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An Alternative Public Health Vision for a National Drug Strategy: "Treatment Works"

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SUBSTANCE ABUSE

AN ALTERNATIVE PUBLIC HEALTH VISION FOR A NATIONAL DRUG STRATEGY: "TREATMENT WORKS"

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I. INTRODUCTION

This article returns to a war waged virtually throughout this century[1]—a war between the theories of punishment and rehabilitation in curtailing the drug epidemic. Today, the terms of the war are recast as supply-side policies based upon law enforcement; destroying crops in source countries; interdiction and increased sentencing; and demand reduction based upon prevention, education, and treatment.[2] The war on drugs has reached a feverish pitch. New policies and statutes have tightened the grip of supply-side policies, with images of battle and hate mongering which go beyond the vilified drug lords and governments which harbor them, to the middle men, the dealers, and even the users.[3]

The in-vogue policies of user accountability and zero tolerance make it acceptable to direct the state's formidable powers at drug dependent persons themselves.[4] Drug dependent persons have profound physical and psychological problems and are primarily concentrated in poor, minority-populated urban areas.[5] As a group, seriously drug dependent people are most vulnerable to the abuse of state power and least able to obtain needed health care services.[6] The government gives scant attention to the needle-borne transmission of diseases such as the acquired immunodeficiency

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1. *See generally* D. MUSTO, THE AMERICAN DISEASE: ORIGINS OF NARCOTIC CONTROL (1987) (examining attempts by state and federal legislators and executives and the medical profession to curtail illegal drug use).

2. *Id.*

3. *See* U.S. OFFICE OF NAT'L DRUG POLICY, NATIONAL DRUG CONTROL STRATEGY 5-6 (1990) [hereinafter NATIONAL DRUG CONTROL STRATEGY 1990].

4. The White House has been promoting a range of penalties for persons caught using or possessing even small amounts of drugs. Among them are: suspension of driver's licenses, suspension of state benefits such as student loans grants and contracts, and criminalization for solicitation without consummating a sale or purchase of drugs. U.S. OFFICE OF NAT'L DRUG POLICY, NATIONAL DRUG CONTROL STRATEGY 126 (1989) [hereinafter NATIONAL DRUG CONTROL STRATEGY 1989].

5. Feldman & Biernacki, *The Ethnography of Needle Sharing Among Intravenous Drug Users and Implications for Public Policies and Intervention Strategies*, in NEEDLE SHARING AMONG INTRAVENOUS DRUG ABUSERS: NATIONAL AND INTERNATIONAL PERSPECTIVES 34 (1988) (NIDA RES. MONOGRAPH 80) [hereinafter NIDA RES. MONOGRAPH 80]; Hopkins, *Needle Sharing and Street Behavior in Response to AIDS*, in NIDA RES. MONOGRAPH 80, *supra*, at 18.

6. *Cf.* Louis Sullivan, Secretary of the Dep't of Health and Human Servs., *Keynote Address to the Healthy People 2000 Conference*, Shoreham Hotel, Washington, D.C., *reprinted in* Fed. News Serv., Sept. 6, 1990, at para. 14 (NEXIS, Omni library) (extolling need to improve health of disenfranchised people without wasting health care resources).

syndrome and hepatitis B.[7] The President's National Drug Control Strategy[8] omits any serious discussion of epidemic, even though intravenous drug users and their sexual partners are the fastest growing source of infection in the population.[9] Spread of the human immunodeficiency epidemic to the heterosexual population and children is almost exclusively attributed to intravenous drug use.

A national drug policy which consists of zealous enforcement of criminal sanctions against users, more prisons, and inadequate treatment is contemptuous of the profound public health dimensions of the drug epidemic. Powerful reasons and new data support an alternative vision of a national drug strategy focusing on prevention, education, and treatment.[10] This is not to suggest that many supply-side policies are inappropriate in an eclectic strategy to impede drug use; these policies simply have overwhelmed public health concerns. The *raison d'etre* of legislation and policies designed to prevent the use of drugs is the health of the user and the public. If policies themselves appear antagonistic to the public health objective, they do not deserve support.

This article first reviews the set of current and proposed federal policies designed to punish users and to hold them strictly accountable for their addiction.[11] Second, it proposes an alternative public health strategy for controlling the drug epidemic based upon social science research.[12] Third, in demonstrating the efficacy and cost effectiveness of prevention and treatment, the article sets the parameters of a public health agenda in curtailing the drug epidemic.[13]

To some, a public health vision for drug control may be seen

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7. *See, e.g.*, NATIONAL DRUG CONTROL STRATEGY 1990, *supra* note 3, at 31, 32, 76, 81 (AIDS/HIV addressed summarily in only four paragraphs).

8. Refer to note 4 *supra*.

9. *See generally* Gostin, *A Decade of a Maturing Epidemic: An Assessment and Directions for Future Public Policy*, 16 AM. J.L. & MED. 1, 23-32 (1990) (claiming that intravenous drug users are probably the population in which HIV infection is spreading most rapidly); Stryker, *IV Drug Use and AIDS: Public Policy and Dirty Needles*, 14 J. HEALTH POL'Y, POL. & L. 719, 719-35 (1989) (urging that the government should provide addicts with sterile needles and syringes because of the high efficiency with which intravenous drug users transmit blood-borne diseases).

10. *See generally* MAJORITY STAFFS OF THE SEN. JUDICIARY COMM. & THE INT'L NARCOTICS CONTROL CAUCUS, FIGHTING DRUG ABUSE: A NATIONAL STRATEGY (1990).

11. Refer to notes 15-57 *infra* and accompanying text.

12. Refer to notes 58-93 *infra* and accompanying text.

13. Refer to notes 94-117 *infra* and accompanying text.

as a failed liberal policy reminiscent of the 1960s. Comprehensive treatment evaluation research in the past two decades, however, has gone virtually unnoticed in the legal literature. When attached to drug policies, the labels "liberal" or "conservative" signal only dogma and fixed views on complicated social problems. What is crucial is what succeeds in reducing the physical, social, and economic dependency of drug use and its associated criminality. The phrase "nothing works" has become a battle cry for those preferring strict punishment and law enforcement over treatment.[14] This article demonstrates that user punishment does not work and that powerful new evidence suggests demand reduction does.

II. "ZERO TOLERANCE": A WAR ON DRUG USERS

Current government policy uses the phrase "zero tolerance" to express the view that all drug use, whatever its scale, must face vigorous law enforcement and criminal sanctions.[15] The policy makes no rational differentiation among experimental first use, casual use, regular use, or serious physical dependency.[16] Furthermore, it makes no differentiation regarding the drug used, unless the drug is a legal one, such as alcohol or a prescription drug.[17] Some assume that all drug use involves a matter of choice, not dependence; others assume that all users need treatment. However, a broad spectrum exists among users in their physical and psychological dependence on drugs, as well as in their need for treatment.[18] This article focuses primarily on serious drug users who have a compulsion to use drugs and who could benefit from treatment. This population consumes as much as seventy-five percent of the heroin and cocaine used in the United States.[19] Serious

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14. Martinson, *What Works?—Questions and Answers About Prison Reform*, 35 PUB. INTEREST 22, 48-50 (1974); *see also* S. WALKER, SENSE AND NONSENSE ABOUT CRIME: A POLICY GUIDE 168 (1985) (conservatives present evidence that rehabilitation is a futile goal).

