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THE CASE AGAINST MORE FUNDS FOR DRUG TREATMENT

INTRODUCTION

Subsidies for drug treatment are by far the fastest-growing major component of federal spending on drug abuse. Advanced by many policy makers as the key to curbing drug use, federal expenditures for drug treatment have risen by 341 percent since 1986 – 20 percent faster than the total drug budget, 30 percent faster than spending for drug law enforcement and 700 percent faster than overall federal spending. This year, the federal government will spend more than $1.1 billion on treatment.[1] And Drug Czar Bob Martinez is calling for more spending on education and treatment.

Despite this explosive growth in spending, there is actually little evidence that drug treatment, federally subsidized or otherwise, ever can be more than a Band-Aid on America's drug crisis. To the contrary, the evidence shows that treatment programs generally fail to get and keep people off drugs. The evidence available on federally-subsidized treatment programs, moreover, suggests that they are often poorly run, fail to follow standard treatment practices, and function as "revolving doors" for addicts seeking respite from the criminal justice system or other problems.

1 These figures exclude spending for drug treatment by the Department of Veterans Affairs. Owing in part to the extraordinary success of drug testing and other drug prevention programs in the military, spending has grown much more slowly in the VA than the overall rate of government spending.

Note: Nothing written here is to be construed as necessarily reflecting the views of The Heritage Foundation or as an attempt to aid or hinder the passage of any bill before Congress.

In some cases, drug treatment can help individuals escape drug addiction and return to productive lives. And even for the majority for whom treatment is not completely successful, it may reduce drug use and the pathologies with which it is associated. For pregnant women, treatment may make the difference between life and death for their unborn children. Thus for humanitarian as well as utilitarian reasons, some public commitment to treatment appears justified.

What is not justified by the evidence is the explosive growth of federal spending on drug treatment in recent years. It is particularly not justified when such spending siphons away resources from more pressing needs in drug law enforcement and corrections. There is no excuse for continued funding of programs that ignore sound treatment practices, waste taxpayer dollars and contribute little, if anything, to winning the war on drugs.

THE BURGEONING DRUG TREATMENT INDUSTRY[2]

In 1987, the last date for which comprehensive data are available, there were 5,100 facilities providing drug treatment in the United States. These were treating 263,000 people, at an annual cost of approximately $1.3 billion. While the recent explosion in drug treatment funding no doubt has increased all these figures, the major methods of treatment and the general distribution of funding almost surely have not changed significantly.

There are three major types of drug treatment programs currently operating in the United States: 1) outpatient (non-methadone) treatment and counseling programs; 2) outpatient methadone maintenance programs; and 3) residential programs.

Outpatient Treatment

Outpatient treatment and counseling is the dominant form of drug treatment in America, in terms of number of patients, number of providers and spending. In 1987 there were 2,765 outpatient drug treatment facilities in America, serving 144,000 people at an average cost of $2,400 per patient per year. Nearly twice as many patients were treated in outpatient clinics in 1987 as in 1982.

These programs vary widely in approach, quality and success rates. At one end of the spectrum are programs consisting of little more than rap sessions, in which former addicts discuss drug abuse with current users, offer assistance with daily problems and serve as points of entry for other types of social services. At the

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2 The material in this section relies heavily on Dean R. Gerstein and Henrick J. Harwood, eds., *Treating Drug Problems* (Washington, D.C.: National Academy Press, 1990); Robert L. Hubbard, *et al*, Drug Abuse Treatment: A National Study of Effectiveness (Chapel Hill, N.C.: University of North Carolina Press, 1989); and Office of National Drug Control Policy, *Understanding Drug Treatment* (Washington, D.C.: U.S. Government Printing Office, June 1990). Data on the number and cost of drug programs, summarized in all three sources, are based on the most recent National Drug and Alcoholism Treatment Survey, conducted by the National Institute on Drug Abuse in 1987.

other end of the spectrum are rigorous outpatient programs that maintain regular contact with patients, encourage (or require) participation in self-help groups such as Narcotics Anonymous and insist on abstinence from drugs, policed by regular urinalysis. In most cases, these outpatient programs treat patients who abuse several types of drugs; cocaine, heroin, marijuana, amphetamines, sedatives and alcohol are among the most prevalent.

