

**GOAL NUMBER ONE:  
REDUCE DRUG USE  
AND THE HARM IT CAUSES OUR SOCIETY**

## **OBJECTIVE: FIND A SOLUTION TO DRUG ABUSE THAT REALLY WORKS**

**Rationale:** For years U.S. drug policy has taken the approach of arresting anyone who can be connected with illegal drugs, and has gotten the same results – death, disease, violence and increasing adolescent drug use. It is time for a critical review of drug policy, not annual plans that promise more of the same. We need to recognize that the War on Drugs is a simplistic, politically motivated approach to a complicated health and social phenomenon. We need to develop a strategy based on more effective approaches.

**QUOTE:** *"I don't think we're going to arrest our way out of this. We've got 1.7 million people behind bars right now."*

**SOURCE:** Drug Czar, General Barry McCaffrey *Talk of the Nation*. (1998, February 25).

### **Recommendation 1: Commission a non-partisan panel of experts to evaluate America's longest war.**<sup>i</sup>

The War on Drugs is approaching a century in length, having been initiated in 1914 with the Harrison Narcotics Act. The drug war gets more expensive each year – the 1999 federal budget of \$17.1 billion is a record and is several times larger than the \$3.6 billion appropriated in 1988. States and local governments spend an additional \$20 billion annually.<sup>ii</sup> *Yet, there is no objective review of the evidence to determine whether a law enforcement-dominated policy is the most effective policy option.*

**QUOTE:** *"... The time has come for President Clinton to do what President Hoover did when Prohibition was tearing the nation apart: Appoint a bipartisan commission of distinguished citizens... -- a blue-ribbon panel to reappraise our drug policy right down to its very core, a commission with full investigative authority and the prestige and power to override bureaucratic concerns and political considerations."*

**SOURCE:** Walter Cronkite, *The Cronkite Report: The Drug Dilemma – War or Peace?* (February 25, 1995).

In order to develop a truly effective drug policy, a national commission should be empowered to analyze our approach and recommend new strategies. This commission should be led by an independent commission and *all* options should be considered for tobacco, alcohol and illegal drugs. ONDCP Director General McCaffrey recently said that legalization is a "legitimate cause for debate in a democracy."<sup>iii</sup> No doubt we need to consider whether criminal controls – relying on police, prosecutors and prisons – or legal controls – relying on regulation, taxation and administrative law – are more effective at controlling drug markets. However, in developing a more effective drug strategy we should remember that the vast majority of immediate policy options are not at the extremes of the debate, but rather involve moderate public health strategies and changes in budget priorities. This document represents a synthesis of centrist approaches to drug control.

### **Recommendation 2: Allow cities and states to experiment with their own approach to drug control.**

Cities and states have always been important sources of innovation and experimentation in public policy. Closer to their citizenry, city councils and state legislatures are often better qualified to identify solutions to problems which seem impossible at the national level. For instance, the city of Boston has been widely recognized for developing an effective strategy for reducing juvenile crime, and it recently had the distinction of being the only large American city to enjoy no juvenile homicides for more than two years.<sup>iv</sup> The program was based on a mixture of community policing and providing at-risk youth with meaningful after-school activities.

States and municipalities need greater flexibility from the federal government to address drug abuse as a public health issue. Federal drug policies that encourage states to adopt punitive approaches, including

excessive penalties and limits to judicial discretion, are undermining productive state drug policy efforts. Federal drug policy must allow state and local governments the flexibility to develop new rational drug policies that emphasize education, economic opportunity, disease prevention, alternatives to incarceration and access to treatment and rehabilitation services, with some oversight to ensure that individual rights are not harmed in the process.

**Recommendation 3: Make efforts at all levels of government to separate the markets for marijuana from other illegal drugs.**

According to a recent report by the World Health Organization (WHO), the hypothesis that adolescent use of hard drugs is a direct effect of marijuana use is the “least compelling of all hypotheses.” The WHO report suggests that the current prohibition on marijuana may do more to introduce children to hard drugs than any other cause, stating, “Exposure to other drugs when purchasing cannabis on the black market increases the opportunity to use other illicit drugs.”<sup>v</sup> This finding has important implications for public policy, and suggests that if we want to reduce heroin and cocaine use, we can move closer to that goal by separating the marijuana market from the market for harder drugs. The Netherlands is the only nation which has implemented such a policy, so it is important to note that even though marijuana is widely available, the Netherlands’ heroin use rate is 160 users per 100,000 population,<sup>vi</sup> while the United States is estimated to have 430 heroin users per 100,000 population.<sup>vii</sup> Thus, when comparing the experience of the two countries, it appears the World Health Organization’s hypothesis that the black market in marijuana increases the opportunity to use other drugs has some merit and also reinforces the hypothesis that marijuana can act as a terminus drug, rather than a gateway. The reality is, for every 104 Americans who have used marijuana, there is only one regular user of cocaine, and less than one regular user of heroin.<sup>viii</sup>

By promoting an absolutist “zero-tolerance” policy for all substances regardless of relative dangers and by accepting the ‘gateway’ myth, we may actually expose those youths and young adults who would briefly experiment with a soft drug like marijuana to more dangerous substances like cocaine and heroin. A public policy that is blind to the reality of drug markets effectively abandons youth who experiment with marijuana – the most widely used illicit drug. This is a tragic example of how ideology and adherence to failed policy can prevent our society from making progress in reducing drug use.

## A Brief Chronology of Independent Drug Policy Reports

**Indian Hemp Drugs Commission. Marijuana. 1893-94. (UK)**

*A seven volume, nearly 4,000 page report on the use of marijuana in India by British and Indian experts who concluded, "the moderate use of these drugs is the rule, and that the excessive use is comparatively exceptional. The moderate use produces practically no ill effects."*

**The Panama Canal Zone Military Investigations. 1916-1929. (U.S.)**

*Recommended "no steps be taken by the Canal Zone authorities to prevent the sale or use of marihuana."*

**Departmental Committee on Morphine and Heroin Addiction. Report. (The Rolleston Report), 1926. (UK)**

*Codified existing practices regarding the maintenance of addicts on heroin and morphine by doctors.*

**Mayor's Committee on Marihuana. The Marihuana Problem in the City of New York, 1965. (U.S.)**

*Concluded marijuana use was non-addictive, and did not lead to morphine, cocaine or heroin addiction.*

**Joint Committee of the America Bar Association and American Medical Association on Narcotic Drugs. Drug Addiction: Crime or Disease? Interim and Final Reports, 1961. (U.S.)**

*Concluded drug addiction is a disease, not a crime; harsh criminal penalties are destructive; drug prohibition ought to be reexamined; and experiments should be conducted with British-style maintenance clinics for narcotic addicts.*

**Interdepartmental Committee. Drug Addiction. (The Brain Report), 1961. (UK)**

*Endorsed the Rolleston Committee's advice which recommended that doctors in the United Kingdom be allowed to treat addicts with maintenance doses of powerful drugs when it was deemed medically helpful to the patient.*

