

FROM:

LAW OFFICES

~~DOUGHERTY & HERB~~

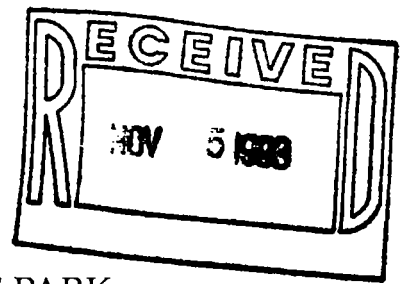
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TO: ~~Mr. John P. Hart~~
~~Deputy Assistant to the President~~
~~for Intergovernmental Affairs~~
c/o ~~The White House~~
~~1600 Pennsylvania Ave., N.W.~~
~~Washington, D.C. 20500~~

**PHOTOCOPY
PRESERVATION**



UNIVERSITY OF MARYLAND AT COLLEGE PARK

SCHOOL OF PUBLIC AFFAIRS

4th November 1993

Melody Heaps
TASC
2nd floor
1500 North Halsted
Chicago, Ill. 60622

Dear Ms. Heaps,

Enclosed is a draft of my paper for the November 13 symposium. It is still missing certain Tables and numbers, particularly in the Appendix, but I believe that there is enough here to provide the discussants with ample targets.

I am usually somewhat tardy in meeting my symposium and writing obligations but this is substantially worse than usual. May I plead the consequences of making a transition to a university while still retaining most of my RAND responsibilities?

Yours Sincerely

A handwritten signature in cursive script, appearing to read "Peter Reuter".
Peter Reuter

DRAFT
SETTING PRIORITIES[#]

Peter Reuter^{*}

Introduction

The most visible political battle in drug policy in recent years has been about the allocation of the federal drug control budget. Discussions about the priority to be assigned different means of reducing drug problems have begun and ended with discussion of the composition of how the federal government spends its money on drug control. For the last decade the federal drug control budget has been heavily weighted toward programs that are classified as "supply side" (interdiction, imprisonment etc.). This has been the cause of much anguish in Congress, which has nonetheless been strangely helpless in shifting resources to the demand side (treatment and prevention), notwithstanding at least one "sense of the Congress" resolution on the matter.

The first half of this paper argues that everything about this debate has been misguided. First, the federal drug budget is a very poor approximation of what the federal government spends to control the drug problem; the debate is about numbers that do not bear scrutiny. Second, the federal drug budget, even if measured correctly, turns out to be a lot less than what is spent by lower levels of government; the debate is focused on the wrong budget. Third, budgets are driven by laws and programs; we should debate those laws and programs and not the budgets that result.

The paper's second half attempts to be constructive, inevitably a more difficult task. Setting priorities requires clarity about goals. Thus the second half begins with an analysis of the current goals (reducing the number of people who use drugs) and the biases that these induce in policy (in particular a slighting of treatment). Starting with the principle that we seek a set of laws and programs that aim to minimize the total harms from drug use and drug control, it asks how we should determine the role of punishment, while accepting the current prohibitions. The exercise is conducted by first identifying some of the various elements that make up what we call "the drug problem,"

[#] Paper prepared for Chicago Legal Forum symposium on drug policy, November 1993

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and then matching the major classes of programs to those elements. What it points to is that each class of drug control program helps primarily with only some of the elements of the drug problem. That in turn generates the proposition that the optimal mix of programs will vary with the nature of the current drug problem, which is important since the problem in fact varies substantially over time and among communities.

The Federal Drug Budget¹

Since 1980 recorded federal expenditures on drug control have grown massively, from \$1.8 billion in Fiscal Year 1981 to \$12.8 billion in FY 1992. Even after discounting for inflation, there has been a five fold growth in these expenditures; Figure 1.

Throughout the period, at least two thirds of the money has been allocated to enforcement programs of various types; source country control (eradication and assisting Andean country military), interdiction (efforts to seize drugs on their way into the United States), domestic enforcement (investigation of high level dealers) and incarceration of convicted dealers. As little as one quarter and never more than one third went to prevention of drug use and treatment of drug abuse or dependency. As the drug problem appeared to worsen during the late 1980s, Congress kept pushing rhetorically for a shift in resources to these latter programs.

Congress has been unable to accomplish its hopes because the federal drug budget is a misleading myth. It is not an appropriated budget, decided on by the administration or Congress but a complex after-the-fact calculation of what agencies claim to be spending on drug control. The numbers in it are highly questionable; it is likely that the federal government is spending a good deal less than it claims and it is possible that the division between supply and demand side efforts is close to even. Moreover, there is no mechanism for shifting funds from one class of programs to the other.

Of the \$13 billion in the Office of National Drug Control Policy (ONDCP)-estimated federal drug budget, only about \$2 billion is appropriated explicitly for drug control; the Drug Enforcement Administration and National Institute on Drug Abuse budgets are examples of that kind of appropriation. Congress can clearly decide to spend more or

¹This section draws heavily on work by my former colleague Patrick Murphy; see his *Keeping Score: The Frailties of the Federal Drug Budget* (RAND, forthcoming)

less on these in light of its views about the drug problem and the appropriate roles of the agencies. The remaining \$11 billion is hidden in agency budgets.

Some agencies simply assign a fixed proportion of their total budget to drug control
Thus from 1986 to 1993 the Coast Guard reported that 19% of its budget, covering sea rescues, fishery enforcement etc., was for drug interdiction; the only way Congress could cut the Coast Guard's drug control budget by \$100 million was to cut the total agency budget by \$525 million. Whether 19% was the correct figure mattered to no one and the Coast Guard had no incentive to make an effort to get the figure right; its appropriation was not directly affected by this figure. For the 1994 budget the Coast Guard lowered the percentage to 14 percent, probably recognizing a decline that had been going on for some years, as well as the declining salience of the drug issue. The 1994 budget may thus show an artifactually large drop in interdiction expenditures.

These kinds of appropriations account for about \$3 billion of "drug money". The remaining \$8 billion comes out of algorithms (often smacking of alchemy) that rival Gramm-Rudman sequestration rules in their complexity. For example, the VA estimates how many of its patients are likely to have primary drug problems, how many will have both drug and alcohol problems or drug problems and other mental disorders etc. and then uses arbitrary (but possibly reasonable) rules to estimate what total of its expenditures on these clients will be classified as drug treatment. Congress, when it makes decisions about the VA budget, has no idea what effect this will have on the 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 FY 1991 figure for the VA in the drug budget, \$368 million when appropriated, had risen to \$611 million when recalculated in FY93!

The federal government labels some funds as drug prevention but in fact the activities supported by the Drug Free Schools Act (DFSA) are multi-purpose prevention programs. They might as easily be labeled Delinquency Prevention; in recognition of this fuzzy purpose, the Department of Education avoids even token evaluations of the grants, most of which are made on a formula basis.

Similarly ONDCP reports that the Health Care Financing Administration (HCFA) which administers Medicaid and Medicare, will spend approximately \$200 million dollars in FY 1992. This figure represents 0.1 percent of HCFA's total expenditures of over \$190 billion. It is not hard to develop a rationale to raise the estimate to 0.2 percent, producing a claim of 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.

The numbers then 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 multi-function programs. It is likely that the overstatement of expenditures (there is a bias against underestimates) is 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 much closer to evenly split between demand and supply side programs. But in any case, the ability to move money from one side to the other is extremely limited. It is essentially impossible to take out of the Coast Guard budget what it spends on drug interdiction and allocate it for treatment or prevention. If Congress wants to expand treatment and prevention it will have to appropriate more money for these, probably away from other health and education programs. That battle is not one that treatment and prevention advocates relish.

Other Budgets

The focus on the federal budget is particularly inappropriate because so much more is spent by lower levels of government out of their own funds. If budgets matter, then it is important to develop estimates of these non-federal expenditures and of mechanisms that might lead to a change in their composition.

ONDCP recently commissioned the Census Bureau to do a detailed study of state and local expenditures on drug control, but the results have not yet been published. In the meantime we are forced to rely on back of the envelope calculations for these figures. The problem is a complicated one because most drug control is carried out by multi-function agencies with weak budgeting systems, and there is no compelling method for extracting the drug function. For example, police agencies do a lot of drug enforcement in the course of routine patrol or detective work; data on the drug squad budget will grossly underestimate the total going to drug control. There are of course conceptual problems as well; how much is the arrest of drug involved offenders for non-drug offenses appropriately labeled drug control? I shall ignore such subtleties and simply focus on the "direct" drug control activities.

Details of the calculation are provided in the Appendix [to be completed]. For the police, the share of all arrests that were drug arrests was used as the basis for allocation; for prosecution the available data forced reliance on the share of all felony convictions that were for drug offenses. The correctional budget presented less of a

problem; we simply used the share of the correctional population that was incarcerated for drug offenses. The problem was to obtain stock rather than flow figures for the offense composition of those populations.

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 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.

For treatment we have the estimates developed by the National Association of State Alcohol and Drug Abuse Directors (NASADAD). Though these are likely to miss some important private sector expenditures², our effort here is to assemble an estimate of what lower levels of government spend, so that is not a problem.

Table 1: Estimated Government Drug Control Expenditures, 1991

Govt Level/ Program	Federal	State	Local
Enforcement			
Prevention			
Treatment			
Total			

When all these pieces are assembled (Table 1) two points emerge. First, the total is higher for state and local governments than for the federal government; for 1991, the figure is about \$21 billion, compared with the federal government's \$12 billion. Second, 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 very much misses the primary budgetary target.

²Schlesinger and Dorwart, R. "Falling Between the Cracks: Failing National Strategies for the Treatment of Substance Abuse" *Daedalus* 1992.

Programs not Budgets

The final element of my trilogy of errors is that budgets reflect policy and discussions of priorities should be couched in terms of policy rather than budgets. The primary determinant of the federal prison expenditures, to pick the easiest example, is the law providing high mandatory minimum sentences for drug offenders in federal court, along with the guidelines established by the US Sentencing Commission. If Congress wishes to spend less on incarcerating drug offenders it will have to cut those minimal 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 times in more crowded and ill-served facilities. While the first change is almost certainly a sensible one, at the federal level, it is not easily implemented without a parole board, abolished by Congress in its recent reform efforts.

A focus on budgets also tends to obscure important differences. The labels, supply side and demand side, are crude ones. William Bennett, in his eloquent "Introduction" to the first *National Drug Control Strategy* objected to the categorization, arguing that enforcement could directly reduce demand. His general point was correct but he missed the fact that it was precisely non-federal enforcement (aimed at the retail transaction) that had this effect. Mark Moore³ noted in 1973 that only enforcement which raised the non-money costs of purchasing drugs, by making them riskier or harder to find, shifted the demand curve. Since the federal government attempts to confine itself to higher level enforcement, rather than street level transactions, the usual categorization is correct for the federal budget.

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 enthuse about. Yet it may indeed be an effective prevention program; 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 likely to be impossible to split out user oriented enforcement from other kinds of local drug enforcement.

*incarceration
impact*

³Moore, M "Achieving Discrimination in the Effective Price of Heroin" *American Economic Review* 63 (2) 270-277, 1973.

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, as Mark Kleiman eloquently advocates, will appear in enforcement budgets but be substantially a demand side program.

Moreover, there are more dimensions to policy than 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 go to the infants of those women. Comparing those gains is complex but it is likely that the latter is 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.

To set priorities one needs an understanding of the nature of the harms arising from illicit drug use, distribution and control. Priorities among programs requires a decision about priorities among problems; that is related to goals for drug policy, the topic to which I now turn.

Goals for Drug Policy

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.

This marked an innovation for drug policy. Though a number of drug policy strategy documents had been issued previously by various administrations⁴, none had provided clarity on the issue of goals, either analytically or quantitatively. Given the increasing emphasis on quantitative objectives (as for example in national security planning documents or in *Healthy People 2000*) the 1988 requirement can be seen as

⁴For example: *White House Paper on Drug Abuse, A Report to the President*, Domestic Council Drug Abuse Task Force, Washington DC, 1975; *Federal Strategy for Prevention of Drug Abuse and Drug Trafficking*, Drug Abuse Policy Office, 1982.

intending to move drug policy from a principally moralistic domain more to the mainstream of public policy.

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 was reflected in the specific goals of the first Strategy, which were heavily reliant on the NHSDA, and to a much lesser extent on the annual survey of high school seniors and 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
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)⁵. 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

⁵The ability to measure these quantities is likely to be developed slowly at best. For a pessimistic view on this topic see Reuter "Prevalence Estimation and Policy Formulation" *J. Drug Issues* Vol. 23, No. 2, 1993, pp. 167-184

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, as suggested in the previous section, 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 a substantial share of those showing up at Emergency Rooms are seeking entry into detoxification rather than reporting acute harms from drug use⁶.

X As enunciated here, the principal goal of our current federal policy is 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 that it is an unlikely one; use reduction and harm reduction⁷ are likely to clash, at least in the medium term.

I suggest that one major reason for the absence of 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 whole⁸.

⁶Pat Ebener has found that the share of DAWN mentions reporting "seeking detox" as the primary motive for coming to the Emergency Room varies substantially across cities, suggesting that total DAWN mentions might be driven by treatment availability in a city.

⁷The 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 U.S., it has been associated with legalization and thus has acquired a more controversial connotation than is warranted. I shall use it for purposes of exposition here but participants may think that a less provocative term should be substituted. Use reduction is a transparent term coined by Rob MacCoun.

⁸One 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.

There are enormous conceptual as well as practical difficulties in estimating the number of "drug related" crimes⁹. No basis currently exists for estimation of the frequency or severity of drug affected infants. The first systematic estimate of incomes from drug selling was developed only in 1991¹⁰ 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. ONDCP had few options for meeting the Congressional demand, apart from the flawed prevalence estimates.

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 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 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 strengthening association between drug abuse and crime. But the federal government's choice of goals is also an important factor. 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.

However, Jonathan Caulkins 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.

⁹Goldstein, Brownstein and Ryan 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. Goldstein, Brownstein, and Ryan "Drug-Related Homicide in New York, 1984 and 1988" *Crime and Delinquency* Vol. 38, No. 4 October 1992, pp. 459-476

¹⁰Office of National Drug Control Policy *What America's Users Spend on Illicit Drugs* Washington, D.C. 1991.

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 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 population¹¹. 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 and it relies on highly speculative city level estimates¹².

The limitation of prevention is that it 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 younger 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.

¹¹On the numbers of cocaine users see E. Wish "U.S. drug policy in the 1990s: Insights from new data on arrestees" *International J. of Addictions* 25 (3) 1990. The treated population has a much higher share of African-Americans than does the population of frequent cocaine users identified in the NHSDA.

¹²See Cooley et al. *An assessment of methodologies for generating heroin prevalence estimates*. Research Triangle Park, N.C., Research Triangle Institute 1990.

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 first *National Drug Control Strategy*. The extraordinary drug problem of the U.S. in the late 1980s is seen primarily as 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 and 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 to have the government seek aggressively to express its disapproval of all drug use. There are no goals that should be traded against the minimization of the number of persons using drugs.

Before examining some consequences of this approach, it is important to distance it from some of the excesses of federal drug policy that are now causing great unease. In particular, very long mandatory prison sentences for minor drug offenders, exemplified by the five year sentences for those convicted in federal court of possession (with intent to distribute) of 5 grams of crack, may be a political product of the use reduction philosophy but is not a necessary consequence of it¹³. However, the prohibition on use of federal funds for research on needle exchange programs seems to me to flow directly from this philosophy. It might be claimed that research has shown that such programs are ineffective but the more reasonable interpretation of that research is that such programs have a modest and positive impact, certainly enough to warrant further investigation¹⁴. The prohibition was ideological in its origins and in political forums, at least until now, most prominent politicians have made that clear; potential reductions in AIDS are not worth the perception of a break in the government's front against drug use.

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 below) but the focus on prevalence turns policy away from nuances of drug control that are extremely

¹⁴For a sober assessment of research on the effectiveness of needle exchange programs, see DesJarlais, D. and S. Friedman "AIDS and Legal Access to Sterile Injecting Equipment" *Annals of the American Academy of Political and Social Science* 1992.

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 (though it need not) increase drug related harms.

A More General Approach to Policy Consequences

Elements of the Drug Problem

Table 2 presents a list of 8 phenomena that I take to constitute some of the major components of what troubles the nation under the rubric "the drug problem". All of them have many elements themselves e.g. the health consequences of drug dependence include an array of problems that affect the users and the rest of the community, such as HIV, TB 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 distinction¹⁵. 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.

¹⁵Goldstein, P. "The drugs/violence nexus: A Tripartite Conceptual Framework" *Journal of Drug Issues* Vol. 14 pp. 493-506, 1986

Table 2. Elements of the Drug Problem

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

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. It is the involvement of young people in the subculture surrounding illicit drugs or with the routine violation of law, and their possible progression to drug dependence, that are the central concerns under that head.

Another set of problems is caused by the dependence or abuse of drugs--e.g. spread of AIDS, crimes committed to support expensive illicit drug use--albeit sometimes because of the conditions of use that society has created. Cocaine sells in illegal markets for about 20 times its legal price; that helps explain the high level of property crime associated with dependence on cocaine. Use of dirty needles by heroin addicts is heavily a function of the prohibition on unauthorized possession of hypodermic needles¹⁶.

¹⁶The 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 and Spain; nonetheless needle sharing is common among IVDUs in those countries and so is HIV. See Miguel, J. de and D. Kirp "Spain: An Epidemic of Denial" in Kirp, D. and R. Baylor (eds.) *AIDS in Industrialized Democracies* New Brunswick, N.J., Rutgers University Press, 1992.

Other problem elements, such as killings of rival drug dealers, are related not directly to drug use but to the distribution of drugs. Even if drugs did not adversely affect behavior, the struggle for market and contract disputes in an illegal setting would generate (at least in the United States) a great deal of violence. Finally, yet others--e.g. the distortion of 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 be much ameliorated. But because different elements of the problems have different sources, lowering drug consumption does not necessarily have the desired effect on the other dimensions. 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 by more stringent enforcement against dealers but suffer, at least in the short-run, a worsening of related crime and health problems. Indeed, drug related homicide appeared to be rising in 1990, just as there was mounting evidence of reduced drug consumption¹⁷.

One approach to understanding the distinction between use reduction and harm reduction is to use this specification of the elements of the drug problem and relate it to the programs that make up most of drug policy¹⁸. The following subsection suggests the relationship between programs and problem elements and then examines how goals of drug policy might affect the choice of program emphasis.

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 (e.g. crop eradication and refinery destruction) and domestic enforcement (including interdiction of smuggled drugs), we can match

¹⁷Office of National Drug Control Policy *National Drug Control Strategy* 1990, pp. 117-121.

¹⁸Mark Kleiman makes a useful distinction by suggesting that drug policy can be divided into laws and programs; Kleiman *Against Excess: Drug Policy for Results* New York, Basic Books, 1992.

program types and the dimensions of the drug problem schematized in Table 1. That matching is presented in Table 3.

Table 3. Matching Programs and Problem Elements

Program Targets
Prevention -> Initiation
Treatment -> Drug Use
Enforcement -> Distribution
Source Country -> Production Controls



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 non-users 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.

?
no
reaching

Other negative interactions, all involving enforcement, can be more serious. Consider for example the upstream effects of interdiction. If more stringent interdiction works primarily through 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 U.S. it decreases the total amount consumed; but it also raises the quantity of exports needed to deliver a ton to the U.S. The second effect turns out, under reasonable assumptions about the demand

and supply curves of the cocaine industry, to be larger than the first¹⁹. Thus interdiction may actually increase source country problems by raising the demand for exports of cocaine.

Program effects can be very complex indeed. For example, enforcement is now principally intended to control distribution-related problems, but it should also affect rates of initiation and drug dependence. By making it more difficult for users to find sellers or making the drug more expensive, enforcement should deter some of the curious or experimental from becoming regular users and persuade some regular users to desist or to enter treatment programs. Alas, there are literally no empirical studies that have estimated this effect.

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.

Programmatic Consequences of the two Approaches

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

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; it is likely that 25 percent of cocaine users account for 75 percent of

¹⁹The analytics of this proposition are provided in Reuter P.; Crawford, G. and J. Cave *Sealing the Borders: The Effect of Increased Military Participation in Drug Interdiction* Santa Monica, CA, RAND, 1988 Appendix A.

Even when looking at the population in need treatment, using the DSM-III-R criteria chosen by the Institute of Medicine panel²³, Dan McCaffrey and Pat Ebener²⁴ 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 previously. 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 the 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."²⁵ The behavioral consequences cannot be dismissed so easily; there is no doubt that heavy marijuana use is a quite frequent behavior and that it can have deleterious effects on cognitive development and performance. Though surprisingly large numbers of persons are sometime frequent marijuana users (i.e. consume at least one joint each day), it is also clear that many pass through that state relatively quickly.²⁶

For harm reduction purposes, marijuana would seem to be a very low priority drug, ~~unless more marijuana usage will result 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

²³Gerstein, D. and R. Harwood (eds.) *Treating Drug Problems* Washington, D.C., National Academy Press, 1990.

²⁴McCaffrey, D. and P. Ebener *Estimating the Need for Treatment from the Household Survey* RAND, unpublished manuscript, 1993.

²⁵*Against Excess* p.253.

²⁶The high school senior data consistently show that the ratio of one time to current daily marijuana users is about 3 to 1; yet these respondents are 17 or 18 years old.

the total weight consumed²⁰. Thus one may attribute to them roughly that share 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 heroin users account for most of the property crime associated with drugs.

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 clients²¹. Reductions in drug use by patients while in treatment is substantial and that seems to be enough to achieve these gains. Most clients are not abstinent for long periods of time but for the harm reduction purposes the temporary gains are quite sufficient. Rydell and Everingham²² find that treatment of frequent cocaine users is cost-effective even if (i) every patient immediately relapses to heavy use after leaving treatment and (ii) one uses a fairly narrow definition of social cost. 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 get 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.

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.

²⁰That also seems to be the case for marijuana. Using data from Monitoring the Future, it appears that 8 percent of marijuana using high school seniors accounted for 57 percent of total consumption in 1990. For heroin, where there are few users other than those who are dependent, the concentration is likely to be much lower.

²¹The 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. Hubbard, E.L., et al., *Drug Abuse Treatment: A National Study of Effectiveness*. Chapel Hill: The University of North Carolina Press, 1989.

²²Rydell, P. and Everingham, S. *Controlling Cocaine: Supply vs. Demand Programs* RAND, unpublished manuscript, 1993.

Compare
to incursion
Harm
reduction

users of marijuana but that does not mean that the marginal user who is persuaded to experiment with marijuana is at anything like the same risk as the average marijuana user of going on to other drugs. If that is the case, marijuana enforcement might be greatly reduced as compared to now and those resources used for more harm-reducing activities.

The above are just illustrations of the many 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 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.

*Damage
only*

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 (e.g. in 1978 when 11 percent of high school seniors reported daily use of marijuana in the previous 30 days) a focus on prevalence had much greater justification than it does now when very low percentages of youth go beyond the briefest experimentation. The problems associated with initiation were much more important ten years ago. If enforcement could meet its historic claim to reduce drug use by raising prices and lowering availability, then toughness (along with prevention) stood on reasonable logical grounds. Use reduction and harm reduction may not have been in great conflict.

Most projections for the next few years are of declining initiation and prevalence, along with a stable population of problematic users generating more crime and disease.

That suggests a change in emphasis is appropriate, as indeed is signaled by the recent Interim National Drug Control Strategy. The harms are now much more dominated by 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. Harm reduction generates a very different set of policy choices from use reduction under these circumstances.

Conclusion

There is no general assertion to 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 the position in a drug epidemic 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.

There may be some general principles. ~~More attention needs to be paid to the relationship between punishment and treatment. Punishment is likely to be more effective if it is tied to treatment. More surprisingly, there is a growing literature suggesting 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 voluntarily²⁷. Moreover, 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 there are important intersections, particularly with respect to alcohol; at the programmatic level, there are few patients with dependency on illicit drugs that do not also have alcohol dependency problems. Integrating policies with respect to alcohol and illicit will 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 that 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.

²⁷ Anglin, M.D. and Y.-I. Hser "Treatment of Drug Abuse" in Tonry, M. and Wilson, J.Q. (eds.) *Drugs and Crime* Chicago, University of Chicago Press, 1990.

APPENDIX

Estimating State and Local Drug Control Expenditures

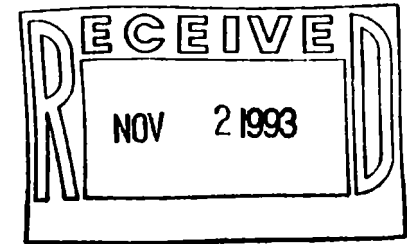
Drug arrests include distribution and possession arrests; for the purposes of estimating costs, the distribution arrests were put together with Part I (i.e. more serious crime) arrests. The cost per Part I arrest was assumed to be three times as great as that for Part II offenses, which were taken to include drug possession but not sale arrests. We then estimated a "cost per weighted arrest" by dividing the total state and local police budget by this weighted arrest number. Expenditures for drug arrests were then estimated by their share of weighted arrests. Sensitivity analysis was done with other figures substituted for the weight of 3 reported in the text. Those different figures are reported in Table A.1

For prosecution there are no misemeanor data. Felony convictions in state courts were the only basis for estimating the share of prosecution costs to be assigned to drug cases. By 1991, it was estimated that almost drug offenses accounted for almost 40 percent of felony convictions.

Better data were available for corrections. For 1991 there is a one-day census of prison inmates, categorized by offense; a similar census was done for jails in 1989. Drug offenses accounted for 20 percent of the prison inmates at the time of census and almost 25 percent of the jail inmates.

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Toward a Rational Drug Policy



November 12-13, 1993

The University of Chicago Law School

Funded by
The Center for Studies in Criminal Justice
Frank D. Mayer Fund
Alcohol and Drug Abuse Prevention Team (ADAPT)

Friday, November 12

4:00 P.M. Keynote Address

- ♦ Mathea Falco
Independent Researcher
Carnegie Corporation of New York

Saturday, November 13

9:00 A.M. Race and the War on Drugs

- ♦ Michael Tonry
Sonosky Professor of Law and Public Policy
University of Minnesota Law School
- ♦ Clarence Lusane
Author
Pipe Dream Blues: Racism and the War on Drugs
- ♦ John P. Walters
Visiting Fellow
Hudson Institute
- ♦ Moderator: Norval Morris
Julius Kreeger Professor of Law and Criminology
University of Chicago Law School

10:45 A.M. Coffee Break

11:00 A.M. Setting Priorities: Enforcement versus Treatment

- ♦ Peter Reuter
Co-Director, Drug Policy Research Center
RAND Corporation
- ♦ Mark A.R. Kleiman
Associate Professor of Public Policy and Research Fellow
in Criminal Justice, John F. Kennedy School of Government
Harvard University

- ♦ Melody M. Heaps
Founder and President
Treatment Alternatives for Special Clients (TASC, Inc.)
- ♦ Moderator: Stephen J. Schulhofer
Frank and Bernice J. Greenberg Professor of Law and
Director of the Center for Studies in Criminal Justice
University of Chicago Law School

12:45 P.M. Lunch

2:00 P.M. Procedural Fairness and the War on Drugs

- ♦ David Rudovsky
Senior Fellow
University of Pennsylvania Law School
- ♦ The Honorable James B. Zagel
Judge
United States District Court for the
Northern District of Illinois
- ♦ Joseph D. Grano
Distinguished Professor of Law
Wayne State University
- ♦ Moderator: Randolph N. Stone
Clinical Professor of Law and Director of the Mandel
Legal Aid Clinic
University of Chicago Law School

4:00 p.m. Closing Address

- ♦ Dr. Lee P. Brown
Director
White House Office of National Drug Control Policy

Reception

Dr. Lee P. Brown is the Director of the White House Office of National Drug Control Policy (ONDCP). Prior to his confirmation as ONDCP Director, Dr. Brown was a Professor of Criminology at Texas Southern University. He has also served as New York City Police Commissioner, Police Chief of Houston, and Atlanta's Public Safety Commissioner. He is the author of numerous articles on police management, community policing, and crime, and is co-author of the book *Police and Society: An Environment for Collaboration and Confrontation*.

Mathea Falco is an independent researcher at the Carnegie Corporation of New York. From 1977 to 1981, she served as Assistant Secretary of State for International Narcotics Matters, and has recently served as Director of Health Policy at the New York Hospital-Cornell Medical Center. Her extensive list of publications include *The Making of a Drug-Free America: Programs That Work* (1992) and *Winning the Drug War: A National Strategy* (1989).

Joseph D. Grano is a Distinguished Professor of Law at Wayne State University School of Law. Before joining the law school, he served as Deputy Assistant Attorney General in the Office of Legal Policy at the United States Department of Justice, and was Associate Professor of Law and Acting Dean of the University of Detroit School of Law. He has written extensively in the area of criminal law, particularly Fourth Amendment issues. His most recent book, *Confessions, Truth, and the Law*, is forthcoming in early 1994.

Melody Heaps is the Founder and President of Treatment Alternatives for Special Clients (TASC, Inc.), which is a not-for-profit agency that provides intervention and case management services to indigent populations in Illinois. Before founding TASC, she served as Acting Director of Program Development in the Illinois Department of Health and in the Illinois Drug Abuse Program. She has also served as a consultant to the United States Department of Justice, the Bureau of Justice Assistance, and the National Institute of Justice.

Mark A.R. Kleiman is an Associate Professor of Public Policy and Criminal Justice at the John F. Kennedy School of Government at Harvard University. Prior to joining the faculty at the Kennedy School, he served as Director of the Office of Policy and Management Analysis in the Criminal Division of the United States Department of Justice. His extensive list of publications includes two books: *Against Excess: Drug Policy for Results* (1992) and *Marijuana: Costs of Abuse. Costs of Control* (1989).

Clarence Lusane is a Special Assistant to the United States House of Representatives Democratic Study Group and is an author of many publications on race and drugs. He has also served as Staff Assistant and Office

Manager to Congressman Walter Fauntroy. His publications include three books: *Pipe Dream Blues: Racism and the War on Drugs* (1991), *The Struggle for Equal Education* (1992), and *African Americans at the Crossroads: The Restructuring of Black Leadership and the 1992 Elections* (1994).

Norval Morris is the Julius Kreeger Professor of Law and Criminology at the University of Chicago Law School. Before joining the University of Chicago Law School, Professor Morris directed a United Nations crime prevention institute in Japan. He edits *Crime and Justice: A Review of Research* with Michael Tonry. He has written extensively on the criminal justice system, his last four books being *The Brothel Boy and Other Parables of the Law* (1992), *Between Prison and Probation* (1990) with Michael Tonry, *Madness and the Criminal Law* (1982), and *The Future of Imprisonment* (1974).

Peter Reuter is Co-Director of the Drug Policy Research Center at the RAND Corporation. He is also a Professor in the School of Public Affairs at the University of Maryland, where he holds a secondary appointment as professor in the Institute of Criminology and Criminal Justice. He is the author of numerous books, articles, and reports, most notably, *Disorganized Crime: The Economics of the Visible Hand* (1983), which was the winner of the Leslie Wilkins Award for outstanding study in criminology and criminal justice.

David Rudovsky is a Senior Fellow at the University of Pennsylvania Law School and is a partner at Kairys & Rudovsky, a law practice focused on civil rights and civil liberties litigation. Before joining the faculty at the University of Pennsylvania, he served as First Assistant Defender in the Defender Association of Philadelphia. His list of publications includes *The Rights of Prisoners* (1987), *Criminal Law in Pennsylvania* (1991), and *Human Rights in Northern Ireland* (1991). He was the recipient of the ACLU Civil Liberties Award in 1990.

Stephen J. Schulhofer is the Frank and Bernice J. Greenberg Professor of Law and Director of the Center for Studies in Criminal Justice at the University of Chicago Law School. Before joining the faculty at the University of Chicago, he was the Ferdinand Wakeman Hubbell Professor of Law at the University of Pennsylvania. He has co-authored a casebook in criminal law, *Criminal Law and Its Processes* (1989, with S. Kadish), and has written numerous articles on such topics as criminal responsibility, rape, battered women, sentencing, and double jeopardy.

Randolph N. Stone is a Clinical Professor of Law and Director of the Mandel Legal Aid Clinic at the University of Chicago Law School. Before joining the law school, he was the Cook County Public Defender, responsible

for the leadership, administration, and management of that office, which represented over 200,000 clients per year. Prior to working for Cook County, he was a Deputy Director at the Public Defender Service for the District of Columbia and a partner at the law firm of Stone & Clark, a litigation firm focusing on criminal matters. His extensive list of publications and bar activities focuses on criminal justice issues.

Michael Tonry is the Sonosky Professor of Law and Public Policy at the University of Minnesota Law School. Before joining the University of Minnesota Law School, he had a private solo law practice and was a professor of law at the University of Maryland School of Law. He has also been a research associate and administrator of the Center for Studies in Criminal Justice at the University of Chicago Law School. His extensive list of publications includes *Between Prison and Probation—Intermediate Punishments in a Rational Sentencing System* (1990), with Professor Norval Morris, and *Human Development and Criminal Behavior* (1991).

John P. Walters is a Visiting Fellow at the Hudson Institute and is presently writing a book about anti-drug policy with Terence J. Pell. In 1992, he was appointed by President Bush as Deputy Director for Supply Reduction in the Office of National Drug Control Policy (ONDCP). Prior to his appointment, he served as Chief of Staff and National Security Advisor to the Director of the ONDCP from the Office's inception in 1989. Mr. Walters is the founder of the Madison Center, a public policy organization devoted to advancing improvements in education.

James B. Zagel is a Judge in the United States District Court for the Northern District of Illinois. He is also a Member of the Codes of Conduct Committee of the United States Judicial Conference. Before his appointment to the federal bench in 1987, Judge Zagel was the Director of the Illinois Department of Revenue and the Illinois Department of Law Enforcement. He has also served as Assistant State's Attorney for Cook County and Chief Assistant Attorney General for Arizona. He has co-authored two books: *Criminal Law and Its Administration*, and *Cases and Comments on Criminal Procedure*.

The Symposium will be held at the University of Chicago Law School, 1111 East 60th Street, Chicago, Illinois 60637. All events are open to the public, and there is no admission charge.

This Symposium was funded through the generosity of the Center for Studies in Criminal Justice at the University of Chicago, the Frank D. Mayer Fund, and the Alcohol and Drug Abuse Prevention Team (ADAPT) at the University of Chicago. The papers presented at this Symposium and related student comments will be published in Volume 1994 of the University of Chicago *Legal Forum*. If you are interested in this publication, please complete the form below. For further information concerning the Symposium, including subscriptions, contact the University of Chicago Legal Forum at (312) 702-9832.

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OVERVIEW OF THE BUSH ADMINISTRATION DRUG STRATEGY

The Anti-Drug Abuse Act of 1988 created ONDCP and set forth its mission: to advise the President on a national drug control strategy and consolidated drug control budget with the overall goal of significantly reducing the production, availability, and use of illegal drugs, both at home and abroad. To achieve this goal, ONDCP was charged with producing the National Drug Control Strategy, which unified anti-drug efforts in a comprehensive plan of action that established drug policies, objectives, and priorities. The following fundamental principles provided the underpinning of the Bush Administration's National Drug Control Strategy:

I. BASIC PRINCIPLES:

The essence of the drug problem is drug use, and demand reduction is the ultimate goal. The success of anti-drug efforts cannot be measured by such criteria as the number of people treated for addiction, treatment results, the number of arrests, conviction rates, or drug interdiction and seizure levels. These are useful indicators, but only address symptoms of the problem. Instead, the levels of drug use remain the paramount indicator against which drug policy success is judged.

"User Accountability" is critical. Drug use can be deterred through a range of meaningful criminal, civil, and social sanctions that persuade drug users to enter treatment, and convince non-users to avoid the use of drugs.

To be effective, the Strategy must be comprehensive and fully integrate supply and demand reduction policies and programs. Supply and demand programs should not be discrete phenomena that are employed in isolation from one another. No single tactic -- pursued alone or to the detriment of others -- can work to contain or reduce drug use. Instead, pressure must be applied along all fronts of the drug war simultaneously, recognizing that prevention is the only answer in the long run, but that in the short run it is necessary to provide drug treatment and to continue interdiction, international, and law enforcement efforts.

The Strategy must be national in scope. The Strategy outlines a partnership between the private sector, and individuals throughout the Nation. There are some things that only the Federal government can do (e.g., international efforts to block drug production and transportation, interdiction, and border security). States and localities, on the other hand, provide publicly funded drug prevention and treatment and bear primary responsibility for arresting, prosecuting, and punishing most of the Nation's drug offenders.

II. ELEMENTS OF THE STRATEGY

DEMAND REDUCTION

A major goal of the National Drug Control Strategy is to prevent Americans from ever using drugs. For those who have begun to use drugs, the goal is to get them to stop. This has led to support of broad-based prevention efforts directed at the mainstream population, as well as special programs targeting hard-to-reach and high-risk groups.

DRUG TREATMENT:

- o Drug treatment works, and the Strategy seeks to improve its availability, quality, and effectiveness.
- o For FY 1993, increased Federal funds will result in the availability of an additional 7,700 drug treatment slots nationwide. The bulk of these would be Federally-funded slots in existing local treatment settings.
- o In 1993, the Nation's total treatment capacity would grow by more than 28,000 slots (633,319 to 661,368). This will allow for the treatment of at least 1.9 million persons with drug problems.
- o Current Federal treatment initiatives:
 - Continuing efforts, working through the Congress, to fund treatment in States and communities with a high need for treatment.
 - A drug treatment/job training initiative.
 - Technical assistance to States to better use Medicaid.
 - Greater efforts to integrate into treatment appropriate AIDS services.
- o Other treatment improvement efforts:
 - Grants to target efforts in selected cities and for special populations (e.g., adolescents, women, ethnic groups, and criminal justice populations).
 - Training efforts and demonstrations to show the efficacy of central intake and referral.

- Better coordination of treatment, rehabilitative, and social services, along with better outreach.
- o Treatment works best when clients are appropriately matched to programs and services. The Strategy addresses through a strong commitment to support the development of Treatment Improvement Protocols, which provide treatment programs with standard procedures for screening and treating specific populations and specific drug problems. The Strategy also supports the establishment of central intake and referral services and of improved access for clients to adjunct services (i.e., general health, social, educational, and vocational services).
- o The NIDA Medications Development Division (MDD), created to focus public and private efforts at developing pharmacotherapies, has moved aggressively to capitalize on recent important discoveries, and has elicited vital assistance from other Federal agencies and the private sector.
- Pharmacological treatment approaches can be used to augment the basic psychological therapies, but, however effective medications may be, psychological approaches are the primary tool in treating addictions.
- The primary psychological approaches are behavioral, supportive and psychodynamic therapies. Critical research will continue to improve these.

DRUG EDUCATION AND PREVENTION:

- o Drug education and prevention programs can be effective in reducing the likelihood that young people will start using drugs.
- o For those who do start, such programs also slow the progression to more frequent use and to the use of more dangerous substances.
- o The most effective school-based prevention programs are **comprehensive**: they start early, provide children with **skills to resist** offers to use drugs and with techniques for **managing stress** without resorting to drug use, provide firm **drug policies** and appropriate assistance for young people **who violate those policies**, and involve parents in prevention activities.
- o The policies of effective programs demonstrate to young people that drug use is wrong, that it is harmful, and against the law.
- o The best school drug prevention activities are but one component of a comprehensive community effort.

- o All of our major epidemiological systems have reported significant declines in drug use and drug consequences over the last two years.
- The National Household Survey on Drug Abuse estimated that current (past month) use of illicit drugs by those ages 12 and over declined by 13 percent, from 14.5 million in 1988 to approximately 12.6 million in 1991.
- Occasional (less than once a month) cocaine use fell by 22 percent between 1988 and 1991.
- Among adolescents, current drug use fell 27 percent and current cocaine use fell 63 percent between 1988 and 1991.

COMMUNITY PARTNERSHIPS: The 1989 National Drug Control Strategy announced a Presidential initiative to assist in combating drug use at the local level. Since that time, hundreds of community partnerships have been established with Federal funds.

PREVENTION INFORMATION: The National Clearinghouse on Alcohol and Drug Information receives 16,000 requests for information each month, and annually provides materials that reach over 18,000,000 Americans.

EDUCATION INITIATIVES: As a condition of receiving Federal funding, Local Educational Agencies (LEAs), State Educational Agencies, and Institutions of Higher Education are required to submit certifications that they have comprehensive drug prevention programs in place.

PUBLIC HOUSING: The 1990 National Drug Control Strategy announced an initiative to assist public housing agencies and residents in eliminating the threat of drugs from public housing. By the end of this year, over 1,300 grants will have been awarded to public housing agencies.

HIGH RISK POPULATIONS: There have been more than 280 Federal grants awarded to programs that target youth at high risk for using drugs. In addition, a national network of research studies targeting substance using pregnant women and their infants has been created.

Another major program has awarded 130 grants to develop comprehensive prevention and treatment systems for substance using pregnant and postpartum women and their infants.

In response to the crisis of drug-affected infants abandoned in hospitals around the country, 24 demonstration grants to prevent abandonment, to train hospital staff, and to expedite adoption of abandoned babies have been awarded.

SUPPLY REDUCTION

The fundamental principle of the National Drug Control Strategy has been to reduce drug use through a combination of supply and demand policies and programs. Supply reduction efforts have the effect of reducing demand and are, in fact, an indispensable ally of demand reduction programs. Neither approach can be expected to be fully successful without the support of the other. The effects of interdiction and other supply efforts may well become more important in coming years, especially as we attempt to address the problems of the more resistant population of hard-core drug users. Well-targeted supply-side efforts work to make drugs more expensive and harder to obtain and improve our chances of succeeding with the prime goal of reducing drug use. In the supply area this means continuing a program to enhance our efforts in the areas of domestic law enforcement, international affairs, interdiction, and intelligence.

DOMESTIC LAW ENFORCEMENT:

Attacking the retail street-level drug dealer in order to dismantle drug trafficking organizations is an integral part of the President's National Drug Control Strategy. This approach has two basic elements: arresting dealer (and deterring others who would take their place) and prosecuting and incarcerating them.

- o The arrest, prosecution, and incarceration of street dealers is primarily the responsibility of State and local law enforcement agencies. The Federal government will continue to assist State and local entities in a number of ways.
 - Continued domestic law enforcement assistance to States and localities through BJA grant funding.
 - Special assistance to target communities hit hardest by drugs through the DOJ "Weed and Seed" program. This initiative will simultaneously eliminate drug dealers from an area and create economic opportunities to preclude their return.
 - Continued support for DEA State and Local Task Forces. There are currently 98 State and local task forces providing invaluable coordination and control to enhance our attack on drug trafficking across jurisdictional boundaries.
- o Of special concern to both the Federal government and State and local law enforcement agencies are drug-related gangs.
 - A 1989 survey of law enforcement officials in 45 cities estimated there are more than 1,400 different youth gangs and over 120,000 gang members in the U.S. Many are involved in serious criminal activity, including drug trafficking and drug-related violence.

- DOJ has begun a Department-wide initiative that targets gangs for special enforcement efforts. Specific drug-involved groups such as Jamaicans, Dominicans, Asians, and others will be targeted by Organized Crime Drug Enforcement Task Forces.
 - In recent years, the DOJ, through its OJP grant program, has supported model gang-related enforcement programs and research studies to gather pertinent information on gang structure and organization. The information gained from this program helps to guide the overall attack on organized crime and gang-related criminal activities.
 - In further support of these other initiatives, the Youth Gang Prevention Program, administered by the Department of Health and Human Services, provides discretionary grants to reduce and prevent drug abuse and drug-trafficking by youth gangs and to divert at-risk youth from gang membership.
 - The Department of Housing and Urban Development Drug Elimination Grant program provides grants to public and American Indian housing authorities and residents of assisted housing to reduce drug activity, much of which is gang-related, in such housing projects. HUD is also promulgating the Clean Sweep model pioneered by the Chicago Housing Authority, which has as a major objective the elimination of drug gang activity from public housing projects.
- o Other domestic law enforcement initiatives in the Strategy include:
- Providing a range of Federal funding to each State, contingent upon the submission of a comprehensive and integrated State anti-drug strategy.
 - Encouraging State and local law enforcement agencies to participate in task forces that bring together the resources of adjoining and overlapping enforcement entities, particularly in situations where sparse resources are spread over great distances.
 - Endorsing DOD support to law enforcement agencies (Federal, State, and local) including those in rural areas and smaller cities. Such support includes Regional Logistic Support Offices and National Guard assistance for counternarcotics activities such as crop eradication; transportation; surveillance; cargo searches; the loan of equipment; communications and command assistance, training, planning and coordination assistance, and other needs-specific responses.