15. NATIONAL DRUG CONTROL STRATEGY 1989, *supra* note 4, at 8, 11, 17-18, 20-21, 24-26; *see also* NATIONAL DRUG CONTROL STRATEGY 1990, *supra* note 3, at 5 ("[T]he proper attitude toward drugs is not indifference, but intolerance.").

16. NATIONAL DRUG CONTROL STRATEGY 1989, *supra* note 4, at 8.

17. *See, e.g.*, NATIONAL DRUG CONTROL STRATEGY 1990, *supra* note 3, at 16-26 (discussion of role of criminal justice system uses only the generic term "illegal drugs").

18. *See id.* at 10.

19. NATIONAL NARCOTICS INTELLIGENCE CONSUMERS COMM., THE SUPPLY OF DRUGS TO THE U.S. ILLICIT MARKET FROM FOREIGN AND DOMESTIC SOURCES IN 1981 107 (1983); *see also* Cloud, *Cocaine, Demand, and Addiction: A Study of the Possible Convergence of Rational Theory and National Policy*, 42 VAND. L. REV. 725, 734, 751-57 (1989) (asserting that, since addicts constitute a majority of the U.S. cocaine market, the best policy to diminish market

health problems affect drug dependent people, who use a disproportionate share of health resources.[20] Further, drug dependent people, because of their need to support their habit, adversely impact public safety.[21]

Drug use, like smoking, heart disease, and AIDS, stems from human behavior, and the primary goal of public health consists of altering behaviors that are dangerous to the health of the person.[22] However, the prevailing theory is that drug use, unlike other behavioral diseases, can be halted by imposing a series of sharp punishments on those who engage in the behavior.[23]

The policies encompassed in the current doctrine of zero tolerance are geared almost exclusively toward detection and punishment of the user.[24] In each case, one cannot envisage easily what public health advantage would accrue from enforcement of the policy. The foundation principle behind zero tolerance provides that no person should be allowed to use drugs without detection by law enforcement officers and punishment from the criminal justice system.[25]

"User accountability" is a doctrine designed to strictly deter any use of illicit drugs. Regardless of the magnitude of the offense, if a person uses drugs, the doctrine holds the person legally accountable.[26] The Anti-Drug Abuse Act of 1988[27] provides that any drug use can be grounds for termination of tenancy in public housing.[28] It also authorizes the courts to deny federal benefits to individuals convicted of possessing illegal drugs.[29] Furthermore, it requires implementation of drug-free workplace policies by recipients of federal funds; these policies encompass drug testing and required personnel action against positive-testing employees,

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demand is to alter addicts' behavior).

20. *Cf.* NATIONAL DRUG CONTROL STRATEGY 1989, *supra* note 3, at 1 (claiming that a 121% increase in drug-related hospital emergency room admissions occurred between 1985 and 1988).

21. *See* NATIONAL DRUG CONTROL STRATEGY 1989, *supra* note 4, at 1.

22. *See* Gostin, *The Future of Public Health Law*, 12 AM. J.L. & MED. 461, 462 (1986).

23. *See* NATIONAL DRUG CONTROL STRATEGY 1989, *supra* note 4, at 18-19, 24-25.

24. *See, e.g., id.* at 21 (the first priority of local drug enforcement is to fight drugs at street level).

25. *See, e.g., id.* at 17 ("There is no such thing as innocent drug use.").

26. *Id.* at 24-26, 126-27.

27. Anti-Drug Abuse Act of 1988, Pub. L. No. 100-690, 102 Stat. 4181 (1988) (codified in scattered sections of U.S.C.).

28. *See* 42 U.S.C. § 1437d-1 (1988).

29. 21 U.S.C. § 853a (1988).

including termination and suspension from work.[30] Finally, the Act allows asset forfeiture, whereby a user's property can be forfeited if the authorities find any amount of drugs.[31]

The National Drug Control Strategy[32] and the Fiscal Year 1991 Budget[33] propose substantial increases in street level drug law enforcement, vigorous prosecution, and increased fines for all misdemeanor state drug offenses.[34] The administration proposes enactment of a similar range of penalties for persons caught using or possessing even a small amount of drugs. Such penalties include (1) suspension of driver's licenses; (2) suspension of state benefits such as student loans, grants, and contracts; (3) eviction of convicted drug users from public housing; and (4) criminalization of offers, attempts, and solicitations to buy drugs without the usual legal requirement of consummating a purchase with actual drugs.[35]

The National Drug Control Strategy specifies a mix of sanctions for juvenile offenders. These sanctions encompass (1) military style boot camps for drug offenders; (2) school suspension; (3) parental notification; and (4) community service involving "arduous and unenviable public chores."[36] This strategy encourages children to report parents who use drugs; it also advises the states to ensure that parental drug use will constitute grounds for child abuse and child neglect under relevant state statutes.[37] Similarly, women who use drugs during pregnancy risk a range of state sanctions that border on criminalizing the status of being drug dependent.[38] A woman may be charged under state child abuse laws for

30. 41 U.S.C. § 701-707 (1988); *see also* NATIONAL DRUG CONTROL STRATEGY 1989, *supra* note 4, at 126-27 (calling for mandatory sanctions against state and municipal employees or contractors discovered using drugs or under their influence while at work).

31. 21 U.S.C. § 881 (1988).

32. *See* NATIONAL DRUG CONTROL STRATEGY 1989, *supra* note 4, at 16-26.

33. NATIONAL DRUG CONTROL STRATEGY 1990, *supra* note 3, at 1 (budget summary).

34. *See* NATIONAL DRUG CONTROL STRATEGY 1989, *supra* note 4, at 16-26; NATIONAL DRUG CONTROL STRATEGY 1990, *supra* note 3, at 3.

35. *See* NATIONAL DRUG CONTROL STRATEGY 1989, *supra* note 4, at 126-27.

36. *Id.* at 25.

37. *Id.* at 16-26, 127.

38. The strategy does not charge these women with possession, an act which justifies criminal sanctions under current jurisprudential thinking. Rather, it charges them for an involuntary physiological activity over which they have no control—the process by which nourishment is delivered to the fetus in utero. The act of ingesting drugs, to be sure, is a conscious act, but the strategy does not charge the woman for that act. Criminalizing a physical status such as being under the influence of drugs or alcohol, or being pregnant, or both, is unconstitutional. *See* Robinson v. California, 370 U.S. 660, 666-67 (1962).

harming her fetus[39] or harming her newborn child who is born suffering from the effects of drugs.[40] She may receive a more severe sentence than persons convicted of similar offenses who are not both drug dependent and pregnant. She also may be charged with delivering drugs to a minor when a drug metabolite is passed through the umbilical cord.[41]

The Anti-Drug Abuse Act of 1990[42] contains some of the administration's most disputed addict-directed proposals. The bill would (1) streamline the procedure for deporting aliens convicted of drug offenses; (2) allow extradition of American citizens to another country even if the United States is not obligated by an extradition treaty with the foreign government; (3) authorize immigration agents to make arrests for nonimmigration crimes, including possession of drugs; and (4) expand the list of drug crimes that would be subject to the death penalty. The ostensible justification for these user-directed law enforcement policies is not merely that they punish, but also that they deter. Deterrence decreases demand for drugs and so indirectly harms suppliers. Tolerating drug use of any kind, advocates argue, actually creates the public health problem by allowing the illicit market in drugs to thrive.[43] Policy makers themselves portray user-directed punishment as a "market force" strategy to lower demand.[44]

Arguments for casting a wide net of law enforcement and criminal sanctions against users are flawed for conceptual, pragmatic, and empirical reasons. The goal of a "Drug-Free America by 1995" serves as the foundation of United States government policy.[45] Besides being an unrealistic goal, it also may be a misdirected goal. The human tragedy of the drug epidemic is not simply that people use drugs, but that serious drug dependency destroys

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39. Most courts have so far refused to utilize child abuse laws to criminalize fetal abuse. *See* Reyes v. Superior Court, 75 Cal. App. 3d 214, 219, 141 Cal. Rptr. 912, 915 (1977); People v. Stewart, No. M508197 (San Diego Mun. Ct. Feb. 26, 1987). Some states, however, are enacting child abuse statutes which explicitly cover fetuses. *See, e.g.*, N.J. STAT. ANN. § 30.4C-11 (West 1981) (stating that an application for care and custody may be filed with the Bureau of Childrens Services on behalf of unborn child).

