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Melody M. Heaps
Melody.Heaps@chicagounbound.edu

James A. Swartz
James.Swartz@chicagounbound.edu

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Recommended Citation
Available at: http://chicagounbound.uchicago.edu/uclf/vol1994/iss1/8
Toward a Rational Drug Policy: Setting New Priorities

Melody M. Heaps and Dr. James A. Swartz†

According to some of the most commonly cited national measures of illicit drug use, the most recent War on Drugs has resulted in, at best, a marginal, perhaps Pyrrhic, victory if not an outright defeat. Slight declines in illicit drug use among the

† Melody M. Heaps is the founder and president of Treatment Alternative for Special Clients ("TSAC"), a statewide not-for-profit agency that helps individuals identify and obtain the services they need to become self-sufficient. She also serves as Vice President of the National Consortium of TASC, is a member of the Center for Substance Abuse Treatment National Advisory Council and of the Illinois Council for the Prevention of Violence, and provides consultation and technical assistance to the National Association of State Alcohol and Drug Abuse Directors ("NASADAD"), the National Institute of Justice, and the Center for Substance Abuse Treatment. Additionally, Ms. Heaps is on the faculty of the National Judicial College and an adjunct professor at Governors State University in Illinois.

James A. Swartz, Ph.D, is presently Director of Research at the Illinois Treatment Alternative for Special Clients (TASC) program and an associate faculty member of the Illinois School of Professional Psychology.

The authors would like to acknowledge the assistance of Esther Futrell in the preparation of this manuscript.


All of these studies have been criticized as having significant methodological problems that limit their utility to some extent. For example, very few subjects studied in the National Household Survey admit to using heroin within the past month, making it extremely difficult to project accurately the overall number of heroin users in this country. United States General Accounting Office ("USGAO"), Drug Use Measurement: Strengths, Limitations, and Recommendations for Improvement 39-40 (1993). Similarly, the Monitoring the Future Study of high school students does not include truants or drop-outs, two groups thought to be at highest risk for using illicit drugs, in its sampling frame. Id at 47-48. More importantly, both studies rely exclusively on self-reported information for their results. Id at 36-37, 46-47. Self-reported data on behaviors that have relatively severe social sanctions, such as the use of illegal drugs, can be particularly prone to underreporting in survey studies. Id at 36-37, 39-40, 47-48.

The problems associated with the Drug Use Forecasting ("DUF") data are more complex and involve not only an inadequate sampling methodology (such as the use of convenience sampling as opposed to random sampling) but also great variability in the sampling frames used in different cities. See Jan M. Chaiken and Marcia R. Chaiken, Understanding the Drug Use Forecasting Sample of Adult Arrestees 3 (LINC, 1993) (Report to
general population and high school students now appear to be reversing. Arrestee data show no significant decline in drug use among this critical population. Other state and local data indicate that the War on Drugs and the policies that sustain it may even have harmful effects that could take years to reverse, such as severe jail and prison overcrowding and the failure to decrease the rate of HIV infection among intravenous drug users. Given that these policies have now been in place for five years and that they have largely failed to achieve their major objectives—such as decreasing the amount of drugs produced in other countries, reducing the supply of illicit drugs in this country, and significantly reducing the number of illicit drug users—it would seem that it is past time to consider a different, potentially more fruitful policy for defining the national ethos on illicit drug use.

Building on Professor Reuter's eloquently stated arguments that drug policy might best be served by an "owlish" strategy of harm reduction or, equivalently, harm minimization, we propose that drug policy would be more productive if it treated illicit drug use as if it were metaphorically akin to a communicable disease and if it emphasized illicit drug use as a public health problem rather than as a moral/legal problem. As opposed to the present

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the National Institute of Justice). The result is that the DUF study is not truly a national survey of adult arrestees. See Lana D. Harrison, Trends in Illicit Drug Use in the United States: Conflicting Results from National Surveys, 27 Intl J of Addictions 817, 836 (1992).

Despite these flaws, these studies are presently the principal barometers of the level of illicit drug use in this country. See USGAO, Drug Use Measurement at 56-57. The figures derived from these studies, while somewhat inaccurate, are heuristically important and provide some idea of what impact the War on Drugs has had over the past five years. See Johnston, O'Malley, and Bachman, Drug Use Among American High School Seniors at 1-20 (cited in note 1) (summarizing results of drug use surveys among high school seniors from 1975 to 1992 and noting that the general decline in the use of illicit drugs has halted); Lloyd Johnston, Patrick O'Malley, and Jerald Bachman, Press Release: Drug Use Rises Among American Teenagers 1-6 (University of Michigan News and Information Service, 1994) (announcing results of the 1993 Monitoring the Future Study).

2 See Harrison, 27 Intl J of Addictions at 835-36 (cited in note 1).


5 Our choice of the metaphor of a communicable disease does not necessarily imply that we endorse the concept that drug abuse and drug dependency are literally disease entities, which is currently the predominant view, albeit one that has guided some very effective treatment programming. We have simply chosen this as a metaphor for the indi-
strategy that primarily seeks to reduce the number of active drug users through severe punishment and police vigilance, our proposed policy would seek to prevent and contain or control illicit drug use, emphasizing the reduction of the harmful individual and social consequences that result from or accompany the use of drugs.

While representing a theoretical shift away from the current policy that, in some instances, has severely but ineffectively sanctioned many addicts and small-time dealers, our proposed policy does not advocate the legalization of drugs. Rather, it urges a middle ground that decriminalizes drug use by repealing many of the stiff mandatory sentencing laws now in effect, by granting greater judicial discretion in sentencing, and by increasing the use of probation in conjunction with legally coerced treatment in lieu of imprisonment for non-violent, addicted offenders.

Our proposed policy would target populations at high risk for "contracting" illicit drug use (or abuse or dependency) in order to "inoculate" those who have not yet contracted the illness and to stem its further "spread" to populations at lower risk. Those who have already become "ill" would receive comprehensive treatment addressing the multiple problems and deficits that characterize the lives of many drug users and abusers. In many instances, the criminal justice system would have to coerce drug users and abusers into submitting to treatment. Thus, implementing our proposed policy would require that the legal and treatment communities cooperate with each another to a greater extent than they do now. Additionally, under our proposed policy, decisions

vidual and social problems related to drug abuse and dependence and for how optimally to respond to these problems.

7 The term "decriminalization" should not be mistaken as being equivalent to "legalization." As Professor Kraska has written (albeit in an article that ultimately argues against decriminalization):

The terms "decriminalization" and "legalization" are often confused. Decriminalization is the reduction in severity of a criminal offense and the penalty associated with that offense. Marijuana possession, for instance, might be decriminalized from a felony offense to a misdemeanor. Legalization, on the other hand, is exactly what the word implies: removing or repealing statutory proscriptions entirely. To wit, possessing marijuana, once a criminal offense, becomes legal under the rubric of legalization.

Peter B. Kraska, The Unmentionable Alternative: The Need for, and the Argument Against, the Decriminalization of Drug Laws, in Ralph Weisheit, ed, Drugs, Crime and the Criminal Justice System 111, 113 (Anderson Publishing Co., 1990) (citations omitted). Thus, by urging that drug use be decriminalized, we do not propose to take drugs out of the criminal justice system. Rather, we argue that inordinately severe penalties for illicit drug use should be reduced, not eliminated, and that such sanctions should include treatment and not simply be punitive in nature.
on whether to implement more controversial programs—such as those offering needle exchanges—would be made according to their effectiveness rather than according to a rigid and predetermined ideology.

