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Report to the Chairman, Committee on Government Operations, House of Representatives

July 1993

CONFRONTING THE DRUG PROBLEM

Debate Persists on Enforcement and Alternative Approaches

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General Government Division

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July 1, 1993

The Honorable John Conyers, Jr.
Chairman, Committee on
Government Operations
House of Representatives

Dear Mr. Chairman:

In response to your request, this report discusses a range of approaches to address the drug problem. As you are aware, the current federal drug control strategy emphasizes enforcement. Drug law enforcement comprises international, border interdiction, and domestic criminal justice system efforts to reduce the availability and use of illegal drugs. This approach includes seizing drugs and arresting, punishing, and deterring drug traffickers and users.

Critics of the enforcement emphasis of the federal strategy contend that an increased reliance on such approaches as drug use prevention, drug treatment, and options to traditional incarceration could more effectively address the drug problem. Other critics of the federal strategy, while recognizing the need for government controls, question the necessity of maintaining a total prohibition on the sale and use of illegal drugs.

Law enforcement alone cannot solve the drug problem. Supporters of enforcement and alternative approaches recognize the need for a combination of approaches. The debate on how to contend with the illegal drug problem centers on determining the most effective combination. The shortage of methodologically sound and conclusive studies on these approaches fuels the debate.

The objective of this report is to identify the major pro and con arguments regarding drug law enforcement and the alternative approaches most frequently discussed. Because of the shortage of studies on these approaches, we did not attempt to evaluate these arguments and therefore do not endorse or reject any particular combination of approaches to confront the drug problem.

Background

Several indicators suggest that the United States continues to have a serious drug problem. Cocaine, heroin, and marijuana remain readily available nationwide, according to federal drug intelligence assessments. Illegal drug use, although declining among certain groups, continues to be

substantial. According to estimates by the National Institute on Drug Abuse, the number of past-year illicit drug users (i.e., those who used an illicit drug at least once during the year) decreased from 28.0 million to 26.1 million between 1988 and 1991. A 1990 study done for the U.S. Department of Health and Human Services estimated the health costs attributable to drug abuse to have been $8.9 billion in 1988.

Drug dealing and drug-related crime continue to ravage many neighborhoods. The Congressional Research Service estimated that drug-related homicides in the United States increased by almost 70 percent from 1986 to 1990. Drug arrests place serious burdens on the criminal justice system, especially on the federal prison system, at least 34 state prison systems, and the District of Columbia system, all of which have inmate populations that exceed prison capacities.

Results

The federal government has steadily increased its annual drug control budget from $2.8 billion in 1986 to $12.0 billion in 1992, approximately 70 percent of which has supported drug enforcement efforts and about 30 percent, drug use prevention and treatment. Supporters of the enforcement emphasis claim that law enforcement activities in recent years have led to substantial drug seizures as well as to the arrest, prosecution, and punishment of many drug traffickers and users. Supporters contend that these seizures and arrests have reduced the availability and use of illegal drugs, both directly and through deterrence. They also claim that the connection between illegal drugs and crime is so strong that an intense law enforcement response to drugs has been necessary. Advocates of alternative strategies suggest that the federal strategy, with its emphasis on enforcement, has not made a serious dent in the nation's continuing drug problem.

We identified a range of alternative approaches that rely less heavily on enforcement. These approaches, which can complement each other, include the following:

- increasing spending on drug use prevention;
- increasing spending on drug treatment;
- expanding use of coercive drug treatment programs that use the criminal justice system to encourage offenders to enter treatment;
- increasing use of penalties other than traditional imprisonment, such as boot camps, intensive supervision probation, civil penalties, and fines, for less serious drug offenders;

- expanding use of conditional discharge programs, whereby less serious drug offenders can avoid drug convictions by meeting conditions imposed by the court, such as by demonstrating abstinence through regular drug tests;
- eliminating penalties for drug use, while continuing to arrest and punish drug traffickers;
- expanding physician prescription authority to allow the prescribing of certain otherwise illegal drugs in the course of treating patients' addictions, as physicians are now allowed to prescribe methadone for heroin addicts; and
- authorizing a regulated drug market in which legitimate businesses could sell one or more currently illegal drugs to adults under controlled conditions.

We discuss the pros and cons of the enforcement and alternative approaches in appendixes I and II.

Scope and Methodology

For this study, we did a literature review and interviewed drug experts from the criminal justice, public health, research, and academic communities to obtain a wide range of views for and against the enforcement and alternative approaches. We also assembled a panel of six experts from these communities to provide guidance. Because of the shortage of conclusive and methodologically sound evaluations of the approaches, we relied heavily on the perceptions and judgments presented to us during interviews and in the literature.

In reviewing information on the enforcement and alternative approaches, we sometimes found more arguments on one side of the debate on a particular approach than on the other. This does not reflect the validity of any one approach. In this report, we simply summarized the major arguments we identified and did not attempt to evaluate them. We provide a detailed description of our objective, scope, and methodology in appendix III.

As arranged with the Committee, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, we will send copies to the Director of the Office of National Drug Control Policy and to other interested parties. We also will make copies available to others upon request.

The major contributors to this report are listed in appendix IV. If you or your staff have any questions concerning this report, please contact me on (202) 566-0026.

Sincerely yours,

Henry R. Wray
Director, Administration of
Justice Issues

Contents

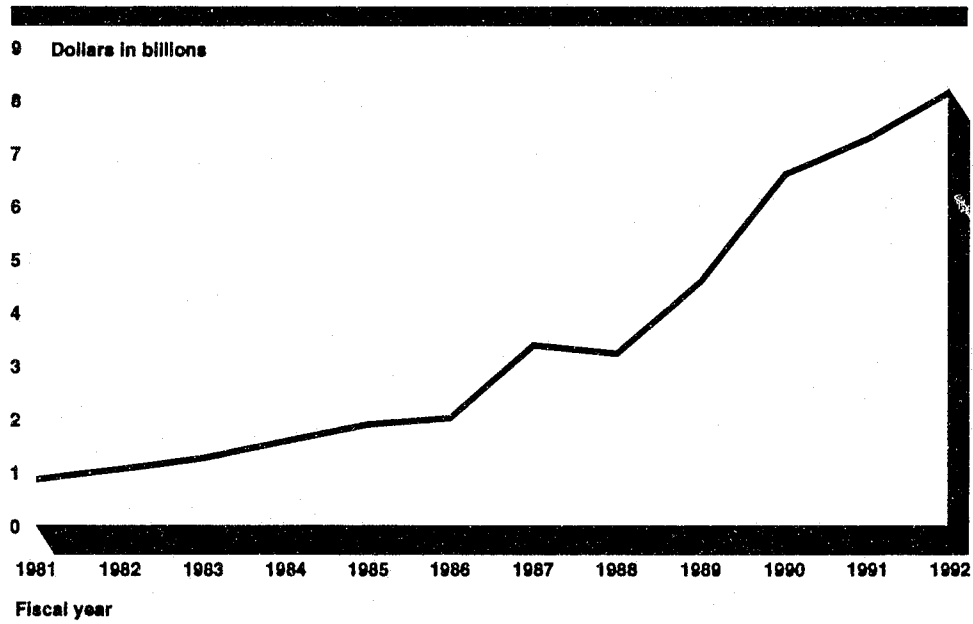
Abbreviations

AIDS	acquired immune deficiency syndrome
DAWN	Drug Abuse Warning Network
DEA	Drug Enforcement Administration
DUF	Drug Use Forecasting
FBI	Federal Bureau of Investigation
HHS	Department of Health and Human Services
HIV	human immunodeficiency virus
NIDA	National Institute on Drug Abuse
NNICC	National Narcotics Intelligence Consumers Committee
ONDCP	Office of National Drug Control Policy
OTA	Office of Technology Assessment
TASC	Treatment Alternatives to Street Crime
TC	therapeutic community
TOPS	Treatment Outcome Prospective Study

The Debate on the Enforcement Approach

The federal drug strategy emphasizes law enforcement and attempts to reduce drug availability and use by seizing drugs and arresting, prosecuting, and punishing drug traffickers and users. About $8.2 billion of the $12.0 billion 1992 federal drug control budget was spent on drug enforcement efforts.[1] As shown in figure I.1, this budget represents a substantial increase from the $2 billion spent on enforcement efforts in fiscal year 1986, when total federal drug control spending was $2.8 billion. As shown in figure I.2, the $8.2 billion in 1992 enforcement spending primarily supported international, border interdiction, and domestic enforcement efforts.

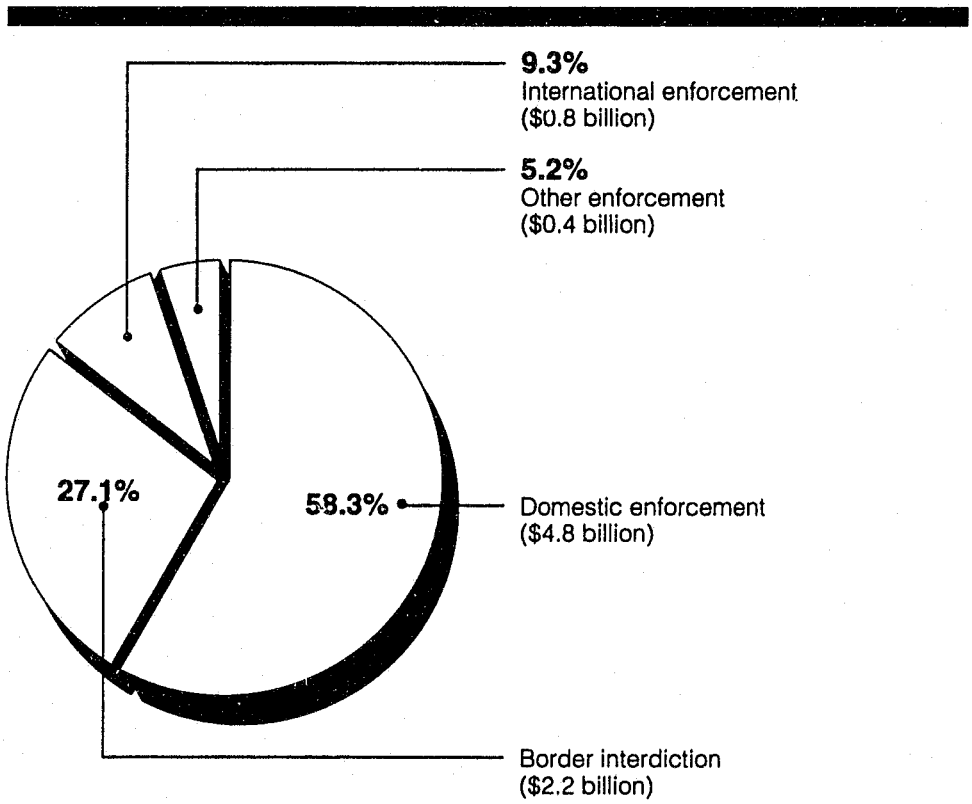
Figure I.1: Federal Drug Enforcement Spending



Source: National Drug Control Strategy, A Nation Responds to Drug Use, Budget Summary, The White House, January 1992.

[1]Throughout this report, references to fiscal year 1992 federal spending represent budgeted amounts that were legislatively authorized.

Figure I.2: Fiscal Year 1992 Federal Drug Enforcement Spending



Note 1: Total fiscal year 1992 drug enforcement spending was $8.2 billion.

