

Persuasion, Help, and Control

Q. How many drug counselors does it take to change a light bulb?

A. Just one, but the light bulb has to really want to change.

Laws and their enforcement are not the only items in the drug-policy toolkit. Programs can also influence the preferences and incentives of current and potential drug buyers. These programs are conventionally thought of as constituting the "demand side" of drug policy, although legislation and enforcement influence demand as well as supply. Demand-side efforts attempt to change drug-related attitudes and behavior in the mass of the population by delivering messages and to change the drug-related behavior of those who have already developed personal drug problems by delivering some mixture of messages, services, and threats.

Enforcement efforts are identified in the public mind with the police, though in fact they engage prosecutors, judges, and corrections officers as well. Demand-side efforts, by contrast, are largely the province of teachers and of a mix of physicians, other health-care workers, and social workers of various kinds: persons engaged in what are called the "helping professions" (a category rarely construed to include police or probation officers). Much of what passes for debate about the relative merits of programs to reduce supply and programs to reduce demand is in fact little more than a reflection of the ideological, professional, social-class, and even ethnic tensions between the police on the one hand and physicians, schoolteachers, social workers, and treatment-program employees (often addicts in recovery) on the other. This chapter is in part an attempt to demystify that debate.

PERSUASION

The Value, Strategy, and Limits of Persuasion Programs

The harm a drug engenders can be reduced by persuading current and potential users not to try it, to use it less frequently, or to restrict its use to relatively safe

times, circumstances, and quantities. In addition to its direct benefits in preventing harm to users, successful persuasion also shrinks illicit markets and their side effects and makes enforcement easier.

These efforts at persuasion are sometimes lumped together as "education," but not all of them take place within institutions labelled "educational." Nor are the goals and methods of these efforts particularly close to those of education; advertising, political campaigning, and religious proselytization all offer equally apt analogies. Those who design, administer, and evaluate anti-drug persuasion efforts conventionally think of and measure success or failure in terms of the programs' impact on the drug-related attitudes and behavior of the target audiences, rather than, for example, how much factual information or analytic material the members of those audiences have absorbed.^{EN1} It is also conventional to describe these persuasion efforts as "prevention," but that ducks the question of what it is they are designed to prevent—use, abuse, or damage—and it begs the question of what role persuasion has, and what role laws and their enforcement have, in preventing drug use and its unwanted consequences.

The enthusiasm for persuasion efforts is pervasive; enforcement professionals and agencies tend to be particularly strong believers in the power of persuasion to shrink the drug markets by drying up the pool of customers.^{EN2} Successful persuasion would indeed be a boon; given two proposed public programs, one relying on persuasion and the other on enforcement, costing similar amounts of public money and preventing approximately equivalent amounts of drug-related harm, there would be strong reasons to prefer persuasion to enforcement. Enforcement involves, as the word suggests, the use or at least the threat of force; persuasion does not. Neither

^{EN1} See, for instance, Mary Ann Pentz, James H. Dwyer, David P. MacKinnon, Brian R. Flay, William B. Hansen, Eric Yu I. Wang, and C. Anderson Johnson, "A Multicomunity Trial for Primary Prevention of Adolescent Drug Abuse," *Journal of the American Medical Association* 261 (22 [June 9, 1989]): 3259–3266.

^{EN2} Mark A. R. Kleiman and Kerry D. Smith, "State and Local Drug Enforcement: In Search of a Strategy," in *Crime and Justice: An Annual Review of Research*, Norval Morris and Michael Tonry, eds. (Chicago: University of Chicago Press, 1986).

teacher nor student risks being killed in a drug education class; every enforcement operation poses some risk both to the police and to their targets. To the extent that persuasion efforts are successful, they reduce the wealth and power of criminal drug-dealing organizations by depriving them of customers; the effects of enforcement, as we have seen, are more ambiguous. Properly designed persuasion can foster the capacities of their audiences to control their own behavior; enforcement, which always aims at restricting the range of choice available to potential drug users, is as likely to weaken those capacities instead. By reducing the potential size of the market, persuasion can increase the effectiveness and decrease the unwanted side effects of enforcement efforts.

But persuasion efforts have their own problems and limitations. Research into a wide range of attempts to improve health-related behavior via "education" has produced a mix of results: some programs were, on balance, positive; some were neutral; and some were actually counterproductive.^{EN3} Nor is this surprising. Insofar as drug abuse is the product of mistakes, they are not primarily the kinds of mistakes that additional information is apt to prevent: the links between knowledge and behavior are more complex than that.

The Problem of Design

Consider the simplest model of drug abuse prevention through education: tell potential users the facts about drugs, and you will persuade them not to use (or abuse) drugs. That model implicitly assumes several things: that the information given will be believed; that believing that information will be enough to convince potential users that using drugs would be unwise; and that they will have the will and the skill to act on that conviction when confronting the most typical drug-initiation situation: an offer to share made by a friend or acquaintance. While each of these assumptions is true to some extent for each potential user, one or more of them is likely to be substantially false for much of the target audience. Some will not believe what they are told; some will not value the negative consequences of drug use as highly as their teachers hope; some will act on impulse or in response to

^{EN3} J. Michael Polich, et al., *Strategies for Controlling Adolescent Drug Abuse* (Santa Monica, Calif.: The RAND Corporation, 1984).

social pressure in ways inconsistent with their considered judgments.^{EN4}

Worse, some who in the absence of drug education might be scared by unknown and ill-defined risks may in fact be reassured, rather than deterred, by what they are told. Not only do they know more about the risks than they did before, they are also more competent to handle them. In effect, drug education can make them better-informed and more self-confident drug consumers. Some of them will be able to use what they have learned to stay out of trouble, but others will surely illustrate the danger of a little learning. Others, who had never seriously considered drug use as a personal option, may be led by the mere fact of the discussion to think about it. Drug education can increase drug-related damage among its subjects (just as high school driver education increases automotive deaths among its subjects^{EN5}) if the program does more to increase the number of people who engage in the risky activity under consideration than it does to decrease the risk.^{EN6}

Moreover, the benefits of information-based education are limited by the fact that those most open to rational persuasion—those who can absorb new information, integrate it into their decision making, and act on their considered judgment in the face of social pressure—are probably those least likely to go from experimentation to self-destructive, chronic, heavy drug use. For the ones most likely to get into trouble—the present-oriented, impulsive, and reckless—accurate information may not help much, because the probabilities may not be sufficiently frightening; no drug currently in widespread use possesses a large risk of great or irreversible damage to someone who uses it once, and only nicotine is more likely than not to turn an experimenter into a compulsive user.

^{EN4} Francis X. Hartmann and Saul N. Weingart, "Strategies for Demand Side: Prevention, Early Intervention and Treatment" (Report to Ford Foundation, Working Paper 87-01-02, 1987).

^{EN5} Louise Potvin, François Champagne, and Claire Laberge-Nodeau, "Mandatory Driver Training and Road Safety: The Quebec Experience," *American Journal of Public Health* 78 (9 [September 1988]): 1206.

^{EN6} Opponents of sex education have made similar arguments, but in that case any claims of a "curiosity effect" would be very weak indeed; adolescents are already curious about sex.

Drugs are risky rather than always deadly, and those risks are concentrated in the future, months or years after initiation. Assume hypothetically (there is no way to know accurately) that trying one's first dose of crack incurs a one-in-six risk of becoming a long-term compulsive crack smoker. To the reader of this book, that should seem an intolerable risk: the same odds as Russian roulette, with sufficiently appalling, albeit less drastic, consequences should the chamber turn out to be full. To a seventeen-year-old convinced of his own invulnerability, however, five chances in six of avoiding serious trouble may seem quite generous odds, particularly if he attributes the difficulties of problem users to their idiosyncratic weakness rather than to the inherent risks of the drug itself. (Nor can it be said that this attribution is incorrect; rather, the adolescent may be underestimating the probability that he will prove to be the weak or unfortunate one rather than one of the strong or fortunate five.)

There is some evidence that those who identify themselves as "venturesome" or "risk-taking" are much more likely than others to use drugs, particularly illicit drugs.^{EN7} Part of the difference between U.S. and foreign rates of illicit drug use may stem from the high value Americans place on trying new things. This suggests a need to design anti-drug messages that will appeal to the risk takers. These messages could either be delivered as part of general classroom or media efforts or aimed specifically to those identified (perhaps simply by questionnaire) as being of adventuresome disposition.

Perhaps persuasion programs should do more to stress the intrinsic disadvantages of drug use, particularly use to excess, and of intoxication. Oscar Wilde once said, "As long as war is regarded as wicked, it will always have its fascination. When it is looked upon as vulgar, it will cease to be popular."^{EN8} Similarly, there may be less to gain from convincing teenagers that drunkenness is risky than from convincing them that it is uncool.

Most persuasion efforts in the classroom and the mass media tend to be broadcast and scattershot. At best, they are designed for the average of a subgroup: say, suburban

^{EN7} This is based on unpublished data from studies conducted by the Gordon S. Black Corporation for the Media Partnership for a Drug-Free America.

^{EN8} Oscar Wilde, *The Artist as Critic: Critical Writings of Oscar Wilde*, Richard Ellman, ed. (London: Allen, 1970).

sixth-grade boys. At worst, they go to the entire population, as in mass-media advertising.^{EN9} But the heterogeneity of the audience necessarily makes whatever message is delivered inappropriate, or at least irrelevant, to some of those who receive it. For example, a "Don't try it," "Just say no" message may be effective with those who have yet to start drug use. For those who have started already, however, threats of dire consequences following any use are likely to be disbelieved and to weaken the credibility of warnings about sources of elevated risk, such as the use of more dangerous substances, binge use, daily use, and mixing drugs. Predictions of an inevitable degeneration from experimentation to chronic abuse can also do active harm by demoralizing users in their efforts to maintain control.

An alternative to designing messages for teachers or media outlets to deliver directly to potential drug users is to aim persuasion efforts at authority figures and opinion leaders. Professional athletes and movie stars are less important in this regard than health-care workers, coaches, and others involved in leading athletic activity, and similar figures to whom potential drug takers, particularly adolescents, might turn for personal advice. Making people who already have the trust and respect of the target audience more sophisticated and persuasive sources of good advice about drugs, and persuading them that giving it is part of their professional responsibility, could pay large dividends. One model to examine is the effort to encourage physicians to deliver anti-smoking messages to their patients.^{EN10}

Designers of persuasion campaigns also need to worry about how their messages will affect those who continue to use drugs and those trying to quit. Anything that makes people afraid of becoming drug users also tends to make them afraid of those who are drug users. To make the population at large even more afraid of drug users is not obviously desirable. Decreasing social tolerance for drug use generally, for use of particular drugs, or for heavy chronic use can presumably lessen the attractiveness of those activities. But decreasing tolerance also reduces the

^{EN9} Joseph Treaster, "Stepping Up the Drug Fight, From Toys to TV Shows: Marketing of Anti-Drug Messages," *New York Times* (16 March 1991): 7, c. 1.

