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Table of Contents

Introduction	1
The Role of States and Their Governors	2
Reducing Demand: Treatment	6
Reducing Demand: Prevention	10
Funding	14
Mandatory Minimum Sentencing and	
the States'Drug Incarceration Boom	17
Peter D. Hart Research Associates Poll	
Conducted for Drug Strategies	25
Sources	27
Governors Leadership Council	20

"I have to address drug policy issues because 171 don't, the budget will be eaten up by incarceration costs, and I won't be able to fund my other priorities such as schools and health care."

 Republican Governor of Idaho Dirk Kempthorne at the Western Governors' Association Drug Policy Academy in Tempe, Arizona, December 2000

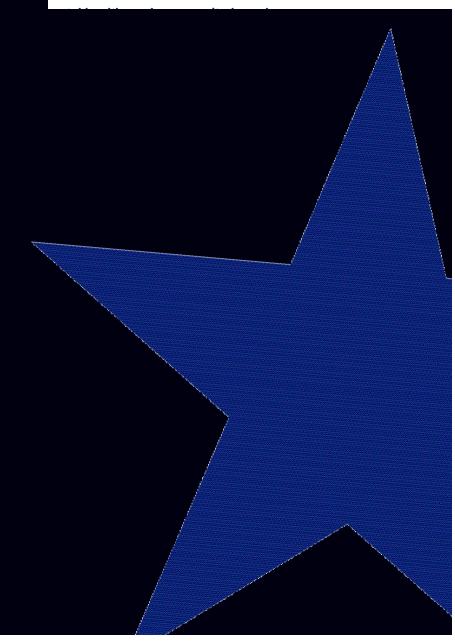
overnor Kempthorne's (R-ID) dilemma is not unique. It is shared by virtually every other state governor and many officials at the local level in the United States, where substance abuse problems cost the nation more than \$275 billion annually. As the economy softened in early 2001, state revenues have declined broadening the ramifications of budgetary choices; 18 states have already reported lower than expected revenues for the 2001 fiscal year.

Although much of the public debate over drug policy involves national strategy, many of the critical choices are made at the state and local level. It is here that budget decisions are made for criminal justice,

In addition, there is a growing trend at the F implementation of social programs to states contributions to the creation and development

Recognizing the vital role that state and lo choices, Drug Strategies, supported by a graph Foundation, has convened a Governors Leaformer governors from both parties. Member issues at the state and local level that shape accompany them. Their observations are inchelp guide state governments in making difficult policy decisions that deal with substance abuse and its attendant problems and costs

Drug Strategies has dealt extensively with at the state and local level, producing in-depolicies and programs addressing substant states (Arizona, California, rural Indiana, Kar Ohio and South Carolina) and four cities (Barbara and Washington, D.C.). In addition, Office commissioned Drug Strategies to cre Action Plan, a guide for improving prevention for youth. These widely publicized reports help by decision makers and have stimulated great for effective strategies.



nder our Federal system of government, individual states have significant latitude to set their own policies on any number of issues, including drug policy. The popularity of devolving Federal responsibilities to the states (as in the case of welfare reform in 1996) promises to expand state governments' flexibility in implementing policy.

"The framers of the Constitution did not believe in an all-knowing, all-powerful federal government. They believed that our freedom is best preserved when power is dispersed. So let me make this pledge to you all: I'm going to make respect for federalism a priority in this administration."

 President Bush speaking to governors at the National Governors' Association Winter Meeting in February 2001

Much of national domestic policy is already in the hands of the states and their local governments. Excluding spending on defense, Social Security, Medicare, and interest on the Federal debt, 80 percent of all government expenditures nationwide are administered by state and local governments. Despite the tendency to focus on the Federal role in drug policy, state and local governments account for the bulk of domestic drug control spending. Excluding interdiction and source-country programs, state and local expenditures of their own revenues comprise an estimated two-thirds of total U.S. drug control spending.

States can offer more fertile ground for drug policy reform than the national political arena, since they are smaller and less politically and socially complex. Different mechanisms for policy reform such as ballot initiatives are available, and the task of political mobilization is less costly and less complicated. Grassroots movements are more readily facilitated in states, and the impetus for reform is often stronger at the state level, where the consequences of policy choices are more immediately evident.

Individual states and localities may also require different policy responses to meet distinct local needs. Varying degrees of wealth; the different needs among urban, suburban and rural communities; and ethnic and cultural differences all affect state and local decision making. Additionally, drug use trends

tend to be local, with a given drug's popularity varying substantially across the country. For example, heroin is the drug of choice for 15 percent of those who seek treatment nationwide; however, this varies considerably among states. In 1998, 34 percent of California's treatment admissions were for heroin compared to 2 percent in Minnesota and 1 percent in Arkansas.

The Federal government has recently reduced its role in a number of domestic programs, giving governors a more active policy role. In the case of welfare reform, for example, the Federal government sets the major goals for the program burrleaves, it up to states to create programs that move people off the welfare rolls.

Policy Reform at the State and Local Level

State and local initiatives can have a profound effect on national policy. Welfare reform, for example, had its roots in the late 1980s in Wisconsin, when then Governor Temmy Thompson (R) launched the development of the Wisconsin Works program, which ultimately resulted in the sweeping welfare reform legislation passed by Concress in 1996.

States, cities, counties and towns also serve as the incubators for innovative drug policies and programs. Drug courts, which provide alternatives to incarceration for low-level drug offenders began at the local level. The success of the first one, launched in Miami in 1989, and others like it, led to the creation of the Drug Courts Program Office within the U.S. Department of Justice. As of October 2000, 585 drug courts have been established nationwice and the number continues to grow. In addition to reducing recidivism among program graduates, drug courts can result in significant cost savings. The drug court in Portland, Oregon, for example, reported criminal justice savings of \$2.5 million over a two-year period for the 440 participants in the program.

The recent spread of methamphetamine use has prompted increased Federal and state funding for prevention, treatment and law enforcement.

Programs designed at the local level to treat and prevent methamphetamine use are now being tested for effectiveness by Federal agencies looking to replicate such programs in other communities.

The rise of the crack cocaine epidemic in the 1980s prompted many states to adopt stiffer penalties for drug offenses, including mandatory minimum prison sentences. These measures, also enacted at the Federal level, have put more people behind bars and have kept them there longer, contributing to the nation's skyrocketing incarceration rate. According to the Bureau of Justice Statistics (BJS), the number of state prisoners serving time for drug offenses soared from 19,000 in 1980 to nearly 237,000 in 1998, a 12-fold increase. In Federal prisons during this period, the number climbed from 4,750 to 63,000.

"Nearly three decades ago, New York enacted some of the toughest drug laws in the nation."

Today, we can conclude that — however well intentioned — key aspects of those laws are out of step with both the times and the complexities of drug addiction. ... I'm hopeful that we can come together in a bipartisan way to enact meaningful reform this year."

 Republican Governor of New York George E. Pataki during his State of the State Address, January 2001

While harsher punishment for drug offenders has swollen state and Federal prison populations to unprecedented levels, illegal drugs nevertheless remain as available as ever. In 1999, high school seniors perceived crack cocaine to be just as available as seniors perceived it to be in 1987 (in both years, 41 percent of seniors considered crack to be "fairly easy" or "very easy" to get). Over the same period, the proportion of high school seniors who see heroin as "fairly easy" or "very easy" to get has risen from 24 percent to 32 percent. In addition, cocaine's average U.S. retail price fell by 55 percent from 1981 to 1998, while the street price of heroin dropped by 42 percent.

Raising the Issue

Use of the governor's bully pulpit can bring specific issues to prominence. Although drug policy is linked to traditional issues, such as crime, education, health and welfare, it is rarely at the forefront of a state administration's agenda. However, Governor Gary E. Johnson (R) of New Mexico, made reforming the state's drug policies the central goal of his administration.

In early 2001, Governor Johnson, based on recommendations from an advisory panel, submitted eight drug policy bills to the state legislature. They addressed the medicinal use of marijuana; stricter rules for asset forfeiture; protecting physicians from prosecution for selling clean syringes to drug users; eliminating civil and criminal liability for an individual who administers an antidote for heroin overdoses under certain conditions; nearly doubling funds for treatment, prevention and education programs; providing treatment rather than incarceration for first- and second-time offenders involved with small amounts of drugs; decriminalizing possession of one ounce of marijuana; and allowing judges to deviate from sentencing guidelines. However, in March 2001, only three of the less controversial bills (antidote for heroin overdose; clean syringes for drug users; and increased funds for treatment, prevention and education) passed the state legislature.

In 2001, Idaho Governor Dirk Kempthorne proposed creating new general revenue funds to expand treatment and rehabilitation services in the state. The state legislature passed the initiative, which includes \$3.2 million for substance abuse education and treatment programs for criminal offenders in prisons and on probation and parole, \$2.2 million for community-based substance abuse treatment offered through the Department of Health and Welfare, and \$576,000 for drug court treatment services.

