Testimony for the Joint Economic Committee, June 19, 2008

Assessing U.S. drug policy and providing a base for future decisions[*]

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Summary

America's drug problem seems to be declining and is certainly less prominent in the public eye than it was twenty years ago. The declines are probably mostly the natural working out of old epidemics rather than the result of tough enforcement. Nonetheless, cocaine, heroin and methamphetamine continue to cause great harm to the nation, particularly to vulnerable minority communities in the major cities. The United States has a larger drug problem than any other western nation, whether measured in terms of the prevalence of problematic drug use or the adverse consequences of drugs, including crime and disease (particularly HIV).

U.S. drug policy is comprehensive but unbalanced. Compared to other wealthy nations it spends more money on drug control and a large share of that, perhaps as much as 75%, goes toward enforcement, particularly arresting, prosecuting and imprisoning low level drug dealers. About 500,000 persons are locked up for drug offenses on any one day. Treatment is provided to a modest fraction of those who need it, the quality of services is low and the mechanisms for linking treatment and enforcement remain weak. Policy measures, whether they involve prevention, treatment or enforcement have met with little success. Prices have fallen and the drugs remain as available as ever.

The forces for major change in drug policy seem weak. Moreover, even if Congress did want to make major revisions, it would have difficulty finding credible evidence to guide it. Not only is there weak monitoring of the nation's drug problems, there is also minimal evaluation of the enforcement programs that dominate expenditures. Without it policy debates will be little more than the exchange of impressions.

America's Drug Problem

Drugs have been part of the landscape of U.S. social problems for at least forty years, from the time of the heroin epidemic of the late 1960s. The principal costs have been the high crime rates and the neighborhood consequences of that, particularly in low income minority, urban communities; the incarceration of large numbers of young males, particularly in those same neighborhoods; and HIV associated with injecting drug use, primarily heroin.

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[*] A fully documented version of this testimony will be posted on my website shortly: http://www.puaf.umd.edu/faculty/reuter/working%20Papers/Publications.htm

[**] Jopnathan Caulkins and Harold Pollack provided valuable comments on an earlier draft. The opinions expressed here are solely my responsibility.

Use

Since 1965, the U.S. has experienced four major epidemics of drugs other than marijuana, in which there have been abrupt increases in new use followed later by sharp declines in new use. After each epidemic there has been a relatively large, but slowly declining, population of dependent users. Each drug has had a distinctive social, geographic and ethnic pattern and each has been strongly associated with crime.

Heroin. The heroin epidemic's surge in initiation began around 1967 and was over by 1974, in the sense that few new addicts started each year after that. The problem was concentrated in a few cities and particularly among African-American and Hispanic males. Many heroin addicts have survived for over thirty years with recurring periods of addiction, treatment, imprisonment and occasional abstinence.

Powder cocaine Initiation in this epidemic peaked in the late 1970s and extended over perhaps a decade. The drug was used by a much broader population, in terms of income, ethnicity and education; it was also less concentrated among males.

Crack cocaine The epidemic began in Los Angeles and New York around 1982 and spread to other cities over the next five years. By 1988 rates of new use had declined everywhere. In each city the surge in initiation was brief, lasting about two years, and was concentrated among young people in poor minority communities.

Methamphetamine By the early 1980s a small number of cities (most notably San Diego) on the West Coast had substantial methamphetamine dependent communities, primarily in working class neighborhoods, both Hispanic and white. Ten years later the drug spread eastwards to mid-America and it was the first in which there were substantial problems in rural communities. The spread is spotty, penetrating most deeply where crack was least common; it is widely prevalent in Houston and relatively rare in Dallas, as revealed by drug testing among arrestees in the early part of this decade. As of 2008 methamphetamine remains almost unknown in some major east coast cities such as New York and Washington. Though the number of users dependent on the drug may still be rising, use in the general population is already well below its late 1990s peak.

Marijuana is by far the most widely used drug in the population. About half of every birth cohort since 1960 has tried the drug by age 21. Since the mid-1970s there has been considerable variation in how many teenagers use it. For example, around 1980

about one in four 18-24 year olds reported in a survey that they had used marijuana in the previous thirty days. The figure fell to one in eight ten years later and since then has risen back to one in six. However past-year marijuana use in the population 12 and over has hardly changed at all since 1988.

In 2000 the federal government estimated that there were about 1 million chronic heroin users, 2.7 million chronic cocaine users and 600,000 chronic methamphetamine users. Much larger numbers, perhaps as many as 5 million, were dependent marijuana users, but this was associated with much more modest problems, both for the users (on average) and on communities.