^{EN10} J. K. Ockene, "Physician-delivered Interventions for Smoking Cessation: Strategies for Increasing Effectiveness," *Preventive Medicine* 16 (1987): 723-737.

social and economic opportunities available to users and ex-users; "hating the sin but loving the sinner" requires a disposition more saintly than we can reasonably expect as a social norm.

Since the most common pattern of illicit drug use is occasional marijuana smoking,^{EN11} and since there is no evidence that occasional marijuana smokers as a group are worse neighbors, coworkers, or fellow students than non-users, generating additional social hostility toward drug users in general is not manifestly wise or just. Even for heavy users of more dangerous drugs, who clearly tend to impose costs on the rest of us, the current level of hostility may be more than adequate: it is easier to find sites for prisons than for drug treatment centers. One good argument for stressing alcohol and tobacco in anti-drug messages is to avoid making drug use an issue of "us versus them." But much of the political impetus behind anti-drug advertising is precisely that of a cultural holy war, pitting the decent normal people who smoke and drink against the hated and despised "drug users."

One of the great accomplishments of Alcoholics Anonymous has been to lessen social hostility toward chronic heavy drinkers. The definition of alcoholism as a disease—whatever its theoretical merits—does a great deal to deflect animus from the drinker or ex-drinker. As a consequence, many AA members are eager to help others down the path to recovery: this is the "Twelfth Step." Ex-users of illicit drugs, by contrast, even those in twelve-step programs, tend to be much more wary of letting anyone know about their status.^{EN12}

In a classroom setting, some of these issues can be finessed. Even within a set curriculum, teachers can tailor messages to fit their students. They can even attempt to communicate some of the complexity of drug use: that it always carries some risks, but fewer if carefully managed.

^{EN11} Lloyd D. Johnston, Patrick M. O'Malley, and Jerald G. Bachman, *Drug Use, Drinking, and Smoking: National Survey Results from High School, College, and Young Adult Populations: 1975-1988* (Rockville, Md.: Department of Health and Human Services, 1989), 30-46, 255, 267-271. National Institute on Drug Abuse, *National Household Survey on Drug Abuse: Population Estimates 1988* (Rockville, Md.: Department of Health and Human Services, 1989), 23-35.

^{EN12} I owe these observations to the Reverend Dr. David Weeks of the North Conway Institute in Boston.

Mass-media campaigns of necessity allow for less variety and less subtlety.

The problem of the choice of messages raises the complicated question of the goal of drug abuse education and of drug abuse prevention generally: should they aim to prevent any use of any drug, any use of a specific list of drugs, or only excessive or inappropriate use? This is a question both of ultimate ends and of tactics.

All persuasion efforts that concentrate on drug use itself, as opposed to more abstract attempts to teach personal responsibility, decision-making skills, and resistance to social pressure, are pulled in two directions by the tension between preaching abstinence and preaching moderation. Knowledge of pharmacology—of drugs and dosages, effects and side effects—is essential to moderate use but may be dangerous to the cause of abstinence. To know that one drug is more dangerous than another is to know that the other is relatively safe. To know how much is too much is to know how much is enough. Learning enough about drugs to be a responsible, moderate user is likely to excite curiosity and to generate feelings of competence and a desire to try out newly acquired knowledge in practice. "The young," said Lord Chesterfield, "are as apt to think themselves wise enough, as the drunken to consider themselves sober enough."^{EN13}

On the other hand, the "Just say no" message suggests that drug use cannot be rule-governed behavior. This leaves those who do not "say no" without any model of when or how to "say when." To the extent that personal rules about moderate drug use need the support of social norms and patterns,^{EN14} abstinence campaigns may be counterproductive if they drive those who would have been moderate users to abstinence and thereby create a population of drug users dominated by those with a tendency toward excess.

Persuasion campaigns that address themselves to the specifics of drug taking, as opposed to more general character development, also face the problem of how to treat licit drugs: what to say about them and how much emphasis to give them. The introduction of the wine cooler has made alcohol an issue for junior high and even elementary school pupils; the early teens are also prime

^{EN13} Philip Dormer Stanhope, Lord Chesterfield, *Letters to his Son* (London: Folio Society, 1973).

^{EN14} Norman E. Zinberg, *Drug, Set, and Setting: the Basis for Controlled Intoxicant Use* (New Haven: Yale University Press, 1984).

years for the initiation of smoking. Those who administer school-based programs (at least outside the tobacco-growing states) are apt to favor a "Just say no" approach to cigarettes, particularly given the rarity of noncompulsive use of nicotine in that form. But alcohol is trickier; complete abstinence is not the norm in mainstream American society, nor is there any mass movement to make it the norm. But teaching minors about responsible drinking is certain to be controversial, particularly since it is illegal for them to buy or possess alcohol. Conveying the message that alcohol is for adults only—an approach that might be summarized as "Just say later"—would be consistent with the law, but identifying alcohol use as adult behavior might only enhance its appeal to adolescents eager to grow up.

On the other hand, it seems unwise to ignore alcohol and tobacco entirely. Not only are they live issues for more of the population—and vastly more of the schoolchildren—than any of the illicit drugs, but to say nothing about them would be to suggest that they are somehow not really drugs at all. Silence about alcohol and tobacco is a very loud silence, one unlikely to go unheard. It would be a bitter irony if anti-drug campaigns had the net effect of encouraging adolescents to smoke and drink.

Persuasion campaigns aimed at licit drugs run into the political clout of the industries that have grown up around the production and distribution of alcohol and tobacco. The largest of the current media-based programs, for example, is run by a consortium of advertising agencies, virtually all of which derive a substantial proportion of their revenues from advertising alcohol and tobacco. The Media Partnership for a Drug-Free America has had nothing to say about the perils of smoking or of the Demon Rum.

The limited body of empirical research on classroom-based prevention programs strongly suggests that success depends on offering students specific reasons not to do whatever the program is trying to prevent.^{EN15} It is not enough for those reasons to be valid for the teachers; they must be persuasive to the students, for whom the present looms much larger than the future and certainties overwhelm moderate risks. In the case of smoking, for example, stained teeth and foul breath today may be a far stronger

^{EN15} J. Michael Polich, et al., *Strategies for Preventing Adolescent Drug Use* (Santa Monica, Calif.: The RAND Corporation, 1983), 146-147.

deterrent to adolescents than the possibility of emphysema in forty years.

This poses a problem for anti-drug education on the "Just say no" model. There is simply no evidence that occasional use of alcohol or marijuana at moderate dosage damages a majority of users, or even a large minority of them. In fact, some evidence suggests that moderate users are, on average, better off in various ways than non-users (which may, of course, mean that well-being leads to moderate use rather than the converse).^{EN16} This lack of factual ammunition creates an unpleasant choice for "Just say no" teachers: stress the virtue of obeying the law (doubtfully efficacious), stress the risk of going from moderate use to excess use (but the risks, for most drugs, are not very high), or misrepresent the facts. That any purchase of illicit drugs helps maintain the black market, with all the damage it does, is surely a good reason not to buy them (though low-dose, occasional use contributes little to criminal coffers), but that argument seems unlikely to have much weight in the decision making of adolescents.^{EN17}

If the majority of the audiences for anti-drug advertising would become drug abusers in its absence, then messages could hardly do harm, just as a brand of mouthwash currently consumed by 1 percent of the population can gain sales from an advertising campaign that attracts attention even if it repels three-quarters of its viewers. But in fact drug abuse is rare, and chronic drug abuse with lasting bad consequences very rare.^{EN18} To be beneficial on

^{EN16} Jonathan Shedler and Jack Block, "Adolescent Drug Use and Psychological Health," *American Psychologist* 45 (5 [May 1990]): 612-630. For a discussion of the longer-term effects of adolescent drug use, see Michael D. Newcomb and Peter M. Bentler, *Consequences of Adolescent Drug Use: Impact on Young Adults* (Newbury Park, Calif.: Sage Publications, 1988).

^{EN17} On the market significance of casual users, see, for example, the calculations in Mark A. R. Kleiman, *Marijuana: Costs of Abuse, Costs of Control* (New York: Greenwood Press, 1989), 34-39.

^{EN18} According to the *National Household Survey*, more than 70 million Americans reported using an illicit drug at some time. National Institute on Drug Abuse, *National Household Survey on Drug Abuse: Population Estimates, 1988* (Rockville, Md.: U.S. Department of Health and Human Services, 1989), 17, Table 2-A. The Institute of Medicine

balance, a persuasion campaign must both improve the status of those who would otherwise get into serious trouble and not arouse unhealthy curiosity in any substantial proportion of the rest. That this problem is more than theoretical is illustrated by the school-based anti-drug education campaigns of the late 1960s and early 1970s, which aimed either to instill fear of drugs in general or to provide accurate and impartial information. Evaluations showed that both types of programs on balance increased the drug abuse problem among their youthful audiences. The scare messages were not believed by those who needed them most, and the information served as consumer education for the drug markets.^{EN19}

If the goal is to minimize the number of people who get into serious trouble with a drug rather than the total number of users, the best way to reach that goal depends on which of two plausible models best describes the relationship between the overall use of a given drug in a given population and its problem use.

One model is based on a chain of "transition probabilities."^{EN20} This model assumes that anyone who experiments with a drug faces some probability of proceeding to regular use, and anyone who uses a drug regularly faces some probability of proceeding to heavy chronic use or repeated binge use. Regular users confront some probability, and abusers a higher one, of getting hurt. All of these probabilities are higher for persons starting at younger ages. Unless one or more of these probabilities is greatly malleable by educational intervention, the best way to reduce the number of people who get hurt is to reduce the number of people who experiment, or the variety of drugs with which they

study panel found that 2.2 million people were clearly and 3.1 million were probably in need of drug treatment.

Institute of Medicine, *Treating Drug Problems* Vol. 1 (Washington, D.C.: National Academy Press, 1990), 97, 101.

^{EN19} J. Michael Polich, et al., *Strategies for Preventing Adolescent Drug Use*.

^{EN20} Mark H. Moore, "Policy Towards Heroin Use in New York City," Ph.D. dissertation (Cambridge, Mass.: Kennedy School of Government, Harvard University, 1973). See also Mark H. Moore, *Buy and Bust: The Effective Regulation of an Illicit Market in Heroin* (Lexington, Mass.: Lexington Books, 1977); Mark H. Moore and Dean R. Gerstein, *Alcohol and Public Policy: Beyond the Shadow of the Prohibition* (Washington, D.C.: National Academy Press, 1981).

experiment, or to retard the age of first use as much as possible. This suggests stressing the distinction between use and non-use and downplaying the distinctions among drugs and between use and abuse.