Methadone Maintenance

Originating in the late 1960s, these programs require heroin patients to show up daily at clinics to receive an orally-administered dose of methadone, a synthetic narcotic drug. Methadone produces little if any high, yet relieves temporarily the addict's withdrawal symptoms and cravings for heroin. It also prevents addicts from feeling the effects of heroin should they take the drug while on methadone. Like heroin, methadone is addictive, although withdrawal is said to be less painful than withdrawal from heroin. Most methadone clinics mainly treat heroin addiction, although most patients also abuse other drugs.

The 330 methadone maintenance programs operating in 1987 treated about 80,000 heroin addicts, or nearly one-third of the total drug treatment population, at a cost of roughly $2,500 per patient per year. The methadone maintenance population has remained nearly unchanged since the mid-1970s.

Residential Treatment

Various residential treatment programs range from very expensive private programs (like The Hazelden Foundation in Minnesota and the Betty Ford Clinic in California) to publicly-funded programs like Phoenix House in New York City and similar programs operated by many urban hospitals. The widely varying treatment methods include short-term detoxification programs (helping addicts withdraw from drugs), "chemical dependency" approaches (three-to-six week programs using the twelve-step Alcoholics Anonymous model) and "therapeutic community" approaches (involving six-to-fifteen months of residence, communal living, peer pressure and extensive counseling). These programs treat all types of drug abuse, although many specialize.

There were about 2,000 residential programs in 1987, treating approximately 37,000 resident patients. Annual costs of these programs vary widely, from as little as $15,000 per patient-year to as much as $30,000 for a hospital stay of just a few weeks.

Public vs. Private Drug Treatment

The growth of drug use among the middle- and upper-middle classes during the 1970s and 1980s was followed, not surprisingly, by the expansion of private-sector drug treatment programs designed to treat those who could afford to pay. As of 1987, nearly 1,300 of the 5,100 drug treatment facilities in the U.S. were privately operated and financed primarily by insurance reimbursements and direct client payments. Of these, 801 were hospital-based programs; more than 331 were outpatient programs; 76 were non-hospital residential programs; and 67 were methadone-based. Client and insurance payments for drug treatment rose from

$79 million in 1982 to $505 million in 1987, equal to 38 percent of all drug treatment revenues.

The cost of outpatient treatment is virtually identical in the private and public sector programs. The average for all patients, however, is higher in private programs ($2,450 per admission versus $1,240 for public sector programs), owing in large measure to the higher proportion of private patients in hospital-based residential programs, which is the most expensive type of treatment.

THE DISHEARTENING REALITIES OF DRUG TREATMENT

Press and congressional advocates of more federal spending on drug treatment extol its benefits. The *New York Times* editorialized last November that "vastly" expanding funding for drug treatment would "shrink crime rates, save hundreds of millions in prison costs and rescue lives by the thousands."[3] Senator Joseph Biden, the Delaware Democrat, proposing to double current spending on drug treatment, is equally insistent, stating that "the nation will mark the time until we provide treatment on demand in cocaine-damaged babies, abused children, crime, violence and human tragedy."[4]

This enthusiasm for drug treatment finds some support among drug policy experts. The authors of the most recent and extensive study of drug treatment programs ever conducted, the Treatment Outcome Prospective Study (TOPS), for example, conclude "that publicly-funded treatment programs are effective in reducing drug abuse and that long-term treatment helps addicts to become more productive members of society"[5] and that "treatment can and does work."[6]

Yet an objective analysis of the evidence on drug treatment is far less encouraging than those rosy assessments would suggest. While drug treatment certainly helps some people some of the time, the majority of those who enter treatment drop out, and the majority who stay in treatment later relapse into drug use. An examination of the most extensive data base on drug treatment effectiveness (which forms the basis for the TOPS study) exposes very disheartening realities about drug treatment programs.[7]

Reality No. 1: People in the final stages of drug abuse are not receptive to easy cures.

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3 "A Surer Way to Control Crime," *New York Times*, November 17, 1990.

4 Joseph R. Biden, *National Drug Strategy*, January 25, 1990.

5 Hubbard, *et al*, p. 163.

6 *Ibid*., p. xvi.