In order to meet the anticipated high demand for treatment services, additional funding would have to be made available for drug treatment and for other services such as educational and vocational training and mental health care. These costs, however, would be more than offset by the decreased use of prison and jail space and the reduction in criminal behavior that results from drug treatment and prevention.8

Our proposed policy would also emphasize research about the types of treatment that work most effectively for particular types of drug users. Substance abuse treatment is effective, but only some of the time for some of the participants.9 Admittedly, we need to know much more about what is and what is not effective and how we can engage a higher proportion of addicts in the treatment process. New, more effective types of treatment are clearly needed for some groups of addicts, such as those who are primarily addicted to crack cocaine.10 Our proposed policy emphasizes intensive research, which in turn will help shape and inform drug policy as new information becomes available.

In the remainder of this Article, we examine in more detail the strategies and implications of our proposed policy. In particular, we discuss the following areas: the populations that should be targeted for the highest levels of intervention; the manner in which the present definition of what constitutes treatment services needs to be expanded; the types of systemic programs needed to respond effectively to the drug problem; and the implications of the adoption of a national health care model versus the current public social health care model. Finally, we broadly outline implementation strategies by which our proposed policy may

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be put into effect. Prior to this discussion, and partially to justify such a significant change from the current policy, we first briefly analyze exactly what the overall impact of the War on Drugs has been.

I. THE WAR ON DRUGS: SURVEYING THE BATTLEFIELD

William Bennett tends to dwell on the obstacles in the way of expanding treatment, rather than on how to overcome them. At times, the drug czar seems uneasy with the notion of treatment itself. Bennett never questions the efficacy of the criminal justice system. That system, like treatment programs, suffers from serious inefficiencies. Across the country, police chiefs, judges, and prosecutors are throwing up their hands, frustrated by their inability to contain, much less defeat, the drug trade. Such problems, however, never seem to find their way into Bennett’s speeches. There, police and prisons are described in only the most glowing terms. The contrast with his pronouncements on treatment could not be starker.11

A. A Punitive, Unfocused Policy

The current War on Drugs, one of several such domestic wars undertaken in this century,12 commenced with the passage of the Anti-Drug Abuse Act of 1988 (the “Act”),13 signed into law by President Bush. The Act provided for a number of initiatives aimed at combatting illicit drug use in this country; these initiatives centered around the creation of the Office of National Drug Control Policy (“ONDCP”),14 which was initially led by Dr. William Bennett.15 From the outset, Dr. Bennett’s ONDCP emphasized law enforcement and interdiction over treatment and education.16

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12 See James A. Incardi, The War on Drugs II 156-57 (Mayfield Publishing Co., 1992), for a fuller history of the multiple drug wars that have been fought (and lost) in this century.
16 The relative emphasis of the War on Drugs on law enforcement and interdiction at
The main thrust of the ONDCP's strategy was to reduce incrementally the total number of illicit drug users, including both problematic users and "casual" users.\textsuperscript{17} The ONDCP failed to consider the ramifications of different levels of drug use. Accordingly, the ONDCP viewed the occasional marijuana user as being as big a problem as the hard-core heroin addict, despite the fact that heroin addicts are much more likely to commit crimes to support their habits and are much more likely to contract AIDS and tuberculosis.\textsuperscript{18} Stopping the marijuana user from ever smoking marijuana again counted as much towards "victory" as did stopping the heroin addict.\textsuperscript{19} Thus, users of even small amounts of illicit drugs have received prison sentences as

\begin{itemize}
\item the expense of treatment is manifest in the budget figures and allocations requested in the ONDCP's 1989 \textit{National Drug Control Strategy}. The ONDCP recommended "a 1990 budget that is 73 percent supply reduction and 27 percent demand reduction." ONDCP, \textit{1989 National Drug Control Strategy} at 112 (cited in note 4). In this context, supply reduction generally corresponds to law enforcement and interdiction, while demand reduction generally corresponds to treatment and education. See \textit{id}.
\item Professor Reuter has noted that the federal drug budget is not an appropriated budget \textit{per se}, but that it reflects "a complex after-the-fact calculation of what agencies claim to be spending on drug control." Peter Reuter, \textit{Setting Priorities: Budget and Program Choices for Drug Control}, 1994 \textit{U Chi Legal F} at 145, 148. Professor Reuter further argues that the federal government spends far less on the War on Drugs than it claims, and that when state and local spending is factored in, a much greater proportion of the total money spent on the War on Drugs goes to law enforcement, as opposed to treatment and education, than is widely publicized. \textit{id} at 151-53. Regardless of the exact amounts allocated for demand and supply reduction, however, the policy emphasis in the ONDCP's \textit{National Drug Control Strategy} remained clearly on the side of enforcement and interdiction during the Bush-Bennett years.
\item \textit{1989 National Drug Control Strategy} at 8 (cited in note 4) ("[T]he highest priority of our drug policy must be a stubborn determination further to reduce the overall level of drug use nationwide—experimental first use, 'casual' use, regular use, and addiction alike.").\textsuperscript{17}
\item For example, the \textit{1992 National Drug Control Strategy} states:
Nonaddicted users, who still constitute the vast bulk of our drug-involved population, must be a principal target of prevention activities . . . . [T]he casual users are still likely to "enjoy" drugs for the pleasure they offer. And they are willing and able to proselytize their drug use, by action or example, to their nonuser peers, friends, and acquaintances. In short, the casual user is the means by which drug use spreads.
\end{itemize}
long as those doled out to dealers, based solely upon the amount of drugs they happened to have in their possession at the time of their arrest.20

The ONDCP’s strategy has produced police sweeps and “buy-and-bust operations,” as well as harsh mandatory sentencing laws and long prison terms even for the possession of relatively small amounts of illicit drugs.21 While receiving some additional funding, drug treatment has not kept pace with law enforcement efforts, especially when state and local programs, which have also emphasized law enforcement, are considered.22 Treatment on demand remains today, as it was at the start of the drug war, a far-off goal.23 After five years of fighting the War on Drugs in

20 Crack cocaine and cocaine powder present the most extreme example of the misuse of mandatory sentencing. Gary Miller writes:
Congress, responding to alarming reports about the highly addictive nature of crack and its association with gang violence, passed tough anti-crack laws in the 1980s. See 21 U.S.C. § 841(b)(1)(A) as amended. The result of this legislation for sentencing purposes is that crack has one hundred times the value of an equivalent amount of powder cocaine. In section 841 of 21 U.S.C., for example, it stipulates that being convicted of a drug offense involving fifty grams of crack will fetch the same ten year minimum sentence as a conviction involving five kilograms of powder cocaine.

The false assumption underlying many of the mandatory sentencing laws is that users can be differentiated from dealers based on the amount of drugs in their possession. This assumption causes concern because there is a desire to punish dealers more severely than users. Legislators assume that larger amounts of a drug indicate that the person is dealing and not merely using drugs. Perhaps this is true at the extremes, when kilograms are being compared to a gram or less. In practice, however, savvy dealers, keenly aware of the laws, will keep only small amounts of a drug on their person or secreted away at any one time. Some users, on the other hand, flush with cash after committing a crime, borrowing money, or getting a paycheck, will purchase the largest quantity of drugs possible for their next binge. The distinction is further blurred by the fact that many users deal small amounts of drugs in order to support their habits. Thus, using the amount of a drug confiscated to indicate whether the arrestee is a dealer or a mere user is very unreliable. See Bruce D. Johnson, et al, Taking Care of Business: The Economics of Crime by Heroin Abusers 61-72 (Lexington Books, 1985) (detailing the complexities and interactions between drug using and dealing among a street sample of New York City heroin abusers).