40. *See In re* Baby X, 97 Mich. App. 111, 293 N.W.2d 736, 738 (1980).

41. *See* Johnson v. State, No. 89-1765 (5th Fla. Dist. Ct. App. filed Aug. 31, 1989); State v. Hardy, No. 128458 (1st Mich. Dist. Ct. App. filed May 3, 1990).

42. S. 2695, 101st Cong., 2d Sess. (1990).

43. *See* NATIONAL DRUG CONTROL STRATEGY 1989, *supra* note 4, at 6-7.

44. *Id.* at 11-12.

45. *See* Drug Free America by 1995 Authorization Act, Pub. L. No. 100-690, § 7603, 102 Stat. 4181 (1988) (codified at 21 U.S.C. § 1502 (1988)).

the person's health, spreads disease, and leads to crime. A preferable goal would be not to punish drug use aggressively *per se*, but to prevent and treat drug dependency. Thus, policies directed toward the user should be based upon health promotion, rather than confrontation and punishment.

The goal of a drug-free America, supported by an ever widening net of detection through drug screening, surveillance, and law enforcement, is a fruitless, impractical endeavor. The National Household Survey on Drug Abuse estimates that some seventy-two and one-half million people have used illicit drugs sometime in their life, twenty-one million of these having used cocaine or crack cocaine; additionally, twenty-eight million people have used illicit drugs in the last year, including eight and one-fifth million who used cocaine or crack cocaine.[46] Defining the behavior of so many people as deviant and criminal is always problematic. A more pragmatic problem concerns the increasingly difficult task of presenting a credible and effective law enforcement program to combat this widespread drug use. The pervading problem of not enough police, drug enforcement officers, judges, or prison beds remains. Notably, the 750,000 people arrested each year for drug offenses represent only a minute fraction of current drug users; more than three quarters of these arrests are for simple possession, typically marijuana, and not for manufacturing, importing, or selling.[47]

Finally, if one uses any reasonable measure of success, empirical evidence suggests that user directed punishment has not been effective. If the true goal of the drug war is protecting the health and safety of the community, and not simply punishing "immoral self-gratifying" behavior, then policies ought to be primarily directed toward reducing harms. The measure of effectiveness of those policies should be lower rates of drug dependency, violent crime, and needle borne transmission of infection, as well as increasing social productivity and adaptability. In a rational policy analysis, judgments about the moral quality of behavior have little value. Any policy to curtail the drug epidemic must be justified by concrete health and social benefits.[48]

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46. NATIONAL INST. ON DRUG ABUSE, NATIONAL HOUSEHOLD SURVEY ON DRUG ABUSE: POPULATION ESTIMATES 1988 17, 29 (1989).

47. *See* BUREAU OF JUSTICE STATISTICS, DEP'T OF JUSTICE, SOURCEBOOK OF CRIMINAL JUSTICE STATISTICS (1989); Nadelmann, *Drug Prohibition in the United States: Costs, Consequences, and Alternatives*, 245 SCIENCE 939, 941 (1989).

48. Moral condemnation of illicit drugs is highly culturally specific. Americans are far

User-directed punishment simply has not worked under any criterion conducive to the public health and safety. Significant shifts in the balance between supply- and demand-side policies can be traced to the early to mid-1970s when policy makers began to place greater emphasis on law enforcement.[49] Zero tolerance is essentially a reiteration of past actions—stricter law enforcement, more prisons, a greater range of criminal and civil sanctions, and more severe sentencing including capital punishment.[50] Yet, in the face of harsh criminal punishment, demand for drugs has proven to be fairly inelastic. The decline in casual drug use[51] reflects a notable achievement of law enforcement. However, this decline may just as easily be a function of prevention and education in schools and significant cultural changes. The decline in casual use is more than offset by a marked increase in drug dependency, regular use of highly addictive drugs such as cocaine, and drug related crime.[52]

Not surprisingly, harsh punishment has proven an ineffective deterrent to serious drug use. Physically and psychologically drug

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more tolerant of other addictive drugs which have harmful health consequences such as alcohol, nicotine, caffeine, as well as some prescription and over-the-counter pharmaceuticals. *See, e.g.*, NATIONAL DRUG CONTROL STRATEGY 1990, *supra* note 3, at 1 (drug strategy "provides a unified, integrated, and truly national policy aimed at the complicated array of problems posed by illegal drugs").

49. In the early 1970s, approximately 45% of the drug abuse budget went to activities relating to interdiction, eradication and other law enforcement, with the remainder going to drug treatment, prevention and education. *See Needles and the Conscience of a Nation*, 1 DRUG POL'Y LETTER 5-6 (1989). By 1976, the proportion was relatively even, with 50.4% going to supply-side policies. *Id.* From the 1980s to the present, however, the law enforcement proportion of expenditures rose substantially to between 73% and 82%, and is estimated at 71% for fiscal year 1991. NATIONAL DRUG CONTROL STRATEGY 1990, *supra* note 3, at 1 (budget summary). In addition, the Anti-Drug Abuse Act of 1986 significantly increased the penalties for drug use. *See, e.g.*, 21 U.S.C. § 844 (1988) (mandating a minimum fine of $1000 and potential imprisonment for mere possession of a controlled substance).

50. Refer to NATIONAL DRUG CONTROL STRATEGY 1989, *supra* note 4, at 23.

51. NATIONAL INST. ON DRUG ABUSE, *supra* note 46, at 17 (finding that the estimated number of Americans using any illegal drug at least once in the last 30-day period dropped from 23 million in 1985 to 14.5 million in 1988).