- Encouraging formation of Federal, State, and local task forces. As a result, the FBI, DEA, INS, BATF, and other Federal law enforcement agencies can be thought of as "force multipliers," particularly in smaller cities and rural jurisdictions.

INTERNATIONAL EFFORTS:

- o The Strategy calls for working with and motivating other countries to act vigorously to curtail domestic drug supply and demand, and to work cooperatively with other nations to end the international trafficking of illicit drugs.
- o Experience has shown that the drug trade is most susceptible to disruption within the trafficker's home country of operations. In recognition of this fact, a special Andean Strategy that attacks the drug trade in the principle cocaine producing countries of Colombia, Peru, and Bolivia was instituted.
- o The Near-Term Goals of the Andean Strategy are:
 - Strengthen the political commitment and institutional capability of the governments of Colombia, Peru, and Bolivia to confront the cocaine trade.
 - Strengthen and diversify the legitimate economies of the Andean nations to enable them to overcome the destabilizing effects of eliminating a major source of income.
 - Work with these countries to increase the effectiveness of law enforcement and military activities against the cocaine trade.
 - Work with the Andean countries to damage and disrupt the cocaine trafficking organizations.
- o Continued international success requires that the struggle at the source of the cocaine trade be maintained. The current mix of economic, law enforcement, and military assistance is vital to continued progress in the fight against the cocaine trade.
- o The heroin trade is more difficult to attack at the source, due to current the political situation in Southwest Asia, the area that has become the key producer of opium and heroin destined for the U.S. market. Diplomatic efforts allied with increased intelligence and interdiction efforts both on the ground and along the heroin production and supply pipeline are key to enhanced success.

INTERDICTION:

- o Interdiction, a visible sign of our Nation's commitment to fight drugs, has both symbolic value as a demonstration of national will and real value as a deterrent to the flow of drugs.
- o In addition, by intercepting and seizing illicit drug shipments and apprehending smugglers, interdiction creates a deterrent effect by raising the perceived risks faced by traffickers and smugglers.
- o Interdiction efforts increase drug organizations' cost of doing business by forcing them to take expensive counter-measures, replace seized assets, and hire and train new employees.
- o Interdiction activities made significant contributions to the overall drug war in Fiscal Year 1991, with record heroin and cocaine seizures. The results for the first half of FY 1992 continue to show substantial progress, with cocaine seizures up 75 percent and heroin seizures up 20 percent over the same period in FY 1991.
- o The Strategy calls for a comprehensive information-based approach to Federal air, maritime, and land interdiction, and for enhanced border systems, operations, and activities. These include:
 - Actions to restrict routes and modes of shipment through establishment of an effective air and maritime surveillance system along the southern U.S. border, in the Bahamas, and in Puerto Rico.
 - Continued diplomatic negotiations to enhance international cooperation against smugglers.
 - Actions to restrict transshipment by encouraging transit countries to strengthen their laws, legal institutions, and programs to apprehend and bring drug traffickers and drug money launderers to justice. Continued support for Mexico's Northern Border Response Force is a key element.

INTELLIGENCE:

- o ONDCP has worked closely and actively with both the Department of Justice and program specialists in the Drug Enforcement Administration to assist where possible in bringing about needed improvements in EPIC. In response to the National Drug Control Strategy, DEA is upgrading EPIC's capabilities.

- o The focus is on improving EPIC's ADP capacity to ensure that it has the capability to process, analyze, and retrieve the immense amounts of information developed by Federal, State, and local law enforcement agencies.

OPENING STATEMENT

THE HONORABLE LEE P. BROWN

DIRECTOR

OFFICE OF NATIONAL DRUG CONTROL POLICY

SENATE JUDICIARY COMMITTEE

FEBRUARY 10, 1994

Good morning Chairman Biden and members of the Senate Judiciary Committee. It is my pleasure to appear before you today to discuss the 1994 National Drug Control Strategy.

Yesterday, the President released the National Drug Control Strategy as mandated by the Narcotics Leadership Act of 1988. This strategy is a bold plan to redirect and reinvigorate this Nation's fight against drug use and drug trafficking. It builds on the foundation laid down in the September, 1993 Interim National Drug Control Strategy, which challenged America to change the way it viewed the drug use problem. The Strategy reflects a fundamental shift in the way the nation responds to the drug abuse problem:

- It recognizes that chronic hard-core drug use and the violence that surrounds it are at the heart of the Nation's current drug crisis,

- It emphasizes the need to empower local communities with an integrated plan of education, prevention, treatment and law enforcement, and

- It changes the way the United States carries out international drug control policy and refocuses interdiction's efforts away from the transit zones to working directly with the transit and source countries.

Previously, National Drug Control Strategies shied away from

aggressively addressing chronic, hard-core drug use. It is the most difficult aspect of the problem. But all too often it is the hard-core users and the traffickers who service them who are involved in violent crime. If we are to stem the tide, we must make more treatment available and mount the most effective possible drug abuse prevention and education programs.

We have delivered to the Congress and the American people a National Drug Control Strategy that tackles the toughest, most resistant drug problems. We do not underestimate the difficulty of the task. But if we are to make progress against drug use and drug trafficking, it will only be made by facing those problems head-on.

The National Drug Control Strategy estimates that there are approximately 2.7 million chronic hard-core drug users in the U.S. and establishes as one of its targets the reduction of chronic drug use at an average annual rate of 5%.

Overall, the Strategy establishes, as an objective, the reduction of all illicit drug use by an average annual rate of 5%.

When we submitted the Interim National Drug Control Policy to Congress in September, 1993, we said our new Strategy would reflect a sea change in the way we responded to America's drug problem.

We have delivered on that promise. As the President pointed out yesterday, we have developed a comprehensive strategy, one that not only significantly increases drug treatment capacity and support for prevention and education, but provides solid support for law enforcement and international narcotic control efforts.

But as the President has noted, drug use is more than a criminal justice problem; it is also a public health problem. Reducing drug use is more complex than simply funding drug supply and demand reduction programs. A comprehensive drug strategy must address the lack of educational opportunities, good jobs, quality health care, affordable housing, and safe neighborhoods.

The FY 1995 Budget and National Drug Control Policy

To carry out the National Drug Control Strategy, the President is requesting a record \$13.2 billion to enhance programs dedicated to drug control and prevention efforts. This reflects an increase of \$1 billion, or 9 percent, over 1994 appropriations. Given the tight fiscal constraints with which the overall President's budget was developed, the 1995 request clearly expresses the Administration's commitment to alleviating the problems associated with drugs, crime, and violence. I should note that as a result of the President's decision to make the Director of ONDCP a member of the Cabinet, I sat with the President when he reviewed the budget submissions of the

OK - [unclear]

Executive Departments with drug control responsibilities. The budget before the Congress is a direct result of the President's determination to make drug control a priority within the Cabinet and of the Administration.

Four major new initiatives are included in the FY 1995 budget to carry out the National Drug Control Strategy:

Reducing Chronic Hard-core Use Through Treatment - The request of \$355 million in addition to those funds currently available in the Substance Abuse Block Grant, plus resources forthcoming from the crime bill, will increase the number of chronic, hard-core users in treatment by 140,000 per year. We propose that these funds go to those most in need and hardest to reach. No serious effort to fight drug abuse can succeed without reaching those who are overburdening our criminal justice system, costliest to our health care system, and overwhelming our social service system. In addition, the President's Health Security Act guarantees drug abuse treatment services to all Americans.

Protecting Children Through Education and Prevention - The Strategy proposes an increase of \$191 million for the Safe Schools Program and the Drug-Free Schools and Communities State Grant Program to inoculate our youth against the dangers of drug use. The Strategy sets forth the specific objective of ensuring that 100% of youths in grades K-12 receive drug and violence

prevention education by the year 2000.

As the recent data for the Monitoring the Future survey showed, our Nation's hard fought effort to shield America's youth from the dangers of drug abuse must be reinvigorated. We cannot let past successes lull us into complacency. I will not stand by and allow a new generation of our youth to get caught in a cycle of illicit drug use and dependency. Accordingly, in addition to the increase in education and prevention resources, I will soon be convening a meeting of national experts in the field of prevention and drug education, and I will ask for their recommendations on how we can prevent a new cycle of youth drug abuse.

Empowering Communities - The National Strategy underscores the importance of the Federal Government in coming to the assistance of those communities hit hardest by drug abuse and drug trafficking. Accordingly, \$1 billion is allocated for community programs, including \$569 million for community policing; \$50 million for community empowerment; \$155 million for Community Partnerships; and \$98 million for the High Intensity Drug Trafficking Areas program.

The Strategy recognizes that the most effective means of preventing drug use and keeping drugs out of neighborhoods and schools is to mobilize all elements of the community through coalitions and partnerships. Therefore, the Strategy will expand

the number of cooperative efforts such as community coalitions, targeting neighborhoods hardest hit by drug violence. It will also work to ensure that all nine of the President's Empowerment Zones and 95 Enterprise Communities are implemented, and address drug use and trafficking in their community-based empowerment plans over the next two years. A second objective of the Strategy is to double the number of community anti-drug coalitions by 1996.

Focusing on Source Countries - The Strategy recognizes that effective international narcotics control will result from successful institution building in drug source and transit nations. As a result, the budget proposes \$76 million in new funds for source country programs to support the controlled shift of resources from the transit zones to the source countries. These new funds will enhance support for conducting law enforcement activities, building judicial institutions and creating an economic and social environment that support alternatives to drug cultivation and trafficking.

Experience has shown that cocaine cartels and other drug trafficking organizations are vulnerable to sustained enforcement efforts by committed governments. Members of such organizations fear loss of profits and fear arrest when they know it will lead to conviction followed by significant punishments and seizure of assets. With the improvement in the U.S. capability to collect

intelligence and build cases against major traffickers, the international program has the potential to continue to increase in effectiveness. Cooperation with other nations that share our political will to defeat the international drug syndicates is at the heart of the international strategy. Its primary goals are to increase multilateral and other organizations' response to the drug threat; and to aggressively increase illicit crop eradication to stop fast-developing opium, and to reduce coca cultivation by 1996.

Making the Streets Safe -- The Strategy recognizes that demand reduction programs drug treatment, prevention and education -- face an uphill battle when drugs are readily available. Similarly, it recognizes that drug law enforcement programs will not succeed if the nation's appetite for illegal drugs is not curbed. Both must work in partnership.

To make streets safe, the Strategy advocates passage of the crime bill provisions to put more police on the streets; expand community policing; expand treatment for incarcerated chronic, hard-core drug users; increase the number and use of boot camps for non-violent offenders; provide for drug courts to offer counseling, treatment and drug testing for non-violent offenders; and control the proliferation of guns, especially assault weapons, in our neighborhoods.

Beyond the crime bill, the Strategy commits the full force of Federal investigative and prosecutive capabilities to target major drug trafficking organizations in order that they may be disrupted, dismantled, and destroyed. The Administration will work toward making drugs harder to obtain and more costly in terms of apprehension, prosecution, conviction and forfeiture.

Other Strategy Highlights

The 1994 National Drug Control Strategy changes the manner in which ONDCP evaluates progress in reducing drug use. The law creating ONDCP requires that the Director of ONDCP establish comprehensive long-range goals for reducing drug abuse and short-term measurable objectives which the Director of ONDCP determines may be realistically achieved in the two-year period from the date of submission of the Strategy.

The 1994 Strategy includes 14 long-term goals, each containing specific two-year objectives. Table 1 lists each of these goals. Goal 1 is the Strategy's overarching goal: reducing illicit drug use. The remaining goals pertain specifically to supply reduction and demand reduction programs. I want to highlight some of the objectives we have established for these goals:

- o Reduce the drug user population at an average annual rate of

5 percent.

- o Increase the number of hardcore users in treatment by 140,000 per year.
- o Reverse the recent increase in drug use by students.
- o Put 100,000 more cops on the streets over the next five years.
- o Enact the first ever guarantee of basic drug use treatment services as part of the President's Health Security Act.
- o Reduce coca cultivation by 1996.
- o Stop the fast-developing opium cultivation in Colombia, Guatemala, and Mexico and by preventing production from spreading to other countries.

How do these goals and objectives compare to past strategies?

Why did we change these goals? How will we measure progress?

First, let me say that past goals are continued in the 1994 Strategy ~~they were not dropped~~. Second, we have expanded the previous goals to reflect the greater emphasis on the problems of hardcore use. And third, given recent criticism by GAO and

others about the problem of existing surveys to measure progress in reducing drug use, we are developing a new survey of hardcore drug users to give us a better measurement tool for tracking progress in reducing the number of users in this critical population.

Now I want to discuss in more detail the linkage between goals in the 1994 Strategy and past Strategies. Past strategies established goals that mostly emphasized the reduction of drug use by casual drug users and goals related to reducing availability. With respect to casual use, these goals included: (1) reducing current (30-day) overall drug use, (2) reducing current adolescent drug use, (3) reducing occasional cocaine use, (4) reducing current adolescent cocaine use, (5) reducing current adolescent alcohol use, and (6) increasing the percentage of students who disapprove of drug use. The 1994 Strategy will continue to track these measures as part of Goal 1: Reduce the number of drug users in America.

Past Strategies included a goal to reduce the health consequences of drug use measured by drug-related hospital emergencies. This measure will be used in the 1994 Strategy against Goal 3: Reduce the burden on the health care system.

And finally, previous strategies included goals pertaining to illicit drug availability. Because of data limitations, measures of perceived availability were used to track progress in achieving the goal of reducing illicit drug availability. The 1994 Strategy will continue to rely on such measures but--given the emphasis on source country supply reduction efforts in the 1994 Strategy--more attention will be paid to measures focusing on cultivation of coca and poppy.

ONDCP Programs

The ONDCP Fiscal Year 1995 Budget reflects a recognition of the increasing concentration of drug problems in hard-core-drug using populations. Consistent with the 1994 National Drug Control Strategy, and this Administration's emphasis on treatment and prevention, the amount of \$45 million is requested for the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide treatment services for chronic hard core drug users.

The High Intensity Drug Trafficking Areas (HIDTA) program has developed into a very effective partnership between Federal, State, and local law enforcement agencies. It is a unique program that empowers national and local law enforcement officials to take a united regional approach to dismantling the most serious drug trafficking organizations. In addition, the

program has effectively combined a multitude of existing smaller task forces at the state and local levels in order to coordinate and concentrate their efforts. The HIDTA budget request allows for continued funding in fiscal-year 1995 of the five original "gateway" HIDTA's (New York, Miami, Houston, the Southwest Border, and Los Angeles), as well as a newly designated HIDTA to increase the focus, coordination, and effectiveness of Federal, State and local efforts against drug distribution networks.

This new HIDTA will serve the Washington-Baltimore metropolitan area and will serve as a prototype for future HIDTA's which will focus on distribution areas, and target funds for the treatment of chronic hard-core drug abusers in the criminal justice system.

The President is also requesting \$10 million and 40 positions for the Office of National Drug Control Policy. This level of funding is consistent with the President's commitment to a more efficient executive branch, while providing coordination and oversight to the nation's overall drug control effort. The proposed funding level will enable the ONDCP to continue advising the President on national and international policies and strategies, and help ensure the effective coordination of drug programs within approximately 50 Federal Agencies and 12 Departments.

ONDCP Reauthorization

The Administration strongly supports reauthorization of ONDCP and has proposed legislation to accomplish this. A recent GAO report on the reauthorization of the agency noted the continued need for a central agency to provide leadership and coordination for the Nation's drug control efforts. Separate reauthorization legislation has passed both the House and Senate. I urge both Houses to conclude an agreement on this legislation as soon as possible.

Conclusion

One final note: in the end, this is not a challenge for the Government alone. We can change our laws and increase the amount of resources we spend to reduce drug use, but still we will have to do more. Individuals must take personal responsibility for their own actions. Families must take responsibility for their children. Communities must challenge their citizens to stand up for common decency and refuse to accept the unacceptable. Society must nurture the values that best represent our character as a nation: work, family, community, opportunity, and responsibility.

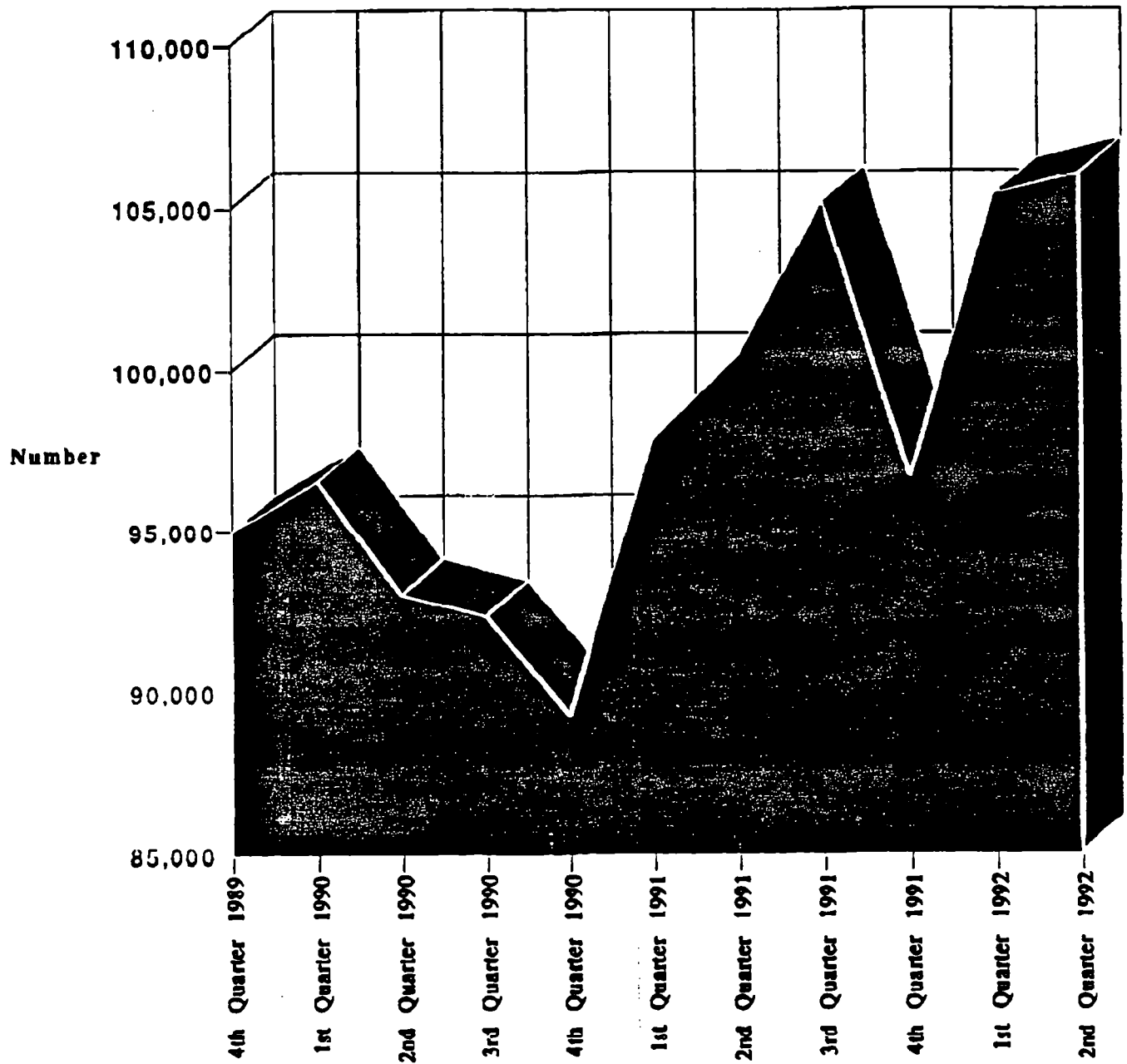
This completes my prepared statement. I would be pleased to answer any questions you may have.

DRUG STRATEGY -- MAJOR TENETS

The key policy findings of a strategy with promise for the next four years would include:

- * Any gains from the first year of the "war on drugs" have been lost, and other areas are worse than at the start of the strategy;**
- * Hard-core addicts are the proper focus of the drug strategy, because reducing casual use doesn't hit the root of the "drug" problem;**
- * Community policing is the key proven law enforcement strategy to combat hard-core drug use and drug dealers;**
- * Drug treatment on demand is other key to controlling drug use, "treatment on demand" only met through the national health care plan -- also justified on grounds that drug abuse has so many other medical costs (overdoses, AIDS, tuberculosis and other illnesses);**
- * Drug education and prevention must be in place to lower the probability of future drug epidemics; and**
- * The drug effort needs a cabinet-level director, along with enhanced powers to coordinate drug policy.**

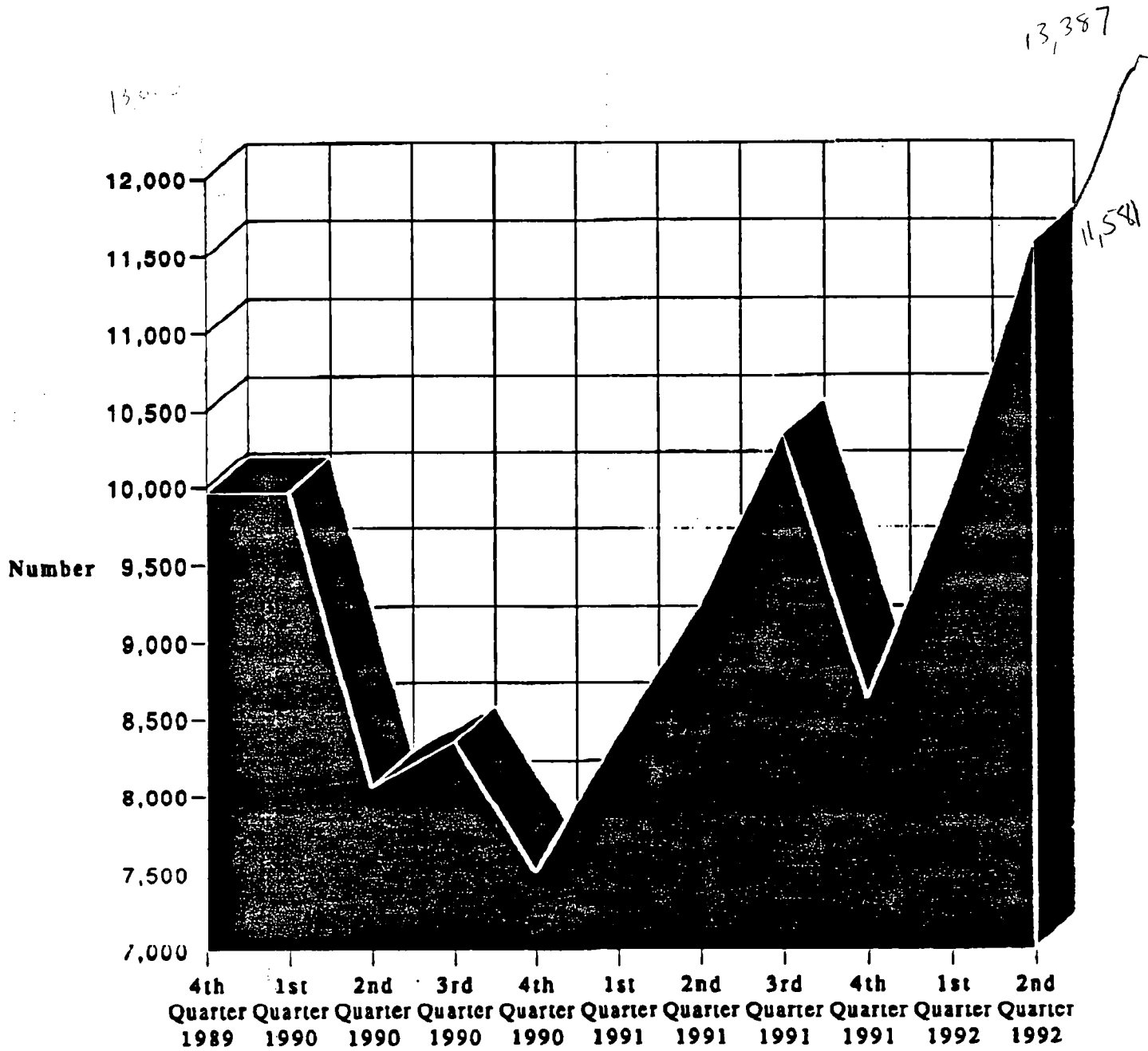
Drug Overdoses: More Than When the Strategy Began



Heroin/overdose.1

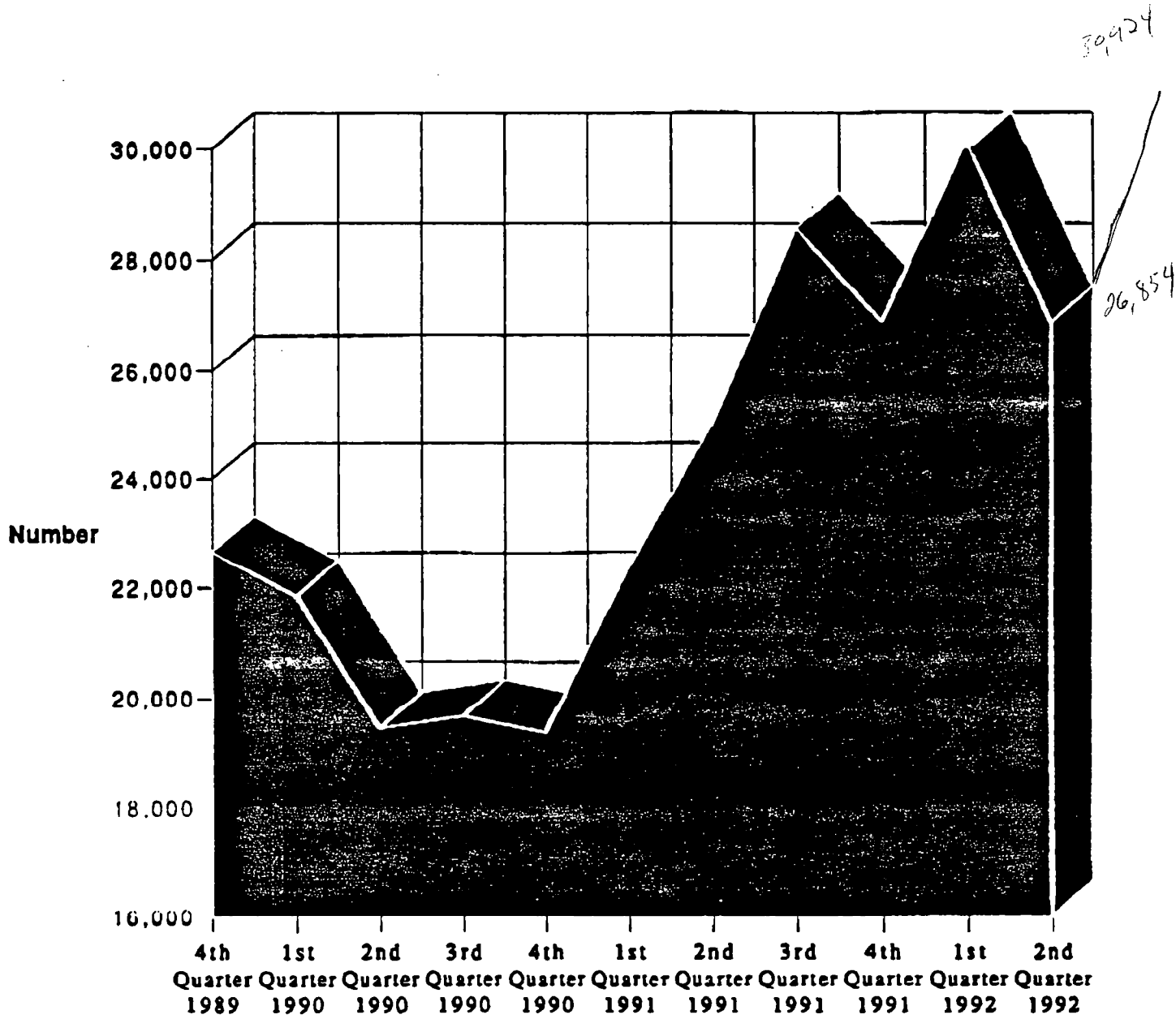
42% among white
47% among 35+yr

Heroin Overdoses

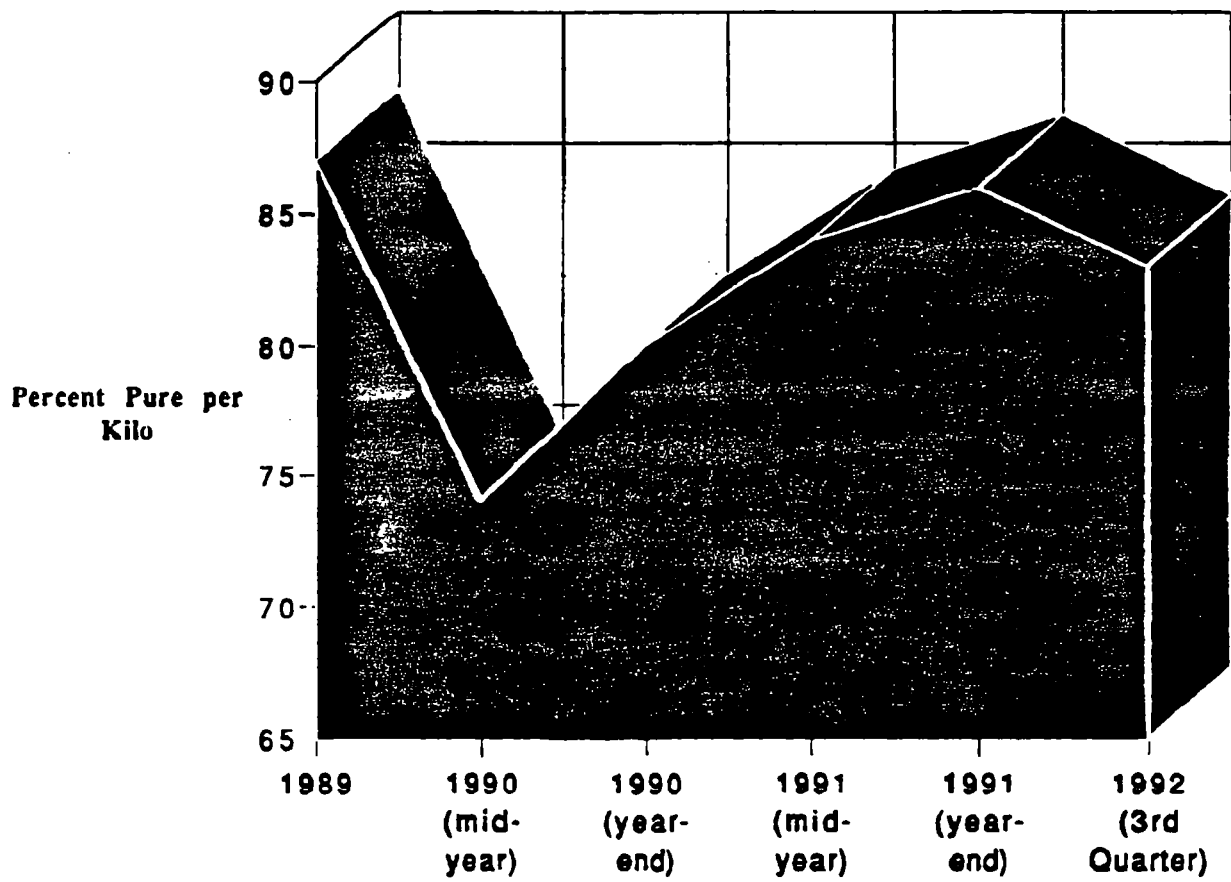


30% increase
among 35 up crowd

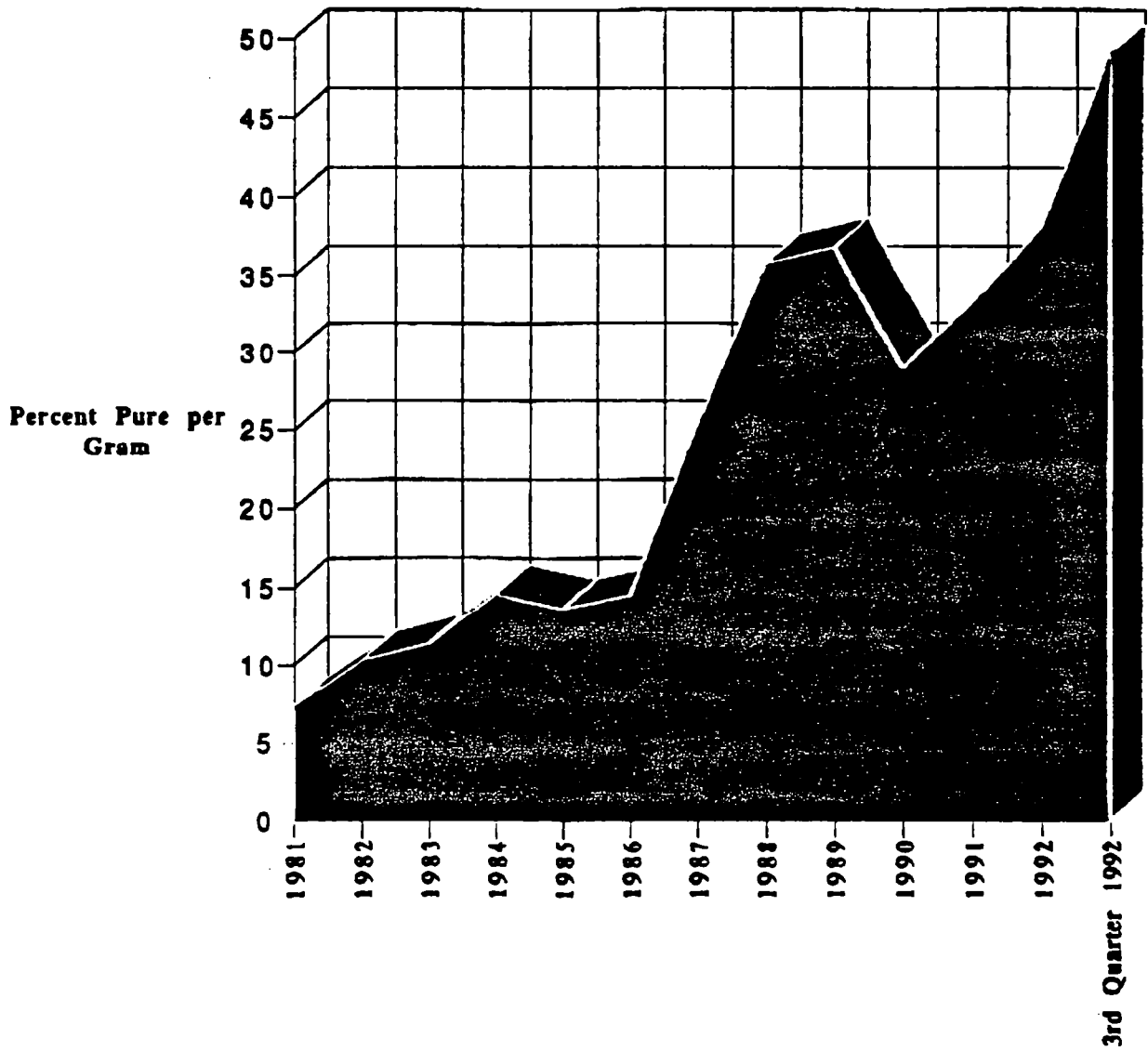
Cocaine Overdoses: More Than When the Strategy Began



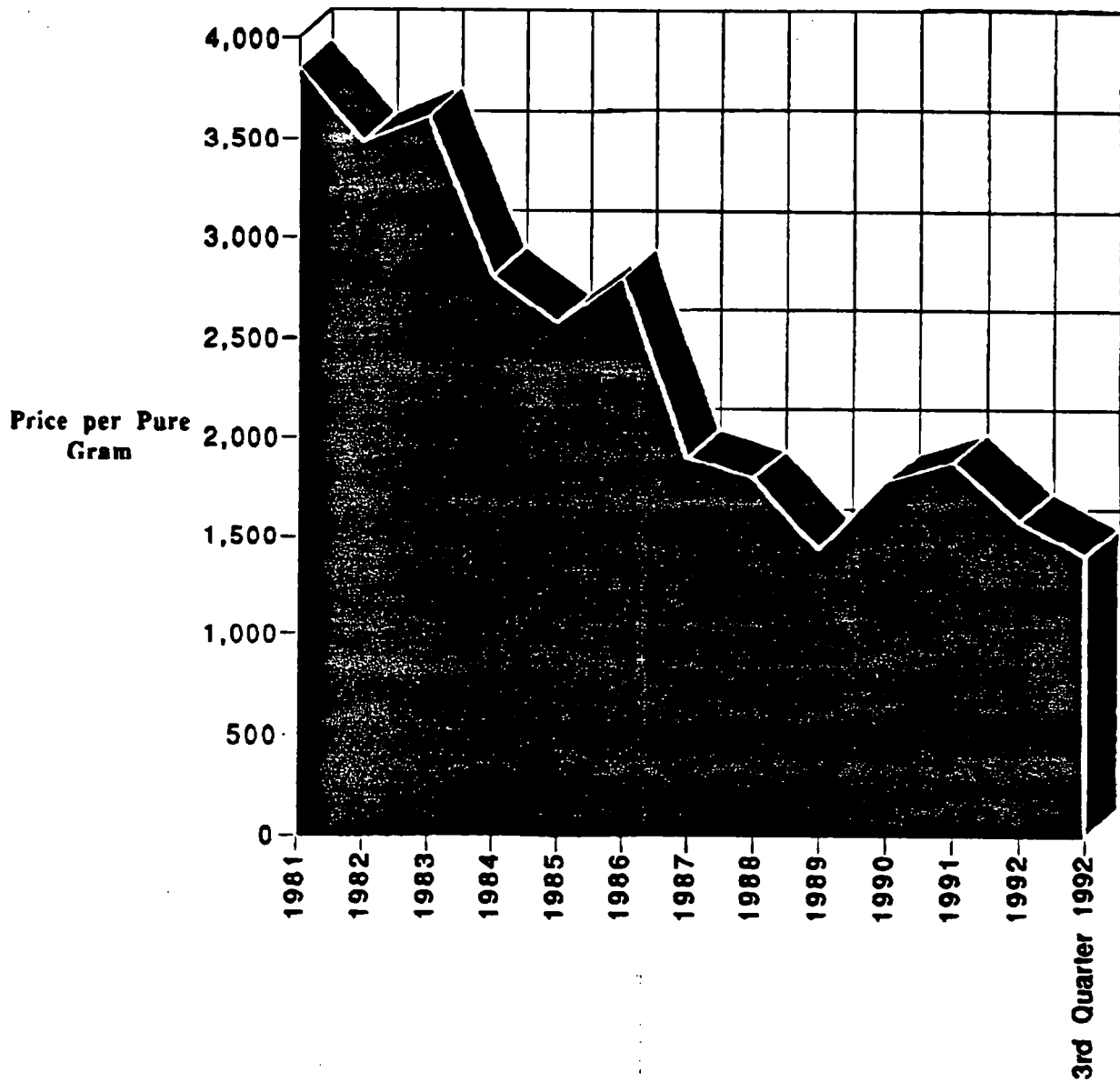
Lost Opportunity: Rising Cocaine Purity for Drug Traffickers



