

The Irrational Politics of American Drug Policy: Implications for Criminal Law and the Management of Drug-Involved Offenders

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I. INTRODUCTION

Most Americans experienced the media feeding frenzy during the closing weeks of 2002, which detailed Senator Trent Lott's veiled, but nevertheless resounding, endorsement of the politics of segregation.¹ His remarks demonstrated exactly how myopic, insensitive, obtuse, dull-witted, and self-serving some of our political leaders can be at times. And it seems to make little difference whether the issue happens to be civil rights, crime control, national defense, the environment, budgetary issues, or other domestic and international affairs. Anachronistic thinking combined with a partisan political style contrived more for "getting votes" than for establishing sound public policy seems to be far too commonplace. This situation appears especially to be the case with regard to American drug policy, and how it impacts law, justice, and the management of drug-involved offenders.

If we have learned anything about drug problems and policies over the years, three things stand out quite prominently. First, the drug problem in the United States is continuously shifting and changing. There are fads and fashions in the drugs of abuse; there are epidemics and pandemics of brews both familiar and strange; and from one decade to the next there is both the persistence, as well as the rediscovery and reformulation, of a variety of venerable and ignoble psychoactive compounds.² Second, drug policy, for the most part, has been

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¹ For readers who may stumble upon this Commentary a decade or more from now, a brief recap of the Trent Lott bungle appears warranted. Lott, the Republican Senator from Mississippi, provoked widespread criticism on December 5, 2002, for commenting that the United States would have been better off if then-segregationist candidate Strom Thurmond had won the presidency in 1948. Speaking at a 100th birthday party and retirement celebration for Senator Thurmond, Lott said, "I want to say this about my state: When Strom Thurmond ran for president, we voted for him. We're proud of it. And if the rest of the country had followed our lead, we wouldn't have had all these problems over all these years, either." Thurmond, then governor of South Carolina, was the presidential nominee of the breakaway Dixiecrat Party in 1948. He declared during his campaign against Democrat Harry S. Truman and Republican Thomas Dewey: "All the laws of Washington and all the bayonets of the Army cannot force the Negro into our homes, our schools, our churches." Thomas B. Edsall, *Lott Decried for Part of Salute to Thurmond*, WASH. POST, Dec. 7, 2002, at A6.

² Alcohol, for example, has been the all-time favorite intoxicant for millennia, and will likely remain so for generations yet to come; opium and other narcotics have been popular in America for well over two hundred years; and cocaine, Quaaludes, PCP, heroin, "crank" (methamphetamine), and LSD just seem to keep coming and going and re-inventing themselves. At the same time, new

approached as a “war,” with “get tough” approaches to users, dealers, and traffickers.³ Third, almost invariably, the least effective policies seem to receive the greatest attention, resources, and support.

Within the context of these concerns, this Commentary offers a brief overview of the history and present status of American drug policy, followed by a discussion of the contemporary policy debate, and the impact of policy on aspects of the criminal law and the treatment of criminal offenders. Importantly, findings from recent research targeting the treatment of drug-involved offenders suggest some future directions that policy makers might wish to consider.

II. AMERICAN DRUG POLICY IN RETROSPECT

The federal approach to drug abuse control has included a variety of avenues for reducing both the *supply of*, and the *demand for*, illicit drugs. The supply-and-demand reduction strategies were grounded in the classic deterrence model: through legislation and criminal penalties, individuals would be discouraged from using drugs; by setting an example of traffickers, the government would force potential dealers to seek out other economic pursuits.⁴ For most people who had a significant investment in the social system, the model seemed to work—at least for a time.

As the United States moved toward the middle of the twentieth century, a small collection of demand reduction components was added: treatment for the user; education and prevention for the would-be user; and research to determine how best to develop and implement plans for treatment, education, and prevention. By the early 1970s, however, when it appeared that existing drug control strategies had won few, if any, battles, new avenues for *supply* reduction were added. There were the federal interdiction initiatives: the Coast Guard, Customs, and Drug Enforcement Administration operatives were charged with intercepting drug shipments coming to the United States from foreign ports. In the international sector there were attempts to eradicate drug-yielding crops at their source. None of these strategies, however, seemed to have any substantial beneficial effects. Drugs managed to slip through the borders to the streets of urban America, and illicit drug use continued to spread.

substances enter and exit—such as crack, ecstasy, and OxyContin—with some visiting only briefly while others experiencing a more prolonged sojourn. One could say that there is always “something old and something new” in the American drug scene, and this seems to be especially the case in the more youthful and young adult drug cultures. *See generally* JAMES A. INCIARDI, *THE WAR ON DRUGS III: THE CONTINUING SAGA OF THE MYSTERIES AND MISERIES OF INTOXICATION, ADDICTION, CRIME, AND PUBLIC POLICY* (2002); *SUBSTANCE ABUSE: A COMPREHENSIVE TEXTBOOK* (Joyce H. Lowinson et al. eds., 2d ed. 1992).

³ EVA BERTRAM ET AL., *DRUG WAR POLITICS: THE PRICE OF DENIAL*, 3–8 (1996); *see also* FRANKLIN E. ZIMRING & GORDON HAWKINS, *THE SEARCH FOR RATIONAL DRUG CONTROL* (1992).

⁴ *See generally* DAVID F. MUSTO, M.D., *THE AMERICAN DISEASE: ORIGINS OF NARCOTIC CONTROL* (1973).

The problems were many. Legislation and enforcement alone were not enough, and early education “scare” programs quickly lost their credibility among youth. For researchers, clinicians, and others with even a basic understanding of the drug problem, treating drug abuse as a medical problem seemed to be the logical answer. The difficulties with this approach, however, were threefold. First, the medical model of treatment was structured around a belief in a stereotypical “addiction-prone personality”—a deep-rooted personality disorder used to characterize just about everyone with a drug problem. However, drug abusers are not all the same. The result was high program-failure rates, regardless of the method of treatment.⁵ Second, based on what is now known about the course of drug abuse treatment, most treatment regimens in the 1950s and 1960s were neither long enough nor intensive enough to have a significant and lasting impact. Third, there were not enough treatment beds available to meet the demand.