For examples of the mandatory sentencing laws that apply to drug-related offenses in Illinois, see Illinois Substance Abuse Act, Ill Rev Stat ch 56 1/2, §§ 1401-05 (1991).

21 See Mark A. R. Kleiman, Against Excess 139-43 (Basic Books, 1992) (noting the increase in “buy and bust” operations among law enforcement agencies generally and the great increase in mandatory sentencing laws requiring stiff sentences even for possession of small quantities of drugs).


23 ONDCP, 1992 National Drug Control Strategy at 57-58 (cited in note 19). The one striking exception to this lack of progress may be the ambitious social experiment now underway in Texas where a massive number of treatment beds, approximately 10,000 of which have been slotted for jail and prison inmates, have been funded by the state gov-
this manner, indeed after five years of continuing to define the problem as a war, the question may now be asked with more than a little justification: what have been the results? To paraphrase President Reagan's description of the results of the "War on Poverty," drugs won.

B. Indicators of a Failed War

While illicit drug use has declined over the last few years among American households and high school students, these trends began in the early 1980s, well before the most recent policies were enacted in 1988. These long-term trends may indicate that the growing social stigmatization of illicit drug use caused the declines, not government policy per se. Nonetheless, public officials backing the current War on Drugs are quick to point to these figures as evidence of their policies' successes. These same officials, however, tend to overlook other, more ominous and blatant signs that this war has been a profound failure. For example, the latest epidemiological report issued by the National Institute on Drug Abuse found that cocaine use and availability remained high in almost every major American city. It also found heroin use and availability to be stable or on the upswing in most areas of the country. Thus, with respect
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Setting new priorities to the illicit drugs that generate the most concern, the most recent epidemiological reports from around the country provide no evidence of a general decline in either use or availability.

Additionally, over the five-year course of the War on Drugs, if other states have experienced similar patterns to those in Illinois, crack cocaine use has spread dramatically from large urban settings to the surrounding metropolitan areas. Because of its cheaper price per dose, crack cocaine has introduced a much larger base of users to cocaine than when the drug was primarily snorted in its powder form. Furthermore, because smoking crack cocaine delivers a larger quantity of cocaine to the brain in a shorter time period than snorting powder cocaine, crack cocaine is much more likely to be misused and to cause addiction. Many of those who use crack cocaine, but by no means all, are poor minorities who live in large urban centers. They often lack a stable residence and so are less likely to be included in the annual Household Survey. Thus, while there may have been a downturn in the number of illicit drug users in the general population, it is possible that when crack cocaine users are factored in, the actual population of illicit drug users is now larger than before the War on Drugs began.

Anecdotal and consequence data reveal several types of new-user populations across the Nation. For example, in Newark, the [emergency room] rate is rising for new, younger users, and intranasal users are younger than injecting users. Similarly, young Chicagoans are being introduced to opiates because of heroin snorting's growing popularity... Heroin is increasingly available in Atlanta, Denver, Honolulu, New Orleans, St. Louis, San Diego, and Washington, DC. Prices are up in Miami and Washington, DC (street level), down in San Francisco, and stable in Detroit, St. Louis, and Washington, DC (kilogram level). Purity is up in Boston, Chicago, Miami, St. Louis, San Francisco, and Washington, DC (street level); it is stable in Washington, DC at the kilogram level.

Id.


Id at 38-39. The Illinois TASC report states, however, that "despite the lower cost per dose, the higher frequency of use actually requires more money to support a crack habit compared to heroin or to cocaine hydrochloride." Id at 39.

See Verebey & Gold, 18 Psychiatric Annals at 514, 518 (cited in note 10).


United States General Accounting Office, Drug Use Measurement at 38 (cited in note 1).
Proponents of the War on Drugs have also typically under-played or ignored the Drug Use Forecasting ("DUF") data suggesting that illicit drug use among arrestees remains high in large American cities, a population thought to account for a large proportion of the illicit drugs used in this country. As this was the very population that alarmed the American public in the first place and that provided a major impetus for passage of the Act, the absence of publicity about the fact that there has been no reduction in drug use by criminals (or alternatively, no reduction in the number of criminalized drug users), while politically understandable, is, at best, duplicitous.

In Illinois, for example, cocaine has remained cheap and plentiful throughout the War on Drugs. Since 1989, between 50 and 60 percent of all felony arrestees in Chicago have tested positive for cocaine use, indicating that they had used cocaine within forty-eight hours of their arrests. The line showing the proportion of Chicago arrestees testing positive for cocaine has remained remarkably flat over this time period. The DUF study shows similarly stable results for the majority of other cities surveyed.

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36 For instance, the 1989 National Drug Control Strategy lists "crime" as the first indicator that the drug problem is getting worse and notes that "[f]ear of drugs and attendant crime are at an all-time high. Rates of drug related homicide continue to rise—sometimes alarmingly—in cities across the country." ONDCP, 1989 National Drug Control Strategy at 1 (cited in note 4).


39 Reardon, Drug Use Forecasting Program at 23-28 (cited in note 1).
Today, heroin is also widely available and very pure. A new generation of users is being initiated into heroin use through snorting, rather than injecting, in order to moderate their edgy cocaine highs. Consequently, heroin use, which had declined sharply in Chicago since 1989, has rebounded over the last year and is now on the upswing. There is also no evidence from either price or purity data that interdiction or enforcement efforts

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41 Snorting heroin, however, is by no means new. For example, in their seminal article on the economic existence of the typical heroin user, Preble and Casey note that between 1947 and 1951, heroin users organized parties of up to twenty people for the purpose of snorting heroin together. Edward Preble and John J. Casey, Jr., *Taking Care of Business: The Heroin User's Life on the Street*, 4 *Int'l J of Addictions* 1, 5 (1969). The method described—creating lines of heroin on a mirror with a razor blade and then snorting them through a rolled-up dollar bill or straw called a "quill"—closely resembles the manner in which many cocaine users snort cocaine. Id. During the post-World War II period, and again today, heroin was relatively cheap and pure compared to its price and potency at other times. See Wiebel, Ouellet, & O'Brien, *Substance Abuse in Chicago* at 94-95 (cited in note 40).

42 The DUF data on the upswing in heroin and the graph are taken from my own analyses of the Chicago DUF data collected by TASC between October 1988 and November 1993. Analyses of the November 1993 data revealed that 40 percent of the sampled arrestees brought to the Cook County Jail Night Bond Court tested positive for opiates. This is the highest recorded level of opiate use since we implemented the DUF study in Chicago as part of the national DUF project funded by the National Institute of Justice. James Swartz, *The Pattern of Opiate Use by Chicago DUF Arrestees by Collection Quarter Calendar Years 1988 to 1994* (unpublished graph) (on file with the University of Chicago Legal Forum).
have even marginally reduced the amount of illicit drugs (except for marijuana) entering this country.\(^{43}\)

![Figure 2](image-url)

**C. The Impact on the Criminal Justice System**

The increased criminalization of certain substances, primarily cocaine, through the passage of “tough” mandatory-sentencing laws at the federal and state levels has not only failed to stem the use of illicit drugs among criminal(ized) offenders, but it has also created its own set of problems. Again, statistics from Illinois serve to illustrate what has clearly become a national problem. Because of mandatory sentencing, the Illinois prison population has swollen to approximately 32,000 inmates, twice its size in 1984.\(^{44}\) Similarly, the Cook County Jail, which houses close to 9,000 inmates each day, a number of whom must sleep on the floor as a result of severe overcrowding, continues to admit approximately 250 new cases daily.\(^{45}\) Many of these new

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\(^{43}\) As Professor Reuter notes, there are currently no good measures of the total quantity of illegal drugs (i.e., heroin and cocaine) entering this country. Reuter, 1994 U Chi Legal F at 159 (cited in note 16). See also the 1992 National Drug Control Strategy at 25-27 (cited in note 19). However, indirect data on price and purity levels, as well as the DUF data, suggest that heroin and cocaine have remained widely available and relatively cheap throughout the Drug War. See Wiebel, Ovellet, & O'Brien, Substance Abuse in Chicago at 92-95 (cited in note 40); Illinois Criminal Justice Information Authority, Illinois Application and Strategy to Control Violent Crime at 7-9, 13 (cited in note 37).