Escalating Heroin Purity

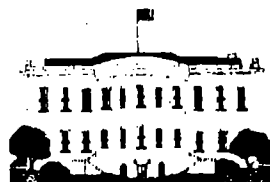


Plummeting Heroin Prices



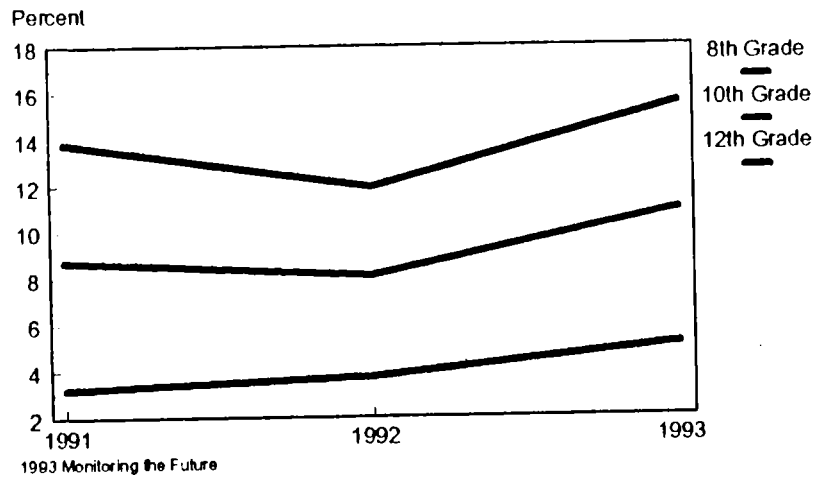
Breaking the Cycle of Drug Abuse

1994 NATIONAL DRUG CONTROL STRATEGY

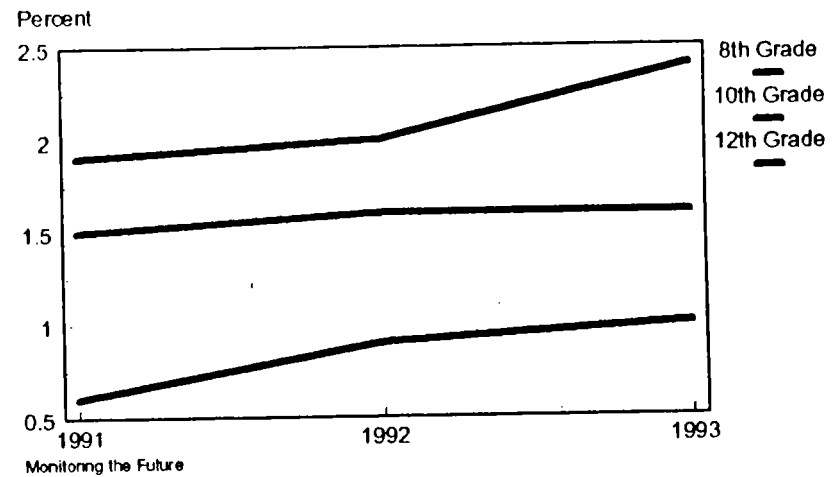


Problem: 8th, 10th, and 12th Grade Casual Use on the Rise

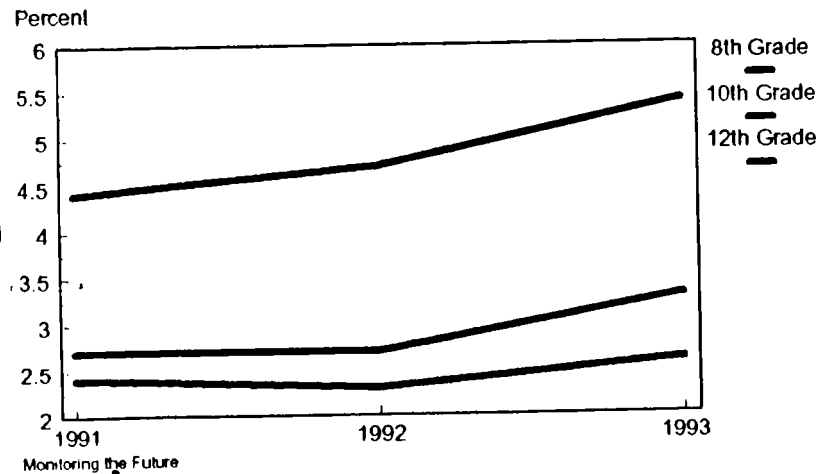
30-Day Marijuana



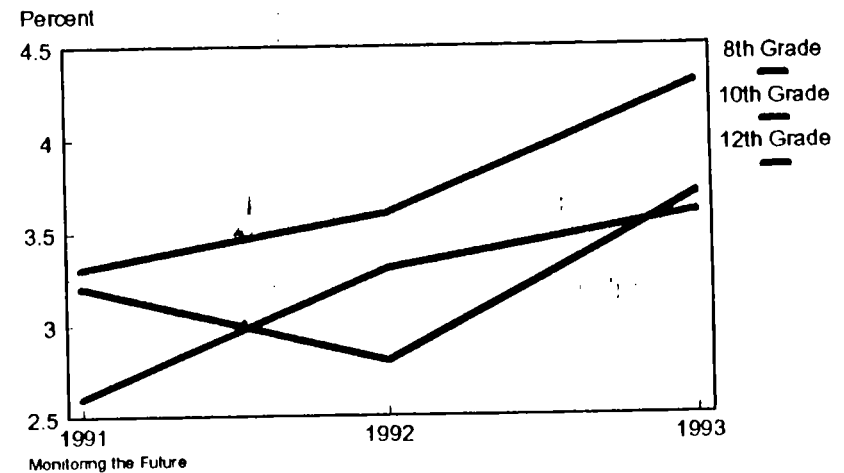
LSD



Inhalants



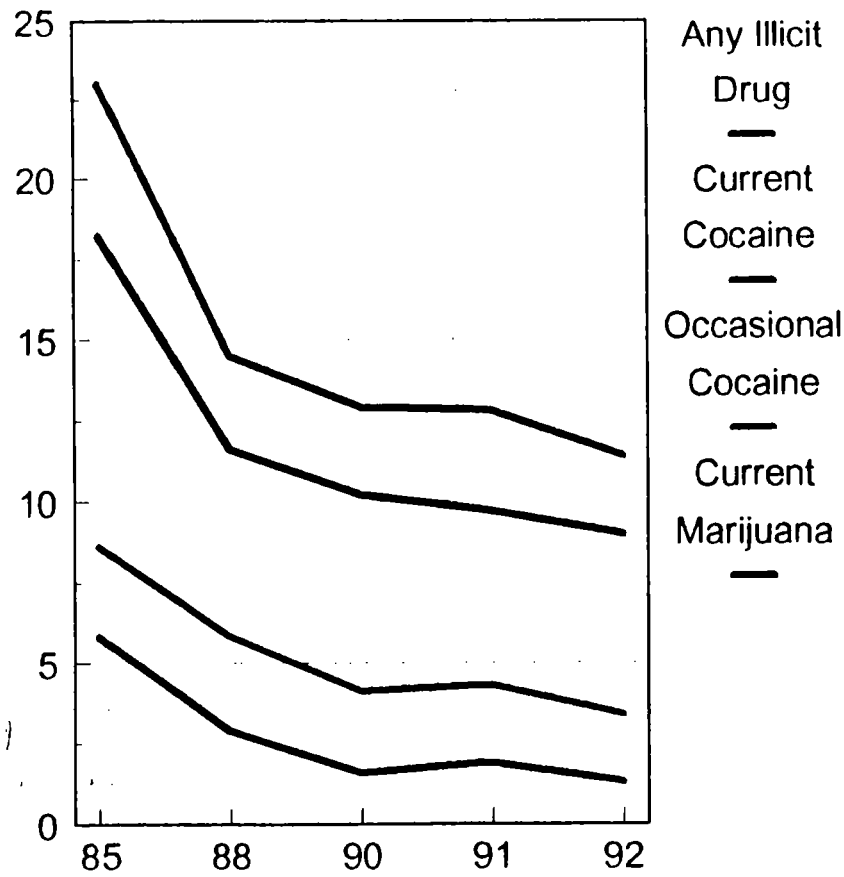
Stimulants



The Drug User Population

Casual Use Declining

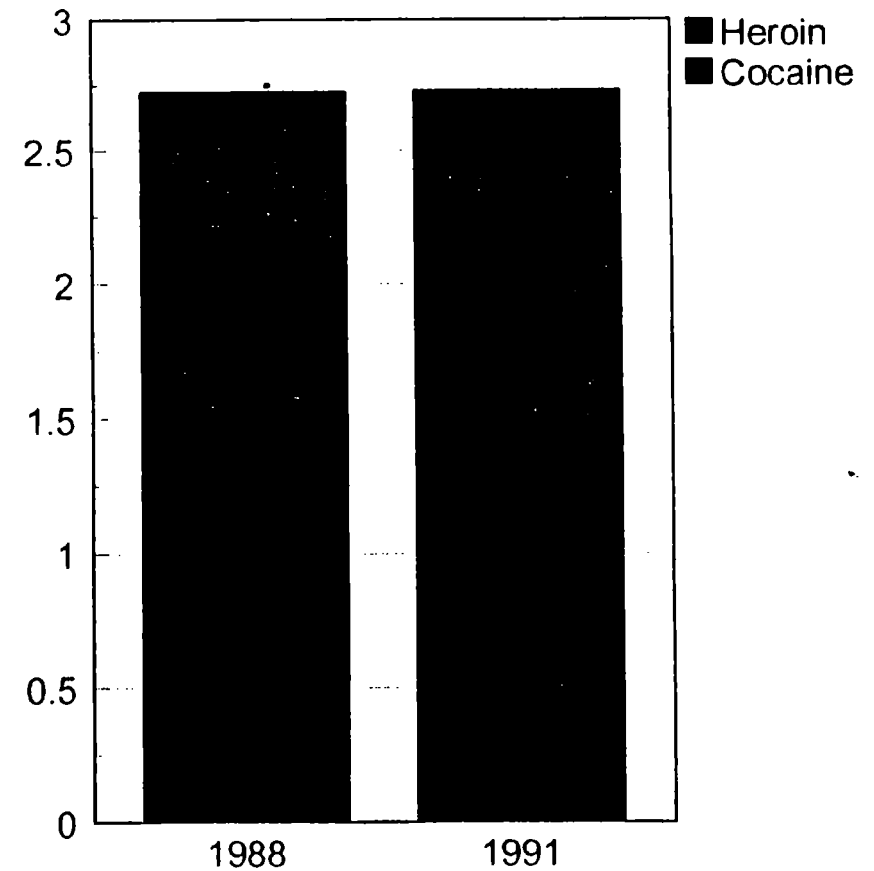
Millions of Users



Source: Household Survey

Hardcore Use Continues Unabated

Millions of Users

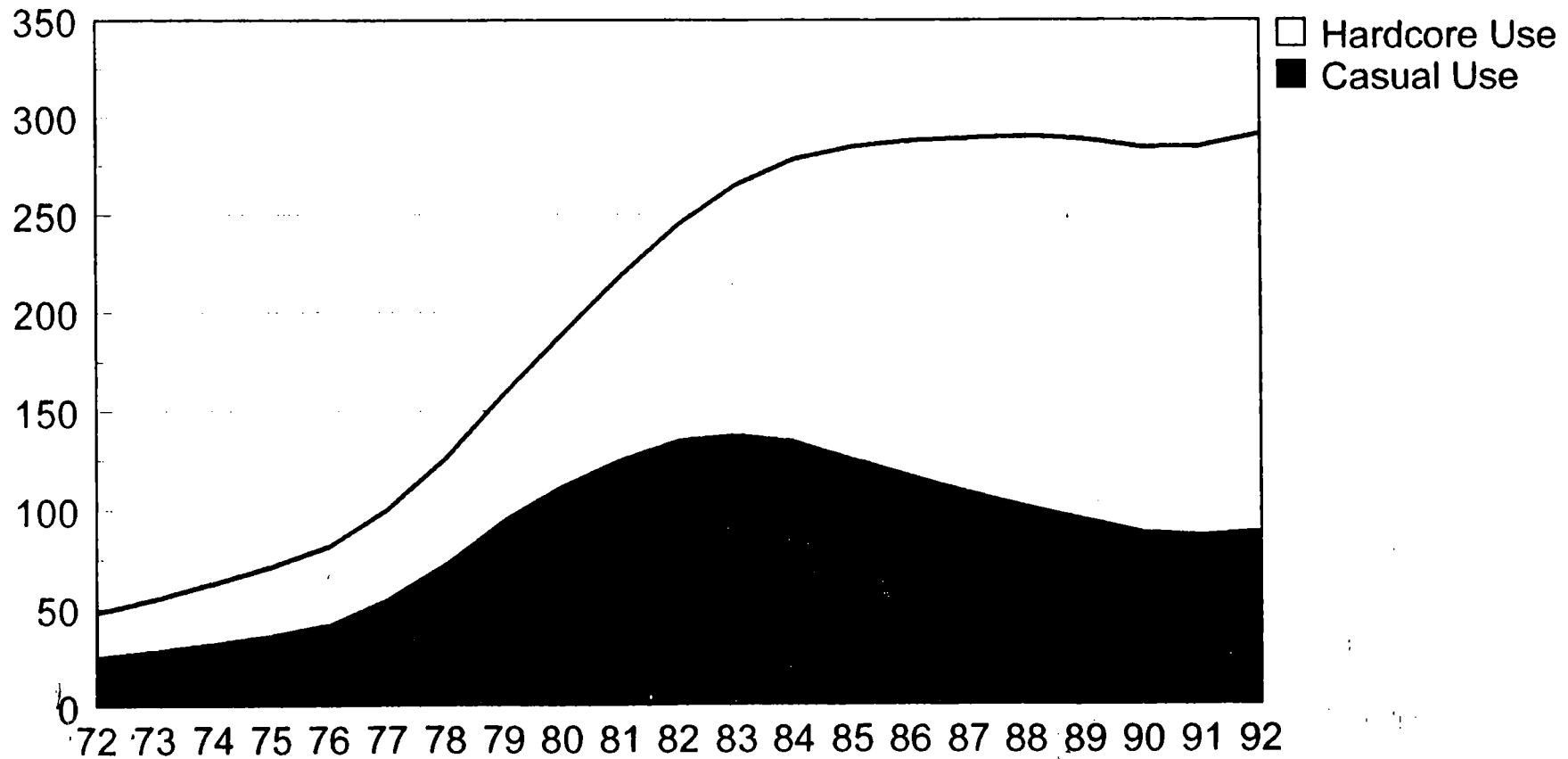


ONDCP estimates.

Hardcore users include individuals who use illicit drug at least weekly and exhibit behavioral problems stemming from their drug use.

Drug Consumption By Type of User

Annual Consumption (Metric Tons of Pure Cocaine)



Source: RAND Work in Progress for ONDCP.

Drug Use and Social Costs

- One study prepared by the Institute for Health Policy at Brandeis University estimated the total economic cost of drug abuse (excludes alcohol and tobacco) at \$67 billion in 1990, up \$23 billion from \$44 billion in 1986.
 - Includes treatment cost, productivity losses, and costs associated with crime, destruction of property, and other losses.
- Researchers at the University of Southern California using the same methodology estimated the economic cost of drug abuse at \$76 billion in 1991.
 - Drug abuse costs are projected to reach \$150 billion by 1997 if current drug use trends continue.

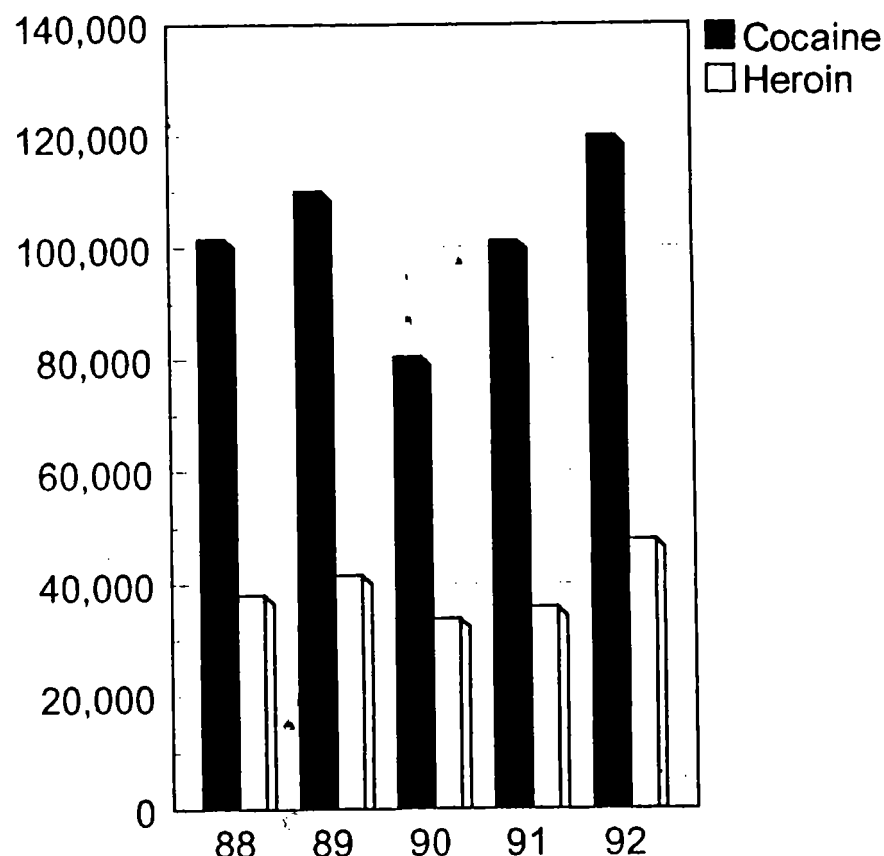
Drug and Crime Linkage

- Drug users commit a disproportionate amount of crime.
 - A survey of hardcore drug users not in treatment found that over 50 percent reported illegal activity in the 30 days prior to the survey.
 - The same survey found that 42 percent of those sampled had income derived in part from illegal sources, mostly from property crimes.
 - There are over 1 million arrests annually for drug abuse violations.
 - NIJ's DUF data show that roughly one-half of arrestees test positive for cocaine.

Drug Use and Health Costs

- Health costs of drug use are enormous and will likely increase as chronic users seek medical attention for their drug-related problems.
- DAWN reports that the need for detox and chronic health problems are the principal reasons for seeking medical assistance.
- The CDC estimates one-third of new AIDS cases are related to injection drug use.
- A recent study of women in California found that 5.2 percent of mothers in that State tested positive for illicit drug use just prior to delivery.

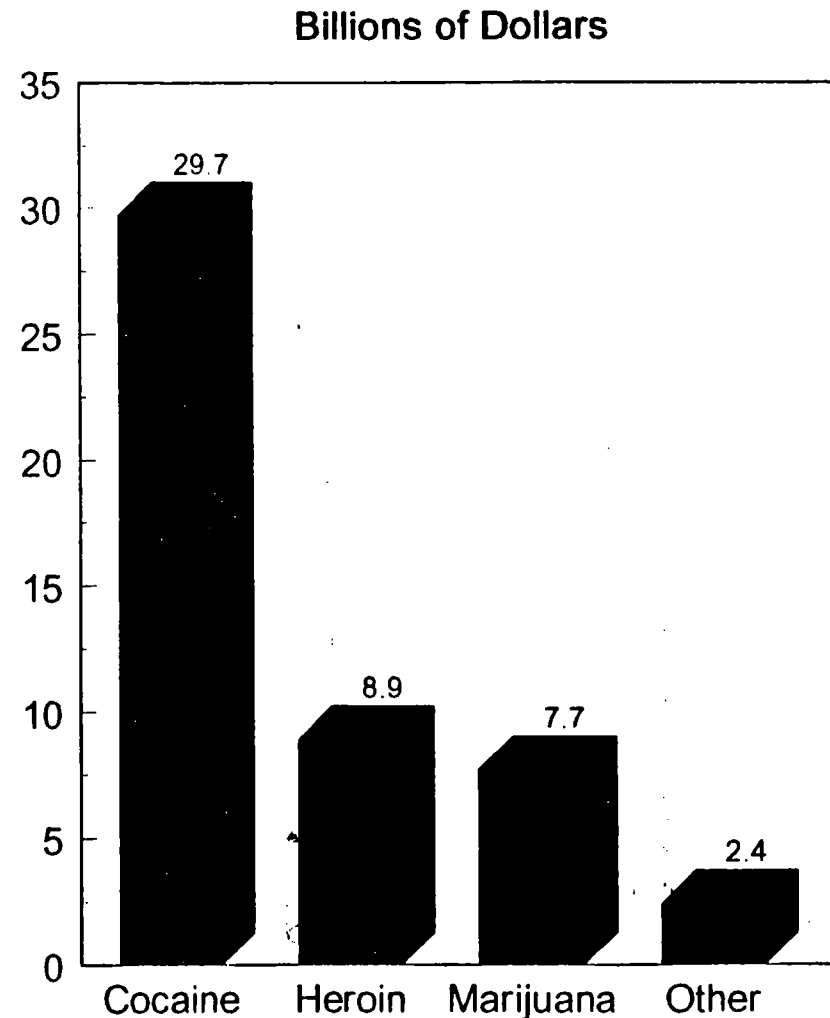
Cocaine and Heroin Mentions
Are Up Dramatically



Source: Drug Abuse Warning Network

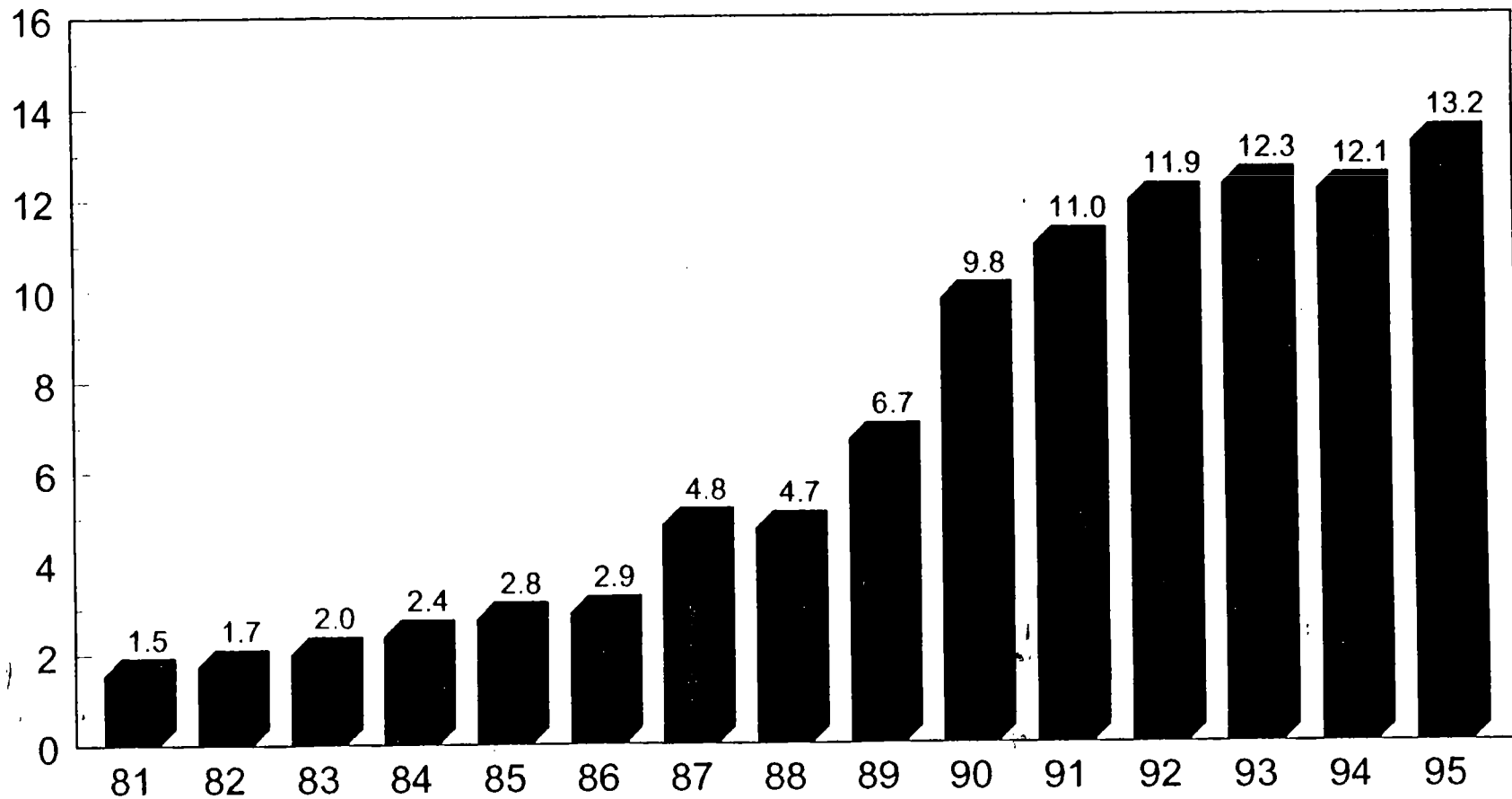
Retail Market for Illegal Drugs

- In 1991 Americans spent about \$49 billion on illegal drugs.
- Cocaine comprises almost 60 percent of this spending.
- By comparison, Americans spent \$19 billion for books, \$28 billion for toys and sports supplies, and \$53 billion for audio and visual products.



Federal Drug Control Budget, 1981-1995

Budget Authority in Billions of Dollars



Federal Drug Control Spending by Function, FY 1993 - FY 1995

(\$ in millions)

	FY 1993 Actual	FY1994 Enacted	FY 1995 Request	FY94-95 \$ Change	FY94-95 % Change
Drug Treatment	2,339.1	2,514.1	2,874.4	+360.3	14.3%
Prevention *	1,556.5	1,602.4	2,050.7	+448.2	28.0%
Criminal Justice	5,685.1	5,700.4	5,926.9	+226.6	4.0%
International	523.4	351.4	427.8	+76.4	21.7%
Interdiction	1,511.1	1,299.9	1,205.6	-94.3	-7.3%
Research	499.1	504.6	531.6	+27.0	5.3%
Intelligence	150.9	163.4	162.8	-0.6	-0.4%
TOTAL	12,265.3	12,136.2	13,179.8	+1,043.6	8.6%

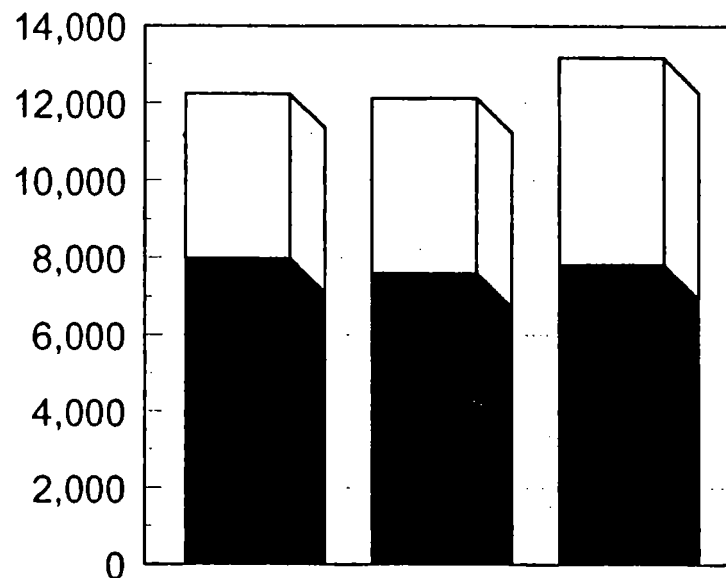
* Education, Community Action, and the Workplace

Supply and Demand Resources

- Of the total \$13.2 billion requested for drug control in FY 1995:
 - 59 percent is for supply reduction programs, and
 - 41 percent is for demand reduction programs.
- The FY 1995 request is \$1.0 billion more than the FY 1994 enacted level.
 - \$827 million of the increase in total resources is for demand reduction programs, and
 - \$217 million is for supply reduction programs.

Supply/Demand Resources

(\$ in millions)



	FY 1993	FY 1994	FY 1995
Supply ■	7,963.4	7,592.3	7,809.4
Demand □	4,301.9	4,544.0	5,370.5

Major Strategy Budget Initiatives

- **Reducing Hardcore Use through Treatment:** \$355 million plus Crime Bill resources increases the number of hardcore users in treatment by almost 140,000 per year.
- **Ensuring Safe and Drug Free Schools:** \$191 million for two programs: the Safe Schools Program, and the Safe and Drug-Free Schools and Communities State Grant Program.
- **Empowering Communities:** \$1.0 billion in total resources for community programs including (1) \$568 million for Community Policing (2) \$50 million for Community Empowerment (3) \$115 million for Community Partnerships and (4) \$98 million for HIDTA.
- **Focusing on Source Countries:** \$72 million in new funds for source country programs to support the controlled shift of resources from the transit zones to the source countries.



OFFICE OF NATIONAL DRUG CONTROL POLICY
EXECUTIVE OFFICE OF THE PRESIDENT
Washington, D.C. 20500

DRUG CONTROL BUDGET HIGHLIGHTS

BACKGROUND

- o The FY 1995 request totals \$13.2 billion. This is 9 percent or \$1.0 billion more than the 1994 enacted level of \$12.1 billion.
- o The amount for demand reduction is \$5.4 billion or 41 percent of total drug control resources; supply reduction is \$7.8 billion or 59 percent.
 - Resources for demand reduction programs increase by \$827 million from \$4.5 billion in FY 1994 to \$5.4 billion in FY 1995; resources for supply reduction programs increase \$217 million or 3 percent from \$7.6 billion in FY 1994 to \$7.8 billion in FY 1995.
 - The supply/demand ratio of 59%/41% in the FY 1995 request compares to 63%/37% in FY 1994 and 65%/35% in FY 1993.
- o In terms of the functional split, the following areas increase:
 - The largest dollar increase is for "Education, Community Action, and the Workplace" (prevention and community-based programs), which increase \$448 million or 28 percent.
 - The next largest dollar increase is for "Drug Treatment", which increases \$360 million or 14 percent.
 - The third largest increase is for Criminal Justice programs, which increases \$227 million or 4 percent.
 - The fourth largest increase is for International Programs, which increase \$76 million or 22 percent.
 - Research increases \$27 million or 5 percent.
- o The following functional areas decrease:
 - Interdiction is \$94 million less than the 1994 enacted level of \$1.3 billion.
 - Intelligence is 0.4 percent less than the 1994 enacted level of \$163 million.

FY 1995 BUDGET INITIATIVES

1. **TREATING HARDCORE USERS:** This \$355 million initiative is targeted specifically for programs to reduce hardcore drug use. Coupled with resources expected from the enactment of the Crime Bill, a total of 140,000 more hardcore users will receive treatment each year. (The \$355 million will treat an estimated 74,000 users; the crime bill will treat at least 64,000 users.)
 - \$310 million for HHS' Substance Abuse Treatment and Prevention Block Grant to treat 74,000 more hardcore users (part of the 140,000 discussed above).
 - \$35 million for a new treatment demonstration program for the hardcore user population.
 - \$10 million for the expansion of treatment services for American Indian and Alaska Native populations.

This initiative should close the current treatment gap of 1.1 million by 9 percent by 1996.

2. **ENSURING SAFE AND DRUG FREE SCHOOLS:** The FY 1995 request includes \$660 million for school-based drug and violence prevention programs, an increase of \$191 million over the FY 1994 request level for two programs:
 - Safe and Drug Free Schools and Communities program is a newly proposed \$480 million prevention program to replace the \$370 million Drug-Free Schools and Communities Program, which expires on September 30, 1994. This programs allows funding for drug education and prevention activities and adds violence as a key component of the program.
 - Safe Schools Program creates a program of targeted Federal assistance to local school districts to address the problem of increasing violence in our schools. The program totals \$20 million in FY 1994 and the President is requesting \$100 million in FY 1995. This program will provide competitive grants to local education agencies with serious school crime, violence, and discipline problems.
3. **EMPOWERING COMMUNITIES TO COMBAT DRUG-RELATED VIOLENCE:** The FY 1995 request includes a total of \$1.0 billion for community-based efforts. Included in this amount is \$733 million for the Community Policing, Empowerment Zone, and the Community Partnership Program.

- The drug component of the Community Policing Initiative to provide 100,000 cops is \$585 million (half is scored as prevention and the other half is scored as law enforcement).
- Empowerment activities are local efforts based on strategic, comprehensive plans. \$50 million is requested for Empowerment in FY 1995 to support residential and nonresidential drug treatment and prevention programs for pregnant women, mothers, and their children.
- Community Partnerships funding is maintained at the FY 1994 enacted level of \$115 million; about \$37 million of the total \$115 million is funding for new partnerships resulting from resources becoming available from the completion of the grant cycle for some of the existing partnerships.
- The HIDTA program will be expanded to include distribution HDTAs. The total request is \$98 million, \$12 million more than the 1994 enacted level.

4. **SOURCE COUNTRY PROGRAM ENHANCEMENT:** The FY 1995 request of \$428 million is \$76 million more than the FY 1994 enacted level of \$251 million. \$72 million of the increase is for the Department of State programs for source countries (under a new consolidated account) to support activities such as training of law enforcement, judicial reform, crop control, sustainable development, source and transit country interdiction, and demand reduction efforts

Budget Summary Tables

Federal Drug Control Spending by Function, FY 1993–FY 1995

(Budget Authority in Millions)

Drug Function	FY 1993 Actual	FY 1994 Estimate	FY 1995 President's Request	FY 94–FY 95 Change	
				\$	%
Criminal Justice System	5,685.1	5,700.4	5,926.9	226.6	4.0%
Drug Treatment	2,339.1	2,514.1	2,874.4	360.3	14.3%
Education, Community Action, and the Workplace	1,556.5	1,602.4	2,050.7	448.2	28.0%
International	523.4	351.4	427.8	76.4	-21.7%
Interdiction	1,511.1	1,299.9	1,205.6	(94.3)	-7.3%
Research	499.1	504.6	531.6	27.0	5.3%
Intelligence	150.9	163.4	162.8	(0.6)	-0.4%
Total	12,265.3	12,136.2	13,179.8	1,043.6	8.6%
Four-Way Split					
Demand Reduction	4,301.9	4,544.0	5,370.5	826.5	18.2%
	35.1%	37.4%	40.7%		
Domestic Law Enforcement	5,928.9	5,941.0	6,175.9	235.0	4.0%
	48.3%	49.0%	46.9%		
International	523.4	351.4	427.8	76.4	21.7%
	4.3%	2.9%	3.2%		
Interdiction	1,511.1	1,299.9	1,205.6	(94.3)	-7.3%
	12.3%	10.7%	9.1%		
Total	12,265.3	12,136.2	13,179.8	1,043.6	8.6%
Supply/Demand Split					
Supply	7,963.4	7,592.3	7,809.4	217.1	2.9%
	64.9%	62.6%	59.3%		
Demand	4,301.9	4,544.0	5,370.5	826.5	18.2%
	35.1%	37.4%	40.7%		
Total	12,265.3	12,136.2	13,179.8	1,043.6	8.6%
Demand Components					
Prevention (w/o research)	1,556.5	1,602.4	2,050.7	448.2	28.0%
Treatment (w/o research)	2,339.1	2,514.1	2,874.4	360.3	14.3%
Research	406.3	427.4	445.4	18.0	4.2%
Total, Demand	4,301.9	4,544.0	5,370.5	826.5	18.2%

(Detail may not add to totals due to rounding)

Drug Control Funding: Agency Summary, FY 1993-FY 1995

(Budget Authority in Millions)

	FY 1993 Actual	FY 1994 Estimate	FY 1995 President's Request
Department of Agriculture			
Agricultural Research Service	6.5	6.5	6.5
U.S. Forest Service	9.6	9.6	9.8
Special Supplemental Program for Women, Infants, and Children (WIC)	12.9	14.6	14.8
Total, Agriculture	28.9	30.7	31.0
Corporation for National and Community Service	9.7	28.5	43.0
Department of Defense	1,140.7	868.2	874.2
Department of Education	700.8	599.1	782.3
Department of Health and Human Services			
Administration for Children and Families	88.9	89.9	89.9
Centers for Disease Control and Prevention	31.2	36.6	36.6
Food and Drug Administration	6.8	6.8	6.8
Health Care Financing Administration	231.9	261.8	292.2
Health Resources and Services Administration	20.9	33.4	38.7
Indian Health Service	44.9	43.3	51.2
National Institutes of Health (NIDA)	404.2	425.2	443.7
Social Security Administration	4.6	20.0	22.8
Substance Abuse and Mental Health Administration	1,299.0	1,360.9	1,603.2 ¹
Total, HHS	2,132.4	2,278.1	2,585.2
Department of Housing and Urban Development	175.0	315.0	315.0
Department of the Interior			
Bureau of Indian Affairs	19.4	22.4	18.1
Bureau of Land Management	10.0	5.2	5.2
Fish and Wildlife Service	1.0	1.0	1.0
National Park Service	8.7	8.8	8.8
Office of Territorial and International Affairs	1.4	1.3	1.0
Total, Interior	40.6	38.7	34.1
The Federal Judiciary	405.6	452.9	505.5
Department of Justice			
Assets Forfeiture Fund	484.3	575.6	487.0
U.S. Attorneys	207.2	207.9	208.7
Bureau of Prisons	1,432.3	1,407.7	1,670.2
Crime Control Fund	0.0	0.0	567.6
Criminal Division	18.0	19.1	19.2
Drug Enforcement Administration	756.6	768.1	767.1
Federal Bureau of Investigation	257.0	257.2	262.4
Immigration and Naturalization Service	147.0	157.4	168.3
INTERPOL	1.9	1.9	2.0
U.S. Marshals Service	247.9	235.1	255.6
Office of Justice Programs	661.4	520.1	135.7
Organized Crime Drug Enforcement Task Forces	385.2	382.4	369.9
Support of U.S. Prisoners	196.8	222.1	262.6
(Detail may not add to totals due to rounding)			

¹ Excludes \$45.0 million that will be transferred from the ONDCP Special Forfeiture Fund for hardcore drug treatment.

Drug Control Funding: Agency Summary, FY 1993-FY 1995

(Budget Authority in Millions)

	FY 1993 Actual	FY 1994 Estimate	FY 1995 President's Budget
Department of Justice (continued)			
Tax Division	1.2	1.2	1.2
Weed and Seed Program Fund	6.6	6.6	6.7
Total, Justice	4,803.3	4,762.5	5,184.3
Department of Labor	65.1	64.8	80.5
Office of National Drug Control Policy			
Operations	15.2	11.7	10.0
High Intensity Drug Trafficking Areas	86.0	86.0	98.0
Gift Fund	0.2	0.3	0.0
Special Forfeiture Fund	15.0	12.5	52.5
Total, ONDCP	116.4	110.5	160.5
Small Business Administration	0.2	0.2	0.2
Department of State			
Bureau of International Narcotics Matters ²	147.8	100.0	—
Bureau of Politico/Military Affairs ²	52.3	15.4	—
Emergencies in the Diplomatic and Consular Service	0.1	0.3	0.3
International Narcotics Control Program	—	—	231.8
Total, State	200.2	115.7	232.1
Agency for International Development²	139.8	44.9	—
Department of Transportation			
U.S. Coast Guard	310.5	314.6	263.1
Federal Aviation Administration	21.0	24.8	16.5
National Highway Traffic Safety Administration	23.8	34.4	27.7
Total, Transportation	355.3	373.8	307.3
Department of the Treasury			
Bureau of Alcohol, Tobacco, and Firearms	151.0	153.8	153.5
U.S. Customs Service	561.0	536.1	505.5
Federal Law Enforcement Training Center	21.9	20.5	18.2
Financial Crimes Enforcement Network	14.7	14.6	15.7
Internal Revenue Service	91.8	90.3	94.6
U.S. Secret Service	56.6	57.1	57.3
Treasury Forfeiture Fund	143.5	230.2	208.8
Total, Treasury	1,040.5	1,102.6	1,053.6
U.S. Information Agency	9.3	9.8	10.0
Department of Veterans Affairs	901.5	940.3	981.1
Total Federal Program	12,265.3	12,136.2	13,179.8
Supply Reduction	7,963.4 64.9%	7,592.3 62.6%	7,809.4 59.3%
Demand Reduction	4,301.9 35.1%	4,544.0 37.4%	5,370.5 40.7%

(Detail may not add to totals due to rounding)

² The funding estimates for these accounts in FY 1995 have been incorporated in the Department of State's International Narcotics Control Program request as part of a planned consolidation. (See page 133 for program description.)

THE WHITE HOUSE

WASHINGTON

July 1, 1993

MEMORANDUM FOR THE PRESIDENT

FROM: CAROL RASCO
JOSE CERDA III

SUBJECT: UPDATE ON DRUG POLICY

While the delay in confirming a new Drug Director has put us in the position of not being able to comply with the statutory requirement for a February 1st National Drug Control Strategy -- and of submitting a budget that does reflect your new Drug Director's recommendations -- the two most obvious increases in your FY 1994 budget complement are consistent with the drug indicators that have been released by HHS since the start of the Administration. So does you work on health care reform.

For instance, the Drug Abuse Warning Network (DAWN) emergency room statistics released by HHS continue to show high levels of cocaine and heroine overdoses. In particular, emergency room mentions of cocaine (up 15% over from the previous quarter) reached the peak levels set in 1989, and heroin mentions (up 16% from the previous quarter) recorded the highest level since the recording of DAWN statistics.

Last week, HHS released the findings of the National Household Survey -- the survey most often referred to by the previous administration to show that casual drug use is falling. The Household Survey again showed a drop in the number of casual users.

Thus, while the Administration has not spoken publicly to the problem, every indicator since January confirms that the "War on Drugs" must now turn to addressing the problem of hard-core use. The FY 1994 budget directly addresses the hard-core drug problem by proposing increases in drug treatment and education, and in community policing programs.

Overall the budget proposes an increase of 10% in demand reduction programs (7% in treatment and 16% in prevention). Also, the Administration's indication that drug treatment will be addressed in health care legislation represents a dramatic shift from previous policies and will do much to increase its availability. More -- and more effective -- drug treatment is the single best policy choice to help address the hard-core use problem.

Your budget -- along with the empowerment zones and the jobs bill -- also proposes dramatic increases in spending for community policing and increased police presence (\$75 million, \$500 million and \$200 million respectively). By increasing the number of police on out streets in community policing roles, we can directly confront hard-core drug use and drug dealers. Community policing strategies have been proven to help close down drug markets and to help identify problem addicts that should get treatment. Up to one third of those in treatment were induced to enter treatment by the criminal justice system.

Finally, though it received no media attention, Lee Brown testified last week that he would produce the Administration's National Drug Control Strategy within 60 days. As we mentioned, the strategy is past due, and -- without it -- the Congress has resisted appropriating our policing and treatment monies. Today's announcement provides an opportunity to embrace the major tenets of your soon-to-be-released drug strategy.

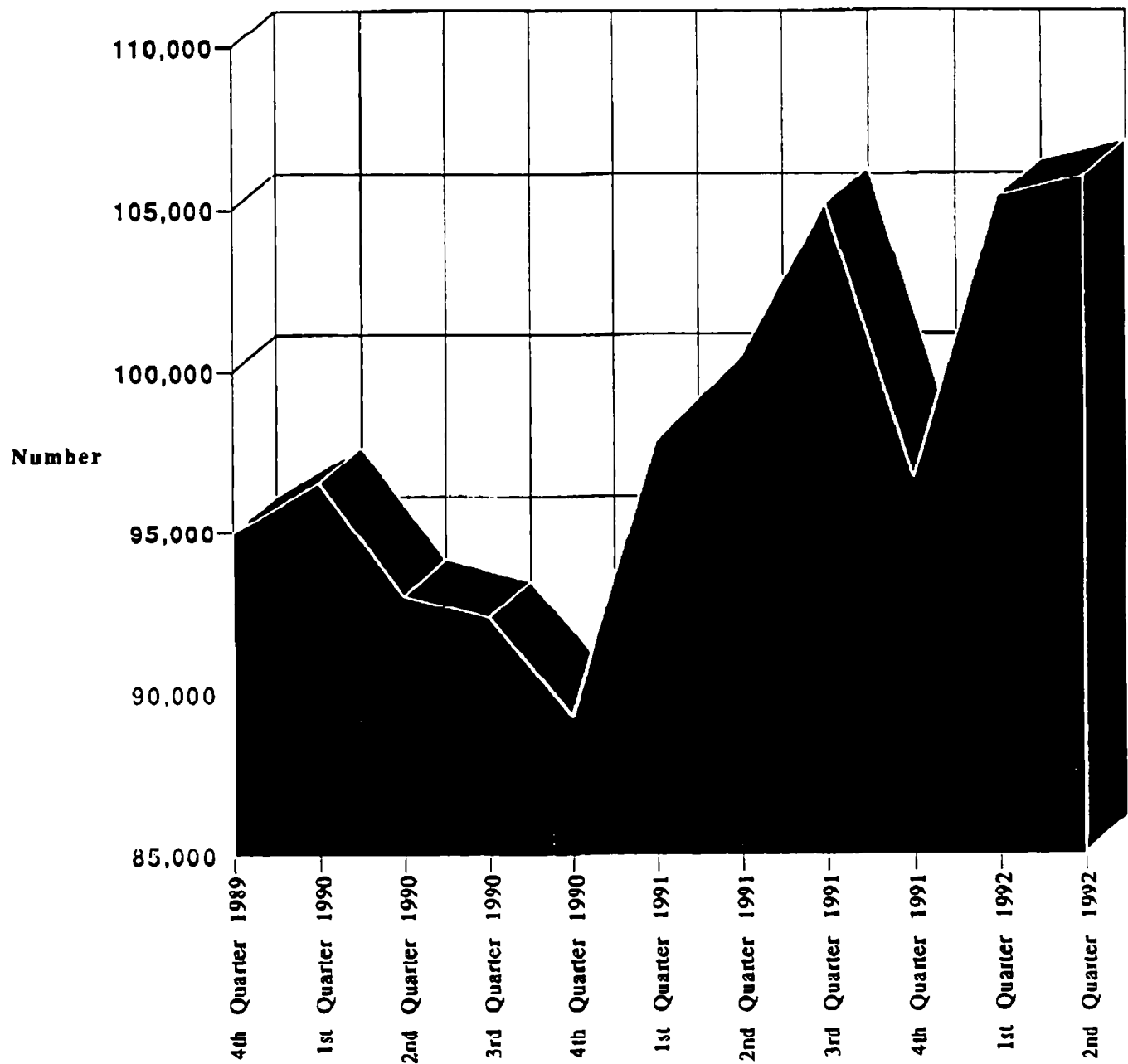
DRUG STRATEGY -- MAJOR TENETS

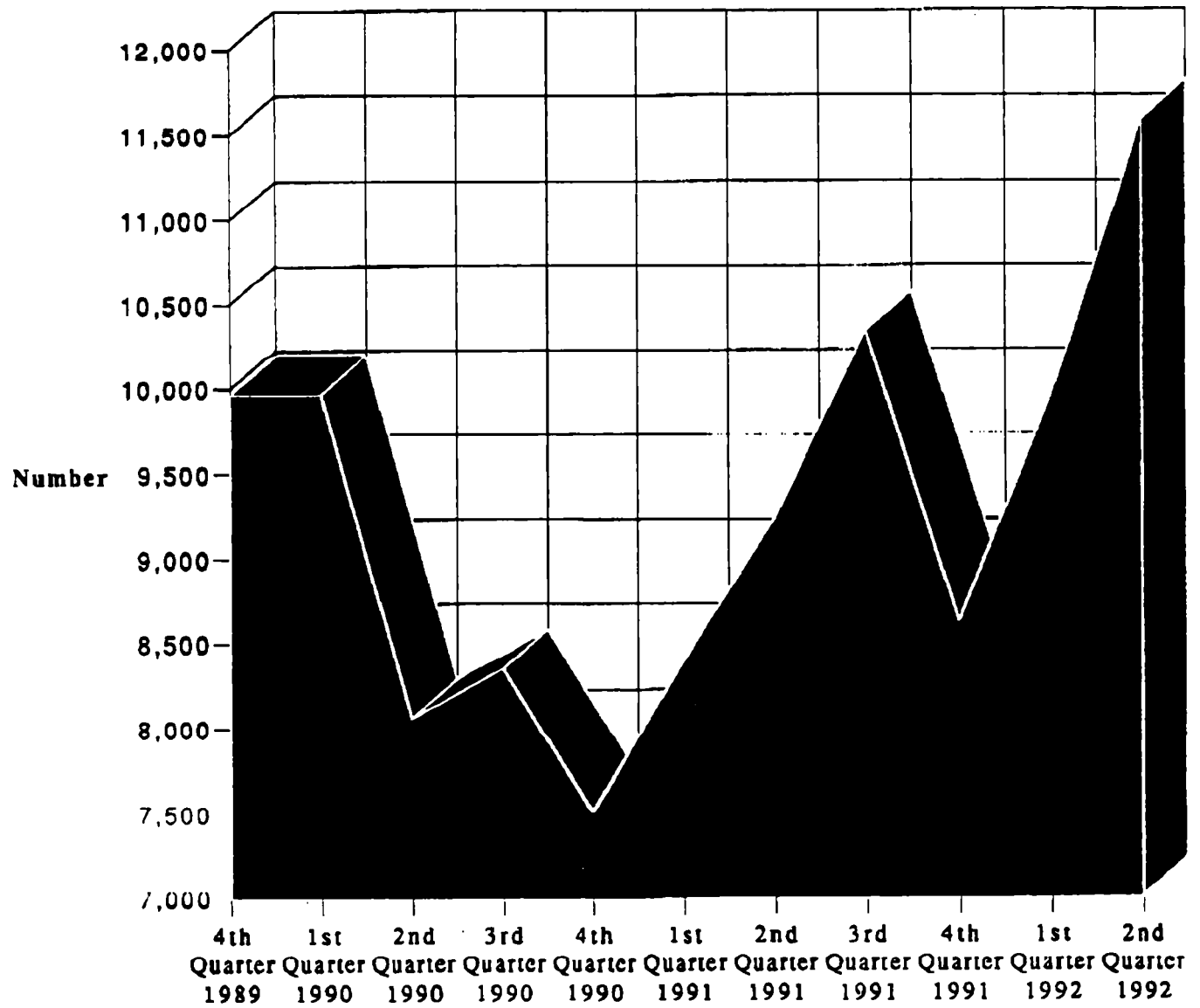
The key policy findings of a strategy with promise for the next four years could include:

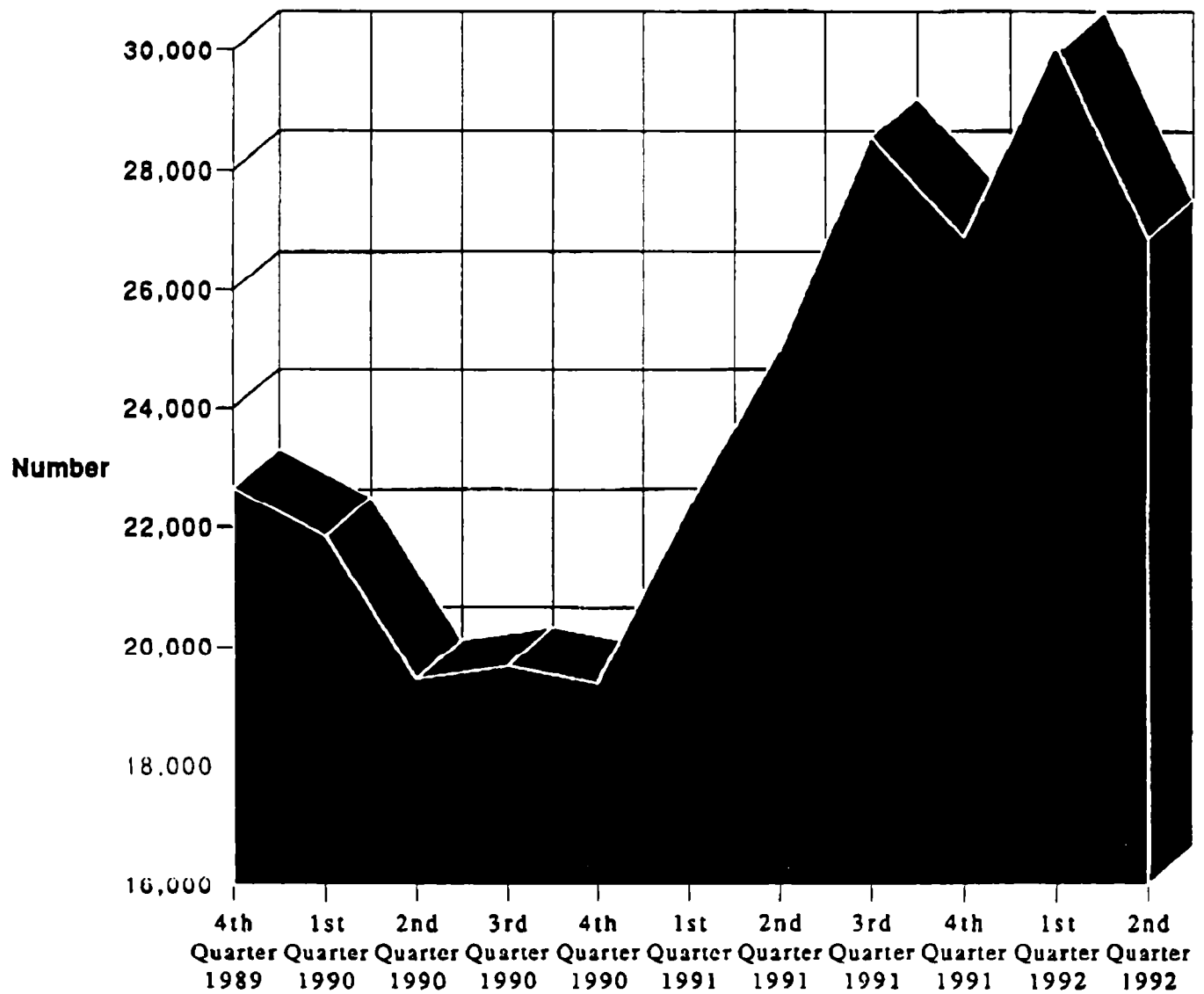
- Any gains in the "War on Drugs" have been lost, and other areas are worse than at the start of the strategy (see attachments).
- Hard-core addicts are the proper focus of a new drug strategy, because reducing casual use doesn't hit the root of the drug problem.
- Community policing is the key proven law enforcement strategy to combat hard-core drug use and drug dealers. We need to put more police officers in our neighborhoods to serve in crime prevention/problem solving roles.
- Drug treatment on demand is the other key to controlling drug use, and treatment on demand can only be met through a national health care plan. This is justified on the grounds that drug abuse has so many other medical costs (overdoses, AIDS, tuberculosis and other illnesses).
- The "carrot and stick" of the criminal justice system must be used to demand that addicted offenders get treatment. We already pay considerable overhead costs for incarcerating drug-addicted offenders and should demand that they be treated. Parole and or probation should also be used to test, if necessary, treat drug addicts in the criminal justice system.
- Drug education and prevention must be in place to lower the probability of future drug epidemics. New data suggesting that drug use among eighth graders has increased supports this commitment.
- Despite the creation of ONDCP to bring coherence to our National Drug Control Policy, the agency has failed in its mission -- and our drug efforts have been characterized by interagency strife, turf battles, and duplicative efforts. Thus, the new Drug Czar will be elevated to cabinet-level, given enhanced powers to coordinate drug policy, and charged with reorganizing and reforming ONDCP.