Reducing demand for drugs has become a priority issue in the Washington state legislature; four bills have been introduced to lower the penalties for drug crimes and to place more emphasis on treatment and prevention programs. Apanel in New York convened to study drugs and the courts has recommended that all nonviolent offenders with substance abuse problems be offered treatment instead of prison.

In June 2000, the Western Governors' Association (WGA) made reducing the demand for drugs one of its ptiority issues through adoption of WGA resolution "Drug Policy in the West." The WGA hosted two Drug Policy Academies to assist member states in developing plans to reduce alcohol and other drug abuse, and held a national drug policy conference in June 2001 in Idaho, hosted by Governor Kempthorne.

"The more local you can make services, the more effective they are going to be. What works in Maine may not work in New Mexico; it is more effective to have policy on domestic issues dealt with on the state and even local level. With drug policy — the more local the better."

 Former Republican Governor of Illinois and GLC member Jim Edgar

Voting for Reform

The state ballot box has become a popular mechanism for reforming drug policy. In 1996, voters in Arizona approved changes in dealing with low-level drug offenders. Proposition 200 initiated a system to provide treatment for all nonviolent drug offenders rather than incarcerating them. Prop 200 also created the Drug Treatment and Education Fund (which receives a portion of the state's alcohol tax revenue) to help fund the new treatment initiative. Cost savings from this new approach were over \$2.5 million in Fiscal Year 1998, according to a recent study. Additionally, more than three quarters of the 2,622 people on probation and diverted into treatment tested free of drugs at the time of the study.

In 2000, California became the second state in which voters approved government-funded treatment, rather than imprisonment, for low-level drug offenders. Proposition 36 was approved by a wide margin (61 percent to 39 percent). The initiative proposed spending \$120 million a year to treat, instead of incarcerate, those arrested for drug possession and ex-convicts who violate parole by using illegal drugs.

Critics of the new California law point to the potential over-burdening of the state's public treatment system due to a lack of adequate funding.

Officials with the state's 110 drug court programs opposed the initiative, citing the lack of sanctions for offenders as removing the coercive power of the courts to keep people in treatment. According to the president of the California Association of Drug Court Professionals, "Drug courts hold drug abusers accountable with regular drug testing and consequences for failing treatment — accountability not found in Proposition 36."

Other state ballot measures aimed at reforming drug laws include:

- Arizona 1996, Proposition 200 approved the use of Schedule I drugs for medical purposes if prescribed by two physicians.
- California 1996, Proposition 215 legalized the use of marijuana for medical purposes.
- Colorado 2000, Amendment 20 approved medical use of marijuana, permitting possession (of up to two ounces) and cultivation (of up to six plants) for medical use.
- Nevada 2000, Question 9 allowed patients to use marijuana upon the recommendation of a physician and directed the legislature to create a legal supply for medical marijuana and to create a state-run, confidential registry of patients immune from marijuana possession and cultivation laws.
- Oregon 2000, Measure 3 barred confiscation of property without conviction of a crime and set priorities for distribution of proceeds from the sale of forfeited property to drug treatment programs.
- Utah 2000, Initiative B barred forfeiture of property involved in drug arrests and other crimes of which owners were unaware or did not consent.

Similar measures defeated in 2000 include:

- Alaska Measure 5 proposed legalizing possession, cultivation, distribution and sale in liquor stores of marijuana and hemp to people over 18.
- Massachusetts Petition P proposed allowing first- or second-time nonviolent offenders to request placement in drug treatment or education, rather than prison; and proposed using fines in drug cases and proceeds from forfeiture of assets used in the commission of drug violations to fund drug treatment programs.

State initiatives allowing physicians to prescribe marijuana for medical purposes will be affected by a U.S. Supreme Court decision in May 2001, which ruled that a Federal law classifying marijuana as illegal has no exception for ill patients. The decision enables the Federal government to prosecute distributors of marijuana for medical purposes, regardless of whether states have approved medical marijuana use.

Public Opinion and Drug Policy

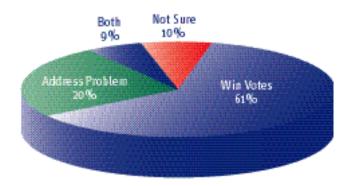
A growing majority of Americans believe that Federal drug control strategy should place greater emphasis on treatment and prevention, and less emphasis on criminal justice, according to a 2000 poll conducted by Peter D. Hart Research Associates for Drug Strategies. Three in five adults said that drug abuse is "more of a public health problem better handled by prevention and treatment programs" than by the criminal justice system. Slightly more than half of adults agreed with that statement just three years ago. While Americans' opinions about how to spend drug control funds are shifting toward treatment and prevention approaches, the Federal government continues to spend considerably more of the \$18 billion drug control budget on supply reduction (67 percent) than on demand reduction (33 percent). The imbalance is even more apparent at the state and local levels, where an estimated 80 percent of spending is

"It is critically important to have a balanced approach. Politically, what has been most popular has been tough penalties and that is where a lot of Federal dollars have gone, but I have always believed that a balanced approach is needed. It is important to start early with prevention and to have effective treatment programs."

 Former Republican Governor of Iowa and GLC member Terry Branstad

Americans are skeptical of politicians who do not propose a balanced approach to the drug problem. According to the Hart Research survey, three in five Americans (61 percent) think that presidential candidates who propose a primarily law enforcement approach to the drug problem — including prison sentences for all individuals convicted of drug possession — are more concerned with winning votes, while only one in five (20 percent) think they are genuinely addressing the drug problem. Nearly twice as many people (38 percent) think that politicians proposing a primarily treatment approach are trying to address the problem. Still, 43 percent of Americans think these candidates are more concerned with winning votes.

Majority of Americans Think Candidates Promoting Get Tough Approaches to Drug Problem Trying to Win Votes



Source: Peter D. Hart Research Associates, 2000

These findings are consistent with a 1995 survey conducted for the American Correctional Association, in which three out of four respondents either strongly agreed (32 percent) or agreed (43 percent) that a balanced approach of prevention, punishment and treatment is better at controlling and reducing crime than imprisonment alone.

esearch has shown that treatment is the most cost-effective way to reduce addiction, the growing burden of drug-related crime and health care costs. Treatment enables addicts to quit drugs, get jobs and become productive members of society. Without treatment, an addict can cost society over \$40,000 annually in criminal justice, health care and other expenses, compared with an average cost of \$16,000 for a year of residential treatment or \$1,500 a year for outpatient treatment.

"Not to see the very critical importance of treatment and prevention is completely to misunderstand what government's role is. It's absolutely imperative that there be adequate funding for treatment."

Former Democratic Governor of North Dakota and GLC member George Sinner

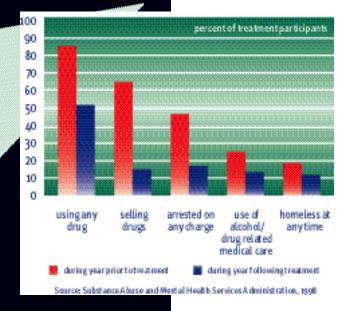
A 1994 California study (CALDATA) found that \$1 invested in alcohol and other drug treatment saved taxpayers \$7 in future costs, most of which were crime related. The Federal government's 1997 National Treatment Improvement Evaluation Study assessed the effectiveness of treatment services for 5,000 clients in publicly-funded programs. Treating these low-income clients saved society an average of \$9,000 per client, compared to \$3,000 spent on treatment — a 3 to 1 ratio of benefits to costs.

Studies of successful drug treatment programs have identified certain elements that enhance effectiveness. Length of time in treatment, intensity of treatment and aftercare are key factors in helping addicts stay clean. Data show that longer, more intensive treatment programs produce better results. According to extensive national studies of tens of thousands of addicts, one-third of those who stay in treatment longer than three months are still drug-free one year later. The recovery rate jumps to two-thirds when treatment lasts a year or longer.

Accountability

As accountability becomes a high priority at all levels of government, so too has program evaluation. Governors and legislators are looking for evidence of success before expanding the budgets of agencies providing social services. In Ohio, for example, the Department of Alcohol and Drug Addiction Services has made accountability its primary focus. From

Addiction Treatment Improves Health, Reduces Threats to Society



Fiscal 1996 to 2001, the General Assembly increased state funds for the Department by 84 percent, based on evaluations that demonstrated that programs were cost effective.

Washington state invests significant resources to evaluate addiction treatment, and research findings reveal numerous benefits derived from the state's treatment system. For example, a five-year study of clients receiving publicly-funded treatment found that the average Medicaid costs of a treated client were \$4,540 less than those of an untreated client. Over the five year period, the state saved over \$1.5 million in Medicaid costs for the 342 treatment participants involved in the study.