52. Virtually all other measures of "success" in the drug war are disappointing. The number of drug-related emergency hospital admissions increased by 121% between 1985 and 1988; felony drug convictions now account for the single largest and fastest growing sector of the federal prison population; three-quarters of all robberies and half of all felony assaults committed by young people now involve drug users; and there is a 28-fold increase in hospital admissions involving crack cocaine since 1984. While Director of the Office of Drug Control Policy, William Bennett concluded that "a wealth of other, up-to-date evidence suggests that our drug problem is getting worse, not better." NATIONAL DRUG CONTROL STRATEGY 1989, *supra* note 4, at 1, 3.

dependent persons have little control over their behavior. Addicts are almost completely present minded—preoccupied with finding and taking drugs.[53] Compulsive drug users have significantly diminished flexibility in their behavior patterns. The social environment of the ghetto, compounded by personal and economic despair, as well as physical craving for drugs, are forces too powerful to deter serious drug use effectively. Admonitions to "say no," backed up with the threat of state sanctions, cannot succeed. Compulsive drug users present the criminal justice system with significant problems because they will continue their addictions irrespective of the disastrous consequences to their livelihood, health, and liberty.[54]

Advocates of user accountability argue that the greater range of sanctions recently introduced will reduce drug dependence and related criminal behavior.[55] However, no data supports this hypothesis; nor do any plans exist to impartially evaluate the effectiveness of the new policies. If the true goal of the national drug strategy is rehabilitating and empowering vulnerable people who are seriously impaired by drugs, then taking away their homes, federal benefits, jobs, or education is hardly a promising policy. Helping drug dependent people to remain in stable and relatively secure environments while providing treatment will likely be more rehabilitative. Indeed, a strong consensus of social science researchers urge that policy makers should pay greater attention to the social determinants of drug abuse and the need for treatment and support services.[56]

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53. *Id.* at 10.

54. *See* Cloud, *supra* note 19, at 736-51.

55. *See* NATIONAL DRUG CONTROL STRATEGY 1989, *supra* note 4, at 24-26.

56. *See, e.g.*, NATIONAL ASS'N OF STATE ALCOHOL & DRUG ABUSE DIRECTORS, TREATMENT WORKS: A REVIEW OF 15 YEARS OF RESEARCH FINDINGS ON ALCOHOL AND OTHER DRUG ABUSE TREATMENT OUTCOMES (March 1990)) [hereinafter NASADAD TREATMENT WORKS]; NATIONAL CRIMINAL JUSTICE ASS'N, TREATMENT OPTIONS FOR DRUG-DEPENDENT OFFENDERS: A REVIEW OF THE LITERATURE FOR STATE AND LOCAL DECISIONMAKERS (U.S. Department of Justice, Bureau of Justice Assistance (Feb. 1990)) [hereinafter NCJA TREATMENT OPTIONS]; R. HUBBARD, M. MARSDEN, J. RACHAL, H. HARWOOD, E. CAVANAUGH & H. GINZBURG, DRUG ABUSE TREATMENT: A NATIONAL STUDY OF EFFECTIVENESS 10 (1989) [hereinafter TOPS STUDY) (The study attempts to guide policymakers by answering three questions: 1) How effective is drug abuse treatment for the individual? 2) What is the return on drug treatment expenditures? and 3) How can effectiveness of treatment be increased?); Simpson, *National Treatment System Evaluation Based on the Drug Abuse Reporting Program (DARP) Follow Up Research*, in DRUG ABUSE TREATMENT EVALUATION: STRATEGIES, PROGRESS AND PROSPECTS 36 (1984) (NIDA RES. MONOGRAPH 51) [hereinafter NIDA RES. MONOGRAPH 51] (despite "widespread popular belief" that drug abuse treatment is futile, study claims "convincing evi-

Whether the law is justified in imposing criminal penalties on sick people with little control over their behavior is a matter for legitimate jurisprudential debate. Nevertheless, whether criminal penalties actually achieve benefits for the public health and safety must be a matter of empirical inquiry rather than ideological assertion. Spending scarce dollars on more law enforcement is unlikely to achieve equivalent benefits to spending more on prevention and treatment.

It may be suggested that it is simply too difficult to measure the benefits of law enforcement and criminal sanctions. Yet, the impact of policies encompassed under the rubric of zero tolerance, despite the inordinate costs and diversion of resources,[57] is not being evaluated at all. Demand reduction, on the other hand, has been subject to rigorous evaluation and, as will be seen, demonstrates high social utility in reducing serious drug use and criminal behavior.

III. TREATMENT WORKS: THE EFFICACY OF DEMAND REDUCTION FOR THE PROMOTION OF THE PUBLIC HEALTH AND SAFETY

A. The Public Health Approach: Setting the Parameters

The drug epidemic is the principal public health problem confronting the United States and other developed and developing countries.[58] The morbidity and mortality attributable to drug use is immeasurable:[59] the number of drug-related emergency hospital admissions increased by 121 percent between 1985 and 1988;[60]

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dence for effectiveness of treatment").

57. The opportunity costs incurred by zero tolerance policies are enormous. In the fiscal year 1991 budget, the federal government requests $1,219 million for domestic crime investigations, $700 million for prosecutions, $1,297 million for corrections, and $172 million for intelligence. The real policy question, hardly addressed by government, is what health and social benefits could be achieved if even a small part of these budget requests were transferred to prevention, education, and treatment. *See* NATIONAL DRUG CONTROL STRATEGY 1990, *supra* note 3, at 7-10 (budget summary).

58. *See generally id.*; NATIONAL DRUG CONTROL STRATEGY 1989, *supra* note 4.

59. The health effects of drug use include direct physiologic effects of the drug, particularly when the addict self-administers an excessive or impure dose. *See* Isner, Estes, Thompson, Constanzo-Hordin, Subramanian, Miller, Katsas, Sweeney & Sturner, *Acute Cardiac Events Temporarily Related to Cocaine Abuse*, 315 NEW. ENG. J. MED. 1438, 1440 (1986); Isner & Chokshi, *Cocaine and Vasospasm*, 321 NEW. ENG. J. MED. 1604, 1604 (1989). *See also* Crumley, *Substance Abuse and Adolescent Suicidal Behavior*, 263 J. A.M.A. 3051, 3051-56 (1990) (observing the association between psychoactive substance abuse among teenagers and increased suicidal behavior).

60. NATIONAL DRUG CONTROL STRATEGY 1989, *supra* note 4, at 1.

200,000 babies, many with low birth weight and mental or physical impairments, are born annually to mothers who use drugs;[61] intravenous use of heroin and cocaine is the largest source of new HIV infections;[62] and felony drug convictions involving physical harm to another person account for the largest and fastest growing sector of the prison population.[63]

Despite the considerable impact of the misuse of illicit drugs on the health of the community, a perennial debate, almost as old as the taking of drugs itself, continues about how to classify the problem. For some, drug use is purely behavioral. Many perceive the use of drugs as a moral rather than a health issue.[64] According to this view, persons who use drugs are autonomous agents able, but unwilling, to control their behavior. To these behavioralists, the criminal law should be used for drug offenders in much the same way as for violent criminals—to punish individuals for aberrant behavior and to deter them from behaving that way in the future. The behavioralists argue that because drug users act willfully, drug use should be regarded as a legal rather than a health problem.[65]

One need not become embroiled in the perennial debate as to whether drug users cannot, or simply will not, modify their behavior. The argument of the behavioralists collapses when one observes that many problems affecting the health of the community relate closely to behaviors; nonetheless, they are properly regarded as health issues susceptible to traditional health education, prevention, community health, and medical approaches. Some examples include smoking and lung cancer, diet and heart disease, intercourse and sexually transmitted diseases, as well as careless behavior and iatrogenic injuries.

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61. *Id.* at 2; *see also* Petitti & Coleman, *Cocaine and the Risk of Low Birth Weight*, 80 AM. J. PUB. HEALTH 25, 27 (1990) (concluding that cocaine use is an "important contributor" to low birth weight "in areas with substantial cocaine use.").

62. *See, e.g.*, Lange, Snyder & Lozovsky, *Geographic Distribution of Human Immunodeficiency Virus Markers in Parenteral Drug Abusers*, 78 AM. J. PUB. HEALTH 443, 443 (1988) (finding that parenteral drug abuses are a "major reservoir" for spread of AIDS virus); CENTERS FOR DISEASE CONTROL, HIV/AIDS: U.S. CASES REPORTED THROUGH APRIL 1990 (May 1990).