Note 2: "Other enforcement" includes regulatory and compliance, research and development, and other drug enforcement spending.

Source: National Drug Control Strategy, A Nation Responds to Drug Use, Budget Summary, The White House, January 1992.

The total federal budget for international drug control efforts in fiscal year 1992 was about $773 million. These international efforts generally involved supporting, training, and assisting foreign drug enforcement and crop eradication units.[2] The State Department spent most of its fiscal year 1992 drug control budget of $293 million to directly support these units. This budget also funded about $7 million in crop substitution assistance[3] and

[2]Crop eradication is the destruction of plants that are being grown to produce illegal drugs.

[3]Crop substitution programs support farmers who change from growing drug crops to growing legal crops.

about $4 million in international drug prevention and treatment programs. In addition, the Agency for International Development spent about $269 million for drug-related economic assistance, most of which was contingent upon effective drug enforcement performance by the recipient countries. The agency also spent about $10 million on drug prevention efforts. Further, the U.S. Drug Enforcement Administration (DEA) spent about $162 million on international efforts such as the Foreign Cooperative Investigations Program, which provided training and investigative assistance in 50 host countries.

Border interdiction efforts consist of air, sea, and land actions to seize drugs at or near U.S. entry points. About $2.2 billion was spent on these efforts in fiscal year 1992. Interdiction efforts are carried out primarily by the Coast Guard, the Customs Service, and the Immigration and Naturalization Service. The Defense Department provides detection, monitoring, and intelligence support for these efforts.

About $4.8 billion was spent on domestic federal drug enforcement activities in fiscal year 1992. These activities included seizing drugs; eradicating marijuana plants; dismantling clandestine drug laboratories;[4] and arresting, prosecuting, and punishing drug traffickers, financiers, and users. Most of this funding supported drug enforcement efforts of the Justice Department (primarily the Bureau of Prisons and DEA), the Treasury Department, and the U.S. courts. In addition, about $1 billion supported state and local drug enforcement efforts. According to a RAND Corporation analysis, total state and local drug enforcement spending was roughly $18.2 billion in 1988.[5]

Although most federal drug enforcement efforts focus on drug traffickers, some are aimed at drug users. According to the U.S. Sentencing Commission, over 10,000 federal defendants were convicted from 1984 through 1990 on a criminal charge of "simple possession" (i.e., of possessing a personal use amount of a drug).[6] Since 1988, under federal law, civil fines of up to $10,000 can be imposed in addition to, or instead of, criminal sanctions for simple possession.

[4]A clandestine drug laboratory produces illegal drugs from chemicals and drug plants.

[5]The RAND Corporation estimated that $21.4 billion was spent on drug enforcement at the federal, state, and local levels in 1988. Because $3.2 billion was spent on drug enforcement at the federal level in fiscal year 1988, the RAND analysis suggests that there was about $18.2 billion in such spending at the state and local levels in 1988.

[6]Special Report to the Congress: Mandatory Minimum Penalties in the Federal Criminal Justice System, U.S. Sentencing Commission, August 1991.

Proponents of enforcement contend that these efforts limit the supply of and demand for illegal drugs. They also suggest that the connection between illegal drugs and crime necessitates an aggressive criminal justice system response to drugs. However, those questioning an enforcement emphasis challenge the significance of its impact. They claim that illegal drug trafficking is so highly profitable that enforcement appears unable to stop it.

The Supply of Illegal Drugs

Drug enforcement has resulted in drug crop eradication, sizable drug seizures, and the dismantling of numerous clandestine drug laboratories, as well as the arrest and conviction of many drug traffickers.

The State Department estimated that in 1991, about 7,000 of 213,000 hectares of coca crops were eradicated in Latin America;[7] about 11,000 of 239,000 hectares of opium crops were eradicated in Asia and Latin America; and about 12,000 of 33,000 hectares of marijuana crops were eradicated in Latin America.[8] Further, about 2,400 metric tons of an estimated 6,000 to 7,000 metric tons of cultivated marijuana crops were eradicated in the United States by DEA in conjunction with other federal, state, and local authorities in 1991.

DEA reported the domestic seizure of about 68,000 kilograms of cocaine in fiscal year 1991, down from about 82,000 and 73,000 kilograms in fiscal years 1989 and 1990, respectively, but exceeding the reported amount for any other fiscal year since 1983. The Office of National Drug Control Policy (ONDCP) presents data that suggest that about 15 to 22 percent of the cocaine shipped to the United States between 1988 and 1990 was seized by federal authorities.[9] DEA also reported the domestic seizure of about 1,100 kilograms of heroin in fiscal year 1991, more than in any other fiscal year since 1983. In addition, DEA reported the seizure of about 107,000 kilograms of cannabis in fiscal year 1991.[10] DEA further reported dismantling 387 clandestine laboratories and seizing $950 million in assets in fiscal year 1991.

[7]One hectare equals about 2.47 acres.

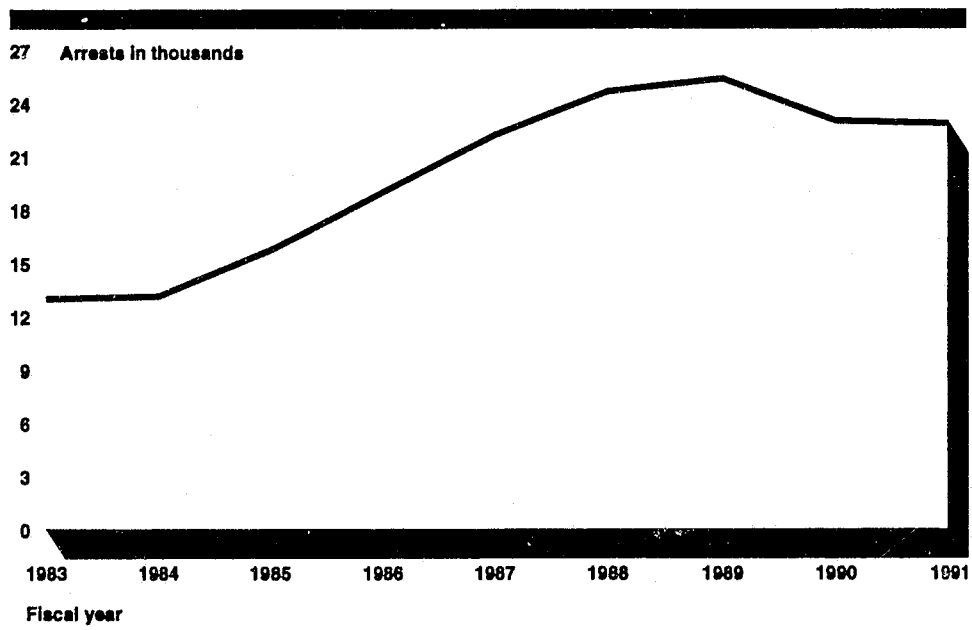
[8]International Narcotics Control Strategy Report, Bureau of International Narcotics Matters, U.S. Department of State, March 1992.

[9]What America's Users Spend on Illegal Drugs, Office of National Drug Control Policy, June 1991.

[10]Cannabis includes both marijuana and hashish (the concentrated resin from the flowering tops of the marijuana plant).

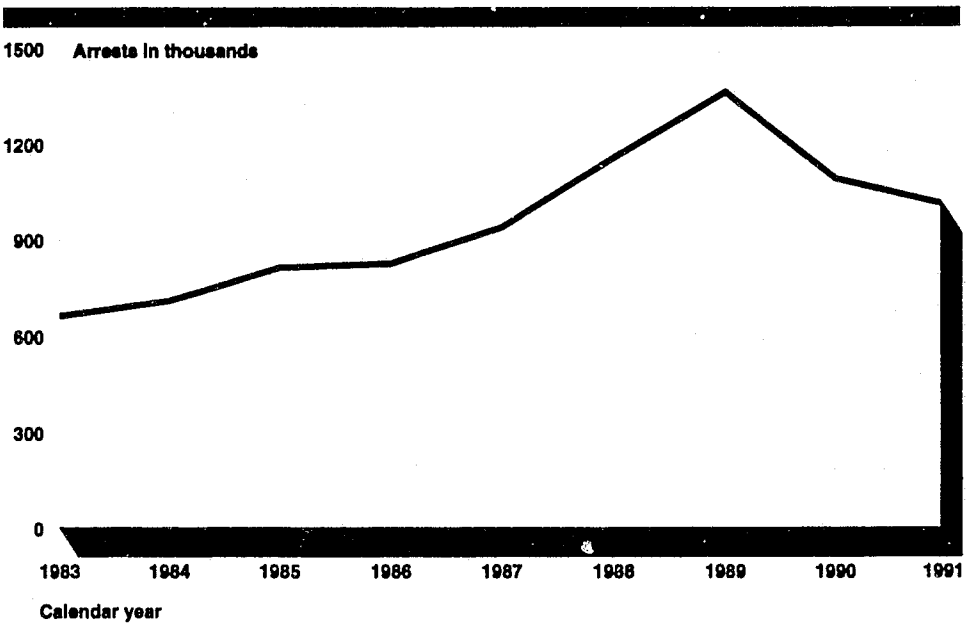
Federal, state, and local drug arrests and convictions have increased significantly since 1983. As shown in figure I.3, annual federal DEA drug arrests almost doubled from about 13,000 to 25,000 between fiscal years 1983 and 1989, then declined modestly to about 23,000 in both fiscal years 1990 and 1991. As shown in figure I.4, the Federal Bureau of Investigation (FBI) estimated that annual state and local arrests for drug violations more than doubled from about 661,000 to about 1,362,000 between 1983 and 1989, then declined to 1,010,000 in 1991. Federal DEA drug convictions increased approximately 60 percent from about 10,000 in 1983 to about 16,000 in 1991. DEA reported that a substantial number of drug violators among those arrested and convicted at the federal level from 1983 to 1991 were high-level dealers, such as heads of illicit drug distribution organizations, financiers, and laboratory operators who were capable of distributing and/or producing large amounts of drugs. Federal DEA drug enforcement efforts led to about 6,600 such arrests and about 5,500 such convictions in 1991.

Figure I.3: Federal DEA Drug Arrests



Source: DEA data.

Figure I.4: State and Local Drug Arrests



Source: FBI Uniform Crime Reporting data.

Supporters of enforcement argue that these efforts have reduced the supply and availability of illegal drugs. Opponents point to the federal drug intelligence assessment suggesting that illegal drug supplies have remained high. The National Narcotics Intelligence Consumers Committee (NNICC)[11] concluded in 1992 that illegal drugs are still readily available throughout the United States.[12] Researchers and local officials in the cities we visited generally concurred with this assessment. Opponents of enforcement also suggest that traffickers grow, produce, and distribute surpluses to compensate for anticipated seizures. These opponents point to State Department estimates that worldwide coca leaf production has steadily increased from about 294,000 metric tons in 1988 to about 331,000 metric tons in 1991.[13] Furthermore, critics contend that drug trafficking

[11]NNICC is a federal interagency mechanism that coordinates drug intelligence collection and produces joint intelligence estimates. It issues periodic reports on the worldwide illicit drug situation, identifying drug trafficking routes and methods and estimating illegal drug production, availability, and consumption. It tracks cocaine, heroin, marijuana, and other dangerous drugs. A senior DEA official serves as chairperson of the group, which also includes representatives from 11 other federal agencies.