Based on these and other findings of effectiveness, in 1999, the Washington state Medicaid agency shifted funds to the Division of Alcohol and Substance Abuse (DASA) to study cost savings derived from increasing treatment services for individuals receiving Supplemental Security Income (SSI). Preliminary findings reveal that after treatment, average medical costs were \$980 per month higher for untreated SSI recipients who were abusing alcohol or other drugs, compared to treated recipients; factoring in the cost of treatment, average medical costs for the untreated were \$774 per month higher. The estimated annual savings in avoided medical costs for the additional clients served were \$4.5 million. These findings encouraged the Medicaid agency to shift even more money to DASA in 2001.

Welfare Reform and Substance Abuse Treatment

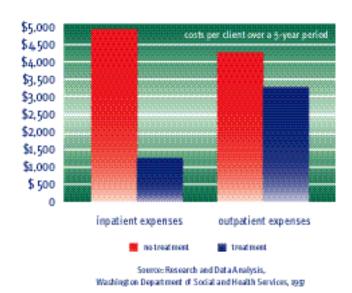
The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 — welfare reform — replaced a Federal entitlement program with state-administered block grants, furthering a trend toward the devolution of design and control of social welfare programs from the Federal government to the states. The law imposed several new guidelines on states, including stringent work requirements and a five-year lifetime limit on benefits, but gave states the freedom to design their own programs. One of the major challenges to states is transitioning, from welfare to work, individuals who have significant obstacles to self sufficiency, including substance abuse.

Several studies of adult welfare recipients have found that between 15 and 20 percent of welfare recipients have substance abuse problems. A 1996 study of recipients in Oregon found that half admitted to having alcohol or drug problems. Without treatment, thousands of people trying to make the transition from welfare to work will face serious difficulties meeting job training and employment requirements created under the Temporary Assistance to Needy Families (TANF) system. Additionally, the law denies welfare benefits to anyone convicted of a drug felony, and authorizes states to drug-test welfare recipients.

However, states have wide discretion to override sections of the Federal law by establishing their own regulations for Medicaid eligibility, drug testing, and the provision of health benefits and food stamps to drug felons. Oregon, for example, neither bans convicted drug felons from receiving welfare benefits nor requires universal drug tests of recipients. Additionally, the state considers people in treatment as meeting the work participation requirement of the Federal law.

The success of welfare reform will depend on providing support for mothers (over 90 percent of households receiving TANF funds are headed by women) in a variety of areas, including substance abuse treatment. However, treatment availability is already severely limited. To address this problem, a number of states have implemented systems to integrate substance abuse treatment into welfare-to-work programs. Typically, these systems involve an expansion of funding for substance abuse treatment, screening and referral within welfare contexts, and coordination of treatment with employment programming. New Jersey is going further in its approach by piloting a program in two counties that offers intensive case management to women identified as in need of substance abuse treatment.

Addiction Treatment Significantly Decreases Medicaid Costs in Washington State



"Governors recognize that achieving sustained independence from welfare requires more than just an entry-level job. Further, those that remain on the welfare rolls often struggle with multiple barriers to employment, such as mental health and substance abuse issues, which will require a greater share of resources."

 Democratic Governor of Indiana Frank O'Bannon and Republican Governor of Connecticut John Rowland supporting the welfare reform policy passed at the Winter 2001 meeting of the National Governor's Association, in a letter to members of Congress, March 7, 2001

Accountability in Washington's Public Treatment System

Heeding calls for increased accountability, Washington state's Division of Alcohol and Substance Abuse (DASA) places evaluation and research at the forefront of its agenda. While many states are working to build data infrastructures, Washington has spent the last decade collaborating with researchers and tracking treatment outcomes. In 2000, the state released "Tobacco, Alcohol & Other Drug Abuse Trends in Washington State," the eighth in a series of trends reports since 1993. The report details economic costs, prevalence, and prevention and treatment outcomes in the state.

The emphasis on accountability enables DASA to show policy makers the impressive results of publicly-funded programs. In response, the state legislature has significantly increased funding for treatment services: In 1988, DASA's biannual budget was \$72 million; in 2000 it was \$220 million. The Governor's proposed plan for the next budget cycle includes a \$14 million increase for DASA. Treatment officials within the state attribute much of their budgetary growth to accountability and research outcome measures. DASA has also been able to parlay outcomes in increased employment and reduced social costs into additional funds from other state agencies. DASA received \$8 million over two years in TANF funds based on state indicators showing treatment positively affects employment outcomes. In 1999, the state Medicaid agency shifted \$2.5 million in funds to DASA to treat substance abusing clients. A preliminary study finding significant cost-savings in medical care for treated clients persuaded the state Medicaid agency to shift even more funds to DASA.

While DASA attracts a great deal of funds from its research efforts, the agency embraces a low-cost methodology. Much of the research generated by DASA comes from secondary data used to track client progress. Various state administrative databases that include information on employment, medical costs and re-incarceration are consistently tracked, enabling the Division to show outcomes without relying on the self-reporting of clients. For example, every quarter, the Division works with the Employment Security Division to track the employment status of all clients discharged from treatment. Using social security numbers, DASA can determine if clients are employed and their current wages. In 1999, the state received funding from the Federal government to develop a statewide outcomes monitoring system to build on the employment and arrest components of data gathering. Along with Washington, Oklahoma and Maryland received Federal funding to use state administrative databases to track employment outcomes among treatment clients. For more information, contact the Washington Division of Alcohol and Substance Abuse, 360-438-8206.

New Jersey's Approach to Welfare and Substance Abuse

Attempting to overcome the barrier that substance abuse poses to moving women from welfare to work, several states, including New Jersey, have implemented programs that screen women for substance abuse problems in welfare settings. When appropriate, women are referred to treatment and followed for utilization review. In addition to this statewide program, New Jersey is piloting a more intensive project in two counties to compare the effectiveness of the different approaches.

The more intensive Substance Abuse Research Demonstration (SARD) project is a five-year collaborative effort of the New Jersey Department of Human Services, Mount Sinai School of Medicine, Rutgers University and the National Council on Alcohol and Drug Dependence-New Jersey. Women screening positive for substance abuse problems are assigned to a team of case managers who identify and attempt to resolve barriers to entering and remaining in treatment, including tangible barriers, such as transportation and childcare, and psychological barriers, such as denial that treatment is needed. Case managers also engage in extensive outreach efforts including home visits and contacting family members. Once women enter treatment, case managers assist treatment programs in coordinating needed services and meet with clients weekly. Clients receive incentive vouchers for attending treatment that can be used to purchase certain items, such as children's toys or cosmetics.

New Jersey set aside \$20 million in TANF funds for the statewide welfare project and the SARD; \$7 million supported program implementation costs, and \$13 million was for treatment. Of the \$7 million, around \$4 million supported program infrastructure for both programs and direct services for the lesser intensive statewide program, and nearly \$3 million covered SARD services including the intensive case management teams. In addition, the state received \$4 million from Federal sources for an independent evaluation of the joint projects.

The SARD project engages women in treatment at significantly higher rates than the less intensive program, according to early findings from an evaluation of the two approaches funded by the National Institute on Drug Abuse, the Administration for Children and Families, and the Annie E. Casey Foundation. The study found that 88 percent of clients in the SARD project entered substance abuse treatment versus 65 percent of women in the less intensive program. Differences were especially marked for outpatient treatment: 86 percent of clients in SARD entered outpatient treatment versus 53 percent of the other women. Additionally, the SARD project retained women in treatment at higher rates. SARD clients attended 42 percent of the days they were assigned to treatment versus 22 percent for other clients, and SARD clients attended about five times more outpatient sessions than women in the less intensive program. To learn more about the New Jersey project, contact the New Jersey Department of Human Services, 609-292-6883.

reventing alcohol, tobacco and other drug use among the nation's children was the first of five goals outlined last year in the National Drug Control Strategy; however, only 13 percent of the Federal drug budget supports prevention programs and research. Prevention spending lags at the state level as well, where only 20 percent of state drug budgets cover both prevention and treatment.

"If I had an extra dollar to spend, I'd spend it on prevention."

— Former Republican Governor of Illinois and GLC memb<mark>er</mark> Jim Edgar

Extensive research during the past two decades has identified a number of prevention strategies that measurably reduce drug use. These strategies share a common goal: strengthening "protective factors" (i.e., well-developed social skills, strong family bonds, attachment to school, and active involvement in the community and religious organizations), while reducing "risk factors" that increase vulnerability to drug abuse (i.e., substance abuse by a parent; lack of parental guidance; disruptive, abusive family relationships; school failure; early experimentation with drugs; and living in a community where substance abuse and dealing are pervasive).

