Drug Use</td>
</tr>
<tr>
<td>Enforcement</td>
<td>Distribution</td>
</tr>
<tr>
<td>Source Country</td>
<td>Production Controls</td>
</tr>
</tbody>
</table>

Programs are usually evaluated in terms of the targets suggested by this mapping. Thus primary-prevention programs are evaluated mostly in terms of their effect on initiation into drug use; successful prevention efforts will reduce the percentage of nonusers or experimental users who become regular users. Reductions in drug-related violence are neither expected nor measured. Similarly, treatment programs are evaluated in terms of reducing the extent of drug dependence and associated harms.

Of course, programs may affect more than their principal targets; the effects can even be negative. Increasingly, effective treatment may actually worsen initiation problems by removing the most visible and striking negative role models of addicted drug users. That is not a reason for failing to provide funding for drug treatment; it merely points to the difficulty of doing only good.

Other negative interactions, mostly involving enforcement, can be more serious. Consider, for example, the upstream effects of interdiction. If more stringent interdiction works primarily by raising the percentage of shipments intercepted, rather than by raising the labor costs of smuggling through increased incarceration of smugglers, then it may actually increase the export demand for the drug. That is because interdiction has two effects on export demand. By raising prices in the United States, it decreases the total amount consumed. In addition, it also raises the quantity of exports needed to deliver a ton to the United States.
This second effect, under reasonable assumptions about the demand and supply curves of the cocaine industry, turns out to be larger than the first. Thus interdiction may actually increase source-country problems by raising the demand for exports of cocaine.

This matching of program types against goals provides a framework for systematic comparative assessment of programs and policies. We must ask of particular policies not simply how they will affect levels of drug use, but also what their consequences will be for other dimensions of the drug problem. For example, evaluations of street crackdowns should determine their effect on the crime rate and on recruitment rates. Similarly, in allocating resources between prevention and treatment, we must compare the benefits of reduced initiation now with those of reduced heavy use now; the flow of benefits over time may be very different for the two kinds of programs.

D. Programmatic Consequences of the Two Approaches

To illustrate the contrast between the use- and harm-reduction approaches, consider two examples of policy issues: the share of treatment in total funding and the emphasis given to marijuana in enforcement.

1. Treatment.

It is clear that many, arguably the great majority, of the harms associated with illegal drugs are the consequence of the behavior of the relatively small number of persons who use expensive drugs frequently. They account for most of consumption; for example, as already mentioned, 22 percent of cocaine users account for 70 percent of the total weight consumed. Thus one may attribute to them roughly the same proportion of the violence and income generated by the drug trades. Heroin addicts, totaling perhaps only 750,000, account for most of the drug-related AIDS cases. No more than two million cocaine and

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81 Reuter, Crawford, and Cave, Sealing the Borders: The Effect of Increased Military Participation in Drug Interdiction at 133-41 (cited in note 31).
82 See note 54.
heroin users account for most of the property crime associated with drugs.\textsuperscript{84}

Treatment, even the rather low-quality treatment available to most drug users lacking private insurance coverage, has a measurable impact on the crime and health status of clients.\textsuperscript{85} Reductions in drug use by patients while in treatment is substantial, which seems to be sufficient to achieve these gains.\textsuperscript{86} Most clients are not abstinent for long periods of time,\textsuperscript{87} but for harm-reduction purposes, the temporary gains are quite sufficient. Rydell and Everingham find that treatment of frequent cocaine users is cost-effective when compared to drug enforcement, even if (1) every patient immediately relapses to heavy use after leaving treatment, and (2) a fairly narrow definition of social cost is used.\textsuperscript{88} Current treatment then may well be a cost-effective intervention in terms of harm reduction.

In the use-reduction framework, the failure to achieve long-term abstinence is a much more fundamental problem. Treatment, as already suggested, will receive short shrift if policy goals are expressed in terms of the number using drugs on even an occasional basis in the course of a year. Moreover, program performance will be assessed on abstinence rates per dollar; treatments that, for a fixed sum, can achieve abstinence for a small number of patients will be preferred over those that can reduce (but not eliminate) drug use in a relatively large number of patients.