The alternative view is that virtually everyone will experiment with drugs (including alcohol). On this view, the probabilities of proceeding to regular use or to abuse are variables influenced by personal and social characteristics: norms and customs about drug use, the individual's knowledge about the relative dangers of various drug-use practices, and his capacity to make sensible personal decisions and ability to act on those decisions in the face of social pressure or temptation to excess. If this view is correct, drug education should aim at establishing controlled drug-use patterns, give considerable information about the characteristics of different drugs, and teach strategies for managing one's own drug habits.^{EN21}

Since both the chain-of-probabilities model and the responsible-use-versus-abuse model are likely to capture parts of the truth, designers of persuasion programs aimed directly at drug-related behavior are in a quandary. Designing a single program that accommodates both viewpoints seems close to impossible, and appropriately targeting different messages at different audiences seems only slightly easier.

The only apparent escape from this box is to focus attention away from drugs as a topic and toward moderation and self-command as ideals to be cherished and skills to be developed. Making the young aware that their own behavior under temptation or social pressure is a potential problem that they need to learn to manage, and giving them guidance and exercise in managing it, may properly be called an educational mission. It addresses a problem not of a minority but of virtually everyone, and its applications go well beyond drug use. Strategies for developing and observing personal rules, identifying and resisting

^{EN21} This argument is made in Norman Zinberg, *Drug, Set, and Setting: The Basis for Controlled Intoxicant Use* (New Haven: Yale University Press, 1984). Examples of drug education materials written from this viewpoint include Andrew Weil and Winifred Rosen, *Chocolate to Morphine: Understanding Mind-Active Drugs* (Boston: Houghton Mifflin, 1983), and Edward Brecher, *Licit and Illicit Drugs: The Consumers Union Report on Narcotics* (Boston: Little, Brown, 1972).

impulses and social pressures to transgress those rules, recognizing an offer as the occasion for a decision, and analyzing the issues at stake in that decision are relevant to the management of one's sexual, nutritional, automotive, academic, or television-watching behavior as well as one's drug-use behavior.

In a program of education and training for self-command or moderation, drugs would enter in two ways, both important but neither central. First, drug consumption would appear as an example: an area in which individuals often behave in ways not congruent with their own interests. Temporal myopia and the failure to defer gratification, ignorance about or neglect of risk, failure to identify choice points, and social pressure could all be identified as contributors to bad choices. Second, intoxication itself would appear as an independent contributor to distorted decision making and unanalyzed behavior.

Project DARE, the most widespread of the school-based anti-drug programs, is not primarily about drugs. Only three of the thirteen lessons in the original DARE curriculum address drug use; the rest are a mix of exercises in values clarification, material about personal decision making, and skill-building activities featuring role-playing.^{EN22} If DARE were not sponsored and operated by police departments, it might have elicited the same complaints from parents and clergy that have dogged other values-clarification programs, particularly those dealing with sexual behavior.

Given what we know about advertising and classroom education, expecting televised or blackboard "moderation education" to greatly improve the capacity of the rising generation for temperance in its most general sense would be unduly optimistic. But intemperance—not only the intemperate use of drugs—is so costly a problem that even small gains would repay substantial investments.

The Problem of Evaluation

^{EN22} Bureau of Justice Assistance, "An Invitation to Project DARE: Drug Abuse Resistance Education" (Washington, D.C.: Department of Justice 1988); William DeJong, "Project DARE: Teaching Kids to Say 'No' to Drugs and Alcohol," Report prepared for National Institute of Justice (Washington, D.C.: Department of Justice, March 1986).

If it were easy to measure the effects of persuasion programs, the theoretical problems about designing and implementing them would be relatively unimportant; trial and error would be sufficient to develop programs that worked, even if no one could quite explain why. Unfortunately, the measurement problem is even more subtle and profound than the design problem.

The frequency of drug abuse is hard to measure, because drug abuse is hard to observe: self-reports are unreliable, and official records (such as criminal histories) are often incomplete and hard to get at for research purposes. Small uncertainties about the frequency of drug abuse matter greatly in the process of evaluation, because the frequency itself is so low. A persuasion program that actually reduced the lifetime prevalence of cocaine abuse in a given population from 5 percent to 4 percent would have to be counted a great success for having eliminated a fifth of the problem without arresting anybody. In practice, though, no one will be able to say for sure whether the rate of abuse before the intervention was really 5 percent rather than 4 percent, or whether the rate after the intervention was really 4 percent rather than 5 percent, and the research reports are likely to conclude that "the intervention did not have a statistically significant effect on the target variable." The element of time further complicates things; six years must pass before we can start to measure the effects of a program aimed at sixth-graders on their drug-use status at graduation from high school. Six years is a long time to wait between the first trial and the first results, and a long time in the history of schools and drugs. The knowledge that Program X was a good program six years ago is only mildly helpful in determining its usefulness today; the kids have changed, the schools have changed, and the drug scene has changed.

Evaluations of the wave of school-based drug-prevention programs during the 1980s have now begun to come in. Some are quite encouraging. It is apparently easier to discourage marijuana use than tobacco use, and tobacco use than alcohol use.^{EN23} However, virtually all of these studies rely on self-reports about attitudes toward drugs or about the prevalence of drug use (not abuse), measured one or two years after the intervention. One carefully designed and carefully evaluated program, aimed at inner-

^{EN23} Phyllis L. Ellickson and Robert M. Bell, "Drug Prevention in Junior High: A Multi-Site Longitudinal Test," *Science* 24 (March 1990): 1299-1305.

city sixth-graders and including both school-based and community-based elements, seems to have reduced the frequency of alcohol, tobacco, and marijuana use—all around 10 percent in the control group—by about one-third: a very impressive performance.^{EN24} If the self-reports are accurate, and if those abstaining because of the program included one-third of those who would otherwise have gone on to serious drug problems, and if early drug use is an independent risk factor for developing problem use rather than simply a marker for it (or if, alternatively, the program succeeded in shifting the entire population toward less drug use), then that program must be judged a success and, despite its substantial costs, well worth replicating in other, similar populations. We should know by sometime in the mid-1990s. DARE, the most widely implemented program, has shown somewhat disappointing results in evaluations performed so far, but the data are still coming in.^{EN25}

The methodological problems in evaluating media-based campaigns are even more daunting; just separating the "experimentals" (those who have received the messages) from the "controls" (those who have not) is anything but simple. If one effect of anti-drug advertising is to decrease social tolerance for drug use, one likely result will be to reduce the willingness of those who continue to use drugs to say so when surveyed. Self-reports are always tricky to interpret; programs that tend to make them even less reliable are therefore especially hard to evaluate except by following the life histories of large samples of participants and nonparticipants. (Measurement is somewhat simpler for the licit drugs, whose consumption is accurately measured for tax purposes and sufficiently widespread that relatively small changes show up clearly.)

Most evaluations of mass-media anti-drug campaigns have shown no measurable results.^{EN26} An exception was the

^{EN24} Mary Ann Pentz, James H. Dwyer, David P. MacKinnon, Brian R. Flay, William B. Hansen, Eric Yu I. Wang, and C. Anderson Johnson, "A Multicommunity Trial for Primary Prevention of Adolescent Drug Abuse," *Journal of the American Medical Association* 261 (22 [June 9, 1989]): 3259-3266.

^{EN25} Evaluation and Training Institute (ETI), "DARE Longitudinal Evaluation Annual Report, 1987-88" (Los Angeles, Calif.: Evaluation and Training Institute, 1988).

^{EN26} Brian Flay and S. Sobel, "The Role of Mass Media in Preventing Adolescent Substance Abuse," in *Preventing*

series of anti-tobacco television advertisements aired under the FCC's Fairness Doctrine before cigarette commercials were banned from television. Even at only 20 to 25 percent of the frequency of positive advertising, the negative commercials appear to have been quite effective: so effective, in fact, that the advertising ban seems to have actually increased smoking.^{EN27} The fact that smoking was (and is) more common than the use of any illicit drug gave the anti-smoking advertisements a larger target to shoot at than anti-drug commercials have, and the accumulating evidence of the health hazards of smoking gave them powerful ammunition. It would be much easier to repeat that success with beer than with cocaine, because beer is more widely used and less widely feared.

The largest current media-based anti-drug campaign has been that conducted by the Media Partnership for a Drug-Free America. Its promoters claim to be using \$1 billion per year's worth of space in newspapers and magazines and time on television and radio, all of it donated. An evaluation of that program shows that variations in the intensity of the campaign among otherwise similar areas produced substantial effects as gauged by the self-reported attitudes of a sample of visitors to such "central areas" as downtown business districts and shopping malls.^{EN28} These results were sufficiently interesting to deserve follow-up by other methods, such as panel studies and measurements of adverse drug consequences. The Media Partnership campaign has been the subject of several criticisms focused on its methods: many of its "facts"—including those used in its frank appeal to employers to fire their illicit drug-using employees—appear to have been invented or misquoted, and some of its appeals to children are as likely to produce anxiety as to reduce drug use. As

Adolescent Drug Abuse: Intervention Strategies, T. J. Glynn, C. G. Lyekefeld, and J. P. Ludford, eds. NIDA Research Monograph 47 (Rockville, Md.: National Institute of Drug Abuse, 1983).

^{EN27} Gideon Doron, *The Smoking Paradox: Public Regulation in the Cigarette Industry* (Cambridge, Mass.: Abt Books, 1979).

^{EN28} The evaluation was performed by Gordon S. Black Corporation. See its "Partnership Attitude Tracking Study: A Summary of the Fourth Year Results" (Rochester, N.Y.: Gordon Black Corporation, 1991). The results are summarized in *Partnership for a Drug-Free America Newsletter* 4 (3 [Fall 1990]).

noted, its advertising-agency sponsorship and its reliance on donated print space and broadcast time virtually forces it to ignore alcohol and tobacco.

Thinking about these fundamental problems, and about the mixed evaluation results from other programs designed to promote healthier behavior, ought to modify the enthusiasm of those who believe, or assert, that well-designed education could render legal restrictions unnecessary, or at least allow a substantial reduction in enforcement efforts.^{EN29} Thus the demand that enforcement be cut back to pay for expanded persuasion efforts, or that funding be "balanced" between the two approaches, can hardly be based on a careful calculation that the decrease in desire for drugs resulting from an additional dollar of persuasion will more than compensate for the increase in availability resulting from a dollar not spent on enforcement. Open drug dealing also sends a message: how much of the value of a drug-resistance class is lost if its pupils have to walk past crack dealers on their way home? The widespread faith in prevention through persuasion seems to rest on the feeling that persuasion would be wonderful if it worked, rather than a well-founded conviction that we know how to make it work.