Matching adult volunteers with disadvantaged youth — mentoring — can effectively prevent drug use. The state of Kansas initiated a program to fund satellite mentoring facilities in all of its 105 counties in response to the successful results of a Big Brothers/Big Sisters chapter in Wichita. A 1995 national evaluation of Big Brothers/Big Sisters of

America found that young people in the program were almost 50 percent less likely to begin using drugs than their peers not involved in the program. An even stronger effect was found for minority Little Brothers and Sisters, who were 70 percent less likely to initiate drug use than similar minority youth.

School-Based Prevention

In most communities, schools are the focal point of substance abuse prevention. The vast majority of funding for school-based prevention programs comes from the Federal government's Safe and Drug Free Schools and Communities (SDFSC) program, which reaches 97 percent of the nation's school districts.

SDFSC funding, totaling over \$560 million annually, significantly outpaces state spending of approximately \$80 million on school-based drug prevention.

There have been various attempts among Federal lawmakers to combine the Safe and Drug Free Schools and Communities program with other education programs. The goal is to form one large block grant for states, giving them more flexibility in education spending. The change would allow state policy makers to decide how much Federal money will be spent on education priorities, including drug and violence prevention programs. Opponents are concerned that without a specific allotment of funds for school-based drug prevention, these programs will disappear.

"The secret to all of this is to start the prevention process early on. There's only so much time in a school day to do everything that needs to be done, so you have to say this is as important as math and reading and everything else for the sake of our children."

 Former Republican Governor of New Mexico and GLC member Garrey Carruthers

Empowering Communities

As the crack cocaine epidemic devastated cities across America more than a decade ago, citizens came together from all walks of life to create community strategies to combat substance abuse. Since then, antidrug coalitions have played a pivotal role in mobilizing community support for more effective responses to local alcohol and other drug problems.

Coalition leadership in some cases comes directly from state and local government. In Indiana, then Governor Evan Bayh (D) formed the Commission for a Drug Free Indiana in 1989 to serve as a central coordinator for antidrug coalitions across the state. The commission, funded by fines paid by DUI offenders and various Federal funds, operates through six Regional Coordinating Offices, with advisory boards including representatives from law enforcement, business, social service agencies, religious groups and other community organizations. These regional offices provide technical assistance to local coalitions

Child Welfare and Substance Abuse

Treatment for a parent often means prevention for a child. The connection of substance abuse with child abuse and neglect poses a serious and costly challenge to states. National studies suggest that between 40 percent and 80 percent of all child abuse and neglect cases involve parental alcohol and other drug abuse. Eighty percent of states report that parental substance abuse and poverty are the top two problems among child welfare agency caseloads. According to the Center on Addiction and Substance Abuse (CASA) at Columbia University, in 1998, states spent more than \$5 billion on child welfare problems that were caused or exacerbated by substance abuse.

State child welfare and substance abuse treatment systems often work independently, failing to address common issues; however, several states are taking innovative approaches to this problem. Delaware and New Hampshire, for example, are using Federal foster care assistance funds (Title IV E) to place substance abuse specialists in county child welfare agencies to do immediate, on-site substance abuse assessments and link clients with treatment programs. Illinois and Maryland go a step further, using these funds to tailor treatment programs to meet the needs of child welfare clients, including enhancing parenting skills and providing housing assistance.

Additionally, 27 family drug treatment courts exist nationwide, and 51 more are in the planning stages. These courts adapt the traditional drug court model to address child abuse and neglect cases involving substance abuse. An evaluation of 10 family courts in 2000 found that, on average, 12 percent of participants tested positive for drug use while in the program compared with an average rate of over 30 percent for non-drug court participants.

particularly in terms of sustained funding, staff and coordination. A strong advocate of prevention, Congressman Rob Portman (R-OH) started the Coalition for a Drug. Free Greater Cincinnati in 1995, an umbrella organization to oversee antidrug initiatives in ten counties in three neighboring states (Ohio, Kentucky, Indiana). On the Federal level, Congressman Portman sponsored new legislation, the Drug Free Communities Act, to provide sustained Federal support for coalitions, which became law in 1997. Congress authorized \$10 million in grants for fiscal year 1998. Within three years, Federal support had grown to \$40 million (FY 2001) which was awarded to 300 grantees in 49 states. The Senate is considering legislation, introduced in January 2001 by Senator Charles Grassley (R-IA), to reauthorize the Drug Free Communities Act for five years with total funding of \$255 million.

at the county level. This blend of state government and local community efforts has clear advantages,

Tennessee's Approach to Substance Abuse Prevention

Lacking a comprehensive health course that reached students statewide, Tennessee officials decided to incorporate the Life Skills Training (LST) program into their school curriculum. LST, one of the best-evaluated substance abuse prevention programs nationwide, provides information on alcohol, tobacco and marijuana and addresses substance use risk and protective factors. The skills developed in the program apply to numerous health risk behaviors.

The State Department of Education, in partnership with the University of Tennessee Training
Department, analyzed various prevention programs in relation to the state's needs before choosing
LST. The LST curriculum targets middle and junior high school students, the ages when substance use
increases most dramatically. The three-year curriculum consists of 15 sessions in the first year (sixth or
seventh grade), ten sessions in the second year, and five to eight sessions in the third year. The content
of the program falls into three general categories that cover the effects of alcohol, tobacco and other
drugs on the body; the development of personal or self-management skills; and the honing of students'
social and resistance skills.

Using grant funds from tobacco companies, the state piloted the program at a set of schools, which included training teachers and supplying curriculum materials. Based on the positive response from students and teachers, education officials decided to extend the program statewide. The state conducted a Training of Trainers (TOT), in which LST certified trainers trained 25 teachers in the state. These 25 teachers will train an additional 400 teachers who can reach 250,000 students. The TOT enables states to control and maintain their own training resources without having to invest more and more dollars in professional training. Schools using trained teachers to run the program do not have to hire additional personnel, so costs are limited to curriculum materials. The TOT in Tennessee cost \$22,000. The cost to provide LST materials to one class of 30 students for one year is \$250.

The LST program has consistently been shown to significantly reduce smoking, drinking and marijuana use, with reductions ranging from 50 percent to 75 percent in participating schools compared with nonparticipating control schools. The program has also been found to effectively decrease use of inhalants, narcotics and hallucinogens. Other evaluation studies have demonstrated the effectiveness of the program in both urban and suburban schools, and among white, African American and Hispanic youth. In 2001, LST was named an Exemplary Program by the U.S. Department of Education. For more information contact the Tennessee Department of Education, 615-532-4710; for LST curriculum information, 800-636-3415, www.lifeskillstraining.com.

Illinois' Child Welfare and Substance Abuse Program

Since 1995, Illinois'Office of Alcoholism and Substance Abuse (OASA) and the Department of Children and Family Services (DCFS) have operated a statewide assessment, referral, treatment and care coordination system for substance abusing parents involved with the child welfare system. Through the initiative, parents are screened for alcohol and other drug abuse problems and referred for treatment. OASA funds treatment providers specifically to serve referrals from the child welfare system. As a condition of accepting the additional funding, providers agree to conduct assessments within 48 hours of the referral. DCFS also provides funding for child care while the parents are in treatment.

Despite the collaborative effort, problems existed, including connecting clients with treatment, retention and relapse. In 1999, DCFS applied for and received a waiver to use Federal foster care and child welfare assistance funds (Title IV-E) to shore up the existing services. The Federal waiver process provides an opportunity for states to design and test a wide range of approaches to improve and reform child welfare.

The enhancement involves using Recovery Coaches to address weaknesses and missing components in the current treatment system. The overarching goal of the Recovery Coach is to "latch-on" to the substance abusing parent as early as possible and stay engaged through the treatment and recovery process. This includes aggressive and persistent outreach to re-engage parents who drop out of treatment. The coaches also help the families coordinate multiple services (often the families are involved with several state agencies) and help resolve any conflicts that arise. The coaches are not employees of the child welfare or treatment agencies, giving them independence to maintain an objective voice throughout the treatment process. While focusing on neither the parent in treatment nor the child specifically, the coach's primary concern is the entire family being served.

Another recent addition to the original package of services is an alcohol and other drug abuse assessment unit located on-site at juvenile court. Judges can refer parents appearing at temporary custody and other hearings directly to the unit for an assessment and same day treatment referral. Judges and case workers receive feedback on the results of the assessment by the next business day at the latest.

The program, currently in a pilot phase in Cook County, has an on-going evaluation component; initial findings are expected in May 2001. For more information, contact the Illinois Department of Children and Family Services at 312-641-2505.