63. *See* NATIONAL DRUG CONTROL STRATEGY 1989, *supra* note 4, at 1.

64. *See, e.g.*, Berke, *Bennett Doubts Value of Drug Education*, N.Y. Times, Feb. 3, 1990, at A1, col. 2 (during Senate committee hearing, Bennett questioned effectiveness of drug education and endorsed aggressive law enforcement).

65. For one of the most thoughtful arguments for law enforcement as effective deterrence, see Wilson, *Against the Legalization of Drugs*, 89 COMMENTARY 21, 24-26 (1990).

A public health strategy for confronting the drug epidemic first must seek a definition of "public health." This is a research question in itself.[66] A logical boundary for a public health strategy would encompass all programs directly designed to prevent or intervene in ill health caused by drug use. Public health programs are designed to prevent, treat, or care for low birth weight infants, needle borne transmission of infections, and morbidity and mortality (both physical and mental) associated with drug use. A public health strategy would include, but would not be limited to: (1) community health education and outreach; (2) counseling; (3) clean needle and bleach programs; (4) drug treatment (both voluntary and mandatory); and (5) emergency, nursing, psychological, medical, and rehabilitative services. Health systems set up in foci not themselves designed to promote health, such as criminal justice, corrections, and the workplace, would be included within the parameters of a public health strategy.[67]

A national drug strategy founded on public health would neither accept nor reject the two antithetical positions that so dominate the current sterile policy debate—criminalization versus legalization.[68] Accordingly, this article does not focus on programs related to criminalization or interdiction (*e.g.*, better solutions to prevent farming of coca or opium crops; smuggling drugs across the U.S. border; arresting and prosecuting drug traffickers, dealers,

66. The effort to set the parameters of the public health strategy for confronting the drug epidemic gives rise to a number of questions, including: (1) How do legal and political institutions identify and administer to the problem of drug use? (responsibility for drug abuse programs is variously located in departments of health, public health, mental health, or specialized agencies for drug control); (2) why have drug prevention and intervention programs been separate and apart from the mainstream of medical and hospital care?; and (3) are therapeutic interventions paid for through medicaid, medicare, or private health insurance? Lack of consistency in structuring, financing and delivery of drug abuse programs through conventional health and public health mechanisms has been an important part of the problem of inadequate services.

67. What is the logical endpoint for a public health inquiry? Must the public health strategy be designed to lower morbidity and mortality associated with drug use, prevent dependence on drugs without having to show a causal relationship with prolonging or preserving life, or prevent any use of drugs even if only casual or recreational? The broadest public health approach would be to prevent and to treat ill health associated in any way with the use of drugs. Deterrence of and punishment for casual use of drugs may, or may not, be justified on other grounds, but it does not come within the parameters of a public health approach.

68. *Compare* Nadelmann, *Drug Prohibition in the United States: Costs, Consequences and Alternatives*, 245 SCI. 939, 939 (1989) (arguing for controlled legalization) *with* Wilson, *supra* note 65 at 28 (concluding that legalization increases drug use, degrades the human personality, and causes increases in accidents and violence).

and users) or legalization (*e.g.*, licensing, sale, and taxation of drugs). A neutral health inquiry is imperative irrespective of which of the two extreme positions dominate. Neither criminalization nor legalization deals directly with a whole host of health problems. Whether we continue to severely punish drug users or relax legal restraints in the future, people will continue to be dependent on drugs and the health inquiry will have to proceed anyway.

B. Systemic Deficiencies in Treatment Availability

The concentration of resources on enforcing drug laws would be far less illogical if drug dependent people were first given a realistic opportunity to enter treatment. The use of punishment, rather than treatment, as a first resort speaks unmistakably about the state's motive. Systemic deficiencies in treatment availability are well documented across America.[69] States estimate that less than twelve percent of the more than twelve million drug dependent people actually receive treatment.[70]

As of September 25, 1989, 66,766 persons in forty-four states responding to a national survey were on treatment waiting lists; one-half of these people had been waiting for at least thirty days, and in many urban areas, ninety to one hundred percent of persons on the lists had waited at least thirty days,[71] with some waiting for as long as six months to a year.[72] Waiting lists, moreover, may be grossly understated, because many programs are so full they do not add people to their lists.[73] People on drug treatment

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69. *See* REPORT OF THE PRESIDENTIAL COMMISSION ON THE HIV EPIDEMIC 94-103 (1988) (outlining obstacles and recommendations to combat the spread of HIV through intravenous drug use); Kerr, *Shortage of Drug Treatment Imperils AIDS Control*, N.Y. Times, Oct. 4, 1987 at A32, col. 1 (citing federal aid cutbacks and rising numbers of cocaine addicts seeking treatment as two main causes of lack of treatment facilities); Marriott, *Addicts Awaiting Treatment Often Face Delays and Panic*, N.Y. Times, Jan. 10, 1990, at A1, col. 5 (describing the chronic shortage of treatment centers in New York and New Jersey).

70. NASADAD TREATMENT WORKS, *supra* note 56, at app. I.

71. *Id.*

72. *See, e.g.*, INSTITUTE OF MED., NATIONAL ACAD. OF SCI., CONFRONTING AIDS: DIRECTIONS FOR PUBLIC HEALTH, HEALTH CARE, AND RESEARCH 108 (1986) (the time period for many waiting lists for treatment ranged up to a year even before the HIV epidemic); INSTITUTE OF MED., NATIONAL ACAD. OF SCI, CONFRONTING AIDS: UPDATE 1988 85 (1988) (waiting lists exceeding a month discourage many addicts from seeking treatment) [hereinafter AIDS: UPDATE 1988]; REPORT OF THE PRESIDENTIAL COMMISSION ON THE HIV EPIDEMIC 96 (1988) (finding six month waiting lists at treatment facilities in three out of four cities).

73. *See* Malcolm, *In Making Drug Strategy No Accord on Treatment*, N.Y. Times, Nov. 19, 1989, at A1, col. 1.

waiting lists commit more crimes and have less interest in entering treatment.[74] A drug dependent person cannot be relied upon to reappear for a treatment opening at some future time. The result is an ever increasing spiral of drug use, violence, and HIV infection.

Statistics clearly document a rapid decline in the 1980s in the percentage of the drug abuse budget going to treatment.[75] Between fiscal years 1972 and 1979, block grants earmarked for treatment increased from 69.3 million to 336.5 million dollars. By fiscal year 1986, the total funds allocated dropped to 235 million dollars—less than two-thirds of the fiscal year 1979 budget. In constant dollars, the level of federal funding for treatment declined by more than fifty percent in the 1980s.[76]

The relatively low level of funding for treatment, the long waiting lists, and the absence of adequate services in the drug abuse, health care, and criminal justice systems attest to society's perception of drug dependent people as morally blameworthy rather than ill. The data also demonstrates the low value given to public health relative to law enforcement. Expenditures on demand reduction to bridge the gulf between services and current needs would be not only a symbol of humanity toward a reviled and vulnerable population, but also highly beneficial and cost effective in promoting the public health and reducing crime.