**Interdepartmental Committee. Drug Addiction, Second Report. (The Second Brain Report), 1965. (UK)**

*Made recommendations for the monitoring and licensing of doctors in the United Kingdom who prescribe maintenance doses of drugs.*

**Advisory Committee on Drug Dependence. Cannabis. (The Wooton Report), 1968. (UK)**

*Endorsed conclusions of the 1965 New York report which said marijuana was non-addictive and did not lead to morphine, cocaine or heroin addiction. Also endorsed the conclusions of the Indian Hemp Commission.*

**Government of Canada, Commission of Inquiry. The Non-Medical Use of Drugs, Interim Report, (The Le Dain Report), 1970. (Canada)**

*Recommended serious consideration be given to decriminalization of marijuana for personal use.*

**National Commission on Marihuana and Drug Abuse, Drug Use in America: Problem in Perspective, 1973. (U.S.)**

*Appointed by President Nixon, it recommended possession of marijuana for personal use be decriminalized.*

**National Research Council on the National Academy of Sciences, An Analysis of Marijuana Policy, 1982. (U.S.)**

*Recommended immediate decriminalization of marijuana possession and suggested the United States experiment with allowing states to set up their own marijuana controls, as is done with alcohol.*

**Advisory Council on the Misuse of Drugs, AIDS and Drug Misuse, Part 1 1988, Part 2, 1989. (UK)**

*Concluded that "The spread of HIV is a greater danger to the individual and public health than drug misuse." Supported a comprehensive health plan that promoted abstinence, but above all health and life.*

Figure 8

## OBJECTIVE: REDUCE DRUG ABUSE AND USE AMONG YOUTH AND YOUNG ADULTS

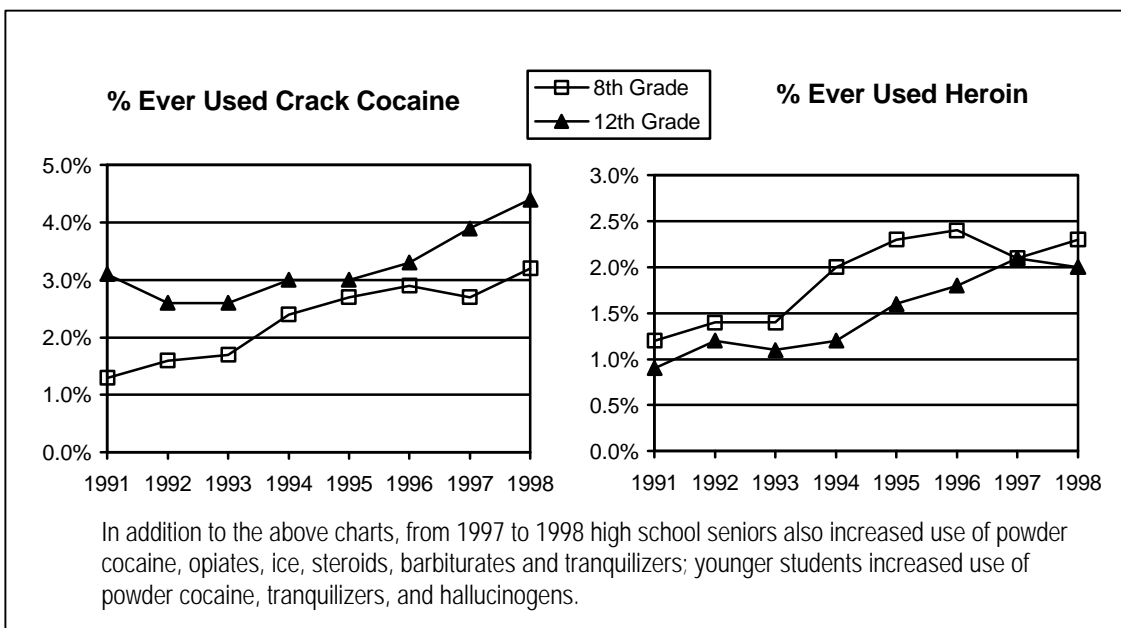
**Rationale:** Our nation should focus its efforts on fact-based education as well as programs to dissuade adolescents from the use of alcohol, tobacco and illegal drugs.

Adolescent drug use has been rising steadily since 1991, which is the longest sustained increase in adolescent drug use since the *Monitoring the Future Survey*<sup>ix</sup> began. After the release of the 1998 *Monitoring the Future Survey*, the ONDCP issued a surprising press release which stated “Second Straight Year of No Significant Increases, Many Categories of Youth Drug Use Fall Significantly.” General McCaffrey is quoted as saying, “The 1998 Study shows that we have turned the tide of youth drug use.”<sup>x</sup> Unfortunately, a review of the actual survey data shows a sharply different result.

**QUOTE:** “The principal component of our drug strategy ought to be based on prevention programs aimed at adolescents.”

**SOURCE:** Drug Czar, General Barry McCaffrey *Talk of the Nation*. (1998, February 25).

Survey data indicate that modest declines in the use of the traditionally popular drug marijuana comprised the major portion of lowered numbers. This decline masked a continuing rise in hard drug use by our youth. For instance, the percentage of high school seniors reporting lifetime marijuana use dropped by 0.5%, but the percentage of high school seniors reporting lifetime crack use increased by 0.5%. Twice as many students reported using heroin by the 8<sup>th</sup> grade in 1998 as was reported in 1991. Nearly three times as many students reported using crack by the 8<sup>th</sup> grade for the same time period. Exchanging marijuana use for crack and heroin is clearly not the type of trade-off that most parents would like to see. The ONDCP’s failure to mention any of these significant issues in their official press statement cheats parents, educators and journalists out of their ability to understand the dimensions of adolescent drug use.



**Figure 9** Adolescent use of crack and heroin. Source: *1998 Monitoring the Future Survey*, Institute for Social Research, University of Michigan.

**Recommendation 1: TRIPLE the current National Drug Control Strategy budget share for reducing youth and young adult drug use.**

Despite claims that the War on Drugs is being fought to save future generations of children from being hooked on drugs, and despite Drug Czar Barry McCaffrey’s promise to focus his office’s efforts on youth drug use prevention, *the ONDCP is budgeting less than 12% of the \$100 billion it is planning to allocate between 1998 and 2003 for reducing youth drug use.*<sup>xi</sup> This number is appallingly low and should be significantly increased. For an effective drug control strategy, we believe that at least one-third of the budget should be focused on reducing youth drug use; therefore we recommend that the ONDCP TRIPLE its budget share to 34% for reducing youth and young adult drug use.