7 The TOPS study, reported in Hubbard, *et al*, examines drug treatment outcomes for nearly 10,000 patients who entered 37 different treatment programs (including all three major types of programs) between 1979 and 1981. Researchers followed all patients through the course of their treatment, conducting regular follow-up interviews for as long as five years after patients first entered treatment.

Perhaps the most striking aspect of the TOPS data lies in the characteristics of the patients entering treatment:

- Seventy percent of the patients in the outpatient programs and 81 percent of the patients in residential programs abused more than one drug.
- Thirty-three percent of those in outpatient programs and 75 percent of those in methadone maintenance programs had been in treatment before.
- Eleven percent of those in residential programs and 24 percent of those in methadone maintenance received most of their income from public assistance.
- Forty-one percent of all patients (60 percent in residential treatment programs) admitted to having engaged in predatory criminal activity during the previous year.[8] Indeed, approximately as many patients reported crime as their primary source of income as reported full-time work.

More than anything else, these statistics paint a picture of the terrible social costs of drug abuse. Those seeking treatment represent the end of a drug abuse pipeline, which takes in healthy, productive (or potentially productive) individuals and spits out people who are largely incapable of participating in mainstream society, prey regularly on law-abiding citizens and are unlikely ever to recover fully. The terrible plight of those who enter drug treatment is a powerful argument for efforts to deter people from ever using drugs, or if they have started, to stop before they reach the end of the drug abuse pipeline.

Reality No. 2: Most people who enter drug treatment programs do not complete them.

Virtually all experts agree that the longer individuals stay in treatment, the more likely the program will succeed. The amount of time in treatment is so important to success that the TOPS study does not even discuss outcomes for those who are treated for less than three months.[9] Analysis of the TOPS data base suggests that the critical threshold for successful treatment may be six months to a year.[10]

8 "Predatory" activity was defined as aggravated assault, robbery, burglary, and so forth, but did not include "drug defined" acts such as drunk driving or drug dealing or "consensual" acts such as gambling and prostitution. *Ibid.*, p. 83.

9 See, for example, *Ibid.*, p. 94-97. Though not discussed in the text of the report, some data on those who dropped out of treatment are included in summary tables in an appendix to the report.

10 Gerstein and Harwood, p. 168.

The trouble is that the vast majority of patients do not stay in treatment for six months, or even for three months. In fact, only 36 percent of those entering outpatient programs and 45 percent of those entering residential programs complete three months of treatment. Even among those who stay three months, only 50 percent in outpatient programs and 38 percent in residential programs actually complete treatment.[11]

Reality No. 3: Most people who complete treatment relapse into drug use and associated behaviors.

The most daunting reality of drug treatment is that most individuals who participate in treatment programs, even for three months or longer, do not stop using drugs.

The TOPS data base contains information on post-treatment drug use of the same drugs used regularly before treatment. For psychotherapeutic drugs (like sedatives and amphetamines) and heroin, the data show that slightly more than half of all regular users who spent three months or more in treatment return to drug use within one year. For cocaine, the relapse rate within one year is between 53 percent and 60 percent, depending on type of treatment. For marijuana, the success rate is even lower: More than 80 percent of all regular marijuana users return to marijuana use within a year of leaving treatment.

Predatory Crime. The TOPS data do show some reductions in drug-associated behavioral problems. Example: two-thirds of those who completed three months or more of treatment and who admitted to engaging in predatory crime prior to treatment told post-treatment interviewers they were no longer criminally active. (The credibility of these reports is, of course, questionable). Graduates of outpatient and residential programs also showed significant improvements in employability, with the proportion working increasing from a range of 15-27 percent before treatment to a range of 35-38 percent after treatment. Yet participants in methadone programs actually are less likely to hold jobs after treatment than before, perhaps reflecting the long-run debilitating effects of continued heroin use.

If anything, the TOPS findings may present an unduly rosy picture of drug treatment since other studies have found even less encouraging results. For example, analysis of the only other large data base on treatment outcomes (the Drug Abuse Reporting Program, based on 1969-1972 data) found no significant impact of outpatient treatment on crime and little impact on drug use.[12] Similarly, data from the client-Oriented Data Acquisition Process (ODAP) show that dropout rates in

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11 Methadone maintenance programs, perhaps because few of them insist on or even encourage abstinence from drug use, have lower drop-out rates. Still, nearly one-third of all methadone patients drop out within three months.