C. *Treatment Outcome Studies*

Policy makers perceive drug dependency as a chronic relapsing illness, with unfavorable prognosis and inefficacious interventions.[77] This view provides one explanation for the low level of funding and support in the community for drug treatment. Yet, a great deal of evaluative research demonstrates that treatment provides favorable outcomes in reducing drug use, needle sharing, and criminality, and in increasing employment and social adjustment.[78]

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74. Brown, Hickney, Chung, Craig & Jaffe, *The Functioning of Individuals on a Drug Abuse Treatment Waiting List*, 15 AM. J. DRUG & ALCOHOL ABUSE 261, 271 (1989).

75. *See* Cloud, *supra* note 19, at 783-84. Refer to note 49 *supra* and accompanying text.

76. Cloud, *supra* note 19, at 784.

77. *See* Kleber, *Treatment of Drug Dependence: What Works*, 1 INT'L REV. OF PSYCHIATRY 81, 81 (1989).

78. *See* NCJA TREATMENT OPTIONS, *supra* note 56, at 1-2 (recognizing that "[d]rug experts and criminal justice practitioners almost universally agree that reducing the demand for drugs through prevention and treatment holds the best hope of controlling drug abuse"); NASADAD TREATMENT WORKS, *supra* note 56, at 13; Senay, *Clinical Implications of Drug*

The Treatment Outcome Perspective Study (TOPS)[79] and the National Treatment Based on the Drug Abuse Reporting Program (DARP) are the two major longitudinal studies which lead social scientists to the near unanimous conclusion that "treatment works."[80] Both TOPS and DARP studied the outcome of participants in a number of treatment modalities, including methadone maintenance, residential therapeutic or therapeutic community, and out-patient drug free. No significant differences were detected based upon the modality of treatment.[81]

The TOPS study measured significant declines in drug use in all treatment modalities, and the effects endured. Overall, less than twenty percent of participants in any modality were regular users of any drug three to five years after entering treatment.[82] These effects were evident for nonopioid as well as opioid drugs.[83] Abstinence from drugs is the most rigorous measure for treatment. Abstinence rates averaged forty to fifty percent, while improvement rates (a reduction in drug use) averaged from seventy to eighty percent. The DARP study found similar abstinence and improvement rates. The DARP study showed a seventy-four percent reduction in daily heroin use among 405 opioid addicts twelve years

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Abuse Treatment Outcome Research, in NIDA RES. MONOGRAPH 51, *supra* note 56, at 139.

79. *See* TOPS STUDY, *supra* note 56.

80. Numerous publications have reported the DARP study. *E.g.*, THE EFFECTIVENESS OF DRUG ABUSE TREATMENT: EVALUATION OF TREATMENT OUTCOMES FOR 1971-1972 DARP ADMISSION COHORT, Vol. IV (S. Sells & D. Simpson eds. 1976) [hereinafter DARP STUDY]; Simpson, *supra* note 56, at 29-41; Simpson & Sells, *Effectiveness of Treatment for Drug Abuse: An Overview of the DARP Research Program*, 2 ADVANCES IN ALCOHOL & SUBSTANCE ABUSE 7 (1982).

81. TOPS STUDY, *supra* note 56, at 7; DARP STUDY, *supra* note 80.

82. TOPS STUDY, *supra* note 56, at 125.

83. *Id.* An opiate is any preparation or derivative of opium. Opium contains some 20 alkaloids, including morphine and codeine. Heroin, or diacetylmorphine, is a bitter, white, crystalline power, prepared from morphine by acetylation. STEADMAN'S MEDICAL DICTIONARY 709, 1094 (Williams & Wilkins 25th ed. 1990). "Heroin and morphine are true narcotic analgesics in the sense that their use produces a marked indifference to pain. In addition, when injected intravenously a warm flushing of the skin and intense pleasurable sensations in the lower abdomen will result." People v. McCabe, 49, Ill. 2d 338, 342, 275 N.E.2d 407, 410 (1971).

The principal non-opioid drug is cocaine. Cocaine is not related to the opium poppy. Cocaine is a crystalline alkaloid obtained from the leaves of erythroxylon coca. Unlike the opioid narcotics, which are depressants, cocaine stimulates the central nervous system. It produces a euphoric state and reduces fatigue and hunger in the user. THE SLOANE-DORLAND ANNOTATED MEDICAL-LEGAL DICTIONARY 152 (1987). Crack is a smokable form of cocaine. *See generally Mechanisms of Cocaine Abuse and Toxicity* 1-353 (1988)(NIDA RES. MONOGRAPH 88)(containing 22 articles relating to the physical and psychological effects of cocaine).

after they first entered treatment.

Numerous smaller studies have reaffirmed repeatedly the findings of TOPS and DARP. The findings suggest the following: Treatment is effective in reducing drug use; the effects are most pronounced the longer a person remains in treatment; and the results are enduring over time. The research literature has focused upon treatment for opioid dependency because it had been the drug of choice. Treatment evaluation of cocaine use, while less rigorous to date, shows similar levels of efficacy.[84]

The benefits of treatment extend far beyond reduced levels of drug use. Treatment reduces crime as well as needle sharing and increases social productivity, such as employment and family integration. The relationship between drug use and crime is inescapable. Drug dependent offenders overload prosecutors' offices, jails, and courts in major urban areas across the country, with the result that most receive little or no prison time and no treatment.[85] Extensive reviews of the connection between drug use and crime have found a strong correlation between the two. Many drug dependent people commit their crimes as a means of obtaining money to purchase their drugs.[86] Almost universally, social scientists report that reducing demand for drugs through prevention and treatment decreases the level of drug-related criminal activity. Both the TOPS[87] and DARP[88] studies concluded that much lower

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84. *See*, BURT ASSOCS., DRUG TREATMENT IN NEW YORK CITY AND WASHINGTON, D.C.: FOLLOW-UP STUDIES (NIDA 1977); Kosten, Rounsaville & Kleber, *A 2.5 Year Follow-up of Cocaine Use Among Treated Opioid Addicts*, 44 ARCHIVES GEN. PSYCHIATRY 281, 281 (1987) (finding a significant correlation between length and success of treatment); Simpson, Joe, Lehman & Sells, *Addiction Careers: Etiology, Treatment, and 12-year Follow-up Outcomes*, 16 J. DRUG ISSUES 107, 107 (1986) (after 12 years, only 25% of 405 opiod addicts reverted to regular use). The greater availability of treatment slots for heroin addicts, as opposed to cocaine addicts, presents an overriding public policy problem. As the drug epidemic moves steadily from heroin to cocaine dependency, treatment resources must adapt to meet this need.

85. *See* NCJA TREATMENT OPTIONS, *supra* note 56, at 1; U.S. GOV'T GEN. ACCT. OFF., CONTROLLING DRUG ABUSE: A STATUS REPORT 19 (1988).

86. *See* Greenburg & Adler, *Crime and Addiction: An Empirical Analysis of the Literature*, 3 CONTEMPORARY PROBLEMS 1920 (1974); R. GANDASSY, J. WILLIAMS, J. COHEN & H. HARWOOD, DRUGS AND CRIME: A SURVEY AND ANALYSIS OF THE LITERATURE 52 (1980).

87. The TOPS study found that three to five years after leaving treatment, the proportion of clients involved in predatory crimes was one-third to one-half of the pre-treatment level. TOPS STUDY, *supra* note 56, at 161.

88. DARP found that more than 50% of therapeutic community clients had been arrested before admission, but only 33% were arrested in the first year and 28% in the third year following treatment. Furthermore, out-patient arrest records declined from 87% before admission to 34% one year after treatment and to 22% in the third year. DARP STUDY,

incidences of criminal behavior occurred after treatment.

