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Operation Tripwire Revisited

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ABSTRACT: A major new proposal to refocus national efforts on heroin addicts in the criminal justice system, called Operation Tripwire, was announced on 1 October 1977. The proposal called for the universal testing of offenders in the criminal justice system for drugs, and the establishment of sustained drug-free status, confirmed by repeated drug testing, as a condition of release to the community. Despite its being grounded in a large body of solid research evidence and meeting vital social needs, Tripwire was never implemented. Today, with the introduction of the Drug Use Forecasting program, we have a more convincing indication of the enormous drug abuse problems in the criminal population. It may be time to dust off and update the original Tripwire idea. If that is to happen, it will require the convergence of many political, media, and fiscal forces, all based on research. The potential beneficiaries of such a development are many, but the odds against it remain long.

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IN the fall of 1977, Robert L. DuPont, then director of the National Institute on Drug Abuse (NIDA), proposed a major new initiative to test the urine of all parolees and probationers in the country for heroin use, making clean urines a condition of continued release to the community. This was called "Operation Tripwire," to signify that the urine test was to trigger imprisonment as a sanction for heroin use.

The Tripwire idea was never implemented, and, in fact, the proposal itself was one of the factors that led to the request by the secretary of the Department of Health, Education and Welfare for the resignation of DuPont as NIDA director a few months later. The climate of the times was hostile to this proposal as federal drug abuse officials were then promoting decriminalization of marijuana and cocaine, not new ideas to reduce heroin use among criminal offenders.

The first part of this article rekindles the memory of that period and explores what was then known about drug abuse and crime, as it related to drug testing within the criminal justice system, and the factors that led to the rejection of this idea.

Today we have a wider definition of the problem of illicit drug abuse. Urine-testing technology and practices have developed substantially. We also have hard data on drug use by arrestees provided by the National Institute of Justice's Drug Use Forecasting system, which was conceived and implemented in 1987 by Eric Wish, Paul Cascarano, John Spevacek, and Joyce O'Neil, with the strong support of James K. Stewart, the director of the National Institute of Justice.

The second section of the article dusts off the Tripwire proposal, suggests that it now include all illicit drugs, and puts it at the center of the criminal justice system (CJS) efforts in the 1990s to cut the link between illicit drug use and crime. The potential beneficiaries are many, including drug-abusing criminal offenders themselves, their families, and communities. In addition, an updated Tripwire proposal offers hope to the criminal justice system, which is now being crushed by the load of drug-involved offenders. Most important of all, a new Tripwire proposal offers hope to the communities hardest hit by illicit drug abuse, communities made unlivable by drugs, especially poor urban communities.

The social institutions having the broadest and most powerful impact in these communities are the schools, Aid to Families with Dependent Children, and the criminal justice system. If these communities are to rid themselves of the modern plague of drug abuse, these institutions offer the greatest hope. Because of the higher levels of controversy surrounding the schools and Aid to Families with Dependent Children, when it comes to effective antidrug efforts,[1] the last best chance for these communities to end the two-decade-long drug abuse epidemic lies with the CJS. The CJS has the most direct impact on the youths

1. Robert L. DuPont, "Should Welfare Mothers Be Tested for Drugs?" in *Winning the Drug War: New Challenges for the 1990s*, ed. Jeffrey A. Eisenach (Washington, DC: Heritage Foundation, 1991), pp. 83-95.

at highest risk, teenagers and young adults engaging in criminal behavior. The Tripwire proposal is powerful medicine to help solve this problem in these besieged communities.

Finally, the third section of the article focuses on the general problems of research and policy in the criminal justice system, using the issue of drug testing in the criminal justice system as a model for this broader perspective.

DRUGS AND CRIME, 1977

The modern American experience with drugs and crime dates from the late 1960s, when there was a dramatic upsurge in the rates of crime and illicit drug use throughout the country, despite the widespread economic prosperity at the time and despite the major funding then taking place for community development and poverty programs.[2] Washington, D.C., at a time when it was a federal city not yet governed by home rule, was a focus of unique concern. The city was labeled in the 1968 presidential election as the "crime capital" of the nation.