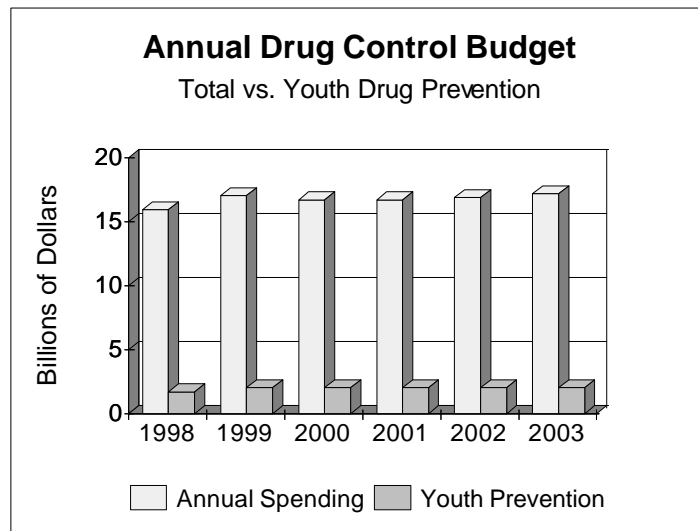


Figure 10 Source: ONDCP, 1998 National Drug Control Strategy, p. 59.

**Recommendation 2: Focus funding and efforts on strategies that have documented success in reducing youth drug use.**

According to SAMHSA, “alcohol and drug use tends to be a chosen activity engaged in during unstructured and unsupervised time.”<sup>xii</sup> Therefore, existing and expanded funding should not be spent on simplistic anti-drug advertising campaigns, but rather should be invested in youth. Programs which provide positive and enriching activities, “offset the attraction to, or otherwise meet the needs usually filled by alcohol, tobacco and drugs.”<sup>xiii</sup>

Researchers have noted that “adolescence is a period in which youth reject conventionality and traditional authority figures in an effort to establish their own independence... drug use may be a ‘default’ activity engaged in when youth have few or no opportunities to assert their independence in a constructive manner.”<sup>xiv</sup>

Moreover, twice as many youths from low-income families are unsupervised for more than three hours per day than youths from high-income families.<sup>xv</sup> In an independent study of the Big Brother/Big Sister Program, researchers found that “Little Brothers and Little Sisters were 46% less likely to start using illegal drugs, and 27% less likely to start drinking.” Little Brothers and Little Sisters also did better in school, had better attendance records, and felt slightly better about how they would perform in school.<sup>xvi</sup> Constructive activities and mentoring programs provide a strong environment for youths and young adults to reject all forms of drug use and provide benefits across a wide array of indicators, such as school performance and self-esteem. These kinds of strategies should be central to our efforts to reduce youth and young adult drug use because they actually work.

**FACT:** A study conducted by SAMHSA and the Department of Health and Human Services reviewed 127 alternative activity programs for their effect on reducing youth drug use. It concluded, “alternatives programming appears to be the most effective among those youth at greatest risk for substance abuse and related problems.”

**SOURCE:** Carmona, Maria and Kathryn Stewart. (1996). “A Review of Alternative Activities and Alternatives Programs in Youth-Oriented Prevention” *CSAP Technical Report No. 13*. Washington, DC: Center for Substance Abuse Prevention/ SAMHSA.

### **Recommendation 3: Use facts, not scare-tactics to educate youth.**

Education is a key component of any plan to change self-destructive behavior. In order for it to be effective and not undermine its purpose, education must be completely factual and rational. By relying on scare-tactics and unfounded assertions, the current drug policy has failed to achieve its purpose. Nowhere can this be more clearly seen than where exaggerated claims about marijuana lead youth and young adults to disbelieve information about harder drugs as well.<sup>xvii</sup> Statements like the one shown at right by Alan Leshner, director of the National Institute on Drug Abuse, can confuse children. Since half of all kids try marijuana before graduating from high school, there is a great deal of informal knowledge about the drug among youth. Being told by public officials that there is no substantive difference between marijuana and other drugs like heroin and cocaine, can “send the wrong message” to kids – leading to experimentation with more dangerous drugs. By focusing educational campaigns on information which is scientifically accurate, we can achieve our educational goals and become a more credible force with the younger generation.

**QUOTE:** “...classifying drugs as either ‘hard’ or ‘soft’ is off the mark... Marijuana is neither ‘soft’ nor ‘benign’; rather it is a drug with a high potential for abuse.

**SOURCE:** Alan Leshner, Director of NIDA. *Boston Globe*, “Marijuana Isn’t a Harmless Drug” (November 22, 1998).

### **Recommendation 4: Redirect DARE funding into more productive and effective programs.**

Support for the DARE (Drug Abuse Resistance Education)<sup>xviii</sup> program must be reconsidered. Federally funded research conducted by the Research Triangle Institute found that DARE had no effect on youth and young adult drug use, and that *DARE students were no less likely to use drugs than students who were not involved with the program.*<sup>xix</sup>

**FACT:** A federally funded Research Triangle Institute study found that DARE students were no less likely to use drugs than students who had not gone through the program.

**SOURCE:** Ennett, S. T., et. al. (1994, September). “How Effective is Drug Abuse Resistance Education? A Meta-Analysis of project DARE Outcome Evaluations.” *American Journal of Public Health*.

A key aspect of DARE’s failure to be effective stems from the program’s basic premise – the idea that police are appropriate teachers of health information. Police do not teach children about sex education, hygiene or dental care, so why are they teaching children about drugs? It sends the wrong message that drugs are a law enforcement issue, rather than a public health issue. More importantly, a police officer may intimidate adolescents who have experimented with drugs from asking lifesaving questions out of fear that they will get into trouble.

In spite of DARE’s documented lack of success and its inherent weaknesses, the federal drug education budget provides a ‘set aside’ for DARE, ensuring that it continues to squander the few prevention dollars this country spends on adolescent drug education. This is a failure on the part of our government to protect children from the dangers of drug use and drug abuse. At the very least, DARE should be required to compete with other drug education programs and prove that it can be effective.

Furthermore, since federally sponsored studies indicate that nearly 50% of all students try an illegal drug before they graduate from high school, and 85% of students try alcohol,<sup>xx</sup> the goal of drug education should be broadened to include reducing the harms related to alcohol and other drug use, as well as preventing adolescent alcohol and other drug use from the outset.

## **Recommendation 5: Be responsible with the provision of anti-drug messages.**

The ONDCP's newly launched \$2 billion advertising campaign to make children aware of the dangers of drug use has been approached in an unscientific and irresponsible way. There is no evidence that advertising is likely to prevent drug abuse, and in fact highlighting drug use may have the reverse effect. In the 1960s, media stories which promoted the dangers of using glue to intoxicate oneself only served to inform children that the common substance could produce a high, and "to popularize rather than to discourage the practice."<sup>xxxi</sup> Prior to 1959, glue-sniffing was virtually unknown, but with its publicity, the number of high school students who reported trying it at least once rose to about 1 in 20 by the mid to late 1960s.<sup>xxii</sup>

Today, the ONDCP is running a series of advertisements on household inhalants which airs during children's cartoons and while parents are away at work. Just as with the glue-sniffing stories of the 1960s, it is very likely that most young people do not know that inhaling the vapors of everyday household products can produce a high, until they view the advertisements on television. Sending this information into the homes of children without parental consent is irresponsible and has enormous potential for tragedy as children may decide to experiment with the chemicals found under every kitchen sink. According to David Kiley, the Senior Editor of the advertising industry's *Brandweek*, the research relied upon by the ONDCP, "hardly stands up to the slightest breeze of inquiry. In some cases the validity of key parts of the research is even refuted by the people responsible for it."<sup>xxiii</sup>

### **OBJECTIVE: REDUCE DRUG ABUSE AND USE AMONG WOMEN**

**Rationale:** Detailed information on women's drug use is limited. Data that examines gender and race-ethnicity and age are rarely published.<sup>xxiv</sup> The *1997 National Household Survey on Drug Abuse* found that 34.3% of white women, 19.2% of Latinas, and 24.9% of African-American women reported using an illegal drug in their lifetime. This survey, presents an incomplete assessment of total drug use since it did not include women who were homeless, in colleges and universities, or in institutionalized populations.