Given the perceived inadequacy of the traditional approaches to drug-abuse control, federal authorities in the late 1970s drew up plans for a more concerted assault, both legislative and technological, on drugs. From federal policymakers came dramatic increases in funding for a “war on drugs,” with much of the new monies earmarked almost exclusively for law enforcement and interdiction activities. Further, the new and evolving federal strategy made the entire war chest of United States military power available to law enforcement, for training, intelligence gathering, and detection. And there was more—asset forfeiture legislation, extradition treaties, and a host of expanded foreign assistance initiatives aimed at stopping the drugs at their source.⁶

From 1980 through the middle of that decade, the drug control budget more than doubled, from less than \$1 billion to well over \$2 billion. At the same time, however, the quantity of illegal drugs reaching the streets of urban and rural America and the number of drug users increased dramatically; drug prices were dropping, yet the purity and potency of the drugs were improving. Moreover, between 1981 and 1986, federal funding for drug treatment was cut by 40 percent. The results of the cuts included sharp reductions in the available number of treatment centers, overcrowding of available centers, and tens of thousands of drug

⁵ See RAYMOND GLASSCOTE, M.D., ET AL., *THE TREATMENT OF DRUG ABUSE: PROGRAMS, PROBLEMS, PROSPECTS* (1972); MARVIN R. BURT ET AL., *DRUG ABUSE: ITS NATURAL HISTORY AND THE EFFECTIVENESS OF CURRENT TREATMENTS* (1979); *ADDICTS AND AFTERCARE: COMMUNITY INTEGRATION OF THE FORMER DRUG USER* (Barty S. Brown ed., 1979).

⁶ See John Dombrink & James W. Meeker, *Beyond “Buy and Bust”: Nontraditional Sanctions in Federal Drug Law Enforcement*, 13 *CONTEMP. DRUG PROBLEMS* 711, 711–40 (1986); John Dombrink & James W. Meeker, *Racketeering Prosecution: The Use and Abuse of RICO*, 16 *RUTGERS L.J.* 633, 633–54 (1985); James Meeker & John Dombrink, *Criminal RICO and Organized Crime: An Analysis of Appellate Litigation*, 20 *CRIM. L. BULL.* 309, 309–20 (1984); U.S. GEN. ACCOUNTING. OFFICE, *PROFITABILITY OF CUSTOMS FORFEITURE PROGRAM CAN BE ENHANCED* 3 (1989).

abusers seeking help who were turned away. Then came the “drug crisis” of 1986 and the rediscovery of *crack-cocaine*.⁷

III. THE CRACK EPIDEMIC REVISITED

The national media discovered *crack-cocaine* in 1986.⁸ For *Newsweek*, crack became the biggest story since Vietnam and the fall of the Nixon presidency. Other media giants compared the spread of crack with the plagues of medieval Europe. By the end of 1986, the major daily and weekly news magazines had presented the nation with more than one thousand stories in which crack figured prominently.⁹ Not to be outdone, network television offered hundreds of reports on drug abuse, capped by CBS’s *48 Hours on Crack Street*, a prime-time presentation that was one of the highest rated documentaries in television history.¹⁰ Media stories emphasized certain supposed features of the crack-cocaine story: the high addiction rate of the drug caused users to commit crimes to support their habits; youths were drawn into the crack selling business; violence associated with attempts to control crack distribution networks turned some communities into urban “dead zones” where crime was totally out of control; crack engendered a “hypersexuality” among users, and the drug was contributing to the further spread of HIV and AIDS.¹¹

The media stories succeeded in two regards: first, they inflamed public concern, even though the media claimed simply to be reflecting it. As purveyors of horror stories about new flavor-of-the-month drugs, the media had become pushers in their own right.¹² Second, they incited lawmakers to react to the drug

⁷ JAMES A. INCIARDI, *THE WAR ON DRUGS II: THE CONTINUING EPIC OF HEROIN, COCAINE, CRACK, CRIME, AIDS, AND PUBLIC POLICY* (1992).

⁸ Crack is not a particularly new drug. Recent history and folklore suggest that it was originally known as “garbage freebase,” and that it first appeared in the San Francisco freebase culture of the early 1970s. The product of a short-cut method for transforming cocaine hydrochloride into the base state (and hence, without removing impurities), the drug was used for only a short period, and then set aside as an inferior commodity. See James A. Inciardi, *Beyond Cocaine: Basuco, Crack, and Other Coca Products*, 14 CONTEMP. DRUG PROBLEMS 461, 461–92 (1987).

⁹ INCIARDI, *supra* note 7.

¹⁰ See JIMMIE L. REEVES & RICHARD CAMPBELL, *CRACKED COVERAGE: TELEVISION NEWS, THE ANTI-COCAINE CRUSADE, AND THE REAGAN LEGACY* (1994).

¹¹ See MITCHELL S. RATNER, *CRACK PIPE AS PIMP: AN ETHNOGRAPHIC INVESTIGATION OF SEX-FOR-CRACK EXCHANGES* (1993); DALE D. CHITWOOD ET AL., *THE AMERICAN PIPE DREAM: CRACK COCAINE AND THE INNER CITY* (1996); TERRY M. WILLIAMS, *CRACKHOUSE: NOTES FROM THE END OF THE LINE* (1992).