HELPING AND CONTROLLING PROBLEM USERS

Under any system of laws, enforcement efforts, and persuasion programs, there will be some users who get themselves into patterns of drug use that are a menace to their well-being or the well-being of others.

A very small proportion of the drug-using population accounts for a very large proportion of the harm done to, and by, the users of virtually all drugs. (Nicotine in the form of tobacco is an exception.) Most of the benefits of controlling drug use come from controlling problem use: excessive use, use under inappropriate circumstances, and use by those who are unusually apt to behave badly under the influence.

Most laws and programs are blunt instruments; they hit equally at problem and nonproblem users. Prohibitions and taxes make no distinctions among users. While regulations might attempt to distinguish "problem" from other users by making drug use a licensed activity, we have no working model of such a policy. Enforcement, whether directed at

^{EN29} See Ethan Nadelmann, "The Case for Legalization," *The Public Interest* 92 (3 [Summer 1988]): 3-32.

sellers or buyers, is naturally undiscriminating. Persuasion efforts, whether in the mass media or in the schools, are addressed to the entire population, or at best to large subgroups, not specifically to the few who are or may become problem users.

Programs directed specifically at helping and controlling problem users have the advantages and the disadvantages of concentrated remedial programs in comparison with broad-based programs of prevention. The relationship between treatment and prevention is the same as that between performing coronary bypass surgery on those with advanced artery disease and encouraging citizens at large to watch their weight and exercise more. Remediation costs more than prevention on a per-subject basis, but it needs to be applied only to a relative few. Which sort of program generates more good per additional dollar spent—in the language of policy analysis, which is more cost-effective at the margin—depends on the available technologies and on the population sizes. A generic debate about the merits of remediation versus prevention (whether by persuasion or by legal restriction and enforcement) seems largely fruitless.

Efforts to deal with problem users are frequently lumped together as "drug treatment." But this assumes that there is a disease (or cluster of disease states) properly called "drug abuse" and that someone knows how to make it better.^{EN30} Since the ethics of therapy put the patient's interest first, calling the process of dealing with problem users "treatment" also implies that the welfare of problem users is or ought to be its paramount concern. At least in the case of drug-involved offenders, this may well be false. The "treatment" label also raises complicated questions about the right to refuse treatment, now recognized as a basic right of the mentally and physically ill.

The actual process of picking up the pieces once drug-taking consumption has gotten the better of someone is substantially more complicated, with respect to means, ends, and rights, than the word "treatment" implies. A sensible approach to problem users would blend attempts to help with attempts to exert social control. The right mix for each individual depends both on how much damage his problem does to other people and on whether the user

^{EN30} For a critique of this concept, see Herbert Fingarette, *Heavy Drinking: The Myth of Alcoholism as a Disease* (Berkeley: University of California Press, 1988).

desires (at some level) to adopt a different behavior pattern. The actual mix of service and coercion delivered to any given user under any given set of programs and policies depends partly on these factors, partly on the social and economic status of the user, and partly on how the problem comes to the attention of the system. A convicted burglar sentenced to drug treatment in lieu of prison can be threatened with referral back to court for failure to comply with its rules, while a treatment client who enters voluntarily can, at most, be expelled from the program.

Many efforts to help and control problem drug users do not address themselves to the problem of drug use at all. Setting the broken arm of someone who fell down the stairs drunk is no different from setting the broken arm of someone who fell down the stairs sober. A year in prison for a burglary committed to buy a bag of heroin is the same as a year in prison for a burglary committed to buy a meal. For now, we will restrict ourselves to those measures of help and control that directly address the drug-related aspects of the user's behavior.

Therapy

The literature on drug treatment is full of ambiguities and equivocal results. The data are sketchy and the methodological problems daunting. Since most of the research is old, much more is known about treating heroin than about treating cocaine, and about treating men than about treating women.^{EN31}

Just making sense of the variety of drug treatment programs is no simple task. One way to start is with taxonomy.^{EN32} The universe can be divided first between programs requiring paid staff, and which therefore cost money, and individual or group self-help, which is effectively free. Resource-using programs can be further classified using three dichotomies: residential (inpatient)

^{EN31} Institute of Medicine, *Treating Drug Problems: Vol. 1* (Washington, D.C.: National Academy of Sciences Press, 1990).

^{EN32} Much of the discussion here relies on the review article by M. Douglas Anglin and Yih-Ing Hser, "Treatment of Drug Abuse," in *Drugs and Crime* Vol. 13, Michael Tonry and James Q. Wilson, eds. (Chicago: University of Chicago Press, 1990).

or nonresidential (outpatient), short-term or long-term, and drug-assisted or drug-free.

Individual self-help is the most widely practiced, but the least discussed, of the treatment options. That some drug users cannot manage their own habits and need outside help is sometimes taken to imply that being helped is the primary, or even the only, approach to revising one's drug-taking behavior. But a glance at the most widely used drugs suggests how untrue that is. Approximately one-quarter of all current drinkers—more than twenty million Americans—report having had difficulty managing their drinking at some time during their lives, but fewer than 10 percent report having such problems currently.^{EN33} The balance—several times as many people as have ever attended an Alcoholics Anonymous meeting, let alone sought professional help—presumably have brought their problems under control on their own or with a little help from their friends. The arithmetic for marijuana is similar; millions of people who used to be daily marijuana smokers are no longer, yet only a tiny fraction of that number of people have received any kind of treatment for marijuana abuse.^{EN34} Surveys of former smokers suggest that more than 90 percent quit entirely independently, and that in fact those who have sought formal help have a lower success rate than those who have relied on themselves (presumably because those who sought help were poorer bets to start with, most of them having failed on their own).^{EN35}

^{EN33} National Institute on Alcohol Abuse and Alcoholism, *Alcohol and Health 7th Special Report to the U.S. Congress* (Washington, D.C.: Department of Health and Human Services, 1990), 266.

^{EN34} National Institute on Drug Abuse, *National Household Survey on Drug Abuse: Main Findings 1985* (Rockville, Md.: U.S. Department of Health and Human Services, 1988), 16; Lloyd D. Johnston, Patrick M. O'Malley, and Jerald G. Bachman, *Drug Use, Drinking, and Smoking: National Survey Results from High School, College, and Young Adult Populations: 1975-1988* (Rockville, Md.: National Institute on Drug Abuse, 1989), 215, 216.

^{EN35} M. Fiore, et al. "Smoking Cessation: Data from the 1986 Adult Use of Tobacco Survey," in *Smoking and Health 1987: Proceedings of the 6th World Conference on Smoking and Health*, Tokyo, 9-12 November 1987 (New York: Excerpta Media, 1988); J. L. Schwartz, *Review and Evaluation of Smoking Cessation Methods: U.S. and Canada, 1928-1985* (Rockville, Md.: National Institute of Health, 1987).

Current drug abuse control policies do not reflect the importance, or even the possibility, of unassisted desistance. "Telling people to quit" is not the name of a program, except in the case of tobacco smoking. (The Media Partnership, for example, has directed its messages to potential users and to the employers, parents, spouses, and children of current users, but rarely directly appeals to users to quit.) Population sizes are part of the reason: compulsive cigarette smoking is much more common than compulsive drinking, and enormously more common than compulsive use of any illicit drug. Therefore a poster that says "Quit smoking" will be relevant to a far higher proportion of those who see it than a poster that says "Stop shooting up." But since most drug desistance is informal, more attention could be given to increasing the frequency of unassisted quitting.

Group self-help is the second most widely used mode of drug treatment. The twelve-step programs—Alcoholics Anonymous and its offspring—are by far the biggest of the group self-help efforts. They require no resources other than a meeting room and some literature. Their success rate among those who join and remain active is apparently very high. Fewer than half of those who join remain active, however; the chances of success seem to rise with a member's education and social status.^{EN36} Amazingly little is known about the effects of AA on problem drinking, and even less about Narcotics Anonymous or Cocaine Anonymous.^{EN37} The most recent comprehensive study of drug treatment dismissed group self-help as a "quasi-treatment modality."^{EN38}

Since discussions of drug treatment tend to be dominated by employees of the industry that provides paid treatment, the tendency to downplay the role and value of individual and group self-help is natural. Still that tendency is unfortunate; since professional help is expensive, most long-term care for those with drug problems will have to be of the self-help variety. One way to think of the role of short-term formal treatment programs, particularly residential detoxification and "chemical dependency"

^{EN36} Institute of Medicine, *Treating Drug Problems: Vol. 1*, pp. 170-174; Richard Rawson, "Cut the Crack: Policy Makers' Guide to Cocaine Treatment," *Policy Review* (Winter 1990): 17.

^{EN37} Institute of Medicine, *Treating Drug Problems: Vol. 1*, p. 135.

^{EN38} *Ibid.*

programs, is as a way of getting their patients ready to join and succeed in group self-help programs. That is in fact the acknowledged goal of many short-term alcohol treatment efforts.^{EN39}

Residential programs, because they provide both 24-hour staffing and room and board, are far too expensive for long-term use by large numbers of patients. But short-term residential programs, both the 5-to-7-day variety called *detoxification* and the 28-day variety called *chemical dependency treatment*, aim to break the current cycle of daily use or repeated binge use, ease the symptoms of withdrawal by providing care and reducing temptation, and prepare their clients for reentry into the world with strategies for avoiding relapse, including referrals to group self-help programs.

One way to manage the detoxification process is to give drugs. Some of those involved are from the general psychiatric armamentarium and are not drugs of abuse. There is some indication that antidepressants can help heavy cocaine users get through the sluggishness and inability to experience pleasure that characterize the period following discontinuation of heavy cocaine use.^{EN40} But the drug user can also be "treated" with his favorite drug or a close substitute. Patients with histories of long-term heavy drinking are sometimes encouraged not to quit suddenly, because the effects of sudden withdrawal from alcohol can be severe, even life-threatening. Instead, they are given decreasing doses from day to day.^{EN41} Heroin addicts can be helped through the withdrawal process with decreasing doses of methadone. Cigarette smokers can phase down their frequency or switch to another form of nicotine intake, such as chewing nicotine gum, on the way to abstinence.

^{EN39} Herbert D. Kleber, "Treatment of Narcotics Addicts," *Psychiatric Medicine* 3 (4 [1987]): 389-418; National Institute on Drug Abuse, "Effectiveness of Drug Abuse Treatment Programs" (Rockville, Md.: National Institute on Drug Abuse, 1981).

^{EN40} Robert Willar, "A Drug to Fight Cocaine," *Science* (March 1986): 42.

^{EN41} The current clinical practice is to use the benzodiazepine family of minor tranquilizers instead. National Institute on Alcohol Abuse and Alcoholism, *Alcohol and Health 7th Special Report to the U.S. Congress* (Washington, D.C.: Department of Health and Human Services, January 1990), 266.