\(^{44}\) The Illinois Task Force on Crime and Corrections, Final Report 19-20 (1993) (noting that the incarceration of violent criminals has also recently been contributing to the overcrowding problem).

\(^{45}\) These figures were presented by Cook County Department of Corrections manage-
inmates are incarcerated as a direct result of the sentencing changes and enforcement practices carried out as part of the War on Drugs.\textsuperscript{46} The increased number of drug-related arrests has also placed a substantial burden on the court system, resulting in delays and increased caseloads.\textsuperscript{47}

The exact magnitude of the Drug War's contribution to the prison overcrowding problem is difficult to estimate. One common measure, simply calculating the change in the proportion of the incarcerated population with a drug-related offense, is misleading because drug users commit many types of crimes and are not convicted solely of drug possession or sales.\textsuperscript{48} It is likely that many of those now incarcerated for theft, burglary, and robbery are addicts who committed their crimes to obtain money to buy drugs.\textsuperscript{49} Without the hope of receiving any treatment, they are likely to resume using drugs upon release and, as a result, to commit new offenses.\textsuperscript{50} The larger point, however, is that while thousands more people than ever before are now serving time in federal and state prisons, there has been little or no drop in the crime rate as measured by arrest statistics.\textsuperscript{51} Additionally, as mentioned before, there has been virtually no reduction in the rate of illicit drug use among those being arrested and incarcer-


\textsuperscript{47} See Steven Belenko, The Impact of Drug Offenders on the Criminal Justice System, in Weisheit, ed, Drugs, Crime and the Criminal Justice System at 35 (cited in note 7) (discussing in detail the general effects of the War on Drugs on overburdening the legal system).


\textsuperscript{49} For example, 31 percent of the state prison inmates surveyed in 1991 by the Bureau of Justice Statistics reported being under the influence of drugs at the time they committed their offenses. Another 17 percent reported that they had committed their crime in order to get money for drugs. Beck, et al, Survey of State Prison Inmates 1991 at 22 (cited in note 46).


\textsuperscript{51} In 1990, the total number of arrests reported in the United States was 8,965,099, a 30.8 percent increase over the 6,852,016 reported in 1981. Bureau of Justice Statistics, Sourcebook of Criminal Justice Statistics—1991 439 (1992).
ate.\textsuperscript{52} So much for the deterrent effects of the get-tough policies.

Many of the inmates in both the federal and state systems are small-time, non-violent drug users and dealers or petty thieves who, because of mandatory sentencing laws, must serve relatively long sentences.\textsuperscript{53} For example, we recently completed a survey of 891 Cook County Jail inmates receiving drug treatment in the Jail and found that theft, burglary, and possession of a controlled substance were the most commonly reported offenses on their arrest histories, accounting for over half of all their previous arrests.\textsuperscript{54} At the same time, half of the surveyed inmates had never been in drug treatment before entering the Jail's program despite the fact that, on average, they had been using illicit drugs for over ten years.\textsuperscript{55} Yet almost half of the surveyed inmates were sentenced to serve a significant amount of time in the Illinois Department of Corrections, where there is presently little or no treatment available.\textsuperscript{56} Because substance abuse treatment, particularly intensive programs such as therapeutic communities, is so scarce, the inmates are very unlikely to receive any treatment, even if they request it, before they are released back to their communities.\textsuperscript{57}

\textsuperscript{52} See Harrison, 27 Intl J of Addictions at 835-37 (cited in note 1).

\textsuperscript{53} United States Department of Justice, An Analysis of Non-Violent Drug Offenders with Minimal Criminal Histories 15 (1993). Ironically, the first National Drug Control Strategy spoke of the need for flexible sentencing policies: "Punishment should be flexible—let the penalty fit the nature of the crime." ONDCP, 1989 National Drug Control Strategy at 19 (cited in note 4). As we discuss in the text, however, this has not happened in practice, and, if anything, the punishments for drug-related crimes in a regime of determinate sentencing have grown more inflexible and disproportionately harsh.


\textsuperscript{55} These statistics come from the same study that resulted in Lurigio and Swartz, Life at the Interface, 17 Evaluation and Program Planning 205 (cited in note 54). Dr. James Swartz has further analyzed the data (on file with the University of Chicago Legal Forum).

\textsuperscript{56} Id. At the time of the survey, there were only about 180 residential treatment beds in Illinois for 32,000 inmates. Conversation with Dr. Anthony Schaeb, Chief of the Mental Health Services for the Illinois Department of Corrections, Oct 21, 1994. TASC, along with the Illinois Department of Corrections ("IDOC"), the Illinois Department of Alcoholism and Substance Abuse, and Gateway Treatment Services, has been involved in a recent project funded by the Center for Substance Abuse Treatment that added 220 treatment beds at the Sheridan Correctional Facility. Tom McNamee, New Drug War Tactic; Illinois Prison Tries Treating Inmate Addicts, Chi Sun-Times 1-20 (Feb 20, 1994). These additional beds comprise well over half of the available number of residential treatment beds within IDOC facilities.

\textsuperscript{57} See Matt O'Connor, Addicts Have Nowhere to Go, And Many Go Back to Prison, Chi Trib 2-1 (Oct 30, 1988).
Housing inmates has become an expensive proposition, even with creative ways of managing the overflow such as double- and triple-bunking cells and using floor space for sleeping.\textsuperscript{58} Because there is literally no more room to house the continuous flow of new inmates, the Illinois prison system has reached the point of equilibrium whereby the number of releasees must roughly equal the number of new admissions.\textsuperscript{59} Therefore, statutes that reduce sentences in return for good behavior have been relaxed.\textsuperscript{60} Most offenders, even those who have committed violent crimes, are eligible for good-time credit. Thus, under the strange calculus imposed by the War on Drugs, violent offenders are serving shorter sentences to make room for drug offenders.\textsuperscript{61} Of course, violent offenders are being returned to our streets surreptitiously in order to preserve the politically (and publicly) cherished "tough-on-crime" image.

It is hard to measure the social and economic damage that has been done by enacting and enforcing severely punitive measures that have disproportionately affected a large number of

\textsuperscript{58} A member of a film crew making a public relations film on jail-based treatment told Dr. James Swartz that the Cook County Jail was so overcrowded that groups of inmates were forced to walk around the grounds in shifts in order to allow other inmates places to sleep. After an hour or so, the group that had been walking around in a large circle traded places with the group that was napping and so on.

To their credit, the Cook County Board President and the Cook County Sheriff have recognized both the severe overcrowding problem at the jail and the need for expanded drug treatment. This past year, they implemented a Day Reporting Center at the Jail and greatly expanded the number of beds available for treatment both in the community and at the Jail. See Lisa Price, \textit{Day Care for Criminals in Cook County Jail a Success}, Cable News Network (Dec 3, 1993); Andrew Fegelman, \textit{Reporting Center an Alternative to Prison, Jail}, Chi Trib 2-1 (Nov 5, 1993). The Day Reporting Center is a model of its kind and provides a wide variety of services to its participants, including drug treatment, GED classes, vocational training, and martial arts instruction. \textit{A Sign of Hope at Cook County Jail}, Chi Trib 1-14 (Sept 27, 1993). These programs have gone a long way towards reversing some of the policies of the past and, if well implemented, could significantly affect not only the crowding problem at the Jail, but also the drug problem in Cook County. The development of these programs represents a model for what enlightened public leadership in cooperation with community-based social service organizations can accomplish.