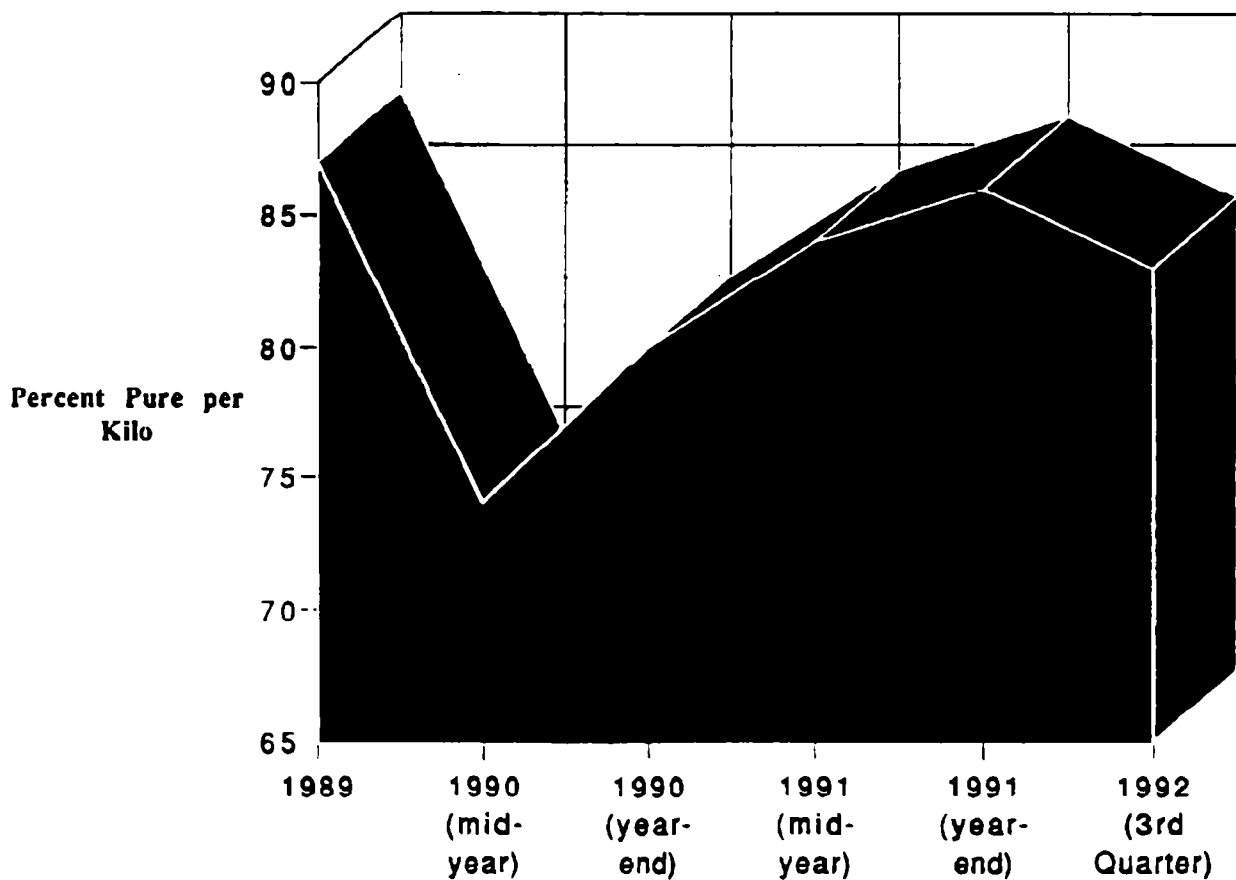
Overdoses/total.1

Drug Overdoses: More Than When the Strategy Began

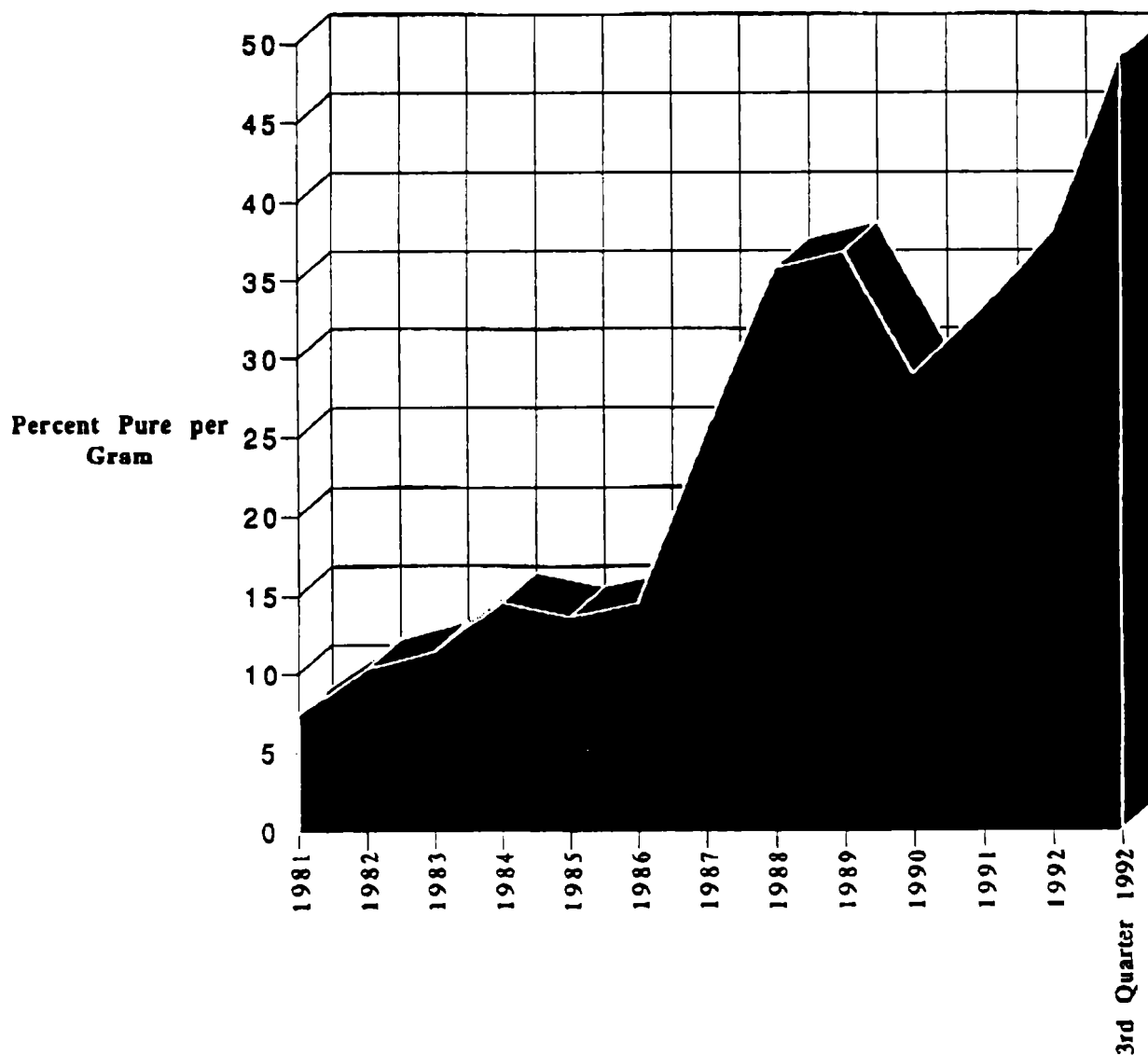


Heroin/overdose.1**Heroin Overdoses**

Cocaine/overdose.1**Cocaine Overdoses: More Than When the Strategy Began**

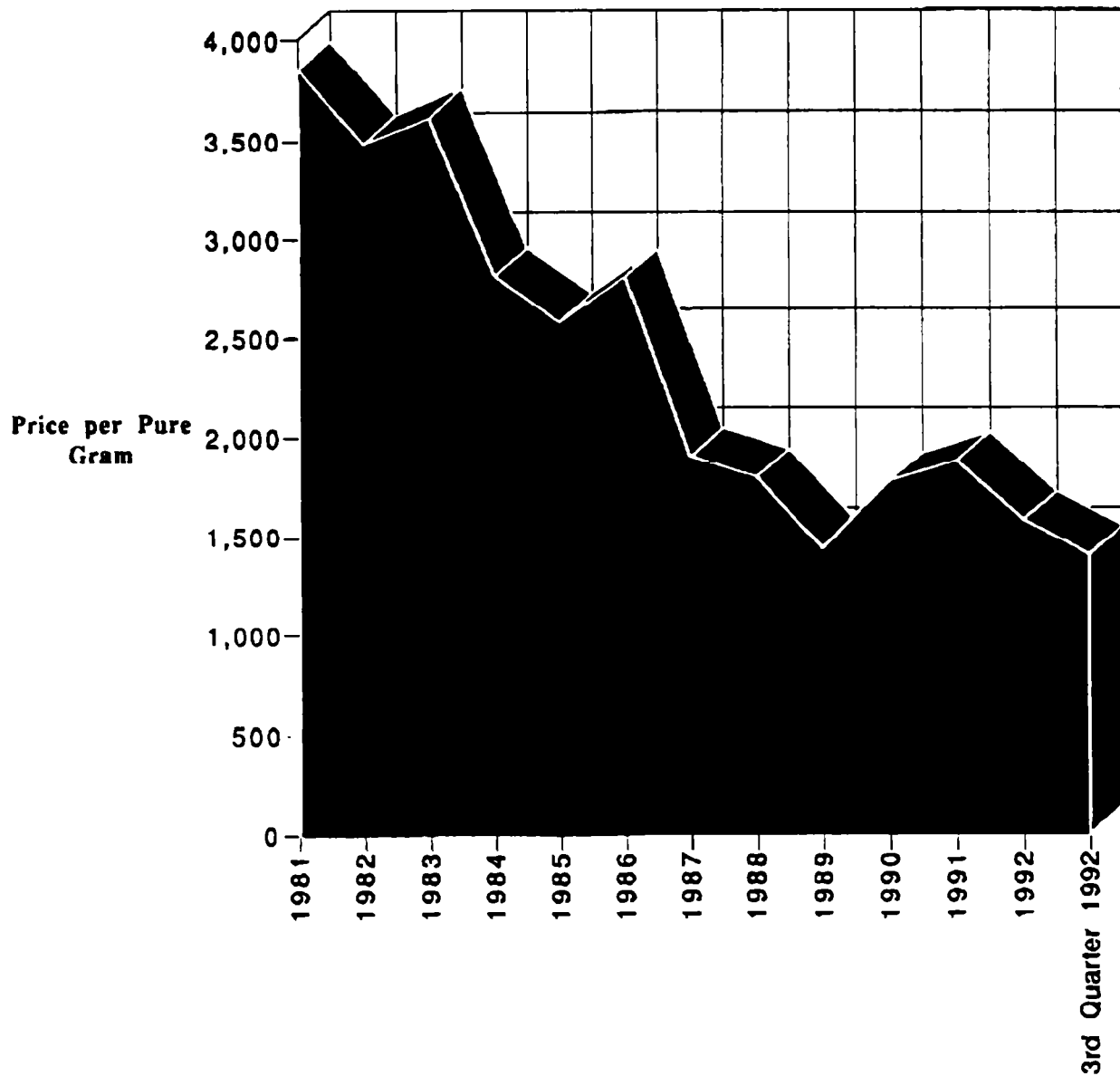
Cocaine/kilo.2**Lost Opportunity: Rising Cocaine Purity for Drug Traffickers**

heroin/gram.1

Escalating Heroin Purity

Heroin/price.2

Plummeting Heroin Prices





Center on Addiction
and Substance Abuse
at Columbia University

OCT 31 1994

October 25, 1994

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Ms. Carol Rasco
Assistant to the President for Domestic Policy
White House, Room 2W/W
1600 Pennsylvania Avenue, N.W.
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Joseph A. Califano, Jr.
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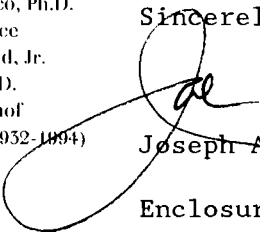
James E. Burke
Betty Ford
Douglas A. Fraser
Barbara C. Jordan
Donald R. Keough
LaSalle D. Leffall, Jr., M.D.
Manuel T. Pacheco, Ph.D.
Linda Johnson Rice
E. John Rosenwald, Jr.
George Rupp, Ph.D.
Michael P. Schulhof
Frank G. Wells (1932-1994)

Dear Carol:

I want you to have an advance copy of our report on gateway drugs.
I think you will find it interesting.

The report will be released at a press conference at the National
Press Club on Thursday at 10:00 AM.

Sincerely,



Joseph A. Califano, Jr.

Enclosure



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E. John Rosenwald, Jr.
George Rupp, Ph.D.
Michael P. Schulhof
Frank G. Wells (1932-1994)

Cigarettes, Alcohol, Marijuana: Gateways to Illicit Drug Use

October 1994

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President and Chief Executive Officer of Sony Corporation of America

Frank G. Wells (1932-1994)

(former President and Chief Operating Officer of The Walt Disney Company)

This report was prepared by Jeffrey C. Merrill, Vice President for Policy and Research at CASA; Kimberley S. Fox, Senior Program Manager; Susan R. Lewis, Research Associate and Gerald E. Pulver, Data Manager. The report was funded by core grants from the Carnegie Corporation of New York and the Ford and Robert Wood Johnson Foundations. Data analysis was done by CASA's Substance Abuse Data Analysis Center made possible by a grant from The Henry J. Kaiser Family Foundation.

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FOREWORD

This report of the Center on Addiction and Substance Abuse at Columbia University (CASA) addresses the controversial subject of the relationship of smoking cigarettes and drinking alcohol to the use of marijuana, cocaine, heroin and other illicit drugs. This report is the most comprehensive national analysis ever undertaken of all these relationships among children and adults, as experimenters and regular users. The report reveals remarkably consistent statistical relationships between the use of cigarettes and alcohol and the subsequent use of marijuana, and between the use of cigarettes, alcohol and marijuana and the subsequent use of illicit drugs like cocaine, regardless of the age, sex, ethnicity or race of the individuals involved.

For decades, public health professionals and social scientists have argued among themselves, and debated with tobacco and alcohol company representatives, about whether a relationship exists between children smoking cigarettes and drinking beer, wine coolers or other alcohol, and the subsequent use of drugs such as marijuana, cocaine and heroin. Those who argue for the decriminalization or legalization of marijuana have claimed that smoking marijuana is not related to experimentation with or addiction to other drugs, such as cocaine and heroin. The potent statistical relationships demonstrated in this report have profound implications for personal conduct and public policy. For the recent rise in the use of cigarettes, alcohol and marijuana by America's children and teenagers may be the harbinger of an increase in the use of illicit drugs like cocaine.

Over the past 30 years, scientific and medical research has produced an overwhelming body of evidence that smoking cigarettes is, in and of itself, highly dangerous, increasing sharply the risk of cancer, heart disease and deadly respiratory ailments. There is also a considerable and convincing body of evidence that the use of beer, other alcohol or marijuana is especially dangerous to children and teenagers because it can impede their social and intellectual development (marijuana is especially damaging to short-term memory and attention span) and lead individuals to engage in dangerous activities, such as reckless driving, premature and unprotected sex and/or violence. The long-term costs of tobacco, alcohol and marijuana abuse impose a staggering financial burden on our health care, welfare and disability systems, both public and private, at a time when political pressures are building to reduce these entitlement programs. The cost in terms of human suffering is incalculable.

If smoking and drinking lead a large number of children and teenagers to use marijuana; and if smoking, drinking and using marijuana lead a large number of children and adults to experimentation, regular use and addiction involving substances like cocaine, this signals a public health threat of far more serious and sinister dimensions for children and teenagers than had previously been recognized.

Here are some highlights of the CASA report's analysis of the connection between the gateway drugs--tobacco, alcohol and marijuana--and subsequent use of cocaine and other illicit drugs:*

* Use is defined as "having ever used."

- 89% of those individuals who use cocaine first used all three gateway substances. 99.9% of individuals who use cocaine first used a gateway drug.
- 90% of children and adults who use marijuana first smoked cigarettes or drank alcohol.
- Children 12-17 years old who use marijuana are 85 times more likely, who drink are 50 times more likely, and who smoke are 19 times more likely, to use cocaine than children who have never used those substances.
- Children 12-17 years old who use all three gateway drugs are 266 times more likely to use cocaine than children who never used a gateway drug.

The report also found that the younger children are when they use gateway drugs, and the more often they use them, the more likely they are to use cocaine, heroin, hallucinogens and other illicit drugs:

- 60% of children who smoke pot before age 15 move on to cocaine; only 20% of those who smoke pot after age 17 use cocaine.
- Children who are heavy cigarette smokers are 13 times more likely to use heroin than other children who smoke.

Use of gateway drugs in childhood is related to experimentation and regular use of illicit drugs as adults.

- An adult who uses all three gateway drugs is up to 323 times more likely to use cocaine.
- An adult who as a child smoked is 3 times more likely, as a child drank is 6 times more likely, and as a child used marijuana is 17 times more likely, to use cocaine regularly than an adult who as a child never used these substances.

The statistics in the report measure the use of any drug by children or adults as well as regular drug use among adults. The importance of measuring any drug use is that regular use follows from experimentation and virtually no one who experiments with drugs like cocaine and heroin believes they will become addicted.

The statistical relationships in the report probably understate the risks because they are based on individuals admitting the extent of their use of cigarettes, alcohol and marijuana. Particularly with respect to use of illegal drugs like marijuana and cocaine, but also with respect to the abuse of alcohol and the number of cigarettes smoked, individuals tend to minimize or even deny their use.

By and large, the statistical relationships recounted in the report hold regardless of the race, sex or ethnicity of the individuals involved. They are far more powerful than those which first revealed the nexus between cigarette smoking and lung cancer and

emphysema, cholesterol levels and heart disease, and exposure to asbestos and lung cancer. The 1964 Surgeon General's report on smoking found male smokers nine to ten times likelier to develop lung cancer than non-smoking males. The 1968 report of the Framingham Study found men with high cholesterol to be two to four times likelier to suffer coronary heart disease than men with low cholesterol. In 1981, Dr. Irving Selikoff found the risk of lung cancer to be five times greater for individuals with heavy occupational exposure to asbestos.

For the most part, the risks of using illicit drugs like cocaine for children who smoke, drink and/or use marijuana found in this report are many times higher than the risks recorded in 1964 Surgeon General's report on smoking, the Framingham heart study or the Selikoff asbestos study.

It is important to note that this report reveals only statistical relationships, such as those of the use of cigarettes, alcohol and marijuana by children and adults to their subsequent experimentation with or regular use of illicit drugs like cocaine. Like the 1964 Surgeon General's report on smoking with respect to emphysema and women, this report of the Center on Addiction and Substance Abuse at Columbia University does not pretend to establish causality. We know that millions of Americans who smoke and drink never move on to marijuana, cocaine, heroin or other illegal drugs. Nevertheless, the statistical relationships revealed are so powerful and the risk to America's 20 million 12-17 year old children so great that the implications of this report are profound. The statistical message is clear: The younger an individual uses any gateway drug (cigarettes, alcohol or marijuana), the more often an individual uses any gateway drug, the more

gateway drugs an individual uses, the likelier that individual is to experiment with cocaine, heroin and other illicit drugs and the likelier that individual is to become a regular adult drug user and addict.

With the use of gateway drugs on the rise among America's children, this report is a siren call to action for everyone from the President to parents.

For parents, the message is clear: If your child makes it through the teenage years without smoking cigarettes or repeatedly drinking beer or alcohol, the odds are overwhelming that he or she will never smoke marijuana; and if your child makes it through those years without using any of the gateway substances, your child is almost certain to make it through his or her entire life without using hard drugs.

For teachers in elementary and high schools, for physicians and nurses, and for national, state and local public health officials, the message is also clear: It is imperative to step up health promotion and disease prevention programs to encourage children not to smoke, drink or use marijuana.

For governors and mayors, state legislatures and city councils, the study underscores the importance of taking firm and effective steps to keep cigarettes, beer and other alcohol out of the reach of teenagers. Existing laws which prohibit sale of cigarettes and alcohol to teenagers should be vigorously enforced; the use of vending machines to sell cigarettes should be stopped; and store owners who sell cigarettes and alcohol to minors should be fined and/or have their licenses revoked. The high incidence of illicit drug use among children and adults who use marijuana indicates that there is nothing benign about smoking pot, and teachers and public health and law

enforcement officials who wink at marijuana use are doing a great disservice to America's children.

For America's research community there is also a significant message here. The CASA study uncovers a dramatic statistical tie between alcohol and cigarettes and marijuana, cocaine and other illicit drugs. There are obviously many other issues related to why an individual uses drugs--genetic and environmental factors, peer pressure, poverty, accessibility, mental health. When the Surgeon General's report on smoking was issued in 1964, indicating much weaker relationships between cigarette smoking and lung cancer, emphysema and heart disease, the American scientific and research community invested its energies and billions of dollars in research to understand those relationships. Similar efforts were mounted in response to early information from the Framingham heart and Selikoff asbestos studies. As a result, we understand a great deal about the medical relationships between cigarette smoking and a number of cancers, heart disease and respiratory ailments; about the relationship of cholesterol to heart disease (resulting in recommendations that Americans reduce the fat and increase the fiber content of their diets), and about the relationship between asbestos exposure and lung diseases. The statistical relationships revealed in this report are a call for the American research community to turn more of its genius and resources to the relationship of cigarette smoking and drinking beer and other alcohol to the use of marijuana, and the relationship of the use of all three of those substances to the use of drugs like cocaine, heroin and hallucinogens.

The questions for researchers are many: Does smoking reflect an individual propensity to use other drugs? Does drinking? Are there genetic markers that distinguish those individuals whose smoking and drinking will lead to the use of hard drugs from those who will never use them? What is the role of family life? Religious conviction? Poverty? Peer pressure? Are there differences in the brain receptors in individuals whose smoking and drinking lead to the use of marijuana and on to the use of heroin and cocaine, and the brain receptors of individuals who smoke and drink and never use any other drugs? What protective factors mitigate against cigarette, alcohol and marijuana use? How can those factors be stimulated? Does the use of cigarettes and alcohol create a psychological climate which makes the use of illegal substances easier? Does the use of marijuana or alcohol as a child put an individual in contact with others who will use harder drugs and thus increase the likelihood of abuse and addiction to those drugs? How can we make programs that help individuals quit smoking, drinking and smoking pot more effective?

The CASA analysis is based on a meticulous review of the medical and scientific literature, various state and regional studies, anecdotal evidence and the National Household Survey on Drug Abuse conducted by the National Institute on Drug Abuse, which surveys more than 30,000 American households. Like all public health analyses, this study builds upon the work of many individuals in government and in the private sector, scientists and epidemiologists too numerous to mention, but including Denise Kandel, Kazuo Yamaguchi and Lloyd Johnston. CASA was able to conduct this analysis because SADAC, its Substance Abuse Data Analysis Center, possesses the capacity to

analyze a large number of combinations of national data sets on the use and abuse of drugs, alcohol and cigarettes with related data on health care, criminal justice and the U.S. Census.

The study was conducted under the direction of Jeffrey Merrill, Vice President for Policy and Research and a professor at Columbia University's School of Public Health, and Kimberley Fox, Senior Program Manager, with the assistance of Susan Lewis and Gerald Pulver in gathering the data, as well as Diane Willis and Greg Armbruster in designing the charts. They benefitted from the valuable advice of Denise Kandel, a professor at Columbia University's School of Public Health, and others who work in this field.

This study was made possible by core grants from the Robert Wood Johnson, Carnegie and Ford Foundations, and by the Kaiser Family Foundation grant which helped to establish SADAC.

Joseph A. Califano, Jr.

Chairman and President

Section I

Introduction

Considerable and convincing evidence already exists that smoking by children and teenagers, as well as drinking and using marijuana, are in and of themselves dangerous to children's health and can impede social and intellectual development. The long-term costs of such use impose an enormous burden on our health care, welfare and disability systems. But, if smoking and drinking also lead a large number of children and teenagers to experiment with hard drugs and possibly become addicted to substances like heroin and cocaine, then alcohol, cigarettes, and marijuana are gateways to a public health problem of far more serious dimensions.

Since the 1970s, proponents have argued for the theory that cigarettes, alcohol, and/or marijuana are "gateways" to the use of other drugs. Through both longitudinal and cross-sectional studies, some research has identified a specific sequence of drugs through which users typically progress. Work by Kandel and Yamaguchi has suggested that most cocaine users start with either cigarettes or alcohol and then progress to marijuana before moving on to cocaine. Ellickson, Hays, and Bell have argued that the gateway theory is most applicable to white, non-Hispanic drug users. Welte and Barnes, as well as other researchers, have argued that cigarettes play a larger role as a gateway drug for women than for men.

Research by Kandel and Yamaguchi has further suggested that adolescent cocaine users begin using gateway drugs an average of two years earlier than those adolescents who do not use cocaine. Ellickson et al. found evidence that weekly smoking may come

before the initial use of hard drugs and that increased marijuana use accompanies hard drug use. A 1993 study by the General Accounting Office examined the relationship between drugs and alcohol and sought to identify social risk factors related to alcohol or drug use among youth.

However, not all researchers agree with the gateway theory, and some have proposed an alternative explanation referred to as the "common syndrome theory." Donovan and Jessor have argued that problem behaviors, such as drinking, smoking, using drugs, having sex at an early age, and engaging in anti-social activities "reflect a single, underlying factor" among certain adolescents, rather than any unique impact of the gateway drugs.

Most of the research propounding the gateway theory was based upon regional and local data, or was confined to one segment of the population or a single gateway drug. This report by the Center on Addiction and Substance Abuse at Columbia University (CASA) is the first and most comprehensive *national* assessment of the impact on *both* children *and* adults of *all* three gateway drugs--cigarettes, alcohol, and marijuana--and the subsequent use and abuse of cocaine, heroin, hallucinogens, inhalants and other illicit substances. The study is the culmination of a careful and comprehensive review of the literature, builds upon previous research, and conducts extensive, new analyses of NIDA's 1991 National Household Survey on Drug Abuse.* These new risk analyses were made possible by CASA's Substance Abuse Data Analysis Center (SADAC). Funded through a grant from the Kaiser Family Foundation, SADAC can

* See the Appendix for a description of the database.

conduct extensive analyses on a large number of national data sets reporting on the use and abuse of drugs, alcohol and cigarettes and on related issues such as health care, criminal justice and the U.S. Census.

In its national assessment, CASA finds strong statistical evidence between the childhood use of cigarettes and alcohol and the subsequent use of marijuana, and the childhood use of all three of these gateway substances and the subsequent experimentation with and regular use of drugs like cocaine and heroin, across all age groups and regardless of gender, race or ethnicity.

Section II

Findings

CASA compared illicit drug use* by children age 12-17 who reported using a gateway drug--cigarettes, alcohol, or marijuana--with those who did not. The study also compared adults age 18 and over who used a gateway drug before age 18 with adults who had either never used these drugs or had not used them before age 18.

First, this study examines whether there is a difference in the use of illicit drugs between those who ever did and did not use gateway drugs as children. Second, the study looks at whether the *age of initiation* of using gateway drugs affects the probability of using illicit substances. Next, the study examines whether the *quantity or frequency* of gateway drug use affects an individual's likelihood of using illicit substances.

* The following are definitions of terms used throughout this report:

Illicit drugs: cocaine (including crack), heroin, hallucinogens (including LSD), marijuana and hashish, and the nonmedical use of sedatives, tranquilizers, stimulants, analgesics and inhalants.

Gateway drugs/substances: cigarettes, alcohol, and marijuana.

Adults: age 18 and older.

Children: age 12 to 17.

Regular use: current use of a given substance on a monthly or more frequent basis.

Relative risk: an epidemiological term, used to measure the strength of an association, found by dividing, in this case, the incidence rate of drug use in an exposed group (e.g., smokers) by the incidence rate of drug use in an unexposed group (e.g., non-smokers).

Levels of alcohol consumption are defined as follows:

Frequent: drinking weekly or more;

Moderate: drinking on a monthly to weekly basis;

Occasional: drinking any less often.

Regardless of gender, race, or ethnicity, the probability of illicit drug use was considerably higher for those who as children used a gateway drug. The younger children started using one or more of the gateway drugs, the greater their likelihood of using illicit substances. Similarly, the greater the quantity or frequency of gateway drug use by children, the more likely they will move on to illicit substances. The data also reveal that children who experiment with more than one gateway drug are likelier to use other drugs than children who use only one gateway drug. While these relationships were especially strong for children, they held for adults as well, and gateway drug use is not only associated with experimentation, but also with regular adult use of illicit drugs.

These findings are presented in detail in the discussion that follows.

CHART 1:
Prevalence of Drug Use

Chart 1 provides, for reference, the overall prevalence of tobacco, alcohol, and other drug use for adults 18 and over and youths 12 to 15 and 16 to 17 years old. For all substances except cigarettes, usage is simply defined in terms of "having ever consumed" the substance. For cigarettes, "ever use" is defined as having smoked at least 100 cigarettes (five or more packs). This definition is based upon the accepted standard used by the National Household Survey on Drug Abuse of the National Institute on Drug Abuse and the National Health Interview Survey of the U.S. Public Health Service.

The data in the National Household Survey on Drug Abuse are probably conservative because they are drawn from interviews with children and adults. Self reports of cigarette, alcohol, and drug use often understate the extent of use. For example, while people might admit alcohol use, they may not always be forthcoming in reporting actual frequency. Most individuals fear admitting to illicit drug use, particularly frequent use. Furthermore, since this is a household survey, drug users who do not have a permanent address are often excluded. This is a problem especially for heroin users. Thus, with respect to illicit drug use, these figures probably significantly underestimate prevalence. Finally, underreporting is likely to be higher among children because consuming cigarettes and alcohol, as well as drugs, is illegal for this population, and because many children had an adult present at the time of the interview.

The drug of choice across age groups is alcohol: Nearly 90 percent of adults, 69 percent of 16- to 17-year-olds, and more than one-third of 12- to 15-year-olds report ever drinking. While not displayed on this chart, the primary alcoholic beverage consumed is beer, particularly among children. On the National Household Survey on Drug Abuse, for those who drink and indicated a preference, 61% of children and 48% of adults named beer as their drink of choice over wine and liquor. The next closest drink of preference was wine or wine coolers, with 27% of both children and adults indicating this as their usual beverage. For children, these findings are consistent with those released in a 1991 report by the Inspector General of the U.S. Department of Health and Human Services, which estimated that 1.1 billion cans of beer are consumed by junior and senior high school students each year, compared with 300 million bottles of wine cooler.

Cigarette smoking also is quite common, with more than half of adults reporting having smoked at least 100 cigarettes in their lifetime. The large jump in the percentage of youths, from ages 12-15 to ages 16-17, who smoke cigarettes and use marijuana and cocaine, indicates that use of these substances increases sharply in these mid-teen years.

Chart 1

Prevalence of Drug Use **Percent Who Have Ever Used**

Drug	Youths 12-15	Youths 16-17	Adults 18+
Cigarettes*	5.7%	20.5%	52.1%
Alcohol	35.1%	69.3%	88.9%
Marijuana	6.6%	26.1%	35.4%
Any Illicit Drug	13.7%	33.1%	38.9%
Any Drug Except Marijuana	10.5%	18.5%	21.2%
Cocaine	1.0%	5.3%	12.5%

* These percentages include only individuals who have smoked at least 100 cigarettes.

CHARTS 2 - 4:

Children Who Use Gateway Drugs **Are At Greater Risk of Using Other Drugs**

These three charts examine the relationship between the use of each gateway drug and the subsequent use of illicit substances for children age 12-17. Children who report ever using cigarettes, alcohol or marijuana are much more likely to report using illicit drugs than children who have never tried a gateway drug. For example, more than 40% of children who have smoked use an illicit drug, as compared with only 7% of non-smoking children. A child who smokes is almost 6 times likelier to use any illicit drug and more than 19 times likelier to use cocaine than a child who never smoked.

For alcohol (Chart 3) this relationship is even stronger. Children who drink are 7.5 times more likely to use any illicit drug, more than 22 times likelier to use marijuana, and 50 times likelier to use cocaine than children who never drank. The correlation between marijuana and cocaine use is particularly high. As Chart 4 indicates, children who have used marijuana are more than 85 times likelier to use cocaine than children who have never used marijuana. These associations are consistent for both boys and girls.

Chart 2

Children* Who Smoke Are More Likely To Use Other Drugs

Drug	% Who Use Other Drugs		Increased Likelihood Of Drug Use
	Never Smoked	Ever Smoked	
Any Illicit Drug	7.0%	41.5%	5.9
Marijuana	2.5%	30.3%	12.1
Cocaine	0.3%	5.8%	19.3

*Age 12-17

Chart 3

Children Who Drink Alcohol Are More Likely To Use Other Drugs

Drug	% Who Use Other Drugs		Increased Likelihood Of Drug Use
	Never Drank	Ever Drank	
Any Illicit Drug	5.0%	37.5%	7.5
Marijuana	1.2%	26.7%	22.3
Cocaine	0.1%	5.0%	50.0

Chart 4

Children Who Use Marijuana Are More Likely To Use Other Drugs

Drug	% Who Use Other Drugs		Increased Likelihood Of Drug Use
	Used Marijuana Never	Ever	
Any Illicit Drug (Except Marijuana)	8.1%	46.4%	5.7
Cocaine	0.2%	17.1%	85.5

CHARTS 5 - 7:

Adults Who Started Using Gateway Drugs As Children **Are More Likely To Use Other Drugs**

In the previous three charts, the statistical relationship between the use of a gateway drug and children's subsequent use of illicit substances is clear. The data also indicate that adults who use one of the gateway substances as children are more likely to use illicit drugs.

Charts 5 - 7 examine adult use of illicit substances based upon whether an individual had tried a gateway drug by age 18. While the relationships are not as strong as they were for children, they remain significant. For example, an adult who started smoking as a child is 3 times likelier to use marijuana and 4 times likelier to use cocaine than one who did not smoke as a child. As can be seen in Chart 6, adults who started drinking before 18 have a higher risk of using illicit drugs than those who had not used alcohol before the age of 18. Adults who used marijuana as children are significantly more likely to use other drugs, particularly cocaine: Adults are 12 times more likely to use cocaine if they had tried marijuana as children than if they had not.

Chart 5

Adults Who Started Smoking As Children Are More Likely To Use Other Drugs

Drug	% Who Use Other Drugs		Increased Likelihood Of Drug Use
	Did Not Smoke By Age 18	Smoked By Age 18	
Any Illicit Drug	19.0%	49.8%	2.6
Marijuana	15.3%	46.5%	3.0
Cocaine	4.1%	17.0%	4.1

Chart 6

Adults Who Started Drinking As Children Are More Likely To Use Other Drugs

Drug	% Who Use Other Drugs		Increased Likelihood Of Drug Use
	Did Not Drink By Age 18	Drank By Age 18	
Any Illicit Drug	14.1%	52.5%	3.7
Marijuana	10.9%	49.0%	4.5
Cocaine	2.3%	18.2%	7.9

Chart 7

Adults Who Used Marijuana As Children Are More Likely To Use Other Drugs

Drug	% Who Use Other Drugs		Increased Likelihood Of Drug Use
	Did Not Use Marijuana By Age 18	Used Marijuana By Age 18	
Any Illicit Drug (Except Marijuana)	10.1%	59.2%	5.9
Cocaine	3.6%	43.1%	12.0

CHARTS 8 - 10:

Adults Who Started Using Gateway Drugs As Children

Are More Likely To Use Drugs Regularly

Charts 5 - 7 examine *any* lifetime use of illicit drugs by adults who used cigarettes, alcohol, or marijuana as children. Charts 8 - 10 reveal that similar relationships hold as well for *regular* (i.e. monthly or more frequent) drug use among adults. This finding indicates that cigarette, alcohol, and marijuana use as a child can be a gateway not only to experimental or short-term use, but to continued or regular use as well. Chart 8 shows the relationship between childhood smoking and the *regular* use of illicit substances by adults. Adults who started smoking as children are almost 4 times likelier to be regular users of an illicit drug and 3 times likelier to use cocaine regularly than adults who did not smoke as children. As seen in Charts 9 and 10, similar relationships hold for children who drink or use marijuana and their later, regular use of other drugs as adults. Adults who started drinking as children are 4 times likelier to use an illicit drug regularly and 6 times likelier to use cocaine regularly. Even more dramatically, Chart 10 shows that while adults who used marijuana as children are 12 times more likely ever to use cocaine, they are 17 times more likely to use cocaine regularly.

Chart 8

Adults Who Started Smoking As Children Are More Likely To Use Drugs Regularly

Drug	% Using Drugs at Least Monthly		Increased Likelihood Of Regular Drug Use
	Did Not Smoke By Age 18	Smoked By Age 18	
Any Illicit Drug	2.2%	7.9%	3.6
Marijuana	1.3%	6.1%	4.7
Cocaine	0.4%	1.2%	3.0

Chart 9

Adults Who Started Drinking As Children Are More Likely To Use Drugs Regularly

Drug	% Using Drugs at Least Monthly		Increased Likelihood Of Regular Drug Use
	Did Not Drink By Age 18	Drank By Age 18	
Any Illicit Drug	2.0%	8.0%	4.0
Marijuana	1.2%	6.2%	5.2
Cocaine	0.2%	1.2%	6.0

Chart 10

Adults Who Used Marijuana As Children Are More Likely To Use Drugs Regularly

Drug	% Using Drugs at Least Monthly		Increased Likelihood Of Regular Drug Use
	Did Not Use Marijuana By Age 18	Used Marijuana By Age 18	
Any Illicit Drug	1.9%	19.4%	10.2
Marijuana	1.0%	16.3%	16.3
Cocaine	0.2%	3.4%	17.0

CHARTS 11 - 15:

The Younger An Individual Starts Using Gateway Drugs,

The Greater The Risk of Using Other Drugs

The younger children start smoking, drinking, or using marijuana, the more likely they are to use illicit drugs. As shown in Chart 11, more than half of adults who start smoking before age 15 use an illicit drug in their lifetime, compared to only a quarter of those who did not start smoking until they were beyond age 17. As Chart 12 indicates, individuals who start smoking before age 15 are more than 3 times likelier to use cocaine than those who start smoking after age 17. Those who start smoking before age 15 are 7 times more likely to use cocaine than those who never smoked.

Charts 13 and 14 examine a similar relationship between drinking and the use of illicit drugs. More than 67% of individuals who start drinking before age 15 use an illicit drug, compared with less than 25% of those who did not drink until they were over age 17 and with only 4% of those who never drank. As seen in Chart 14, more than 30% of individuals who drink before age 15 use cocaine, while just 4.5% who did not drink until they were older than 17 use cocaine. An individual who starts drinking under age 15 is 101 times more likely to use cocaine than someone who never drank.