12 *Ibid.*, p. 107, 127; see also Gerstein and Harwood, p. 168.

therapeutic community programs average 90 percent, with some programs exceeding 95 percent.[13] And an independent analysis of the TOPS data base strongly challenges the crime-related benefits of outpatient treatment, finding no improvement at all.[14]

A possible explanation for the surprisingly positive conclusions of the TOPS authors is that the 37 programs selected for study intentionally were chosen from among "stable, established programs" that were "believed to have effective programs of treatment."[15] The programs also tended to be larger than the typical program and, at least for outpatient programs, admittedly "were more oriented towards intense professional treatment than the typical outpatient drug-free program."[16] It is little wonder that the data base resulting from such a selection could lead the authors to conclude that treatment is reasonably effective.

THE BENEFITS OF DRUG TREATMENT

There are, of course, some benefits from drug treatment. There is strong evidence that drug use and its associated behavior declines significantly for patients while they are being treated and that treatment often results in reduced drug use, even if it does not lead to abstinence.[17]

It appears, moreover, that some forms of treatment produce much better results than others. A growing body of research suggests that treatment works best when it includes drug testing, the threat of criminal penalties for relapse and when the twelve-step Alcoholics Anonymous method is used.

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13 The CODAP data were compiled by the National Institute on Drug Abuse from 1976-1981 based on reports from treatment programs in 54 cities. See discussion in Gerstein and Harwood, p. 164.

14 *Ibid.*, p. 170.

15 Hubbard, *et al*, p. 19.

16 *Ibid.*, p. 20. For a more realistic, and current, assessment of drug treatment programs in a large city, see Joseph S. Drew and Anne O. Hughes, *Evaluation of Publicly Funded Drug Programs in the District of Columbia* (Washington, D.C.: Mayor's Advisory Committee on Drug Abuse, September 1990). This study finds that "figures for budget, terms of contract, length of contract, opening and closing dates and program capacity are either not existent or not comparable," that "quality of publicly funded drug abuse programs... would appear to vary widely," and, ultimately, that the best that could be said was that "the citizens are receiving at least some services for the monies allocated." (p. 106).

17 There is considerable debate, however, about the long-run benefits of reducing drug use in contrast to achieving abstinence. Dr. Mark S. Gold, a dry treatment specialist, for example, argues that "there is no hope for effective treatment so long as the patient continues to use drugs. Personality problems, emotional difficulties and psychiatric disorders need to be addressed as they arise, but the chances of success are virtually nil unless the patient is drug-free." See Mark S. Gold, "Successful Treatment Programs for Cocaine and Crack," in Jeffrey A. Eisenach, ed., *Winning the Drug War: New Challenges for the 1990s* (Washington, D.C.: Heritage Foundation, 1990), p. 34.

The Importance of Testing

One finding that now appears beyond serious dispute is that regular testing for drug use during and after treatment contributes dramatically to the success of drug treatment programs. Drug treatment practitioners are especially firm in their conviction on this point. Dr. Mark S. Gold, Director of Research at Fair Oaks Hospital in New Jersey, reports that 85 percent of those completing the hospital's treatment program for cocaine use, which includes regular drug testing, remain drug free after six months.[18] Dr. Richard Rawson, Director of the Matrix Center (an outpatient drug program in southern California which has treated over 1,800 cocaine abusers since 1983), explains: "Just the knowledge that he may be tested can help the patient stay straight, and it gives his counselors a good indication of how well treatment is working."[19]

The National Institute of Medicine's recent study, *Treating Drug Problems*, mentioned drug testing only briefly, but suggests that urinalysis is one key component for "rigorous" drug programs "implemented according to best clinical practice."[20]

The Importance of Court Referral

Drug treatment patients referred by criminal courts are more likely to be cured than those who enter without legal pressure.

The TOPS study finds:

Consistent with the findings of prior research, the criminal justice client... stayed in treatment longer than the client with no criminal justice involvement.... Clients referred from the criminal justice system were significantly less likely to report weekly or daily use of their primary problem drug in the year after treatment.[21]

18 *Ibid.*, p. 35.