2. Marijuana as an enforcement target.

Most of those who report using illicit drugs use only marijuana; in the 1991 MTF survey, such persons accounted for nearly 50 percent of all young adults reporting use of some illicit drug within the past year.\textsuperscript{89} Even when looking at the popula-

\textsuperscript{84} 1.1 million is a rough estimate of the total number of cocaine users arrested annually. Wish, 25 Intl J of Addictions at 401 (cited at note 69).
\textsuperscript{85} The standard cite is to the TOPS study, which found that after only one year in treatment there were significant reductions in future drug use and criminal activity; longer periods in treatment increase the likelihood of these positive effects. See Robert L. Hubbard, et al, Drug Abuse Treatment: A National Study of Effectiveness 165, 179-84 (University of North Carolina Press, 1989).
\textsuperscript{86} Id. The value of those gains is explored below.
\textsuperscript{87} For instance, roughly 13 percent of heavy cocaine users who complete a treatment program do not return to heavy use after treatment. C. Peter Rydell and Susan S. Everingham, Controlling Cocaine: Supply versus Demand Programs xv, 39-42 (RAND, 1994).
\textsuperscript{88} Id at xv, 39-42.
\textsuperscript{89} For example, of those aged twenty-nine and thirty, 14 percent reported use of some
tion in need of treatment, using the DSM-III-R criteria for dependence utilized by the Institute of Medicine panel, McCaffrey and Ebener estimate that almost half use no illicit drug other than marijuana. If one seeks to reduce measured prevalence of drug use, particularly among the young, marijuana is a very attractive target. Moreover, marijuana is the only drug for which tougher enforcement has been able to raise price on a consistent basis; even after adjusting for the higher potency of contemporary marijuana, the drug is at least five times as expensive as it was a decade earlier. Ounce prices of $250 are not uncommon.

What are the harms associated with marijuana use? Put aside for a moment its status as a gateway drug to others whose use is known to cause substantial and lasting damage. It is certainly not medically recommended, but Mark Kleiman, having written a book on marijuana policy, summarized matters recently by stating: “Aside from the almost self-evident proposition that smoking anything is probably bad for the lungs, the quarter century since large number of Americans began to use marijuana has produced remarkably little laboratory or epidemiological evidence of serious health damage done by the drug.” The behavioral consequences cannot be dismissed so easily; there is no doubt that many people use marijuana quite heavily, and that such use can seriously disrupt an individual's education, personal relationships, and career development. Though surprisingly large numbers of persons are sometimes frequent marijuana users (that is, they consume at least one joint each day for a month), it is also clear that many pass through that state relatively quickly.

illicit drug in the past year; only 5 percent reported use of any illicit drug other than marijuana. Lloyd D. Johnston, Patrick M. O'Malley, and Jerald G. Bachman, National Survey Results on Drug Use from the Monitoring the Future Study, 1975-1992 Volume II, Young Adults table 5A at 41-42 (Department of Health and Human Services, 1993).

Dean R. Gerstein and Henrick J. Harwood, eds, 1 Treating Drug Problems 70 (National Academy Press, 1990). The DSM-III-R criteria are a list of characteristics drug addicts often exhibit, such as “Important social, occupational, or recreational activities given up because of substance use.” Id table 3-2 at 71.


Moore, Supply Reduction and Drug Law Enforcement at 125 (cited in note 76).


Kleiman, Against Excess at 259-64 (cited in note 40).

Id at 253.

Id at 258-59.

The high school senior data consistently show that the ratio of one-time to current
For harm-reduction purposes, marijuana would seem to be a very low-priority drug, unless more marijuana usage results in substantially higher rates of usage of drugs such as cocaine and amphetamines. The existing research is not dispositive on this point. It may well be true that the vast majority of cocaine users were previously users of marijuana, but this does not mean that the marginal user is at anything like the same risk as the average marijuana user of progressing to other drugs. If this is the case, then marijuana enforcement might be greatly reduced over current levels and those resources used for activities that will reduce more harm.