\textsuperscript{60} Ill Rev Stat ch 38, § 1003-6-3 (1991). The statute was made more lenient by 1990 Ill Laws 86-1090, 86-1373.

\textsuperscript{61} The Illinois Task Force on Crime and Corrections notes that the National Council on Crime and Delinquency found that good-conduct credit does not adversely affect public safety. Illinois Task Force on Crime and Corrections, \textit{Final Report} at 32 (cited in note 44). We argue, however, that good-conduct credit programs (as well as meritorious good-conduct credit, supplemental meritorious good-conduct credit, and education credit, all components of Illinois's Good-Time Credit Program) have been necessitated by the overcrowded conditions in penal institutions, which in turn have been partially caused by the War on Drugs.
poor, young, undereducated, primarily African-American males. By emphasizing their "criminal nature," we may be further stigmatizing and alienating them from a society that they perceive as devoid of any opportunity for advancement through legal means. This is not a plaintive, hand-wringing argument urging that they are in need of sympathy and are all hapless victims of a cruel society. Rather, this argument simply acknowledges that the consequences of this continued War on Drugs may result in more crime, not less, and produce greater numbers of intractable criminal addicts, not fewer. Had effective treatment and community-based intervention programs been made available earlier, many of these offenders might have committed fewer or no crimes, avoided imprisonment, and never become addicted in the first place.

Drug use has also become closely linked to the spread of AIDS. Here, too, current policies have largely failed to reduce the problems attributable to a drug-related social issue. Intravenous drug users spread AIDS to each other by sharing contaminated needles and "works," and crack cocaine users, especially female users, often exchange sex for drugs. As a result, both groups are at high risk for contracting and spreading AIDS. The number of AIDS cases attributable to intravenous drug use has increased at an alarming rate; presently, intravenous drug use is the second most common cause of HIV infection. While no governmental policy could have completely prevented this tragedy, treating illicit drug use as primarily criminal has pre-

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65 Chitwood, et al, A Community Approach to AIDS Intervention at 31-34 (cited in note 18). "Works" are the supporting apparatus needed to inject drugs. These typically include a spoon for heating and dissolving heroin in water, a swab of cotton for filtering impurities out of liquefied heroin, a heating device (sometimes just matches), a tourniquet, and a hypodermic syringe.
66 Id; Ratner, Sex, Drugs, and Public Policy at 11-14 (cited in note 64).
vented the development of potentially beneficial programs aimed at reducing the spread of HIV infection and AIDS among illicit drug users. For example, even though needle-exchange programs have proven effective in reducing the rate of HIV infection, a policy banning federal funding for these programs remains in place, and many states implement barriers to block access to these programs. In Illinois, although there is solid evidence that some prison inmates contract HIV while incarcerated, prison officials remain adamantly opposed to condom-distribution programs and refuse even to discuss the issue.

There is evidence that, contrary to prior speculation, intravenous drug users respond to risk-reduction programs and are willing to change their pattern of drug use to avoid contracting AIDS. Illinois DUF data, as well as data from our own TASC clients, have shown significant downturns in the level of intravenous drug use as a result of the user communities' growing awareness of the risk and consequences of HIV infection. Similarly, a street-outreach program designed to reduce the rate of HIV infection among intravenous drug users in Chicago has yielded successful results. Many of these programs, which have largely been implemented in piecemeal fashion, owe their existence to the continued efforts of a few extremely dedicated and sometimes foolhardy individuals. If these programs could be implemented on a broader level without having to surmount the additional hurdles of tacit and explicit federal disapproval evidenced by the no-funding-allowed policy, their impact would surely be wider and more substantial.

69 "The Federal Government's first comprehensive study of whether giving clean needles to addicts can help prevent the spread of AIDS has concluded that it does, and that the Government should finance a significant expansion of such programs." Philip J. Hilts, Giving Addicts Clean Needles Cuts Spread of AIDS, U.S. Study Finds, NY Times A21 (Oct 1, 1993). "Needle exchange programs in the United States have been in a legal limbo over the past five years. A patchwork of state and Federal laws, including a Federal ban on financing such programs, and state laws that prohibit the possession of needles or purchase of needles without a prescription, severely restrict such initiatives in 47 states and the District of Columbia." Id.

70 See Ray Long, Increase in AIDS Burdens Prisons; State Considers New Hospice for Inmates, Chi Sun-Times 1-1, 22 (Dec 6, 1993).


72 Illinois TASC, Extent of and Trends in Drug Use at 91 (cited in note 30).

73 Wiebel, Ouellet, & O'Brien, Substance Abuse in Chicago at 103-04 (cited in note 40).

74 See Hilts, NY Times at A21 (cited in note 69).
II. CHANGE OUR PRIORITIES

The key, then, is reducing demand. And there seems no better way of accomplishing this than by assisting the inner-city communities that are the chief source of that demand. That assistance should not only provide more treatment but should also address the broader needs that community leaders believe must be met if the demand for drugs is to be reduced. This, remarkably, remains the most poorly financed part of our entire strategy. The Coast Guard is getting more boats, Customs is getting more planes, and Latin America is getting more arms, but REACH [a Detroit community group] is having trouble adding thirty kids to its daycare rolls, and the Ad Hoc Group Against Crime [a community group in Kansas City, Missouri] cannot find the money to open an athletic center.\footnote{Massing, NY Rev at 33 (cited in note 11)}

For these reasons, and based on our own work with many of those who have come into the criminal justice system in Illinois, we conclude that current policies are misguided and need to be changed. These policies fail to manage or ameliorate the problems of drug use, abuse, and dependency, and the associated social ills of crime, disease, and the disenfranchisement of many young, primarily minority males. Therefore, we suggest that the emphasis of these policies should be shifted away from treating drug use as primarily a law enforcement issue and towards treating it as a health issue. Our proposed policies would stress prevention, education, and treatment, with the principal goal of reducing the multiple harms caused by or concomitant with illicit drug use and abuse such as crime, AIDS, crack babies, abused and neglected children, lost wages, and productivity, and the greater utilization of the public health care system caused by the poor physical health of many addicts.

As stated at the outset, we believe that a good strategy for managing the drug problem in this country would approach drug abuse and dependency as similar to a communicable disease. Such a strategy would continue to try to decrease the number of new users and addicts, to reduce the number of existing users and addicts, and to minimize the social and individual consequences of drug use for those who cannot stop using drugs. The
strategy would target individuals and communities where a significant drug problem exists or could develop; expand not only the number of available substance abuse treatment slots, but also the comprehensiveness of such treatment; and enlist many tools, including the criminal justice system, the public education and welfare systems, and community programs, to respond to the drug problem. The strategy would also consider the economic realities imposed by changes now underway in the health care system.