19 Richard A. Rawson, "Cut the Crack: The Policymakers Guide to Cocaine Treatment," *Policy Review* (Washington, D.C.: The Heritage Foundation, Winter 1990), p. 17.

20 Gerstein and Harwood, p. 125.

21 Hubbard, *et al*, pp. 132-133.

The TOPS study finds such results even more pronounced for participants in the Treatment Alternatives to Street Crimes (TASC) Program. This identifies drug abusing criminals entering the criminal justice system, refers them to drug treatment and monitors their progress, often using drug testing.[22] The TOPS results are corroborated by research on programs in Arizona, California, Georgia and other states.[23]

The Importance of the "AA" Approach

So-called "twelve-step" programs, based on the now-famous Alcoholics Anonymous (AA) model, are an essential component of successful drug treatment programs. There is, of course, almost no systematic research on the benefits of these programs because the participants are anonymous. The one study available, however, shows dramatic results. This study examines the post-treatment drug use of over 1,000 patients at fifty different residential treatment locations. It finds that the strongest single determinant of long-term success is regular attendance in self-help groups modeled on AA. In these, nearly 80 percent of regular attendees recover, compared with only 49 percent for those not attending such groups.[24]

Robert DuPont, former Director of the National Institute on Drug Abuse and currently a drug treatment practitioner in Maryland, calls AA and related programs a "modern miracle" and attributes to them much of the success of other forms of drug treatment. Writes DuPont:

> Today these [residential] programs that do work educate and link individuals and families to the twelve-step programs.... People get well and stay well by going to meetings that are free to everyone, rich and poor alike.

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22 L. Foster Cook, Beth A Weinman, *et. al.* "Street Crime," in Karl Leukfield and Frank M. Tims, *Compulsory Treatment of Drug Abuse: Research and Clinical Practice*, (Washington, D.C.: U.S. Government Printing Office, 1988) pp. 99-105.

23 On the program in Maricopa County, Arizona, see Thomas Agnos, "Mandatory Drug Treatment for Drug Users," in Eisenach, ed., *Winning the Drug War*, pp. 21-25. On the California Civil Addict Commitment Program, see Office of National Drug Policy, *National Drug Control Strategy* (Washington, D.C.: U.S. Government Printing Office, 1989), pp. 42-43. On Georgia's Intensive Probation Supervision Program, see Billie S. Erwin and Lawrence A. Bennett, "New Dimensions in Probation: Georgia's Intensive Probation Supervision," National Institute of Justice, 1987. For a general review, see Leukfield and Tims; and Gerstein and Harwood. Because most of these programs involve drug testing, it is not entirely clear whether the involvement of the criminal justice system, the testing, or a combination of the two is responsible for the resulting improvement in outcomes.

24 Comprehensive Care Corporation, *Evaluation of Treatment Outcome* (Irvine, California: Comprehensive Care Corporation, 1988), cited in Gerstein and Harwood, p. 173.

> My richest chemically dependent clients in Montgomery County, Maryland, who often want to buy recovery, find that it is not for sale at any price. They cannot send their assistants. They cannot hire therapists to cure them. They do not get well from chemical dependence unless they go to twelve-step programs in a community of recovering people, day after day after day.[25]

The most effective drug treatment programs in America, in other words, are not run by government, and do not receive public or private money.

TREATMENT AVAILABILITY: SHORTAGE OR SURPLUS?

Calling in late 1990 for another $40 million for drug treatment programs, Representative Henry Waxman, the California Democrat who chairs the Health and Environment Subcommittee of the House Energy and Commerce Committee, argued:

> Every day there are thousands of people in this country who come to terms with their drug addiction and decide to seek treatment, but cannot get it... Because when they finally get to the clinic doors, they are turned away; they are told there are no slots; they are told to come back in six weeks or six months, or maybe a year.[26]

The facts show otherwise. Indeed, the best available evidence suggests that there is no shortage of treatment facilities in America. On the contrary, there may well be a surplus.

A 1990 report by the General Accounting Office (GAO), for example, shows that in New York, one of the states most often said to lack adequate treatment capacity, there is no wait for treatment at all. The study, which focuses on treatment availability for intravenous drug users at methadone clinics, finds that while some treatment programs are filled, these programs regularly refer applicants to other programs that offer similar services but are operating below capacity.