Drug-related Problems

The most conspicuous consequence of drug use in the U.S. has been the crime associated both with its marketing and with the need to obtain money to purchase the substances, which are very expensive. A cocaine or heroin habit in the mid-1990s cost about $15,000 per annum, far more than an alcoholic had to spend for his source of intoxication. Given that regular use of cocaine or heroin made employment difficult, it was hardly surprising that crime was a principal source of earnings to pay for the drugs. Of those arrested in American cities early in this decade, a large fraction were regular users of expensive drugs, though the drugs varied a great deal by city. See Table 1

Table 1 Percentage of Adult Male Arrestees Testing Positive for Drugs in Five Major Cities, 2002

Primary City	Any NIDA-5 Drug*	Marijuana	Cocaine/ Crack	Opiates	Methamphetamine
Chicago, IL	85.2%	49.4%	47.9%	26.0%	0.3%
Dallas, TX	58.0%	35.3%	30.7%	6.1%	4.0%
Los Angeles, CA	62.3%	36.4%	32.1%	5.8%	14.8%
New York, NY	81.0%	44.3%	49.0%	15.0%	0.5%
Phoenix, AZ	71.1%	41.5%	27.1%	5.0%	31.2%
Median (36 cities)	63.9%	41.5%	30.4%	5.9%	5.3%

* The NIDA-5 drugs are cocaine, opiates, marijuana, methamphetamine, and PCP.

In the early stages of the crack epidemic there was enormous violence associated with that market. As the users and sellers of crack aged, that violence fell sharply. Evidence for the aging of the crack using population can be found in data on treatment

admissions. Whereas in 1992 less than 10 percent of those seeking treatment with smoked cocaine as their principal problem were over 45 years old, in 2005, that figure had risen to about 40 percent.

Injecting drug use has been a major vector for the spread of HIV, accounting for about one third of the deaths that have occurred from that disease, about 200,000 by 2007. Overdose deaths amount to more than 10,000 per annum; this number measures only those who die of acute drug-related causes, not those whose death might result from chronic effects, such as liver failure due to Hepatitis B. It also does not include homicides that might be drug-related; since there were about 15,000 homicides each year in the early part of this decade, it is plausible that a few thousand were related directly to drug selling and more indirectly via selling's effect on gun ownership among criminally inclined youth.

There are three important effects that are subtler and even harder to measure. Many children suffer abuse or neglect because of their parents' addiction and/or absence because of drug-related incarceration. Inner city neighborhoods have become crime ridden, disorderly and unsightly as a consequence of open-air drug sales. This has immiserated the lives of the residents and driven out investment. Similarly, the possibility of earning large sums of money as a successful drug dealer may have led many youth in these same communities to abandon education early and enter the drug trade, even though most of them will earn less than minimum wages during the first few years of their career and have a high risk of being imprisoned. The best estimate of total revenues from drug selling, done in 2000, was that it generated about $60 billion, about 60 percent from cocaine sales. Though the great fortunes are made high up the distribution chain, most of the money goes to those near the bottom, reflecting the very pyramided nature of drug distribution; retailers are at least one hundred times more numerous than high level dealers.

Comparisons with other western nations

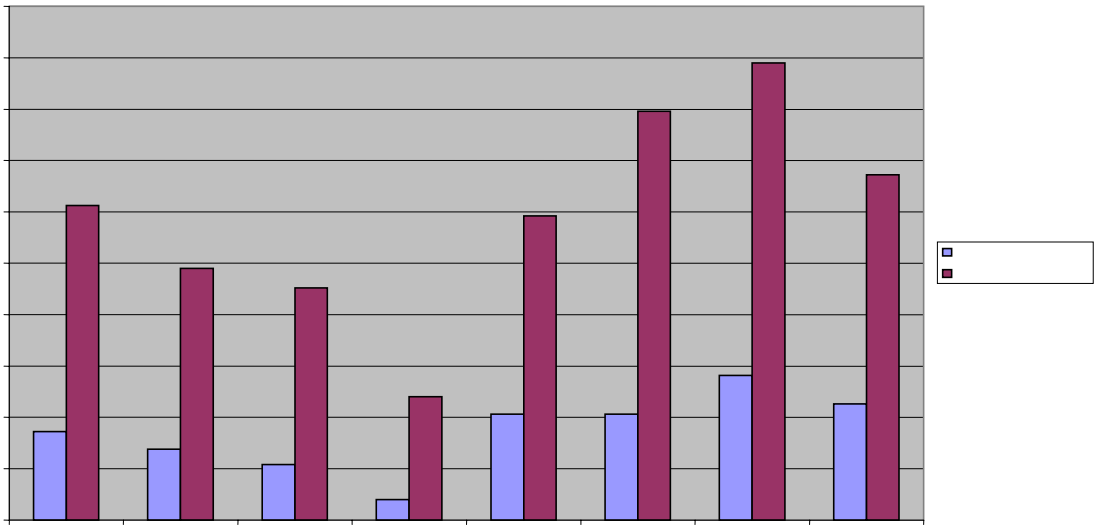
Comparisons between the drug problems of the U.S. and other similarly rich nations is complicated by differences in how the data are collected and analyzed. For example, figures on death rates associated with drug use in other nations may use the term "drug-related" more narrowly (France) or more broadly (Germany) than does the