Ithough treatment has proven effective, programs are still scarce. In 1999, treatment was available for less than one in three of

estimated 10 million Americans with severe alcohol or drug problems. Untreated addiction can be very costly for states and localities in terms of crime, health and other related costs. According to the Center on Addiction and Substance Abuse (CASA) at Columbia University, states spent over \$80 billion —13 percent of their total budgets — on substance abuse-related costs in 1998; of those funds, only four cents of each dollar was spent on treatment and prevention. The remaining 96 cents were spent on substance abuse-related criminal justice, health care and other costs.

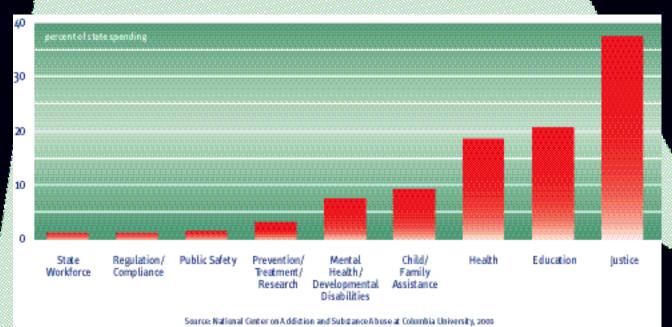
"If we made major investments in treatment programs, we could reduce the crime level because these people would no longer need to commit crimes to buy drugs. At the bottom line, it is not a sexy issue to treat people. We all demand the best health care in the world, but when it gets down to paying for it, you lose peoples' undivided attention."

Former Republican Governor of New Mexico and GLC member Garrey Carruthers The CASA report found that states spent more on the problem of substance abuse than they did on Medicaid (\$70 billion) or on transportation (\$51 billion), and they spent as much on substance abuse as on higher education. Despite the high costs of substance abuse to the states, the highest percentage of a state budget spent on prevention, treatment and research was New York's 1 percent; the vast majority of states spent less than half of a percent on these activities.

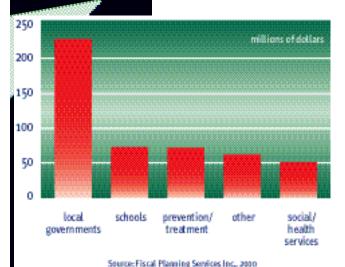
Without the resources to strengthen existing services, create new research-based programs, and attract and retain qualified staff, the demand for addiction treatment will not be met. More than half of drug addicts on treatment waiting lists are lass interested in entering treatment at the end of the waiting period than when they first applied. The longer addicts wait for treatment, the more likely they are to resort to criminal activity to obtain drugs.

Public-sector treatment has been especially burdened in big U.S. cities which were hard hit by crack cocaine in the late 1980s and high-potency heroin in the mid-1990s. Some states and cities have significantly increased funding to better meet the demand for treatment. Maryland, for example, increased funding for Baltimore to combat its well

Prevention and Treatment Account for Less than 4 Percent of State Spending on Substance Abuse



States Dedicate Only a Small Portion of Alcohol Beverage Taxes to Prevention and Treatment Efforts



documented drug problem by nearly \$10 million in Fiscal 2001 to help the city provide drug treatment on request. San Francisco is committed to closing the treatment gap and has significantly increased funding in recent years, recording a 10 percent increase in the number of patients in treatment between 1996 and 1999. However, substantially more financial resources are required, as treatment in the two cities reaches less than a third of those in need.

State Revenue Sources

Where state policy makers are reluctant to increase budgets, other sources of funds can be tapped for prevention and treatment, particularly state alcohol and tobacco excise tax revenues. A number of states already use some portion of these revenues for prevention and treatment efforts; however, funding varies dramatically among states. For example, Washington state dedicated \$48 million of its cigarette, tobacco and liquor excise taxes to drug and alcohol programs in 1997, while Nevada spent \$600,000 and Tennessee spent \$100,000. In 1997, states dedicated \$465 million of alcohol taxes to various purposes; \$67 million was allocated for substance abuse treatment and prevention.

Increasing state excise taxes on alcohol and tobacco products could provide even more funding for prevention and treatment. According to a 1998

national survey sponsored by the Robert Wood Johnson Foundation, four in five Americans favor increasing alcohol taxes by five cents per drink if the revenue is used for prevention and treatment efforts. In addition to generating more revenue for treatment and prevention, research has shown that increasing the price of alcohol reduces consumption and alcohol-related problems, including accidents, violence and disease. Youth and young adults are especially sensitive to alcohol price increases. State alcohol and tobacco excise tax rates vary widely. For example, as of January 2001, the excise tax on beer ranges from 92 cents per gallon in Hawaii to two cents per gallon in Wyoming.

In addition to excise tax revenues, the 18 "control" states (that are involved in controlling the sale of alcoholic beverages through state-run stores or private retailers) can choose to divert profits from alcohol sales to prevention and treatment efforts. Virginia, for example, allocates \$12 million of alcohol revenue to substance abuse services each year; lowa applies \$10 million.

"lowa is a liquor control state, and we use some of the mark-up on liquor sold to liquor stores for prevention and treatment programs. In a time when we were financially strapped, we were able to use the profit that the state was making off the liquor being sold to provide more money for prevention and treatment. It is a significant profit center for the state."

 Former Republican Governor of Iowa and GLC member Terry Branstad

Another potential source of new funds for many states is revenue from the 1998 tobacco settlement, through which tobacco companies will give \$206 billion to 46 states over the next 25 years. While most states have broadly allocated these funds for health care services, a handful of states have approved line items for alcohol and drug addiction programs. In lowa, the state Division of Substance Abuse received a funding increase of \$5 million in fiscal 2001 from the state's tobacco settlement pool.

Substance Abuse Treatment Parity

Parity laws, designed to expand access to mental health and substance abuse treatment, continue to be on the agenda in many states. In 2000 alone, parity legislation was introduced or carried over in 25 states. Parity laws require health insurers to offer the same level of benefits for mental illness or chemical dependency as for other physical disorders and diseases. The most far-reaching of these measures are referred to as "full parity" because they do not allow discrepancies in the level of benefits. Twenty-three states have passed full parity legislation for mental illness; however, only five of these laws include full coverage for substance abuse treatment.

Vermont's full parity law is considered the most comprehensive in the country because of its generous coverage for substance abuse services. First introduced in 1987 by then-Representative Howard Dean (who is now Governor), the law passed in 1997. In 1999, the Vermont Health Care Administration reported that the cost of implementing mental health and substance abuse parity was less than the previously projected 3.4 percent increase in premiums. Only Connecticut, Maryland, Minnesota and Virginia have passed similar full parity laws (North and South Carolina both have full parity laws that include substance abuse, but the laws only apply to state employees). Massachusetts has full parity for substance abuse treatment but only when the chemical dependency coincides with a mental illness; without a co-occurring disorder, the substance abuse treatment is not covered under the law.

On the Federal level, limited parity for mental health treatment became law in 1996; however, there is no law concerning substance abuse treatment parity. While Federal legislation for substance abuse treatment parity has yet to pass, under a directive from former President Clinton, all Federal employee health plans include parity for substance abuse and mental health treatment. As of January 2001, all nine million employees of the Federal government and their families were covered. In March 2001, Senator Paul Wellstone (D-MN) and Congressman Jim Ramstad (R-MN) introduced Federal parity legislation in their respective houses of Congress; as of June 2001, neither bill has passed.

Opponents of parity legislation argue that it will significantly increase costs to third party payers. However, a series of studies published in 1998 and 1999 showed that the costs of parity are small, while the benefits to individuals, employers and society are significant. One report conducted by the Substance Abuse and Mental Health Services Administration found that mental health and substance abuse treatment parity would increase insurance premiums by 3.6 percent, with substance abuse treatment benefits accounting for only 0.2 percent of that increase.

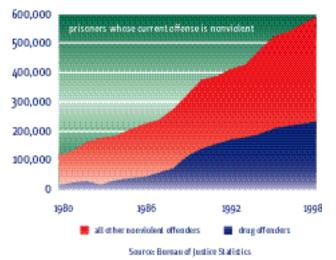
While the costs of implementing substance abuse treatment parity are relatively small, the savings in other health costs can be substantial. Health care costs for treated alcoholics are nearly 25 percent lower than for untreated alcoholics. General health care costs for families of substance abusers can be as much as three times higher than those for other families; however, these costs also drop substantially after successful treatment.



Inforcement has dominated state drug control strategy for the past two decades. Rapidly rising drug arrests coupled with stiff new sentencing laws have led to an exponential increase in the number of drug offenders in state prisons. The number of state inmates for whom drug offenses were the most serious charge jumped from 19,000 in 1980 to 236,800 in 1998 (the most recent available figure). This surge in state drug prisoners accounts for nearly one-third of the expansion in the nationwide prison population, which has quadrupled in size since 1980. The rate of growth in the states' drug prisoner population was 50 times greater than that of the U.S. population overall.