¹² A similar situation occurred in 2001 and 2002 with OxyContin, a highly effective opioid painkiller. Since its introduction in 1996 by Purdue Pharma, it has been a boon to cancer patients and others with intractable pain. But the drug also has a high abuse potential when not used as prescribed. When incidences of overdoses and pharmacy robberies appeared, the national media, always eager for a sensation, created a new drug panic. The media frenzy was quite similar to that of crack. See, e.g., Paul Tough, *The Alchemy of OxyContin*, N.Y. TIMES MAG., July 29, 2001, at 32–37, 52, 62–63.

problem as “politicians.” For example, aware that the White House was planning a late summer initiative against drugs, Democrats in the House and Senate hastily drafted their own approach to the matter—an anti-drug bill that initially appeared modest, but which gathered rather expensive moss as it was rolled from one committee to the next. In addition, politicians on the election beat began vaulting over one another, hoping to reach the front-lines of the parade, in order to demonstrate their thorough and unconditional disapproval of cocaine, heroin, marijuana, and other illegal substances. It was politics at its best and politics at its worst.

The aftermath of political frenzy over the crack problem was a series of legislative initiatives at federal, state, and local levels that did more to exacerbate the drug problem than to alleviate it. There were mandatory sentencing laws that imposed fixed prison terms for users convicted of possession of even small amounts of cocaine; there were expansions of both domestic and international interdiction activities; there was the simplistic and unworkable “Just Say No” campaign, which proffered a non-interactive (and ineffective) “no use” message to students.

By 1992, the federal drug control budget had risen to almost \$12 billion, with only a small portion slated for prevention and treatment. For politicians, addressing the drug problem meant little more than “getting tough on drugs.” After all, it was easy to count the numbers of arrests and convictions for drug crimes, of users and dealers placed in prison cells, and of seizures of cocaine-laden vessels in the Caribbean, and this number counting made for good fodder for those on the election beat. Increasing the number of treatment beds appeared to be a “soft” approach, and as for prevention, that was not something you could count.

One of the more unfortunate trends of the era was the movement to prosecute pregnant addicts. In 1987, Dr. Ira J. Chasnoff of Northwestern University Medical School in Chicago estimated that 375,000 infants were drug-exposed each year, and that most of these had been exposed to cocaine, particularly crack.¹³ Research on the effects of perinatal substance abuse at the time characterized crack-exposed children as moody, often inconsolable, less socially interactive, and less able to bond than other children. Reports suggested that drug-exposed children were less attentive and less able to focus on specific tasks than non-exposed children. And there were numerous other harmful effects attributed to prenatal cocaine exposure. Many studies characterized these effects as irreversible and suggested that no amount of special attention or educational programs would turn these cocaine-exposed infants into well-functioning or adjusted children.

These dramatic findings sparked a wave of media reports lamenting the fate of a new generation of “crack babies.” Media stories documented the epidemic-like figures of cocaine-addicted infants being born in large, urban hospitals across the United States. More often than not, the media publicized case studies of children who had been profoundly affected by prenatal exposure to multiple drugs,

¹³ Ira J. Chasnoff, *Perinatal Effects of Cocaine*, CONTEMP. OB/GYN, May 1987, at 163–79.

not exclusively cocaine. However, headlines which read “The Crack Children,” “Crack Babies Born to Life of Suffering,” “A Desperate Crack Legacy,” and “Crack in the Cradle,” focused much of the public’s attention on the dangers of cocaine and created the image that “crack babies” were severely damaged human beings.

Accounts of behavioral disturbances among cocaine-exposed children led various state and county attorneys to prosecute mothers-to-be who “abused their fetuses” by taking illegal drugs. Charges included child abuse, child neglect, child endangerment, assault, and even manslaughter.¹⁴ Prosecutors just couldn’t help themselves—they needed to get tough and punish—and, as a result, many pregnant women testing positive for crack and other drugs ended up serving time in jail or prison. And, most unfortunately, because of this prosecutorial strategy, the great majority of drug-involved pregnant women avoided receiving essential prenatal care in an effort to avoid prosecution.

All of this would have been bad enough, but it turned out that the early research that the media and prosecutors relied on proved to be flawed. The National Institute on Drug Abuse reported that predictions of a “lost generation” of cocaine-exposed children had been overstated, and that many of the early research studies of prenatal cocaine exposure suffered from a variety of methodological flaws.¹⁵ The reality is that, for the many cocaine- and crack-exposed infants born in the United States each year, maternal crack use alone is not typically the prime factor in their infants’ difficulties. As it turns out, women who use crack during pregnancy are also much more likely than other women to use other illegal drugs, as well as to use alcohol and cigarettes. Furthermore, inadequate prenatal care has been correlated with substance use, particularly with the use of crack. Because of inadequate prenatal care, many pregnant addicts deliver prematurely, and the characteristics of premature infants mimic those attributed to crack-cocaine babies. Quite simply, the most significant single predictor of developmental problems for children may be the socioeconomic status of the family.

In the final analysis, the notion of the “crack baby” is a myth. So-called “cocaine babies” and “crack babies” are more likely suffering from their mothers’ multiple drug use (particularly alcohol), and/or are “poverty babies” suffering from a lack of medical care and poor nutrition.

¹⁴ See, e.g., *Alaska v. Grubbs*, No. 4FA S89 415 Criminal (Alaska Aug. 24, 1989); *People v. Stewart*, No. M 508197 (San Diego Mun. Ct., Feb. 23, 1987); *United States v. Vaughn*, No. F-2172-88B (D.C. Super. Ct. Aug. 23, 1988); *Florida v. Johnson*, No. 89-1765 (Fla. Cir. Ct., July 13, 1989); *Illinois v. Green*, No. 88-CM-8256 (Ill. Cir. Ct. filed May 8, 1989); *Whitner v. South Carolina*, 492 S.E.2d 777 (S.C. 1997); *Wyoming v. Pfannestiel*, No. 1-90-8CR (Laramie County Ct., Wyoming, Feb. 1, 1990).