A. Target High-Risk Groups

Evidence from studies of the etiology of adolescent drug abuse suggests that a viable prevention model would include simultaneous attention to a number of risk factors in different social domains. . . . The evidence further suggests that prevention efforts target populations at greatest risk of drug abuse because of their exposure to a large number of risk factors during development.76

Recent information on how the AIDS epidemic has spread in New York City and on how crack cocaine use has spread in Illinois will serve to show: (1) how these two phenomena have similar aspects, and (2) why the communicable disease model is a useful way to conceptualize how drug use spreads within and between communities. Researchers have found that rates of HIV infection vary substantially not only from region to region but also among different areas in the same city.77 For example, an epidemiological study of the spread of AIDS in New York City found that HIV infections among gay men tended to cluster in only two of nine zip codes and that HIV infections among intravenous drug users were also concentrated in particular locations.78 Noting the similarities between the pattern of infections seen in the AIDS epidemic and in previous epidemics, one researcher observed:

The thing that leaps out at you is the way that almost every historical epidemic was socially, culturally deter-

78 See id.
mined... If you begin to think of that in terms of AIDS, you realize that the public concept of a virus that floats free and gets picked up almost at random [misses the point].

Thus, there are "epicenters" of the AIDS epidemic where the risk of infection is much higher.

As with the spread of AIDS, the spread and distribution of illicit drug use in America has been extremely uneven and has been largely concentrated in specific areas, primarily the poorer neighborhoods in large urban centers. Thus, just as some groups are at higher risk for contracting AIDS, some groups are also at higher risk for using and abusing illicit drugs. The spread of crack cocaine in Illinois demonstrates this pattern. Based on search-and-seizure evidence and on TASC client self-reports, the use of crack cocaine, while widespread, has been concentrated in a few major metropolitan areas in Illinois. In particular, the extremely impoverished African-American communities in Chicago and East St. Louis were the initial focal points of the crack cocaine epidemic. While these areas remain the hardest hit, they appear to have served as the launching points for the spread of crack cocaine use to other areas of the state.

This pattern implies that, like AIDS and other infectious diseases, illicit drug use is concentrated in epicenters marked by social and cultural boundaries. Individuals who live within these epicenters are at the highest risk for becoming illicit drug users and, consequently, for becoming addicted to drugs. Therefore, rather than following a diffuse and unfocused policy, we urge that the government target the communities at highest risk for producing addicts—they are relatively easy to identify—for the most intervention.

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79 See id at 26 (quoting Dr. Albert Jonsen).
80 ONDCP, 1992 National Drug Control Strategy at 6-7 (cited in note 19).
81 Chicago and the Collar Counties, Rockford, Peoria, Springfield, and Champaign-Urbana have been the communities most affected. Illinois TASC, Extent of and Trends in Drug Use at 40 (cited in note 30).
82 Id.
83 Id. While law enforcement officers seized crack cocaine in thirty-six counties in 1991, the drug was centered most heavily in the few major metropolitan areas. Id.
84 The first National Drug Control Strategy did, in fact, propose to target certain individuals. However, the targeted individuals were to be casual users or non-addicts generally because, as the report argued, it was these individuals who were most "contagious": they were most likely to "proselytize [their] drug use—by action or example—among [their] remaining non-user peers, friends, and acquaintances." ONDCP, 1992 National Drug Control Strategy at 33 (cited in note 19). When the target is drawn so large as
Targeted interventions have been shown to be especially effective in reducing the rate of HIV infection in certain locales.\textsuperscript{55} For example, in comparing the changes in the infection rates in communities with targeted versus non-targeted intervention programs, one author has noted that

data now emerging, mostly from abroad, [ ] show it is possible to reverse the course of an AIDS epidemic or even to prevent one if efforts are intense and narrowly focused. Such efforts have succeeded even among supposedly recalcitrant populations like intravenous drug users.

Australia, for example, has managed to control the rate of new infection in the last five years by targeting high-risk groups. And Tacoma, Wash., has kept its HIV infection rates among intravenous drug users negligible while rates in New York and other cities have soared to between 50 and 80 percent of such drug users.\textsuperscript{56}

Targeted efforts are likely to be more effective than current policies in reducing illicit drug use. We estimate that if intensive and comprehensive prevention and intervention services could be provided in only twenty to thirty communities across Illinois, the reduction in crime, illicit drug use, and HIV infection would be enormous.\textsuperscript{57} Because different levels of vulnerability to different

to include all casual users, it becomes such a broad mark that it loses much of the sense of being a target at all. Moreover, this approach ignores the fact that heavy drug use appears to be concentrated in certain areas, most notably those of high social and economic isolation and poverty. We propose that it is the users in these specific areas who are most likely to become addicted to drugs and who are most likely to suffer from and themselves cause the harmful effects of drug use—i.e., commit crimes. In other words, the problems and consequences of the middle-class "weekend warrior" drug use are not equivalent to or as likely to have as large of a social impact as those of the cocaine-using, poor, jobless, inner-city resident. We believe that the likelihood of addiction developing from casual use is as closely tied to social circumstances as it is to individual predisposition to addiction. See Dean R. Gerstein and Henrick J. Harwood, eds, \textit{Treating Drug Problems} 65 (National Academy Press, 1990) (noting that few experimental drug users become addicted). We do not argue that casual use should be ignored or go unpunished; instead, we merely make the case that drug policy should not focus on all casual users. Given the relatively limited funding available for tackling the drug problem, it makes better sense to draw a more circumscribed target around those casual users most at risk for becoming addicts, especially when considering where prevention and treatment efforts should be the greatest. See also Sheigla Murphy and Marsha Rosenbaum, \textit{Women Who Use Cocaine Too Much: Smoking Crack vs. Snorting Cocaine}, 24 J of Psychoactive Drugs 381 (1992) (contrasting two women who use cocaine, one who grows up in middle-class circumstances and the other who must struggle in poverty).

\textsuperscript{55} Kolata, NY Times at 1-26 (cited in note 77).
\textsuperscript{56} Id.
\textsuperscript{57} We advocated a similar solution in Illinois TASC, \textit{Extent of and Trends in Drug
aspects of the illicit drug problem exist, a wide range of interventions and programs would be necessary. For instance, primary prevention and intervention programs should be available for children at high risk for delinquency and drug abuse. Research has shown that comprehensive programs that include the provision of prenatal and postnatal care, educational infant day-care or pre-school programs, early childhood education, parent training, and school-based academic competence promotion are especially effective in reducing these risks.\(^6\) Similarly, more programs and services should be available for addicted mothers and their children, who are also at very high risk for becoming addicted later in life and who probably already have medical problems and difficulties in school.\(^9\) Such programs now exist on a limited basis in Illinois and around the country, but they need to be greatly expanded within the targeted communities and made available prior to involvement with the criminal justice system.

As illustrated by the partial list of prevention and intervention programs enumerated above, these programs need not be specifically geared towards reducing drug use \textit{per se} in order to achieve this end. Individuals are at risk for becoming drug users for a variety of reasons related to individual, familial, and other contextual factors.\(^5\) Programs that reduce the effects of these specific risks will thus decrease the chance that a given individual will become an illicit drug user, or at least lessen the chance that she will become dependent on illicit drugs. In other words, in formulating a rational policy designed to reduce the harms associated with illicit drug use while continuing to work on reducing the number of users and abusers, we need to think of a broad range of interventions, not simply interventions that are tied specifically to drug use and abuse.

Within these epicenter communities, many individuals are already prone to criminal behavior as a result of, or concomitant with, their illicit drug use.\(^9\) For these individuals, the intervention of the criminal justice system may be inevitable,\(^9\) but our

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\(^9\) Hawkins, Catalano, and Miller, 112 Psych Bulletin at 82-83 (cited in note 76).


\(^9\) See Bureau of Justice Statistics, \textit{Drugs, Crime, and the Justice System} at 2-6 (cited in note 8).