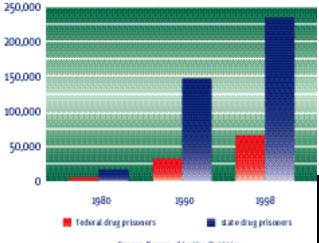
Drug offenders account for half of the increase in the total population of nonviolent state prisoners. In 1998, the majority of the 236,800 imprisoned drug offenders had either no criminal history (17 percent) or prior convictions only for drugs or other nonviolent offenses (59 percent). The number of women serving time for state drug offenses has risen ten-fold since 1986, nearly twice the rate of increase for men. Many women inmates have no criminal history or involvement with high-level trafficking, and have been implicated in drug crimes through spouses or boyfriends.

Drug Offenders Account for Growing Numbers of Nonviolent State Prisoners



Every state now has criminal laws that include some combination of determinate sentencing, sentencing guidelines, and mandatory minimum prison sentencing, while a dozen states have also abolished discretionary parole. New York and Michigan led the way in the 1970s with harsh new mandatory sentencing legislation. New York's "Rockefeller Drug Laws"

State Drug Prisoners Outnumber Federal Drug Prisoners by Nearly Four to One



Source: Bureau of Justice Statistics

require a minimum prison sentence of 15 years to life for selling two ounces or for possessing four ounces of heroin or cocaine — the same punishment faced by a person convicted of murder in New York. In Michigan, a first-time offender possessing 50 grams (1.75 ounces) of cocaine or heroin faces a minimum prison sentence of 10 to 20 years. According to the most recent comprehensive survey, 36 states had enacted some form of mandatory minimum sentencing for drug offenses by 1996.

The Federal government also enacted stiff drug sentencing laws during the 1980s, including a mandatory minimum five year sentence for a first-time offense of possessing more than five grams (about a teaspoon) of crack. Drug offenders now account for nearly 60 percent of the 135,000 Federal prison inmates. While drug offenders constitute a smaller fraction (21 percent) of all state prison inmates, the total state prison population (1.231 million) is nine times the size of the Federal prison population. State prisons hold the vast majority of drug inmates nationwide, including 75 percent of all drug trafficking prisoners and 95 percent of all drug possession prisoners.

Stiff new prison penalties for drug offenses continue to be enacted. During the 1990s, many states raised mandatory minimum penalties for sale of drugs to a minor or near a school. The Federal government and some states have also targeted newly popular drugs, including methamphetamine and MDMA ("ecstasy"). Since 1998, Idaho, Iowa, Missouri and Nebraska have all imposed stiffer prison sentences for

methamphetamine manufacturing and distribution. In July 2000, New Jersey imposed a mandatory minimum prison term of three and one-third years for possession with intent to distribute five ounces or more of ecstasy. In March 2001, the U.S. Sentencing Commission, under pressure from Congress, quadrupled the Federal guidelines for sale of 200 grams (seven ounces) of ecstasy from sentences of 15 months to five years — an equivalent penalty for dealing 500 grams (1.1 pounds) of powder cocaine.

Mandatory minimum drug laws are also having an impact in smaller states like Connecticut and lowa, whose overall incarceration rates between 1995 and 2000 outpaced the national average by 71 percent and 83 percent respectively. Connecticut's courts sent nearly twice as many drug offenders to prison under mandatory sentences in 2000 than they did in 1995, while in lowa the number of people sent to prison under mandatory minimum drug laws more than tripled. Drug offenders in lowa account for nearly half the increase in the state's incarceration rate from 1995 to 2000.

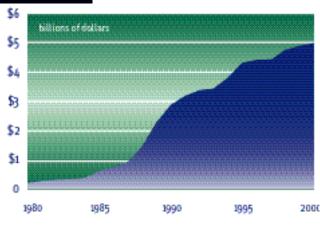
Mandatory minimum laws are intended to broaden the range of drug offenses subject to mandatory prison time while limiting (if not eliminating) judicial discretion and enhancing prosecutorial leverage However, the nature and implementation of these laws in practice vary considerably from state to state - including differences in drugs targeted, amounts required for mandatory sentences to apply, specific term of three and one-third years. In Arkansas, conviction for exactly the same offense would bring a minimum prison sentence of 15 years. Some states give judges significant leeway to impose a less severe penalty, while judicial discretion in other states is very narrowly circumscribed. In Rhode Island, a judge who identifies "substantial and compelling circumstances" is free to set a shorter sentence than would otherwise be required. North Carolina, in contrast, allows judicial discretion only in cases where the defendant has "provided substantial assistance in the identification, arrest or conviction of any accomplices, accessories, co-conspirators or principals."

An Expensive Policy

Prison spending is now the fastest growing category in state budgets, exceeding the rates of increase in state spending on health, welfare, and education. The states spent approximately \$40 billion to incarcerate drug offenders during the 1990s. Spending accelerated sharply in the mid-1980s and has been climbing ever since. During President Clinton's first term, the states spent three times more to incarcerate drug offenders (\$16 billion from 1993-1996) than they did over the course of President Reagan's two terms (\$5.2 billion from 1981-1988).

Costs continue to mount. Mandatory minimums are not only putting more drug offenders behind bars, they are also keeping them there longer. In 1996, the average time served by drug offenders in state prisons was 2.3 years, a full year longer than in 1987. (Although more recent data on time served are not yet available, experts believe that the upward trend has accelerated.) As time served increases, each decision to incarcerate becomes more costly, making a claim on state budgets for years to come.

According to U.S. Department of Labor projections through 2006, the occupation of "corrections officers" is one of the 25 jobs that "have it all: last growth, high earnings, and low unemployment."



Source: Bereau of Justice Statistics

State Spending to Imprison Drug Offenders Rises Dramatically Do Mandatory Minimums Reduce Drug Dealing and Drug Use?

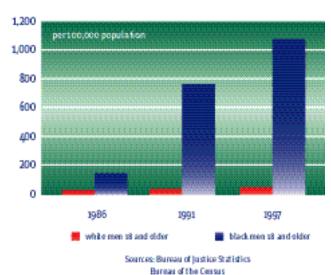
The policy rationale behind mandatory minimum sentences has been two-fold. First, they would impose certain, severe punishment on the most dangerous drug offenders, especially high-volume dealers and those with histories of violence. Second, by incapacitating more drug dealers, scaring others out of the drug business and deterring others from entering, the stiffer penalties would make illegal drugs harder to find and thereby reduce drug use and its related harms. Are these policy goals being achieved?

Mandatory minimum drug laws are intended to ensure stiff penalties by eliminating the sentencing disparities that can occur when judges exercise discretion. In practice, however, far more low-level dealers face prosecution under mandatory minimum laws than do their bosses and suppliers, the so-called drug "kingpins." Low-level dealers bear the brunt of the tougher sanctions for two reasons. First, retail-level "street" dealers are easier to arrest because they vastly outnumber the higher-level drug suppliers (importers, wholesalers) and because they operate more openly, making numerous small transactions and taking relatively few precautions.

Second, the sentencing criteria set down in mandatory minimum drug laws tend to penalize marginal participants in the drug trade more than they do their bosses. In an effort to reduce sentencing disparities, mandatory minimum laws typically base sentencing on a few key factors, including type and amount of drug and number of prior convictions. By law, judges are not allowed to take into account case-specific information that may be more relevant to the actual seriousness of the offense and the punishment that should be imposed.

"I think there is a political argument to be made that we have made a huge mistake in taking all the discretion away from the judiciary. A lot of people are already at the point of thinking that mandatory minimum sentencing isn't really working, because the folks who are coming out of the prisons are pretty much coming out the way we sent them in." High-level dealers generally hire others (known as "mules" or "couriers") to hold and transport their drugs. The increased risks associated with possession under mandatory minimum laws therefore fall almost entirely on the low-level employees of the drug distribution system, not on those who own or control the drugs. Furthermore, kingpins who are arrested may be in a better position to avoid mandatory minimums by cooperating with prosecutors than are their underlings, whose peripheral involvement gives them little information with which to bargain for a more lenient sentence. The wide net cast by stepped-up drug enforcement and mandatory minimum sentencing catches an abundance of small fish, but comparatively few big fish.

State Drug Incarceration Rate Soaring for Black Men



The extent to which low-level dealers bear the brunt of the arrest-and-incarcerate strategy is under-

scored by the soaring drug incarceration rate of black men. Disadvantaged minorities (to whom the rewards of drug dealing can appear enormous compared to the legitimate job opportunities available) dominate the ranks of those in the drug trade who are most vulnerable to enforcement — the low-level dealers. In 1997, black men 18 years and older accounted for half of all state drug prisoners, even though they comprised only 4 percent of the U.S. population. By comparison, white men made up 30 percent of the U.S. population in 1997, but only 16 percent of state drug prisoners. If current trends prevail, 1 in 50 black men in America will be serving time in state prison for a drug offense by the year 2010.