[12]The NNICC Report 1991, The Supply of Illicit Drugs to the United States, National Narcotics Intelligence Consumers Committee, July 1992.

[13]International Narcotics Control Strategy Report, March 1992.

profits may be so high that as long as there are buyers, there will be providers. In a 1991 report, we said that the failure to significantly reduce cocaine supplies through interdiction efforts was a result of high profits and the inability of current technology to efficiently find cocaine hidden in containers, large vessels, vehicles, and other conveyances.[14] We observed that interdiction alone had not raised cocaine traffickers' costs and risks enough to make a difference.

The Demand for Illegal Drugs

Supporters argue that drug enforcement can reduce the demand for drugs. They point to the recent results of the National Household Survey on Drug Abuse of the National Institute on Drug Abuse (NIDA).[15] NIDA, as shown in figure I.5, estimated that from 1988 to 1991,[16] the number of past-year users of illicit drugs (i.e., those who used any illicit drug at least once during the year) decreased from 28.0 million to 26.1 million and that the number of past-year cocaine users decreased from 8.2 million to 6.4 million.[17] Proponents maintain that enforcement increases the inconvenience of buying drugs and raises drug prices, thereby discouraging some drug use. In addition, drug enforcement presents the risk of arrest to those who purchase or possess illegal drugs, also discouraging some individuals from using these substances.

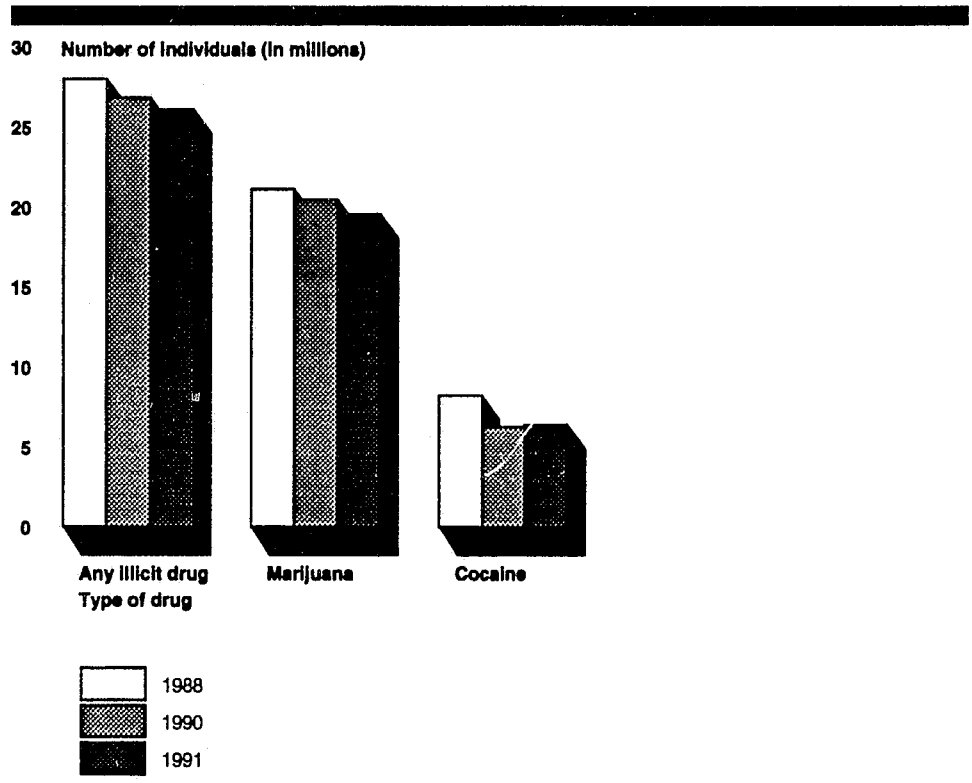
[14]Drug Control: Impact of DOD's Detection and Monitoring on Cocaine Flow (GAO/NSIAD-91-297, Sept. 19, 1991).

[15]The household survey provides data on the prevalence, incidence, and trends of drug use for persons age 12 and older living in households. Results are based on personal interviews with individuals randomly selected from the household population who record their responses on self-administered answer sheets. Until October 1, 1992, NIDA, an agency of the U.S. Department of Health and Human Services, was responsible for the household survey. Currently, the household survey is the responsibility of the Substance Abuse and Mental Health Services Administration of the same department.

[16]National Household Survey on Drug Abuse: Population Estimates (1988, 1991), National Institute on Drug Abuse, U.S. Department of Health and Human Services.

[17]In the 1988 household survey report and the 1991 report (as revised on February 27, 1992), NIDA estimated that the number of cocaine users who reported using cocaine "once a week or more" declined from 862,000 to 654,000 from 1988 to 1991.

Figure I.5: Estimated Past-Year Drug Users



Source: NIDA household survey data.

Critics question the role of enforcement in the reported reduction in drug use. They claim that any reduction is more the result of prevention and treatment efforts or of social and cultural changes. Other critics point to the Drug Use Forecasting (DUF)[18] studies that show a continued high rate of drug use among booked arrestees—in 20 of 24 urban areas studied,[19] more than 50 percent of the sample of male booked arrestees tested positive for cocaine, opiates, marijuana, or other drugs in 1991.

[18]The DUF program, sponsored by the National Institute of Justice, estimates drug use among samples of booked arrestees charged with criminal offenses in major urban areas. DUF estimates are based on information from voluntary, anonymous urine tests and interviews conducted quarterly in participating urban areas.

[19]Drug Use Forecasting, Drugs & Crime, 1991 Annual Report, National Institute of Justice, December 1992.

Questions have been raised about the validity of the household survey and DUF reports as sources of drug use data. Some experts question the decision not to include certain high-risk population groups, such as the homeless and prisoners, in the household survey. In a June 1993 report, we noted methodological limitations with these data sources. For example, the self-reporting of illegal drug use in general household surveys has not been sufficiently validated, and the geographic areas covered by the DUF studies have not been shown to be representative of the urban areas identified in the DUF reports.[20]

Experts we met with maintained that enforcement does reduce the demand for drugs among people with the most to lose, such as those who are gainfully employed. They said that those with less to lose, such as the long-term unemployed, are less concerned about arrest. Experts also said that enforcement is more successful in reducing demand among occasional users than among frequent or addicted users, who are less in control of their use and therefore less likely to be deterred by the potentially adverse legal consequences. Local officials told us that reductions in cocaine use have been primarily among casual users and within suburban and middle- and upper-income populations. They expressed particular concern about the rise of crack cocaine use in their inner-city neighborhoods.[21]

Drug enforcement supporters claim that to the extent enforcement discourages the abuse of illegal drugs, associated health costs are lowered. A 1990 study done for the U.S. Department of Health and Human Services (HHS) estimated the health costs attributable to drug abuse to have been $8.9 billion in 1988.[22] This figure included $3.0 billion in the lost lifetime earnings of those who died in 1988 from drug abuse, $2.7 billion in direct health care costs, and $3.2 billion in drug-use-related acquired immune

[20]Drug Use Measurement: Strengths, Limitations, and Recommendations for Improvement (GAO/PEMD-93-18, June 25, 1993).

[21]Experts pointed out that the introduction of crack cocaine was a marketing strategy to make cocaine, expensive in its powder form, more accessible to lower-income individuals.

[22]The Economic Costs of Alcohol and Drug Abuse and Mental Illness: 1985, Rice, Dorothy P., et al., Institute for Health & Aging, University of California, San Francisco, for the U.S. Department of Health and Human Services, 1990. This report includes cost estimates for 1985 and 1988.

deficiency syndrome (AIDS) costs. Drug Abuse Warning Network (DAWN)[23] data on drug-related deaths[24] in 27 metropolitan areas indicate that in 1991 there were about 3,000 cocaine-related, 2,300 heroin-related, and 200 marijuana-related deaths in these areas.[25] As shown in figure I.6, DAWN estimated a substantial number of drug-related emergency room episodes nationwide in 1991.[26] In addition, injection drug use is the second most common risk behavior reported for AIDS cases in the United States in that the human immunodeficiency virus (HIV) can be transmitted among injection drug users through the sharing of contaminated needles or syringes. Infected drug users can then transmit the virus to their sexual partners and, through prenatal exposure, to their children. The additional medical and educational costs attributable to children prenatally exposed to drugs represent another major concern.

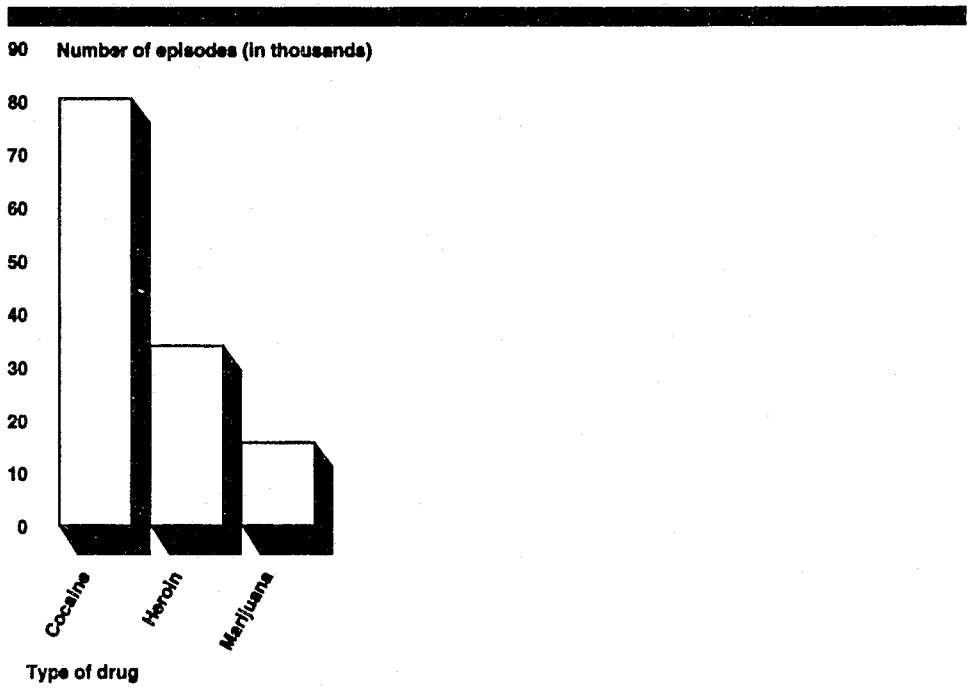
[23]DAWN is a large-scale program that gathers data on drug-related deaths and emergency room episodes based on mentions from a sample of medical examiners and hospitals in selected locations throughout the United States. Medical examiners may mention more than one drug in connection with a drug-related death; hospital emergency rooms may mention more than one drug in connection with a drug-related emergency room visit (episode). Until October 1, 1992, NIDA was responsible for DAWN. Currently DAWN is the responsibility of the Substance Abuse and Mental Health Services Administration.

[24]These deaths included multiple-drug-related deaths and should not be aggregated. In such deaths, the extent of the responsibility of one drug versus other drugs for the fatality was not determined. The deaths included drug-induced deaths from overdoses and drug-related deaths in which the drug use, in combination with a physiological condition, a medical disorder, or an external physical event, caused death. Heroin-related deaths also included deaths related to morphine and other opiates not specified as to type. Marijuana-related deaths also included hashish-related deaths. Drug-related homicides and deaths in which AIDS was reported were excluded.