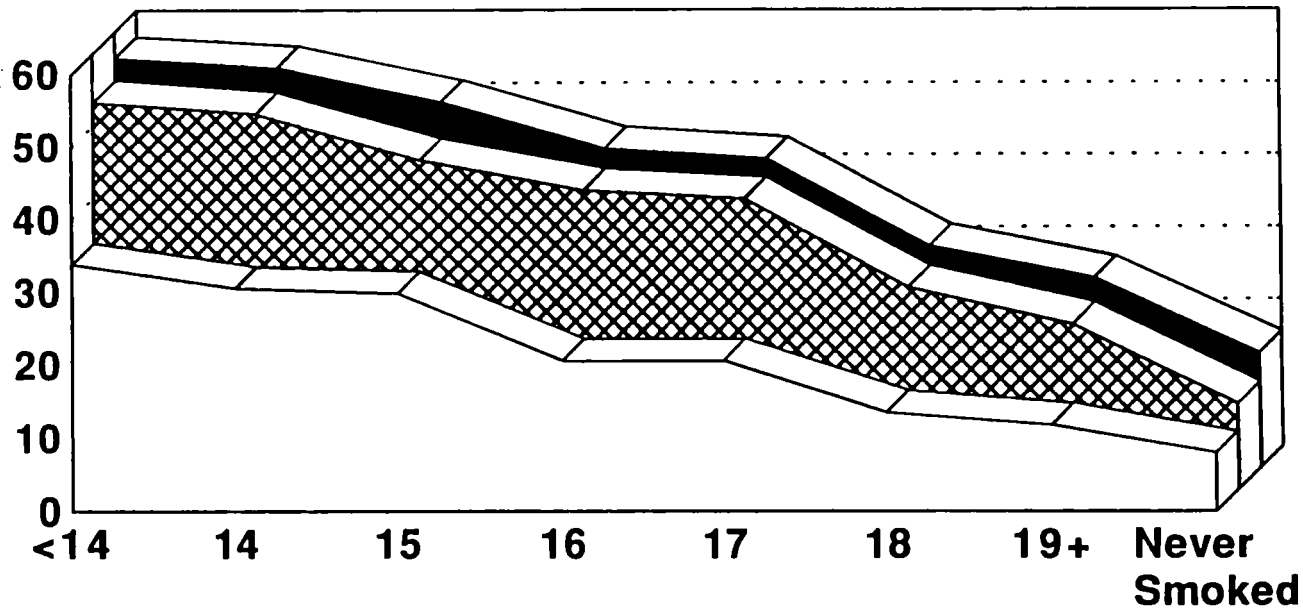
Chart 15 demonstrates a similar relationship between early use of marijuana and greater risk of using other drugs as an adult. More than three-quarters of those who use marijuana before age 15 went on to use some other illicit drug, while just over a third of those who started marijuana use after age 17 did. The relationship between early use of

marijuana and cocaine is even more pronounced: Three out of five adults who use marijuana before age 15 subsequently use cocaine, compared to only one out of five adults who did not use marijuana until after age 17. Those who start using marijuana before age 15 are 149 times more likely to use cocaine than those who never used marijuana.

Chart 11

**The Younger An Individual Starts Smoking,
The Greater The Risk Of Using Other Drugs**

% Reporting Ever Using Other Drugs



Age First Smoked

Used Any
Drug

Used
Marijuana

Used Drugs
Except MJ

Chart 12

**The Younger An Individual Starts Smoking,
The Greater The Risk Of Using Cocaine**

% Reporting Ever Using Cocaine

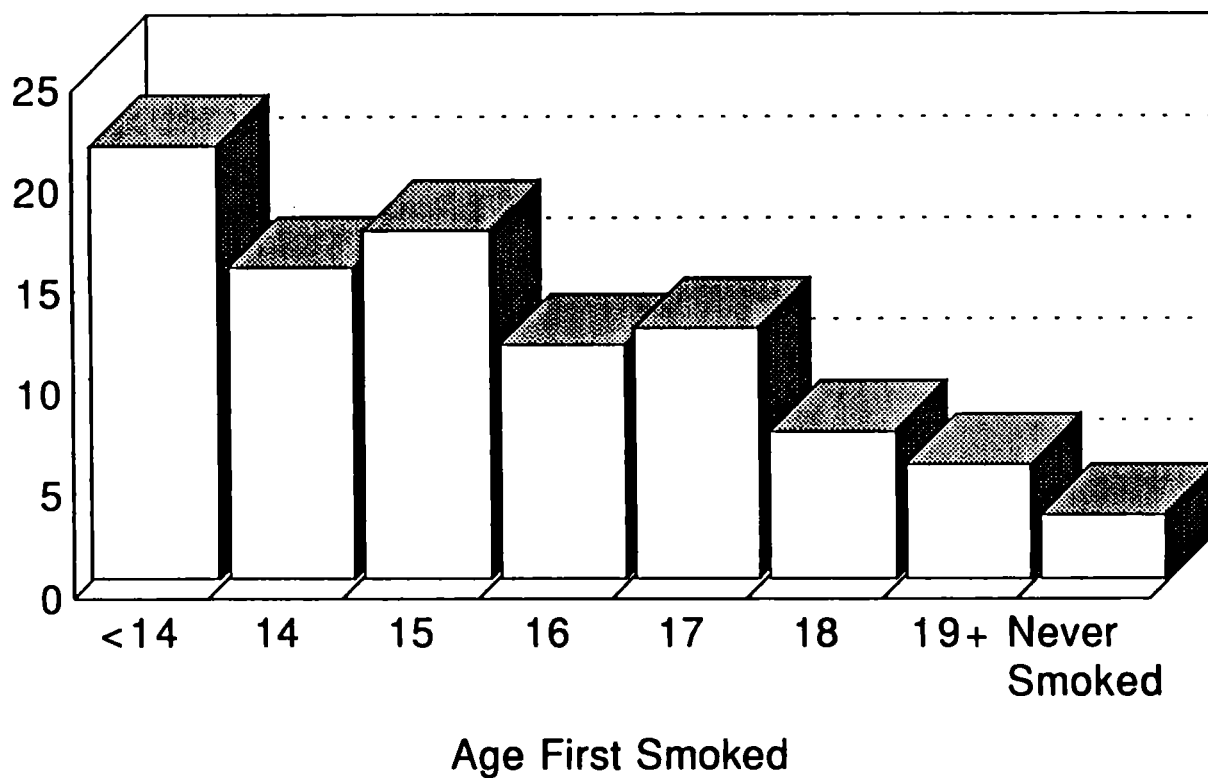
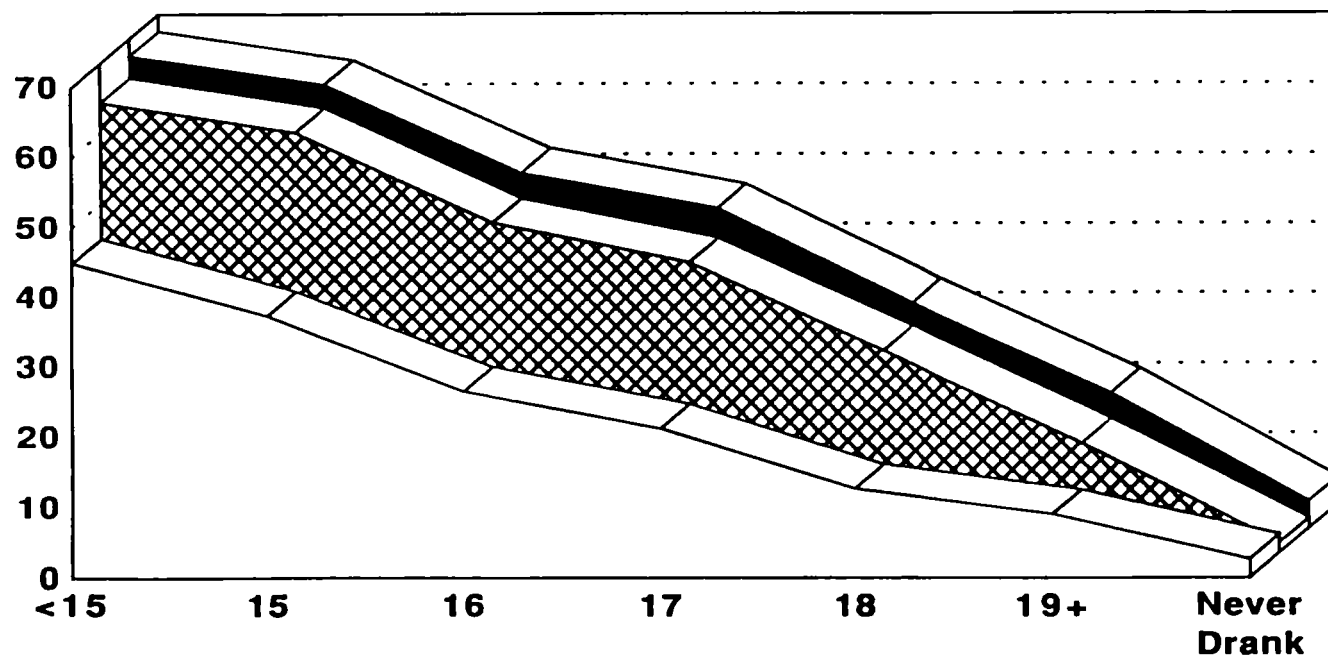


Chart 13

**The Younger An Individual Starts Drinking,
The Greater The Risk Of Using Other Drugs**

% Reporting Ever Using Other Drugs



Age First Drank Alcohol



Used Any
Drug



Used
Marijuana



Used Drugs
Except MJ

Chart 14

**The Younger An Individual Starts Drinking,
The Greater The Risk Of Using Cocaine**

% Reporting Ever Using Cocaine

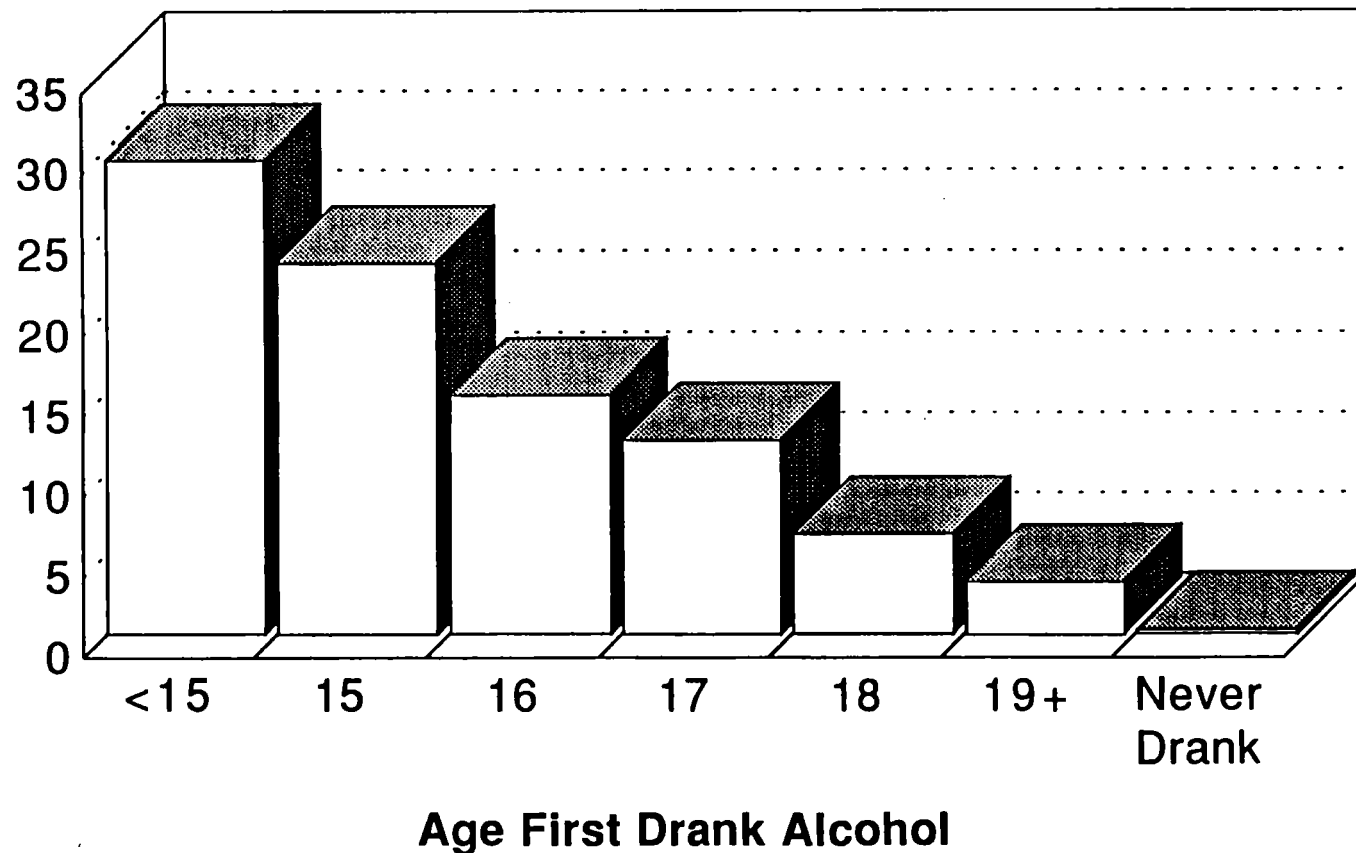
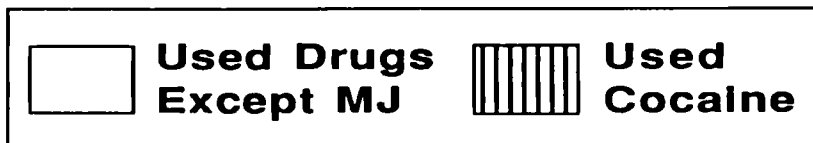
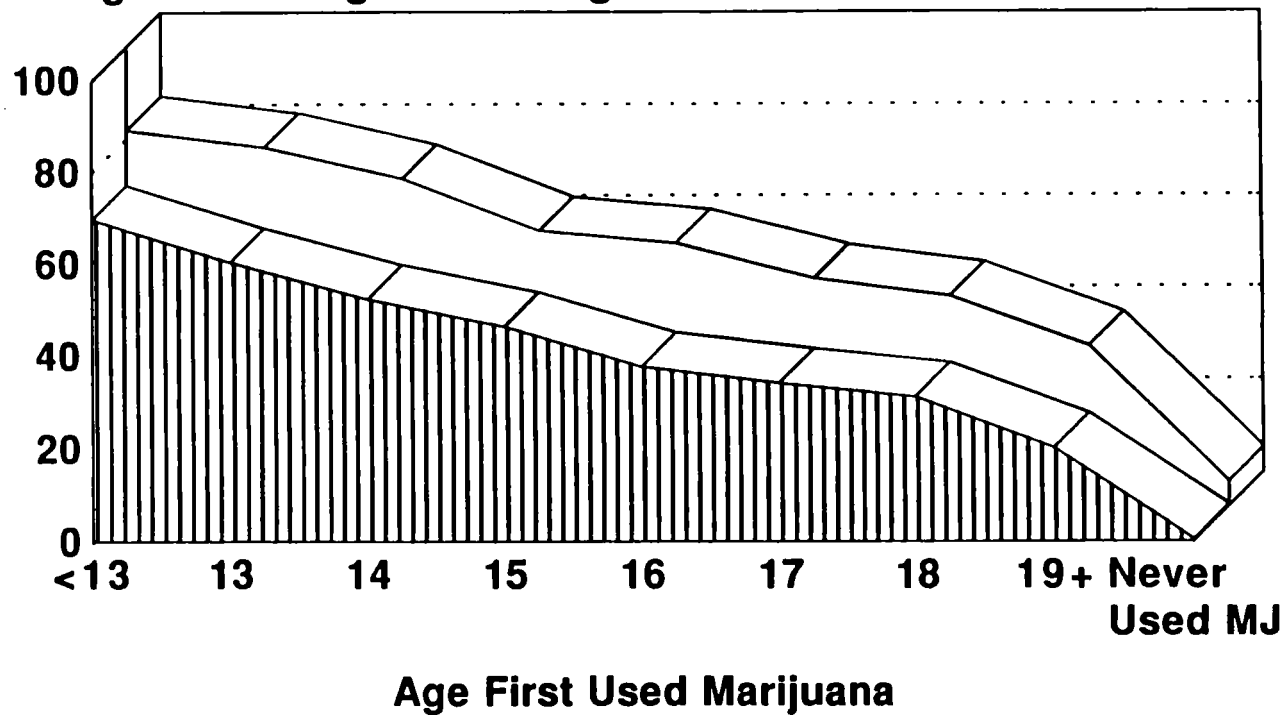


Chart 15

**The Younger An Individual Starts Using Marijuana,
The Greater The Risk Of Using Other Drugs**

% Reporting Ever Using Other Drugs



CHARTS 16 - 18:

The Younger An Individual Starts Using Gateway Drugs,

The Greater The Risk of Regular Adult Drug Use

The relationship between the age of initiation of gateway drugs and any use of illicit substances is clear from the previous charts. But does the same relationship apply to those who become *regular* users of other drugs as adults? Charts 16 - 18 address this question.

For all three gateway substances, the probability of regular drug use among adults *increases* as the age of initial use of gateway drugs *decreases*. Adults who began smoking before age 15 are three times more likely to be regular drug users than adults who did not start smoking until they were over 17. Similarly, children who start drinking before age 15 are over 5 times likelier to be regular drug users as adults than those who did not start until after age 17, and are over 7 times likelier to be regular cocaine users. Similar relationships exist between early marijuana use and adult use of other drugs. Adults who smoke marijuana before age 15 are 6 times more likely to use cocaine regularly than those who did not smoke marijuana until after age 17.

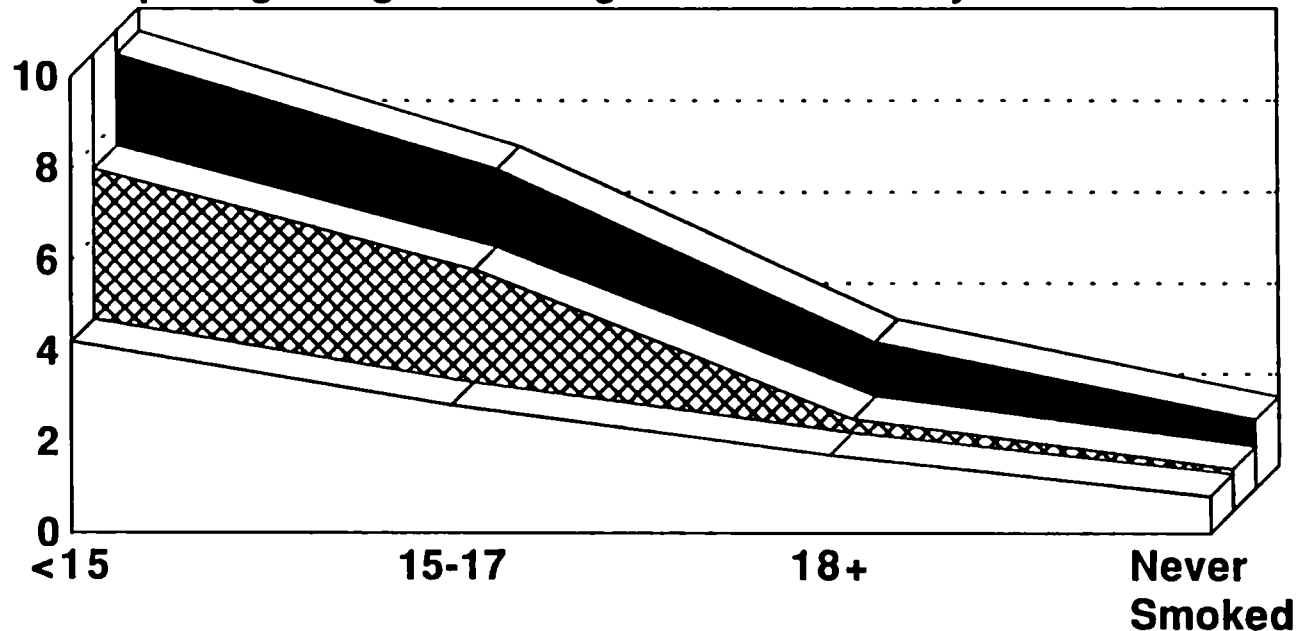
The significance of these charts is not only that early gateway drug use is a predictor of *any* adult use of illicit substances, but that it also increases the likelihood of *regular* use as an adult. As the age at which a child initiates the use of any one of the gateway substances decreases, the probability that, as an adult, he or she will regularly use marijuana, cocaine or an illicit substance increases. For those who began using a

gateway substance after age 17, the probability of later, regular use is closer to that of adults who have *never* used a gateway substance than to those who began use before age 15.

Chart 16

**The Younger An Individual Starts Smoking,
The Greater The Risk Of Regular Adult Drug Use**

% Of Adults Reporting Using Other Drugs At Least Monthly



Age First Smoked

**Used Any
Drug**

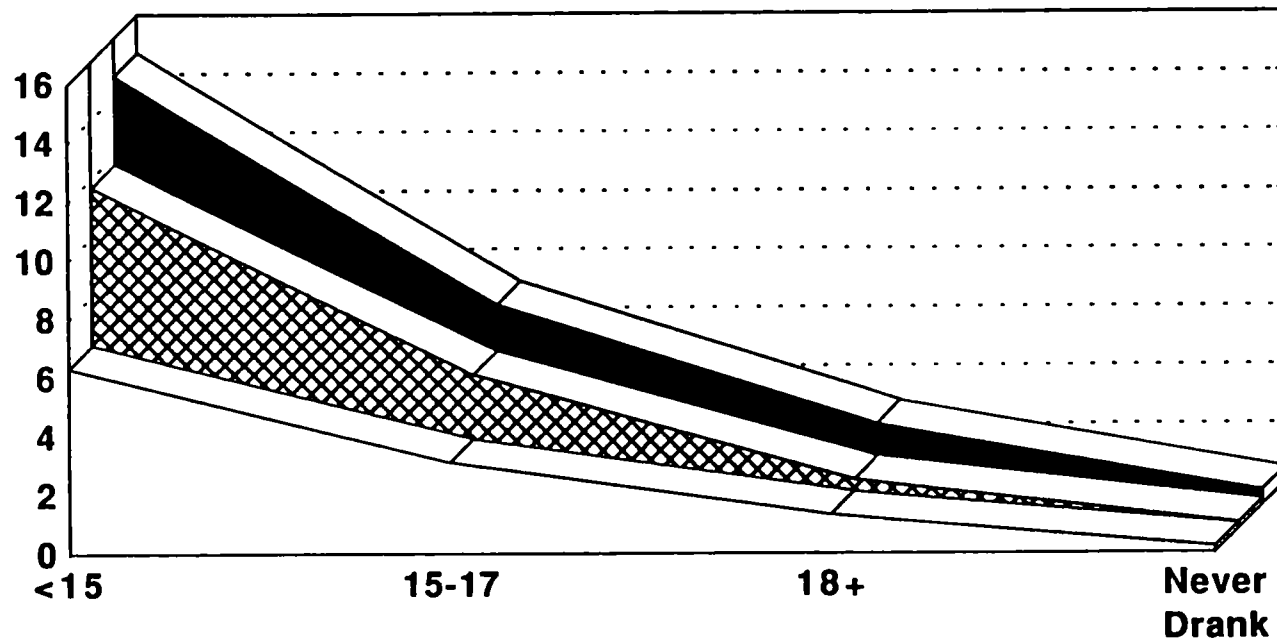
**Used
Marijuana**

**Used Drugs
Except MJ**

Chart 17

**The Younger An Individual Starts Drinking,
The Greater The Risk Of Regular Adult Drug Use**

% Of Adults Reporting Using Other Drugs At Least Monthly



Age First Drank Alcohol



**Used Any
Drug**



**Used
Marijuana**

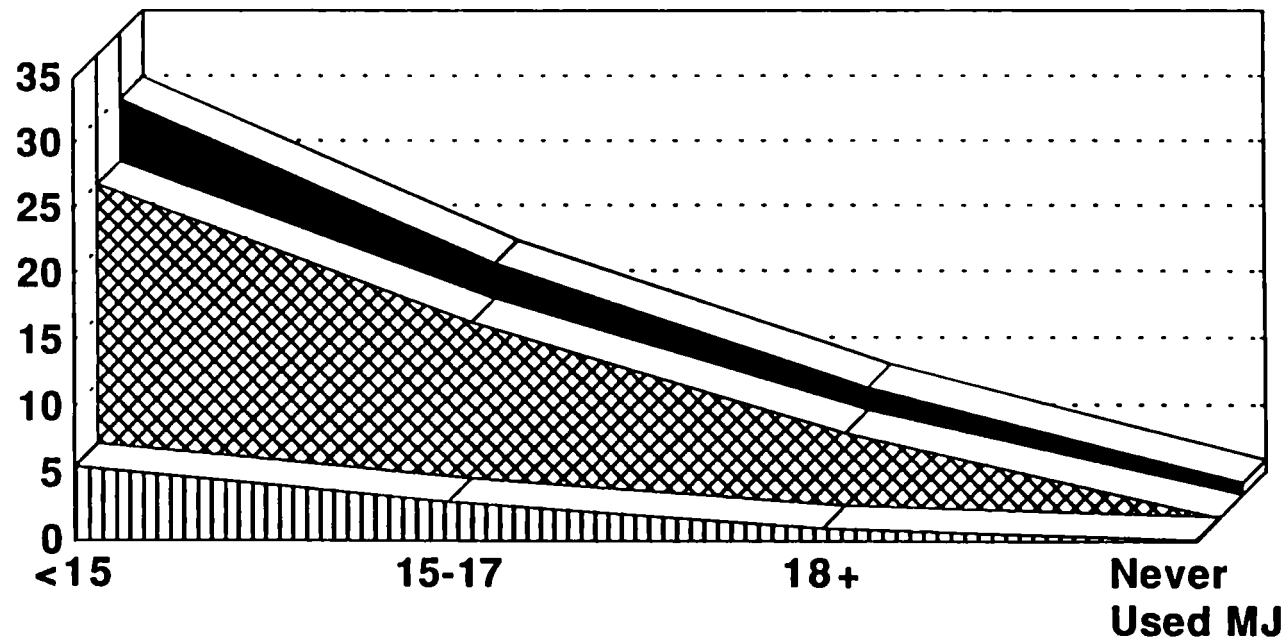


**Used Drugs
Except MJ**

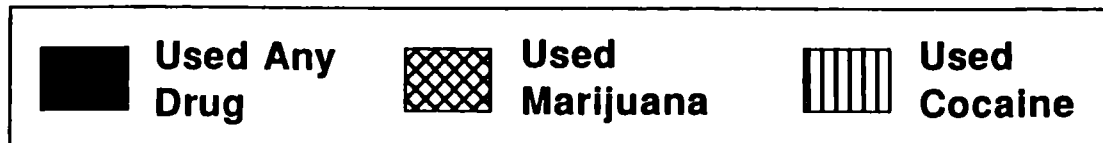
Chart 18

**The Younger An Individual Starts Using Marijuana,
The Greater The Risk Of Regular Adult Drug Use**

% Of Adults Reporting Using Other Drugs At Least Monthly



Age First Used Marijuana



CHARTS 19 - 22:

The More Children Use Gateway Drugs,

The Greater Their Risk of Using Other Drugs

The greater the intensity and frequency of gateway drug use during adolescence, the higher the likelihood of illicit drug use. Chart 19 illustrates this with respect to children smoking and their use of illicit drugs. For example, a child who smokes more than 15 cigarettes a day is more than twice as likely to use an illicit drug and 16 times more likely to use cocaine than one who smokes but on less than a daily basis. They are 10 times likelier to use an illicit drug and 104 times likelier to use cocaine than someone who never smokes. Children who smoke a pack a day are also 13 times more likely to use heroin than children who smoke less heavily.

Our analysis also indicates that smoking as a child may be a somewhat more important predictor of adult illicit drug use for women than for men. Adult women who smoked daily as children are almost 4 times more likely to use cocaine than women who have never smoked daily; but adult men who had smoked daily as children are less than twice as likely to use cocaine as those who did not smoke daily. With respect to alcohol and marijuana, no discernible differences between men and women were found.

Charts 20 and 21 demonstrate a similar relationship between the amount that children drink and their risk of using other substances. In this case, alcohol consumption is defined as frequent if the child drinks weekly or more often, moderate if the child drinks on a monthly to weekly basis, and occasional if the frequency of drinking is any

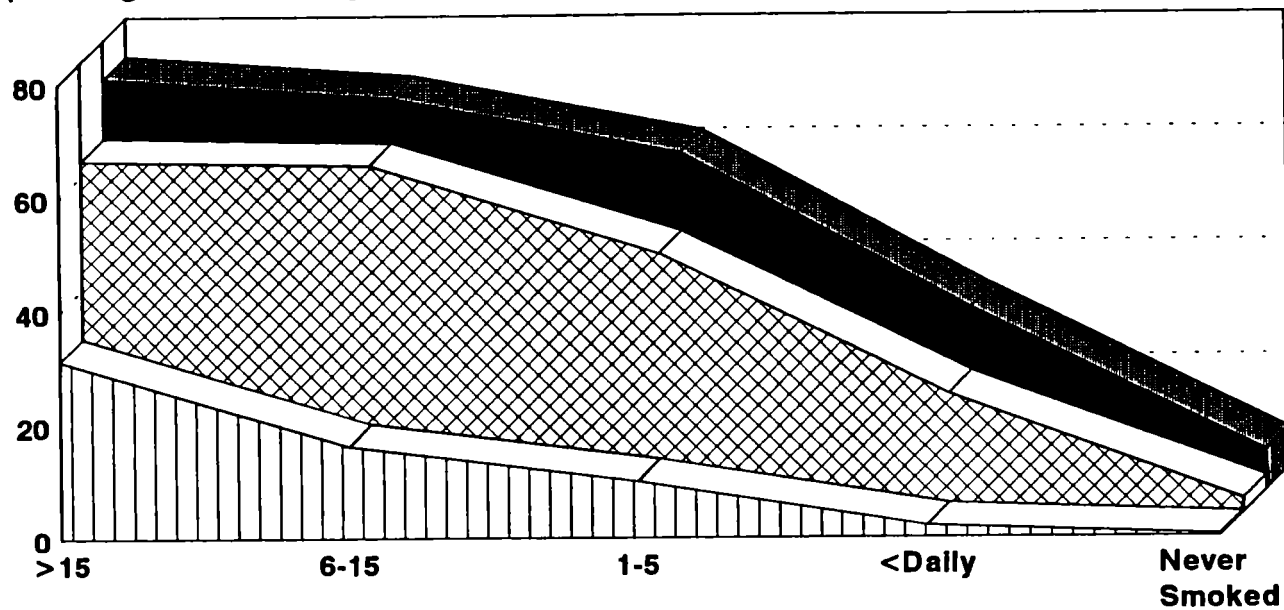
less often. In Chart 20, less than one in three children who drink occasionally have ever tried illicit drugs, while three out of four who drink weekly or more have tried an illicit drug. A similar relationship exists between the level of drinking and marijuana. Chart 21 shows that one in five children who drink on a weekly basis report using cocaine, while only one in 40 of the occasional drinkers report cocaine use.

As Chart 22 shows, the intensity of marijuana use by children is also highly correlated with the use of other drugs, particularly cocaine. Eighty-six percent of children who report using marijuana 50 or more times have tried another illicit drug, while only about one in four of those who experimented once or twice with marijuana have used another illicit drug. A disturbing 45% of the heaviest group of marijuana users tried cocaine, while only 6% of the experimenters had. A child who reports using marijuana 50 times or more is 223 times likelier to use cocaine than a child who never used marijuana.

Chart 19

The More Children Smoke, The Greater Their Risk Of Using Other Drugs

% Reporting Ever Using Other Drugs



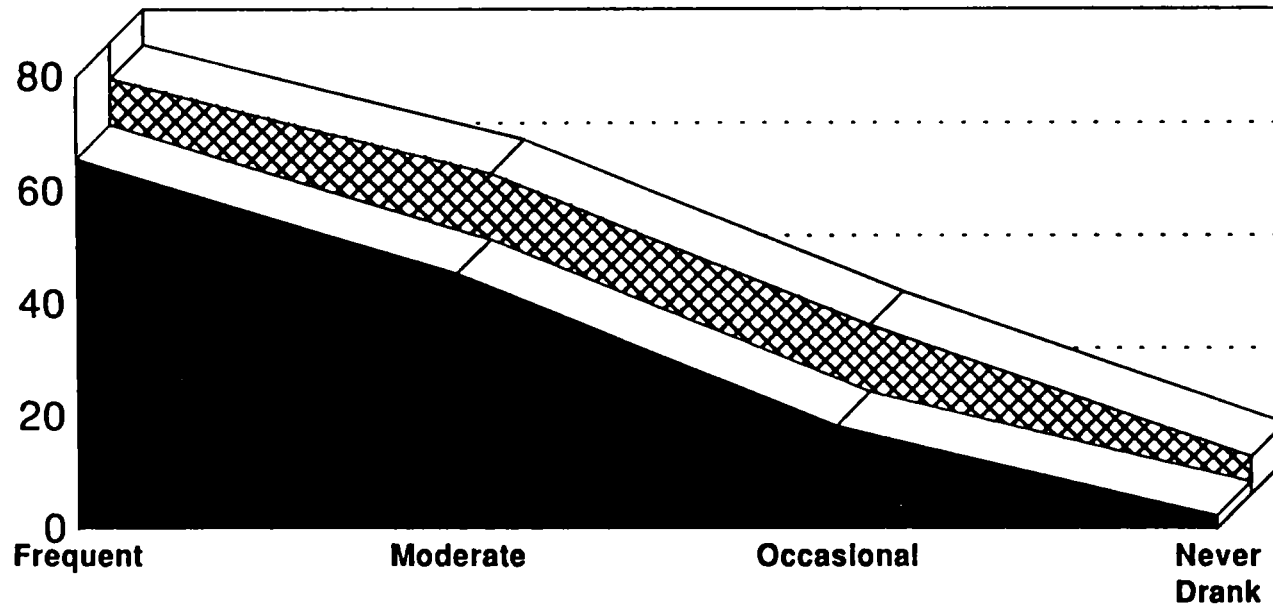
Number of Cigarettes Smoked Per Day



Chart 20

The More Children Drink, The Greater Their Risk Of Using Other Drugs

% Reporting Ever Using Other Drugs



Alcohol Consumption in the Past Year



Used Any
Drug



Used
Marijuana

Frequent is at least weekly; moderate, at least monthly; and occasional, less than monthly.

Chart 21

The More Children Drink, The Greater Their Risk Of Using Cocaine

% Reporting Ever Using Cocaine

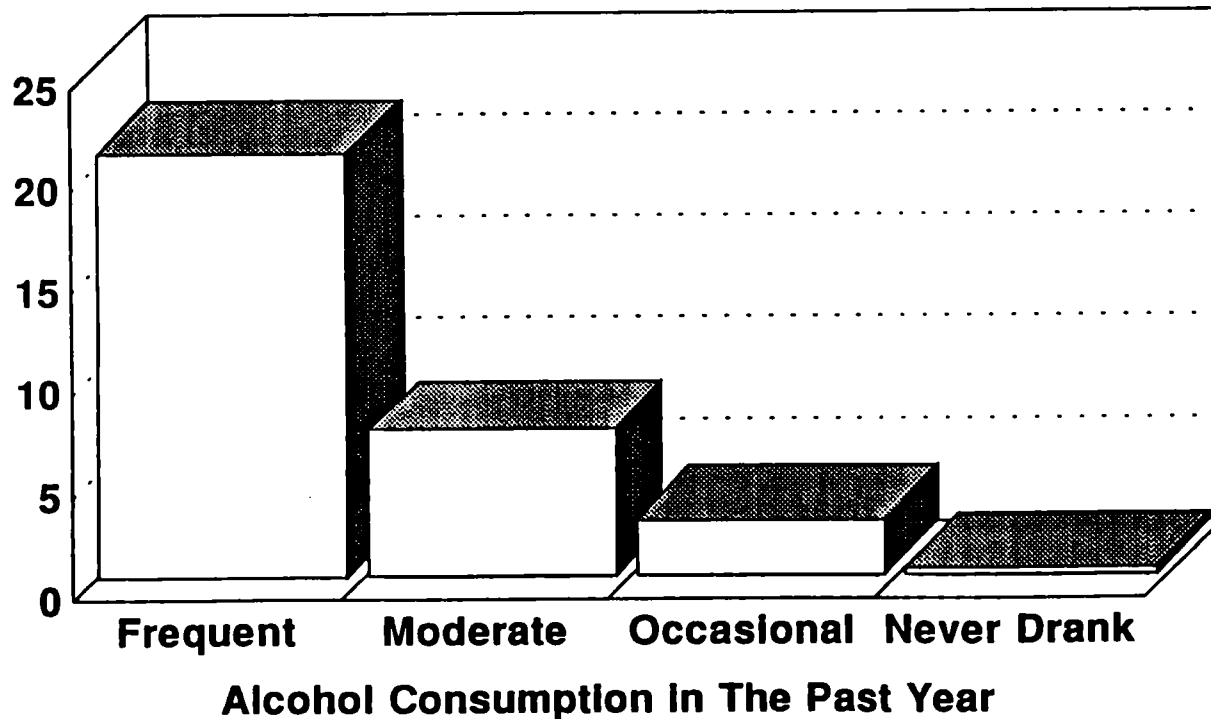
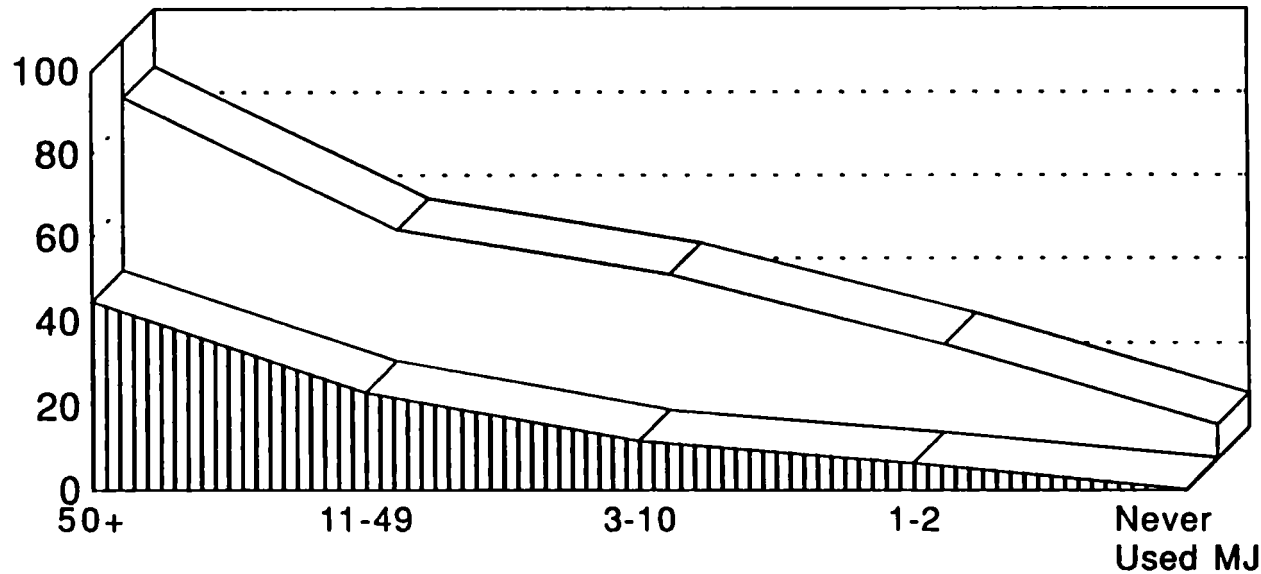


Chart 22

The More Children Use Marijuana, The Greater Their Risk Of Using Other Drugs

% Reporting Ever Using Other Drugs



Number of Times Used Marijuana

Used Drugs
Except MJ

Used
Cocaine

CHARTS 23 - 24:

People Who Use More Than One Gateway Drug

Are More Likely To Use Other Drugs

The following two charts deal with the relationship between the number of different gateway substances individuals have used during their life and their use of illicit drugs. The greater the number of gateway substances an individual uses, the more likely that individual is to use another drug.

Chart 23 shows that a child who has not tried any gateway substance is unlikely to use an illicit drug, while a child who has used cigarettes, alcohol *and* marijuana is 17 times more likely to use an illicit drug and 266 times more likely to use cocaine. For adults, a similar relationship holds, as can be seen in Chart 24. For both children and adults, the use of one substance, regardless of whether it is cigarettes, alcohol or marijuana, leads to a higher likelihood of using other drugs than using no gateway substance. However, the use of two substances in any combination (i.e. cigarettes and alcohol, alcohol and marijuana, or cigarettes and marijuana) leads to a even greater likelihood of using other drugs than the use of one substance; use of all three substances presents the highest likelihood. An adult who uses all three gateway substances is 104 times more likely to use cocaine than one who has tried a single gateway substance; a child who uses all three gateway drugs is 77 times more likely to use cocaine than a child who has tried only one gateway drug.

Chart 23

The More Gateway Substances Children Use The Greater Their Risk Of Using Drugs

Number of Gateway Substances Used	Percent Used Cocaine	Increased Likelihood Of Cocaine Use	Percent Used Drugs Except Marijuana	Increased Likelihood Of Drug Use
None	.07%		2.9%	
One	0.2%	3.5	9.8%	3.3
Two	1.2%	17.2	19.5%	6.6
All Three	18.6%	266.3	49.8%	16.9

Chart 24

The More Gateway Substances Adults Use The Greater Their Risk Of Using Other Drugs

Number of Gateway Substances Used	Percent Used Cocaine	Increased Likelihood Of Cocaine Use	Percent Used Drugs Except Marijuana	Increased Likelihood Of Drug Use
None	.1%		2.6%	
One	.3%	3.1	4.7%	1.8
Two	2.1%	19.3	7.8%	3.0
All Three	35.5%	322.7	51.6%	19.5

CHART 25:

The Sequence of Gateway Drug Use:

Alcohol and Tobacco, then Marijuana, then Other Drugs

The charts displayed thus far reveal a strong and consistent relationship between childhood use of cigarettes, alcohol, or marijuana--alone or in combination--and the later use of other drugs. What is equally important, however, is the progression from one drug to another.

Chart 25 tracks the sequence of drug use for cocaine users. Sixty-five percent of all cocaine users follow a similar path of first smoking cigarettes or drinking alcohol, and then using marijuana before going on to try cocaine. More than half (52%) of all cocaine users began their drug use by first smoking cigarettes and then proceeding to drinking alcohol, using marijuana, and finally taking cocaine. While this chart does not show all the permutations of drug use sequences, 89% of all cocaine users first used all three gateways and almost all used at least two gateway drugs prior to using cocaine. Virtually no one tried cocaine without first using either cigarettes, alcohol and/or marijuana.*

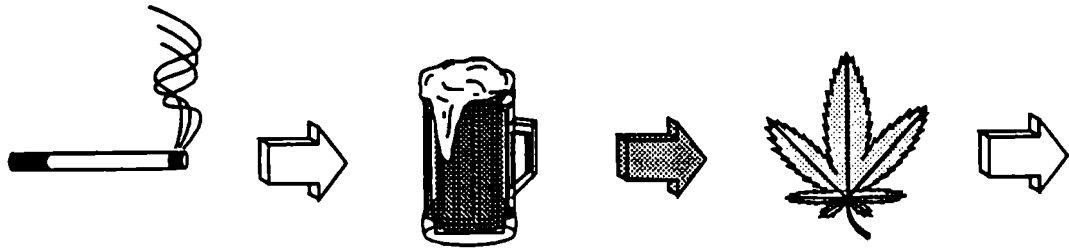
* Only 0.1% report using cocaine without first using a gateway drug.