We do know that drug addiction has increased steadily among girls and women and, in the case of certain drugs, more rapidly than among boys and men.<sup>xxv</sup> From 1992 to 1997, for example, regular use of cocaine increased for women while men's cocaine use declined slightly.<sup>xxvi</sup> Addiction to legally prescribed drugs is also a more serious problem for women than men.<sup>xxvii</sup> Emergency room visits by women because of drug-related problems rose 35% between 1990 and 1996.<sup>xxviii</sup>

Women who abuse drugs often face a greater social stigma than men because they fail to fulfill our society's standard for female morality as well as their traditional role as the stabilizing force in the family.<sup>xxix</sup>

The extent of drug use among women, the causes of addiction, and its effect on women's lives and bodies are not fully understood because addiction has traditionally been treated as a male disease.<sup>xxx</sup> However, the problem of drug addiction among women cannot be separated from other aspects of their social conditioning. Studies of women who seek treatment for alcohol and other drug problems have revealed a dramatic connection between domestic violence, childhood abuse, and substance abuse.<sup>xxxi</sup> Women substance abusers have high levels of depression, anxiety, and feelings of powerlessness, and low levels of self-esteem and self-confidence.<sup>xxxii</sup> Punishing women strips them of control over their lives, exacerbates underlying problems, and fails to provide any strategy for long-term prevention.

Policy makers must recognize the connection between drug addiction among women and other health, social and economic problems that women face. The only effective way to address drug abuse is simultaneously to address the problems of violence and sexual abuse, unsafe housing, unemployment,



stereotyped sexual roles, lack of health care and lack of child care which contribute to the depression and hopelessness that are underlying causes of substance abuse.

The barriers to treatment for women must be addressed. First, only 41% of women who need drug treatment actually receive it.<sup>xxxiii</sup> Second, most programs are based on male-oriented models that are not geared to the needs of women.<sup>xxxiv</sup> The lack of accommodations for children is one of the most significant obstacles to treatment for women. Most clinics do not provide child care and many residential treatment programs do not admit women with children.<sup>xxxv</sup>

Treatment programs have traditionally failed to provide the comprehensive services -- including prenatal and gynecological care, contraceptive counseling, appropriate job training, and counseling for sexual and physical abuse -- that women need. The typical focus on individual pathology may exclude social factors, such as racism, sexism and poverty that are essential to an understanding of drug abuse in women.

### **Recommendation 1: Fund prevention programs that target women.**

Federal and state governments must increase the amount of funding for prevention efforts that target women and girls about the risks of alcohol and drug use. Prevention strategies and programs must be community-based and sensitive to women's diverse cultural backgrounds and must be developed with significant input from women from local communities.

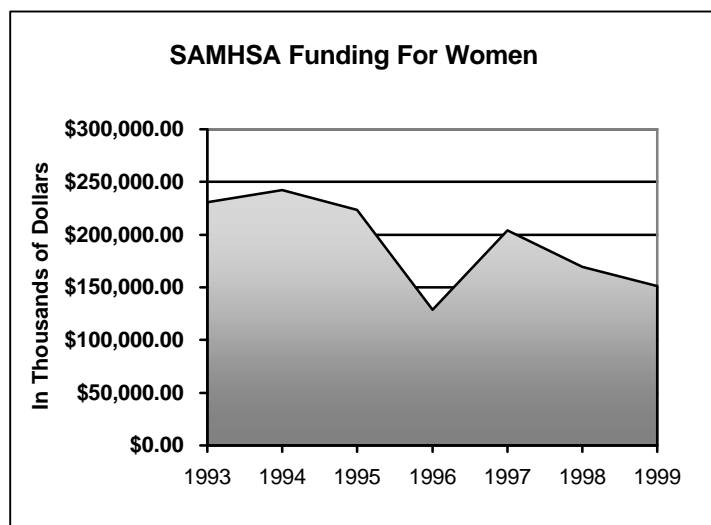
A critical component of a comprehensive national drug prevention strategy for women is widely available needle exchange programs. AIDS is the third leading cause of death among women of reproductive age in the United States, and the number one cause of death for African-American women.<sup>xxxvi</sup> In 1997, women accounted for 22% of AIDS cases, compared to seven percent in 1985. Among teenage women ages 13 to 19, the number of cumulative AIDS cases multiplied over 16 times between June 1989 and December 1997; for women ages 20 to 24 the number has multiplied more than nine times. *Injection drug use accounted for 28% and 14% of cases in women of these age groups, respectively.*<sup>xxxvii</sup> Women constitute the fastest growing group of new HIV cases in the United States.<sup>xxxviii</sup>

### **Recommendation 2: Increase services for women.**

SAMHSA funding for women reached its peak in 1994 when gender-specific demonstration programs only represented three percent of SAMHSA's total budget. SAMHSA funding designated for women has dropped 38% since 1994.<sup>xxxix</sup>

Congress should mandate increased funding for treatment facilities designed specifically for women. The goal should be universal access to both outpatient and residential treatment services for all women who are addicted to drugs and alcohol.

Federal and state guidelines must be established to ensure that programs are geared specifically to the needs of



**Figure 11** Source: Substance Abuse and Mental Health Services Agency, as provided by Drug Strategies, *Keeping Score*, 1998.

women. Guidelines should be flexible enough, however, to enable local programs to adjust to the particular needs and experiences of the communities they serve.

Programs must be designed to overcome the current barriers to women's access to and participation in treatment. The following features are essential to increasing the accessibility of treatment for women:

- Treatment should be provided on a sliding scale basis and Medicaid reimbursements should be accepted.
- Facilities must be accessible in light of poor transportation systems either by locating them at convenient sites within the community or by providing transportation.
- Programs must provide on-site child care and/or allow children to reside with their mothers.
- Programs should provide early education and pediatric services for children, either on-site or by referral.
- Gender sensitivity training must be provided for program staff.
- Programs must develop specific outreach efforts to draw women into treatment.
- Women should be contacted where they live, work and socialize and through community events.

### **Recommendation 3: Fund research on women's experiences**

Congress should increase the amount and proportion of funding devoted to research that explores the particular experience of women who abuse alcohol and other drugs. Federal funding of research projects should be greatly expanded. The research should answer the following questions about women and drug abuse:

- How prevalent is drug use among women, both pregnant and non-pregnant?
- What are the underlying causes, including social, psychological, biomedical, and economic factors, of women's drug abuse?
- How effective are various addiction prevention and treatment programs, including gender-specific treatment models and women-only facilities?