\(^9\) See id.
proposed policy views this intervention as an opportunity to use the criminal justice system as a tool for change. Through a variety of sentencing options and sanctions, non-violent substance-abusing offenders should be coerced into participating in either community-based or corrections-based substance abuse treatment programs.

The research on coerced treatment has produced some surprisingly positive results. It was initially conjectured that individuals who were forced into substance abuse treatment would lack motivation and would do poorly compared to individuals who voluntarily sought treatment. Researchers have found, however, that individuals who are coerced into treatment do just as well as, and in some cases even better than, those who are not coerced. Apparently, the threat of increased sanctions for non-compliance is enough to motivate some individuals to continue in and comply with the treatment protocols until they internalize the motivation to succeed at treatment. Furthermore, without criminal justice involvement, many of these individuals would never enter treatment on their own. For this reason, we see the continued involvement of the criminal justice system as an important element in helping to reduce and contain illicit drug use in this country.

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94 Id at 31; Hubbard, et al, The Criminal Justice Client in Drug Abuse Treatment at 76 (cited in note 93).

95 Anglin, Efficacy of Civil Commitment at 26-28 (cited in note 93).

96 A fuller discussion of the debate on whether drugs should or should not be legalized is beyond the scope of this Article. As stated earlier, we feel that drugs should not be made legal but should be decriminalized; abolishing mandatory sentencing and reducing the penalties associated with illicit drug use should be the goal. See note 7. Another argument in favor of keeping certain drugs illegal is that laws and norms favorable toward drug use have been identified as one of the antecedents of adolescent drug abuse. See Hawkins, Catalano, and Miller, 112 Psych Bulletin at 97 (cited in note 76). In this respect, we are in complete agreement with the 1989 and 1992 editions of the National Drug Control Strategy, as well as with Professor Kraska. See note 7. The studies of Professor Anglin and, to a lesser extent, Dr. Hubbard, clearly imply that legal coercion may be one of the best tools for motivating addicts to get into and remain in treatment. See notes 93-96 and accompanying text. In turn, this finding supports the continued involve-
Treatment programs and options like TASC are already in existence, but the story is a familiar one. For the most part, the amount of treatment available, especially residential treatment, falls far short of the need. According to some estimates, the demand for treatment would not be met even if the current amount of treatment available were doubled.

The coordination between the judiciary and the treatment community has been poor in practice. For example, in Cook County, individuals who pass through the Cook County Jail's treatment program are either not sentenced to continue their treatment post-release, or they are sentenced to receive treat-

ment of the criminal justice system in the War on Drugs.

Our strategy, however, diverges from the one advocated in the various editions of the National Drug Control Strategy: we believe that more emphasis should be given to sanctions that include treatment, rather than those that are harshly punitive. We also differ in recommending that less emphasis be placed on deterring those casual users who have a relatively low risk of becoming addicts and that we focus more on treatment and prevention for individuals who are at much higher risk of developing a dependence on illicit drugs or who are already addicted. Because these users are relatively easy to target, and because a disproportionately large amount of the harms attributable to illicit drug use are caused by (for example, crime) or occur to (for example, infection with HIV) these individuals, we believe that targeting them would produce the greatest overall reduction in harm. See Reuter, 1994 U Chi Legal F at 168 (cited in note 16). Therefore, in line with the goal of reducing the harms of illicit drug use (and not necessarily reducing the numbers of users, since there are probably many more so-called "casual users"), we argue that criminal justice sanctions are important to maintain. Such sanctions may be the only way to intervene with high-risk individuals.

The following account of the new emphasis to be followed by the Clinton Administration is encouraging:

Clinton and [ONDCP Director Lee] Brown have concluded that the more than $56 billion spent on anti-drug efforts since 1988 has had only marginal success, primarily in reducing the number of casual users. The flow of drugs, despite the use of military and Coast Guard aircraft and ships for interdiction, has continued uninterrupted. A study released last week shows that drug use is up among U.S. teenagers, Administration officials noted.

Brown said the Administration is redirecting its emphasis to hard-core users who are disproportionately represented in crime, health care problems and the disruption of education.


TASC and TASC-like programs, which seek to assess, monitor, and place addicted criminal justice offenders in drug treatment, have formally been in existence since 1972. These programs provide an infrastructure for expanding both the services available and the population receiving drug treatment. See Inciardi and McBride, Treatment Alternatives to Street Crime at iii-iv (cited in note 93).

See Bureau of Justice Statistics, Drugs, Crime, and the Justice System at 109 (cited in note 8).

See id.

See Lurigio and Swartz, 17 Evaluation and Program Planning at 209-14 (cited in note 54).
ment in the community as if they had never been in treatment in the first place. Thus, some participants who have been in the Jail's residential program for six months or more enter a community-based treatment program and start over from the very beginning, with new counselors and peers. This scenario can easily lead to treatment burn-out if the individual begins to feel that all previous efforts were for naught.

To respond to these problems, the judiciary must consider both the chronic nature of addiction and a specific individual's treatment history and needs. Those who need long-term care should receive sentences long enough to ensure that they complete treatment. Those who have successfully completed prisoner jail-based residential treatment programs should be given the opportunity to advance to an intensive outpatient program or a halfway house upon release.

Unless all of the parties that provide substance abuse treatment to criminal offenders are closely coordinated, treatment and its results will be less than optimal. Calls for increased treatment availability and for better coordination in the delivery of treatment are, of course, not new. There have been many voices calling for such changes for years now, but to little apparent effect.

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102 This is based on preliminary analyses of data collected as part of our study of over 850 arrestees treated in a jail-based, residential treatment program. Of the 400 or so who were released to the community following their jail stays, only about half were placed in community treatment. Of these, the majority were placed in residential treatment in the community regardless of the length of time or progress made in the jail program.

103 The same preliminary analyses revealed that after the first 121 days spent by an individual in a treatment program, no further benefits accrued in terms of reducing recidivism. A similar study found that participants who stayed in a prison-based treatment program longer than twelve months actually did worse than those who stayed for only nine to twelve months. Harry K. Wexler, et al, Outcome Evaluation of a Prison Therapeutic Community for Substance Abuse Treatment, in Carl G. Leukefeld and Frank M. Tims, eds, Drug Abuse Treatment in Prisons and Jails, NIDA Research Monograph 119, 156, 171-72 (United States Department of Health and Human Services, 1992).

104 These arguments are based on our experiences in providing case-management services over the last fifteen years to literally thousands of addicted criminal offenders in Illinois. For the past few years, the Chicago Community Trust has funded a project led by TASC to develop new strategies for providing appropriate sanctions and treatment options over the entire criminal justice continuum, from arrest to pre-trial to post-sentence. This project grew out of a long-standing recognition by both treatment providers and criminal justice administrators of the need for coordinated services and graduated sanctions that better suit the needs of addicted offenders while continuing to guard community safety. See also Gerstein and Harwood, Treating Drug Problems at 54-55 (cited in note 84).

105 Id.
B. Make Treatment Comprehensive

Addicts, especially those who turn to crime to support their habits, typically have a variety of problems and deficits. Many are poorly educated or illiterate and lack the skills necessary to secure even a low-paying job. Some have severe psychological problems, such as depression, that make it difficult for them to participate in treatment programs which are often rigorous and demanding. Large numbers of addicts have medical problems resulting from their chronic use of drugs. And, as mentioned earlier, many addicts are either already infected with HIV or at high risk of becoming infected.

Female drug users have an additional set of hurdles to overcome before they can successfully utilize treatment. Attending residential programs is difficult or impossible for many women because they bear primary responsibility for child care. Thus, child care services must either be available at treatment programs or elsewhere in the community. Women are also more prone than men to having a variety of medical ailments related to their addictions. Finally, there is evidence that many treatment programs, especially residential ones, were largely designed by and for men and are consequently poorly suited psychologically for women.