Hallucinogens were widely used by American youths for the first time in the late 1960s, especially on the nation's most prestigious campuses, with their effects being glorified as "consciousness expansion" by Timothy Leary, the Harvard professor, and other pied pipers of drug abuse. Marijuana use soon surpassed hallucinogen use as illicit drug use spread to all segments of America's youths.[3]

The federal role in drug abuse at that time was more or less limited to research on opiates and to law enforcement targeted on drug trafficking.[4] The federal research interest was centered in Lexington, Kentucky, where the government's small research-oriented treatment program for addicts had been located since the 1930s on the remarkable assumption that taking addicts out of large cities into the fresh air of the "narcotics farm" would help them kick their habits. The Addiction Research Center (ARC) at Lexington was not only the source for virtually all non-law-enforcement federal drug abuse activities but a major foundation on which the National Institute for Mental Health, the National Institute on Alcohol Abuse and Alcoholism, and the NIDA were built. Until the late 1960s, ARC was virtually the only place in the world where biological research on addiction took place.

ARC was the place where a distinguished physician-researcher, George E. Vaillant, got his start by establishing, with a follow-up of 100 addicts released from Lexington, that the best prognosis for addicts' achieving prolonged abstinence occurred not with prolonged incarceration but with short periods of incar-

2. James Q. Wilson and Robert L. DuPont, "The Sick Sixties," *Atlantic Monthly*, Oct. 1973, pp. 91-98.

3. Robert L. DuPont, *Youth and Drugs: Society's Mixed Messages*, DHHS pub. no. (ADM) 90-1689 (Rockville, MD: Department of Health and Human Services, Office for Substance Abuse Prevention, 1990), pp. 1-3.

4. Robert L. DuPont, "The Drug Abuse Decade," *Journal of Drug Issues*, 8:173-87 (1978).

ceration followed by intensive and prolonged supervision in the community with reincarceration being the swift consequence of return to illicit drug use.[5] This pioneering research supported the development of the civil commitment programs in New York and California and a much smaller program in the federal government, created by the Narcotics Addiction Rehabilitation Act, begun in 1967.[6]

In August 1969, a group of college students working within the District of Columbia Department of Corrections tested the urine of people recently incarcerated. They found that 45 percent tested positive for heroin use. A self-report questionnaire administered to these arrestees showed that their heroin use had begun within the previous three years and that the rate of new heroin use was directly correlated with the rate of serious crime in the city.[7]

From 1965 on, methadone maintenance treatment became more widely used in New York City under the leadership of physician-researchers Vincent Dole and Marie Nyswander. In Chicago, a brilliant young research physician, Jerome Jaffe, created the multimodality drug abuse treatment concept in which a central publicly funded treatment program offered a spectrum of treatment options, including both methadone detoxification and methadone maintenance, as well as a variety of drug-free treatments, especially the therapeutic community.[8]

The newer forms of treatment for addiction, therapeutic communities and methadone maintenance, focused on heroin addicts. Neither approach was primarily dependent on civil commitment, an idea that was eclipsed, even in California and New York, where it was most fully developed, by the early 1970s. Civil commitment programs were found to be expensive and difficult to administer. They were overwhelmed by the rising rates of heroin addiction, which pumped ever larger numbers of addicts into already underfunded facilities. By the early 1970s in the United States, drug abuse treatment meant a combination of voluntary treatment —mostly methadone treatment—

5. George E. Vaillant, "A Twelve Year Followup of New York Narcotic Addicts: I. The Relation of Treatment to Outcome," *American Journal of Psychiatry*, 122:727-37 (1966); idem, "A 20 Year Followup of New York Narcotic Addicts," *Archives of General Psychiatry*, 20:237-41 (1973).

6. William H. McGlothlin, M. Douglas Anglin, and B. D. Wilson, *Narcotic Addiction and Crime* (Los Angeles: University of California, Los Angeles, 1977).

7. Robert L. DuPont, "Profile of a Heroin-Addiction Epidemic," *New England Journal of Medicine*, 285:320-24 (1971); Nicholas J. Kozel, Robert L. DuPont, and Barry S. Brown, "Narcotics and Crime: A Study of Narcotic Involvement in an Offender Population," *International Journal of the Addictions*, 7:443-50 (1972); Urbane F. Bass, V. W. Brock, and Robert L. DuPont, "Narcotic Use in an Inmate Population at Three Points in Time," *American Journal of Drug and Alcohol Abuse*, 3:375-86 (1976); Nicholas J. Kozel and Robert L. DuPont, *Criminal Charges and Drug Use Patterns of Arrestees in the District of Columbia*, National Institute on Drug Abuse Technical Paper (Rockville, MD: National Clearinghouse on Drug Abuse Information, 1977).

8. National Commission on Marihuana and Drug Abuse, "History of the Treatment of Opiate Dependence," in *Drug Use in America: Problem in Perspective* (Washington, DC: Government Printing Office, 1973), pp. 305-42.

and treatment linked to the criminal justice system—mostly therapeutic communities.