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25 Robert L. DuPont, "Should Welfare Mothers Be Tested for Drugs?" in Eisenach, ed., *Winning the Drug War*, p. 88. DuPont's enthusiasm is shared his fellow practitioners. See Gold, p. 35: "Any treatment program that does not embrace the Twelve Step approach and encourage patients to participate stands little chance of success"; and Rawson, p. 17: "Every successful treatment program also encourages participation in a 12-Step or AA type program."

26 "Drug Treatment Gets a Boost," *Congressional Quarterly* August 11, 1990, p. 2593.

The GAO also surveyed treatment programs in California and Oregon, finding that although the centers in these states usually do not follow New York's referral practices, intravenous drug users are seldom turned away because of a lack of space. Moreover, high-priority patients (like pregnant women and HIV-infected addicts) are admitted promptly.[27]

According to the most recent nationwide survey of drug treatment programs, conducted before the huge increases in federal drug treatment funding in 1989, 1990 and 1991, publicly-funded methadone programs in 1987 were operating at 95 percent of capacity. Publicly-funded programs in general, however, were operating at only 84 percent of capacity, and private programs were operating at 66 percent of capacity. Indeed, the study finds that private programs have additional capacity available equal to 40 percent to 80 percent of current caseloads.[28]

Why, then, the constant drumbeat for more funding? For two reasons:

Low Demand. First, some of the evidence used to argue for greater treatment capacity is based on counting all the drug abusers with serious drug problems who are presumed to need treatment.[29] No attempt is made to differentiate between those who need treatment and those who do not want treatment. In fact, recent research shows that very few addicts demand treatment. Instead, roughly 90 percent go into treatment only after significant pressure from family, the law, an employer or a combination of the three.[30]

Second, waiting lists are typically the basis upon which the claims of Waxman and others often rest. Such lists are a poor measure of the demand for drug treatment. Advises Mitchell S. Rosenthal, director of Phoenix House: "Waiting lists are soft. You've got one guy on four lists for two weeks and he's not waiting anymore anyway. Addicts by nature call for help one moment and an hour later they're far away, emotionally or geographically. It's a motivation built on sand."[31]

WHAT NEEDS TO BE DONE

The main benefits of drug treatment may be political. Demanding federally-subsidized drug treatment allows politicians to appear to be doing something about drug use. Extra federal funds spent on drug treatment facilities in the home state or district then allow the politician to bring home pork. Since 1986, Congress has,

27 United States General Accounting Office, *Drug Treatment: Some Clinics Not Meeting Goal of Prompt Treatment for Intravenous Drug Users*, GAO/HRD-90-98BR, 1990.

28 Gerstein and Harwood, pp. 204-208. The authors assert that despite this evidence of nationwide excess capacity, there are long waiting lists in some cities and some states. This assertion, however, does not appear to be consistent with the GAO's findings. For further anecdotal information, see Drew and Hughes, whose survey of treatment programs in the District of Columbia found few with waiting lists.

29 For the best example, see Gerstein and Harwood, Chapter 3.

30 Office of National Drug Policy, *Understanding Drug Treatment*, 1990 p. 9.

31 Quoted in Andrew H. Malcolm, "In Making Drug Strategy, No Accord on Treatment," *New York Times*, November 19, 1989.

with the full cooperation of the Reagan and Bush Administrations, more than quadrupled spending on drug treatment programs.

The available evidence nevertheless casts considerable doubt on the wisdom of this vast commitment of federal dollars, for several reasons.

First, while drug treatment may help a small number of Americans to end their dependence on drugs, it cannot stop others from following them down the same path. By contrast, a greater emphasis on law enforcement, prevention and education approaches would deter drug use before it started or encourage people to stop drug abuse before reaching its final, terribly destructive stages.

Ignoring Success Level. Second, there is virtually no evidence that government-funded treatment programs observe the principles of effective treatment such as drug testing and the twelve-step method. One reason for this is that Administration efforts to insist on increased accountability for drug treatment programs have been rejected by Congress, apparently on the grounds that such a requirement would be too burdensome. In fact, there is no requirement today for federally-subsidized treatment programs to demonstrate any level of success, let alone require drug testing or any other approach shown to succeed.