Needle sharing is an integral part of the ritual of intravenous drug use and is an effective means of transmitting blood-borne infections such as HIV.[89] Entry into treatment results in prompt and significant reductions in drug use, drug injections, and needle sharing. Additionally, addicts enrolled in treatment have consistently lower HIV seroprevalence rates than those not in treatment.[90]

Finally, treatment culminates in wider social benefits, including more stable employment for clients. However, gains in employment are not as dramatic as other indicators of success. The research results point to the need for additional resources for employment and training services for clients to reduce their dependence on society, to increase their productivity, and to provide the incentive to remain drug free.

D. Cost Effectiveness of Treatment

The Presidential Commission on the HIV Epidemic observed that treatment on demand can save money as well as lives. At a purely economic level, the commission reported that the annual cost of keeping a person in prison is $14,500 compared to as little as $3,000 for drug treatment.[91] This compares with a lifetime cost of treating a person with AIDS of $50,000 or more.[92]

Comprehensive cost benefit analysis shows that state level funding of drug abuse programs is economically justified. The studies focused on the following: (1) Reduced costs relating to arrest, prosecution, and incarceration; (2) reduced property theft; (3) reduced cost due to an improved labor market; and (4) reduced medical treatment costs. The TOPS study concluded that there was an eleven to thirty percent decline in these indirect costs as a consequence of drug abuse treatment. A comprehensive study of

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supra note 80.

89. *See* Stryker, *IV Drug Use and AIDS: Public Policy and Dirty Needles*, 14 J. HEALTH POL., POL'Y & LAW 719, 721 (1989).

90. NATIONAL INST. OF DRUG ABUSE, EFFECTIVENESS OF DRUG ABUSE TREATMENT AS AN AIDS PREVENTION STRATEGY (1989).

91. REPORT OF PRESIDENTIAL COMMISSION ON THE HIV EPIDEMIC 95 (1988). Estimates for drug treatment costs for IV drug users in 1987 were $3,000 for out-patient methadone maintenance, $2,300 for drug free outpatients and $14,600 for drug free non-hospital residential patients. NASADAD TREATMENT WORKS, *supra* note 56, at 25.

92. *E.g.*, Fox, *Financing Health Care for Persons with HIV Infection: Guidelines for State Action*, 16 AM. J.L. & MED. 223 (1990) (discussing various state programs for dealing with the costs of providing care for AIDS patients).

drug abuse treatment in California found a benefit-cost ratio of 1:12, that is, for every dollar spent on effective drug treatment, twelve dollars of social costs were saved.[93]

IV. An Alternative Public Health Vision: Expanding Access to Demand Reduction Services

If policy makers concur that prevention and treatment, properly designed, funded, and executed, is beneficial as well as cost effective, a vexing question remains: What is the best method to reach the drug users to reduce demand? The overarching problem with existing treatment services is that they are ghettoized, often far removed from the silent world of the illicit drug user. Virtually all traditional drug treatment facilities remain separate and apart from the mainstream health care system.[94]

Drug treatment occurs, if at all, when a drug user himself seeks out services, has the persistence to wait his turn on the list, and voluntarily remains in treatment for the duration necessary to obtain results. This system appears, at best, haphazard and idiosyncratic and, at worse, perpetuates the revolving door between drug use, needle sharing, and brief stays in detoxification or in prison. Indeed, all the evidence points to (1) large numbers of unrecognized cases of serious drug dependence;[95] (2) many cases which do come forward being placed on lists where the individual progressively loses interest in treatment;[96] (3) short periods of detoxification or prison with few going on to sufficiently long stays in treatment to make a difference;[97] and (4) repeated contacts with emergency medical services and with the criminal justice system.[98] This pattern suggests that the current segregated treatment system has failed to reach large numbers of drug users or to keep them in treatment.

For policy makers, the lesson from the social science research

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93. V. Tabbush, The Effectiveness and Efficiency of Publicly Funded Drug Abuse Treatment and Prevention Programs in California: A Benefit Cost Analysis (UCLA, Mar. 1986).

94. Lewis & Gordon, *Alcoholism and the General Hospital*, 1983 Bull. N.Y. Acad. Med. 181, 182 (citing institutional constraints and the stigma of treatment programs as reasons for hospitals not having facilities in house).

95. *Id.*

96. AIDS: Update 1988, *supra* note 72, at 85.

97. U.S. Gov't Gen. Acct. Off., *supra* note 85, at 19.

98. *Id.*

remains relatively simple. To reduce the dual epidemics of drugs and AIDS, policy makers must develop a strategy to identify as many unrecognized cases as possible. Drug dependent people must be given the opportunity and initiative to enter and remain in treatment for durations which maximize the chance of positive outcomes.

The health care and criminal justice systems represent two distinct foci for enhancing the capacity to identify and treat drug dependent persons.[99] Large numbers of unrecognized and untreated drug users come into contact with both types of facilities. It simply makes no sense to have a seriously dependent person pass through an emergency room, hospital, courtroom, or prison and fail to identify that person as one who needs treatment. Even if these settings do identify the person as a drug user, they lack sufficient capacity and expertise to provide treatment or to make a referral. Further, the settings are not designed or funded to provide treatment, and the training and experience of staff are inadequate to provide expert care for the seriously drug dependent person.[100]

A. Health Care System

Seriously drug dependent people have multiple health problems. This occurs not only because of their physical and psychological dependency, but also because they are often poor, malnourished, and even homeless.[101] As a result of their multiple health problems, many drug dependent persons come into contact with the traditional health care system in such services as hospitals, emergency rooms, community health and mental health centers, family physician offices, health maintenance organizations and the like.

The number of drug related hospital admissions increased by 121 percent between 1985 and 1988,[102] including a twenty-eight fold increase in admissions involving smoked cocaine (crack).[103]

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99. REPORT OF THE PRESIDENTIAL COMMISSION ON THE HIV EPIDEMIC, 97-98 (1988) (recommending health care facilities provide treatment on demand and more emphasis be placed on identification and treatment of drug abuse in the prison population).

100. Kennedy, *Chemical Dependency: A Treatable Disease*, 81 OHIO ST. MED. J. 77, 77 (1985).

101. REPORT OF PRESIDENTIAL COMMISSION ON THE HIV EPIDEMIC 93 (1988).

102. NATIONAL DRUG CONTROL STRATEGY 1989, *supra* note 4, at 1.

103. *Id.* at 3.

Patients, many already HIV positive, pass through the health care system without being diagnosed either as drug dependent or HIV positive. Studies show pitifully low levels of accuracy in identifying and diagnosing substance abuse.[104] Even when physicians recognize substance abuse, they most likely refer the patient outside their primary care practice.[105]

Blinded studies of sentinel hospitals throughout the United States suggest that as many as 80,000 cases of HIV infection pass through American hospitals each year undetected.[106] In large urban areas, up to fifty percent or more of these cases of HIV infection are likely to be among unrecognized and untreated IV drug users.[107] Studies of medical centers and emergency rooms indicate that a substantial number of patients have recently used an illicit drug, and many may be seriously dependent.[108]

Although the health care system has the unique capacity to identify and care for patients, systematic problems remain in utilizing the mainstream health care system for these purposes. Integration of drug treatment into primary care hospitals, community health and mental health centers, health organizations, and other providers will require a sizeable influx of resources for training, facilities, staff, and reimbursement. It also will necessitate fundamental reform of federal regulations to allow physicians to prescribe methadone and future chemical treatments in a similar

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104. *See, e.g.*, Lewis & Gordon, *supra* note 94, at 182 (stating that many hospitals pretend not to notice the high frequency of substance abusers passing through their facility); Kennedy, *supra* note 100, at 77 (less than one third of physicians surveyed felt competent to recognize and treat substance abuse).