With these three exceptions, the drug laws do not allow for gradual withdrawal strategies.

Residential detoxification is delivered almost entirely in hospitals, serves mostly heroin and cocaine users, is paid for largely from public funds, and focuses on tending its clients through the immediate discomfort of cessation. Since the symptoms of withdrawal from most drugs are not, medically speaking, very serious, it is not obvious that detoxification needs to be conducted on a residential, let alone a hospital inpatient, basis.^{EN42} Outpatient detox is possible; that is, some people who have severe enough drug problems to need help with the short-term pains of kicking the habit nonetheless have enough willpower and social support to break their old habits while remaining in their old settings. But that group does not include everyone who could benefit from detoxification. Removing someone temporarily from the scenes and companions associated with drug taking can be both a symbol of, and a practical aid to, the resolution to "get clean." Those in especially bad trouble, or with especially slender private resources, are apt to need a period of residential treatment.

Yet "detox" has a poor reputation; an Institute of Medicine study panel summarized the conventional wisdom: "<el> researchers have found no effects from detoxification that are discernibly superior to those achieved by untreated withdrawal <el>" and concluded that "<el> detoxification is not a treatment."^{EN43} The most likely result of any single detoxification episode is a relapse into drug use and a return to detoxification; "treatment recidivism" for detox programs has been estimated as high as 80 percent.^{EN44}

But this glass could usefully be seen as 20 percent full rather than 80 percent empty. Given the personal and social damage associated with a heroin or crack habit, \$2500 or so seems a very modest price to pay for a one-in-five chance

^{EN42} Institute of Medicine, *Treating Drug Problems: Vol. 1*, pp. 174-176.

^{EN43} Ibid., p. 176.

^{EN44} The data are extremely imperfect. For heroin, see D. S. Lipton and M. J. Maranda, "Detoxification from Heroin Dependency: An Overview of Methods and Effectiveness," *Advances in Alcohol and Substance Abuse* 2 (1): 31-55. For alcohol, see Donald Cahalan, *Understanding America's Drinking Problem* (San Francisco: Jossey-Bass, 1987), 136.

of a lasting cure.^{EN45} Even a detoxification that eventuates in a relapse produces a period of abstinence and a longer period of reduced drug use and crime as compared with the behavior of the same user if he does not try to quit. If the chances of success are cumulative, as they appear to be for smoking—the best single predictor of success in quitting cigarettes is the number of attempts to quit^{EN46}—even repeated detoxifications may be worth the price. Again, one should factor in the possibility that some of those who are successfully and lastingly detoxified in a hospital would have succeeded on their own, but the question to ask is not whether detox outperforms unassisted desistance, but whether the availability of a comfortable setting and some palliative care increases the number of attempts to quit. The observation that more than 80 percent of coupons for free detox passed out to heroin users in New Jersey as part of an AIDS-control project were used suggests that there is an unmet demand for this service.^{EN47} The benefit-to-cost ratio of detox programs could be even better if it were administratively feasible—as it is certainly clinically possible—to cut costs per day and thus finance more attempts or longer stays, by using nonhospital facilities.^{EN48}

Long-term residential programs pursue more ambitious goals. They seek to transform their clients' personalities and render them more or less permanently drug-free. Most of them work on the "therapeutic community" (TC) model pioneered for heroin users by Synanon, Daytop Village, and Phoenix House: group living under strict rules, confrontational group-encounter sessions, staff recruited largely from among ex-clients. While less expensive per day

^{EN45} Cost figure derived from Institute of Medicine, *Treating Drug Problems: Vol. 1*, pp. 290, 291.

^{EN46} J. O. Prochasta and C. C. Diclemente, "Stages and Processes of Self-Change of Smoking: Towards an Integrative Model of Change," *Journal of Consulting and Clinical Psychology* 51 (3 [1983]). Office of Smoking and Health, *Nicotine Addiction: The Health Consequences of Smoking* (Rockville, Md.: Department of Health and Human Services, 1988).

^{EN47} J. Jackson and L. Rotkiewicz, "A Coupon Program: AIDS Education and Treatment," Presented at the Third International Conference on AIDS (Washington, D.C.: June 1987).

^{EN48} Institute of Medicine, *Treating Drug Problems: Vol. 1*, p. 16.

than detoxification programs, TCs more than make up for the difference in duration: they cost about \$13,000 to \$20,000 per client per year, and nine months is considered the minimum desirable length of stay, with up to two years not uncommon.^{EN49} Like the self-help groups, TCs claim very impressive success rates among those who come and stay but suffer very high rates of voluntary or involuntary separation, particularly in the first few months. Only 15 to 25 percent of TC entrants stay the course.^{EN50} While therapeutic-community members often have even more powerful reasons to succeed than AA members, the demands of these programs are considerably greater; they are virtually total institutions.^{EN51}

Detoxification and outpatient counseling share a problem: they do little or nothing to change the daily environments their clients face and in which they acquired the habits they are trying to break. Therapeutic communities attempt to solve this problem by creating an artificial environment that is designed to rebuild and to reshape the personality of the member. Some persons seeking treatment seem to need, and to be willing to accept, the discipline of such an institution, including the temporary sacrifice of most of their outside interests and connections. Others, however—most of those who enter—find that the demands are greater than they are willing to tolerate.

^{EN49} Ibid., pp. 154-167; "Understanding Drug Treatment" (Office of National Drug Control White paper, June 1990).
^{EN50} Institute of Medicine, *Treating Drug Problems: Vol. 1*, p. 167.

^{EN51} On the total institutions generally, see Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Chicago: University of Chicago Press, 1970). On therapeutic communities, see Sethard Fisher, *Residential Treatment of Felon Drug Addicts: State Agents as Therapists* (New York: P. Lang, 1987); Robert Weppner, *The Untherapeutic Community: Organized Behavior in a Failed Addiction Treatment Program* (Lincoln: University of Nebraska Press, 1983); B. Sugarman, "Structure, Variations and Context: A Sociologized View of the Therapeutic Community," and G. De Leon, "The Therapeutic Community for Substance Abuse: Perspective and Approach," both in *Therapeutic Communities for Addictions*, G. De Leon and J. T. Ziegerfuss, Jr., eds. (Springfield, Illinois: Charles C. Thomas, 1986).

This suggests the need for a treatment modality that does more to alter a user's environment than detoxification or outpatient counseling but is less all-embracing than a therapeutic community. The Oxford House movement represents an attempt to fill that gap. An Oxford House is a cooperative living arrangement for persons trying to change their drug (including alcohol) use habits. Many are also members of twelve-step groups. The members share rent and chores and support themselves with ordinary jobs. The rules, developed and administered by each house unit, tend to be simple. Members stay as long as they like; since the arrangement is largely unsubsidized, they face no pressure to move out to make room for new members. The movement has grown as long-time members of established houses become the nuclei of new ones.^{EN52}

The Oxford Houses presume a far greater degree of personal and economic self-reliance on the part of their members than do the therapeutic communities, and in fact seem to serve a more affluent and better-educated clientele who have fewer major personality disorders and shorter criminal histories than many TC clients. They also need and receive far less public money, though small subsidies have recently been made available to fund the start-up costs of new houses. It is possible that they will develop into a substantial drug-treatment resource, particularly as a follow-up to short-term detoxification or chemical dependency treatment.

It may be the case that additional financial encouragement could quicken the growth of the Oxford Houses. But the important scarcity at the moment appears to be, not money, but experienced members ready to form the leadership of new establishments. How far the Oxford House model can be adapted to serve very poor drug users and drug users with other personal problems on top of their drug habits remains to be seen; to date, there is no formal evaluation of the Oxford House movement even for its current membership.

Long-term nonresidential programs come in two basic varieties. One, outpatient counseling, provides advice support services for a drug-free life. For those with private health insurance, this can mean psychotherapy, intensive family counseling, and a range of other activities, cheap compared with inpatient treatment but still likely to run into the thousands of dollars per year.

^{EN52} Peter Cerlson, "The Oxford House Experiment," *Washington Post Magazine* (12 November 1989): 15.

For the uninsured, it is likely to mean an hour a week of group therapy and a little social work. There is evidence that those who stick with such programs reduce their drug use and improve their lives, though it is hard to tell whether this means that those who stay tend to get better or that those who get better tend to stay.^{EN53} In many cases, fewer than 20 percent of outpatient nonmethadone clients complete a course of treatment, a discouraging finding given that they tend to be less badly off to start with than, for example, entrants into therapeutic communities.^{EN54} The sheer variety of such programs and their clients precludes drawing any precise conclusions about them; probably some programs are good for some of their clients, but no one knows which programs or which clients.

The other kind of long-term outpatient treatment is methadone maintenance for heroin users. Methadone is a synthetic drug closely related to heroin. Pharmacologically, the chief difference is that methadone is longer-acting. It substitutes for heroin in staving off the withdrawal symptoms of opiate dependency. Its long-acting nature means that a single daily dose is sufficient, and users can therefore hold normal jobs.

Methadone does not prevent heroin users from getting high, though it may reduce the subjective thrill of any given dose of heroin by competing for receptor sites. (There is a drug, naloxone, that does prevent heroin intoxication by blocking opiate receptor sites; not surprisingly, there is little demand for naloxone among heroin addicts.) Indeed, methadone produces a high of its own, and is in great demand as a street drug, the sources being clinic patients and staff.^{EN55} But because methadone is given to clinic patients orally rather than by needle, they do not experience the euphoric "rush" that heroin users achieve. This, and the limits that clinics put on the amount of methadone they distribute, tempts methadone clients to supplement their methadone supply with black-

^{EN53} For evidence of the limited effectiveness of such programs, see Sung-Yeon Kang, "Outcomes for Cocaine Abusers After Once a Week Psychosocial Therapy," *American Journal of Psychiatry* 148 (May 1991): 630-635.

^{EN54} Institute of Medicine, *Treating Drug Problems: Vol. 1*, p. 169.

^{EN55} Barry Spunt, Dana E. Hunt, Douglas S. Lipton, and Douglas Goldsmith, "Methadone Diversion: A New Look," *Journal of Drug Issues* 16 (1986): 569-583.

market heroin. They also often use other black-market drugs.^{EN56} Clinics discourage this practice by administering urine tests to their clients and sometimes sanctioning them by deprivation of "take-home" privileges, reduced dosages, or even expulsion from the program for repeatedly positive tests.

Perhaps the best-established fact in the drug treatment literature is that methadone works. Methadone clients use substantially less heroin and commit substantially fewer crimes than they would if they were not on methadone, and methadone maintenance has the highest retention rates among all treatment modalities.^{EN57} Costs are significant but not prohibitive: about \$300 per month, which means that the entire estimated heroin population could be maintained on methadone for between \$1 and \$2 billion per year.