Those responsible for implementing mandatory minimum drug laws often use what discretion they have to avoid applying sentencing they consider unjust. Judges are predictably troubled by mandatory minimums. Some prosecutors also find the mandatory minimum penalties excessive, and often avoid their imposition by filing charges for different, roughly comparable offenses *not* subject to mandatory minimum prison sentences.

Putting more drug dealers behind bars was supposed to make illegal drugs harder to find, thereby reducing drug use and its related harms. Incapacitating enough dealers and deterring others from selling drugs would, in theory, make drugs more scarce and more expensive. But neither incapacitation nor deterrence has made a dent in the drug trade: with a black market commodity such as drugs, locking up one distributor simply creates a job opening for someone else. The openings created by incarcerating low-level street dealers are readily filled by replacements, either from within the same drug organization or from a competitor moving in on the market. Even where replacement is not immediate, remaining dealers can pick up the slack in the local market by selling more drugs themselves.

"Twice, at least, I vetoed mandatory sentencing of drug offenders. When I left office the legislature immediately passed a law requiring mandatory incarceration for even first offenders. Since then we have more than doubled our percentage of people incarcerated. Moral of the story is that the system of incarcerating people that aren't dangerous to society is a horrible mistake from every point of view. Now the legislature has repealed mandatory minimums for first-time offenders and ordered a review of the effectiveness of mandatory minimum drug sentencing overall."

 Former Democratic Governor of North Dakota and GLC member George Sinner

The large and increasingly expensive increase in the number of drug offenders behind bars over the past two decades has failed to diminish drug dealing. Retail prices for cocaine and heroin are now only about half their 1981 levels. Crack, singled out for particularly tough sentencing in Federal law, is no more expensive at the retail level than powder

cocaine. Moreover, high school seniors report that crack is as easy to obtain now as it was in 1987 at the height of the crack epidemic, and that heroin is significantly easier to get now. There were an estimated 319,000 more hardcore cocaine and heroin users in 2000 than there were in 1990. Since 1986, notwithstanding the tough drug new laws, the drug-induced death rate nationwide has increased by 50 percent.

Public Opinion: Open to Alternatives to Incarcelation

The proliferation of mandatory minimum drug laws in recent years reflects the assumption by many politicians that the public demands harsh punishment for drug offenders. Although some state lawmakers may have misgivings about the wisdom of mandatory minimums, they may nonetheless support these laws as political insurance against being labeled "soft" on drugs and crime. No politician wants to be on the wrong side of public opinion, and the prevailing view has been that the public overwhelmingly supports stringent enforcement and stiff prison sentences for drug offenders. A careful reading of recent public opinion polls, however, shows that politicians have far more latitude to promote alternatives to incarceration than they may suppose.

Survey questions that explore a broad range of public opinion on crime and punishment illuminate instructive distinctions that the public makes, for example, between violent and nonviolent offenders; high-level drug traffickers and low-level dealers; and drug dealers vs. drug users or those charged with possession. Not surprisingly, people are most concerned about repeat violent offenders and most willing to exact harsh retribution for such crimes. But the public's eagerness to put violent criminals behind bars does not translate into a general preference for more incarceration. For example, when the Los Angeles Times asked Americans in 1994 what would be the most effective way to reduce crime, "mandatory life sentences for three-time violent felons" (22 percent) was the single most popular response (out of eight options). But at the same time, the least popular response was "money for more state prisons" (3 percent). Similarly, a 1996 Gallup poll found that percent of Americans would vote for a proposition to give "major drug dealers life imprisonment without parole." But when a February 2001 Pew Research Center poll asked whether a move "away from the

idea of mandatory prison sentences for nonviolent drug offenders" was a "good thing" or a "bad thing," 47 percent of Americans considered it good, compared to 45 percent who found it to be bad.

This closely divided response is noteworthy in three respects. First, by specifying "nonviolent drug offenders," the survey narrows a category that otherwise would probably have been construed to include violent offenders. Second, the virtual tie between those who favor and those who oppose a move away from mandatory minimums undermines the prevailing political assumption that the public strongly supports these laws. Finally, the fact that even a slim plurality of the American people favors a move away from mandatory minimums is especially notable given that very few elected officials have had a bad word to say (publicly, at least) about mandatory minimums. In this case, public opinion is ahead of the politicians.

"While I was governor, one of the statistics that made an impression on me, was that regardless of why somebody got to prison, when they got there, probably the single best way to keep people from coming back was intensive drug and alcohol treatment programs. There has not been corresponding attention paid to that. So you can debate putting a lot of folks in prison for drug offenses, but what does not seem to be at issue is that we are not doing much to make sure that they don't go back."

— Former Democratic Governor of Mississippi and GLC memocr Ray Mabus

support for arresting drug users. Thirty percent of Americans considered arresting drug users a very effective way to control drug use, down from 42 percent in 1989 and the lowest rating among the five options presented. Over the same period, the proportion of Americans who believe that arresting drug users is *not* very effective has risen from 20 percent to 34 percent. Moreover, only 4 percent of Americans rate arresting drug users as the single most effective way to curb drug use. These findings reinforce the results of a May 2000 survey by Peter D. Hart Research Associates, which revealed little enthusiasm for incarcerating people simply for possessing drugs. Most Americans think that someone convicted of possessing illegal drugs should be fined and required to participate in drug treatment rather

than sentenced to serve time in jail or prison. Even in the case of cocaine possession, Americans prefer the penalty of a fine and treatment (53 percent) to a prison sentence (28 percent).

The Pew poll reinforced Peter Hart's 2000 finding that a majority of Americans (60 percent) see drug use as more of public health problem than as a crime problem to be handled by the criminal justice system. According to the Pew survey, 52 percent of Americans thank that "all in all, drug use should be treated more like a disease," while 35 percent think that it should be treated more like a crime.

Some Promising Options

Sentencing large numbers of low-level drug offenders to stiff prison terms has proved to be an expensive failure. Criminal justice professionals including many prosecutors — find mandatory sentencing laws unduly harsh, and often seek to cushion defendants from the full impact of the law. The available evidence suggests that drugs are at least as readily available today as they were 15 to 20 years ago, before the drug incarceration boom began in earnest. The public — long assumed by politicians to want ever-harsher drug laws — is skeptical of incarceration as the dominant response to nonviolent, lowlevel drug offenders. Many lawmakers, anticipating a budget squeeze for the first time in nearly a decade, are questioning whether drug incarceration is costeffective. Voters in some states, such as Arizona and California, have already passed ballot initiatives that divert nonviolent drug offenders away from prison into

But the arrest-and-incarcerate strategy of drug control retains significant momentum. Most states have some form of mandatory minimum drug law on the books, and get-tough laws are far easier to enact than they are to repeal. Furthermore, continuing prison expansion has developed a dynamic of its own by creating jobs and increasing the political influence of those with economic interests in prison expansion.

of those with economic interests in prison expansion.

Translating the incipient dissatisfaction with mandatory minimum sentencing into more humane and effective drug control alternatives will require stronger public support for positive options, not just skepticism about incarceration. This principle is well evidenced in Connecticut, where the state waged an effective marketing campaign to gain public support for its Alternative to Incarceration Program (AIP), which was

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adopted in 1990 to slow the state's costly prison boom. AIP gives judges a wide array of options when sentencing offenders, including outpatient and residential drug treatment. Program developers built in a highly visible community service component, and they successfully publicized estimated cost savings from the program. Effective marketing and evidence of programmatic success led the state legislature in 1994 to continue the program indefinitely.

Connecticut's approach can be useful in other areas of the country, where public support for alternatives to incarceration and drug treatment lags. Abundant research has shown drug treatment not only to be effective in reducing drug use and its related harms, but to be significantly more cost effective — dollar for dollar — than get-tough enforcement strategies such as mandatory minimums. Nonetheless, treatment funding remains woefully inadequate. Of the estimated five million hardcore drug users nationwide, nearly 60 percent do not receive treatment.

"You have to create a marketing campaign for supporting prevention and treatment. You need advocates for diversion programs, including sheriffs and police chiefs and prosecutors, standing up with people who run treatment programs saying this works and is a lot smarter financially and a lot more humane than what we are doing. People will listen."

 Former Democratic Governor of Oregon and GLC member Neil Goldschmidt

Treatment options must be considerably strengthened, particularly programs that deal primarily with indigent clients. Private health insurers should be required to provide the same coverage for substance abuse as for other illnesses. Treatment options within the criminal justice system should be expanded. Drug courts and prison-based treatment with aftercare in the community reach only a small percentage of drug offenders. Probation and parole should be strengthened. More than four million Americans are on probation and parole, and at least half of them had a drug problem when arrested. Nationwide, an estimated 60 percent of all cocaine is sold to persons under some kind of criminal justice supervision. Requiring frequent drug tests of drug-involved probationers and parolees could be an inducement for them to participate in treatment.