105. Gottlieb, Mullen & McAlister, *Patient's Substance Abuse and the Primary Care Physician: Patterns and Practice*, 12 ADDICTIVE BEHAVIORS 23, 23 (1987).

106. *See* St. Louis, Rauch, Peterson, Anderson, Schable, Dondero, and the Sentinel Hospital Surveillance Group, *Seroprevalence Rates of Human Immunodeficiency Virus Infection at Sentinel Hospitals in the United States*, 323 NEW ENG. J. MED. 213, 214 (1990) (random and anonymous survey found presence of HIV infection even when underlying behavioral risk factors were absent); Gordin, Givert, Hawley & Willoughby, *Prevalence of the Human Immunodeficiency Virus and Hepatitis B Virus in Unselected Hospital Admissions: Implications for Mandatory Testing and Universal Precaution*, 161 J. INFECTIOUS DISEASES 14, 14 (1990); CDC Strategic Planning Meeting, Counseling and Testing for HIV Infection in Acute Care Hospitals, Atlanta, Ga., Apr. 5-6, 1990 (report available from CDC).

107. *See* Des Jarlais, Friedman & Stoneburner, *HIV Infection and Intravenous Drug Use: Critical Issues in Transmission, Dynamics, Infection Outcomes, and Prevention*, 10 REV. INFECTIOUS DISEASES 151, 151 (1988).

108. *See* Bailey, *Cocaine Detection During Toxicology Screening of a University Medical Center Population*, 25 J. CLINICAL TOXICOLOGY 71, 71 (1987); Lindenbaum, Carroll, Daskal & Kapusnick, *Patterns of Alcohol and Drug Abuse in an Urban Trauma Center*, 29 J. TRAUMA 1654, 1654 (1989).

manner as they currently prescribe in other areas of medicine.[109]

B. *Criminal Justice System*

Numerous indicators point to the extent to which drug users come into contact with the criminal justice system. A minimum of fifty percent of male arrestees in urban areas test positive for cocaine;[110] between seventy-five and eighty-three percent have used drugs in the past, and more than one third were under the influence of drugs at the time of the offense.[111] Additionally, over one-fourth of incarcerated inmates in some rural prisons test positive for illicit drugs.[112]

Despite the large number of drug dependent persons coming into contact with the criminal justice system, few comprehensive treatment programs exist. One national survey found that only four percent of state prison inmates received any treatment, and almost half the nation's state prisons were not served by any identifiable drug abuse treatment program.[113] For many in the criminal justice system, routine urine testing is the only "treatment" provided.[114]

Systematic treatment of persons in the criminal justice system is fully consistent with the research presented earlier. Criminal justice system settings (*e.g.*, diversion, probation, prison, and parole) provide optimal opportunities for treatment: (1) drug users come into contact in large numbers with these programs; (2) they are captive participants who otherwise have unproductive time; (3) they are already subject to state control because of their offenses

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109. Current methadone maintenance regulation has a chilling effect on the ability and willingness of health care providers to offer drug treatment services. Very few providers in the health care system can prescribe methadone because most have not sought approval to do so. *See, e.g.*, 21 C.F.R. § 291 (1990) (detailing conditions for and methods of methadone treatment); Methadone Maintenance and Detoxification: Joint Revision of Conditions for Use, 54 Fed. Reg. 8954 (1989) (containing commentary and interpretation of the final rule codified at 21 C.F.R. § 291).

110. CDC, *Urine Testing for Drug Use Among Male Arrestees-U.S.*, 38 MORBIDITY & MORTALITY WKLY REP. 780, 781 (1989).

111. U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, DRUG AND CRIME FACTS (1989).

112. Vigdul & Stadler, *Controlling Inmate Drug Use Cut Consumption by Reducing Demand*, CORRECTION TODAY, June 1989, at 96.

113. F. Tims, *Drug Abuse Treatment in Prisons* 13 (NIDA Research Report No. ADM 86-1149, 1981, reprinted 1986).

114. *See Drug Testing Common, Often Random in Institutions*, PROBATION & PAROLE CORRECTIONS COMPENDIUM, Aug. 1986, at 57.

so that the same level of constitutional concerns raised by civil commitment are not presented; and (4) they may remain under control for considerable periods providing the best opportunity for successful treatment outcomes. Evaluative research directed specifically to mandatory treatment in the criminal justice system shows that the benefits are equal to, or greater than, voluntary treatment in the drug abuse treatment system.[115]

The National Treatment Alternative to Street Crimes (TASC) is the major model for treatment in the criminal justice system.[116] TASC employs creative dispositions such as deferred prosecution, community sentencing, diversion to the civil treatment system, pretrial intervention probation, and parole supervision under the influence of legal sanctions for probable and proven crimes. Already, TASC has proven that a demand reductions model works better, more humanely, and costs less than the model of punishment and retribution which has so dominated government thinking in the last decade and more.[117]

V. CONCLUSION

The National Drug Control Strategy's asserted objective to stop all drug abuse before the end of the century may be laudable. Its policies, however, create more harms than they prevent. By using law enforcement and retribution as a first resort, government policies cruelly sever drug dependent people from the health care system. Far from facilitating drug treatment through an influx of resources and creative policies for reimbursement, diversion from criminal justice, and accessible treatment, the government has created insuperable barriers between drug dependent persons and the services they require. Innumerable obstacles stand in the way of widespread treatment services in the drug abuse, health care, and criminal justice systems. The emphasis on reporting and punishing any drug use discourages individuals from seeking treatment. If the consequences of confiding in a health care provider or social worker include denial of governmental benefits, removal of parental rights, or even loss of liberty, drug dependent people will be

115. *See, e.g.*, TOPS STUDY, *supra* note 56, at 161 (finding substantial reduction in reoccurring crimes for inmates treated while in prison); DARP STUDY, *supra* note 80.

116. *See* Hubbard, Collins, Rachal & Cavanaugh, *The Criminal Justice Client in Drug Abuse Treatment*, in NIDA RES. MONOGRAPH 86 57, 57 (1988); Cook & Weinman, *Treatment Alternatives to Street Crime*, in NIDA RES. MONOGRAPH 86, *supra*, at 99, 101.

117. *See* NCJA TREATMENT OPTIONS, *supra* note 56, at 9.

less likely to trust the treatment system. If the only systematic case finding is through law enforcement rather than public health surveillance, and if the result of a positive urine test is to sanction rather than to treat, drug dependent people will continue to be alienated from the systems designed and funded to help them.

The objective of a drug-free America, then, may be a laudable goal, but it is insufficient, even counterproductive. Government and society must unambiguously identify whether the true goal of the state should be to deter and punish any drug use, or whether it should be to prevent the tragic morbidity and mortality associated with drug dependency. Once public policy makers enunciate a clear objective to promote the public health of one of America's poorest, most politically insulated, and sickest populations, the directions for funding, services, and policy choices will be guided by mounting social science research showing the efficacy and compassion of public health interventions.