[25]Annual Medical Examiner Data 1991, Data from the Drug Abuse Warning Network (DAWN), Series I, Number 11-B, National Institute on Drug Abuse, U.S. Department of Health and Human Services, 1992.

[26]Annual Emergency Room Data 1991, Data from the Drug Abuse Warning Network (DAWN), Series I, Number 11-A, National Institute on Drug Abuse, U.S. Department of Health and Human Services, 1992.

Figure I.6: Estimated Nationwide Emergency Room Drug-Related Episodes in 1991



Note 1: Heroin-related episodes also included morphine-related episodes.

Note 2: Marijuana-related episodes also included hashish-related episodes.

Note 3: These emergency room episodes included multiple-drug-related episodes and should not be aggregated. In such episodes, the extent of the responsibility of one drug versus other drugs for the episode was not determined.

Note 4: No determination was made on the extent to which nondrug-related factors may have contributed to the person's emergency room condition.

Source: DAWN data.

Critics suggest that discouragement of illegal drug use through enforcement efforts may not reduce health costs associated with substance abuse. They argue that such costs will not be reduced if those discouraged from using illegal drugs instead begin abusing legal substances, such as alcohol and tobacco, which experts also consider to be drugs. The U.S. Centers for Disease Control and Prevention estimated that about 105,000 alcohol-related deaths occurred in 1987 and 434,000 tobacco-related deaths occurred in 1988.

Drug-Related Criminal Activity

Supporters of drug enforcement suggest that a strong connection exists between illegal drugs and criminal activity. The District of Columbia estimated that in 1991, more than one-third of the city's record 489 homicides were drug-related. Drug-related homicide data have been challenged because no clear, uniform guidelines exist to determine when such a crime has occurred. For example, a police determination that a homicide was drug-related may be based on the police finding drugs on the offender or victim, although the catalyst for the homicide may actually have been a personal or gang feud unrelated to drugs.

Several researchers reported a correlation between a person's level of cocaine or heroin use and the likelihood and frequency of his or her involvement in criminal activity. The 1990 study done for HHS estimated that property losses stemming from crimes committed by drug users to support their drug habits amounted to $759 million in 1985.[27] A jail inmate survey done by the Bureau of Justice Statistics in 1989 found that 28 percent of the inmates reported they were under the influence of illegal drugs or both illegal drugs and alcohol at the time of the offense for which they were sentenced.[28] The National Institute of Justice's DUF program reported that in 16 of the 24 urban areas studied, more than 40 percent of the sample of male booked arrestees tested positive for cocaine in 1991.[29] In 18 of 21 urban areas, 40 percent or more of the sample of female booked arrestees tested positive for cocaine in 1991.

Critics point out that a positive test for drugs at the time of arrest does not mean that the person was necessarily under the influence of the drug at the time of the offense, because urine tests for cocaine and heroin only indicate use within 2 to 3 days of the test and the test for marijuana detects use sometime in the previous several weeks. Critics also note that many drug users reported having been involved with criminal activity, such as property crime, before their involvement with illegal drugs. A 1986 survey of state prison inmates by the Bureau of Justice Statistics found that 50 percent of the inmates who had ever used a major drug, such as

[27]The Economic Costs of Alcohol and Drug Abuse and Mental Illness: 1985, 1990.

[28]Drugs and Jail Inmates, 1989, Bureau of Justice Statistics, U.S. Department of Justice, August 1991.

[29]Drug Use Forecasting, Drugs & Crime, 1991 Annual Report, National Institute of Justice, December 1992. Positive tests for the use of marijuana or opiates (i.e., heroin and other derivatives of the opium poppy plant) among booked arrestees were lower than for cocaine use. For example, in 22 of 24 urban areas, less than 30 percent of the sample of male booked arrestees tested positive for marijuana use in 1991; in 23 of 24 urban areas, less than 20 percent of male booked arrestees tested positive for opiate use.

cocaine or heroin, and 60 percent of those who had ever used a major drug regularly did not do so until after their first arrest.[30]

Enforcement's supporters also claim that enforcement helps restore order on the streets by reducing the number of outdoor drug markets, which can greatly improve the quality of life in the affected neighborhoods. Opponents maintain that enforcement often merely shifts drug dealing operations to other neighborhoods or indoors. Proponents of enforcement also contend that drug enforcement helps limit the power of criminal organizations involved in drug trafficking. Critics claim that a successful enforcement action against one drug dealing organization may only empower another group that takes over the curtailed group's market. One researcher observed that enforcement successes against some drug trafficking organizations have resulted from tips from competing organizations.

The Criminal Justice System

Those who challenge the efficacy of drug enforcement point to the serious burdens these efforts have placed on the criminal justice system in terms of police priorities, court costs, and prison space. Critics suggest that applying more police resources to drug enforcement may limit funding for other police efforts. Civil cases, which represent the majority of cases filed in the federal courts, have been pushed further back on the court-trial calendar by drug-related criminal cases.[31] The Sentencing Project[32] found that in 1989 the United States had the world's highest known prison and jail incarceration rate, with 426 federal, state, and local inmates per 100,000 population.[33] It concluded that the "war on drugs" was probably the largest single contributing factor. As shown in figure I.7, the number of imprisoned federal drug offenders rose from about 9,500 in 1985 to about 30,500 in 1991. The proportion of federal prison inmates who were drug offenders rose from 34 percent to 57 percent over this time period. The proportion of state prison inmates who were drug offenders rose from about 9 percent in 1986 to about 22 percent in 1991. These large numbers of drug offenders contribute to overcrowding. According to the Bureau of Justice Statistics, the prison systems of the federal government, at least 34

[30]Drug Use and Crime, Bureau of Justice Statistics, U.S. Department of Justice, July 1988.

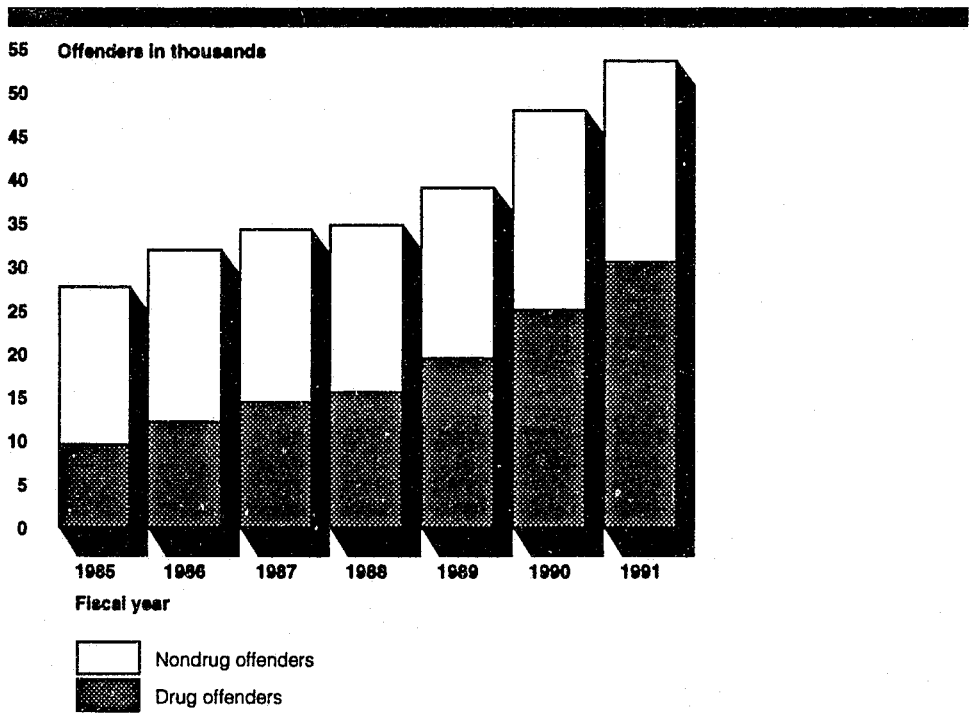
[31]National Drug Control Strategy, A Nation Responds to Drug Use, Budget Summary, The White House, January 1992.

[32]The Sentencing Project is a national, nonprofit organization that promotes sentencing reform and the development of alternative sentencing programs.

[33]Americans Behind Bars: A Comparison of International Rates of Incarceration, The Sentencing Project, January 1991.

states, and the District of Columbia have inmate populations in excess of prison capacities.[34]

Figure I.7: Sentenced Drug Offenders in the Federal Prison System



Source: Federal Bureau of Prisons data.

Enforcement supporters respond that additional resources for the criminal justice system could ease these burdens, particularly if the resources are directed toward the courts and correctional systems that must process drug arrests. One expert said that any further funding for police to make more drug arrests would be of limited value if the courts and the corrections system are not able to effectively handle the additional drug cases and convictions these arrests generate. The expert argued further that drug arrests are more of a deterrent if everyone properly arrested is in some manner punished.

[34]Prisoners in 1991, Bureau of Justice Statistics, U.S. Department of Justice, May 1992.

Critics of providing additional resources for drug enforcement, however, suggest that money could be better spent on drug use prevention or treatment to reduce the demand for drugs. Other critics recommend less of an emphasis on incarceration and more reliance on other options that could represent less costly and more promising ways to help drug offenders (particularly street-level, nonviolent dealers and drug users) turn their lives around. As we discuss in appendix II, these options could include coercive drug treatment, alternative penalties, and conditional discharges.

The Debate on Alternative Approaches

Advocates of alternative approaches claim that the enforcement emphasis of the current strategy has not made a serious dent in the nation's continuing drug problem. They therefore suggest that an increased reliance on other approaches, such as drug prevention and treatment as well as sentencing and correctional options to incarceration, should be considered. About 70 percent of the federal drug control budget has supported drug enforcement efforts, and about 30 percent has supported drug prevention and treatment. Proponents of sentencing and correctional options to incarceration suggest that, although these options are funded by the criminal justice system, they could lower the cost of enforcement by reducing the reliance on imprisoning drug offenders. Drug enforcement supporters contend that any significant deemphasis on enforcement will lead to a dangerous expansion of drug availability and use.

Expanding Drug Prevention Efforts

One alternative approach is a drug control strategy that would include an increased reliance on drug prevention programs, which are intended to persuade people not to start using drugs or, if they have started, to stop. Prevention programs include education programs to increase student awareness of the dangers of drugs; drug testing in the workplace to discourage employee drug use; and comprehensive efforts that attempt to address some underlying causes of drug abuse through a variety of personal development, community, and social programs.

In fiscal year 1992, federal drug prevention spending was about $1.7 billion—or about 14 percent of the federal drug control budget. This amount represents a significant increase from the $186 million spent in fiscal year 1986 when drug prevention spending constituted about 7 percent of the federal drug control budget. Federal prevention activities, primarily implemented by HHS and the Department of Education, include such efforts as (1) disseminating prevention information; (2) assisting schools, workplaces, community groups, and public housing projects to prevent drug abuse; and (3) requiring federally funded educational agencies and institutions, as well as federal contractors, to establish drug prevention programs.