This research should not focus solely on the effects of drug use during pregnancy but throughout a woman's life span. All research should be done in the context of delivery of health care and its purpose should be to improve the health of all women.

## **OBJECTIVE: REDUCE DRUG ABUSE AND USE AMONG ALL AMERICANS**

**Rationale:** Simple common sense tells us that government spending to reduce alcohol and other drug use should focus on the most effective tactics. Unfortunately, years of politicization and the creation of numerous bureaucracies which derive funding from drug control spending have diverted our drug control budgets away from effective tactics and toward entrenched bureaucratic interests.

The ONDCP's 1999 drug control budget is a prime example of the misuse of public money. The RAND Corporation's thorough and scientific examination into the costs and benefits of treatment, interdiction, eradication and prison building has shown that investing additional resources in treatment is the most effective strategy to curtail drug use and abuse, yet the ONDCP's budget still focuses 2/3 of its budget on law enforcement and other ineffective tactics.

According to RAND's widely respected study, for each additional dollar spent on cocaine treatment, a social benefit of reduced cocaine consumption, crime and increased productivity valued at \$7.46 is

received, while each additional dollar spent on eradicating coca overseas represents a *loss of eighty-five cents*.<sup>xi</sup> Amazingly, the Drug Czar's office is requesting \$4.6 billion for source-country eradication and interdiction in 1999 (Goals 4 and 5), and plans annual spending increases in these areas over the next four years.<sup>xli</sup> Total spending on this approach would reach \$23 billion between 1999 and 2003. Given the choice of investing one dollar in a bank that will give us 15 cents at year's end or one that will give us over 7 dollars, the government has opted for the 15 cents. By continuing this waste, the government is failing to help those in need of treatment and failing to reduce the consumption of drugs in our communities.

### **Recommendation 1: Provide drug treatment upon request and a variety of treatment options.**

With so much talk by Congress and the White House about the damage that drugs cause our society, one would think our drug-treatment facilities were wide-open, and eagerly awaiting patients who have finally heeded the calls of our government to break their addiction. Not so. An addict can wait many months between a request for treatment and the availability of a treatment slot. A policy that chooses to provide prison cells rather than treatment beds makes a mockery of its claims to have a strategy to decrease drug use in America.

**FACT:** *In a study commissioned by the Drug Czar's Office and the US Army, the RAND Corporation has determined that for each additional dollar spent, domestic law enforcement costs 15 times more than simple drug treatment to achieve the same benefit of reduced cocaine consumption, reduced crime and reduced violence.*

**SOURCE:** Rydell, C. P. & Everingham, S.S. (1994). *Controlling Cocaine*, xvi. Santa Monica, CA: Drug Policy Research Center, RAND.

The provision for treatment upon request has been Federal law since 1988. Section 2012 of the Anti-Drug Abuse Act of 1988 sets out the purpose of the law, which is:

To increase to the greatest extent possible the availability and quality of treatment services so that treatment on request may be provided to all individuals desiring to rid themselves of their substance abuse problem.<sup>xlii</sup>

Yet, the 1998 *National Drug Control Strategy*, which provides a 10-year plan for US national drug strategy, makes no provision for making treatment-on-request a reality. The President, the Congress, researchers and drug abuse professionals all agree treatment on request should be made available, yet the ONDCP has not even mentioned it as a goal.

Furthermore, treatment options need to be expanded to address the variety of needs persons with drug problems have. Some people will respond quite readily to abstinence-based programs like Narcotics Anonymous and Alcoholics Anonymous. Others will require methadone therapy to stave off the symptoms of opiate addiction, or a gradual weaning from their addiction through doctor-supervised maintenance programs. For more specific recommendations of treatment options, please see the section entitled, "Allow Doctors Greater Freedom to Address Public Health Issues."

### **Recommendation 2: Enact legislation that provides full continuum insurance coverage for substance abuse treatment.**

If our society is truly serious about reducing drug use, then we must make every effort to move those people who wish to be treated for drug addiction into treatment facilities. One of the most effective means to do so is to provide "full continuum" insurance for substance abuse. As stated in a report commissioned by the Connecticut State Legislature, this would "include screening, assessment, intervention, detoxification, short-term and long-term inpatient rehabilitation, outpatient and intensive outpatient services, family treatment, and methadone maintenance treatment."<sup>xliii</sup> This was also the goal of legislation introduced in the 105<sup>th</sup> Congress.<sup>xliiv</sup> By providing addiction treatment through medical

insurance, we reduce the need for people to rely on public funding and facilities to treat substance abuse problems.

### **Recommendation 3: Reduce children’s exposure to cigarette and alcohol advertising.**

One of the main goals of advertising is to create demand for a product, industry or idea. As two of the largest sources of illness and death in America, it is not beneficial to glamorize or promote cigarettes and alcohol to young children. An effective drug control strategy would examine ways to reduce children’s exposure to such marketing, perhaps by limiting alcohol ads to television programs which are rated for adult content. The marketing of addictive products to children must be addressed, while balancing the commercial speech rights of legal businesses to market their products or educate the public on policy issues related to their industry.

## **OBJECTIVE: REDUCE THE SPREAD OF INFECTIOUS DISEASE**

**Rationale:** As surprising as it may seem, many criminal laws to control drug use actually work against vital public health goals, such as the suppression of AIDS/HIV and Hepatitis-C. Clearly, any policy that sacrifices the health and well being of the entire community by spreading deadly communicable diseases in an effort to “send the right message” needs to be amended so that it does not cause greater damage to society than the drug use itself.

**QUOTE:** “A meticulous scientific review has now proven that needle exchange programs can reduce the transmission of HIV and save lives without losing ground in the battle against illegal drugs.”

- Donna Shalala, Secretary Dept. HHS

**SOURCE:** HHS News. (1998, April 20). *Research Shows Needle Exchange Programs Reduce HIV Infections Without Increasing Drug Use*. Washington, DC: HHS Press Office.

### **Recommendation 1: Repeal all State and Federal laws designed to prevent access to and possession of sterile syringes and injection equipment.<sup>xlv</sup>**

Needle exchange programs are one of the most effective means of stemming the devastating and costly tide of AIDS and Hepatitis in our communities. Each day, 33 Americans<sup>xlvi</sup> become newly infected with HIV, and 50% of these cases are due to the sharing of contaminated needles.<sup>xlvii</sup> Women and children are even more severely impacted by needle contamination. Ninety (90%) percent of all new AIDS cases in women and in children under 13 for which the exposure group is known are injection related.<sup>xlviii</sup> Each person living with AIDS will need approximately \$195,000 in treatment over their lifetime<sup>xlix</sup> and can potentially infect thousands of other individuals; meanwhile, a clean syringe only costs about eight cents. These needless deaths and costs can be avoided through the use and promotion of needle exchange programs and provision of syringes in pharmacies. Laws which exist to limit the supply of clean needles, simply ensure the proliferation of contaminated needles.