U.S. The U.S. household surveys, conducted face-to-face rather than through telephone, are likely to generate reports of use from a higher percentage of users. Thus the Figures in this section should be treated as indicative rather than precise.

The United States, shows a very high prevalence of cannabis use but not more so than some other nations (Figure 1). It has a much higher rate of dependence on expensive illicit drugs, captured below in the measure "problematic drug use"[1] (Figure 2). There are other countries that have heroin and marijuana prevalence rates comparable to the U.S. but none that then adds such a large problem with cocaine and stimulants. Nor does any other Western country experience such a variety and severity of drug-related problems. Only data on drug-related deaths can be presented in a roughly systematic way (Figure 3) but reports of, for example, violence in drug markets, are exceptionally high in the U.S.

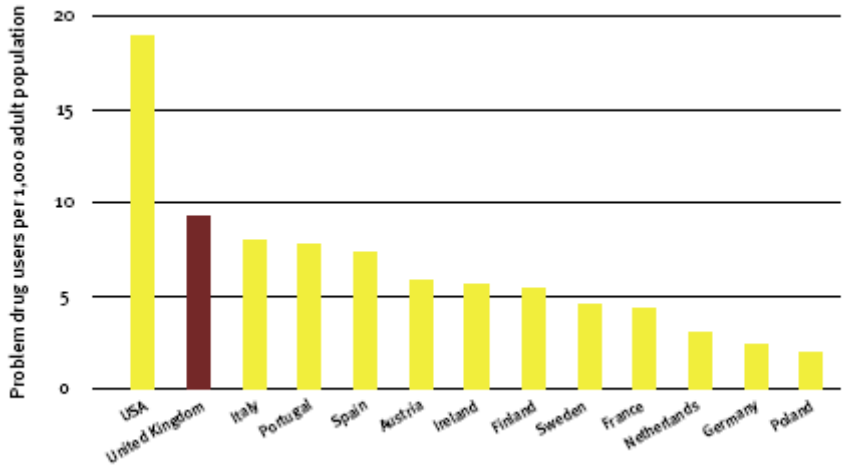
This is not to imply that the U.S. problems are worse because of policy; indeed I believe there are much more fundamental social cultural and economic influences that account for the differences. But these data do make it hard to argue that U.S. drug policy has been successful.