Proponents of increased spending on prevention programs contend that such efforts can be effective in reducing drug use but disagree on which prevention programs are the most effective and on how they can best be implemented. Supporters claim that sufficient prevention efforts decrease the need for expensive drug treatment later. They also point to reductions in the use of alcohol, tobacco, and illegal drugs as indicators of prevention

program success. However, even supporters disagree as to whether increasing student awareness of the dangers of drugs is effective; whether the dangers of drugs should be presented in a factual or an exaggerated manner; and whether drug education programs should include resistance training, which trains students through role-playing to develop skills to be able to reject peer pressure to use drugs. They also disagree on the extent to which drug testing in the workplace is appropriate and the extent to which more comprehensive programs should be funded in efforts to prevent drug abuse.

Opponents argue that decreases in the use of alcohol, tobacco, and illegal drugs have resulted more from social and cultural changes or enforcement efforts than from drug prevention programs. Research on the effectiveness of prevention programs has generally been mixed.

Drug Education

How effective increasing student awareness of the dangers of drugs is in discouraging drug use has not been established. In a 1990 study, we reported that student groups from 18 schools in 6 school districts across the country had told us that school-based drug education programs were very helpful and that without them more students would probably use drugs.[1] Some prevention researchers suggested, however, that although drug education programs may increase knowledge about drugs, they have had little impact on drug use. A few studies indicated that these programs may actually stimulate some students' interest in, and demand for, drugs. In a March 1993 review, we concluded that there has been limited progress in terms of rigorous evaluations of the effectiveness of drug education programs.[2]

Whether drug information should be presented in a factual or an exaggerated manner is an important concern. Supporters of the factual approach say that messages that greatly exaggerate the negative effects of particular drugs and fail to provide realistic information lack credibility. One local official said that prevention efforts have been successful in decreasing cigarette smoking because information has been presented in an honest and factual way. Advocates of a more dramatic approach argue that some exaggeration of the dangers of using drugs can be effective with certain groups, such as the very young, by making them fear the possible consequences of experimenting with drugs.

[1]Drug Education: School-Based Programs Seen as Useful but Impact Unknown (GAO/HRD-91-27, Nov. 28, 1990).

[2]Drug Education: Limited Progress in Program Evaluation (GAO/T-PEMD-93-2, Mar. 31, 1993).

Many researchers and officials contend that different types of drug education programs should be targeted to different age, socioeconomic, and ethnic groups. Some suggest, however, that certain information and media programs, even when they have tried to be culturally sensitive, have been ineffective with high-risk groups. For example, a 1992 study found that drug education and media programs presented by the "mainstream" culture, even when they have used celebrities admired in the community, have not been successful with inner-city youths because the messages did not speak to their "street" and "peer-directed" culture.[3]

Advocates of resistance training programs contend that drug awareness programs by themselves are insufficient and that students also need to be trained to resist peer pressure. There have been a few useful evaluations of resistance training programs. For example, one study by the RAND Corporation found that these programs help prevent or reduce marijuana use among adolescents.[4] Some studies also have indicated that this training has been effective in reducing cigarette smoking among the young. However, there is little evidence so far that this training has reduced the use of other drugs by adolescents.

Workplace Drug Testing

Drug testing in the workplace may also be viewed as a form of drug prevention. Supporters claim that testing has been very successful in preventing drug use among armed services personnel. Of the military personnel responding to a 1988 military survey, 76 percent said that the armed services' drug testing programs reduced drug use, and 23 percent said that the testing kept them from using drugs.[5] Proponents also maintain that testing can be effective for civilian employees by raising the personal risks of drug use and by encouraging users to enter treatment. Proponents contend that drug testing is absolutely necessary for those employees whose work can directly affect public safety, such as airline pilots.

Opponents argue that for many occupations, drug testing is not an appropriate drug prevention measure because it focuses on drug use, not on whether such use is having any impact on work performance. They

[3]Reaching the Hip-Hop Generation, Motivational Educational Entertainment Productions, Inc., for the Robert Wood Johnson Foundation, May 1992.

[4]Prospects for Preventing Drug Use Among Young Adolescents, Ellickson, Phyllis L., Robert M. Bell, RAND Corporation, March 1990.

[5]1988 Worldwide Survey of Substance Abuse and Health Behaviors Among Military Personnel, Bray, R.M., et al., Research Triangle Institute, 1989.

claim that subjecting workers to drug tests without cause is a violation of the workers' civil rights.

Comprehensive Programs

In a 1992 report, we examined drug prevention programs that took a community-based, comprehensive approach to reaching young people by dealing with a wide range of problems in their lives (as opposed to the narrower approach of combating drug use alone).[6] In addition to drug education, these programs provide such services as academic assistance, vocational preparation, self-esteem enhancement activities, coping and communication skills training, and recreational activities. We concluded, however, that while some of these programs showed promise, there have been few solid evaluations of their effectiveness.

In a March 1993 report, we reviewed the approach of supporting coalitions of public and private sector organizations that engage in coordinated efforts within a local community to prevent drug abuse.[7] These coalitions include alliances of a variety of groups, such as housing, health, education, business, religious, and civic organizations. We observed that preliminary research results indicate that these community coalitions may hold promise in preventing drug abuse but that more research is needed.

Some prevention advocates claim that social programs that expand job and family support opportunities can also be effective drug prevention efforts. These advocates argue that such efforts can decrease drug abuse by dealing with social conditions that place individuals at higher risk for substance abuse. Critics maintain that a drug strategy need not address adverse social conditions, such as poverty, because they contend either that drug use is not caused by these conditions or that the conditions exceed the proper scope of a drug strategy.

Expanding Drug Treatment Efforts

Another alternative approach is a drug control strategy that would include an increased reliance on drug treatment programs, which endeavor to reduce drug demand by helping individuals overcome their substance abuse problems and lead healthier, more productive lives. The three

[6]Adolescent Drug Use Prevention: Common Features of Promising Community Programs (GAO/PEMD-92-2, Jan. 16, 1992).

[7]Community Based Drug Prevention: Comprehensive Evaluations of Efforts Are Needed (GAO/GGD-93-75, Mar. 24, 1993).

primary types of drug treatment are methadone maintenance (mostly outpatient) and residential and outpatient nonmethadone programs.[8]

In fiscal year 1992, federal drug treatment spending was about $2.1 billion—or about 17 percent of the federal drug control budget. This represents an increase from the $628 million spent in fiscal year 1986 but a decrease from drug treatment's 22 percent share of the federal drug control budget in that year. Federal treatment efforts, primarily implemented by HHS, the Department of Veterans Affairs, and the Department of Justice, include such activities as (1) expanding and improving the drug treatment system, (2) researching medications for treating addiction, and (3) incorporating drug treatment for offenders into the criminal justice system.

Advocates of drug treatment claim that many drug abusers achieve abstinence as a result of their treatment experience. In addition, they argue that because drug addicts have a tendency to relapse, the benefits of drug treatment must also be measured by standards other than just abstinence, such as reduced use, decreased criminal activity, or improved employment records. One researcher said that even a decrease in the severity of crimes committed (e.g., property crimes versus violent crimes) should also be considered a benefit of the treatment experience. Researchers advised that the longer individuals remain in drug treatment, even if they do not complete the program, the more positive the treatment outcomes are.

Supporters of expanded drug treatment efforts claim that the demand and need for treatment are greater than the nation's current ability to provide it. ONDCP estimated in 1992 that treatment capacity could serve only about 1.7 million of the 2.8 million drug users who could benefit from such treatment.[9] Several city officials told us they had waiting lists for public drug treatment services, especially for residential treatment.

[8]Methadone maintenance, the most commonly used treatment for heroin addiction, combines the prescribing of methadone, an orally ingested synthetic opiate, with counseling and other rehabilitative services. The residential and outpatient nonmethadone treatment types offer a variety of counseling and rehabilitative services and generally do not prescribe medications to treat drug dependence. Short-term detoxification supervises drug addicts' withdrawal to abstinence and can serve as a gateway to treatment.

[9]National Drug Control Strategy, A Nation Responds to Drug Use, The White House, January 1992.

A study of California drug treatment services estimated that every $1 invested in treatment saves more than $11 in social costs.[10] Citing this study, the National Association of State Alcohol and Drug Abuse Directors argued that although drug treatment costs between $2,300 and $14,600 per person per year, these figures are low compared with not providing treatment and, as a consequence, having to pay up to $50,000 per year to incarcerate a drug-dependent offender or up to $100,000 per year to care for an injection drug user who contracted AIDS by sharing a contaminated needle or syringe.[11]

Opponents of expanding federal treatment efforts claim that treatment is oversold, pointing to what they consider to be high rates of people dropping out of treatment and low rates of abstinence achieved. Opponents also suggest that more research is needed on the natural progression of drug abuse in individuals before the effectiveness of treatment programs can be determined. Otherwise, they argue, it will not be clear whether a positive outcome is due to treatment or the natural course of usage behavior.

The most recent national evaluation of drug treatment studied drug users who entered treatment no later than 1981 and therefore might have limited applicability to the current population of drug abusers. A new national evaluation of drug treatment, known as the Drug Abuse Treatment Outcome Study, is expected to report its first set of results by late 1994.

As we mentioned earlier, there are three primary types of drug treatment—methadone maintenance and residential and outpatient nonmethadone treatment—any one of which may be the most appropriate treatment for a particular user.

Methadone Maintenance

Methadone maintenance is the most commonly used treatment for heroin addiction. It has been used to treat hundreds of thousands of heroin abusers over the past 25 years in a wide variety of social, economic, and geographical settings. This type of treatment combines the use of methadone, an orally administered synthetic narcotic, with counseling and other rehabilitative services. One dose of methadone is nonintoxicating

[10]The Effectiveness and Efficiency of Publicly Funded Drug Abuse Treatment and Prevention Programs in California: A Benefit-Cost Analysis, Tabbush, Victor, University of California, Los Angeles, March 1986.

[11]Treatment Works, The Tragic Costs of Undervaluing Treatment in the "Drug War", National Association of State Alcohol and Drug Abuse Directors, March 1990.

and frees the addict from withdrawal symptoms and opiate-craving anxiety for 24 to 36 hours. Federal regulations encourage programs to move users to total abstinence, although the regulations recognize that some users need prolonged methadone maintenance.

The Institute of Medicine[12] concluded in a 1990 report that methadone maintenance has been the most rigorously studied treatment type and that it has yielded positive results in terms of reducing the illicit drug use and criminal activity of opiate-dependent individuals.[13] After a review of treatment effectiveness research, the Office of Technology Assessment (OTA) concluded in 1990 that this treatment's safety and effectiveness have been established in numerous studies and that for a substantial majority of opiate users who enter methadone maintenance, drug use and criminality decrease and health improves.[14]

Because most heroin users inject the drug, methadone maintenance is considered to be a key treatment to help prevent the spread of HIV. Some methadone supporters believe that injection heroin users placed on waiting lists for methadone maintenance should be provided methadone on an interim basis, even with limited or no counseling, until they can be admitted to a treatment program that provides methadone and full counseling services. They reason that the AIDS crisis warrants such an attempt to reduce injection drug use. In a 1990 study, we reported that federally sponsored research had found that interim methadone maintenance (the provision of methadone without counseling and rehabilitative services) had not significantly reduced injection heroin use and the corresponding risk of HIV infection.[15] We recommended that interim methadone maintenance not be implemented until further research demonstrates that it is significantly more effective than no treatment at all in preventing injection drug use and the corresponding risk of AIDS. There is recent evidence that HIV-positive patients who are receiving methadone maintenance treatment and are not injecting drugs

[12]The Institute of Medicine was chartered by the National Academy of Sciences to advise the federal government on public health policy matters.