While opponents claim that needle exchange programs “send the wrong message,” the U.S. Government has funded seven reports on clean needle programs for persons who inject drugs, and each of the reports concluded that clean needle programs reduce HIV transmission and do not increase drug use. The reports were conducted by the National Commission on AIDS, the General Accounting Office, the University of California, the Centers for Disease Control, the National Research

**FACT:** *Needle exchange programs reduce the spread of AIDS and increase the likelihood of injection drug users entering drug treatment programs.*

**SOURCE:** National Institutes of Health Consensus Panel. (1997, February 11-13). *Interventions to Prevent HIV Risk Behaviors*, 6. Kensington, MD: NIH Consensus Program Information Center.

Council, the Institute of Medicine, the Office of Technology Assessment, and the National Institutes of Health Consensus Panel. In fact, Baltimore's Health Commissioner Peter Bielensohn, has found that instead of "sending the wrong message," quite the opposite is true as stated in his testimony before Congress:

Finally, although some legislators expressed concerns that the [needle exchange] program would make it more likely that injection drug users would use more frequently, that has not been the case - our clients report a 22% decrease in their frequency of [drug] use since joining the NEP [needle exchange program].<sup>1</sup>

Equally important, the National Institutes of Health have concluded that "individuals in areas with needle exchange programs have an increased likelihood of entering drug treatment programs."<sup>ii</sup> Thus, needle exchange programs reduce AIDS *and* work toward reducing drug abuse.

## **Recommendation 2: Make prevention and treatment of Hepatitis-C a high public health priority.**

Just as with the emergence of HIV, which was spread in part by the sharing of needles, a newly recognized strain of Hepatitis, known as Hepatitis-C Virus (HCV) is rapidly emerging as a major blood-borne disease. According to the Centers for Disease Control and Prevention, "HCV infection is a major cause of chronic liver disease in the United States and worldwide. At least 85% of persons with HCV infection become chronically infected and chronic liver disease with persistently elevated enzymes develops in approximately 70% of all HCV infected persons."<sup>iii</sup> Unlike the inexpensive intervention of decriminalizing needle possession, the CDC says "the estimated cost for each [infected] person for a 6-month course of therapy is \$200,000."<sup>iiii</sup> In 1998, it was estimated that approximately 4,000,000 Americans were infected with Hepatitis-C. The cost and devastation that will be caused by this epidemic can be greatly reduced through a strong and effective education campaign, combined with outreach to at-risk populations and access to sterile syringes. There is also a need for drug users to have access to medical care, accurate information about the possibility of disease progression once infected, an all out effort for a cure and for drug users to be included in developing new therapeutic interventions.

## **GOAL NUMBER ONE: CHAPTER SUMMARY**

We need to reduce the harm that drug use and abuse cause in our society. This requires that we find solutions to drug abuse that really work. Some important strategies to consider include forming a commission of non-partisan experts to evaluate the effects of the current drug control model and allowing cities and states greater flexibility to experiment with their own approaches to drug control. It is also important that drug policy not be based on clearly erroneous concepts like the 'gateway' theory which have been rejected by prestigious groups such as the World Health Organization. Separating the markets for marijuana and other illegal drugs may also be a wise approach because research shows that it is the black market which introduces youth to more harmful substances.

Reducing drug use and abuse among youth and young adults is another important goal in reducing the harm caused by drugs. An effective drug control strategy would implement Drug Czar Barry McCaffrey's assertion that "The principal component of our drug strategy ought to be based on prevention programs aimed at adolescents."<sup>liv</sup> Making this the principal component requires that it receive a principal share of the funding. To carry out this goal, we need to do two things: raise the spending on youth prevention from its current paltry level of 12% of the drug control budget to 34% and spend that 34% of the budget on programs that actually work as demonstrated by science and research. Investments in our youth, such as after school programs, Big Brother/Big Sister programs, and other enrichment activities are effective and the Federal government's research as published by SAMHSA confirms this. Meanwhile, programs like DARE, television ads and other scare-tactics have not been proven effective at reducing drug use. Funding for programs should be competitive and based on results, not politics.

We must also seek to reduce drug use and abuse in all age groups and in all sectors of society, with special emphasis on the needs of women. Since treatment has been shown to be the most effective tool to reduce drug consumption in this country, it should be a serious component of our national drug control strategy. Instead of putting 2/3 of our funding into law enforcement measures, we should fully fund treatment centers so that treatment is available upon request, and enact legislation that provides full-continuum insurance coverage for drug and alcohol addiction. In the struggle against the harms of drug and alcohol addiction, the lack of treatment availability in the United States virtually ensures that we will continue to suffer horrendous social costs from these diseases.

Finally, we must stop the spread of diseases associated with injection drug use. With the high number of new HIV and hepatitis infections, laws against the possession of clean needles are a virtual death sentence. Needle exchange programs do not increase drug use, but do save lives. A ban on federal funding for needle exchange programs is pure folly. Claims that decriminalizing needle possession will lead to increased drug use have been never been proven. Seven reports funded by the U.S. Government between 1991 and 1997 are unanimous in their conclusions that clean needle programs reduce HIV transmission, and none find that clean needle programs cause rates of drug use to increase.<sup>iv</sup>

## A Partial List of Organizations Supporting Needle Exchange

Academy for Educational Development	National Alliance of State and Territorial AIDS Directors
Advocates for Youth	National AIDS Treatment Advocacy Project
AIDS Action Council	National Association of Alcoholism and Drug Abuse Counselors
AIDS National Interfaith Network	National Association of County and City Health Officials
AIDS Policy Center for Children, Youth and Families	National Association of People With AIDS
AIDS Related Community Services	National Association of Protection and Advocacy Systems
AIDS Resources, Information and Services of Santa Clara County	National Association of Social Workers
American Academy of Pediatrics	National Association of State Alcohol and Drug Abuse Directors
American Academy of Psychiatrists in Alcoholism and Addictions	National Black Police Association
American Foundation for AIDS Research	National Catholic AIDS Network
American Medical Association	National Council of Jewish Women
American Medical Student Association	National Episcopal AIDS Coalition
American Nurses Association	National Gay and Lesbian Task Force
American Pharmaceutical Association	National Health Law Program
American Psychiatric Association	National Latino/a Lesbian and Gay Organization
American Psychological Association	National Lesbian and Gay Health Association
American Public Health Association	National Minority AIDS Council
American Society of Addiction Medicine	National Native American AIDS Prevention Center
Association for Professionals in Infection Control and Epidemiology, South Jersey	National Network for Youth
Association of Nurses in AIDS Care	National Puerto Rican Coalition
Association of Schools for Public Health	National Ryan White Title IIIb Coalition
Association of State and Territorial Health Officers	National Task Force on AIDS Prevention
California Latino Civil Rights Network	National Association of Psychiatric Health Systems
Californians for Justice	New Hampshire Medical Society
Centers for Disease Control and Prevention	Medical Society of New Jersey
Center for Women Policy Studies	New Jersey Pharmaceutical Association
Children's Hospital of New Jersey	Kaiser Foundation
Committee for Children	Marin County Board of Supervisors
Funders Concerned About AIDS	Marin County AIDS Advisory Commission
Gay and Lesbian Medical Association	Minnesota Department of Health
Gay Men's Health Crisis	Commissioner's Task Force on HIV/STD Prevention
Housing Works, Inc.	Texas Board of Pharmacy
Human Rights Campaign	Texas Sheriffs Association
Illinois State Medical Society	U.S. Conference of Mayors
Illinois Alcoholism and Drug Dependence Association	World Health Organization
Institute for Family-Centered Care	
Mothers' Voices Against AIDS	
National AIDS Fund	

<sup>i</sup> On April 16<sup>th</sup>, 1997, Rep. Cummings (D-MD) with 19 democratic cosponsors introduced H.R. 1345 a bill to create a *Commission on National Drug Policy*.