¹⁵ NAT’L INST. ON DRUG ABUSE, *New NIDA Research Suggests Crack Baby Epidemic Overblown*, SUBSTANCE ABUSE LETTER, Oct. 17, 1994, at 3.

IV. FROM THE REAGAN AND BUSH YEARS TO THE CLINTON/GORE ADMINISTRATION

Ever since the law-and-order days of Barry Goldwater and the presidential election of 1964, crime control in American politics has been safe Republican territory. Republicans have been viewed as tougher on crime than Democrats, more willing to expand government powers to fight crime, even at the cost of individual rights. Then came President Bill Clinton, a Democrat. He supported the death penalty and presided over four executions in Arkansas during his twelve years as governor. During the first two years of his presidency, Clinton signed the Brady Handgun Violence Prevention Act as well as a major crime bill, which increased law enforcement initiatives, expanded the scope of the federal death penalty, and authorized mandatory life sentences for many three-time felony offenders.

On matters of drug policy, Clinton was relatively silent during the presidential campaign, focusing instead on pressing economic issues. Once he was president, however, Clinton's stated positions on drug matters departed from those of the Reagan and Bush administrations. It appeared that the Republican war on drugs, with its emphasis on supply reduction, would take a back seat. Clinton seemed to favor a "demand reduction" strategy that stressed education, prevention, and treatment, while maintaining basic law enforcement initiatives. The implementation of this new drug strategy, however, was slow, and many of the policies of previous administrations endured.

In 1993, Dr. Lee P. Brown, the previous head of the Atlanta, Houston, and New York City police departments, was appointed Director of the Office of National Drug Control Policy. Brown became Clinton's first "drug czar." After only two years, he announced his resignation, expressing frustration with the political climate in Washington in which he was frequently criticized for putting too much focus on education and treatment.¹⁶ Once again, partisan politics took center stage. Brown should be credited for advocating treatment for chronic drug abusers as the most humane and effective way to reduce overall demand for cocaine and heroin, but his success in moving the White House and Congress toward a more progressive position on drug control was limited.

Caving in to political pressure, President Clinton nominated General Barry McCaffrey on January 23, 1995 to replace Lee Brown. Clinton selected General McCaffrey because he was a decorated veteran of both the Vietnam War and the Gulf War. As the Commander-in-Chief of the United States Southern Command, McCaffrey had been heavily involved in United States drug war efforts in Latin America. Clinton's choice was an obvious political attempt to compete for votes in the coming election year by appearing to be as "tough on drugs" as the Republicans. With McCaffrey, the President hoped to remove all doubt that he

¹⁶ Pierre Thomas & Jim McGee, *Brown Ends Two-Year Tenure as Drug Policy Chief*, WASH. POST, Dec. 13, 1995, at A27.

was committed to the drug war. Unfortunately, McCaffrey's "drug war" experience was with interdiction, the least effective strategy. Supporters of drug prevention and treatment feared that McCaffrey's military background would lead to further militarization of the drug war domestically and internationally. In fact, McCaffrey turned out to be a bit of a blessing in disguise for some, as he emphasized the importance of treatment during his tenure as "czar."

During the remainder of the Clinton Presidency, the "war on drugs" emphasized supply reduction. By 1999, the drug control budget had expanded exponentially to approximately \$12 billion, and yet, as in years past, the funds earmarked for supply reduction were almost four times those for demand reduction. Largely as a consequence of this emphasis on drug enforcement on the nation's streets, approximately 6.3 million adults—some 3.1% of the nation's adult population—were under correctional supervision (prison, probation, or parole) at the end of the 1990s.¹⁷

On March 22, 2000, as the Clinton Administration neared its end, the White House released its new *National Drug Control Strategy*. It seemed to have something for everyone.¹⁸ The goals and objectives included education, prevention, partnerships with the media, drug abuse treatment, research, enforcement, foreign assistance initiatives, interdiction, protection of United States borders, development of medications, provision of health services for drug abusers, and much, much more. Not surprisingly, many professionals working on the front lines of the drug problem were dissatisfied, for good reason. Drug abuse was *not* under control, and it appeared that billions of taxpayer dollars were being allocated for approaches that did not work. Specifically, one of the major objections to the drug strategy focused on an initiative called *Plan Colombia*, a \$1.3 billion aid package to assist the Colombian government in its efforts to reduce heroin and cocaine production within its borders. Critics believed that these funds could have accomplished far more had they been channeled into demand reduction efforts of education, prevention, and treatment.

V. DRUG ABUSE EDUCATION AND PREVENTION

The National Institute on Drug Abuse has identified scores of science-based drug abuse education and prevention programs that have stood the test of long-term evaluation.¹⁹ Despite such scientific evidence, the largest portion of prevention dollars are allocated for less effective (although highly visible)

¹⁷ PRESS RELEASE, U.S. DEP'T. OF JUSTICE, PROBATION AND PAROLE IN 1999, PRESS RELEASE 1 (July 23, 2000), at <http://www.ojp.usdoj.gov/bjs/pub/pdf/pp99pr.pdf>.

¹⁸ OFFICE OF NAT'L DRUG CONTROL POLICY, NATIONAL DRUG CONTROL STRATEGY, 2000 ANNUAL REPORT (2000).

¹⁹ See, e.g., Richard L. Spoth et al., *Randomized Trial of Brief Family Interventions for General Populations: Adolescent Substance Use Outcomes 4 Years Following Baseline*, 69 J. CONSULTING & CLINICAL PSYCHOL. 627, 627-42 (2001); see also Nat'l Inst. on Drug Abuse Website, available at www.nida.nih.gov (last modified Oct. 16, 2003).

initiatives. Two prominent examples of failure are the hundreds of D.A.R.E. (Drug Abuse Resistance Education) programs that have been initiated, and youth anti-drug media campaigns.