[13]Treating Drug Problems, Volume 1, Gerstein, Dean R., Henrick J. Harwood, editors, Institute of Medicine, National Academy Press, 1990.

[14]The Effectiveness of Drug Abuse Treatment: Implications for Controlling AIDS/HIV Infection, Office of Technology Assessment, September 1990.

[15]Methadone Maintenance: Some Treatment Programs Are Not Effective; Greater Federal Oversight Needed (GAO/HRD-90-104, Mar. 22, 1990).

have a slowed progression to AIDS versus HIV-positive injection drug users who are not receiving treatment.[16]

Methadone maintenance is a controversial type of drug treatment. Opponents believe it is not a valid treatment because it substitutes one addictive drug for another. Also, they point out that many methadone patients continue using heroin to varying degrees and some commit other crimes, including selling their take-home doses of methadone. In addition, although the methadone maintenance approach only treats heroin addiction, many heroin addicts also use other drugs. In our March 1990 study, we reported the use of cocaine and alcohol by many methadone patients.[17]

No medication comparable to methadone has been shown to stabilize cocaine addicts. However, the use of antidepressant drugs to treat cocaine addiction is currently being studied.

Residential Treatment

Residential nonmethadone treatment programs vary in length from short-term programs of about 28 days to longer term programs of about 9 to 15 months. In recent years, many of these programs have targeted cocaine addicts. Several local officials told us that their biggest need was for publicly funded residential treatment facilities, for which they had the longest waiting lists. One local health official said that residential programs are best for people who do not have jobs or housing, because individuals who have both often do not have an incentive to enter a residential facility unless coerced by the criminal justice system.

The most intensive residential drug treatment approach is known as the therapeutic community (TC). TC programs typically last from 9 to 15 months and are staffed in part by former addicts. TCs try to achieve broad attitudinal and lifestyle changes (including abstinence) through group therapy, confrontation, and peer pressure. Many TC programs also offer academic and vocational training. In contrast, the shorter term residential programs typically focus more on achieving abstinence than on broader lifestyle changes. Any of the residential treatment approaches also may incorporate such steps for users as admitting addiction, acknowledging an

[16]Methadone Maintenance: A Policy Paper, Lipton, Douglas S., Ph.D., Stephen Magura, Ph.D., National Development and Research Institute, Inc., December 1991.

[17]GAO/HRD-90-104, March 22, 1990.

inability to overcome addiction without the help of a higher power, and confronting the harm caused by abusing drugs.[18]

Critics claim that retention rates for TCs are low. Estimates of graduation rates range from 10 to 25 percent. However, the Institute of Medicine estimated in 1990 that 33 to 50 percent of the clients remain in the program long enough (i.e., at least several months) to benefit from the treatment in terms of decreased levels of drug use and criminal activity and increased levels of employment.[19] One of the more significant studies of the effectiveness of residential programs was the Treatment Outcome Prospective Study (TOPS), which attempted to interview, 1 year after treatment, 977 individuals admitted to 14 residential programs in 1979 and 1980.[20] TOPS concluded that over 50 percent of those patients who used heroin regularly during the year before treatment and who remained in a residential program for at least 3 months "did not use heroin with any frequency in the year after treatment."[21] TOPS also concluded that 47 percent of those patients who used cocaine regularly during the year before treatment and who remained in a residential program at least 3 months did not use cocaine with any frequency in the year after treatment.[22] Although TCs are more expensive than other types of treatment, costing about $13,000 to $20,000 per year (as opposed to about $3,000 per year for methadone and other outpatient programs), supporters argue that for some drug users a TC is the most appropriate and cost-effective form of treatment.

Although clients who complete a residential treatment program are encouraged to continue in aftercare programs, critics claim that such outpatient programs, other than self-help groups, are often not available.[23] Critics contend that without aftercare programs, individuals returning to

[18]These steps are part of the 12-step approach of Alcoholics Anonymous.

[19]Treating Drug Problems, 1990.

[20]Drug Abuse Treatment, A National Study of Effectiveness, Hubbard, Robert L., et al., 1989. The study was able to contact for follow-up interviews 81 percent of these individuals 1 year after treatment. The study also attempted to contact, 3 to 5 years after treatment, a group of individuals who were admitted to treatment in 1981.

[21]About 30.9 percent of those the study attempted to contact at various times after treatment had used heroin regularly during the year before treatment and had remained in the residential program for at least 3 months.

[22]About 27.6 percent of those the study attempted to contact at various times after treatment had used cocaine regularly during the year before treatment and had remained in the residential program for at least 3 months.

[23]Self-help groups include Narcotics Anonymous and Cocaine Anonymous modeled on Alcoholics Anonymous.

the environment in which their addiction developed often turn to drugs again.

Outpatient Programs

The third primary treatment type, outpatient nonmethadone treatment, represents a wide range of programs. These programs have been much less extensively evaluated than methadone maintenance and residential treatment programs. Lack of program uniformity makes the evaluation of outpatient treatment particularly difficult.

Outpatient programs may provide individual counseling; group counseling, including support groups, confrontation therapy, and family therapy; recreational and social activities; and health and social service referrals. In addition, outpatient treatment programs may provide aftercare services for individuals who have completed a residential treatment program to help them remain abstinent as they return to their community environment.

According to the 1990 Institute of Medicine report, retention rates in outpatient programs are lower than in methadone maintenance and residential treatment programs.[24] The Institute of Medicine concluded that those who remain in outpatient treatment for more than 3 months have improved treatment outcomes. TOPS also studied outpatient programs. According to TOPS, which attempted to interview 1,129 individuals admitted to 10 outpatient nonmethadone programs in 1979 and 1980,[25] 42 percent of those patients who used cocaine regularly during the year before outpatient treatment and who stayed in treatment for at least 3 months did not use cocaine with any frequency in the year after treatment.[26]

Appropriate Treatment

Treatment supporters claim that appropriate treatment works, pointing out that it is not a question of which treatment type is better but rather which treatment is better for particular types of drug users. These proponents maintain that it is imperative for proper assessments to be done to determine the type and intensity of drug dependence, as well as

[24]Treating Drug Problems, 1990.

[25]Drug Abuse Treatment, A National Study of Effectiveness, 1989. The study was able to contact for follow-up interviews 82 percent of these individuals 1 year after treatment.

[26]About 12.8 percent of those the study attempted to contact at various times after treatment had used cocaine regularly during the year before treatment and had remained in the outpatient program for at least 3 months.

any other personal challenges (e.g., pregnancy) a drug user may be facing, so that the individual is placed in the type of treatment program that can best address the person's particular needs. According to the OTA report on drug treatment, drug abusers who were matched to the appropriate treatment were better motivated, stayed in treatment longer, and engaged in less substance abuse 6 months after treatment.[27] In a 1992 report, we found that many drug experts believed that research on matching clients to the appropriate type of treatment was among the highest priorities for further treatment research.[28]

Increasing Use of Coercive Treatment

Another approach is to increase use of coercive drug treatment, which connects the treatment and criminal justice communities by encouraging offenders to participate in drug education or treatment programs as an alternative to prosecution or the imposition of more punitive measures.

Advocates contend that by the criminal justice system's encouraging offenders to participate in treatment, drug users are motivated to enter treatment earlier and to stay in treatment longer, which as noted earlier, correlates with improved treatment outcomes. Supporters claim that additional resources should be targeted for this approach because government-supported drug treatment is too often unavailable for coercive treatment to be a realistic option. Several local officials said that very few public drug treatment facilities existed for drug offenders in their cities. Opponents of coercive treatment suggest that this approach is inefficient in that it forces into treatment some drug offenders who may not have a serious drug problem.

Drug treatment in prison is one example of coercive treatment. Given the increased incarceration of drug offenders, efforts have been made by federal and state prisons to encourage inmates to participate in substance abuse treatment. However, in a 1991 study, we reported that as of April 1991 only 364 of the 27,000 federal inmates with moderate to severe substance abuse problems were receiving the intensive drug treatment designed for them.[29] In another report, we concluded that although over 500,000 state inmates might have had substance abuse problems, state

[27]The Effectiveness of Drug Abuse Treatment, September 1990.

[28]Drug Abuse Research: Federal Funding and Future Needs (GAO/PEMD-92-5, Jan. 14, 1992).

[29]Drug Treatment: Despite New Strategy, Few Federal Inmates Receive Treatment (GAO/HRD-91-116, Sept. 16, 1991).

prisons could only provide drug treatment to just over 100,000 inmates in 1990.[30]

The Institute of Medicine estimated that about two-thirds of prison treatment is of the outpatient nonmethadone type and about one-third of the TC type in which inmates are housed separately from the general prison population for 6 to 12 months.[31] Inmates entering drug treatment are usually offered the possibility of early parole if they successfully complete the program. Corrections officials reported that most inmates would not enter treatment without this incentive.

Increasing Use of Alternative Penalties

Instead of traditional imprisonment, the courts can impose a variety of alternative penalties on offenders, such as boot camps, intensive supervision probation, civil penalties, and fines. These penalties can be imposed in conjunction with opportunities for offenders to have their criminal justice system records expunged for certain offenses.

Those who support an expanded use of these alternatives for less serious drug offenders, such as street-level, nonviolent dealers and drug users, claim that imposing alternative penalties may reduce prison crowding and corrections costs and may be more effective in helping drug offenders turn their lives around. They suggest that imprisonment hardens offenders rather than helps them improve. Further, they contend that other correctional supervision programs, such as boot camps or intensive supervision probation—which emphasize attitudinal changes and skills development through coercive treatment, education, or job training programs—are more likely to rehabilitate offenders than are prisons and jails. Supporters of civil penalties and fines for those found possessing personal use amounts of an illegal drug suggest that these sanctions send an appropriate message of public disapproval of drug use at less expense to the criminal justice system.[32]

Critics of alternative penalties claim that rehabilitation efforts such as those provided in boot camps or intensive supervision probation programs do not work and that imprisonment at least protects society from offenders while they are incarcerated. Other critics contend that boot

[30]Drug Treatment: State Prisons Face Challenges in Providing Services (GAO/HRD-91-128, Sept. 20, 1991).

[31]Treating Drug Problems, 1990.

[32]Possessing a personal use amount means having a small amount of an illegal drug under one's control for one's own consumption without an intent to sell the substance.

camps and intensive supervision probation are not necessarily less expensive penalties than traditional imprisonment, because some offenders might have been sentenced to less costly traditional probation were it not for the existence of these alternative programs. Opponents also allege that alternatives such as civil penalties and fines may be less of a deterrent to the commission of drug offenses than more punitive sanctions.

In the following sections, we discuss four examples of alternative penalties: boot camps, intensive supervision probation, civil penalties, and fines. We also review the option of imposing these penalties in connection with an opportunity to have the criminal justice system record of the offense expunged.

Boot Camps

Boot camps are primarily for young, nonviolent, first-time offenders and provide a military-like environment to promote personal discipline through drill instruction, rigorous physical conditioning, and offender maintenance of quarters and grounds. Boot camp sentences are generally shorter than the incarceration sentences that courts would otherwise impose. Twenty-six states operate a total of 57 boot camps with an inmate capacity of 8,880. The federal government has two boot camps with an inmate capacity of about 300.