Figure 1 Last Year Marijuana Use in the U.S. and 7 Other Nations



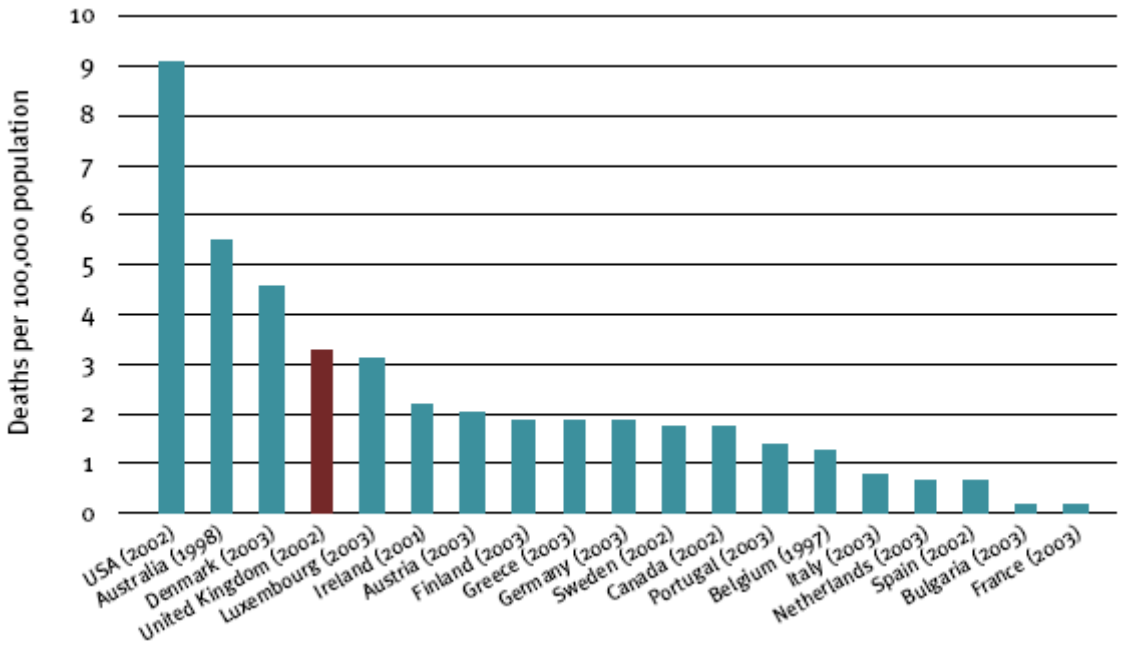
[1] For the United States I used estimates of the number of chronic users of cocaine, heroin and methamphetamine, with an adjustment for overlap among the populations. The drug-specific estimates were take from *What America's Users Spend on Illicit Drugs 1988-2000* (ONDCP, 2001)

Figure 2 Problem Drug Use in the U.S. and 11 Other Nations



Note: Estimates from various years, 1999-2004

Figure 3: Acute Drug-Related Deaths in the U.S. and 17 Other Nations



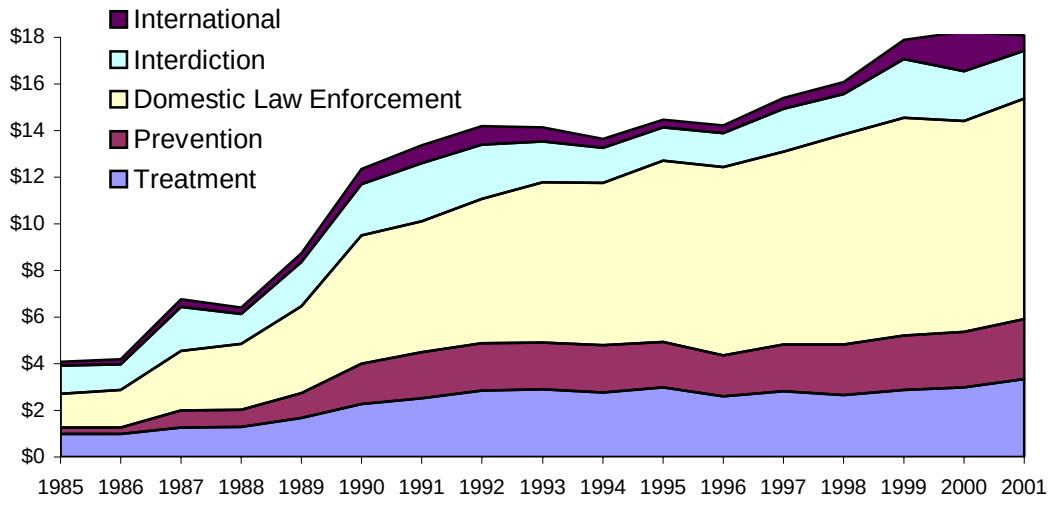
The Policy Response

Though President Richard Nixon was the first president to declare a "war on drugs" in the 1970s, the federal government, under presidents Nixon, Ford and Carter, gave considerable emphasis to treatment, particularly to provision of methadone maintenance for heroin addicts, as a way of combating crime problems. President Carter was notably more liberal on drug policy than any later president, even expressing a view that the punishment for marijuana possession should be no more severe than the consequences of the drug itself.

Since 1981, when Ronald Reagan became president, the response to drug problems has consistently emphasized enforcement, particularly against sellers of cocaine. This emphasis is bipartisan: the Clinton administration was just as tough on drugs as the administrations of Presidents George H.W. Bush or George W. Bush.

The federal government has allocated about two thirds of its drug control funds to enforcement since 1985; see Figure 4. However this is not a full description of the national drug control budget, since it represents only about half of all drug control expenditures. State and local governments also spend large amounts, perhaps as much as the federal government, and their expenditures are even more tilted toward enforcement.