D.A.R.E. was founded in Los Angeles in 1983. It was designed to give youths skills to avoid involvement in drugs, gangs, and violence. D.A.R.E. was the brainchild of Los Angeles Police Chief Darryl Gates, who wanted to get uniformed police officers into public schools armed with prevention programs intended to help students avoid drugs. Initially, there were two separate programs, one devoted to self-esteem and goal setting, and the other aimed at resisting the influences of cigarette and alcohol advertisements. The Los Angeles School District combined and rewrote the two programs, and implemented the plan in fifth-grade classrooms. The self-esteem and goal-setting portions of the program failed, however, and actually may even have motivated some children to try drugs.²⁰

Despite attempts to update the program, D.A.R.E. remains controversial.²¹ There are those who claim (despite the absence of supporting evidence) that D.A.R.E. prevents student drug use, while others report that D.A.R.E. has no effect on drug use. Despite criticisms and doubts about its effectiveness, D.A.R.E. programs continue around the country (with massive federal and corporate subsidies) and even internationally. D.A.R.E. continues because it is highly visible, and puts police and politicians in good light. And yet, as recently as January 2003, the United States General Accounting Office concluded that D.A.R.E. was ineffective in preventing the use of drugs among youth.²²

As for anti-drug media campaigns, no doubt everyone has seen the well-known “this is your brain on drugs” message on television. That was one of the earlier iterations of the media initiative. In 1998, the Office of National Drug Control Policy, along with the Partnership for a Drug-Free America and The Advertising Council, Inc., launched the National Youth Anti-Drug Media Campaign. The campaign utilizes a variety of media to reach young people, and those persons most influential in their lives. At the core of the youth-targeted message are the claims that most teens do not use or approve of drug use, that use of specific drugs has many negative consequences, that remaining drug-free has positive consequences, that there are skills young people can learn to enable themselves to stay drug-free, and that there are positive ways young people can use their time after school and on weekends.

²⁰ Jodi Upton, *DARE Wary of Outside Reviews: From the Outset, Founder Wasn't Interested in Researchers' Studies about Effectiveness*, DETROIT NEWS, Feb. 27, 2000, at A10.

²¹ Charlie Cain, *Is Drug Message Falling on Deaf Ears?*, DETROIT NEWS, Aug. 20, 1997, at A7; Daniel Sneider, *As Teens Use Climbs, Schools Seek New Answers: Anti-drug Educators Test Classroom Alternatives to DARE Program*, CHRISTIAN SCI. MONITOR, Mar. 24, 1997, at 3.

²² U.S. GEN. ACCOUNTING OFFICE, *YOUTH ILLICIT DRUG USE PREVENTION: DARE LONG TERM EVALUATIONS AND FEDERAL EFFORTS TO IDENTIFY EFFECTIVE PROGRAMS* (2003).

Many observers suspected that the media messages would have little impact on youths. In 2002, the Westat Corporation and the Annenberg School of Communication at the University of Pennsylvania completed their preliminary evaluation of the campaign.²³ The findings were damaging. In general, there was little evidence of direct favorable effects on youth. Moreover, for some youth cohorts, those with the highest exposure to the media ads appeared more likely to initiate marijuana use.

VI. TREATING DRUG-INVOLVED OFFENDERS IN CORRECTIONAL SETTINGS

Amidst the billions of dollars funneled into drug control, there have been some bright spots. One of these is RSAT—the Residential Substance Abuse Treatment Program. The RSAT initiative provides states with funding for substance abuse treatment in correctional settings. The rationale for RSAT is that, although there is a need to punish offenders, it is important they not return to prison. Hence, the RSAT initiative is an attempt to break the cycle of drug use and crime, and simultaneously make the inmate’s prison time more productive. The RSAT program is largely an outgrowth of a unique and successful correctional treatment system initiated in Delaware in the late 1980s.²⁴

The Delaware program is based on the notion that for drug-involved individuals who come in contact with the criminal justice system, “drug abuse” and “criminality” are mere symptoms of a complex behavioral disorder that cannot properly be addressed through short-term outpatient treatment, vocational rehabilitation, or imprisonment. The symptoms of this disorder might be referred to as crime-related “impedimenta” to social functioning,²⁵ including inadequacy,²⁶

²³ Robert Hornik et al., *Evaluation of the National youth Anti-Drug Media Campaign: Fourth Semi-Annual Report*, NAT’L INST. ON DRUG ABUSE, May 2002, at xi.

²⁴ OFFICE OF NAT’L DRUG CONTROL POLICY, *Drug Treatment in the Criminal Justice System*, ONDCP DRUG POLICY INFO. CLEARINGHOUSE FACT SHEET, Mar. 2001, at 4–5.

²⁵ DOUGLAS S. LIPTON, *THE THEORY OF REHABILITATION AS APPLIED TO ADDICT OFFENDERS* (1989).

²⁶ “Inadequacy” is characterized by a pervasive feeling of inability to cope with needs; a generalized feeling of helplessness; the inability to plan ahead; frequent feelings of despair, negativism, and cynicism; diffuse anxiety, not seen as related to a specific cause; the perception of tasks as likely to lead to failure rather than success; and, a disproportionate fear (and anticipation) of rejection. *Id.* at 13.

immaturity,²⁷ dependency,²⁸ limited social skills,²⁹ being ill-equipped in education,³⁰ vocational maladjustment,³¹ cognitive deficiency,³² compulsive pathology,³³ organic pathology,³⁴ anti-social attitudes,³⁵ catalytic impulsivity,³⁶

²⁷ "Immaturity" is characterized by the inability to postpone gratification; a general attitude of irresponsibility; a preoccupation with concrete and immediate objects, wishes, and needs; an orientation of the individual as "receiver" and a tendency to view others as "givers;" manipulative ness; selfishness; and, petulance. *Id.* at 13.