That methadone works is not surprising. It gives heroin addicts some of what they want, legally, reliably, and usually free of charge. Assuming that their alternative was to continue as users of heroin, this leaves them better off and reduces their incentive to commit crimes for money. Predictably, when free public programs are terminated and methadone clients are forced to pay for their treatment, their condition deteriorates and their crime rates increase.^{EN58}

Treatment by methadone does not "cure" addiction; it substitutes a legal addictive drug for an illegal one. The advantages of methadone maintenance as practiced in the United States over heroin maintenance as once practiced in Britain are partly operational (once-daily administration, ability to work, less of a tendency to steadily escalating dosage, somewhat less of a problem with illicit resale of maintenance supplies) and partly symbolic (the drug being given out is not called heroin).

Nor does methadone turn heroin addicts into model citizens; few of them were model citizens before they became heroin addicts, and years of street hustling do

^{EN56} General Accounting Office, "Methadone Maintenance: Some Treatment Programs Are Not Effective; Greater Federal Oversight Needed" (Report to the Chairman, Select Committee on Narcotics Abuse and Control, March 1990), 17-20.

^{EN57} Institute of Medicine, *Treating Drug Problems: Vol. 1*, Ch. 5.

^{EN58} M. D. Anglin, W. H. McGlothlin, G. R. Speckart, and T. M. Ryan, "Shutting Off Methadone: The Closure of the San Diego Methadone Maintenance Program" (Final Report, National Institute on Drug Abuse, 1982).

nothing to improve either one's character or one's legitimate economic opportunities. But it does convert some people who would otherwise be very badly off and represent a major social headache into people who are only somewhat badly off and represent a minor social headache. That is not a bad result for only \$300 per person per month.

The one serious objection to methadone maintenance is that it traps some former heroin users who would otherwise have quit into daily opiate use. Despite its mythology, heroin use is not a permanent condition.^{EN59} There is no way to tell how many successful methadone clients would otherwise be successful ex-addicts. In the case of clients entering treatment voluntarily, the advantages of methadone in attracting and retaining them seem overwhelming. The case for giving methadone to offender/addicts who are forced into treatment by the criminal-justice system and who are liable to more coercion to quit seems weaker.

The success of methadone in managing the lives of heroin addicts has led to calls for the development of an analogous chemical to treat compulsive cocaine use. But methadone manages a dependency syndrome by averting withdrawal symptoms. It seems doubtful that the reinforcement-based compulsion typical of heavy cocaine users could be managed by maintenance with a substitute. Any stimulant is a partial substitute for cocaine, and although the drugstores are full of licit nonprescription stimulants in the form of caffeine "stay-awake" pills, there is no evidence to date that cocaine users have any interest in them.

Publicly funded voluntary drug treatment could be expanded either quantitatively, by accepting more clients into existing programs, or qualitatively, by enriching the content of the programs or moving clients from lower- to higher-resource programs. While it seems logical that any treatment is better than none and that more is better than less, even those weak claims are only weakly supported by evidence, except in the case of methadone treatment for heroin users. The question of magnitude—of how much improvement could be expected from the next million or billion dollars of annual expenditure for more or better treatment—is even more wide open.^{UN1} The conviction of

^{EN59} Bruce Johnson, "Once an Addict, Seldom an Addict," *Contemporary Drug Problems* 7 (1 [Spring 1978]): 48-49.

^{UN1} For a brave attempt from pre-cocaine days, see Henrick J. Harwood, "Economic Costs to Society of Alcohol and Drug Abuse and Mental Illness: 1980." Submitted to Alcohol, Drug

treatment advocates that moving resources from drug law enforcement to drug treatment would decrease the total harm associated with drug taking may be correct, but on current evidence it remains what Mark Twain called "a vagrant opinion, without visible means of support."

Balancing Treatment and Enforcement

Much has been said and written about the appropriate "balance" between treatment spending and spending on enforcement. But the facts of the case are not easy to determine, and the appropriate basis for making such a judgment is far from obvious.

The only federal money explicitly allocated for drug treatment consists of money granted to state departments of substance abuse treatment, which get about half of their funds from federal block grants. Federal support for those agencies amounts to about \$1 billion per year,^{EN60} which is indeed a far cry from the \$15 billion to \$20 billion spent annually on drug law enforcement, including both the budgets of drug enforcement agencies and expenditures on drug enforcement by general police, prosecution, and corrections agencies. Moreover, while the overwhelming bulk of drug law enforcement is aimed at the illicit drugs—since enforcement of the terms of liquor licenses by alcoholic beverages control authorities is cheap, and there is almost no attempt to enforce the ban on noncommercial transfers of alcohol to minors—much of the public substance abuse treatment money appears to be spent on the treatment of alcohol abuse.

Thus if we could compare enforcement spending with spending on publicly financed treatment for the illicit drugs alone, the imbalance about which treatment advocates complain so bitterly would look even more extreme than it now does. But not all public funds that pay for drug treatment go through "drug treatment" budget lines. Community-based mental health clinics are never counted as part of the "drug treatment" budget, but a substantial proportion of their client base presents them with

Abuse, and Mental Health Administration (Research Triangle Park, N.C.: Research Triangle Institute, June 1984). Harwood's calculations are based on data from the treatment outcome perspective study (TOPS).^{EN60} Office of National Drug Control Policy, *National Drug Control Strategy* (Washington, D.C.: GPO, 1990); Institute of Medicine, *Treating Drug Problems: Vol. 1*, pp. 211-219.

substance abuse problems. The same is true of drug-abuse treatment provided by the Veterans Administration or the Bureau of Indian Affairs, and of the government-paid health care or health insurance provided to public employees (including the military) and their families; that money is budgeted as part of other activities and considered by treatment recipients as part of their entitlement to health care. In some states, Medicaid programs cover some forms of drug treatment.^{EN61}

The biggest single source of public funds for drug treatment, if one could tally it all up, would probably turn out to be the tax subsidy to employer-paid health insurance and to corporate "employee assistance" programs. Employers' vigorous efforts to tighten the rules governing alcohol and drug treatment provided under employee group health plans suggests that the cost of such treatment is a noticeable part of the more than \$200 billion per year in employer-paid health care, all of which is tax-deductible expense to the employer and tax-free income to the employee.^{EN62} Thus a simple comparison of public enforcement spending with public treatment spending is misleading, and debates about the allocation of drug money between enforcement and treatment may be less important in determining how much treatment is actually provided than are rules about the eligibility of substance abuse treatment for financing by health insurance (including Medicaid and Medicare). Indeed, health insurance coverage may be the most sensible context in which to debate the question of how much money to spend on treatment, because drug treatment can be compared with other health-care measures as alternative means of improving the well-being of individuals. Whether treatment can actually serve the other purposes that drug law enforcement serves is far less clear.

The great, largely unspoken argument for drug treatment instead of enforcement as the primary tool of drug policy

^{EN61} General Accounting Office, "Substance Abuse Treatment: Medicaid Allows Some Services but Generally Limits Coverage" (Report to Congressional Requesters, June 1991), 3-4.

^{EN62} M. A. Morrissey and G. A. Jensen, "Employer-Sponsored Insurance Coverage for Alcoholism and Drug Abuse Treatments," *Journal of Studies on Alcohol* 49 (1988): 456-461. United States Bureau of the Census, *Statistical Abstract of the United States* (Washington, D.C.: Department of Commerce, 1989), 90-93.

is that treatment expresses compassion for users while enforcement expresses only anger. To the moderate left ("liberals" in the current rather than the classical sense), this is a powerful appeal.^{UN2}

But as Machiavelli pointed out, compassion in action may hurt the visible few.^{EN63} If drugs are traps for many users—and otherwise what is the point of offering treatment?—is it, in the end, more compassionate to let people walk into the trap and then help them make the painful climb back out, or to build a high, ugly fence around the trap in the form of drug law enforcement?

At its best, treatment is only a partial substitute for prevention, for the same reasons that hospital trauma units are only partial substitutes for safer cars. By definition, treatment intervenes only after a person has established a pattern of drug use that causes problems for that person and others and is no longer fully under voluntary control. Changing such a pattern is virtually always painful and apt to leave some lasting disability, including vulnerability to future episodes of abuse. Someone who has never had a problem is, on average, better off than a problem user "in recovery." If, then, we imagine two alternate sets of programs, one, weighted toward preventative measures of enforcement and persuasion that allowed a thousand bad drug habits to develop and treated none of them, and the other, weighted toward treatment, that allowed two thousand bad habits to form and treated half of them successfully, the first would be preferred.

Treatment as Social Control

All treatment programs mix the delivery of service with the imposition of control, but the mix varies. No program will tolerate a client who is repeatedly disruptive or abusive or who repeatedly arrives on the premises visibly under the influence. All will use the moral authority of the service provider or self-help group to encourage the behavior patterns—chiefly abstinence from drugs—they aim to produce. Some programs go much further. Therapeutic communities, whose clients are surrounded by rules and under unremitting pressure from the staff and from one another both to

^{UN2} In addition, as Jonathan Caulkins of Carnegie-Mellon University has pointed out, there is an implicit false syllogism of the form: "Enforcement doesn't work, but something must work, therefore, treatment works."

^{EN63} Machiavelli, *The Prince*, Ch. 17.

conform and to demonstrate their commitment to the goals of the organization, are the clearest examples. But many outpatient programs require strict adherence to schedules and even routinely test their clients' urine to determine whether they are continuing to buy and use black-market drugs. Urine testing is very common among methadone programs, and even required by some states' methadone-treatment rules.

There is good evidence that strong controls contribute to good treatment outcomes.^{EN64} But they have two great disadvantages: they cost money (or staff time, which comes to the same thing) and they tend to drive away clients.

One consequence of the growth in demand for methadone maintenance that followed the rise of AIDS—growth not matched either by increased funding or by the training of additional staff—was a steady decrease in the level of control efforts. Many methadone clinics became little more than drug-distribution centers, partly to cope with increasing workloads and partly because, in the face of the AIDS threat, the importance of keeping clients in some sort of treatment seemed too overwhelming to make expulsion for repeated use of illicit drugs a credible threat. One result of decreased control at the clinics seems to have been worse outcomes for the clients; a study by the General Accounting Office found that in some New York City clinics as many as 40 percent of all methadone recipients were using cocaine.^{EN65}

Most clients enter drug treatment voluntarily. For them, the operators of treatment programs need to worry about "marketing" issues: factors leading to recruitment and retention. Clearly, those who never enter a program cannot benefit from it; since the length of stay in treatment is an important factor in its success, those who enter but are quickly repelled or expelled also do not gain much. These considerations tend to push programs away from making strong demands on their clients. Methadone programs, which have a drug to give out, can be more demanding without having their clientele drift away (unless there is a less-

^{EN64} A. T. McLellan, G. E. Woody, L. Luborsky, and L. Goehl, "Is the Counselor an 'Active Ingredient' In Substance Abuse Rehabilitation?" *Journal of Nervous Mental Disorders* 176 (1988): 423-430.