The above are just illustrations of the many positive consequences of shifting from a focus on use to a focus on the social damage done by illicit drugs. Such a shift would clearly provide a better basis for integrating alcohol with illicit drugs for policy purposes. The goal of drug policy would be to minimize the harm done by psychoactive drugs, regardless of their legal status; a use-minimization policy forces a sharp distinction, since there is no claim that society should attempt to minimize the number of people who consume alcohol.

3. Goals and timing.

This discussion of the goals of drug policy has been quite general so far; it has argued that prevalence goals may lead to inappropriate programmatic choices. But there are also important issues of timing that merit consideration.

During the period in which a substantial segment of the youthful population was at risk of becoming very involved in drug use (for example, in 1978 when 10.7 percent of high school seniors reported daily use of marijuana in the previous thirty days), a focus on prevalence had much greater justification than it does today, when very low percentages of youth go beyond brief experimentation. The problems associated with initia-
tion were much more important ten years ago. If enforcement could have met its historic claim of reducing drug use by raising prices and lowering availability, then toughness (along with prevention) would stand on reasonable logical grounds. Use reduction and harm reduction would not be in great conflict.

Most projections for the next few years suggest declining initiation and prevalence, along with a stable population of problematic users generating more crime and disease, though Monitoring the Future results for 1993 showed the first upturn in marijuana use since 1979, pointing to the difficulty of projecting changes in such culturally-determined behavior. This suggests that a change in emphasis is appropriate, as indeed is signaled by the first Clinton Administration National Drug Control Strategy. The greatest harms of drug use are now those related to drug dependence and distribution, for which drug treatment offers a great deal more promise than either enforcement or prevention. Long prison sentences for drug dealers, as are now being handed out by the federal criminal justice system, seem to serve less and less purpose.

CONCLUSION

The federal budget has been the battlefront on which the war about drug policy has primarily been waged. Even if budgets were appropriate for the battle, the federal budget would be the wrong battlefront, because of its questionable accuracy and incomplete coverage. But budgets are blunt instruments, particularly given that drug control functions are so deeply buried inside the principal agencies. Priorities should be set in policy terms and implemented in budgets; the battles should be about priorities first.

No general assertion can be made about the priority to be given punishment as opposed to treatment or prevention. The optimal mix is not some eternal verity, true across all communities or time. Certainly much depends on how old the epidemic is.

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103 1994 NDCS at iii-iv (cited in note 18) (“Message from the President”).
104 The expected time served by drug offenders receiving federal prison sentences rose from just under five years in 1985 to seven years in 1990. See Bureau of Justice Statistics, Sourcebook of Criminal Justice Statistics—1993 table 5.36 at 513 (1994).
and on the problems relating to drug use. Amphetamine use in Stockholm in 1993, long after the drug had become an accepted part of the drug scene there, presents a very different set of problems than cocaine use in Houston in 1983, with its attendant violence and corruption.

Some general principles, however, can be discerned. More attention should be paid to the relationship between punishment and treatment. Punishment is likely to be more effective if it is tied to treatment. More surprisingly, a growing literature suggests that a significant part of the treatment-susceptible population will do no worse when they are legally coerced into treatment than they would if entering voluntarily. Of course, many will not enter treatment except when coerced. Punishment and prevention have a less intimate relationship, but the difficulty of providing effective prevention in communities in which the sale of drugs is conspicuous and ubiquitous is obvious. The notion of "Weed and Seed," if not its execution, has a good deal of logic.

This analysis has referred only to illicit drugs, violating the revisionist view that the licit addictive and/or psychoactive substances, alcohol and tobacco, belong in the same policy domain. Clearly important intersections exist, particularly with respect to alcohol: at the programmatic level, few patients who are dependent on illicit drugs do not also have alcohol-dependency problems. Integrating policies with respect to alcohol and illicit drugs may help raise the priority for drug treatment as opposed to enforcement; experience with alcohol-dependent relatives and friends is common enough that there is an instinctive sympathy for those with drinking problems, which contrasts with the moralistic attitude toward drug dependency. Integration may also ease the political path toward a harm-reduction approach. But illicit drugs, with the distribution- and production-related violence and corruption, raise distinctive problems: an integrated policy is not a uniform policy, and the optimal role of law enforcement is likely to be greater for illicit drugs than for alcohol.