Programs differ on the extent to which they provide additional services such as counseling, education, and job training. One official told us that if boot camps do not provide these additional services, then the camps' primary products are "fit felons." New York State boot camps provide substance abuse counseling and high school equivalency classes in addition to physical conditioning programs. Inmates also spend several hours a day working in the surrounding community. Florida reportedly saves about $1.6 million a year by diverting to boot camps 400 offenders sentenced to prison. In a 1993 report, we observed that boot camps appear to be less costly than traditional prisons, primarily because of the reduced amount of time boot camp inmates serve versus the amount of time they would have served in prison.[33] We also observed that recidivism data on those completing boot camps are limited and that early measurements only show marginal improvement over traditional forms of incarceration.

[33]Prison Boot Camps: Short-Term Prison Costs Reduced, but Long-Term Impact Uncertain (GAO/GGD-93-69, Apr. 29, 1993).

Unlike state programs, federal boot camp inmates are not given early release but graduate to a community corrections facility and then to home confinement. Offenders in community corrections programs receive counseling and treatment services, work in the community under close supervision, and submit to regular drug testing. Offenders assigned to home confinement are permitted to leave their homes only for specific purposes, such as counseling, employment, or drug testing.

Intensive Supervision Probation

Intensive supervision probation and parole programs target certain offenders for closer monitoring than those assigned to traditional probation and parole programs. The increased surveillance may involve curfews or electronic monitoring and characteristically includes frequent meetings—up to five times a week—with a probation or parole officer. Intensive supervision probation and parole may also include community service, education, employment, drug testing, and drug treatment requirements.

In a 1990 report, we observed that offenders who complete intensive supervision probation and parole commit new crimes at a rate generally lower than that of traditional parolees but higher than that of traditional probationers.[34] We also observed that per capita costs of intensive supervision probation and parole programs are less than those of prison but exceed those of traditional probation and parole. According to a RAND Corporation researcher, a recent RAND study of 12 intensive supervision probation and parole programs in 7 states found that these programs cost about 50 percent more than traditional probation or parole. Some individuals placed on traditional probation and parole, although monitored less closely than those placed on intensive supervision probation and parole, may also be required to submit to regular drug tests or to participate in a drug treatment program.

Civil Penalties

Civil penalties include the loss of certain privileges or benefits, such as drivers' licenses or student loans. Beginning October 1, 1993, states may have their allotment of federal highway funds cut if they do not adopt provisions mandating a 6-month suspension of driving privileges for anyone convicted of a drug offense. Supporters contend that civil penalties can have a deterrent effect but only if they are tailored to the individual drug offender. For example, suspending a drug offender's driver's license

[34]Intermediate Sanctions: Their Impacts on Prison Crowding, Costs, and Recidivism Are Still Unclear (GAO/PEMD-90-21, Sept. 7, 1990).

would be effective only if the person has access to a car. Critics claim that such civil penalties may limit a person's opportunity to lead a productive life, which may in turn promote further drug use.

In a 1992 report, we concluded that a provision of the 1988 Anti-Drug Abuse Act permitting federal and state judges to disqualify convicted drug offenders from receiving over 400 types of federal grants, licenses, and loans has had limited effectiveness.[35] Reasons for the provision's limited effectiveness include (1) the fact that the sanction applies only to new benefit applications, not to benefits offenders may already be receiving; (2) the administrative difficulties in ensuring compliance; and (3) the unlikelihood that drug addicts would seek these grants, licenses, and loans. Welfare, social security, and veterans' benefits are not covered by this provision of the act.

Fines

Nine states have controlled substance laws that stipulate a range of criminal or civil fines and do not mention incarceration for the first-time possession of a small amount of marijuana.[36] The fines range from about $100 in five states to up to $1,000 in Oregon. Mississippi, Nebraska, and New York give judges the option of imposing short periods of incarceration for the second or third offense. Minnesota and Nebraska may require participation in a drug education program along with the fine. Many of these states have adopted streamlined arrest procedures to handle such offenses.

Supporters of imposing criminal or civil fines on those convicted of possessing personal use amounts of an illegal drug argue that this approach can conserve limited criminal justice resources for more significant crimes. They suggest that a fine alone is a sufficient sanction for a drug user not convicted of drug trafficking or any offense other than simple possession. Proponents contend that a fine sends the appropriate message of societal disapproval of the conduct, without providing the criminal justice system with another offender to supervise.

Opponents of this approach claim that more lenient penalties for possessing small amounts of marijuana or any other illegal drug could lead to increased use, which might in turn lead to an expansion of illegal drug

[35]Drug Control: Difficulties in Denying Federal Benefits to Convicted Drug Offenders (GAO/GGD-92-56, Apr. 21, 1992).

[36]The nine states are California, Colorado, Maine, Minnesota, Mississippi, Nebraska, New York, Ohio, and Oregon.

dealing operations. Limited survey data on the level of marijuana use before and after the nine states reduced their penalties for possessing small amounts of marijuana in the 1970s make evaluating the impact of these changes on usage patterns very difficult.

Criminal Justice Record Expunctions

Opportunities for expunging the criminal or civil records of those convicted of less serious drug offenses may improve such offenders' employability because they would not have to report the drug conviction on a job application. In California, conviction records relating to the offense of possessing a small amount of marijuana are automatically expunged after 2 years. Ohio law explicitly provides that a conviction for possessing a personal use amount of marijuana need not be reported in any application for employment. Opponents contend that expunctions inappropriately deprive employers of an opportunity to obtain information about the past illegal behavior of their potential employees. They also maintain that expunctions may reduce the legal risk of using illegal drugs, which may lead to increased use.

Increasing Use of Conditional Discharges

Conditional discharge programs allow courts to dismiss charges against less serious drug offenders if they complete a period of accountability during which they meet certain conditions, such as successfully completing a drug education or treatment program or demonstrating abstinence through regular drug tests.

Supporters maintain that conditional discharge programs encourage more offenders to complete treatment, while reducing the productivity losses associated with their being unemployed or underemployed as a consequence of their having a criminal record for a drug offense. Opponents of this approach claim that the possibility of having courts dismiss such drug charges can lead to additional drug offenses because the legal risks of such behavior are reduced.

The Treatment Alternatives to Street Crime (TASC) effort is, in part, a conditional discharge program. TASC assesses drug users accused of a crime and referred by prosecutors or the courts, evaluating their suitability for treatment and attempting to match them with the most appropriate treatment program. TASC then monitors their progress and reports back to the criminal justice system. TASC also provides these services to probationers and parolees referred by the criminal justice system. In 1992, 195 TASC programs operated in 26 states and 2 territories. Between 1987

and 1991, over $5 million in Justice Department block grant funds supported this treatment alternative program.

In a 1993 report, we concluded that although evaluations of the TASC approach have been very limited, largely because of inadequate data collection by TASC programs, some evidence exists that those referred by TASC tend to stay in treatment longer than those with similar characteristics who enter treatment.[37] Longer stays in treatment have been associated with better outcomes.

Eliminating Penalties for Drug Use

The approach of eliminating both criminal and civil penalties for possessing personal use amounts of an illegal drug—and focusing all drug enforcement efforts on drug trafficking—is not in effect by law anywhere in the United States for any illegal drug. However, this approach is followed for alcohol in "dry" counties, where it is illegal to sell but not to use alcohol. Some states and localities allow injection drug users to obtain needles and syringes through needle exchange programs in an attempt to limit the spread of HIV from the sharing of injection equipment. Other states allow over-the-counter pharmacy sales of needles and syringes.

Certain countries in Western Europe have eliminated all penalties for possessing personal use amounts of illegal drugs such as cocaine, heroin, and marijuana. Penalties for such possession have been eliminated in Spain. In the Netherlands, although it is against the law to possess illegal drugs for personal use, the Opium Act (as amended in 1976) established as prosecutive policy the principle that taking into account the risks to society, every possible effort must be made to ensure that drug users are not caused more harm by criminal proceedings than by the use of a drug itself. The prosecutive guidelines developed in response to the 1976 amendments have been made public and indicate that those possessing personal use amounts of an illegal drug are not subject to arrest and prosecution. The sale of small amounts of marijuana and hashish in "coffee houses" is also tolerated. Penalties against users were eliminated in Italy in 1975 but were reimposed in 1990. These penalties for simple possession are primarily civil in nature.

Those who support eliminating user penalties contend that this approach conserves criminal justice system resources for drug trafficking offenses and other serious crimes. Supporters also believe that in a less punitive

[37]Drug Control: Treatment Alternatives Program for Drug Offenders Needs Stronger Emphasis (GAO/GGD-93-61, Feb. 11, 1993).

environment, drug users are more likely to present themselves to treatment facilities.

- Opponents claim that the elimination of user penalties would signal government acceptance of illegal drug use and lead to an increased number of drug users, some of whom would develop drug dependencies. In addition, they contend that the resulting increased demand for illegal drugs could lead to an expansion of illegal drug dealing. Opponents also point out that the opportunity to employ the coercive treatment approach on those possessing a personal use amount of an illegal drug would be lost.

The results of eliminating user penalties in Spain, the Netherlands, and Italy have been mixed. According to a RAND Corporation researcher, little evidence exists of significant cocaine use in Spain, the Netherlands, and Italy (or in Western Europe in general). Although the number of heroin-related deaths has been rising in Spain, Italy, and Western Europe in general, according to the RAND researcher, no such increase has occurred in the Netherlands. Some researchers attribute this situation in the Netherlands to less injection heroin use and more smoking and snorting of the drug, which appears to reduce the possibility of a heroin overdose death. While in Spain, Italy, and southern France about one-third to one-half of known injection drug users are HIV positive, according to the RAND researcher, the association between injection drug use and HIV infection generally appears to be low in the Netherlands as well as in the rest of Western Europe. Limited survey data exist on the level of drug use before and after Spain, the Netherlands, and Italy eliminated their penalties for the simple possession of an illegal drug, making an evaluation of the impact of these changes on usage patterns extremely difficult.

Needle exchange programs attempt to reduce the spread of HIV that can result from drug users sharing injection equipment. The programs seek to encourage injection drug users to exchange used needles and syringes for new, sterile ones and to link such users to drug treatment and public health services. Opponents of these programs argue that providing needles to injection drug users gives the appearance that public officials condone illegal drug use. In addition, critics contend that providing needles may actually increase injection drug use.

In a March 1993 report, we examined published studies on needle exchange programs in Australia, Canada, the Netherlands, Sweden, the

United Kingdom, and Tacoma, Washington.[38] We found that these studies suggested that needle exchange programs may hold some promise as an AIDS prevention strategy. Specifically, the studies suggested that these programs may reduce needle sharing and may help link injection drug users to drug treatment and other health services without increasing injection drug use.

Supporters of permitting over-the-counter pharmacy sales of injection equipment claim that this approach could expand access to sterile equipment. Critics contend that such sales may not offer the opportunity for public health workers to ensure the proper disposal of used equipment and to connect injection drug users to counseling and treatment.

Expanding Physician Prescription Authority as a Drug Treatment Alternative

A partial lifting of the prohibition on distributing illegal drugs could involve permitting physicians to prescribe the drugs in the course of treating the physical and psychological drug dependence of their addicted patients.[39] For many years, British physicians were permitted to prescribe heroin in the course of treating their addicted patients. During the 1960s, in response to a large increase in the number of heroin addicts and to some overprescribing of heroin, tighter regulations were placed on this practice, limiting its use. Moreover, with the advent of methadone, physicians relied less on prescribing heroin for addicts. A few health districts in Britain still permit such prescriptions. In these districts, physicians are allowed to prescribe injectable, smokable, and oral heroin, morphine, methadone, and cocaine.