²⁸ "Dependency" is characterized by difficulty in coping with unstructured or complex environments; anxiety in situations requiring independent action; feelings of guilt with respect to the above elements of dependency; and, feelings of resentment toward what is believed to be the source of dependency. *Id.* at 13.

²⁹ "Limited in social skills" is characterized by a lack of ability to articulate feelings and ideas, and a resulting inability to communicate meaningfully with others except at superficial levels; lack of ability to function in subordinate-superordinate roles (e.g., inability to take orders from a superior in a work situation); inability to "take the role of the other," (i.e., empathize with others); and, inadvertent, socially disapproved behavior (e.g., use of language inappropriate to various social situations, dress inappropriate for job interviews, failure to conform to norms of personal hygiene). *Id.* at 14.

³⁰ "Ill-equipped in education" is characterized by functional illiteracy or a conspicuous disproportion between the individual's level of education and his or her potential level, or both. *Id.* at 14.

³¹ "Vocational maladjustment" is characterized by a lack of appropriate technical skills for employment that would be meaningful to the individual, or a conspicuous disproportion between the aptitudes of the individual and realistic opportunities, or both. *Id.* at 14.

³² "Cognitive deficiency" is characterized by a state of mental retardation, restricted mental potentiality, or incomplete development existing from birth or early infancy, as a result of which the individual is confused and bewildered by any complexity of life, overly suggestible and easily exploited, and able to achieve a mental age within a range of only 8 to 12 years. *Id.* at 14.

³³ "Compulsive pathology" is characterized by a sense that criminal behavior is forced upon the individual against his or her will; inability to obtain any lasting satisfaction from the act committed (e.g., no apparent gain to the individual from act nor any reason for injury to another); and, repetition of such acts. *Id.* at 14.

³⁴ "Organic pathology" involves such things as glandular and neurological anomalies (e.g., brain damage, organic brain disease). Conduct stemming from organic pathology is not usually typified by any single behavioral pattern. *Id.* at 14.

³⁵ "Anti-social attitudes" consist of a configuration of values and viewpoints which are defined by society as delinquent, criminal and anti-social. An individual who possesses anti-social attitudes demonstrates positive affective toward trouble, toughness, smartness, excitement, fate, autonomy, and short-run hedonism. *Id.* at 15.

³⁶ "Catalytic impulsivity" is a characteristic that requires the presence of a catalyst for it to appear (i.e., criminal acts only occur while the normally over-controlled person is affected by the catalyst). The catalyst may take the form of alcohol or an overwhelming need stemming from psychic or physical dependence (e.g., narcotics) or a specific emotional stimulus (e.g., cursing one's mother). The central concept of catalytic impulsivity is the impulsive, spontaneous, unplanned nature of the criminal act while the offender is under the influence of, or is affected by, the catalyst. Under normal circumstances the catalytic impulsive individual is not anti-social and possesses adequate and even excessive self-control. Under the influence of the catalyst, however, there is first a recognition of the imminence of the criminal act, then the criminal act almost invariably precipitates and there is total disregard for the consequences of such acts. *Id.* at 15.

habitual impulsivity,³⁷ and substance dependency, including alcoholism or drug addiction, or both.³⁸ These characteristics may appear singly, or in combinations of two, three, four or more, in any individual at any given time. Drug abuse treatment and psychiatric literatures have documented the presence of such “impedimenta” among substance abusers through literally hundreds of studies.³⁹

To reiterate, drug addiction is typically just one symptom of a complex set of problems that cannot be addressed simplistically. There is a wealth of literature that suggests that drug abuse is “over-determined” behavior. That is, physical dependence is secondary to the wide range of influences that instigate and regulate drug-taking and drug-seeking behaviors. Drug abuse is a disorder of the whole person, affecting some or all areas of functioning. With the vast majority of drug offenders there are cognitive problems, psychological dysfunction is common, thinking may be unrealistic or disorganized, values are misshapen, and frequently there are deficits in educational and employment skills. The research and clinical literature also document that the great majority of drug abusers were victims of physical abuse, sexual abuse, and/or neglect as children.⁴⁰ As such, drug abuse is a

³⁷ “Habitual impulsivity” differs from catalytic impulsivity by the absence of the need for a catalyst as a trigger. An habitually impulsive individual may use alcohol or drugs, but the crucial aspect is that these substances are neither necessary nor sufficient for the criminal act to occur. The act itself is always spontaneous and unplanned, and the individual who possesses this characteristic is temperamental, exhibits a low frustration tolerance and high reactivity. His or her volatile temperament typically demonstrates rapid mood swings. The triggering source for impulsive criminal acts cannot be definitively indicated. Such a characteristic may be seen in individuals who react variously to situations of temptation, slight provocation, and frustration. Rages may be a typical reaction for one offender, while another may react by random shoplifting or driving dangerously. *Id.* at 15.

³⁸ Offenders with “substance dependency” typically (1) have several years experience as a street drug addict or alcoholic, (2) have many failed treatment experiences, (3) are driven to use their chosen substance regardless of consequences while on the street, (4) are preoccupied with thoughts about their substance of choice while institutionalized, and (5) intend using the preferred substance upon discharge. *Id.* at 15.