Treatment success, however one wants to define it, is directly related to the provision of services that address the addict’s needs. Just as prevention services must be comprehensive in

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107 See Bureau of Justice Statistics, Drugs, Crime, and the Justice System at 9, 14 (cited in note 8).
109 Bureau of Justice Statistics, Drugs, Crime, and the Justice System at 10 (cited in note 8).
112 This is true even though women with children may be more likely to participate in treatment, because treatment is a function of age. Id at 241.
113 Id at 234.
115 James W. Sidall and Gail L. Conway, Interactional Variables Associated with Re-
order to be effective, so too must the treatment itself. Addicts who successfully complete a treatment program but who cannot get work because they have no marketable skills or are uneducated will quickly return to drug dealing, crime, and addiction when returned to their communities.\(^\text{116}\) Thus there needs to be a variety of services and programs within communities that offer viable alternatives to street life.\(^\text{117}\) These services would include programs such as neighborhood recreation centers that afford young addicts a place to socialize and stay off the streets, and programs that provide safe housing alternatives for those who lack a stable residence. In addition, recent work has recognized the importance of implementing culturally relevant programming to put the participants' treatment experiences in a context that is meaningful and applicable to their daily lives.\(^\text{118}\) Given the importance of the "ancillary" services or programs in making treatment successful, newly funded programs must either be internally comprehensive or have ready access and connections to a variety of community-support programs.

Many of these points have also been made for some time, but putting them into practice has proven to be an elusive goal. One reason is that funding for new programs has been made available in a piecemeal fashion: here, a program for treating incarcerates; there, a treatment program based in the community; elsewhere, AIDS services for one specific group but not for another. Additionally, both federal and state funding, especially for demonstration programs, is withdrawn after several years.\(^\text{119}\) Obtaining continued funding is often difficult, especially when there is a change in political administrations. In analyzing the difficulties involved in setting up comprehensive programs to prevent delinquency, Professor Yoshikawa observed:

Many problems associated with scaling up from local or demonstration programs—maintaining program quality,
serving the needs of culturally and ethnically diverse populations, acquiring broad public support, developing local delivery channels, overcoming political opposition, and obtaining and maintaining funding—stand in the way of the goal of a national early family support and education initiative.\footnote{120}

These observations also apply to the difficulties in setting up comprehensive substance abuse treatment programs. In contemplating future initiatives for programs for substance users and abusers, we must factor both their comprehensiveness and longevity into the funding equation lest we continue to support fragmentary, underfunded, and short-lived efforts that have limited effectiveness.

To this end, it may prove helpful to organize a national substance abuse planning board to develop a coordinated and cohesive federal plan. An effective planning board would require the participation of different department bureaucracies, as well as private and community experts. One of the planning board’s objectives would be to develop standards for the delivery of enhanced treatment services like those described above, which states and communities would be required to adopt. Another objective would be closer coordination between all federal agencies dealing with the national substance abuse problem.

C. Prioritize Research and Tighten the Link Between Research and Treatment

Under the present federal system, the Center for Substance Abuse Treatment (“CSAT”) funds and oversees the provision of substance abuse treatment, while the National Institute on Drug Abuse (“NIDA”) funds and oversees treatment research.\footnote{121} This arrangement makes some sense from the perspective that the two tasks are very different. It has also proven, however, to be an obstacle when it comes to understanding what makes treatment effective and to evaluating different types of treatment programs. For example, it has been TASC’s experience as a CSAT grant recipient that CSAT encourages evaluation research done in conjunction with newly funded programs. However, CSAT’s level of research funding is typically inadequate for conducting a mean-

\footnote{120} Yoshikawa, 115 Psych Bulletin at 45 (cited in note 88).
\footnote{121} See Lurigio & Swartz, 17 Evaluation and Program Planning at 212-14 (cited in note 54).
meaningful research study. On the other hand, it has been TASC's experience that NIDA encourages scientists to study new types of treatment programs but does not provide substantial funds for new or particularly innovative treatment programs. Thus, research of innovative programs is underfunded, while, ironically, research of non-innovative programming is overfunded.

This schism between research and treatment, as unintentional as it may be, hurts our efforts to find out what works, what does not, and how we can provide better treatment. It will probably be difficult to achieve a high level of cooperation between two distinct federal agencies with their own bureaucracies and ethos, but it is the only arrangement that makes any real sense if we hope to provide more effective substance abuse treatment.

The research arena is also the ideal domain for funding more experimental or controversial programs on a limited basis. For example, research funding could settle the debate over the effectiveness of needle-exchange programs. Instead of merely arguing over whether such programs encourage drug use or save lives and reduce the rate of HIV infection, it would be far better to fund small projects to determine which argument is correct. If the research shows that controversial programs are effective, then they could be funded on a wider basis. However, if research shows that the programs are ineffective, then other types of programs should be explored. Arguing a priori that a program would produce a given set of results based simply on intuition, and then refusing to fund even experimental studies of such a program on ideological grounds, has greatly impeded our progress in the area of substance abuse treatment. Research on existing experimental programs, even when these programs are controversial, should be a priority in our drug policy.

CONCLUSION

This brief outline of some of the fundamental underpinnings for a rational drug policy is somewhat incomplete. We do not know, for example, how changes in our national health care system will affect the provision of public health services. It may be that a national health care system will provide more comprehensive services to members of poorer communities. Alternatively, a new national health care system may be so financially constricted that substance abuse treatment services will remain inadequate.

It does seem clear to us, however, that with managed care's emphasis on the bottom line and on making treatment delivery
more efficient, the costs and benefits of substance abuse treatment will be scrutinized more closely. Even though research has demonstrated that, in general, treatment is effective, there remains a wide variation between programs with respect to their quality and effectiveness. The advent of a national plan for managed care will likely hold treatment programs more accountable for the services they deliver and for their outcomes, with the potential for weeding out those that are relatively less effective.

We also project that substance abuse treatment services will remain at a premium. And while clients should not receive more treatment than they need, they should receive as much treatment as they need. Therefore, under a national health care plan there will also be (should also be) a greater emphasis on careful, standardized screening and assessment so that clients are placed in the type of treatment that best fits their needs.

We have also not gone into great detail about the specific types of services needed by all groups, nor have we discussed at much length how we will balance the funding equation between law enforcement and treatment, although we have explicitly stressed the need to give greater emphasis to the role of treatment and prevention. These are the kind of things that would need to be worked out, argued over, and no doubt compromised on. Despite the lack of such details, however, it should be absolutely apparent that we can no longer afford to continue along the course of the last decade, and that changes in the priorities established by the most recent War on Drugs are long overdue.

We expect that implementing our proposed policy would bring lower levels of drug-related crime, lower rates of HIV infection among high-risk populations, decreased utilization of publicly funded health services, increased education and employment in the targeted areas, and decreased pressures on our jail and prison systems. Given, however, that the effects of some of the initiatives we are proposing, especially those in the area of prevention, may take years to realize, this course requires some measure of patience, a seemingly rare commodity these days.

There are literally millions of illicit drug users and abusers in this country, and no single effort or set of policies can entirely undo or completely mitigate the damages caused by drug use. It is clear from the results of this country's previous efforts that addiction is and remains a formidable foe, one that is not per-

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suaded by reason nor daunted by lengthy prison sentences or border patrols. Nevertheless, by directing resources towards users or potential users who are most affected or at risk, and by not aiming at too broad a target, as has been the case in the past, we feel that we can maximize the beneficial impact of these resources.