Supporters of this approach argue that permitting some physicians to prescribe certain illegal drugs for their addicted patients could attract more users into treatment where they could be helped to stabilize their lives, be encouraged to reduce or discontinue their drug use (in some instances the prescriptions gradually would be for less potent substances), and to the extent that patients continue to use drugs, be counseled to do so in the least harmful manner possible.

Opponents of this approach argue that such a system may create an incentive for occasional users to increase their use to a level at which they can be diagnosed as addicts eligible to receive the drug from their doctors.

[38]Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy (GAO/HRD-93-60, Mar. 23, 1993).

[39]This authority would be in addition to the legal right physicians currently have to prescribe some of these drugs for other conditions. For example, they can currently prescribe morphine, an otherwise illicit drug, for pain relief.

In addition, an illegal diversion of these drugs from addicted patients to others may occur if patients are permitted to take their prescribed drugs home. Critics of prescribing cocaine in particular claim that a stabilizing dose of cocaine, a short-acting stimulant, does not exist.

Few rigorous evaluations of this approach in Britain have been done. A 1980 study compared 42 heroin addicts offered prescriptions for injectable heroin for 1 year with 46 heroin addicts offered prescriptions for oral methadone for 1 year at the Drug Dependence Clinic of the University College Hospital of London.[40] Comparing the two groups after 1 year, no differences existed in employment, health, or consumption of non-opiate drugs. Those receiving injectable heroin were more likely to stay in treatment and less likely to be arrested. However, those assigned to the oral methadone group were more likely to have ceased opiate use or to have used smaller amounts than those who had been assigned to the injectable heroin group.

Authorizing a Regulated Drug Market

The approach representing the greatest departure from the current strategy involves the conversion of the illegal drug market for one or more currently illegal drugs, such as cocaine, heroin, or marijuana, to a regulated drug market. The various models for a regulated market that have been proposed differ with respect to who would produce and distribute the substances, how the substances would be packaged and labeled, and whether and what type of advertising would be permitted. These models include an enforcement role to address activities that would still be illegal, such as selling or using any drug that remains illegal or illicitly providing a legal drug to a minor.

Supporters of a regulated market for one or more currently illegal drugs maintain that the approach would substantially reduce the burden of drug arrests on the criminal justice system. They also argue that it would liberate inner-city neighborhoods from most drug-related violence by permitting legitimate businesses to distribute the substances. They contend that most drug-related violence can be attributed to disputes among illegal drug dealers. Proponents also claim that because drug prices would be lower in a regulated market that would not have the high profits of the illegal market, users would be less inclined to commit offenses to obtain money to support their habits. One researcher estimated that prices for illegal drugs are from 8 to 70 times higher than they would be if the

[40]"Evaluation of Heroin Maintenance in Controlled Trial," Archives of General Psychiatry, Volume 37, Hartnoll, Richard L., et al., August 1980.

drugs were sold legally in a regulated market.[41] One study of a sample of drug-related homicide events in 1988 in New York City concluded that about 74 percent of the 218 events in the sample were related to the illegal nature of the drug market, about 4 percent to attempts to finance drug habits, about 14 percent to the behavioral influences of drugs, and about 8 percent to a combination of these factors.[42]

Proponents maintain that a regulated market would not lead to a substantial increase in use, especially if funds targeted to drug enforcement were used for drug prevention and treatment instead. In addition, supporters point out that drugs could not be more available with a regulated market than they are now in many drug-dealing neighborhoods. Also, supporters reason that government officials could monitor the quality and ensure the proper potency labeling of these drugs, thereby reducing the adverse health effects (e.g., the overdose deaths) that can be attributed in part to the lack of such monitoring under prohibition.

Opponents assert that some individuals arrested for drug-dealing offenses are career criminals who would be involved in other criminal activity (such as car theft or burglary) if the illegal drug market were replaced by a regulated market. In addition, critics contend that to the extent that drug use increases in a regulated market, crimes committed because of the behavioral influences of these drugs would also likely increase. Further, regarding the argument that fewer crimes would be committed by drug users to support their habits because of the lower prices in a regulated market, opponents claim that the price of illegal crack cocaine is already so low that it would not be much cheaper in a regulated market.

Another major argument against the regulated market approach is that ending the prohibition of a drug could expand use to an intolerable level by (1) connoting societal approval of the drug, (2) increasing the drug's availability in terms of ease of purchase and lower price, (3) eliminating the risk of arrest for possessing a personal use amount of the drug, (4) lowering the perceived health risks of using the drug when the

[41]"Supply Reduction and Drug Law Enforcement," Moore, Mark H., in Drugs and Crime, Tonry, Michael, James Q. Wilson, editors, 1990. Mark Moore estimated that the prices of illegal cocaine, marijuana, and heroin are 8, 15, and 70 times more expensive, respectively, than they would be if these drugs were sold legally in a regulated market.

[42]"Who's Right: Different Outcomes When Police and Scientists View the Same Set of Homicide Events, New York City, 1988," Ryan, Patrick J., Ph.D., et al., NIDA Research Monograph 103, Drugs and Violence: Causes, Correlates, and Consequences, 1990. These conclusions were made by the authors of this study based on interviews with the police. The police themselves had earlier indicated that only 177 of these homicide events were drug-related and that 35 percent of them were related to the illegal nature of the drug market, about 28 percent to attempts to finance drug habits, about 11 percent to the behavioral influences of drugs, 9 percent to a combination of these factors, and 17 percent to other drug-related factors.

government monitors the quality and potency labeling of the substance, and (5) removing the danger of becoming a crime victim when purchasing the drug because one could purchase the substance from a legitimate business in a low-crime area. Opponents contend that increased use could occur even among those under 21 years of age, who presumably would not be allowed to purchase these substances under any regulatory scheme but who could illegally obtain the otherwise legal product from adults just as minors currently are able to obtain alcohol.

A Regulated Market for Marijuana

Arguing that marijuana is not a particularly harmful drug, some advocate the regulated market approach for it, while supporting the continued prohibition of other currently illegal drugs. Although NIDA estimated that there were over eight times as many weekly users of marijuana as there were weekly users of cocaine in 1991, DAWN estimated that over six times as many cocaine emergency room episodes as marijuana episodes occurred that year. DAWN data also indicated that in 1991, of the single-drug-induced deaths in 27 metropolitan areas,[43] 210 were cocaine-induced deaths, 148 were heroin-induced deaths, but only 2 were marijuana-induced fatalities.[44] In addition, NIDA estimated that there were over eight times as many weekly users of alcohol as there were weekly users of marijuana in 1991. However, DAWN reported that in 1991, of the multiple-drug-induced deaths in 27 metropolitan areas, 26 times as many deaths were from alcohol in combination with other drugs (1,615) as were from marijuana and hashish in combination with other drugs (62).[45]

Supporters contend that a regulated market for marijuana could separate marijuana users from illegal drug dealers who might try to sell them more potent drugs such as cocaine or heroin. Proponents maintain that permitting the retail sale of marijuana in coffee houses has not led to a higher level of marijuana use in the Netherlands than in the United States. A 1987 survey of marijuana use in Amsterdam reported that 9.6 percent of respondents 16 years and older indicated that they had used marijuana at

[43]A drug-induced death is a death involving a drug overdose in which a toxic level usually is found or suspected. Heroin-induced deaths also included deaths induced by morphine and other opiates not specified as to type. Marijuana-induced deaths also included hashish-induced deaths.

[44]The 1991 NIDA household survey did not estimate weekly or monthly heroin use but did estimate past-year use. NIDA estimated that there were about 28 times as many individuals who used marijuana at least once in the past year as there were individuals who used heroin at least once in the past year.

[45]DAWN does not report alcohol-induced deaths, only the deaths induced by the use of alcohol in combination with other drugs.

least once in the past year.[46] The 1988 NIDA survey of U.S. households reported that 10.6 percent of respondents 12 years and older indicated past-year marijuana use. Advocates also cite the drug enforcement savings that would result. In 1989, police made over 300,000 marijuana arrests at the state and local levels. In fiscal year 1991, 21 percent of federal DEA drug arrests were for marijuana, involving about 340 DEA investigative staff years.

Opponents contend that a regulated market for marijuana would lead to increased marijuana use and that such use would be harmful to public safety and health. Claiming a connection between marijuana use and crime, they point to DUF data showing that in 11 of 24 urban areas studied, 20 percent or more of the sample of male booked arrestees tested positive for marijuana in 1991.[47] In addition, opponents argue that heavy marijuana smokers, like tobacco smokers, are at risk for cancer, bronchitis, and emphysema. Finally, those opposed to this approach argue that marijuana is a gateway drug, as are tobacco and alcohol, to other more harmful substances.

[46]The Pragmatic Dutch Approach to Drug Control: Does It Work?, Ruter, Frits, 1988. Household survey of 4,194 residents of Amsterdam by Musterd, S., P. Sandwijk, and I. Westerterp, University of Amsterdam.

[47]Drug Use Forecasting, Drugs & Crime, 1991 Annual Report, National Institute of Justice, December 1992.

Objective, Scope, and Methodology

The objective of our work was to provide information as requested to the House Committee on Government Operations on the range of potential alternative approaches to the enforcement emphasis of the current federal drug control strategy. To meet this objective, we (1) examined the major arguments for and against the enforcement approach, (2) identified alternative approaches, and (3) reviewed the major arguments for and against these alternatives. This report provides information concerning the debate on drug strategies but does not evaluate the arguments presented or endorse or reject any particular approach.

To obtain information and perspectives on these drug strategies, we discussed drug control issues with ONDCP, DEA, and NIDA officials as well as with police, prosecutive, and public health officials in Chicago, Houston, New York City, Philadelphia, and Washington, D.C.—5 of the 10 largest metropolitan areas in the country. We also met with other drug experts from the research and academic communities.

In addition, we obtained a wide range of views on drug strategies by conducting an extensive literature search. On the basis of our identification of drug strategies, we judgmentally selected a sample of the literature that provided arguments for and against the approaches. We also reviewed drug enforcement and health data from federal, state, and local criminal justice and public health offices. Because of the shortage of methodologically sound and conclusive evaluations of the identified approaches, we relied heavily on the perceptions and judgments presented to us during interviews and in the literature.

We assembled a panel of six outside experts to assist us in this project. These consultants were selected because they represented both a wide range of views on the drug problem and a variety of specialties in the drug field. These experts were M. Douglas Anglin, Director of the University of California, Los Angeles, Drug Abuse Research Group; Luceille Fleming, Director of the Ohio Department of Alcohol and Drug Addiction Services; Frank Monastero, criminal justice consultant and former Acting Deputy Administrator of DEA; Samuel Myers, Jr., the Roy Wilkins Chair Professor of Human Relations and Social Justice at the University of Minnesota; Darrel Stephens, Executive Director of the Police Executive Research Forum and former Chief of Police of Newport News, Virginia; and Kevin Zeese, Vice President and Counsel of the Drug Policy Foundation. We convened a meeting with these experts in January 1992 as we began our research to obtain their guidance on our preliminary identification of the major drug strategies and the related pro and con arguments. In July and

August, we met with each of the consultants individually to obtain their views on a written summary of our post-research identification of these strategies and arguments.

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