³⁹ See, e.g., TREATING DRUG PROBLEMS (Dean R. Gerstein & Henrick J. Harwood eds., 1990); George De Leon, *Psychopathology and Substance Abuse: What is Being Learned from Research in Therapeutic Communities*, 21 J. PSYCHOACTIVE DRUGS 177, 177–88 (1989); H. Westley Clark & Joan Ellen Zweben, *Legal Vulnerabilities in the Treatment of Chemically Dependent Dual Diagnosis Patients*, 21 J. PSYCHOACTIVE DRUGS 251, 251–58 (1989); J. Calvin Chatlos, *Adolescent Dual Diagnosis: A 12-Step Transformational Model*, 21 J. PSYCHOACTIVE DRUGS 189, 189–202 (1989); Sheila B. Blume, *Dual Diagnosis: Psychoactive Substance Dependence and the Personality Disorders*, 21 J. PSYCHOACTIVE DRUGS 135, 135–38 (1989); JOHN C. BALL & ALAN ROSS, THE EFFECTIVENESS OF METHADONE MAINTENANCE TREATMENT (1991).

⁴⁰ See Patricia A. Harrison et al., *Multiple Substance Use Among Adolescent Physical and Sexual Abuse Victims*, 21 CHILD ABUSE & NEGLECT 529, 529–39 (1997); Timothy Ireland & Cathy S. Widom, *Childhood Victimization and Risk for Alcohol and Drug Arrests*, 29 INT’L J. ADDICTIONS 235, 235–74 (1994); Laura Whitmire Johnsen & Lisa L. Harlow, *Childhood Sexual Abuse Linked with Adult Substance Use, Victimization, and AIDS-Risk*, 8 AIDS EDUC. & PREVENTION 44, 44–57 (1996); Martha A. Medrano et al., *Histories of Childhood Trauma and the Effects on Risky HIV Behaviors in a Sample of Women Drug Users*, 25 AM. J. DRUG & ALCOHOL ABUSE 593, 593–606

response to a series of social and psychological disturbances. Therefore, the goal of treatment should be “habilitation” rather than “rehabilitation.” Whereas rehabilitation emphasizes the return to a way of life previously known and perhaps forgotten or rejected, habilitation involves the client's initial socialization into a productive and responsible way of life. What the large drug offender population needs is habilitation in long-term residential treatment.

Numerous drug abuse clinicians and researchers believe that the “therapeutic community,” commonly referred to as the “TC,” is perhaps the most viable form of treatment for drug-involved offenders, particularly for those whose criminality has resulted in incarceration.⁴¹ Drug-involved offenders who come to the attention of state and federal prison systems typically have long arrest histories and patterns of chronic substance abuse, and the intensive nature of the TC regimen tends to be best suited to their long-term treatment needs.⁴² This approach is especially efficacious in a correctional institution because the TC is a total treatment environment isolated from the rest of the prison population—separated from the drugs, violence, and other aspects of prison life that militate against rehabilitation. Typically, the primary clinical staff members in such programs are former substance abusers who themselves underwent treatment in therapeutic communities. The treatment perspective in the TC is that drug abuse is a disorder of the whole person; that the problem is the *person* and not the drug; that addiction is a *symptom* and not the essence of the disorder; and that the primary goal is to change the negative patterns of behavior, thinking, and feeling that predispose drug use.

Based on a wide body of literature in the fields of treatment and corrections, as well as clinical and research experiences with correctional systems and populations, it appears that the most effective strategy involves three stages of TC treatment intervention. Each stage in this continuum is an adaptation to the client's changing correctional status: incarceration, work release, and parole (or other forms of community supervision).⁴³

The primary stage of treatment should consist of a prison-based therapeutic community. Segregated from the negativity of the prison culture, recovery from

(1999); Martha A. Medrano et al., *Prevalence of Childhood Trauma in a Community Sample of Substance-Abusing Women*, 25 AM. J. DRUG & ALCOHOL ABUSE 449, 449–62 (1999).

⁴¹ COMPULSORY TREATMENT OF DRUG ABUSE: RESEARCH AND CLINICAL PRACTICE: NIDA RESEARCH MONOGRAPH NO. 86 (Carl G. Leukefeld & Frank M. Tims eds., 1988); THERAPEUTIC COMMUNITY: ADVANCES IN RESEARCH AND APPLICATION: NIDA RESEARCH MONOGRAPH NO. 144 (Frank M. Tims et al. eds., 1994) [hereinafter THERAPEUTIC COMMUNITY]; DRUG ABUSE TREATMENT IN PRISON AND JAILS: NIDA RESEARCH MONOGRAPH NO. 118 (Carl G. Leukefeld & Frank M. Tims eds., 1992) [hereinafter DRUG ABUSE TREATMENT].

⁴² GEORGE DE LEON, *THE THERAPEUTIC COMMUNITY: THEORY, MODEL, AND METHOD* (2000).

⁴³ Steven S. Martin et al., *Assessment of a Multistage Therapeutic Community for Drug Involved Offenders*, 27 J. PSYCHOACTIVE DRUGS 109, 109–16 (1995); James A. Inciardi et al., *Therapeutic Communities in Prison and Work Release: Some Clinical and Policy Implications*, in THERAPEUTIC COMMUNITY, *supra* note 41, at 259–67.

drug abuse and the development of pro-social values in the prison TC involves essentially the same mechanisms seen in community-based TCs. Therapy in this stage is an ongoing and evolving process lasting a year or slightly longer, if needed. It is important that TC treatment for inmates begin *while they are still in the institution*. In a prison situation, time is one of the few resources that most inmates have in abundance. The competing demands of family, work, and the neighborhood peer groups are absent. Thus, there is the time and opportunity for focused and comprehensive treatment, perhaps for the first time in a drug offender's career. In addition, there are other new opportunities presented: to interact with "recovering addict" role models, to acquire pro-social values and a positive work ethic, and to initiate a process of understanding the addiction cycle.