Chart 25

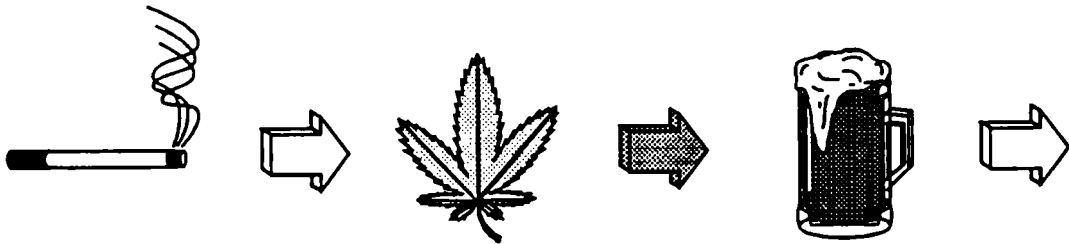
Paths to Cocaine Use

Of All
Cocaine
Users:

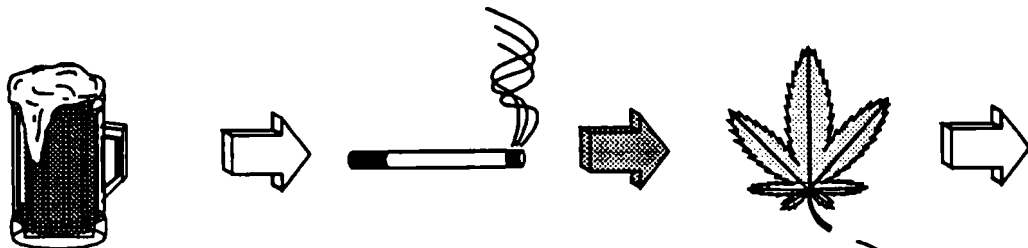
52%



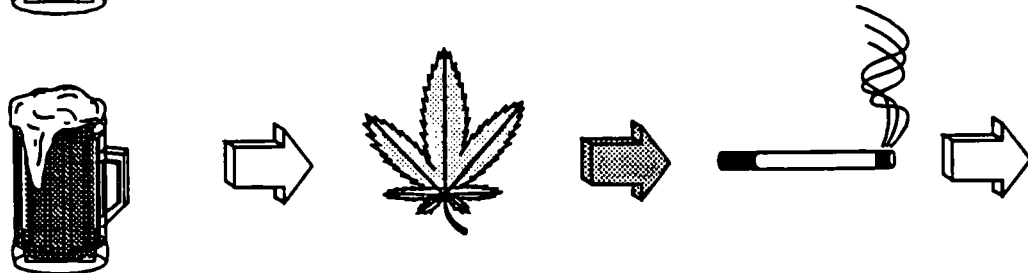
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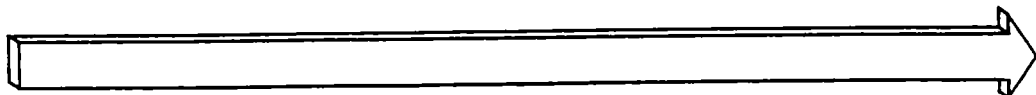
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COCAINE

These percentages have been rounded to the nearest whole number.

Section III

Trends in Adolescent Use of Gateway Drugs

CASA's findings have serious implications, especially given the recent release of data showing a reversal in the trend of substance use and abuse among high school students. Until 1992, substance use among America's adolescents had generally been decreasing since the late 1970s. However, in 1993 substance use among adolescents started to increase again. The 1993 edition of the yearly survey of substance use among America's youth, Monitoring the Future, reported increases in the use of illicit drugs by 8th, 10th, and 12th graders.

- *Tobacco:* Between 1977 and 1992, the percent of high school seniors who had smoked cigarettes in their lifetime had declined from 75.7% to 61.8%. However, in 1993, for the first time since 1977 the rate actually rose, albeit by only 0.1%. Daily use increased across grades as well: For 8th graders, the portion who smoked on a daily basis increased by 19% over the previous year; for high school sophomores, the increase was 15%; and for seniors, daily smoking increased by 10%. Currently, nearly one in five high school seniors smokes daily and more than one in ten smoke more than half a pack per day. Cigarette smoking may be decreasing among adults, but may be on the rise among adolescents.

- *Alcohol:* While alcohol consumption by teens has always been high, heavy use is now increasing for younger students, particularly those in the 10th grade. In 1993, almost 10% more high school sophomores reported getting drunk in the last month than in 1992. The portion who reported a binge drinking episode (as defined by having consumed five or more drinks in one sitting) in the last two weeks increased by 9%. In fact, almost one in four high school sophomores reported binge drinking in 1993.
- *Marijuana:* The percentages of students who used marijuana in their lifetime, in the past year, in the past 30 days, and who use it daily increased for all three grades. The percentage who used marijuana in the past year increased from 7.2% to 9.2% for eighth graders, from 15.2% to 19.2% for tenth graders, and from 21.9% to 26.0% for twelfth graders. In fact, for high school seniors, this was the first time since 1985 that the rate for marijuana usage had actually increased over the previous year and represented the largest single percentage increase since the survey began in 1975.

More disturbing is the fact that the perception of the dangers of these substances appears to be declining among children. This rise in the use of tobacco, alcohol, and marijuana is significant in and of itself; it is even more significant in light of this CASA study because, for thousands of these adolescents, these drugs are gateways to other, more dangerous substances. The increase in the use of alcohol, cigarettes and marijuana

by 12- to 17-year-olds signals an increase in the use of cocaine, heroin, and other illicit substances in the future.

Section IV

Implications for Future Action

This analysis reveals a strong statistical relationship between the use of gateway drugs and the use of illicit substances. This correlation should be sufficient to persuade both government and the private sector to step up efforts aimed at preventing children from smoking, drinking and using marijuana. But it also provides ample evidence to support a major investment in research to determine if a causal relationship between gateway drugs and other substances exists--and if so, why that relationship exists.

The current situation with respect to the statistical evidence about gateway drugs is somewhat reminiscent of early research on the relationships between smoking and lung cancer, as well as cholesterol and heart disease and asbestos and lung cancer. In all three cases, strong statistical arguments could be made for causal links, but little clinical evidence existed:

- In 1964, Smoking and Health: Report of the Advisory Committee to the Surgeon General of the Public Health Service found a *nine- to ten-fold* risk of developing lung cancer for male smokers as compared to nonsmokers (U.S. Department of Health, Education, and Welfare, 1964). The report considered that risk as establishing a causal relationship. However, the report explicitly noted that, for emphysema, "a relationship exists between cigarette smoking and emphysema, but it has not been established that the

relationship is causal." The report was also unable to nail down a causal relationship between smoking and lung cancer among women.

- In 1968, The Framingham Study: An Epidemiological Investigation of Cardiovascular Disease found men with high cholesterol to be *two to four* times more likely to have coronary heart disease than men with low cholesterol (Dawber, 1980). However, a similar relationship was not found for women.
- In 1981, Dr. Irving Selikoff found a *five-fold* risk of lung cancer for people with heavy occupational exposure to asbestos (Peto, 1986).

In these cases, relative risks from two to nine were sufficient to draw attention to smoking, cholesterol, and asbestos and to begin the scientific and biomedical research that demonstrated causal relationships. As a result of this research, a body of evidence has emerged clearly establishing causal relationships, for example, between smoking and emphysema and, among women, between smoking and lung cancer.

In examining the relationship between gateway drug use and the use of other illicit drugs, CASA has found far higher relative risks, as high as 322 (see Chart 24). As with early evidence of the dangers of smoking, high cholesterol, and asbestos exposure, a significant investment in such research on gateway substances is required.

The data is already robust enough to make a strong case to step up efforts to prevent childhood use of cigarettes, alcohol, and marijuana and to take firm steps to reduce children's access to gateway drugs. For children and teens, cigarettes and alcohol, as well as marijuana, are *illegal* substances.

Appendix

The National Household Survey on Drug Abuse

The 1991 The National Household Survey on Drug Abuse (NHSDA) is the 11th in a series of national, cross-sectional, multi-stage probability surveys of American households undertaken by the National Institute on Drug Abuse to obtain accurate data on levels and patterns of drug and alcohol use and abuse. The universe for the NHSDA is the general U.S. household population 12 years of age and older.

In 1991, the NHSDA had a sample size of 32,594. The sample was stratified by age (12-17, 18-25, 26-34, and 35 and older) to permit oversampling of younger respondents to allow more detailed analysis and to support more precise estimates for these age groups. The 1991 NHSDA also oversamples blacks, Hispanics, residents of six metropolitan areas, and persons in low-income areas in these metropolitan areas. The sample is weighted for non-respondents.

Participants in the NHSDA are interviewed in their homes, with parental consent obtained for respondents 12 to 17 years of age. To reduce respondents' inhibitions about reporting drug use, information on non-medical drug use is recorded privately and mailed by the respondent on separate answer sheets with no individual identifiers. Furthermore, in cleaning the data, the Office of Applied Statistics created consistency checks that correct discrepancies in answers reported at various stages of the survey.

The major indicators of drug-use prevalence reported on the NHSDA are: 1) ever use or lifetime prevalence, 2) past-12-month use or annual prevalence, and 3) past-30-day use or current use. Drugs covered in the survey include marijuana, including

hashish; cocaine, including crack; inhalants; hallucinogens, including PCP; heroin; alcohol; cigarettes and smokeless tobacco; and stimulants, sedatives, tranquilizers, and analgesics (used nonmedically). Data also are tabulated to produce an indication of any illicit drug use, regardless of the specific substance.

While the NHSDA is the only drug use data collection project conducted on a cross-section of American households, there are some limitations to the database. Specifically, the NHSDA is not a particularly good source of data on heroin abuse and other serious drug problems because many of the affected individuals, such as the non-sheltered homeless and residents of institutions like long-term hospitals and jails, are not reached in a household survey.

Because it relies entirely on self-reporting, the NHSDA may underestimate drug use. While some studies confirm the validity of the self-report method, others found underreporting of actual use, particularly among arrestees, pregnant women, and discharged clients. Also, more than a quarter of subjects age 12 to 17 had someone else in the interview room for a portion of the survey, which may affect truthfulness of reporting.

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RH - Fun + Games.
AS

Dear Bill:

Here is a test of the facts intended to refresh the memory of the recent past, using multiple-choice responses.

Question #1: During which Administration did the overall volume of domestic cocaine consumption reach its highest recorded level (and in which year)?

Answer: A. Reagan
B. Bush
C. Clinton

Question #2A: During which Administration did heavy cocaine use begin to rise, after half a decade of decline (and in which year)?

Answer: A. Bush, 1991
B. Clinton

#2B: Which Administration claimed success in reducing the use of cocaine by Americans (and in which year)?

Answer: A. Bush, 1991
B. Clinton

Question #3: During which Administration (and in which year) did emergency room mentions for cocaine continue their fall, then begin a rise that continues today ?

Answer: A. Bush, 1991
B. Clinton

Question #4: During which Administration (and in which year) did emergency room mentions for heroin continue their previous fall, then begin a rise that continues today?

Answer: A. Bush *1991*
B. Clinton

Question #5A: During which Administration (and in which year) did adolescent drug use continue its previous fall, then bottom out?

Answer: A. Bush, 1991-2
B. Clinton

#5B: During which Administration (and in which year) did the perception by high school seniors that the use of marijuana posed a 'great risk' peak, then begin to fall?

Answer: A. Bush, 1991
B. Clinton

#5C: During which School Year did the use of drugs by

eighth grade students begin to rise? During which school year did the use of drugs by eighth, tenth and twelfth grade students, as a group, begin to rise?

Answer: A. 1992-3
B. Other

Question #6: Which Administration continued to add money for interdiction, while interdiction success rates continued to decline (and in what years)?

Answer: A. Bush, 1989, 1990, 1991, 1992
B. Other

ck.

Answers and Sources: 1. B (Adt Assoc. study...)
2A A (RIDA, NIDA, 1985-93)
3 A (1991 National Drug Control Strategy)
4. A (SAMHSA Reports, 1989-94)
5A. A (NIT Survey, 1989-94)
B. B (NIT Survey, 1989-94: SAMHSA Advance Report #5, January 1994)
C. A (NIT Survey, 1993-94)
6 A (International Narcotics Control Strategy Report, 1992. Department of States; Adt Associates, under contract to ONDCP; RAND Corp. work in progress for ONDCP)

April 27, 1994

Impact of the \$23.2 million cut to the FY 1995 SAMHSA Budget

- o The Strategy emphasizes the importance of drug prevention and treatment programs in order to accomplish the number one priority with regard to drugs in America -- reduce drug use.
- o It also recognizes the importance of the Federal role in drug use prevention in fostering cooperation among Federal, State and local agencies.
- o It further recognizes the need for community based prevention efforts to protect America's Neighborhoods through community action.
- o Recent survey data indicate that drug use has increased among adolescents, the perceived risk of harm of use has decreased and Emergency Room mentions related to drug use are also up.
- o The Strategy also articulates three Resource areas as the Administration's 1995 funding priorities:
 - Treatment for hardcore users;
 - Prevention for youth through the school and community programs; and
 - International Program efforts.
- o It is for these reasons that the President's budget requests an all time high for prevention and treatment programs of \$5.4 billion.
- o A reduction to any of the treatment and prevention programs would be counterproductive.
- o Further, a reduction to SAMHSA programs of \$23.2 million would hamper drug prevention efforts at the community level, particularly for high risk youth.
- o It is anticipated that this reduction will directly impact funding for the Community Partnership prevention program and the High Risk Youth prevention program.
- o In light of the recent data with regard to adolescent use, we can not afford to take any reductions to these programs.



OFFICE OF NATIONAL DRUG CONTROL POLICY
EXECUTIVE OFFICE OF THE PRESIDENT
Washington, D.C. 20500

June 21, 1994

MEMORANDUM FOR SENIOR STAFF

FROM: PAT WHEELER
PUBLIC AFFAIRS

A handwritten signature in dark ink, appearing to read "PW", is written over the printed name "PAT WHEELER".

SUBJECT: RAND STUDY

Attached are news articles and editorials on the recently released Rand Report. Note that all of the editorials are very pro-treatment, info you may want to share with appropriate constituencies.

Unfortunately, most of them are critical for this administration not spending more on treatment, although they note that there has been an increase this year for treatment funds.

SEATTLE POST-INTELLIGENCER

JUN 20 1994

Drug treatment most effective *PAS*

A federally financed study has cast doubt on U.S. drug policy, concluding that its emphasis on law enforcement to reduce cocaine production and smuggling should be shifted to reduction of demand through treatment of drug addicts.

According to Rand, a California research firm, of the \$13 billion spent annually by the United States at all levels, public and private, to control cocaine use, only \$1 billion goes for treatment.

But the Rand study found that treatment is by far the most cost-effective method of reducing cocaine consumption.

The study estimates that annual cocaine consumption can be reduced 1 percent by spending an additional \$34 million for treatment. To achieve the same 1 percent reduction would cost "an additional \$246 million in domestic enforcement efforts against drug dealers and their agents, or \$366 million for interdiction, or \$783 million for source country control" (interdiction in the country in which the drug or its raw material originate).

"Boosting the cocaine treatment

budget to \$4 billion by reallocating 25 percent of supply-control spending would allow all heavy cocaine users to be treated once each year (vs. the 30 percent treated today)," the study declares. "The effects . . . would include a one-third reduction in annual cocaine consumption, a significant drop in the number of users and, as a result, a decrease in the cocaine-related costs of crime and lost productivity estimated at \$10 billion."

And none of this takes into account the effects of added prevention and education efforts that could be financed by redistributing supply-reduction funds.

The study doesn't question that there is an important role, a major role, for enforcement, "but treatment is the winner by a wide margin because it is relatively inexpensive relative to its effects . . . the cost advantages of treatment over supply control . . . are so great that their ranking is not in doubt."

In short, an unbalanced policy that loads too heavily the supply-reduction side of the equation is doomed to waste money, and lives.

BURRELLE'S

NewsExpress

PAGE 9 OF 9

KANSAS CITY STAR

JUN 20 1994

BEST COPY AVAILABLE

Treatment pays *ppd*

As the country has increasingly struggled with the human and economic bills for drug addictions, lawmakers and civic leaders frequently argue about the most cost-effective use of public money to deal with the problem.

Police or therapists? Jail or clinics? A soft approach or a hard-nosed one toward people who use illegal drugs?

Until recently the controversy proceeded without enough empirical evidence for policymakers to draw a very satisfying conclusion. In the meantime, budgets for drug control, always underfunded, came down on the side of law enforcement; after all, officials have to think about the good of the greater number of citizens.

A recent report from the Rand Corp. is a welcome addition to the discussion. It's cheaper to treat cocaine users than it is to control the supply of cocaine, either overseas or in this country, the prestigious research organization says.

Moreover, it's not just marginally cheaper or somewhat cheaper, but treatment saves money in big chunks. It works 23 times better than

cutting overseas supplies, the report claims, and seven times better than seizing cocaine here. In addition, if the supply control budget were cut by a fourth but treatment funds were doubled, consumption would drop from 314 metric tons a year to 294 metric tons a year, Rand researchers said.

It may take some time and educational efforts to convince the public. Strangers to addictions and therapy for it often mistrust treatment programs as never-ending mazes that coddle troublemakers but show little results. A few years ago, calls for tougher law-and-order efforts dominated debates about the war on drugs.

Fortunately, sane-professional and political leaders prevailed in many communities, insisting that treatment programs and enforcement be equally strengthened. Jackson County is one of the best examples. Not only did voters approve a sales tax for a dedicated budget but mechanisms have been established to expand services on both sides of the law.

Jackson County leaders' vision was ahead of its time. So was that of voters.

Jun 20 '94 3:39 P.03

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SAN DIEGO UNION-TRIBUNE

JUN 19 1994

DRUG CEASE-FIRE?

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BURRELLE'S

NEWS EXPRESS

PAGE 2 OF 5

By ROBERT ZIMMERMAN

G-1

President Clinton's drug czar, H. Lee Brown, is trying gamely to give the familiar rhetoric of the war on drugs a fresh twist. The administration is carrying out yet another retargeting of efforts to discourage production of illegal drugs abroad and block their delivery to users on American streets. At the same time it is putting more money into treatment and prevention, trying to bring down the demand for drugs. The bottom line, as Brown says proudly, is a \$13.2 billion expenditure for the next fiscal year — "the largest federal drug control budget ever."

The biggest budget ever would be easier to swallow if we could see some relationship between dollars spent on anti-drug programs and the magnitude of America's drug problem. The federal government has spent \$100 billion on the drug war since 1980, and state and local governments have sunk as much or more into their own anti-drug efforts. Interdiction and enforcement have been eating up more than half the drug budgets, but they have never been able to claim that more than 10 percent of the drugs heading into the country are being intercepted.

No matter how many drug offenders are shipped off to prison, there are more to take their place. For all the interdiction patrols and drug-bust headlines, cocaine, heroin and marijuana are as available and as cheap as ever in most cities. And drugs are at the heart of the street violence and gang warfare casting a pall over urban neighborhoods and triggering new anti-crime legislation.

The new drug strategy pursued by Brown's office of National Drug Control Policy may be falling out of step with the drug scene. It notes a decline over the years in "casual" or intermittent drug use and says the worst of the problem now lies with hard-core drug users.

Well, in the late 1980s there was an apparent decline in casual drug use, signs that the "Just Say No" campaigns in the schools were succeeding and that a consciousness of the risk of doing drugs was carrying over

into the young adult population. Today we can't be sure of that.

The annual surveys conducted by the University of Michigan of attitudes and drug use among U.S. high school students have taken an ominous turn. Teen-agers are exhibiting a softening in their attitude toward the risk of experimenting with drugs, says Lloyd Johnson, who directs the surveys. The number admitting they smoke pot, sniff glue, use LSD or drink alcohol is on the rise.

Meanwhile, the semi-annual hospital statistics gathered for the Drug Abuse Warning Network have been reporting increases in drug-related admissions to emergency rooms. Heroin-related emergencies jumped by 44 percent between 1992 and 1993. The "Pulse Check" on drug use released by Brown's office last March reported that inhaling heroin has become the "in" thing among party-goers

who would have been snorting cocaine a few years ago.

So, is the drug problem getting better or getting worse?

One thing we know is that the Drug Enforcement Administration, the FBI and the local cops and prosecutors are doing what they're paid to do — arresting drug offenders and putting them in jail. The Justice Department's prison budget is now higher than the budget for the FBI. Two out of three of the 81,000 inmates in federal prisons are drug violators, their

prisons swollen by mandatory sentencing laws. By a recent count there were 330,000 persons serving time in state and federal prisons for drug violations, requiring construction of new cellblocks to make room for more. If

See Cease-fire on Page G-4

ZIMMERMAN is a San Diego writer specializing in drug and alcohol topics and is editor emeritus of the UCSD quarterly *Prevention File*.

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BURRELLE'S

NEWS EXPRESS

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the drug war could be won with punitive deterrents, drugs should be fading from the scene. Instead there are signs of a growth in their popularity.

Peter Reuter of the RAND Corp. believes U.S. drug policy can best be understood in terms of a contest between hawks and doves, and the hawks are clearly in charge. To be anything but hawkish on the drug issue is politically dangerous, as Surgeon General Joycelyn Elders found out with her call for a study of the pros and cons of legalizing drugs. The hawks, having no tolerance toward people who use drugs and even less for the dealers who cater to them, put their chips on tough enforcement. They are skeptical toward the effectiveness of addiction treatment.

Doves, on the other hand, believe that people are going to use drugs whether the law allows it or not, and that by reducing or abandoning criminal penalties — legalizing or decriminalizing drug use — the country could avoid the crime and corruption that the outright prohibition has brought with it.

Reuter calls attention to a third force — the owls.

Where drug policy is concerned the characteristic of owls is not that they are especially wise but that they have their

eyes wide open. Owls see things as they are, not as they ought to be. They recognize that prohibition of drugs is spawning crime and that sending drug offenders to prison in wholesale numbers is creating a climate of oppression and a sort of ineffective revolving-door justice.

But they also realize that legalizing drugs would risk a devastating surge in drug use in exchange for whatever it would accomplish in reducing crime. The owls see drug use not so much as a moral failing but as a reflection of social conditions that make it easy for many in bleak, inner-city neighborhoods to surrender to the quick escape of crack cocaine and other drugs. They see addiction as an illness from which people can recover.

Even if their message lacks the simplicity and clarity of the competing birds, says Reuter, owls may yet come to dominate the aviary. The Clinton strategy has the hawkish tone we would expect — no let-up in enforcement — but something owl-ish has crept into it, and that may be all for the better.

Lee Brown has called for an end to the rhetoric of war in the anti-drug effort and declares that drug use should be viewed as a "public health problem." This gets to the heart of the matter. Drug use is a communicable disease that flourishes, like malaria, in a receptive environment. In this case the swamp where cocaine and heroin infect victims in greatest numbers is the in-

ner-city neighborhood blighted with poverty and a dead-end outlook for the future.

The Clinton strategy is on target when it ties in solutions to the drug problem with efforts to create jobs, preserve families, and curb youth violence. Prevention programs can hope to persuade young people growing up in middle-class suburbs that drinking and drugging are destructive and will interfere with their goals in life. This is harder to do in neighborhoods in which school dropout rates are high and the most beckoning goals are those involved with gang identity and the quick rewards promised by drugs.

But creating family and social conditions that discourage initiation into drug use is an elusive, long-term goal. What do we do in the here and now?

Lee Brown and his strategists join the owls when they show a willingness to abandon one interdiction policy that was not producing results: the use of military patrols to seek out drug smugglers in "transit zones" like the Caribbean.

The hawks in recent years have reacted to the drug traffic with a Vietnam-like response: send in more troops. The owls look at such escalation and do not see any impact on the price and availability of drugs on the street. So why not try something different? Let's hope the plan for new initiatives in drug-producing countries does not run afoul of the Clinton administration's penchant for pratfalls in for-

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BURRELLE'S

NEWS EXPRESS

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KANSAS

P. 06
3:48
Jun 23 '94

eign relations.

As a career policeman before going to Washington, Lee Brown has the silhouette of a hawk but he does not join his fellow raptors in devaluing the role of treatment in the anti-drug strategy. "Treatment works," he says, and the administration is putting an additional \$355 million into programs for chronic drug users. The emphasis will be on new treatment programs in prisons, and encouraging probation for persons charged with non-violent drug offenses who might do well in therapeutic communities or other supervised treatment regimens.

Here, a wise owl will remember that the landmark Institute of Medicine study on drug treatment released in 1990 warns that clients must be matched carefully with different modes of treatment, and high relapse rates are not unusual on the road to recovery. While ignoring the treatment option is short-sighted, relying on it as a quick fix can be disappointing. Prison alternatives should be kept under an owl's gaze to assure they are not being abused.

The administration's \$191 million of new funds for prevention deserves the same caution. Outcome studies have shown the limited value of school-based alcohol and drug prevention programs when they are not linked with efforts to change the wider environment in which young

people are growing up. Schoolroom lectures about the danger of alcohol and drugs must compete with advertising and promotions linking alcoholic beverages with good times, a rock music scene steeped in allusions to drug use, and the notion instilled in our culture that pain is something easily avoided with pills promising fast, fast, fast relief. How much of our "drug problem" is in reality a reflection of hedonistic attitudes endemic in modern society?

Drugs have been part of Western civilization since the lotus-eaters beguiled Homer's Greek warriors on their way home from Troy. The early end of Kurt Cobain and the lost weekend of Jennifer Capriati repeat a familiar tale of folly and surrender. The hawks have failed to show that threats of discovery and certainty of punishment are sufficient to squeeze off traffic in illegal drugs. The doves have few takers for their notion that drugs can be legalized and controlled without inviting degrees of abuse and addiction worse than what we see today.

Enter the owls, alert to what works and what doesn't in interdiction, punishment, treatment and prevention. Perhaps they can help direct a strategy of containment of the illegal drug problem while we undertake the task of cleaning up a social environment that makes drugs irresistible to so many.

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BURRELLE'S

NEWS EXPRESS

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CHICAGO TRIBUNE

JUN 19 1994

Fight cocaine from the demand side

4/2
One of the nation's best research labs has confirmed what decades of frustration should have taught America about its cocaine habit: Treating users is more effective than busting pushers.

Seven times more, according to a new study by the California-based RAND Drug Policy Research Center.

The study should prompt the Clinton administration to speed its promised shift in anti-drug strategy to a more balanced attack in which treatment plays as big a role as arrest and confiscation.

Currently the U.S. spends—at all levels, public and private—about \$13 billion a year on cocaine control, only \$1 billion of which goes for treatment. If treatment's share were raised to \$4 billion, RAND estimates, total cocaine consumption could be slashed by a third, which would yield a \$10 billion societal savings in less crime and more productivity.

One reason treatment is the more cost-effective alternative is that cocaine consumption, while stuck near its mid-'80s peak, is becoming more concentrated on a small number of heavy, as opposed to occasional, users. The number of users has dropped to 7 million from 9 million, RAND says, but the number of heavy users—those who indulge once a week

or more—has grown to 1.7 million, accounting for two-thirds of consumption.

Treatment programs cut consumption directly, researchers say, as opposed to police action against sellers and suppliers, which has the indirect effect of raising the price of the drug. RAND estimates that 80 percent of those undergoing treatment stay clean while in therapy, and 13 percent remain drug-free thereafter.

Neither in-patient nor out-patient programs are cheap, but it would cost seven times more to achieve those same results with what RAND calls "domestic enforcement" (police action), and even more through border "interdiction" and overseas "source country control."

None of this means dealers should be allowed to operate with impunity or that drug running should go unchallenged.

It does mean, however, that treatment programs—which now account for less than 10 percent of our anti-drug effort—ought to be put on a more equal footing with enforcement activities.

Fighting the demand is just as important as fighting the supply.

BURRELLE'S

NEWS EXPRESS

PAGE 1 OF 5

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Study Says Anti-Drug Dollars Are Best Spent on Treatment

By JOSEPH B. TREASTER

A dollar's worth of drug treatment is worth seven dollars spent on the most successful law-enforcement efforts to curb the use of cocaine, researchers say in a new study.

The study by Rand, a California research organization that has worked closely with the Federal Government, was partly financed by the White House, which immediately rejected its main points.

The Rand study is the first to quantify the relative merits of treatment versus enforcement, an issue long debated in the search for an effective anti-drug strategy.

The researchers say they do not advocate treatment to the exclusion of all other anti-drug efforts. But they do advocate cutting 25 percent of the Federal, state and local money spent on combatting cocaine producers, traffickers and dealers and spending it instead on the treatment of drug abusers. This, they said, would shrink the cocaine market, with its associated crime and violence, by one-third over 15 years.

Rand estimates that Federal, state and local governments this year will spend nearly \$13 billion to combat the importation, distribution and consumption of cocaine, which, it says, runs about 330 tons a year.

The researchers said the 25 percent shift of money to treatment from enforcement would increase the money available for treatment to \$4 billion from \$933 million.

They said that for every \$34 million allocated to treatment, cocaine consumption would be reduced by 1 percent, or a little more than three tons. To achieve the same effect with enforcement, the study said, the Government would have to spend \$246 million on domestic law enforcement or \$366 million on anti-smuggling programs or \$783 million for anti-drug programs in countries where cocaine was produced.

The Rand researchers did not study the various forms of treatment programs or assess the merits of particular programs. Rather, they made their projections by reviewing data on treatment and by calculating the decline in cocaine consumption while addicts were in rehabilitation programs and, afterward, for a conservatively estimated 13 percent who stayed off the drug or sharply curtailed use.

Though the number of people using cocaine has steadily declined since the mid-1980's, the researchers say, total consumption is largely unchanged because the number of heavy users has increased.

The White House said it did not

want to divert money to treatment programs from international and domestic law-enforcement efforts. Rather, officials said, the Clinton Administration is pursuing a "balanced approach," similar to that of the Bush Administration in which pressure is applied on several fronts, with a minority share of spending going for treatment and prevention programs.

In its last anti-drug budget, the Bush Administration devoted 35 percent to treatment and prevention; the Clinton White House is proposing to spending 41 percent in fiscal 1995.

The official in the White House anti-drug office who oversees treatment and prevention programs, Fred W. Garcia, said the Administration recognized that "treatment is an effective, viable, cost-effective approach" that should be applied to the drug problem. However, he continued: "We need a comprehensive approach. We don't want to get into a situation where we're taking resources from one end to plug another."

A principal researcher in the Rand study, C. Peter Rydell, said the study's core message was that "we're underfunding treatment." He added, "We're not using the best thing we've got to the fullest extent."

Dr. Herbert D. Kleber, a former Bush Administration official who had tried in vain to get substantial in-

creases in spending for drug treatment, said that despite growing evidence, a general perception was that it is ineffective. Moreover, Dr. Kleber said, political leaders fear that spending more money on drug treatment and less on law enforcement will hurt them politically by making them look "soft on crime."

"There's still almost a moralistic feeling that, 'Why should we be putting tax dollars into treating something that people have brought on themselves?'" Dr. Kleber said. "The answer is, we do it not just because it's good for the addict; we do it because it's good for the rest of society. It reduces crime, health care costs, welfare costs and the cost of the whole legal system."

The Administration says it is most concerned with hard-core drug abusers, who consume most of the drugs and are believed to be responsible for most drug-related crime and violence.

Yet the Administration is moving slowly to treat the four million to six million heavy users of cocaine and other drugs. About 1.4 million of them are now in public and private treatment programs, and the latest Clinton anti-drug budget would provide rehabilitation for 74,000 more, an increase of about 5 percent.

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HOUSTON POST

JUN 18 1994

DRUG WAR TACTICS

Treatment needs more emphasis as weapon *PA30*

A NEW STUDY is on target in suggesting that our national drug war employ a more balanced attack of treatment, enforcement and education.

The study, conducted by the Rand organization, focused on cocaine and concluded that an increased emphasis on drug treatment could cut consumption by one-third and reduce the costs of cocaine-related crime.

However, the researchers warned that treatment is no panacea; enforcement will still be important.

The Rand study also found that the number of cocaine users has declined by almost 20 percent since its peak in the 1980s to the current level of 7.3 million users, but that total consumption had remained the same due to an increase in heavy users.

The U.S. strategy over the past decade in fighting drugs has generally been to get "tougher" on drug users and pushers. This has had some successes, but as the increase in heavy cocaine users and the recent upsurge in heroin use indicate, the strategy has scored no decisive victory.

The Clinton administration, includ-

ing drug czar Lee Brown, has stressed a balanced attack in fighting drugs, made up of education, prevention, treatment, and enforcement. But while this mixed strategy is exactly what is needed, the funding has not been as balanced as the rhetoric.

The Rand study reported that about \$14 billion was spent on fighting cocaine by the local, state and federal governments in 1992, with only \$1 billion of that used for treatment.

The success of treatment has been mixed. It is difficult to "cure" a drug addict, and it is very costly — though, according to the Rand study, not as costly as enforcement.

If one lesson has been learned, it is that efforts to stem the supply of drugs have not succeeded. The drug war will finally be won when the demand is cut by convincing Americans that illicit narcotics use offers only financial destitution, family disintegration and personal degradation.

Successful strategies have been found to reduce cigarette consumption. If given a chance to work, they might also become powerful weapons in the war on drugs.

BURRELLE'S

NewsExpress

PAGE 3 OF 6

SAN JOSE MERCURY NEWS
Tuesday, June 14, 1994

Costs of cocaine

They'd fall if funds went to treatment instead of drug war

TREATMENT for hard-core drug users is "the number one priority" of President Clinton's drug policy, says John Carnevale, director of planning and budget for the Office of National Drug Control Policy.

In the words of Jean-Luc Picard: Make it so.

→ Treatment for heavy cocaine users is 23 times more cost-effective than trying to control the Colombian coca crop, according to a Rand study sponsored by the government. Treatment is 11 times more cost-effective than trying to stop cocaine before it crosses the border. Treatment is seven times more effective than domestic law enforcement.

But drug war tactics got 18 times more money than treatment in 1992, Rand said. Some \$18 billion was spent trying to control the supply of cocaine; less than \$1 billion was spent trying to limit the demand.

Of 7.8 million cocaine users, only 1.7 million use at least once a week, the study concluded. But these heavy users

are responsible for two-thirds of cocaine consumption. Spending another \$8 billion to fund treatment would cut cocaine consumption by a third, even though most hard-core users drop out of treatment or go back to the drug.

If money's tight, the government should cut supply-control dollars by 25 percent to free up money for treatment, suggested Jonathan Caulkins, co-director of Rand's Drug Policy Research Center, at a press conference Monday.

Clinton wants more treatment money, but not enough to provide help for all hard-core users. He is cutting interdiction funding, but wants more money to fight drugs in foreign countries.

According to Rand, cutting cocaine consumption by 1 percent would cost \$783 million for control at the source country, or \$866 million for interdiction, or \$246 million for domestic enforcement, or \$84 million for treatment.

If Rand is right, our spending strategy is all wrong.

Don't abandon drug war

OPPOSING VIEW Cuts in law enforcement would make drugs easier to get and create more users.

By Clay Shaw

The Rand study that proposes to solve the nation's drug problem by spending more money on treatment and by gutting drug interdiction and law enforcement budgets is like asking President Clinton to lose weight while sitting in a McDonald's.

Neither will work, and here is why:

The Rand study assumes that drug interdiction does not work. The reality is that cutting interdiction will make drugs easier to obtain.

Studies show that for every \$1 invested in interdiction, \$20 worth of drugs is kept off our streets. Since first becoming involved in the drug war, military-assisted drug interdiction efforts have produced remarkable results.

In 1990, only 10 kilos of drugs per day were disrupted; by 1993, the total was almost 500 kilos of drugs per day. For an expenditure of 0.5% of the total defense budget, military assistance in interdiction has helped double law-enforcement agencies' successes every year.

The study also assumes that cuts in drug interdiction and law enforcement can be

made painlessly by those looking for more money for treatment. Again, not true.

These cuts increase the availability of drugs, reduce street prices and create more first-time users. Plus, they send the signal to drug traffickers that our borders are open again. We should never go back to the 1970s and '80s, when border states such as Florida were practically a free-trade zone for the drug lords.

Finally, many believe that if offered treatment, drug addicts will accept and turn their lives around. Not true.

Statistics show that only one in four hard-core users can be successfully treated, and there currently is no proven method for treating cocaine addicts. Unfortunately, getting addicts into treatment is not the same as getting addicts off drugs.

Like it or not, in a time of tight budgets, many regard overall drug spending as a zero-sum game. While more treatment is a good idea, it cannot be done at the expense of law enforcement and supply-reduction resources.

Slashing drug interdiction and crime-fighting is a prescription for failure. The only way to truly treat drug addiction is to reduce the supply of drugs through drug interdiction.

Rep. Clay Shaw, R-Fla., is a member of the Congressional Narcotics Abuse and Control Caucus and co-chair of the House Republican task force on drugs.

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**USA
TODAY**

THURSDAY JUNE 16, 1994

Today's debate: **FIGHTING DRUGS**

P. 12A

Focus on drug treatment

OUR VIEW Helping drug users get treatment will slow the revolving prison door and cut drug demand.

What's the best way to cut the demand for drugs and take a bite from crime?

Simple: Get heavy users to stop using drugs so they don't have to commit crimes to feed their habits.

That common-sense conclusion was confirmed this week by a federally funded study by the Rand Corp. It found treatment is seven times more cost effective in cutting cocaine demand than local enforcement, 11 times more effective than border interdiction, and 22 times more effective than trying to control foreign production.

The research also supports the need for adequate funds for local law enforcement. Such spending helps funnel drug users into treatment programs and, when coupled with education, can keep others from trying drugs.

But the study concludes that it makes no sense for federal, state and local agencies to spend 12 times as much trying to dry up cocaine supplies as is spent on treating cocaine addicts.

That conclusion is supported by the 12-year history of the drug war.

The campaign has bagged tons of illicit drugs and tossed hundreds of thousands of drug users into prison. But cocaine consumption remains at 6.5 million pounds a

year, the same level as 1982.

A rise in the number of heavy users — in the case of cocaine, 15% since 1985 — has left the demand for drugs, and hence the profits from drug-dealing, high. As a result, the drug war has been a miserable failure at cutting crime.

Indeed, enforcement without treatment has created a revolving prison door. Each year, 200,000 drug-addicted convicts are released from prison without treatment. Eighty percent of them return to prison within a few years.

The Clinton administration plans to close that door — but only a little.

It has proposed spending 40% of its 1995 drug budget on education and treatment. Treatment alone would increase 14% to nearly \$2.9 billion.

Yet only about \$200 million of the treatment budget will go to long-term rehabilitation; the rest goes to quick fixes that don't stick. Heavy drug abusers are left with only 12,000 slots. It's not enough. There are an estimated 1.7 million heavy cocaine users in the nation, and each one may require up to two years of therapy to kick the habit.

Meanwhile, the administration still will spend \$1.7 billion on interdiction and controlling foreign production, activities that have done nothing to cut the demand that attracts drugs to our shores.

America can't afford such waste. It's time to spend more to get addicts off drugs and less on failed efforts to keep drugs off the streets.

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Date: JUN 16, 1994

How to Be Effective Against Cocaine

RAND study shows power of fighting demand

Intuition tells us, and evidence grows, that the national policy on cocaine abuse is badly out of kilter. Federal and local police agencies spend about \$12 billion a year in trying to stem supply, but the supply seems endless as long as demand remains high. We spend about \$1 billion a year in public and private money on treating users, but skeptics wonder whether this makes a real difference.

Well, it does, and we could do well by diverting much of the money spent on enforcement into treatment of heavy users to cut the demand. That is the burden of a new statistical study from the RAND Corp. It concludes that one dollar spent on treatment results in \$7 worth of overall savings to society. By contrast, the study finds, each dollar spent on control—in helping foreign governments cut supply and interdicting and reducing domestic distribution—returns only 89 cents in savings. In other words, the war on cocaine suppliers is getting us almost nowhere.

Statistics on drug control and abuse are notoriously squishy. But the RAND re-

searchers, Susan S. Everingham and C. Peter Rydell, have made one of the first attempts at systematically comparing through computer modeling the cost-effectiveness of various approaches to cocaine abuse.

They conclude that the best value for the money involves

reallocating about \$3 billion, or about a quarter, of the yearly enforcement money to allow for treatment of nearly all of the 1.7 million heavy cocaine users. This, they calculate, would cut annual cocaine consumption by half by the year 2007 and result in a one-third (\$10 billion) reduction in annual societal costs.

Such computer simulations have their limitations, but the study suggests a middle ground between those who would legalize cocaine altogether and those who would impose even harsher criminal penalties. While the RAND researchers do not advo-

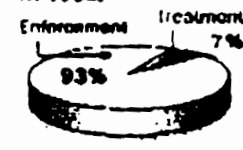
cate dropping enforcement, their view that treatment is more cost-effective is one that has gained acceptance even among many top police officials and prosecutors. This argument goes only so far, however, because it will never be possible to get all users into

treatment. And indeed, RAND agrees that treatment is not a panacea. The real issue is how to get the most value for each dollar spent.

Both sides of the enforcement-versus-treatment equation are imperfect. Drug enforcement spawns police corruption; treatment programs are often money-making slums. But the balance of evidence supports the Clinton Administration's tentative view that treatment and education must be emphasized. The cocaine epidemic will not end until the demand for the product drops.

Imbalance on Cocaine

U.S. public and private agencies spent \$13 billion combatting cocaine in 1992.



LOS ANGELES TIMES JUN 14 1994

Treatment Called Best Way to Cut Cocaine Use

■ **Health:** RAND study says programs to control addiction are seven times more cost-effective than law enforcement methods in reducing consumption.

By RONALD J. OSTROW 921
TIMES STAFF WRITER

WASHINGTON—Drug treatment programs are seven times more economical than law enforcement efforts in reducing the use of cocaine and appear to be the most effective method of all, according to a major study released Monday by the RAND think tank.

Making such programs available to all heavy cocaine users would reduce consumption of the drug by a third, the study said.

While the work by Santa Monica-based RAND tends to support the treatment-based approach to drug addiction favored by the Clinton Administration, it raises questions about another Administration policy—trying to stem the flow of drugs from the countries that produce and distribute them.

The study, based on research by C. Peter Rydell and Susan R. Everingham, was said to be the first of its kind to compare the cost-effectiveness of various co-

caine control programs.

Fred W. Garcia, a deputy director in the White House national drug control policy office, which helped fund the \$340,000 study, hailed the conclusion on the relative value of treatment. But he was less enthusiastic about evidence that the least effective programs are those designed to control cocaine at its source—primarily in Peru, Bolivia and Colombia.

He said that the study did not take into account other objectives of international drug strategy—such as strengthening U.S. national security, "promoting the development of democratic institutions and the rule of law and fostering economic security and growth."

The number of cocaine users in the United States has dropped from 8 million in the early 1980s to a little more than 7 million today. Nonetheless, overall consumption stands at its mid-1980s peak because the number of "light users" has declined while "heavy users" have increased, according to the study. Heavy users accounted for more than two-thirds of cocaine demand, up from less than half in 1980.

The study defined heavy use as once a week or more and light use as at least once a year, but not as often as weekly. At the end of 1992, the nation had 5.6 million light users and 1.7 million heavy users.

RAND found.

Using 1992 data, the study said that federal, state, local and private sources spent a total of \$13 billion for four types of cocaine control programs examined by the study. Domestic enforcement—drug arrests, jails and prisons—accounted for 73% of the cost. Interdiction (trying to stop the drugs from entering the country) accounted for 13% of the cost, and treatment and source-country control, 7% each.

Treatment was defined in the study as a mixture of relatively inexpensive outpatient and relatively expensive residential programs designed to treat both the physical and psychological reasons for addiction. Their average cost was estimated at \$1,740 per patient.

In finding that treatment for heavy users was seven times more cost-effective in reducing cocaine consumption than domestic enforcement, the study said that annual consumption could be cut 1% if \$34 million more were spent on treatment, while \$246 million would be needed to achieve the same reduction through domestic enforcement.

Interdiction would need \$366 million of additional spending to do the job, while source-country control would require \$783 million.

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Voices: Should tax dollars be spent on drug rehabilitation or more prisons?

A new report by the non-profit Rand Corp. indicates that treating drug addiction is more cost-effective than increasing arrests or interdicting drugs at the border. The Clinton administration has pressed for more emphasis on drug treatment. USA TODAY asked readers how they would like to see the tax money spent as Congress joins the debate.

P-12A



Paulette Dilworth, 42
Asst. equal empl. dir.
Atlanta, Ga.

The energy spent helping people who are addicted is more beneficial than building lots of prisons. If you can get people off drugs, you stop those who are trying to sell them. It's not realistic to think drugs will completely disappear, but cutting demand helps.



Jon Halvorson, 49
Mayor
Lacey, Wash.

You have to have a broad strategy. Nothing will make drugs magically go away. Public safety and law enforcement must be a primary concern, but intervention and treatment are also necessary. You have to attack the problem from many angles.



Mimi Yee, 32
Intl. marketing mgr.
New York, N.Y.

Drug rehabilitation depends largely on the individual. In certain cases, it does work. Law enforcement has to be a priority, however. I think the idea should be to stop drugs at the source.



Vern Gaugush, 55
Athletic director
Wausau, Wis.

It costs more to incarcerate people than it does to treat them at the front end. I look at how effective the anti-smoking campaign was on my son's generation. We need education and treatment. If you wait until after the fact, it's too late.



Tonya Crawford, 25
Teacher
Houston, Texas

Treatment depends on what kind of help they receive. You'd have to make sure the treatment center offered a quality program. Otherwise, they'd be addicted again. If someone commits a crime, he should be arrested, prosecuted and locked up.

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The Miami Herald

JUN 14 1994

Date

IN WASHINGTON 10A

From Herald Wire Services

ILLEGAL DRUGS**Study: Don't just seize cocaine, treat its users**

Treating heavy cocaine users is the cheapest, most efficient way to reduce the hundreds of tons consumed each year in America, many times more effective than seizing the drug in the United States or trying to stop its production abroad, the Rand Corp. said Monday.