Third, there is no convincing evidence that the demand for drug treatment exceeds the supply. There is excess supply in virtually every segment of the drug treatment industry. And allegations of shortages and long waiting lists in some specific areas do not appear to hold up under careful examination.

For these reasons, further increases in federal funding for drug treatment should be strongly opposed. Indeed, federal spending on drug treatment should be reduced, with the savings in the anti-drug budget used for more effective anti-drug strategies, such as law enforcement, teaching students to avoid drug use and increased use of drug testing in the criminal justice system and elsewhere. Better use should be made of the funding that remains.

Such a strategy would have four basic central elements:

1) The criminal justice and drug treatment systems should be combined into a single system in which drug abuse is recognized as a crime as well as a medical problem.

In the current system, predatory criminals regularly walk into government-funded offices, admit to criminal use of drugs and receive, in effect, the reward of public assistance. The criminals make no commitments to obtain this assistance, and these criminals at any time can drop out of treatment and return to crime. Instead, those who wish to benefit from publicly-funded drug treatment should be required to admit to illegal drug use and agree, in return for suspended prosecution or summary probation, to participate successfully in treatment. Those who fail (for instance, by repeatedly failing drug tests) should be returned to the criminal justice system for full prosecution. To make clear that drug treatment is an alternative to prosecution only if treatment is pursued successfully, federal funding for drug treatment programs should be transferred from the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) block grant program to the

Bureau of Justice Assistance, which is part of the Department of Justice. ADAM-HA should retain responsibility only for research.

2) The federal government should fund only those programs that require drug testing for patients, with clear and significant consequences for those who continue to use drugs.

The evidence shows that drug testing is a necessary condition for successful treatment. Federally funded programs thus should require drug testing of all patients as a condition of probation or suspended prosecution. This should be monitored by the courts.

3) Drug treatment funding should be privatized, and private-sector providers should be encouraged to seek drug abusers in need of treatment.

While there is little evidence of excess demand for drug treatment, there is strong evidence that many Americans who might benefit from treatment fail to apply. The private sector should be recruited to seek out these individuals and encourage them to obtain treatment, with the understanding that eligible patients must admit to illegal activity and demonstrate a willingness to participate in a rigorous program that includes drug testing. Public funds for drug treatment should be diverted into a "fee for success" arrangement with private providers, who should be paid on the basis of the number of patients who successfully complete treatment and continue to test negative for drug use for at least six months after treatment. The fees should be set high enough to compensate for the fact that some patients will fail to complete even the best programs, and should reflect the differing costs of treating differing types of drug problems. Fees should be adjusted to give private providers an extra incentive to seek out pregnant women who abuse drugs and recruit them into residential treatment programs for the duration of their pregnancies.

4) The success of twelve-step programs should be recognized.

Regular participation in a twelve-step or similar program modeled on the Alcoholics Anonymous formula should be made mandatory for participants in publicly-funded outpatient programs and for those completing residential programs. Equally important, George Bush publicly should recognize Alcoholics Anonymous and its associated programs through his "Thousand Points of Light" program.

CONCLUSION

Liberals and conservatives agree that drug use and abuse is a serious national problem. For liberals, the answer to this mainly seems to be increased federal funding for drug treatment. But drug treatment will make only a minor contribution to curing America's drug ills. There is, moreover, virtually no credible evidence that there is a pervasive shortage of drug treatment, even in major cities where the problem is said to be most acute.

To be sure, some government funding of drug treatment programs makes sense. The current level of funding, however, is more than adequate. What is needed is not more treatment but more effective organization of treatment programs. To do this, drug treatment should be incorporated into the criminal justice system and publicly-funded drug-treatment programs should use drug testing, the twelve-step method and enforce a penalty for relapse.

Liberal Bandwagon. With federal spending on drug treatment already soaring and the Bush Administration apparently unwisely jumping on the liberal bandwagon for still more funding, reform of drug treatment ought to be high on the conservative agenda for drug abuse policy.

These recommendations if adopted would create a drug treatment system significantly more successful and cost-effective than today's. It will be a system that helps far more people escape from drugs, has a far greater impact in reducing crime and other pathologies associated with drug use and, in the final analysis, costs far less than the current morass of federally-subsidized drug treatment programs.

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