^{EN65} General Accounting Office, "Methadone Maintenance: Some Treatment Programs Are Not Effective; Greater Federal Oversight Needed." Report to Select Committee on Narcotics Abuse and Control (Washington, D.C.: March, 1990), 17-20.

demanding methadone program across the street or across town). The trade-offs are clear: a low-control, low-hassle treatment system can attract and retain more clients and serve them for less money, but a high-control system can achieve better results with those it does serve.

The issues are different for the large minority of drug-treatment clients who are there involuntarily, having been caught committing a crime—perhaps only that of buying or possessing drugs—and sentenced to treatment in addition to, or more commonly in lieu of, other punishment.^{UN3}

Recruiting them is no problem, and retaining them, while not assured—since they can always choose not to go to treatment and face the legal consequences—is at least a smaller problem than with voluntary clients. Moreover, the benefit to others of controlling the behavior of a drug user who is also an offender, especially if the offense is some form of theft, assault, or drug dealing, is apt to be much stronger than the benefit to others of controlling a drug user who enters treatment under his own steam. The potential value of using treatment programs to control and monitor the behavior of drug-using offenders is enormous; the extent to which potential is realized depends on the willingness and capacity of treatment providers to monitor aggressively and report violations back to the criminal-justice agencies that made the initial referrals and on the willingness and capacity of the agencies to punish repeated violations and thus give meaning to treatment-program rules.

There are two considerations about the use of treatment as a mechanism of punishment and control: how well it compares with the ethics and mechanics of therapy, and whether the treatment component adds enough to the monitoring process to justify requiring it for the unwilling. The availability of mandated and monitored abstinence as a sentencing option seems to challenge the need for mandated treatment.

It might be better to require abstinence and make therapy optional. Even if those offenders who chose therapy continued to have their urine tests (or whatever) done at the treatment site, it would be clear that those tests were being administered for, and by the authority of, the court or the probation department, that the therapist had no discretion about reporting the results, and that a decision

^{UN3} In some cities, this is managed under an administrative structure known as TASC: Treatment Alternatives to Street Crime.

by the client or the program to terminate therapy would have no direct effect on the client's legal situation. This would uncomplicate the responsibilities of the treatment providers, reduce the incentives for clients to try to con their therapists, and relieve clients and staff alike by getting the unwilling out of the way of the willing. Some mandatory treatment programs, particularly the commercial "education" programs that judges in some states impose on drunken-driving convicts, amount to little more than punishment by boredom and humiliation. Worse, there is probably a limit on how many of the attendees of a twelve-step meeting can be there involuntarily without substantially compromising the value of the group for themselves and their colleagues.

However, these conceptual advantages may or may not be outweighed by practical disadvantages. It may be that therapy, or at least therapy of some kinds, even if unwillingly undergone, yields enough additional reduction in future drug use and crime to justify imposing it on those who have made their drug use a problem for the rest of us. They may not, after all, be the best judges of how to quit; merely telling them to quit, without more specific instruction, may be ineffective. Much might be learned from a few random-assignment experiments, comparing testing and sanctions plus mandatory treatment, testing and sanctions plus voluntary treatment, and testing and sanctions alone.

ALLOCATING AND MANAGING TREATMENT RESOURCES

The best-known symptom of the inadequacy of current support for publicly funded drug treatment services is the existence of waiting lists. Since the desire to quit may be intermittent, telling someone who wants to desist from drug use to wait in line is obviously a bad idea, even worse than "rationing by queueing" for other medical services. This has led the proponents of increased treatment funding to formulate a slogan: "Treatment on demand."^{EN66}

A closer look at the treatment system reveals a more complicated pattern than simple scarcity; while some programs have waiting lists, others have unfilled slots. Sometimes there is a complete mismatch between the services available and the services a client needs; sometimes the

^{EN66} *Treatment is the Answer: A White Paper on the Cost Effectiveness of Alcoholism and Drug Dependency Treatment* (Washington, D.C.: National Association of Addiction Treatment Providers, March 1991).

mismatch is between a client without private resources or insurance and a program not geared to taking public funds.^{EN67} But it can also happen that the same city has both waiting lists for methadone maintenance and empty methadone slots. In general there is no system to match clients and slots, not even a simple database of vacancies.

The simplest step toward a more coherent treatment system would be the creation of an agency or agencies that could provide for those seeking treatment the type of service travel agencies provide to those seeking intercity transportation: up-to-date information about what is available at what price and the ability to make a reservation for any vacant capacity. A variety of individuals and agencies now provide treatment information and referral, but in the absence of a central database or standard compensation mechanism any one referral service tends to work with only a few of the possible providers.

A "travel agency" system would be a considerable advance over the current chaos. But more could be asked for. First, clients could reasonably want access to information about programs' processes and records of success, independently gathered, or at least audited, and in some standardized form to facilitate program-to-program comparisons. Even at the level of program types, currently available data are grossly inadequate;^{EN68} at the level of individual programs, they are virtually nonexistent.

More ambitiously, one could ask the referral service or services to serve as "gatekeepers" to the entire treatment system, assigning clients to treatments on the basis of need and appropriateness, with due regard to cost-effectiveness. Such "utilization-management" for publicly paid treatment is a central recommendation of the Institute of Medicine study panel.^{EN69} In addition to providing cost control, an agency with utilization-management authority could insist on the collection of data and create incentives for programs to compile good records of success, as well as eliminating potentially destructive competition for clients (for example, among methadone programs) on the basis of lax controls on client behavior. It is possible

^{EN67} For a description of the "two-tiered" treatment system, see Institute of Medicine, *Treating Drug Problems: Vol. 1*, pp. 200-219.

^{EN68} This is a frequent refrain of the IOM study panel, Institute of Medicine, *Treating Drug Problems: Vol. 1*, pp. 132-199.

^{EN69} *Ibid.*, pp. 250-252.

that drug-treatment clients, whose problem by definition includes difficulties in self-management, may not be the best judges of what treatment programs will be able to help them.

On the other hand, in the absence of clear evidence about "what works" or even a consensus about what success means, it is not obvious that the criteria built in to any given system of utilization management would do better at matching clients to programs than the current quasi-market. Utilization management presupposes, and cannot be made to substitute for, a clear set of judgments about what programs work with which clients.

On the privately paid side of the system, utilization management is handled by health insurers and Health Maintenance Organizations. Treatment providers and treatment seekers complain that "managed care" pays too much attention to cost-saving and not enough to therapeutic effectiveness. It probably does; in the absence of effectiveness data such a bias is understandable and perhaps inevitable.

Treatment clients want help (without too much hassle). Providers want to pursue their therapeutic missions (and pay their bills). Third-party payers, whether state agencies or health insurers, want to stretch their treatment dollars as far as they will go (or save them if possible). All agree that the current situation could be improved on. If there were a consensus, or even clear evidence, about the direction in which improvement lay, there might be enough political pressure to force movement in that direction even against whatever economic interests and therapeutic concepts happened to come out behind in the process. In the meanwhile, getting from where we are to a functioning travel-agency system would represent considerable progress.

COERCIVE CONTROL OF PROBLEM USERS

Within the relatively small group of drug users whose habits are a problem for themselves and for their intimates, there is an even smaller group whose drug use chronically harms or threatens strangers, by leading them to act irresponsibly under the influence or to commit crimes (including drug selling) to obtain money for drug purchases. Some of the irresponsible behavior is criminal in itself: assault, for example, or disorderly conduct. Much of the rest is made criminal by special statutes making it a crime to engage in specific activities (driving

is the most familiar example) while intoxicated, whether or not any direct harm results.

These user/offenders are the problem drug users most worth controlling, at least from the viewpoint of their neighbors. They are also in some ways the easiest to control, because repeated criminal activity eventually leads to arrest and conviction, and those who have been convicted can be subjected to legal restrictions and to intensive means of investigation that cannot be applied to the general population.

Chronic drug-involved offenders thus present an attractive target for intervention. They do enough damage to others that the cost of even quite expensive programs can be covered by relatively modest changes in their behavior. Many of them are easy to identify, because they are repeatedly arrested; discovering which frequent arrestees are also drug users requires only cheap and simple chemical tests. And the complicated ethical and legal questions about coerced therapy are vastly simplified when the subjects have been convicted of, or pleaded guilty to, crimes and when restrictions are imposed as part of a sentence or a formal agreement in lieu of criminal processing.

Mandatory Abstinence, Testing, and Sanctions

Anyone who commits a crime under the influence of an intoxicant or in order to get money to buy one should be required to abstain from the use of any intoxicant for a period of time equal to the maximum prison term that can be imposed for the crime, and that requirement should be supported by frequent chemical tests to ensure compliance and by swift and predictable sanctions for noncompliance (including failure to appear for scheduled tests). If such a principle were accepted and put into practice, chronic drug-involved offenders would no longer be able to maintain their chosen life-style. Even if this had only a modest impact on the volume of drug sales—and the impact might be substantial for crack and heroin—it would at least reduce the frequency of predatory crime.

An abstinence requirement would be a good general deterrent, a good specific deterrent, and an aid to incapacitation. Making the effective loss of drug-use privileges a consequence of committing crimes would be a means of punishment, and thus of deterrence: those who enjoy using drugs would have to be careful not to get caught committing crimes. Compared to other deterrent

punishments, drug deprivation has attractive characteristics: it is unpleasant without being damaging (if anything, it may be therapeutic); unlike prison, it does not interfere with the ability of the person undergoing punishment to hold a job, go to school, maintain family ties, or pay restitution to his victim; and it economizes on scarce prison space. Thus it offers a good way to discourage crimes by the entire class of heavy drug users.

In order for such a program to work, it is not necessary that the drug be criminogenic for all of its users, that all of the offenders' criminal activity be directly related to their drug taking, that the requirement for abstinence be perfectly complied with, or that all deviations from abstinence be detected and punished. Much less will do. It is necessary only that there be a causal relationship between drug use and offending for some offender/users and that the system of testing and sanctions be sufficient to reduce drug use among them.