The think-tank authors said \$14 billion was spent in 1992 on federal, state, local and private efforts to fight cocaine, with less than \$1 billion for treatment.

"A \$3 billion expansion would get us to the point of being able to offer treatment once per year to every heavy user," said Jonathan Caulkins, co-director of Rand's Drug Policy Research Center.

Florida Department of Law Enforcement spokesman John Joyce said enforcement is still the

key. "Taking resources away would be a problem," he said. "If they found new money [for treatment] it would be fine."

ETC.

■ Rep. David Obey and two other liberal Democrats in the House called Monday for reforms to bar the filibuster, a hallowed Senate tradition. The filibuster — unlimited debate or the threat of it — "has become the principal tool of gridlock," Obey said.

■ Key tobacco foes are seeking a quick House vote on legislation that would require the Food and Drug Administration to regulate tobacco, but forbid a ban on cigarettes. They asked Rep. Porter Goss, R-Fla., and other Rules Committee members to act as early as today to allow the vote.

■ Transportation Secretary Federico Peña announced a rail-highway crossing safety program that emphasizes closing as many of the country's 280,000 grade crossings as possible.

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Study: Drug Treatment Is Best Bang for Buck

By William Douglas P. A21
WASHINGTON BUREAU

Washington — Treatment for cocaine addiction is the most cost-effective weapon in the nation's war on drugs and should receive far more funding, according to a new study released yesterday.

The Rand Corp. study recommends shifting 25 percent of the nation's drug-control budget to fund treatment of heavy users of cocaine and crack, a smokable form of the drug. That would cut U.S. consumption of the drug by one-third, the study concludes.

Treating cocaine abuse is seven times more cost-effective than other drug-fighting strategies, including interdiction

and incarceration, according to the nonprofit institute.

The Office of National Drug Control Policy, which, along with the Army, funded most of the study, agreed with most of the Rand findings, but dismissed the idea of shifting funds.

"In the final analysis, an effective national strategy cannot be accomplished by funding some effective programs at the expense of others," said Fred Garcia, deputy director of the demand reduction division of the drug control policy office.

The study says cocaine use in the nation could drop by 1 percent if federal, state and local governments spent an additional \$34 million on treatment.

To achieve the same results, the gov-

ernments would have to spend an additional \$246 million on domestic law enforcement; \$366 million more on interdiction, the confiscation of cocaine or cocaine-related assets by agencies like the U.S. Customs Service, Immigration and Naturalization or the U.S. military; or \$783 million extra to quash cocaine production at the source in countries like Colombia, Peru and Bolivia.

In 1992, the United States spent \$13 billion combating drugs, about \$1 billion of which went toward cocaine treatment, according to the study.

Cocaine use exploded in the mid-1980s with the introduction of crack. The Rand study says the nation's cocaine consumption has remained at its

peak level, even though the number of users has dropped from nine million to about seven million. That's because the number of heavy users — those who used cocaine at least once a week — has increased to an estimated 1.7 million. Heavy users accounted for about two-thirds of the cocaine demand in 1992, the study says. In 1980, less than one half of demand was from heavy users.

President Bill Clinton's drug-policy experts say treatment is at the forefront of the national drug-control strategy. Clinton has asked Congress for \$13.2 billion for his antidrug plan for fiscal 1996, of which \$2.9 billion is targeted for drug treatment.

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**USA
TODAY**

TUESDAY JUNE 14, 1994

White House balks at study urging more drug treatment

 By Dennis Cauchon *P.2A*
 USA TODAY

The Clinton administration quickly rejected the conclusion of a major cocaine policy study that it ordered and funded.

The Rand Drug Policy Research Center study concludes \$3 billion should be switched from federal and local law enforcement to treatment. The report says treatment is the cheapest way to cut drug use.

The change also would lower violent crime related to the drug trade, said center co-director Jonathan Caulkins.

But the drug czar's office swiftly rejected slashing law enforcement spending.

"We're not going to rob Peter to pay Paul," says John Carnevale, director of planning and budget at the Office of National Drug Control Policy.

Clinton wants a \$355 million rise — about 14% — in treatment spending next year, a 28% increase in prevention spending and 21% more in international supply reduction.

Caulkins said study sponsors — the drug czar's office and the Army — tried to get Rand to soften its conclusion that law enforcement money should be cut. "We by and large ignored them," Caulkins said.

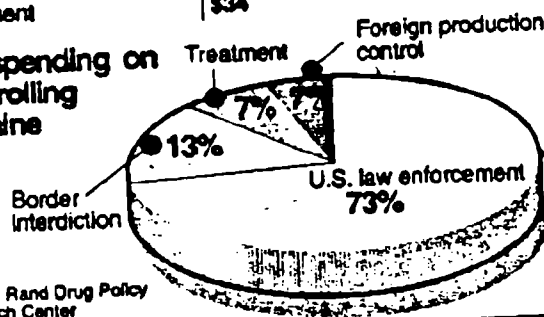
Cocaine consumption has re-

Drug treatment cheaper: study

Treatment is far more cost effective than law enforcement in trying to reduce illegal cocaine use, a study says. How much would have to be spent annually on various strategies to reduce cocaine use by 1% over 15 years:

Program	Cost (in millions)
Foreign production control	\$783
Border interdiction	\$356
U.S. law enforcement	\$246
Treatment	\$34

'92 spending on controlling cocaine



Source: Rand Drug Policy Research Center

By Web Bryant, USA TODAY

mained about 290 metric tons a year since 1985, despite major law enforcement efforts, says the \$340,000 study by Rand, a non-profit research institute.

"This is a very significant study," said Arnold Trebach, president of the Drug Policy Foundation, which opposes the drug war. "It's the first time the cost effectiveness of treatment

vs. enforcement has been measured in a scientific way."

But Eric Voith, chairman of the International Drug Strategy Institute, a pro-drug-war group, was lukewarm to Rand's finding: "I absolutely support increased treatment, but you have to be very careful how and if you cut enforcement spending."

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**USA
TODAY**

MONDAY JUNE 13, 1994

Study: Drug treatment cost-effective

Treating hard-core drug addicts is seven times more cost-effective in reducing cocaine consumption than increasing arrests or stopping drugs at the border, according to a report released today by the non-profit Rand Corp.



BROWN: Increasing treatment dollars

The study found that annual cocaine consumption could be reduced by 1% if the federal government spent an additional \$34 million on treatment. To achieve the same effect, the government would need to spend an additional \$246 million for domestic enforcement, \$366 million for border interdiction or \$783 million to control drugs in their source countries, the report indicated. The United States spends \$13 billion a year to eradicate cocaine. Only \$1 billion of that is spent on treatment, Rand reports. Earlier this year, drug czar Lee Brown said the administration would spend an additional \$355 million to increase drug treatment. That will provide treatment for more than 140,000 chronic drug users.

— Penny Bender

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**USA
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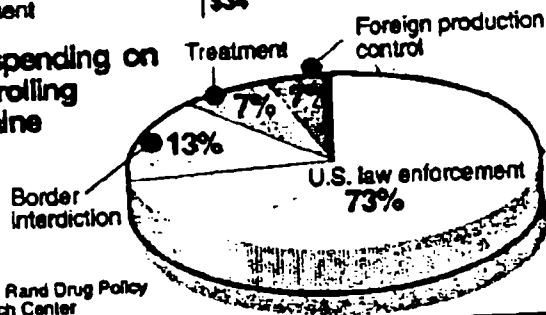
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P. A21

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peak level, even though the number of users has dropped from nine million to about seven million. That's because the number of heavy users — those who used cocaine at least once a week — has increased to an estimated 1.7 million. Heavy users accounted for about two-thirds of the cocaine demand in 1992, the study says. In 1980, less than one half of demand was from heavy users.

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OFFICE OF NATIONAL DRUG CONTROL POLICY
EXECUTIVE OFFICE OF THE PRESIDENT
Washington, D.C. 20500

July 20, 1994

MEMORANDUM FOR FRED GARCIA

FROM:

DAN SCHECTER 

SUBJECT:

Heritage Foundation Report on Clinton Drug Program

In response to your request, the following is a brief summary of the highlights of the Heritage Foundation's June 16 report, "How the Clinton Administration is Abandoning the War Against Drugs."

The critique was written by John Walters, who served as ONDCP's chief of staff under former Drug Czar William Bennett, and later as Deputy Director for Supply Reduction and Acting Director. Walters' thesis is that the Clinton Administration's drug policies are undercutting past gains in reducing drug use, and contributing to a likely increase in the availability of drugs on American streets.

The analysis begins by listing a number of actions taken early in the Administration that, according to Walters, undermined existing anti-drug efforts:

- o The President's rare references to the drug problem.
- o Jocelyn Elders' statements on legalization.
- o ONDCP staff reductions.
- o Janet Reno's announced intention to reduce minimum mandatory sentences for drug crimes.
- o Cuts in programs to interdict drugs and eradicate domestic marijuana.
- o Stopping the provision of radar intelligence on trafficker flights to Peru and Colombia.

The Clinton Drug Control Budget

Walters criticizes the Administration's FY 1995 budget request on

several grounds:

- o Major cuts in Federal drug enforcement personnel -- DEA, FBI, INS, Customs, Coast Guard, etc.
- o Cuts in drug prosecutions by U.S. Attorneys.
- o What Walters calls a "phony prevention increase." This refers to the scoring of one-half of the "drug" portion of the community policing request -- \$284 million -- as prevention. This accounts for more than half of the increase for prevention in the 1995 budget.
- o Over-reliance on the "wasteful" block grant as the vehicle for increasing drug treatment funding. Walters points out that the States have always resisted "fencing off" funds for drug treatment, to the exclusion of alcoholism and mental health.
- o Insufficient support for international programs and intelligence.

Over-reliance on Drug Treatment

Walters questions whether the Clinton strategy's emphasis on drug treatment is the most effective way to reduce hardcore drug use. Walters notes that while Federal spending on drug treatment tripled between 1988 and 1994, the number of people receiving treatment actually declined, while the hardcore addict population remained constant.

Walters further points out that drug treatment is less successful for chronic users than casual users, citing ONDCP's recent "Characteristics of Heavy Cocaine Users" report.

Recommendations

- o Apply direct presidential leadership in efforts to discourage drug use among young people.
- o Create a single anti-drug block grant, to give maximum flexibility to State and local governments.
- o Increase military involvement in interdiction.
- o Get tough on drug exporting countries.
- o Step up efforts to prevent drug use by young people, stressing the role of parents and the moral dimension of drug use.
- o Close down open air drug markets in American cities.

- o Expand the use of drug testing in treatment programs, and especially in the criminal justice system.
- o Challenge the local media in communities to get involved in prevention.

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June 16, 1994

HOW THE CLINTON ADMINISTRATION IS ABANDONING THE WAR AGAINST DRUGS

INTRODUCTION

The Clinton Administration is taking a new direction in the drug war. But that new direction will allow more cocaine, heroin, and marijuana to reach American streets, and it will cut federal enforcement personnel. It seeks to pour over \$300 million more into a national drug treatment system that has seen federal funding triple since 1988 (to over \$2.5 billion annually) yet serves fewer drug-dependent individuals each year and has manifestly failed to reduce the addict population.

President Clinton effectively abandoned leadership of America's anti-drug effort during his first year in office. Now the Administration wants to dismantle crucial parts of this effort despite a rise in teenage drug use during the President's first year in office that reversed more than a decade of steady and rapid decline. Instead of reversing course on a successful strategy, the Clinton Administration should:

- ✓ **Reassert presidential leadership in combatting illegal drug use.** This means more than speaking out against illegal drug use. It means appointing individuals within his Administration who are serious about combatting illegal drugs and dismissing those who are not.
- ✓ **Let state and local officials use federal anti-drug funds for their highest priorities.** This entails consolidating the roughly \$3.5 billion in federal drug control programs for states into a block grant that can be used at the local level for purposes ranging from treatment and rehabilitation to prevention and law enforcement.
- ✓ **Use the military and get tough with countries that are the source of illegal drugs.** This means putting the U.S. military in charge of stopping the flow of illegal drugs from abroad, requiring federal law enforcement agencies responsible for drug interdiction to operate under the command and control of the military. It also means insisting that cocaine-source countries reduce their net production of

drugs by at least 10 percent per year and by at least 50 percent in five years or face a loss of aid, as well as trade and diplomatic sanctions.

- ✓ **Mount a serious attack on major drug trafficking organizations.** Require the Attorney General to prepare a report within six months identifying all major drug trafficking organizations known to be operating in the U.S., an enforcement plan for dismantling all those organizations within 18 months, and a plan to repeat this strategic planning process yearly.

Americans have changed their views about drugs. They are more aware than ever of the dangers of drug use. During the 1980s, the federal government led successful efforts to reduce casual drug use, to block shipments of drugs to America, and to reinforce local actions to discourage drug use. But that action by the federal government has already lost momentum under Bill Clinton and seems destined to decline even further. It will be a costly mistake. The failure of national leadership makes a renewal of local anti-drug efforts—prevention, treatment, and enforcement—crucial to the future of the drug war.

THE DRUG WAR AND AMERICAN CULTURE

Between 1977 and the end of the 1980s, a conservative cultural revolution took place in America with respect to drugs. Illegal drug use went from being considered fashionable and liberating to being thought of as unfashionable and stupid. Overall, casual drug use by Americans dropped by more than half between 1977 and 1992. From 1985 to 1992 alone, monthly cocaine use declined by 78 percent. This transformation in cultural attitudes reversed the spread of illegal drug use, and it was carried out by the fundamental institutions of American society. Parents were the first group to mobilize. Initially, parent groups forced the Carter Administration to suspend its drug legalization initiatives. Later, parents gained the vocal support of First Lady Nancy Reagan, who helped make the drug problem a national priority.

The moral injunction not to use drugs swept the nation, conveyed by the core institutions of American society: families, churches, schools, youth organizations, neighborhoods, workplaces, civic groups, and police. Even the media joined in this cultural revolution. In the early 1980s, a *Time* magazine cover portrayed cocaine as the contemporary equivalent to the martini. By 1990, however, the media were contributing an estimated one million dollars a day to the Partnership for a Drug-Free America's anti-drug ads: "This is your brain. This is your brain on drugs."

National leaders helped give momentum to this institutional mobilization against drug use from their "bully pulpit." From the President down, top officials in the Reagan and Bush Administrations visibly supported the effort, and government programs supplemented the institutional mobilization. Federal anti-drug activity and spending were very important, but the contribution of the federal government never approached the magnitude of the effort supplied by citizens, families, and local institutions throughout the nation. In short, the drug war embodied all the elements of successful conservative domestic reform. The American people, recognizing a dangerous threat to the nation and working through its most powerful domestic institutions, changed the cultural attitudes that were the root of the illegal drug problem; drug use—particularly by young people—declined dramatically. The federal government gave strong moral support, and programs

supplemented the efforts of ordinary citizens. Now, under the Clinton Administration, that progress is being reversed.

THE DISMAL CLINTON RECORD ON ILLEGAL DRUGS

When President Bill Clinton took office, the problem of illegal drugs had undergone a sea change in just a little more than a decade. But instead of taking measured steps to address the residual aspects of the drug problem while supporting existing efforts, Clinton Administration officials immediately began undermining existing anti-drug efforts on almost all fronts:

- ✗ For his entire first year in office, President Clinton mentioned the drug issue only rarely and offered no moral or political leadership or encouragement to those in America and abroad fighting the drug war.
- ✗ The Clinton Administration Surgeon General, Joycelyn Elders, has called repeatedly for serious consideration of drug legalization.¹
- ✗ Just days after the inauguration, President Clinton moved the White House office created to direct national anti-drug efforts to a backwater and slashed its personnel by over 80 percent.²
- ✗ One of the first announced goals of Attorney General Janet Reno was to reduce the mandatory minimum sentences for drug trafficking and related federal crimes—sentences that put teeth in drug enforcement and are an important tool for gaining the cooperation of subordinates in bringing major traffickers to justice.³
- ✗ The Office of Management and Budget proposed, and House appropriators passed, cuts of \$100 million in drug treatment funding and \$130 million in prevention education. Fortunately, these cuts later were partially restored in conference action at the insistence of Republican conferees.⁴
- ✗ President Clinton signed a new directive ordering a massive reduction in Defense Department support for the interdiction efforts that have been preventing large quantities of cocaine and other illegal drugs from entering the United States.

1 See Reuters, "Elders Reiterates Her Support For Study of Drug Legalization," *The Washington Post*, January 15, 1994, p. A8.

2 On February 9, 1993, the White House announced that the Office of National Drug Control Policy (ONDCP) would be cut from 146 staff members to 25. For more detail on drug czarism under the Clinton Administration, see Byron York, "Clinton's Phony Drug War," *The American Spectator*, February 1994, pp. 40-44.

3 See Michael Isikoff, "Reno Has Yet to Make Mark on Crime," *The Washington Post*, November 26, 1993, pp. A1, A10, and A11.

4 See Michael Isikoff, "House Cuts Drug Plan \$231 Million: Clinton Lobbyists Tacitly Concurred," *The Washington Post*, July 2, 1993, p. A9.

- X The Administration accepted a 33 percent cut (from \$523.4 million in FY 1993 to \$351.4 million in FY 1994) in resources to attack the cocaine trade in the source and transit countries of South America.⁵
- X Efforts led by the federal government to eradicate domestic marijuana have been reduced substantially.
- X Most recently, the Clinton Administration has ordered the U.S. military to stop providing radar tracking of cocaine-trafficker aircraft to Colombia and Peru.⁶

While the Clinton Administration spent its first year in office undermining anti-drug efforts, drug use by young people started to rise. The University of Michigan's annual survey of high-school drug use for 1993, released this January, showed that drug use—particularly marijuana use—by 8th, 10th, and 12th-graders rose in 1993 after virtually a decade of steady decline. Even more distressingly, the survey also revealed that student attitudes toward illegal drug use are becoming significantly less hostile, indicating further increases in use are almost certain in 1994.

THE "NEW" CLINTON PLAN

Nine days after the University of Michigan report that teenage drug use was rising, the Clinton Administration presented a "new" drug strategy emphasizing four areas:

- ✓ Reducing hardcore drug use through treatment.
- ✓ Ensuring safe and drug-free schools by improving prevention efforts.
- ✓ Empowering communities to combat drug-related violence and crime.
- ✓ Increasing international programs in source countries and reducing interdiction in drug-transit zones.⁸

The new strategy was accompanied by a drug control budget request for fiscal year 1995 totaling \$13.2 billion, some \$1.1 billion (9 percent) more than the \$12.1 billion enacted for FY 1994. The Administration emphasized that it was seeking increased funds in five key areas: drug prevention, up \$448 million (28 percent); drug treatment, up \$360 million (14 percent); drug-related criminal justice spending, up \$227 million (4 percent); international programs, up \$76 million (22 percent); and drug-related research, up \$27 million (5 percent). The White House requested reductions in two areas: interdiction,

5 ONDCP, *National Drug Control Strategy: Budget Summary*, February 1994, p. 184.

6 David LaGesse, "Military Stops Helping Nations Track Smugglers," *The Dallas Morning News*, May 14, 1994, pp. A1 and A9.

7 Press release by the University of Michigan's Institute for Social Research on the "Monitoring the Future Study" (also known as the National High School Senior Survey—HSS) for 1993, January 31, 1994.

8 ONDCP, *National Drug Control Strategy: Reclaiming Our Communities From Drugs and Violence*, February 1994, p. 1. An "interim" strategy released last September by Clinton Drug Czar Lee Brown received harsh bipartisan criticism for its superficiality and lack of resources. See ONDCP, *Breaking the Cycle of Drug Abuse: 1993 Interim National Drug Control Strategy*, September 1993.

down \$94 million (7 percent), and anti-drug intelligence programs, down \$600,000 (0.4 percent).

The Administration claims that its budget demonstrates a new emphasis on demand reduction, with 59 percent of the request devoted to supply reduction spending and 41 percent to demand reduction spending as compared with 65 percent and 35 percent, respectively, in FY 1993.

ANALYZING THE CLINTON DRUG CONTROL BUDGET

The Clinton Administration portrays its drug control budget as a sharp increase in spending to combat drugs. But as Chart 1 indicates, this is true only when the budget is compared with the slowdown in spending during the Clinton term so far.⁹ Moreover, when the budget is examined more closely, it becomes clear that the spending priorities constitute a step backwards.

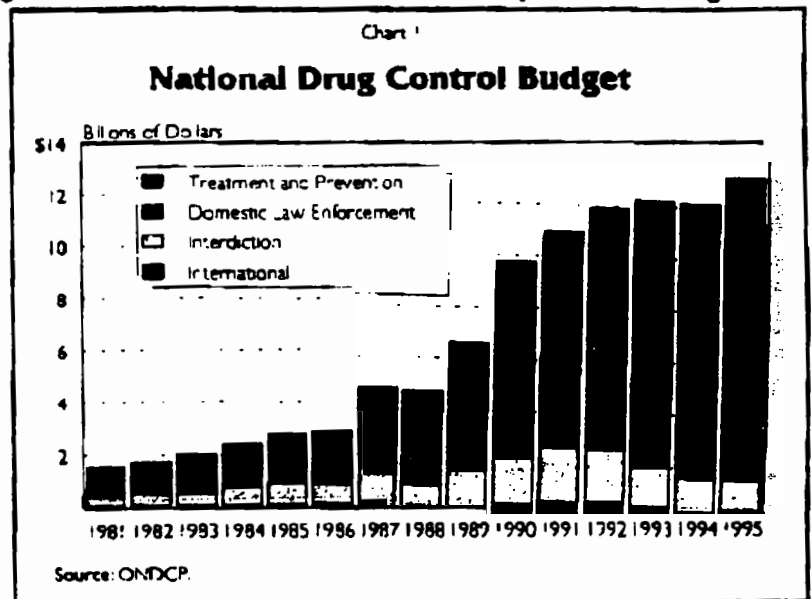
This chart reflects the fact that the Clinton Administration let federal anti-drug spending drop in FY 1994 by roughly \$130 million as compared to FY 1993. The decline is then used as a baseline in some cases to create misleading claims of increases in the FY 1995 budget request, as detailed below.

Specifically, the Clinton budget:

Specifically, the Clinton budget:

1) Cuts federal drug enforcement personnel.

The new Clinton Administration drug strategy calls for substantial cuts in federal drug enforcement personnel. The principal federal drug enforcement agencies are the Drug Enforcement Administration (DEA), Federal Bureau of Investigation (FBI), Immigration and Naturalization Service (INS), Bureau of Alcohol, Tobacco and Firearms (BATF), U.S. Customs Service, and U.S. Coast Guard. Drug enforcement personnel in these agencies would be cut by a total of 625 positions between FY 1994 and FY 1995.¹⁰ These cuts, moreover, are just in the drug enforcement sectors of the



⁹ *National Drug Control Strategy: Budget Summary*, February 1994, pp. 2, 184-187.

¹⁰ *Ibid.*; see the sections discussing each of the enforcement agencies.

multi-mission agencies (total FBI cuts, for example, will be much greater under the FY 1995 Clinton budget)—and are on top of reductions in many of these same agencies between FY 1993 and FY 1994. Staff inside the enforcement agencies also have complained that the Clinton budget understates the actual reductions in personnel and misrepresents some reductions as limited to non-agent personnel when in fact further agent cuts will be unavoidable at the funding levels requested by the President.

2) Cuts federal-state-local enforcement task forces.

The Organized Crime Drug Enforcement Task Forces, which are part of the federal-state-local enforcement task force program, will be cut by 102 positions.¹¹

3) Cuts drug prosecution.

In addition to cuts in enforcement personnel, the Clinton Administration seeks to cut 102 drug prosecution positions in U.S. Attorneys' offices between FY 1994 and FY 1995.

4) Contains a phony prevention increase.

The Administration achieves most of its claimed \$1.1 billion increase in funding requested for FY 1995 by counting one-third (\$567.6 million) of its community policing request as part of the anti-drug budget; half of this (\$283.8 million) is counted as prevention spending.¹²

While most Americans know that law enforcement personnel help prevent crime, the budget portrayal is highly misleading. In all the fanfare about placing greater emphasis on prevention and treatment over enforcement, it turns out that the Administration actually achieved most of its claimed \$448 million increase in prevention—which most Americans assume means such things as drug education programs in schools—by counting in funds to pay the salaries of police on patrol. This means the shift in the supply/demand ratio touted by the Clinton Administration is principally the result of a budget trick and a \$305.5 million cut in drug interdiction funding between FY 1993 and FY 1995—not of real increases in drug prevention and treatment funding.

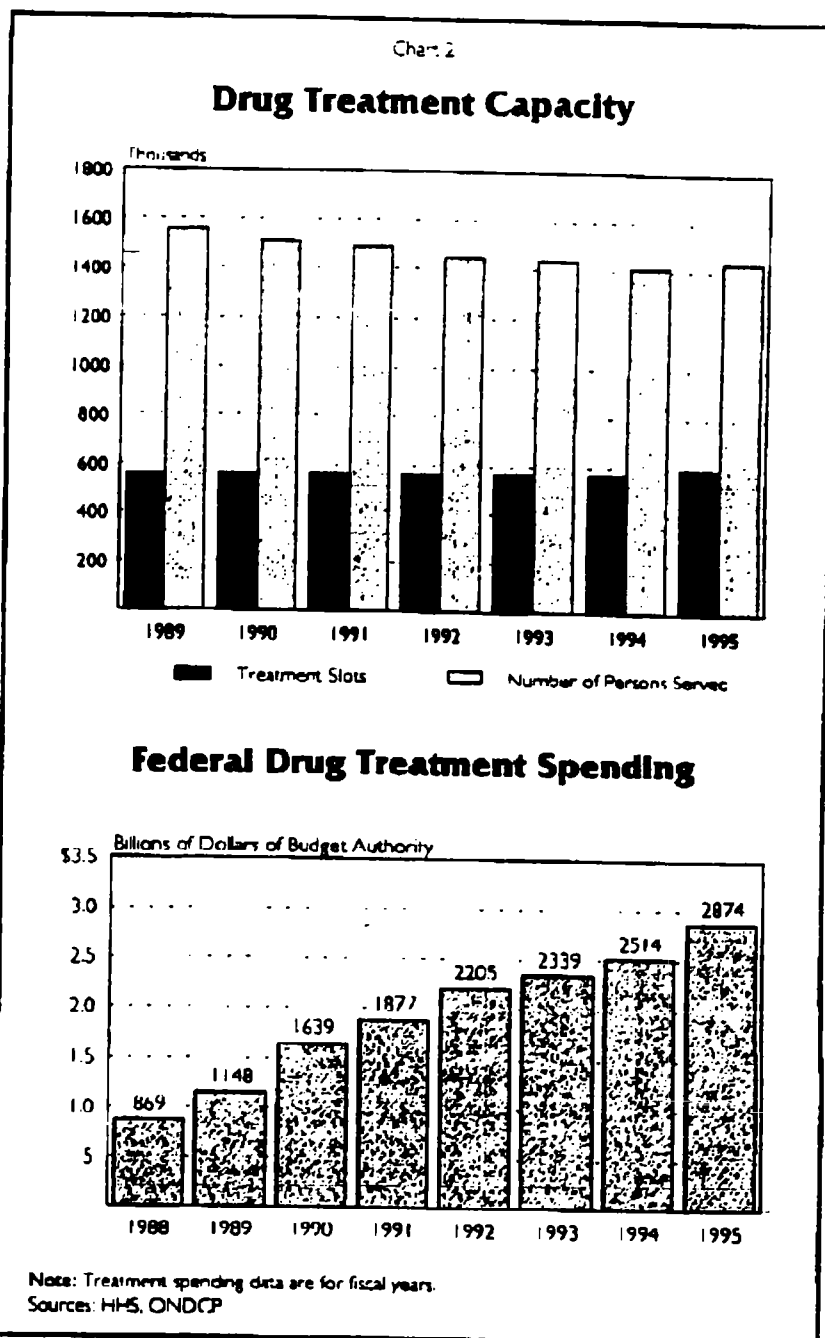
5) Encourages more waste in the drug treatment bureaucracy.

The principal requested increase in drug treatment funding intended to treat hard-core addicts (\$310 million of the claimed \$360 million increase over FY 1994) is to be awarded through a program of block grants to the states for alcohol, drug abuse, and mental health services. The Administration claims it will give real focus to the funds, but this has never happened before.¹³ The multi-purpose nature of the program

¹¹ These cuts overlap with the federal drug enforcement personnel reductions cited above and the prosecution staff reductions cited subsequently.

¹² It should be noted that the FY 1995 Clinton Administration budget includes only a total of \$1.720 billion for community policing funds, which is much below the amount contained in the pending 1993 crime bill (a five-year \$8.9 billion program). Although the President proclaimed his support for the bill—and the community policing provisions in particular—his FY 1995 budget request did not incorporate them.

means that three dollars must be spent on the program to achieve an additional one dollar in spending on drug treatment services, but even this ratio is unlikely.¹³ The state bureaucracies receiving the funds have resisted efforts by past administrations to "fence" funds, and many of them place a higher priority on alcohol and mental health treatment services than they do on treating hardcore addicts. There are other federal programs specifically designed to focus federal funds on drug treatment, but the Clinton budget chose one program proven not to do so effectively. Moreover, as Chart 2 indicates, the Clinton Administration's claim that it will increase treatment



- 13 A discussion of this problem is contained in the last Bush Administration Drug Strategy, which proposed (later enacted) the Drug Treatment Capacity Expansion Program (CEP) to earmark funds exclusively for drug treatment where addicts were concentrated most heavily. See ONDCP, *National Drug Control Strategy*, January 1992, pp. 57-61. Congress funded only \$15.3 million of the \$86 million requested for CEP in FY 1993, however. The Clinton Administration reduced funding to an estimated \$10 million in FY 1994 and requests only \$6.8 million for CEP in FY 1995.
- 14 This would reduce the estimated Clinton increase to \$103 million and put the total change in treatment funding from FY 1994 to FY 1995 below the rate of inflation—meaning a cut in actual treatment services.

slots for hardcore addicts is hard to believe in light of the budget and data tables provided at the end of its own drug strategy.¹⁵

Although federal drug treatment spending almost tripled between FY 1988 and FY 1994, the number of treatment slots remained virtually unchanged and the estimated number of persons treated actually declined—from 1,557,000 in 1989 to 1,412,000 in 1994. The Clinton Administration estimates only 1,444,000 would be treated in 1995.¹⁶

6) Erodes international anti-drug efforts.

The FY 1995 Clinton request for international anti-drug programs is \$428 million, or \$76 million above the amount enacted for FY 1994. However, according to the Administration's own budget, its FY 1995 request is \$96 million below FY 1993 funding and \$233 million below FY 1992. The claimed "new" attention to working with those nations that are the sources of illegal drugs consumed in the United States is neither new nor a real priority for the Clinton Administration. A partnership with the cocaine-source countries of Bolivia, Colombia, and Peru was launched by President Bush at his summit meeting with their presidents in Cartagena, Colombia, on February 15, 1990.

The results of this partnership have been mixed, and the policy question facing the Clinton Administration should have been whether those results can be improved and, if so, how. But the "new" Clinton approach says little about this issue. It merely raises the possibility of more drug crop eradication—the approach generally relied on in the 1980s with very disappointing results.

Other nations are unlikely to take seriously a "new initiative" that has neither the interest of senior foreign policy makers nor significant resources behind it. It seems the drug problem simply is not a part of the foreign policy agenda of the United States under President Clinton; no carrot and no stick face the countries that are the source of the poison that destroys too many American lives every day. This obvious fact, coupled with the first signs of an erosion of the progress against drug use made over the last decade, fuels calls in other countries for abandoning anti-drug cooperation with the United States.¹⁷

15 Treatment funding from *National Drug Control Strategy*, Budget Summary, p. 187. Estimated treatment capacity from *National Drug Control Strategy*, p. 103, Table B-8.

16 Some advocates assert that while the federal government has increased drug treatment spending, state and local governments have cut such spending, but there is no evidence to support this claim nationally. In fact, a study released by ONDCP last year, and undertaken by the U.S. Census Bureau, found that spending by state and local governments on all aspects of anti-drug programming increased between 1990 and 1991 (the two years measured), and treatment spending (under the category health and hospitals) increased 28.1 percent for state governments and 25.2 percent for local governments between 1990 and 1991. See ONDCP, *State and Local Spending on Drug Control Activities: Report from the National Survey of State & Local Governments*, October 1993, p. 5.

17 For example, see "Colombians Press for the Legalization of Cocaine," *The New York Times*, February 20, 1994, p. A6, and Gabriel Garcia Marquez, "The Useless War," *The New York Times*, February 27, 1994, Section 4, p. 15.

7) Destroys intelligence support for the drug war.

More and better intelligence on drug trafficking has been, and remains, the key to disrupting and dismantling the drug trade at home and abroad. Sophisticated intelligence is indispensable to identifying and attacking the most important parts of drug organizations and to bringing those at the top of the most powerful organizations to justice.

The Clinton Administration, however, is now dismantling key parts of this intelligence support. Its cut of \$600,000 in intelligence funding for FY 1995 (as compared to FY 1994) is just a small fraction of the actual reduction sought in classified and unclassified programs, according to informed sources. Law enforcement, interdiction, money laundering investigations, anti-corruption efforts, and drug-related terrorism prevention all depend on first-rate intelligence. If America is to do more with less in tight budget times, intelligence-gathering becomes even more important. No proposal by President Clinton will do more to weaken America's ability to combat the drug trade than his reduction in intelligence support.

CHANGES IN THE DRUG PROBLEM

America has done a remarkable job. The illegal drug problem the country faces today began as part of the radical political and moral criticism of American culture and the related youthful rebelliousness of the late 1960s and the 1970s. These forces were very different from those that drove the national drug use problem in early 20th century America, when medical and pseudo-medical opinion held that cocaine and other narcotics were harmless health and performance enhancers. The result: these drugs were widely dispensed in elixirs, tonics, prescriptions, and even soft drinks.¹⁸ That crisis was reversed by enforcement and a cultural change in popular attitudes about drugs.

While America's "first" drug crisis (as it is sometimes called) ironically grew out of what might be termed today as a desire for fitness or wellness, America's second drug crisis was driven largely by political forces. Faculty members at elite colleges and universities gave intellectual respectability to drug use at a time when those institutions also were centers of political activity. Themes of revolution, liberation, and drugs were intertwined in popular music, in other parts of the entertainment industry, and in the press. Drug use was "anti-establishment." It was described as liberating and at times even presented as a path to "higher consciousness"—a part of political, moral, and spiritual superiority.

Alarm over the high percentage of U.S. troops returning from the Vietnam War as regular heroin and marijuana users triggered the first phase of the current war on drugs. The Nixon Administration responded quickly with screening and treatment programs for returning military personnel. But to the surprise and relief of many, when most heroin- and opium-using GIs returned home, where drugs then were neither as widely available nor as acceptable as in Vietnam, they ceased using drugs.¹⁹

18 See David F. Musto, *The American Disease* (New York: Oxford University Press, 1987).

THE ROOTS OF TODAY'S DRUG WAR

Although a large majority of Americans have always disapproved of drug use, a substantial—and culturally influential—minority stimulated a drift toward the *de facto* legalization of drug consumption during the 1970s. Penalties and enforcement were reduced, use became fashionable, and drug use among the young became more common. When national measurement began in 1975, a majority of high school seniors reported trying an illegal drug at least once prior to graduation. For the next 15 years, the typical high school senior experimented with illegal drugs. The legalization movement perhaps reached its apex in March 1977 when the Special Assistant to the President for Health Issues, Dr. Peter Bourne, testified before the House Select Committee on Narcotics Abuse and Control in favor of the decriminalization of marijuana. Dr. Bourne was joined by officials from the Justice Department, the State Department, the Department of Health, Education, and Welfare, and the U.S. Customs Service. At the time, Bourne and others also considered cocaine a prime candidate for decriminalization.²⁰

Shortly thereafter, Bourne resigned following charges he had used cocaine and improperly written a prescription for a controlled substance. Moreover, the Carter Administration suddenly faced growing popular concern that it was leading the country in a dangerous direction on the drug issue. Parents' groups formed to combat drug use by young people and to challenge political efforts at decriminalization. Bourne had brought the matter to a decisive point; and after his departure from the Carter White House, decriminalization effectively was dead as a serious initiative at the federal level. Still, drug use remained at or very near historically high rates, with cocaine use rates rising into the next Administration. In 1974, one of the first national surveys found an estimated five million Americans had used cocaine at least once. By 1982, that number had more than quadrupled to 22 million.²¹

Two sets of events triggered a reverse in the growing acceptance of cocaine. The first was the shocking violence that Colombian cocaine traffickers—"cocaine cowboys"—brought to Florida. Machine-gun shootouts at shopping centers made national news, along with ruthless killings without regard for the lives of innocent bystanders. The cocaine trade created a new type of wealthy and violent criminal gang; and as the use of cocaine spread, it seemed to bring with it levels of violence never before seen in American cities.

Second, cocaine use took an ominous turn with the development of crack cocaine in the early 1980s. Crack was described as the purest, most intense "high" ever available and perhaps the most powerful addictive drug ever encountered. Quite simply, it was too good. Reports of "almost instant addiction" and of crack and cocaine use by adolescents began appearing in the national media. Then, in 1986, Len Bias, on his way to a profes-

19 *Ibid.*, pp. 258-259. Also see James Q. Wilson, "Against the Legalization of Drugs," *Commentary*, February 1990, p. 22.

20 Musto, *The America Disease*, p. 265.

21 Dana Eser Hunt and William Rhodes, "Characteristics of Heavy Cocaine Users, Including Poly Drug Use, Criminal Activity, and Health Risks," Abt Associates Inc. for ONDCP, Spring 1993, released by ONDCP August 9, 1993, as "Characteristics of Heavy Cocaine Users: A Research Paper," p. 1.

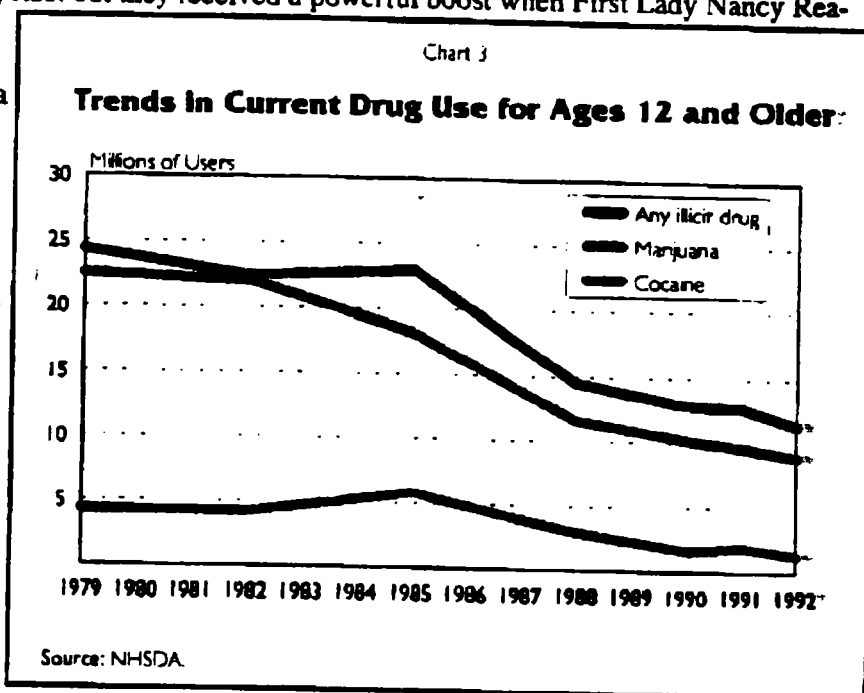
sional basketball career, and professional football player Don Rogers died within days of each other, both from cocaine use. The death of these young men, in outstanding physical condition, shocked America. Young adult users who thought of drugs (cocaine in particular) as exciting and fun started to feel differently. The media now began to describe a crisis: an unprecedented, wealthy, powerful, ruthless, foreign criminal cartel was marketing a deadly addictive substance on a massive scale, with even grade-school children becoming victims. Illegal drug use was portrayed as an enemy within—a cancer threatening all segments of society, particularly the young.

Although a few critics still advocated legalizing drug use, they were relegated to the fringe, and no national political figure even flirted with such a stance—at least not while in office. Instead, there were demands for more criminal sanctions and government spending to combat drugs. In 1988, these demands for a national mobilization culminated in legislation creating a "Drug Czar" who would report directly to the President with the sole job of waging the nation's drug war.²² The Drug Czar was to take charge and turn the tide. The first person appointed to that post was William J. Bennett, in 1989.

THE REAGAN-BUSH COUNTERATTACK: FIGHTING ILLEGAL DRUG USE

Parents' groups already had mobilized to fight illegal drug use by young people at the end of the Carter years; but they received a powerful boost when First Lady Nancy Reagan made their cause her own. Many in the media ridiculed the effort, but it began to build strength as evidence of the danger mounted and prevention activities, endorsed by the President and his wife, began to have an effect. And not only the young got the message.²³

Drug use began to decline during

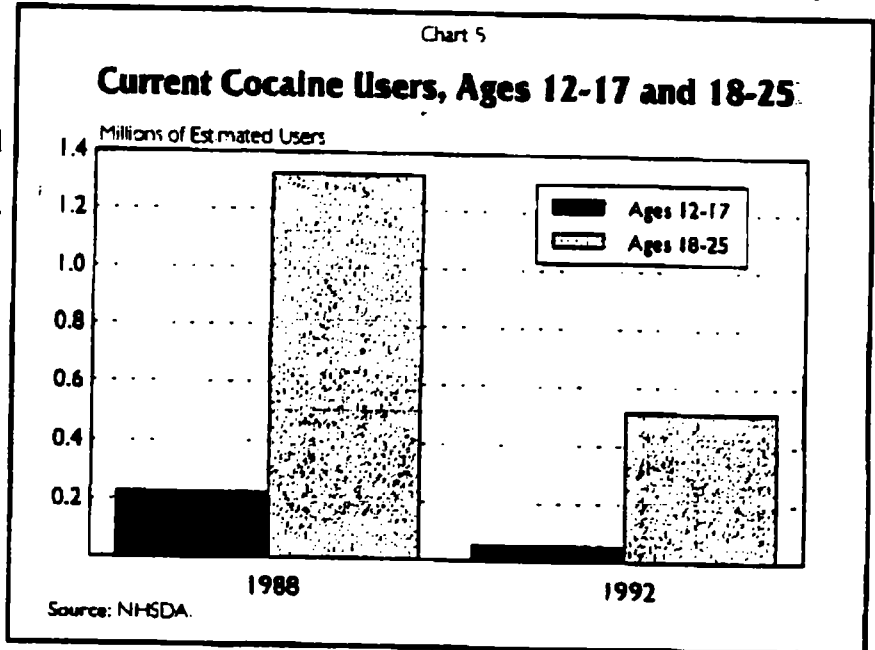
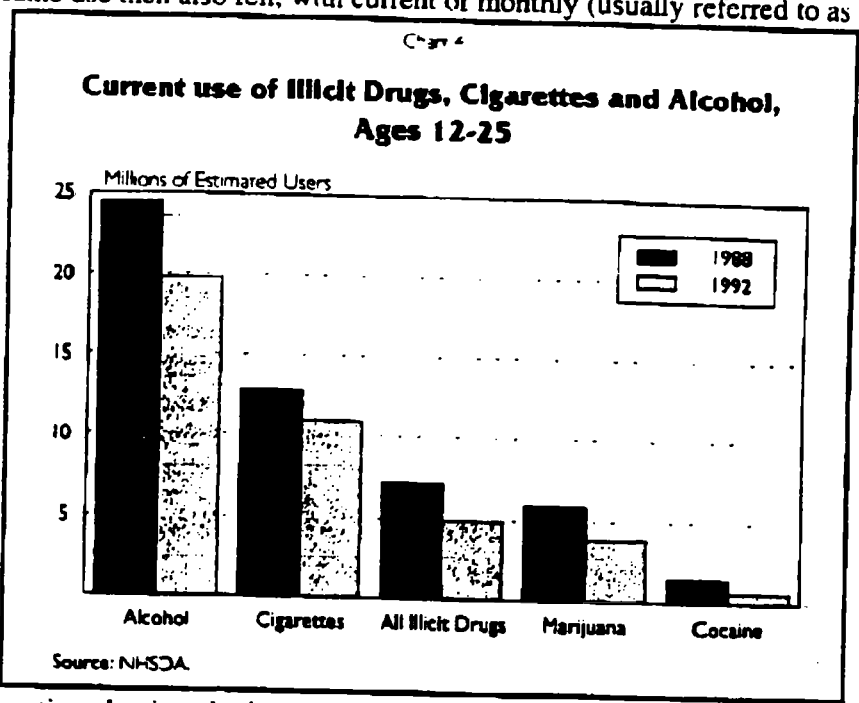


²² The official name of the position was Director of the Office of National Drug Control Policy.