Figure 4. Federal Drug Control Spending by Function, 1985–2001 (billions 2001 $)



As a result of changes in federal budget procedures, it is impossible to show post 2002 changes consistently but there is good reason to believe that the budget has

continued to grow and to show increased emphasis on enforcement. It is likely that total expenditures for drug control, at all levels of government, totaled close to $40 billion in 2007; 70-75% of that went to enforcement. Incarcerating 500,000 inmates for drug offenses alone would cost about $12-15 billion.

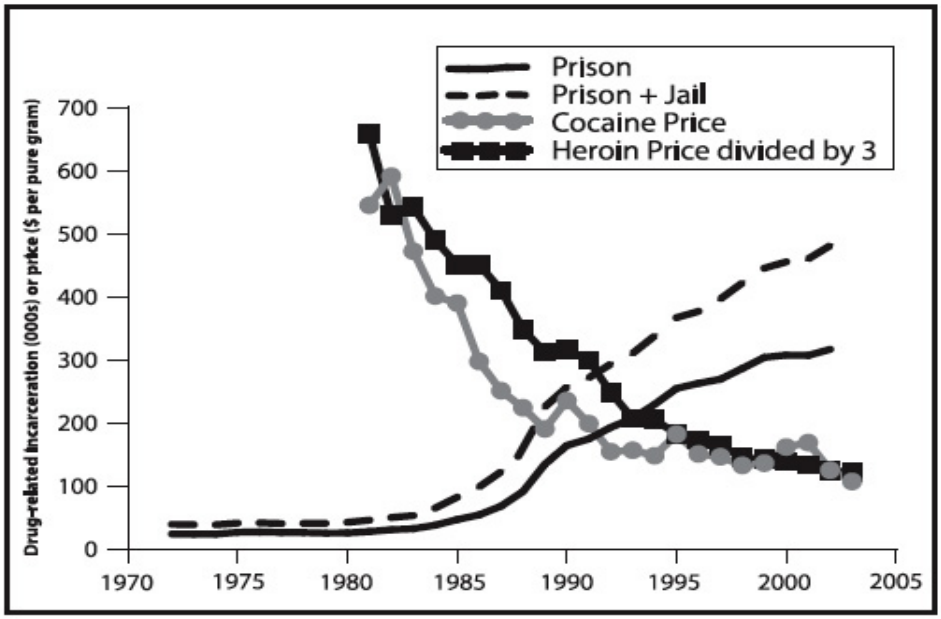
Enforcement The most striking consequence of this emphasis on enforcement is the huge number of individuals being incarcerated for drug offenses. Whereas in 1980 fewer than 50,000 individuals were incarcerated, that figure had risen to 500,000 by 2007. The estimated half million (which includes those in local jails as well as federal and state prisons) consists only of those who have been convicted of drug selling or possession, not those whose property or violent crime may have been related to their drug dependence. What is particularly astonishing is that the number has kept on rising even though there is good reason to believe that the scale of drug dealing has been declining modestly for the last fifteen years. Though many are formally in jail or prison for drug possession offenses, most of those are in fact dealers who were convicted of possession with intent to distribute or who pled guilty to possession charges in order to avoid a longer sentence.

A major concern has been the racial and ethnic composition of the incarcerated drug dealer population. The probability of going to state prison for a drug offense is about 14 times higher for an African-American male than for a white non-Hispanic male. The ratio for Hispanic males is also high. Some of this reflects the greater lengths of statutory sentences for crack cocaine vs powder cocaine; crack cocaine offenses are much more likely to involve black offenders. The growth in the number of prisoners serving time for drug offenses may reflect the same aging of the user and seller populations mentioned earlier. Each time the same offender comes back into court he has accumulated a longer criminal history and is likely to receive a more serious sanction.

In theory tough enforcement should lead to higher prices. As show in Figure 5 that has not happened. Prices for cocaine and heroin have fallen substantially over a long period of time; as compared to the early 1980s prices have fallen by about 80 percent. There is some indication of a price increase in 2007 for cocaine but even that leaves the price well below its 1990s levels. Moreover the price increase might well be short-lived, probably being related to the current conflict around drug markets in Mexico, just as

there was a price spike when the Colombian government tackled the Medellin cartel in 1989-1990. Figure 2 makes the point about the failure by contrasting the decline in prices with the rise in drug prisoners.

Figure 5: U.S. Drug-Related Incarceration and Retail Heroin and Cocaine Prices



Note: prices are adjusted for inflation

Evidence from Monitoring the Future, the annual survey of high school students, shows little change in the perceived availability of cocaine or marijuana over the period since 1980. For example, in 1991 51% of high school seniors reported that cocaine was available or readily available. By 2003 that figure had only fallen to 43%.