<sup>ii</sup> Drucker, Dr. Ernest. (1998, Jan./Feb.). *Public Health Reports*, "Drug Prohibition and Public Health." U.S. Public Health Service. Vol. 114, p. 17.

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- <sup>iii</sup> On December 3, 1998 when a caller to CSPAN's *Washington Journal* asked about legal access to marijuana General McCaffrey said: "... I think it's a legitimate cause for debate in a democracy. The country ought to do whatever it thinks is appropriate. Many of us are uncomfortable with the idea of more psychoactive drugs. We're opposed to it and that's a viewpoint I couldn't express more strongly..."
- <sup>iv</sup> Associated Press. (3 March 1998). "Kennedy Proposes Crime Program." Washington, DC: Associated Press.
- <sup>v</sup> Hall, W., Room, R. and Bondy, S. (1998, March). *WHO Project on Health Implications of Cannabis Use: A Comparative Appraisal of the Health and Psychological Consequences of Alcohol, Cannabis, Nicotine and Opiate Use, August 28, 1995*.
- <sup>vi</sup> Dutch Ministry of Health, Welfare and Sport [VMS]. (1995). *Drug Policy in the Netherlands: Continuity and Change*. The Netherlands.
- <sup>vii</sup> Abt. & Associates, Inc. (1997, September 29). *What America's Users Spend on Illegal Drugs, 1988-1995*. Commissioned by the White House ONDCP; U.S. Bureau of the Census. (1996). *Statistical Abstract of the United States: 1996* (116<sup>th</sup> Edition). Washington, DC.
- <sup>viii</sup> Substance Abuse and Mental Health Administration, *National Household Survey on Drug Abuse: Population Estimates 1997*, Rockville, MD: Substance Abuse and Mental Health Administration (1998, July), pp. 23, 103, 113 [a regular user is someone who used a drug 51 or more days in the past year].
- <sup>ix</sup> The *Monitoring the Future Survey* is an annual survey of drug use by 8<sup>th</sup>, 10<sup>th</sup>, and 12<sup>th</sup> grade students.
- <sup>x</sup> ONDCP, "1998 Monitoring the Future Study: Tide of Youth Drug Use Turns" December 18, 1998 (press release).
- <sup>xi</sup> McCaffrey, Barry R. (1998). *The National Drug Control Strategy, 1998: A Ten Year Plan*. Washington, DC: Office of National Drug Control Policy, p. 58.
- <sup>xii</sup> Carmona, Maria and Kathryn Stewart. (1996). "A Review of Alternative Activities and Alternatives Programs in Youth-Oriented Prevention" *CSAP Technical Report No. 13*. Washington, DC: Center for Substance Abuse Prevention/ Substance Abuse and Mental Health Administration/ Department of Health and Human Services, p. 3.
- <sup>xiii</sup> *Federal Register*, Volume 58, Number 60, March 31, 1993.
- <sup>xiv</sup> Carmona and Stewart, p. 5.
- <sup>xv</sup> Carmona and Stewart, p. 5.
- <sup>xvi</sup> Tierney, Joseph P., Jean Baldwin Grossman, and Nancy L. Resch. (1995 November). *Making a Difference: An Impact Study of Big Brothers/Big Sisters*. P. 49. Philadelphia, PA: Public/Private Ventures.
- <sup>xvii</sup> Perhaps the main justification for a "zero-tolerance" policy towards marijuana, even to prevent blindness in glaucoma patients or to ease nausea in cancer patients, is the belief that marijuana is a "gateway" drug which leads young people to seek ever more powerful drugs like cocaine and heroin. Some research institutions have tried to prove the existence of the gateway effect, but none have succeeded. The National Center on Addiction and Substance Abuse (CASA) is the leading proponent of the theory today, but even it has had to acknowledge that "what is lacking is the basic scientific and clinical research required to establish causality." [Merrill, Jeffrey C. and Kimberly S. Fox. (1994). *Cigarettes, Alcohol, Marijuana: Gateways to Illicit Drug Use*, "Implications for Future Action." New York, NY: CASA.] CASA's researchers have also had to acknowledge that "the majority of gateway drug users never move on to other drugs..." [Merrill & Fox, 1994]. Within its report, CASA acknowledges that the statistical correlation of cocaine and marijuana use "does not necessarily prove that a causal relationship exists." [Merrill & Fox, 1994]. And, although CASA's researchers note that "the majority of marijuana users never use any other illegal drug," CASA refuses to acknowledge that "for the large majority of people, marijuana is a *terminus* rather than a *gateway* drug." [Zimmer and Morgan, p. 32.]
- <sup>xviii</sup> DARE was created by former Los Angeles Police Chief, Daryl Gates. The program employs uniformed police officers to teach drug education to public school children.
- <sup>xix</sup> Ennett, S. T., et. al. (1994, September). "How Effective is Drug Abuse Resistance Education? A Meta-analysis of project DARE Outcome Evaluations." *American Journal of Public Health*.
- <sup>xx</sup> Half the high school students in the United States will try illegal drugs before they graduate. Johnston, L., Bachman, J. & O'Malley, P. (1996). *National survey results from the monitoring the future study*, HHS, National Institute on Drug Abuse.
- <sup>xxi</sup> Brecher, Edward M. *The Consumers' Union Report on Licit and Illicit Drugs*. "How to Launch a Nationwide Drug Menace." Ch. 44. (1972). Little Brown and Company.
- <sup>xxii</sup> *Ibid*.
- <sup>xxiii</sup> Kiley, David. (1998, April 27). "Blind Support for Anti-Drug Ads? Just Say No." *Brandweek*.
- <sup>xxiv</sup> Drug Strategies. (1998). *Keeping Score, 1998: Women and Drugs: Looking at the Federal Drug Control Budget*. Washington, DC: Drug Strategies.