Mandatory abstinence would also help prevent future crimes, by deterring continued drug use among those assigned to it.^{EN70} This specific deterrence would work better for some subjects than for others; as with any nonincarceration sanction, some will comply and some will not. But those who do not comply are those most likely to continue committing other crimes, and thus most worth locking up. Mandatory drug abstinence with monitoring can thus help ensure that scarce prison space is occupied by those who will commit the most crimes if not incarcerated; unlike other programs aimed at such "selective incapacitation," it need not rely on statistical prediction to isolate high-rate offenders but can allow them to identify themselves by means of missed or positive ("dirty") drug tests. In effect, this plan substitutes drug tests for judges' guesses in selecting candidates for prison cells.^{EN71}

^{EN70} Harry K. Wexler, Douglas S. Lipton, and Bruce D. Johnson, "A Criminal Justice System Strategy for Treating Cocaine-Heroin Abusing Offenders in Custody," *Issues and Practices in Criminal Justice* (Washington, D.C.: National Institute of Justice, March 1988).

^{EN71} The literature on "selective incapacitation" is extensive and rather polemical. See Peter W. Greenwood and Allan Abrahamse, *Selective Incapacitation* (Santa Monica, Calif.: RAND Corporation, 1982), and critiques in Cohen, Spelman, Moore, et al., *Dangerous Offenders: Elusive*

It is an ordinary condition of probation or parole that the offender refrain from any lawbreaking during the probation or parole term. Since drug use implies possession, and since the possession of controlled substances is a violation of law, abstinence from illicit drugs is already in principle required of those on conditional release, and probation and parole officers in most jurisdictions have widespread authority to order urine tests to verify that abstinence and to sanction violations by referring the offender back to the court for revocation of conditional-release status and incarceration or reincarceration.

But the current actual system falls short of what is proposed here in several ways. Some offenders are not given probation terms, are given only short terms, or are assigned to "summary" probation, which means that they receive virtually no supervision. Alcohol, since it is not illicit, is not automatically included in the ban, even in the case of those convicted of drunken driving or drunken assault. Arrestees are not routinely screened for the presence of drugs in their systems; absent some other indication in the record, supervisors have no easy way to separate drug-involved offenders from others. Tests are generally administered only "for cause," rather than randomly; there is solid evidence that probation and parole officers are not very accurate at guessing which of their charges are using drugs.^{EN72}

Finally, in most cases the only formal sanction available is the drastic one of referral back to court for possible incarceration. Given the paperwork demands on overworked probation and parole officers and the prison-crowding situation, this sanction is too expensive to be a credible threat; even if supervisors were willing to punish violations with prison time, most judges are not. Consequently, even known drug-involved offenders sentenced to "intensive-supervision" probation are only occasionally punished for continued drug use.^{EN73}

Targets of Justice (Cambridge, Mass.: Harvard University Press, 1984).

^{EN72} Eric Wish, K. A. Klumpp, A. H. Moorer, and E. Brady, *An Analysis of Drugs and Crime Among Arrestees in the District of Columbia* (Springfield, Va.: National Technology Information Service, 1980).

^{EN73} Joan Petersilia, *Expanding Options for Criminal Sentencing* (Santa Monica, Calif.: RAND Corporation, 1987).

A better system would screen all arrestees for the presence of drugs and assign all drug-involved offenders to mandatory abstinence and testing. (Some research and development would be required before alcohol could effectively be included in chemical monitoring, since ethanol is a simple molecule with no distinctive metabolites.) Testing would start out on a random, once-a-week basis: each offender would call in once a day to find out whether his turn had come. There would be a set of predetermined, progressively serious, administrative sanctions for missed or dirty tests, starting with increased test frequency and moving up through fines and hours of unpaid labor, personal curfews, brief periods of incarceration, and, finally, referral back to court. The sanctions should be predetermined both to allow for speedy processing and to maximize deterrence through certainty. The goal of such a program would be to convince most offenders that continued drug use is simply more trouble than it is worth. At least one such program has generated very high levels of compliance and measurable decreases in jurisdiction-wide rates of property crimes, despite a shortage of drug treatment programs; the negative incentive provided by testing was apparently a sufficient aid to willpower even among long-time heroin users.^{EN74}

The converse of progressive discipline for violations is the promise of rewards, in the form of reduced testing frequency, for consistent compliance. This can both encourage those who are doing well and economize on testing capacity and expense: weekly testing costs about \$1500 per offender per year, not much compared to the cost of imprisonment or continued criminal activity but a substantial sum compared with the per-offender budgets of probation departments.

Mandated, monitored abstinence might be extended to those arrested and released on bail; the District of Columbia has pioneered in this area. Whether there is adequate legal basis for testing and sanctioning persons who have not yet been convicted of a crime remains an open question. Since most of the offenders we are most concerned with are arrested frequently, the issue of pretrial testing would be relatively unimportant if all convicted drug-

^{EN74} Mark A. R. Kleiman, Denise Kulawik, and Sarah Chayes, *Program Evaluation: Santa Cruz Regional Street Drug Reduction Program* (Cambridge, Mass.: BOTEC Analysis Corporation, 1990).

involved offenders were automatically assigned long periods of mandatory abstinence.

A program that depended largely on post-arrest screening to identify drug-involved offenders would be imperfect. It would miss some users, and it would identify some who had drugs in them at the time of arrest but whose crimes were not causally related to their drug use. Marijuana, the drug most widely used, most easily detected, and least clearly linked to user crime, probably ought to be excluded from programs for adults, as it is from the D.C. pretrial program, both because its use is so widespread that including marijuana would generate many violations, thus straining the capacity to sanction violators, and because its economics and pharmacology do not suggest any strong link between marijuana smoking and predatory crime. Excluding marijuana however, might attract criticism as an implicit invitation to continue illicit drug taking. Fortunately, a perfect design is not required; only some improvement over the current system, which virtually ignores the link between continued drug use and continued crime.

A serious national program of drug testing and sanctions for offenders who are users of illicit drugs could be mounted for approximately \$5 billion a year in testing and sanctions costs. The cost could be less if marijuana were excluded, both from the initial classification of drug-involved offenders and from the ongoing monitoring. Including alcohol-using offenders, and testing for alcohol, would raise the costs. Such sums do not seem too much to pay to establish some measure of control over the drug users whose habits make the most trouble for the rest of us.

The same analysis applies, *a fortiori*, to drug-involved offenders serving time. That it is possible to emerge from a prison term still a drug addict testifies to prison administrators' reluctance to face up to the problem. More intensive searches of staff, visitors, and prisoners returning from the outside to detect drug smuggling are likely to prove futile. Frequent random testing with loss of privileges for positive tests and follow-up investigation into the source of the drugs could dramatically reduce the scope of the problem in the prisons, but only at the cost of demonstrating how large the problem is, disrupting the informal prisoner economy, straining the capacity of the prison-discipline system, and in some systems generating substantial turnover in the prison staff, including some transfers to the inmate

population. Still, a relatively drug-free prison does not seem an excessively grandiose goal. Here again, there is no legal or even administrative problem with drug testing in the abstract; the difficulty is simply that systematic programs are not in place.

The notion of "civil commitment" for addict/offenders—assigning them to residential drug treatment programs that they are not free to leave—was once hailed as a cure-all for the addict crime problem. It has since lost some of its luster, but there is still evidence that well-designed and managed civil commitment can outperform prison in reducing the subsequent drug use and criminal behavior of those committed. It is not often possible to turn persistent drug-using burglars into members of the Kiwanis Club, but if it is possible to turn them into somewhat less active burglars, that more modest goal is well worth achieving. One careful study of the subject concludes that the differences, in terms of future drug use and crime, between civil commitment and unsupervised release are large enough in favor of commitment to justify its costs.^{EN75} Nor is the difference between the daily life of someone under civil commitment and that of a prison inmate such as to suggest that civil commitment sacrifices deterrence to incapacitation; the prisoner may well be doing easier time.

Some states have created therapeutic communities as separate living units within the walls of their prisons. Unlike the civil-commitment programs, participation in prison TCs is voluntary, but the alternative—the consequence of quitting or being expelled from the therapeutic community—is being back on a cell block. The additional cost of keeping a prisoner in such a community, over and above the cost of having him in prison in the first place, is only a few thousand dollars a year.^{EN76} Once again, it is impossible to measure the benefits of such a program by comparing the recidivism rates of its graduates with those of the general population, because the TC graduates are likely to be self-selected to succeed on the outside. Still, the differences are great enough and the cost (compared to the cost to the state of further

^{EN75} M. Douglas Anglin, "A Social Analysis of Compulsory Treatment for Opiate Dependence," *Journal of Drug Issues* 18 (4 [Fall 1988]).

^{EN76} Harry K. Wexler, G. P. Faulkin, and D. S. Lipton, *A Model Prison Rehabilitation Program: An Evaluation of the Stay'n Out Therapeutic Community* (New York: Narcotic and Drug Research Inc., 1988).

imprisonment or the cost to crime victims of further crimes) small enough to suggest that such programs should be much more widespread. One study comparing prison TC alumni with prisoners from the same facility who applied for TC admission but never made it off the waiting list suggests noticeably better outcomes for the TC group; other studies are less encouraging.^{EN77}

SUMMARY

Opponents of the "war on drugs" sometimes argue that improved education and treatment can control the drug problem more effectively, and with fewer unwanted side effects, than prohibition and enforcement. While it is certain that programs of persuasion directed at potential drug users, and an offer of therapy to those struggling to manage their drug habits, can produce benefits in the form of reduced demand, it is much less clear how great those benefits can be with current techniques of persuasion and therapy. Whether any practicable program of "demand reduction" could work well enough to prevent major increases in consumption and drug-related harm in the face of the substantial reductions in price and search time that would follow a drastic cutback in drug law enforcement is unknown. That such a program could prevent increased drug abuse damage if the changes were from prohibition to free legal availability seems highly improbable. Nor is it obvious that drug treatment should be thought of as competing with drug law enforcement for a share of the drug abuse control budget rather than with other health-care programs for a share of the \$600 billion per year spent on health care in the United States.

Mass-media persuasion efforts should focus on mass-market drugs, especially alcohol and tobacco; there is still lots of bad news to deliver about those drugs, and a substantial body of positive messages to counteract. School-based campaigns should stress the development of decision-making and resistance skills.

Among the established voluntary treatment modalities, the ones most obviously worth expanding are methadone maintenance for heroin users and therapeutic communities for prison inmates. More resources for methadone should mean not only more clients but better-staffed programs, able to exert more control over their clients' drug use. Detoxification, whether drug-assisted or drug-free, may

^{EN77} Ibid.

also be worth expanding, particularly if it can be delivered cheaply in non-hospital settings and linked to forms of follow-up care: counseling, self-help through twelve-step programs, or Oxford Houses.

Those drug users who frequently commit crimes, other than the crime of buying drugs, can and should be compelled to give up their drug use, both as part of their punishment and to reduce their future criminality. Treatment may be a useful adjunct to that process, and the result may well be therapeutic, but its primary mechanism is coercion: quit or else. Under sufficient pressure, most drug users can and will quit, or at least drastically reduce their drug use. The goal of the program should be to make the life-style of a drug-using criminal no longer sustainable.