Treatment Each year about 1 million persons are treated for substance abuse (not including alcohol alone). Large as that number seems, it is small in comparison with estimates of the total number of persons in need of treatment, particularly when one takes account of the growing number of marijuana admissions that are probably seeking help with a legal rather than a health problem[2]. Not including those in prison or jail, there

[2] Marijuana dependence is not rare and is treatable. However a very high share of those entering treatment programs with marijuana as the primary drug of abuse do so as the result of referrals from the criminal justice system. Given the process by which marijuana possession arrests are generated, this suggests that many of those admissions are motivated by the desire for a reduced penalty from the court rather than help in dealing with marijuana abuse or dependence.

may be as many as 4 million persons who have abuse problems with cocaine, heroin and methamphetamine. Need for treatment rarely leads an addict to seek treatment; pressure from family, friends, employers or the criminal justice system is frequently required to get the addict into treatment. So it might not just be lack of expenditures that lead to a large "treatment gap". However the low share of addicts in treatment in the U.S. contrasts with other rich Western nations. For example in the Netherlands, Switzerland the United Kingdom, about half of those with heroin problems are in treatment programs; in the U.S. the fraction may be as little as one sixth.

Treatment is not only inadequate in terms of the number of available slots, it is also of low average quality. Drug treatment, particularly the provision of methadone maintenance, is separated from the mainstream of health care. Wages are very low, many of the workers are not well trained and the turn-over of the workforce is high. Despite this, there is abundant evidence that treatment, even not very good treatment, is both effective and cost-effective. Over 80 percent of those who enter treatment for the first time will either drop out or relapse, so that treatment is itself a career, like drug use. Nonetheless, the reductions in drug use generate large declines in crime and various health risk behaviors; these in turn yield large benefits both to the user and to society.

Prevention There is universal enthusiasm for prevention programs in concept. By international standards the U.S. spends large amounts on prevention per capita and as a share of the drug control budget. Unfortunately much of that money is wasted on ineffective programs. Partly that is the result of a deeply flawed disbursement mechanism, the Safe and Drug Free Schools Act, which amounts to little more than revenue sharing under the rubric of supporting prevention activities. The Bush administration has tried to cut funding but Congress has resisted restrictions on such a politically attractive program.

On the other hand, in recent years the Office of National Drug Control Policy has funded a mass media campaign that repeated evaluations have found to have no effect on youthful drug use. The most popular program in schools, Drug Abuse Resistance Education (DARE) has been evaluated a number of times and found ineffective; in face of negative findings the DARE program has agreed to redesign its efforts, though still using police officers as the messengers. Other prevention expenditures have gone to

programs that have no plausible basis for belief they might make a difference and the opportunity cost of diverting classroom time from other subjects is often overlooked.

International Programs

Expenditures on source country programs (eradication, alternative development, police training, equipment etc.) constitute a tiny share of U.S. drug control expenditures. Even with Plan Colombia at its height, the U.S. was spending no more than $1.5 billion on these programs, less than 10% of federal drug control expenditures and less than 5% of total governmental drug control expenditures. The vast majority of that money was spent in the Andean region. Though Afghanistan dominates world heroin production, the United States imports most of its heroin from Colombia and Mexico. Indeed, these two countries account for the vast majority of the U.S. imports of all illicit drugs, with Mexico serving as the transit point for most cocaine and also producing much of the imported marijuana and methamphetamine. The Bush Administration has pushed for aggressive eradication in Afghanstan but with little success and probably has not pushed very hard given the political risks that such a program would bring to the already fragile Karzai government.

Interdiction programs, which aim to seize drugs and couriers on their way into the United States, account for more money, roughly $3 billion annually. Though most interdiction money is spent inside the U.S. waters, a substantial fraction does go to maintaining ships and planes in the Caribbean and Central American waters, so it has an international component.

There is good reason to doubt the effectiveness of moneys spent against the growers of coca leaf, the source country refiners and even to a lesser extent the smugglers. The basic argument is reflected by the numbers in Table 2. These figures show that the vast majority of the retail price of cocaine is accounted for by transactions in the United States, almost all of that in the form of compensation to U.S. resident dealers for incurring the risks of being imprisoned or injured in the course of the business.