The secondary stage of treatment should be a "transitional" therapeutic community in a work release setting. Since the 1970s, work release has become a widespread correctional practice for felony offenders. It is a form of partial incarceration whereby inmates approaching their release dates are permitted to work for pay in the free community, but must spend their non-working hours either in the institution or, more commonly, in a community-based work release facility. Although graduated release of this sort carries the potential for easing an inmate's process of community reintegration, there is a negative side as well, especially for those whose drug involvement served as the initial gateway to prison. Inmates are exposed to groups and behaviors that can easily lead them back to substance abuse, criminal activities, and reincarceration. Because work release populations mirror the institutional populations from which they come, there remain the negative values of the prison culture; in addition, street drugs and street norms abound. As such, the transitional work release TC should be similar to that of the traditional therapeutic community, with the removal of as many of the external negative influences of the street and inmate cultures as possible. However, the clinical regimen in the work release TC must be modified to address the correctional mandate of "work release." That is, in addition to intensive therapeutic community treatment, clients must prepare for, and obtain, employment in the free community.

In the tertiary stage (aftercare), clients who have completed work release live in the community under supervision of parole or some other supervisory program. For those individuals who entered work release after serving mandatory fixed sentences, there is no parole requirement, and hence, no community supervision. Treatment intervention in this stage involves outpatient counseling and group therapy. Clients are encouraged to return to the work release TC for refresher/reinforcement sessions, to attend weekly groups, to call on their counselors on a regular basis, and to spend one day each month at the facility.

This multi-stage model has been operating in the Delaware correctional system since the mid-1990s, and a comprehensive research program has been established to examine the effectiveness of various components of, and combinations of, the model. The findings of the research have vividly demonstrated that drug-involved offenders who receive prison-based treatment, followed by transitional treatment in a work release therapeutic community, which

is then followed by aftercare, will have significantly lower rates of relapse and recidivism, in both the short and long term, than those receiving little or no treatment.⁴⁴

VII. POSTSCRIPT

Findings from the Delaware experiment demonstrate that treatment of drug-involved offenders can work, and work well. Studies of similar programs in other parts of the United States reflect similar levels of effectiveness.⁴⁵ Overall, drug-involved offenders who receive a full complement of treatment and aftercare in a correctional setting are three times more likely to remain drug-free and arrest-free than those who receive no treatment at all. With this comes reduced crime, safer communities, and reduced costs for police activity, court processing, and incarceration. In addition, drug-free prison releasees who work in legitimate jobs contribute to the national economy as taxpayers, and their dependents no longer need public assistance. Unfortunately, many political observers feel that if treatment fails to have positive outcomes one hundred percent of the time, it is ineffective. But anyone who has been on a diet, or tried to stop drinking or smoking, understands that relapse is commonplace for many people, and that recovery is typically a long and difficult process.

The federal government has embraced the idea of corrections-based treatment, as well as the processing of many offenders through drug courts and other justice-related treatment programs.⁴⁶ But the calamity is that treatment is only as good as the programs to which clients are sent. Cuts in treatment budgets over the years, misplaced emphasis on enforcement and interdiction initiatives, and support for Plan Columbia and other imprudent, unsound, and torpid uses of drug control

⁴⁴ James A. Inciardi et al., *An Effective Model of Prison-Based Treatment for Drug-Involved Offenders*, 27 J. DRUG ISSUES 261, 261–78 (1997); Steven S. Martin et al., *Three-Year Outcomes of Therapeutic Community Treatment for Drug-Involved Offenders in Delaware: From Prison to Work Release to Aftercare*, 79 PRISON J. 294, 294–320 (1999).

⁴⁵ See GARY FIELD, *Oregon Prison Drug Treatment Programs*, in DRUG ABUSE TREATMENT, *supra* note 41, at 142–55; Michael W. Forcier, *Substance Abuse, Crime and Prison-Based Treatment: Problems and Prospects*, 2 SOC. PRAC. REV. 123, 123–31 (1991); Christopher J. Mumola, *SUBSTANCE ABUSE AND TREATMENT, STATE AND FEDERAL PRISONERS* (1999); Michael L. Prendergast et al., *Corrections-Based Substance Abuse Programs: Good for Inmates, Good for Prisons*, 2 OFFENDER SUBSTANCE ABUSE REPORT 81, 81–96 (2002); Harry K. Wexler et al., *Three Year Reincarceration Outcomes for Amity In-Prison Therapeutic Community and Aftercare in California*, 79 PRISON J. 321, 321–36 (1999); Kevin Knight et al., *Three-Year Reincarceration Outcomes for In-Prison Therapeutic Community Treatment in Texas*, 79 PRISON J. 337, 337–51 (1999).

⁴⁶ See Daniel P. Mears et al., *Drug Treatment in the Criminal Justice System: The Current State of Knowledge*, 2002 Urb. Inst. Just. Pol. Center; Daniel P. Mears et al., *Improving the Link Between Research and Drug Treatment in Correctional Settings - Summary Report*, 2003 Urb. Inst. Just. Pol. Center; Daniel P. Mears & Gretchen E. Moore, *Voices from the Field: Practitioners Identify Key Issues in Corrections-Based Drug Treatment*, 2002 Urb. Inst. Just. Pol. Center; Daniel P. Mears & Gretchen E. Moore, *A Meeting of the Minds: Researchers and Practitioners Discuss Key Issues in Corrections-Based Drug Treatment*, 2002 Urb. Inst. Just. Pol. Center.

funds, have left the infrastructure of the nation's residential treatment system in a state of disarray. There appear to be fewer programs each year, and rates of staff burnout and turnover are high. No doubt this is affecting the quality of treatment.

In the final analysis, what legislators and other politicians need to better understand is that we cannot legislate our way out of the drug problem by passing mandatory sentencing and asset forfeiture laws. We cannot police our way out of the drug problem by expanding narcotic enforcement activities. And we cannot build our way out of the drug problem by constructing more penitentiaries and prison cells. The alternative is science-based treatment and prevention activities intended to reduce the demand for drugs. After all, if there were no drug users, there would be no drug problem.