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- <sup>xxv</sup> Drug Strategies (1998), citing NIDA, *Monitoring the Future*, 1975-97; Drug Strategies (1998), citing SAMHSA, November 1997, *Preliminary Estimates from the 1996 Drug Abuse Warning Network*. SAMHSA (November 1997).
- <sup>xxvi</sup> SAMHSA. (1998, August). *Preliminary Results from the 1997 National Household Survey on Drug Abuse*
- <sup>xxvii</sup> H.A. Pincus, T.L. Tanielian, S.C. Marcus, M. Olfson, D.A. Zarin, J. Thompson and J.M. Zito. (1998). "Prescribing Trends in Psychotropic Medications: Primary Care, Psychiatry, and Other Medical Specialities." *JAMA*. 279(7), 526-531.
- <sup>xxviii</sup> Drug Strategies (1998) citing SAMHSA (1997, November), *Year End Preliminary Estimates from the 1996 Drug Abuse Warning Network*. Washington, DC.
- <sup>xxix</sup> Roberts, Dorothy. (1991). *Women, Pregnancy, and Substance Abuse*. Washington, DC: Center for Women's Policy Studies.
- <sup>xxx</sup> Millstein, Richard A. (1998, December). "Gender and Drug Abuse Research." *The Journal of Gender-Specific Medicine*. 1(3); see also Roberts, Dorothy. (1991).
- <sup>xxxi</sup> SAMHSA. (1997). *Substance Abuse Treatment and Domestic Violence*. Washington, DC: SAMHSA.
- <sup>xxxii</sup> Dansky, B.S., Saladin, M.E., Brady, K.T., Kilpatrick, D.G., and Resnik, H.S. (1995). "Prevalence of Victimization and Post Traumatic Stress Disorder Among Women With Substance Use Disorders: Comparison Telephone and In-Person Assessment Samples." *The International Journal of Addictions*. 30(9). 1079-1099.
- <sup>xxxiii</sup> Woodward, A., Epstein, J., Gfroerer, J., Melnick, D., Thoreson, R., and Willson, D. (1997 Spring). "The Drug Abuse Treatment Gap: Recent Estimates." *Health Care Financing Review*. Vol. 18, No. 3. Table 3, p. 15.
- <sup>xxxiv</sup> Paone, D., Chavkin, W., Willets, I., Friedman, P., and Des Jarlais, D. (1992) "The Impact of Sexual Abuse: Implications of Drug Treatment." *Journal of Women's Health*. 1(2). p. 149-153.; see also Roberts. (1991).
- <sup>xxxv</sup> Breitbart, V., Chavkin, W., and Wise, P. (1994). "The Accessibility of Drug Treatment for Pregnant Women: A Survey of Programs in Five Cities." *American Journal of Public Health*. 84 (10).
- <sup>xxxvi</sup> Anderson, R.N., Kochanek, K.D, and Murphy, S. L. (1997). "Report of Final Mortality Statistics, 1995." *Monthly Vital Statistics report*, 45. (11) Supplement 2. Hyattsville, MD: National Center for Health Statistics.
- <sup>xxxvii</sup> Centers for Disease Control, 1997, *HIV/AIDS Surveillance Report 9*, 2. Atlanta, GA: Centers for Disease Control.
- <sup>xxxviii</sup> Centers for Disease Control, 1996, *HIV/AIDS Surveillance Report*, 8, 2. Atlanta, GA: Centers for Disease Control.
- <sup>xxxix</sup> Drug Strategies. (1998).
- <sup>xl</sup> Rydell & Everingham. *Controlling Cocaine: Supply Versus Demand Programs*, RAND Corporation (Santa Monica, CA: 1994), p. xvi).
- <sup>xli</sup> ONDCP, *The National Drug Control Strategy*, 1998, p. 59.
- <sup>xlii</sup> *The Anti-Drug Abuse Act of 1988*. Public Law 100-690. (1988, November 18).
- <sup>xliii</sup> *Drug Policy in Connecticut and Strategy Options: Report to the Judiciary Committee of the Connecticut General Assembly*. (1997, January 21). Connecticut Law Revision Commission.
- <sup>xliv</sup> *The Moynihan-Levin Anti-Addiction and Drug Treatment Access Act of 1998*.
- <sup>xlv</sup> H.R. 2212, *HIV Prevention Outreach Act*, was introduced by Rep. Cummings (D-MD) with 7 co-sponsors on July 22<sup>nd</sup>, 1997. This bill would have required the Secretary of Health and Human Services to make grants to "States and political subdivisions of States" for needle exchange programs.
- <sup>xlvi</sup> *AIDS Official Backs Needle Exchange*. (March 27, 1996). Associated Press. Quoting the Director, Office of National AIDS Policy Sandra Thurman at a National AIDS UPDATE Conference.
- <sup>xlvii</sup> Holmberg, S. (1996). "The Estimated Prevalence and Incidence of HIV in 96 Large US Metropolitan Areas." *American Journal of Public Health*, 86, 642-54.
- <sup>xlviii</sup> Centers for Disease Control. *HIV/AIDS Surveillance Report. HIV and AIDS Cases Reported through December 1997*. Year-end edition, Vol. 9, No. 2.
- <sup>xliv</sup> Holtgrave, DR, Pinkerton, SD. "Updates of Cost of Illness and Quality of Life Estimates for Use in Economic Evaluations of HIV Prevention Programs." *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*, Vol. 16, pgs. 54-62 (1997).
- <sup>i</sup> Bielensohn, MD, Peter. (1997, September 18). Written testimony of Dr. Bielensohn to Subcommittee on National Security, International Affairs and Criminal Justice.
- <sup>ii</sup> National Institutes of Health Consensus Panel. (1997, February 11-13). *Interventions to prevent HIV risk behaviors*, 6. Kensington, MD: NIH Consensus Program Information Center.
- <sup>iii</sup> Centers for Disease Control. *Morbidity and Mortality Weekly Report*. (1997, July 4). Vol. 46, No. 26. Atlanta, Georgia.
- <sup>liii</sup> *Ibid*.

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<sup>liv</sup> ONDCP Director, General Barry McCaffrey speaking on *Talk of the Nation*. (1998, February 25).

<sup>lv</sup> National Commission on AIDS, *The Twin Epidemics of Substance Abuse and HIV*, Washington D.C.: National Commission on AIDS (1991); General Accounting Office, *Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy*, Washington D.C.: U.S. Government Printing Office (1993); Lurie, P. & Reingold, A.L., et al., *The Public Health Impact of Needle Exchange Programs in the United States and Abroad*, San Francisco, CA: University of California (1993); Satcher, D., (Note to Jo Ivey Bouffard), *The Clinton Administration's Internal Reviews of Research on Needle Exchange Programs*, Atlanta, GA: Centers for Disease Control (1993, December 10); National Research Council and Institute of Medicine, Normand, J., Vlahov, D. & Moses, L. (eds.), *Preventing HIV Transmission: The Role of Sterile Needles and Bleach*, Washington D.C.: National Academy Press (1995); Office of Technology Assessment of the U.S. Congress, *The Effectiveness of AIDS Prevention Efforts*, Springfield, VA: National Technology Information Service (1995); National Institutes of Health Consensus Panel, *Interventions to Prevent HIV Risk Behaviors*, Kensington, MD: National Institutes of Health Consensus Program Information Center (1997, February).