Table 2 Cocaine Prices Through the Distribution System

Product	Market Level	Effective Price/kg.
Coca leaves	Farmgate/Colombia	$300
Coca base	Farmgate/Colombia	$900
Cocaine hydrochloride	Export/Colombia	$1,500
Cocaine hydrochloride	Import/U.S.	$15,000
Cocaine (67% pure)	Dealer/U.S.	$40,000
Cocaine (67% pure)	Retail/U.S.	$150,000

The 1985 torture and murder of DEA agent Enrique Camarena in Mexico by drug traffickers tied to Mexican police agencies led to a strong reaction from Congress. Starting in 1986 the president was required each year to certify which nations were "co-operating fully" with the United States in suppressing drugs. This certification procedure became the source of great tension between the U.S. and various Latin American governments in the 1980s and 1990s, even though in all these years the U.S. has failed to certify the major producing and trafficking countries only a handful of times. Since President Bush in 2001 stated that "the main reason why drugs are shipped through Mexico to the United States is because United States citizens use drugs", there has been a great deal less interest in the certification process either in the U.S. or Latin America, though the annual International Narcotics Control Strategy Report continues to be published each year, with its assessment of each country's efforts at drug control.

The United States government has also been very aggressive in its dealings with the United Nations, whether it be in the Commission on Narcotic Drugs (CND), International Narcotics Control Board (INCB) or United Nations Office on Drugs and Crime (UNODC). Harm reduction, the claim that it might be possible to reduce the total damage that prohibited drugs do to society by lowering the harmfulness of drug use, has become widely accepted in Europe (with Sweden as an important exception). However the U.S. has consistently pressed for stands by the UN agencies against harm reduction, in particular against the iconic program of syringe exchange, in face of a strong scientific consensus that such programs do no harm and sometimes do substantial good. The United States is committed to the view that only by reducing the number of users can drug problems be reduced and has been highly critical of other approaches, aided by a number of Asian and African countries that share these broad views. The INCB critique

of drug consumption rooms, heroin maintenance programs and decriminalization of marijuana use are believed to reflect U.S. pressure.

Politics and Public Opinion

From about 1985 to 1995 drug policy was a major issue in U.S. politics, frequently mentioned in campaign speeches and the subject of a great deal of legislation. Since the late 1990s the topic has become invisible, except in the context of international affairs. For example, there has been almost no discussion of drug policy in any presidential election post-1996. The most sophisticated recent study of public opinion on the matter done in 2001 showed a general pessimism both about the problem (seen to be getting worse) and about the effectiveness of different programs. Though support for tough sentencing, particularly of drug users, was not strong, there was also little support for any major changes in policy, even including the removal of criminal penalties for possession of small amounts of marijuana.

There have been some modest changes that suggest a tiring with the "war on drugs" approach. The most significant is the passage (by referendum) of Proposition 36 in California in 2000. Under Prop 36 first or second time arrestees for drug possession were to be evaluated for treatment and were not at risk of being sent to jail or prison. This has been a major intervention affecting tens of thousands of drug users arrested each years. Drug courts, of which there were more than 1,500 by 2007, also represent an effort to deal with drug offenders less harshly by offering treatment rather than incarceration, typically to non-violent offenders. However Arizona is the only other state to adopt a Prop 36 type regime and drug courts, though large in number, still account for less than 5 percent of drug-involved criminal offenders because they have tight restrictions on who is eligible for the program. An experienced heroin addict with numerous convictions for violent offenses would be excluded in most jurisdictions.

Making Policy Choices

The next ten years of U.S. drug policy is likely to be very similar to the recent past. Even if the extent of drug dependence and related harms continues to moderate, there is little effective pressure for relaxation of the intense enforcement of the last two

decades. Drug treatment may receive more support than in the past but that, of itself, will make only a moderate difference. Major legal change is extremely unlikely.

For someone such as myself who has been involved in drug policy analysis for twenty five years what is most prominent about the field is simply the lack of any serious interest in analysis of programs and policies. Congress has not pressed any Administration to justify its policy choices in a systematic fashion but has been content to accept the standard rhetoric and argue about details.

One sign of this neglect of the foundations of policy is the absence of Congressional reaction to the failure of ONDCP to continue to estimate the scale of the nation's drug problem. In the 1990s ONDCP published a series of studies entitled *What America's User Spend on Illicit Drugs* carried out by its research contractor, Abt Associates. The most recent report covers the period 1988 to 2000. It presented for every year from 1988 onward, estimates of the number of frequent users of cocaine, heroin and methamphetamine, as well as the total quantity that they consumed and the money they spent acquiring those drugs, as well as marijuana. The findings, which received little attention at the time, were striking. For example, it showed a decline of nearly one third in the number of frequent users of both cocaine and heroin from 1988 to 2000.