²³ Unless otherwise noted, all the following charts and data on drug use are from the Office of Applied Studies, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, "Preliminary Estimates From the 1992 National Household Survey on Drug Abuse (NHSDA)," Advance Report Number 3, June 1993.

the mid-1980s and by 1992, overall illegal drug use was less than half the peak level in 1979. The decline in cocaine use lagged behind the general trend, fueled by the availability of crack, but cocaine use then also fell, with current or monthly (usually referred to as "casual" or "non-addicted") use dropping almost 80 percent between 1985 and 1992. This was important because casual use is the most common way drug use spreads—from friend to friend. While not every casual user goes on to become an addict, virtually every addict starts as a casual user.

Even more important were the dramatic reductions in drug use by young people during the 1980s and early 1990s. Annual use of any illicit drug by high school seniors dropped from 54.2 percent in 1979 to 27.1 percent in 1992, and cocaine use fell from an annual rate of 13.1 percent at its peak in 1985 to 3.1 percent in 1992.²⁴ This means not only fewer young people exposed to the dangers of drugs, but also fewer adults using drugs in the future. As a detailed study of responses to the National Household Survey on Drug Abuse



24 Press release, "Monitoring the Future Study," January 31, 1994, Table 3.

found: "Regardless of the time (be it the 1970s, 1980s, or 1990s), respondents who have not tried a drug by the time they reach their mid-twenties are unlikely to ever do so."²⁵

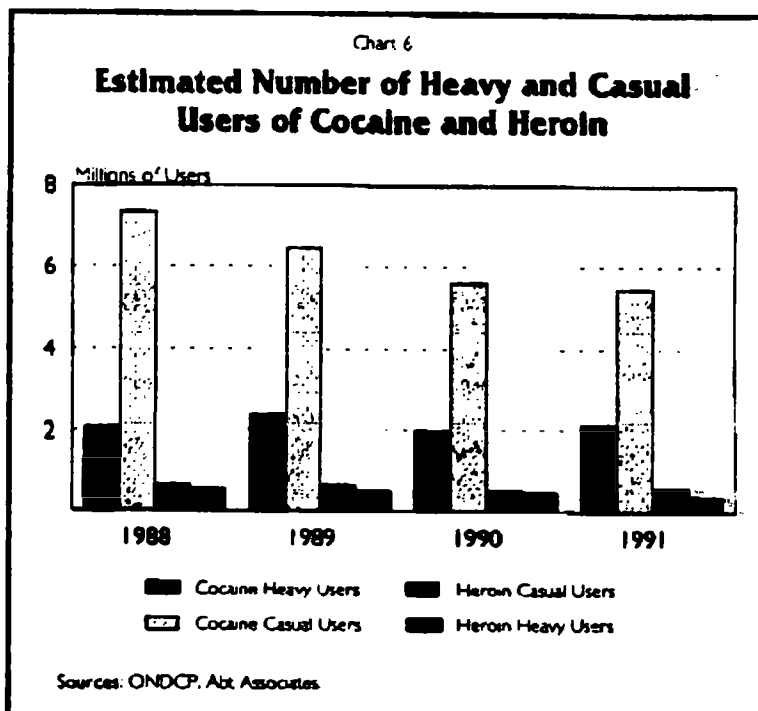
The data in Chart 4, taken from the NHSDA Survey, are instructive for three reasons. First, they show the extent of illegal drug use and its decline between 1988 and 1992 for the age group 12-25. Second, they make clear that the decline in drug use was comprehensive and did not involve merely a shift from one drug to another, or from illegal drugs to cigarettes and alcohol (as sometimes is assumed). Finally, the data show that illegal drug use fell at a greater proportionate rate than did cigarette and alcohol use—this despite the extensive education campaigns against tobacco and alcohol use by the young. Although it is often difficult to dissect cause and effect in human behavior with scientific precision, it seems clear that the categorical legal prohibitions against drugs—actively enforced—played an important part in keeping drug use smaller and making it decline more rapidly. Significantly, where the greatest concern—cocaine use by young people—was brought to bear, the greatest results were produced.

SAVING THE ADDICTED: IS TREATMENT THE ANSWER?

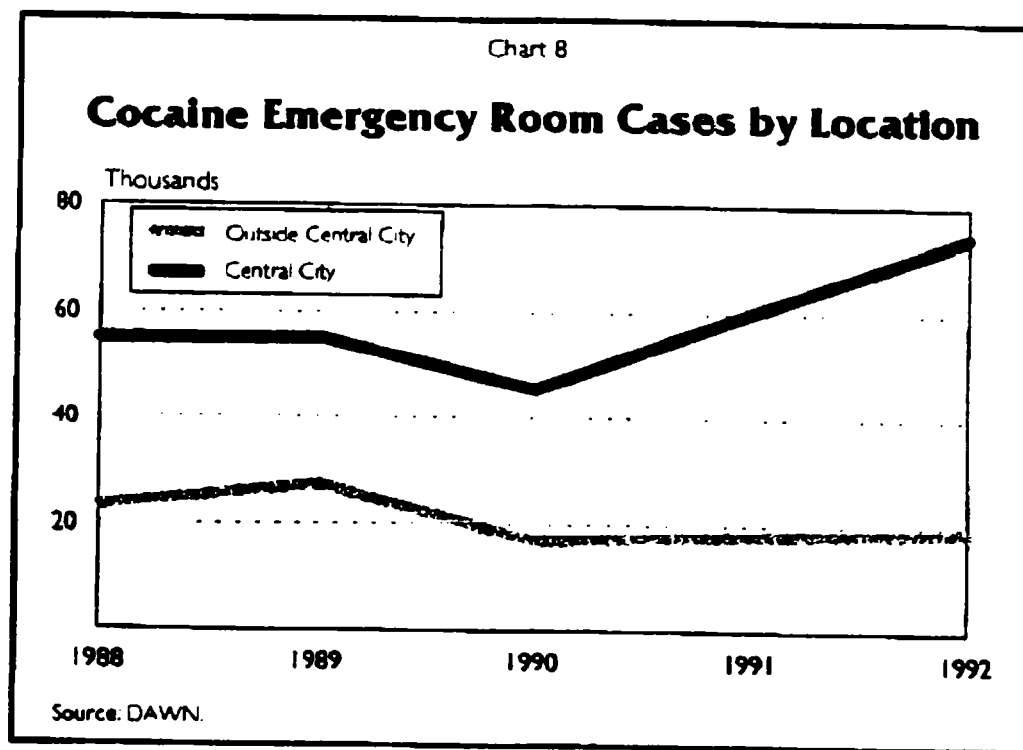
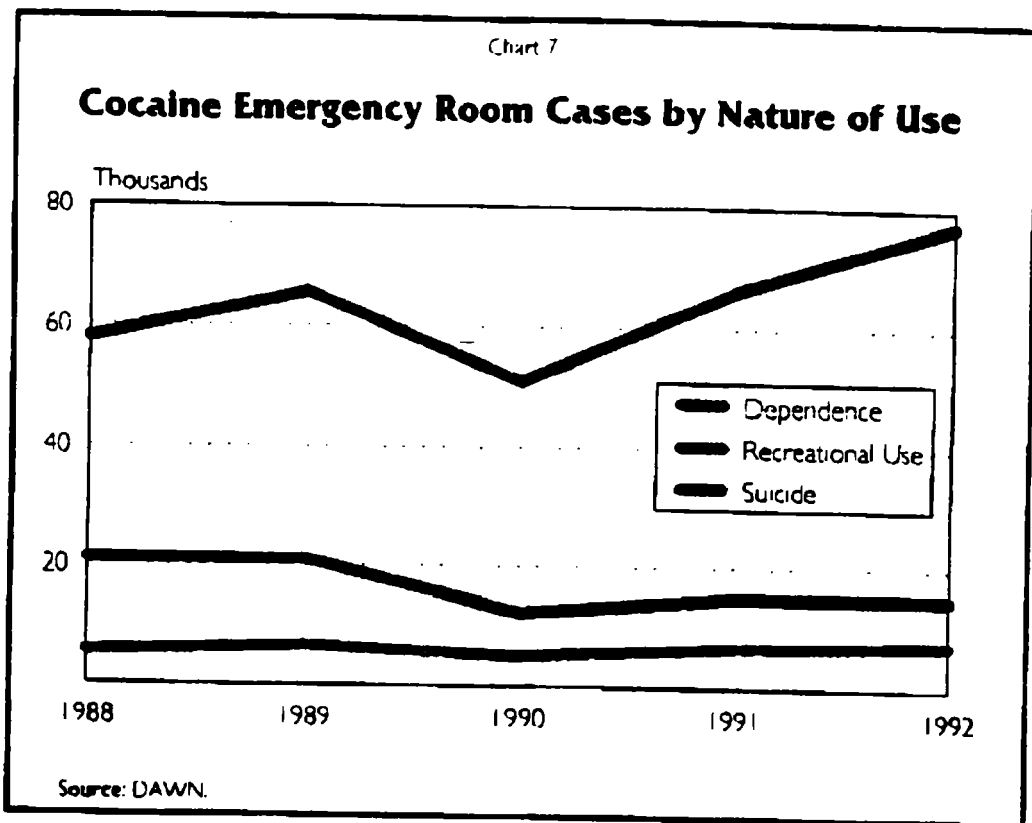
The most obvious casualties of the fad of drug use in the 1960s, 1970s, and 1980s are today's drug addicts.

Chart 6 reveals that the drop in casual cocaine use between 1988 and 1991 was rapid (and thus the source of potential new addicts) even though the heavily-addicted cocaine and heroin user populations remained roughly the same size.²⁶

During this period, drug use became confined increasingly to addicts who have been on drugs for years, with fewer additions to the addict group as a result of the decline in casual use. The demographics of the cocaine-



- ²⁵ Christine Smith and William Rhodes, "Drug Use by Age Cohorts Over Time," Abt Associates, Inc., unpublished, quoted draft, August 11, 1992, p. 3. This is one of several contracted studies done for ONDCP. Some, like this one, have not been released by ONDCP, but the office now wants them to be available to interested individuals.
- ²⁶ William Rhodes, Paul Scheiman, and Kenneth Carlson, "What America's Users Spend on Illegal Drugs, 1988-1991," Abt Associates, Inc., February 23, 1993, released by ONDCP, August 23, 1993, p. 10, Table 1. This study contains the most recent analysis of the size of the drug using population and of the volume and cost of the drugs they consume.



addicted population are difficult to specify precisely, but one useful indicator is the network of hospital emergency rooms that report emergency cases involving drugs. The Drug Abuse Warning Network (DAWN) is managed by the U.S. Department of Health and Human Services. Data from hospitals

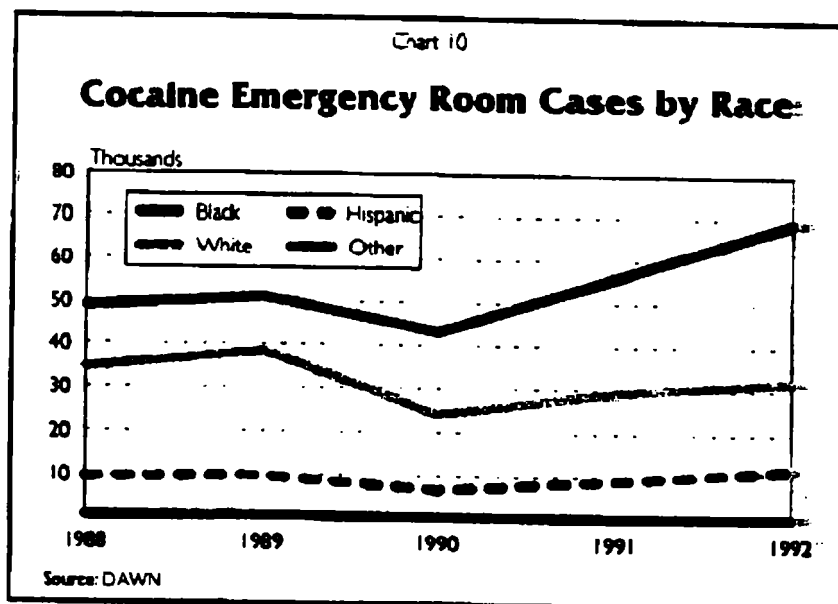
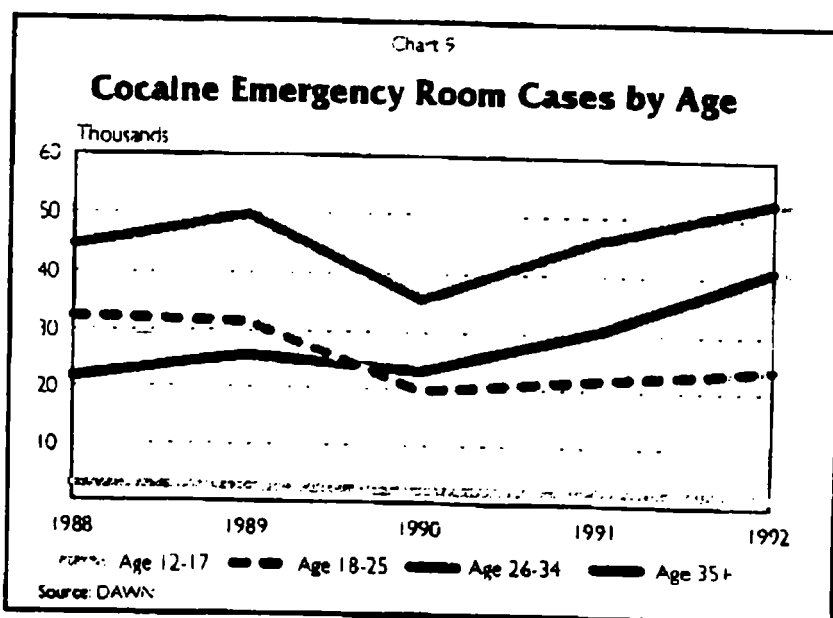
throughout the nation are compiled on a quarterly basis and annual summaries are made, presenting a statistically representative picture of emergency room cases for the nation as a whole.

DAWN reports reveal that increasing numbers of emergency room cocaine cases are related to addictive use rather than to recreational use.²⁷

These cases are focused increasingly in the nation's central cities (see Chart 8).

The population entering emergency rooms for cocaine-related problems is aging (see Chart 9).

Moreover, the DAWN data reveal that cocaine-related emergency room cases are becoming more and more concentrated among black Americans (see Chart 10).



²⁷ The data cited below are from Office of Applied Studies, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, "Estimates From the Drug Abuse Warning Network: 1992 Estimates of Drug-Related Emergency Room Episodes," Advance Report Number 4, September 1993, p. 45.

Similar demographic trends are reflected in the data on heroin emergency room cases.²⁸

Heavy cocaine users also tend to use a variety of other drugs (such as marijuana, heroin, and sedatives) and alcohol.²⁹ Heavy cocaine and heroin users are predominantly male and unmarried (most have never married), and most commit crimes and are frequently involved in the criminal justice system. They commit crimes, including selling drugs, to get money to purchase drugs; but heavy cocaine users, in particular, also commit crimes as a result of "the effects of the drug itself (they become disinhibited and commit crimes), or because of a life-style choice (they participate in both drug use and criminal activity)."³⁰

This heavy user group is the population the Clinton Administration proposes to reduce by a 14 percent increase in federal drug treatment spending and a diminished emphasis on reducing the supply of drugs to which they are addicted. As noted earlier, however, while federal spending on drug treatment increased threefold between FY 1988 and FY 1994, estimated treatment capacity declined; and that capacity, measured in terms of persons served per year, is equivalent to more than half the total estimated number of cocaine and heroin addicts. Since the number of people being treated has changed little, it is reasonable to ask: Why hasn't the system reduced the number of addicts, and how will the Clinton strategy do so?

Most addicts have been through treatment more than once. The harsh fact is that drug addicts like using drugs (even though most of them also dislike some aspects and consequences of their drug use). They sometimes admit themselves to treatment programs, not to stop using drugs, but to regain greater control over their drug use; but the overwhelming majority of addicts entering treatment with the goal of ending their drug use are coerced to do so by the courts, family members, or employers. That is why the liberals who discuss treatment as if it were the opposite of enforcement show a profound ignorance of the reality of drug treatment.³¹

It is also important to understand that some treatment programs simply are not effective, yet are able to remain in business. Sometimes addicts and programs are not matched properly.³² When the cocaine epidemic started, for instance, there were many unused her-

²⁸ *Ibid.*, pp. 46-47.

²⁹ Hunt and Rhodes, "Characteristics of Heavy Cocaine Users," p. 7.

³⁰ *Ibid.*, p. 10.

³¹ The criminal justice system is probably the single greatest cause of addicts entering treatment today. "Drug courts" and so-called diversion programs give less violent addicts a choice of entering and completing treatment or going to jail for an extended period. Former Washington, D.C., mayor Marion Barry may be the best-known example of this practice.

³² In remarks before "The 1993 National Summit on U.S. Drug Policy," May 7, 1993, Dr. Mitchell S. Rosenthal, president of Phoenix House and one of the nation's foremost drug treatment authorities, noted that what he called "disordered drug abusers" (others might call them "hardcore addicts") require long-term, drug-free, residential treatment. This means 18 to 24 months of treatment within a therapeutic community. There are only an estimated 11,000 such slots nationwide, and they cost an estimated \$17,000 to \$22,000 per year. President Clinton's drug strategy completely ignores this problem and points to the proposed "Health Security Act" as the ultimate solution to the nation's treatment needs (*National Drug Control Strategy*, p. 25). That plan explicitly excludes coverage for such long-term treatment, however, and what coverage it would provide is promised for the year 2001!

oin treatment slots but not enough slots for those needing treatment tailored for cocaine addiction. It is vital that the government insist that programs receiving federal funds demonstrate they are effective and increase service capacity in target areas. But the federal government is a very blunt and rather slow instrument with which to accomplish this. The federally funded portion of the treatment system is estimated to be less than half the total national spending on drug treatment, and federal measures for accountability and targeting must attempt to reach through multiple layers of bureaucracy in the federal government and in state and local governments.

The Administration's goal of increasing the success rate of treatment also is likely to prove too optimistic because a growing proportion of the addict population is older, with a long history of addiction from early adulthood. Many of these so-called "hardcore" addicts are addicted to a variety of drugs and suffer from a range of pathologies, including severe mental disorders. The best treatment programs can offer some hope of recovery; but for a substantial percentage of the most severely addicted, there may be no effective treatment today.

A recent study of heroin addicts highlights this problem in stark terms. Five hundred eighty-one narcotics addicts (most of them heroin addicts) were studied at intervals over 24 years. The group originally entered treatment through a criminal justice program, the California Civil Addict Program, between 1962 and 1964. The 1985-1986 follow-up study found only 25 percent of the group tested free of opiates; another 6.9 percent were in a program of methadone maintenance (receiving the drug methadone to block the "high" resulting from heroin use and thus remove the strongest reason for such use); and 27.7 percent (now in their late 40s) had died—and the mortality rate was accelerating. The researchers warn: "The results suggest that the eventual cessation of narcotics use is a very slow process, unlikely to occur for some addicts, especially if they have not ceased use by their late 30s."³³

In August of last year, the Clinton Administration's Drug Policy Director, Lee Brown, released a research paper, "Characteristics of Heavy Cocaine Users," which contains a similar, sobering conclusion regarding the success rates of treatment programs for cocaine addicts:

... while many users benefit from treatment, compulsive use is most frequently a chronic condition. The Treatment Outcome Prospectives Study (TOPS) showed that for every 10 clients who used cocaine regularly during the year prior to treatment, six clients had returned to heavy use one year after treatment, and eight clients had relapsed into heavy use within three to five years after treatment. These statistics do not accurately reflect the success of treatment outcomes. (The TOPS study is the most recent large-scale study of treatment outcomes. Many smaller scale treatment studies show results with better long-term outcomes.) Nevertheless, the TOPS data suggest that *treated cocaine users are more likely than not to return to drug use.*³⁴

33 Yih-ing Hser, M. Douglas Anglin, and Keiko Powers, "A 24-Year Follow-up of California Narcotics Addicts," *The Archives of General Psychiatry*, Vol. 50 (July 1993), pp. 577-584. Quotation from p. 577.

34 Hunt and Rhodes, "Characteristics of Heavy Cocaine Users." Emphasis added.

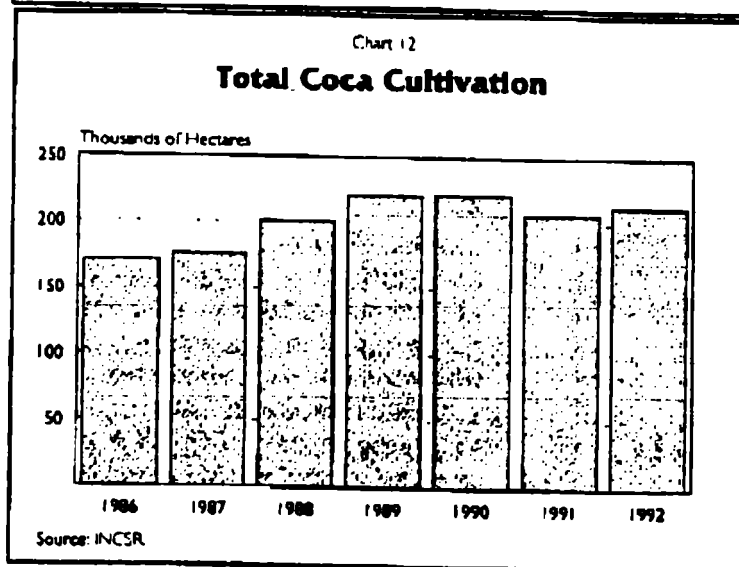
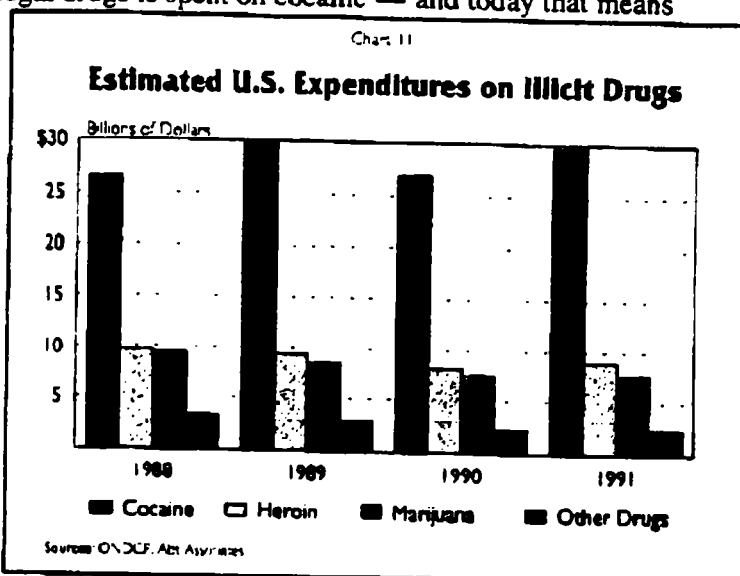
Those who assert today that "treatment is the answer," and those who advocate legalizing drugs and retrieving those who become addicted by expanding drug treatment, never confront the fact that a significant portion of those currently addicted to cocaine and heroin will die of that addiction and that treatment alone cannot save them.

THE SUCCESS OF INTERDICTION

What is increasingly an addict-driven trade today is dominated by cocaine. Three-fifths of the total spent on illegal drugs is spent on cocaine — and today that means crack. The irony is that actual reductions in the population of heavy cocaine users seem to have come not from treatment programs, but from efforts to reduce supply—efforts which President Clinton is now dismantling.

Working from 1989 to 1992 with cocaine source countries (Bolivia, Colombia, and Peru) to reduce coca³⁵ crops did stop the increase in cultivation that occurred during the 1980s but did not substantially reduce the total crop size.³⁶

Eradication of plants under cultivation had been a principal emphasis of U.S. anti-drug policy in the 1980s, but it produced very poor results. It continued, where feasible, during the Bush Administration, even as interdiction and attacks on traffickers' organizations and infrastructure were made the highest priority. Since 1987, eradication ef-



³⁵ Coca is a bush whose leaves are processed to extract cocaine.

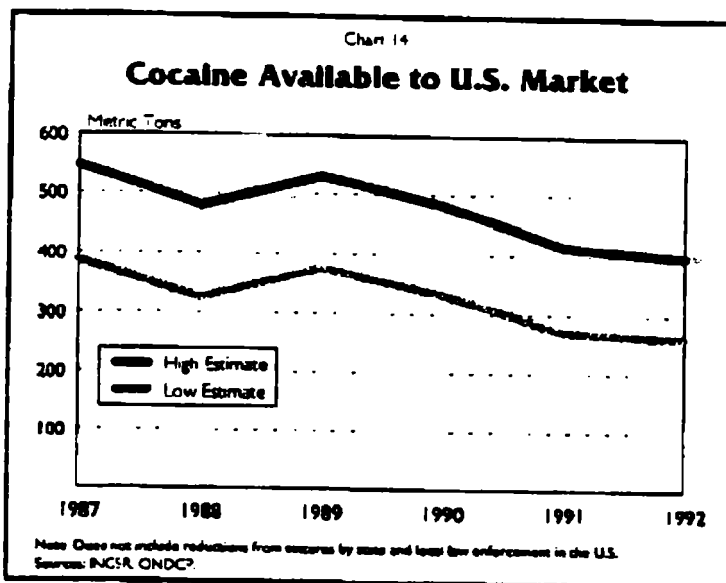
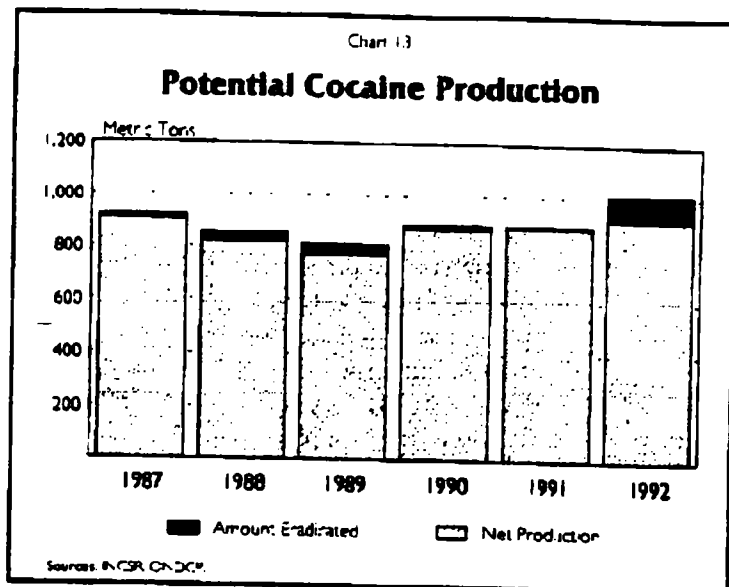
³⁶ U.S. Department of State, *International Narcotics Control Strategy Report (INCSR)*, April 1993, pp. 15 and 16. This chart and the next four charts are based on the INCSR data and on unpublished analyses by the staff of ONDCP's Office of Research undertaken during the Bush Administration.

forts in cocaine source countries have produced a less than 10 percent reduction in estimated potential cocaine production; this reduction came close to 10 percent only in 1992.

While crop eradication has not generally been a success, however, interdiction of cocaine within the source countries and in transit to the U.S. has substantially reduced the potential supply of cocaine that could arrive on American streets.

Thanks to seizures, the amount of the crop that reached the United States declined sharply between 1989 and 1992. In 1992, half or more of potential cocaine production was seized. The biggest area of increased seizures has been in South America, including the Colombian government's war against the drug cartels. Assistance from the United States, particularly military detection and tracking help, supported interdiction throughout the hemisphere and even contributed to forced losses in the face of imminent apprehension by authorities. Interdiction stopped almost twice as much cocaine as was actually consumed. Moreover, efforts to reduce the supply of cocaine seem to have contributed to a reduction in emergency room cases and in the addict population.

Reductions in the supply of cocaine could be expected to lead to an increase in street prices, a decline in purity, or both, or to scarcity if the disruption is large and sudden enough. During the disruption of South American supplies in 1989 and 1991, there were periodic reports by law enforcement agencies that cocaine trafficking groups they had under investigation were experiencing problems securing cocaine or securing it in a timely manner, even at a higher price. These reports could not be rendered as precise empirical data, but the Drug Enforcement Administration does compile data on cocaine prices throughout the nation and reports them on a quarterly and yearly basis. These data reveal that the

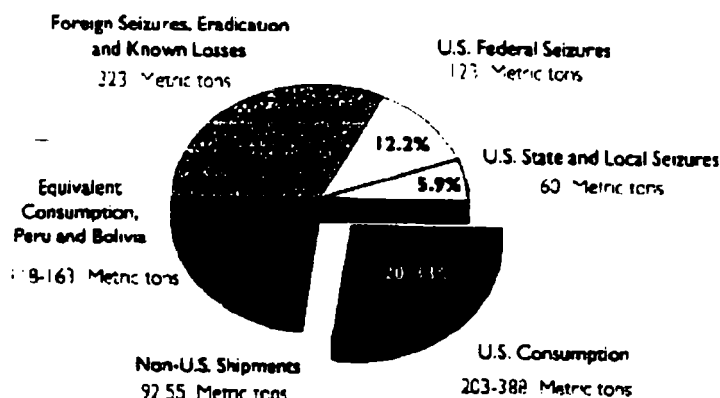


downward trend in prices and upward trend in purity through early 1989 were abruptly reversed.³⁷

The magnitude of this change in availability is perhaps best represented by using a standardized price; that is, a price that reflects both price and purity changes by calculating the cost of a 100 percent-pure gram of cocaine at each point of measurement.³⁸ This reduction in the availability of cocaine—driving the price up and the purity down—coincided with a 27 percent reduction in cocaine emergency room mentions between 1989 and 1990.³⁹

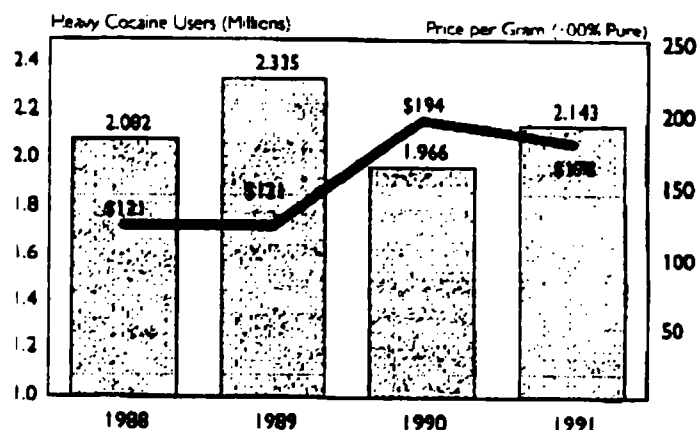
Medical examiner reports of deaths related to cocaine use during this period also declined. Analysis initiated by the Drug Czar's office found cocaine price increases, reductions in purity, and declines in cocaine emergency room cases, deaths, and cocaine use among arrestees for all the more than 20 largest U.S. cities for which data are available.⁴⁰

Chart 15
Estimated Distribution of Cocaine Supply: 1992



Note: Chart uses midpoints where estimates employ a range.
Sources: NCSA, EPIC, ONDCP

Chart 16
Standardized Retail Cocaine Price and Estimated Number of Heavy Cocaine Users



Sources: ONDCP, Abt Associates

37 Unpublished results of an ONDCP-funded analysis of data from DEA's System to Retrieve Information from Drug Evidence (STRIDE), conducted by Abt Associates, Inc., and presented in an ONDCP briefing, "Domestic Cocaine Situation," January 27, 1993.

38 *Ibid.*

39 Office of Applied Studies, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, "Estimates From the Drug Abuse Warning Network: 1992 Estimates of Drug-Related Emergency Room Episodes," Advance Report Number 4, September 1993, p. 45.

Significantly, as Chart 16 shows, this supply reduction and price change coincides with the decline in the number of heavy cocaine users mentioned earlier.

Several points must be emphasized in interpreting these data. Among them:

Any analysis is limited by the available data. Despite the limitations of the data, the reduction in cocaine availability seems beyond question, and that it was a key causal factor of the decline in cocaine use, particularly heavy use, is the most obvious and reasonable conclusion in light of the data. But this cannot be "proven" with the same degree of certainty that would be the case if the available data were more extensive.

It should be remembered that cocaine price and purity are affected by both supply and demand. The National Household Survey on Drug Abuse indicates that casual or non-addictive use of cocaine was dropping dramatically immediately prior to and during the period of stepped-up interdiction. While non-addictive users consume a much smaller quantity of cocaine than heavy or addicted users, an almost 80 percent drop in non-addictive users between 1985 and 1992 certainly reduced demand in a significant, if limited, extent (which cannot be measured with precision by existing surveys and analyses). In order to increase cocaine retail prices and reduce purity, supply reduction efforts would have to cut supply beyond the amount that would have satisfied the reduced demand.⁴¹

Do most prominent cocaine traffickers have sufficient market control to manipulate prices by controlling supply? If they do, price and purity reports cannot be used to indicate market disruption directly and may be of no use at all for this purpose. There is no definitive knowledge of the extent of traffickers' ability to manipulate the cocaine market, but the available evidence suggests they are not able to manipulate prices. In smaller transactions and at the wholesale level in particular areas, law enforcement investigators have reported efforts by particular groups to influence prices by withholding supply, but these have been limited in both scope and duration. Moreover, there is no evidence either of large-scale efforts to manipulate availability or of the ability to do so.

The cost of the entire international drug control effort for programs and assistance to foreign countries rose from \$209 million in fiscal year 1988 to \$660 million in 1992 (its peak). It rose from 4.4 percent to 5.6 percent of the federal drug control budget. Interdiction costs increased between 1988 and 1992, but almost that entire increase involved the estimated cost of Department of Defense (DOD) activities in support of the anti-drug ef-

40 ONDCP, "Price and Purity of Cocaine: The Relationship to Emergency Room Visits and Deaths, and to Drug Use Among Arrestees," October 1992.

41 The decline in heavy cocaine use in the face of increased price indicates an important difference between casual and addictive use. As long as cocaine is easily obtainable, it seems that casual users not deterred by prevention efforts are unlikely to be deterred by even moderate increases in street prices. This is probably because they are paying so little of their disposable income for the drug that price increases do not affect their ability to obtain it. Many heavy users, on the other hand, are using most of their disposable income to purchase cocaine (especially crack). When the price goes up, they generally have to make due with less. This leads some of them to enter detox and treatment and apparently reduces the rate at which those who continue using suffer the health problems that cause them to appear at emergency rooms.

fort. Even with this increase, interdiction costs as a percentage of the federal drug control budget actually declined between FY 1989 and FY 1992.

Measured strictly by results, national prevention efforts produced outstanding results, especially dramatic declines in casual cocaine use; and contrary to conventional opinion, interdiction and cocaine source country programs seem to have been the crucial cause of the only reductions in heavy or addictive cocaine use.

Why did the reduction in cocaine supply not continue throughout 1991 and beyond? One reason is that beginning in the summer of 1991, the movement of U.S. military resources to the Persian Gulf for Desert Shield and Desert Storm reduced interdiction coverage. Those resources were never returned to previous levels; and although there were plans within the Drug Czar's office to make this a major policy issue for presidential decision in connection with the FY 1994 strategy, the Bush Administration ended before that strategy could be crafted.

A second reason is that pressure on the Colombian traffickers declined. In part this was because a significant portion of police and military forces had to be diverted to providing security for a national election and a constitutional referendum. Later, in 1991, after the surrender of several major traffickers, security forces focused on a manhunt for Pablo Escobar (before his first surrender and after his escape). This is not to say that all pressure on the cocaine trade in Colombia ended in 1991. It did not.

Today, all source country governments are reducing their activities against the cocaine trade, and there is no visible effort by the Clinton Administration to prevent the utter disintegration of the most effective international anti-drug partnership of the last decade. If President Clinton lets that partnership collapse, Americans face the prospect of foreign countries permitting the unchallenged production and shipment of illegal drugs to the United States and elsewhere: In short, uncontrolled supplies of illegal drugs.

WHAT IT WILL TAKE TO FIGHT A REAL DRUG WAR TODAY

President Clinton's effective abandonment of the drug war creates a formidable obstacle to building on what has been achieved in the anti-drug effort and to dealing with the remaining problem. Unfortunately, there seems very little likelihood that the federal government will offer the leadership and support that existed in the last two administrations.

If the federal government were serious about finishing the drug war, it would undertake several measures. Among them:

✓ Reassert presidential leadership.

Applying direct presidential leadership is crucial for the renewal of prevention efforts, especially to discourage drug use among young Americans.

✓ **Focus anti-drug spending at the state and local level.**

Congress should combine existing federal anti-drug support to states and localities, which will total over \$3.5 billion for FY 1994,⁴² into a single anti-drug block grant that communities can use for their own anti-drug priorities, from prevention programs to prison construction, from treatment programs to security enhancements in schools and public housing.⁴³

✓ **Use the military.**

To step up interdiction efforts, the federal government must replace the forces that were diverted during the Gulf War. This means putting the U.S. military back in charge of stopping the flow of illegal drugs from abroad and requiring federal law enforcement agencies responsible for drug interdiction to operate under the overall command and control of the military.

✓ **Get tough with drug-exporting countries.**

The United States must insist that cocaine-source countries reduce their net production of drugs by at least 10 percent per year, and by at least 50 percent in five years, or face a loss of aid and the imposition of trade and diplomatic sanctions.

✓ **Combat criminal networks.**

The Attorney General should prepare a report within six months identifying all major drug trafficking organizations known to be operating in the United States. The Justice Department also should develop a plan to deploy federal enforcement personnel to dismantle these organizations within 18 months,⁴⁴ and such strategic planning should be required on a regular basis thereafter.

✓ **Target drug dealers.**

The Administration should launch a nationwide advertising campaign highlighting the existing federal mandatory minimum sentences for such offenses as selling drugs within 1,000 feet of a school, involving a minor in drug selling, possession of drugs with intent to distribute, possession of a firearm while involved in drug sales, and committing acts of violence in connection with drug trafficking. These laws are a powerful deterrent, and the wider the knowledge of them, the more powerful their deterrent effect.

42 Approximately \$599 million in the Department of Education, over \$1.8 billion in the Department of Health and Human Services, and over \$1.1 billion in enforcement and demand-reduction program funding in a variety of other programs.

43 The new program could avoid feeding government bureaucracies by forbidding the use of any funds for administrative purposes and requiring that at least half of all non-law-enforcement expenditures be spent on activities operated by private sector organizations, fully open to religiously affiliated groups (many of which have outstanding programs for young people and the rehabilitation of addicts).

44 Attorney General Richard Thornburgh prepared such a report (*Drug Trafficking: A Report to the President of the United States*, August 3, 1989), but it was not turned into a battle plan for federal drug enforcement.

Of course, it is probably unrealistic to expect President Clinton or the current Attorney General to support any of these initiatives, but it is also irresponsible to take the position that nothing can be done as long as the Clinton Administration turns its back on the drug problem. Citizens and local governments throughout the nation can take decisive steps to reduce today's drug problem dramatically.

✓ **Renew efforts to prevent drug use by young people.**

Drug prevention must be the cornerstone of all anti-drug efforts. With the decline in use by teenagers, general recognition of the importance of effective prevention measures has diminished. Last year's increase in teenage use is a reminder that each generation must be taught that illegal drug use is wrong and harmful. This lesson must be taught by all institutions in the community.

Educators sometimes complain that they lack tested and proven anti-drug curricula that will discourage young people from using drugs when they are exposed to them, but depending on formal lessons and a curriculum misses the point. Children learn about drug use from what the adults around them say and do. Parents teach by example and by what they consistently and seriously portray as right and wrong. The same is true of schools and the communities in which children are raised. If drug use and sale are not seen as aggressively opposed and prevented, children learn they are acceptable despite what some adults may tell them occasionally as a formal lesson.

Teaching drug prevention must be a part of the basic task of teaching children right from wrong. It will always fall mainly to parents to provide that education in the home and to act to ensure that schools and their communities are teaching the same lesson effectively. This is made much easier if national leaders and other adults in positions of responsibility set the right example and speak visibly in support of parents. Since that national support has largely evaporated, parents, churches, schools, youth organizations, and communities are even more crucial as teachers of drug prevention.

✓ **End the *de facto* legalization of drugs in American cities by closing open-air drug markets.**

Open-air drug markets feed addiction and are a visible sign of the toleration of the drug trade in every major city in this country. It is time to end this national disgrace. Reuben M. Greenberg, the chief of police of Charleston, South Carolina, has explained how drug markets can be closed with aggressive, committed leadership and within the current resources of most local law enforcement agencies.⁴⁵ He has demonstrated that the view that drug pushers cannot be driven from city streets without prohibitive costs is simply false. Drug pushers cannot operate effectively when law enforcement personnel are present, and forcing drug deals from open spaces makes them more difficult, dangerous, and less numerous. The Charleston example and others like

45 Reuben M. Greenberg, "Less Bang-Bang for the Buck: A Market Approach to Crime Control," *Policy Review*, Winter 1992, pp. 56-60.

it on a smaller scale conducted by neighborhood patrols in communities throughout the nation point to what can be achieved. Creating the necessary presence and maintaining it in response to relocation efforts by drug dealers is doable if closing drug markets is made a priority. Chief Greenberg did not use massive arrests, and he did not violate civil liberties. What he did do is get pushers off the streets of his community, free poor neighborhoods from criminal siege, and restore a climate that promoted economic renewal.

This approach should be repeated in every city. Mayors, city councils, and police chiefs should pledge to close all open-air drug markets in their communities within one year. Citizens should demand such a pledge and make clear that they intend to insist that those officials who do not keep it are removed from office. It is time to stop claiming that the crime and drug problem in communities can be fixed only by the federal government. Decisive action can and must be taken by local officials and community members.

✓ **Use drug testing in treatment programs.**

Drug testing is a proven tool to discourage drug use by individuals in treatment and those in the criminal justice system. Good treatment programs require testing regularly and apply sanctions against individuals who are caught returning to drug use. Testing arrestees provides a basis for using bail, sentencing, release conditions, and other aspects of the criminal justice system to compel individuals to stop using drugs. Including an extended period of regular testing after convicted drug-using offenders complete their sentences discourages a return to drug use and crime.

Positive drug tests must involve steadily escalating penalties (starting with a one or two-day return to jail or a half-way house and moving to reincarceration for an extended period). Most heavy drug users pass through the criminal justice system, and any short-term costs of creating temporary detention facilities for the enforcement of a drug testing program will save larger costs to the community in repeated criminal justice expenditures on the same individuals and the damage their crimes do to the innocent.

✓ **Challenge the local media.**

The news media brought home to Americans the dangers of illegal drugs in the latter part of the 1980s. They also provided hundreds of millions of dollars in public service messages designed to discourage drug use. The local media can play a crucial part in helping communities do what needs to be done today.

Local media should bring public attention to bear on open-air drug markets. Journalists should help their communities better understand the elements of effective drug prevention programs for young people, where such efforts are being done well, and where they are being done poorly in their cities and towns. Is teenage drug use going up or down? How are the drugs that threaten children entering the community and what can be done to stop them? How can parents get reliable drug prevention information for their children? Which programs have a proven record of success and which are wasting resources? Where can people go to get help?

Many communities have created partnerships between the media and police to publicize wanted criminals and receive tips from citizens that help in their apprehension. These partnerships should be expanded to deal more effectively with drug use. Investigative reports are needed on the major groups or gangs supporting the local drug trade, including the identities of gang members. Such action in the media can stimulate vital community support for effective enforcement. Reporting also is vital in providing citizens with the information they need to hold their local officials accountable for curtailing the drug trade in their communities.

CONCLUSION

The Clinton Administration has turned its back on the drug problem and taken actions that have undermined achievements in prevention, interdiction, and enforcement. The Administration's promise to reduce drug addiction utterly fails to address the problems in the drug treatment bureaucracy that have brought fewer and fewer results despite more and more spending. If America is to prevent a return to the levels of drug use of years past, local communities must take the necessary steps to drive the drug problem from their neighborhoods: make sure children are taught by word and example that drug use is wrong and harmful; close open-air drug markets; and make drug testing a cornerstone of drug treatment and of sanctions on drug users entering the criminal justice system. In addition, local media should systematically, and regularly, report on the state of the local drug war, informing citizens on what needs to be done—and how—to overcome drug use and drug trafficking. Only by taking such decisive actions will America successfully finish the war against drugs.

Prepared for The Heritage Foundation
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