Although outright repeal of mandatory minimums may prove an uphill political battle, it may be feasible for states to pass sunset laws applying to all mandatory minimum drug sentencing provisions on the books. After a period of time, all such provisions would expire unless explicitly renewed in the law. More substantively, drug sentencing policy could pursue a two track approach, reserving mandatory minimums for offenders who are considered the greatest danger to public safety, while allowing judges discretion in sentencing low-level offenders.

Looking to the Future

In the national debate over drug control policy, the Federal government's role understandably receives much attention. Federal policies and funding decisions affect the citizens and governments of every state, and the high-profile interdiction and overseas drug control operations are an exclusively Federal responsibility.

Nevertheless, state and local governments play the dominant role in setting and implementing the array of prevention, treatment and enforcement policies that comprise our national response to illegal drugs. State and local expenditures account for two-thirds of domestic drug control spending.

The states' role is especially pronounced in the realm of drug enforcement. For example, while the stiff Federal drug sentencing laws are well-known, state prisons actually hold nearly 80 percent of the 300,000 drug offenders behind bars nationwide.

The significant authority enjoyed by individual states to chart their own drug control strategies is likely to grow as the Federal government continues to develve responsibility to the states for major social programs. As "laboratories of democracy," the states have considerable freedom to fashion innovative responses to the specific drug problems they face. In doing so, each state can learn from the successes and failures of other states, and adapt strategies proven to work elsewhere to suit their own needs.

Every state faces steep social and economic costs due to drug abuse, so the stakes for making the right policy choices are high. *Critical Choices* offers important examples of state-level innovations worthy of replication and suggests promising alternatives to the costly arrest-and-incarcerate strategy that has dominated the states approach to drug control since the early 1980s.

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Connecticut's Alternative to Incarceration Program

Connecticut's Alternative to Incarceration Program (AIP) was launched in 1990 in response to the state's skyrocketing prison construction expenditures; between 1985 and 1990, the state spent over \$1 billion building prisons. AIP was designed to give judges an array of alternatives to incarceration when sentencing low-risk offenders. Judges can choose from a full continuum of services, including drug court and outpatient or residential substance abuse treatment. Alternative programs include Youth Confinement Centers, where drug-involved offenders ages 16 to 21 receive substance abuse treatment; Project Green, which combines extensive community service in state parks with substance abuse treatment; the Women and Children Program, which allows female offenders to live with their children during their participation in a treatment program; and Alternative to Incarceration Centers, which provide supervision, substance abuse treatment, educational/vocational assistance, counseling and community service opportunities. Overall, services are provided by over 100 private, nonprofit organizations throughout the state.

Community safety is considered each time an offender is recommended for a program, and offenders are sentenced to programs depending on the circumstances and the severity of their crimes. As of 2000, approximately 165,000 offenders had been processed through AIP. Offenders successfully completing AIP, which can last from four months to two years, do not serve prison time. However, offenders who are dismissed from the program for any reason must complete their prison sentence. Based on the positive results of the program, in 1994, the state legislature unanimously passed a bill to continue AIP indefinitely.

In FY 2000, AIP's budget was \$55 million, \$30 million of which is for adult programs and \$25 million for juveniles. All funds are provided by the state. The average annual cost for an offender in the program is \$7,000 per year, versus \$25,000 for incarceration. In 1998 it was estimated that it would have cost \$525 million in prison construction costs and an additional \$94 million in operating costs to imprison the 150,000 offenders in the AIP program.

A three-year longitudinal study of AIP by the Justice Education Center, Inc. completed in 1996, found that program participants were less likely to commit crimes than offenders who had been in prison. AIP graduates had three arrests for every eight arrests in the comparison group, and offenders in the comparison group were rearrested for drug offenses at three times the rate of program clients. For more information on AIP, contact the Connecticut Court Support Services Division, 860-563-1332.

Delaware's Comprehensive Drug Treatment Program for Prisoners

Alcohol- and other drug-addicted offenders in four Delaware prisons have access to the KEY/CREST program, where they receive substance abuse treatment in a therapeutic community setting while in prison, followed by work-release and aftercare services in the community. The KEY program, developed in 1988, provides treatment to inmates in the last 12 to 18 months of their incarceration. Treatment includes individual counseling, group therapy, educational seminars, HIV education, family and parenting education, and 12-step programs. Clients are also encouraged to participate in GED and vocational programs offered by the prison. To increase participation in the programs, Delaware prisons sanction offenders who choose not to participate and offer incentives to those who do. Offenders who are identified as needing treatment, but are unwilling to participate, are not considered for early release.

Upon leaving the correctional facilities, KEY participants enter one of three CREST Outreach Centers, which operate work-release programs based on a therapeutic community model. Developed in 1992, CREST is designed to help inmates make a smooth transition into society. Residents receive six months of intensive substance abuse treatment during which they learn job skills, visit their families and communities, attend AA meetings, work full time in the community, and take part in community service activities as a form of restitution. Upon completing CREST, clients go through a six-month aftercare program during which they return to CREST weekly for group sessions, drug testing and counseling.

KEY/CREST programs are funded through the Delaware Department of Corrections. The programs receive approximately \$4 million per year from the state, funding treatment for approximately 13,000 inmates yearly. It is estimated that treatment costs are \$7.50-\$8.00 per day for each offender in the program.

A 1996 18-month follow-up study conducted by researchers at the University of Delaware found that inmates who participated in KEY, CREST and aftercare were significantly more likely to remain drug free than those not treated (76 percent versus 19 percent). The effects were still visible after three years, with one-third of treated offenders remaining drug-free, compared to 5 percent of the comparison group. In addition, three years after release, 69 percent of inmates completing the programs remained arrest-free compared to 29 percent of the control group. For more information, contact the Delaware Department of Corrections, 302-739-5601.

rom May 16 to 19, 2000, Peter D. Hart Research conducted a nationwide telephone survey among a representative sample of 1,003 adults. The survey explored Americans' attitudes toward drug abuse and drug policy. The margin of error for the survey is ±3.2. For several of the questions, findings include responses from Peter D. Hart Research surveys conducted for Drug Strategies in June 1997, February 1995 and February 1994.

1. Let me ask you about drug abuse, and let's suppose for a moment that you were in charge of deciding how to spend an extra ten million dollars to fight the drug problem in your community. In which one of the following ways would you spend that extra ten million dollars?

	5/00	6/97	2/95	2/94
All of it on law enforcement	3	5	6	7
Three-fourths on law enforcement and one-fourth on prevention, education, and treatment	8	10	14	12
Half on law enforcement and half on prevention, education, and treatment	40	42	44	46
Three-fourths on prevention, education, and treatment, and one-fourth on law enforcement	23	19	19	18
All of it on prevention, education, and treatment	21	20	15	14
None (VOL)	NA	2	1	1
Not sure	5	2	1	2

2. And do you feel that drug use is more of a crime problem better handled by the criminal justice system, or more of a public health problem better handled by prevention and treatment programs?

5/00 6/97 2/95 Criminal justice system 22 32 34 Prevention and treatment programs 60 57 53 Not sure

3. am going to read you two different approaches to dealing with the problem of drug abuse that a candidate for president might propose.

Do you think a candidate who proposes this is genuinely trying to address the drug abuse problem or is more concerned with winning votes?

The drug problem abould be addressed				
	Problem	Votes	Both (VOL)	Not Sure
	Abuse	With Winning	Some Of	
	Address Drug	Concerned		
	Trying To	More		

20

61

43

9

10

The drug problem should be address primarily with a law enforcement app which would include prison sentences for all individuals convicted of possessing illegal drugs

The drug problem should be addressed primarily with a treatment approach, which would include providing drug treatment services as an alternative to incarceration for all individuals con possessing illegal drugs

4. Now I would like you to think about people who are convicted for the possession of certain drugs, but not for their distribution or sale.

Do you think that people who are convicted for the possession of (READ ITEM) should be sentenced to serve time in jail or prison OR do you think they should be fined and required to participate in a drug treatment program?

THIS TABLE HAS BEEN RANKED BY THE PERCENTAGE WHO SAY SENTENCED TO SERVE TIME 5. Do you personally know someone, such as a relative, close friend, neighbor, or someone at work, who became addicted to illegal drugs, as opposed to alcohol or prescription drugs? Yes, know someone who became addicted No, do not know someone who became addicted 53 Not sure

his is a partial list of the sources used in Critical Choices. Detailed citations for this report are available on Drug Strategies' web-

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This project is guided by Drug Strategies' Board of Directors. We are grateful for their help and their wisdom. However, *Critical Choices* reflects the judgment of Drug Strategies alone, not necessarily the views of our advisors or funders.

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