In the 2005 *National Drug Control Strategy*, there was a brief reference to an updated report, probably taking the estimates through 2003. That report has never been published, nor has any other updating appeared. It is hardly a secret that ONDCP has refused to publish the completed 2005 report, yet Congress has never, to my knowledge, publicly questioned ONDCP in its many appearances before various Committees.

These figures are not of merely academic interest. The scale of the drug problem, as experienced in the cities of this country is more closely approximated by a measure of the size of drug revenues and estimates of the profits accruing to dealers than it is by the prevalence of marijuana use in the annual survey of high school students, which is the principal outcome measure used by ONDCP. For health purposes the quantity consumed and the number of chronic users are both important inputs; the number of chronic users is a rough measure of how many people are at risk of serious harms and the amount they consume is a further measure of the severity of their risks.

As important as it is to ensure adequate measurement and monitoring of drug problems, even more emphasis has to be given to providing the analytic base for Congress and state legislatures to make their decisions about policies and programs. For example, do longer prison sentences for crack cocaine have any effect on the share of American cocaine consumption accounted for by crack? How much can increased funding for drug interdiction efforts by the Coast Guard and Customs Service reduce use of cocaine and heroin? How should treatment funding expansions balance access for criminal justice clients and improvements in treatment quality? For none of these questions is there a base of studies that would allow for more than an exchange of impressions among contesting groups.

Consider the interdiction issue. The share of cocaine seized by interdiction agencies in the last decade has been high, perhaps as much as 40 percent. That good news is countered by the fact that, at least until 2007, a high seizure rate did not prevent the continued decline of cocaine prices and stable availability. My interpretation of this comes from a simple economic model in which there are two inherent limits to interdiction as a drug control program.

(1) Seized cocaine is cheap to replace. The import price may be only 15% of retail price. If (as suggest4ed by the 40 percent seizure rate) it is necessary to ship 1.6 kilograms from Colombia in order to sell 1 kilogram to U.S. users, and the retail price is $100,000, then the replacement cost of the seizures is only $9,000, less than 10 percent of total revenues. Raising the fraction seized from 40% to 50%, an impressive achievement, would add only about 3 percent to the retail price.

(2) There are many routes and modalities available to cocaine smugglers. It is difficult to provide persistent and high levels of coverage against all of them simultaneously. Thus smugglers adapt and limit the effectiveness of increased interdiction against any specific mode or route.

My interpretation seems a reasonable one but it is arguable. For example, the underlying model of price formation in drug markets can be contested. Perhaps mark-ups by successive sellers along the distribution chain are done on a proportional rather than an additive basis as my model assumes, consistent with economic research on legal markets. My long-term collaborator Jonathan Caulkins indeed proposed and provided a

theoretical argument for just such a model in 1990. Efforts at empirical testing have been slight and the matter remains unresolved. There probably are no more than five papers that make any effort to test the propositions. To my knowledge no government grant has ever been given to explore this matter. Yet this analysis is central to any serious assessment of the drug interdiction program, roughly a $3 billion budget item. Would increasing the program by one third have a substantial effect on the price and availability of cocaine? There is no basis for answering that question beyond the kind of very primitive exercise that I have suggested.

In 2001 the National Academy of Sciences published a report which reached the same pessimistic conclusion about the state of drug policy decision making, namely that the data and research base was extraordinarily slight. In the seven years since then nothing much has changed. Indeed, for a variety of reasons a number of major indicator systems have been eliminated or made less useful. For example, the Arrestee Drug Abuse Monitoring system, which provided invaluable data on drug use by arrestees, has been eliminated thus removing the basis for estimating the number of chronic users, has been eliminated. The survey consumed too large a share of the resources of the National Institute of Justice and nonone of the other agencies that benefit from these data was willing to provide financial support. Revisions in the Drug Abuse Warning Network have limited its ability to trace patterns of change nationally. The National Institute on Drug Abuse has begun to fund more research on drug markets and indirectly on enforcement but this is still a very modest effort and not driven by policy issues.

Of course decisions have to be made in the next few years and they will be made with whatever information and analysis is available. As should be clear from my assessment above, my own view is that the United States imprisons more people for drug offenses than it ought, provides too little treatment services and fails to find sensible ways of linking criminal justice and treatment. I hope that Congress will undertake a more systematic approach to drug policy in the future and examine more than marginal changes.