Leaders of each of these innovative treatment approaches were physicians and other health professionals personally committed to research. The early 1970s were the Camelot of publicly funded drug abuse treatment. It was an incredibly fertile period of activity led by a handful of scientists who possessed creativity and charisma. They were supported by both political parties without obvious partisanship, from the local and state levels to the federal level.[9]

Innovations in drug abuse treatment at this time were primarily taking place in Washington, D.C., New York, and Chicago. The Narcotics Treatment Administration, Washington, D.C.'s citywide comprehensive drug abuse treatment agency, was created on 18 February 1970. The country's first court-based universal drug testing was begun in the newly created Superior Court on 1 April of that year.[10] These efforts in Washington formed the basis for the modern federal efforts in the drug abuse field, including the White House Special Action Office for Drug Abuse Prevention (SAODAP) and Treatment Alternatives to Street Crime.[11] The Washington experience began with research in the D.C. Jail and led to the publication of more than 100 research papers during the National Treatment Administration's first three years of operation. The Washington program, headed by Robert L. DuPont, grew out of the D.C. Department of Corrections and was closely linked to the rehabilitation components of the local criminal justice system, including pretrial release, probation, parole, and halfway-house programs.[12]

The first White House drug czar, appointed on 17 June 1971, was Jerome Jaffe, the country's most distinguished innovator in the drug abuse field.[13] His first assignment from the President was to go to Vietnam to deal with the explosive problem of heroin addiction among American military personnel. Jaffe's response to this problem was definitive: test the urine of all servicemen before they returned to the United States, making a clean urine a condition for release at home. This approach was known informally in military jargon as "Operation Golden Flow."

The White House drug office was a consistently friendly home for drug

9. Jerome H. Jaffe, "The Swinging Pendulum: The Treatment of Drug Users in America," in *Handbook on Drug Abuse*, ed. Robert L. DuPont, Avram Goldstein, and John A. O'Donnell (Washington, DC: Government Printing Office, 1979), pp. 3-16.

10. Robert L. DuPont and Richard N. Katon, "Development of a Heroin Addiction Treatment Program: Effect on Urban Crime," *Journal of the American Medical Association*, 216:1320-24 (1971); Robert L. DuPont and Mark H. Greene, "The Dynamics of a Heroin Addiction Epidemic," *Science*, 181:716-22 (1973).

11. Strategy Council on Drug Abuse, *Federal Strategy for Drug Abuse and Drug Traffic Prevention 1973* (Washington, DC: Strategy Council on Drug Abuse, 1973).

12. Robert L. DuPont, "How Corrections Can Beat the High Cost of Heroin Addiction," *Federal Probation*, 35:43-50 (1971); idem, "Heroin Addiction Treatment and Crime Reduction," *American Journal of Psychiatry*, 128:856-60 (1972).

13. David F. Musto, *The American Disease—Origins of Narcotic Control* (New York: Oxford University Press, 1987).

abuse researchers of all kinds. Not only was Treatment Alternatives to Street Crime the first national program to link the criminal justice system to substance abuse treatment, but it was an early product of SAODAP,[14] as were the major national drug abuse epidemiological studies, including the Drug Abuse Warning Network, which collected data from emergency rooms and medical examiners around the country; the Client Oriented Drug Abuse Program, which gathered data about drug abusers in all federally funded treatment programs; the National Drug Abuse Treatment Utilization Survey; and the National Household Survey on Drug Abuse. In 1975, SAODAP began support for the Monitoring the Future Project of the Institute for Social Research at the University of Michigan, Ann Arbor, which annually conducts the National High School Survey for the National Institute on Drug Abuse. This survey remains the nation's largest and most frequently administered drug use survey.[15]

One of the many brilliant researchers who worked with SAODAP in that era was John A. O'Donnell, who had worked for years at the ARC. He and his young colleague, Richard R. Clayton, studied drug use among American young men and established the linkage between the use of gateway drugs and the risk for subsequent heroin use, and many of the most fundamental characteristics of modern American drug abuse epidemiology.[16]

The nation's most distinguished black physician in the drug abuse field was Beny J. Primm, who in the late 1960s founded the comprehensive methadone treatment program in Brooklyn called the Addiction Rehabilitation and Treatment Center. When Dr. Jaffe was sent by the President to Vietnam in June of 1971, he took Dr. Primm with him.

Since the end of the first American drug abuse epidemic in about 1920, heroin addiction had been the central drug problem that preoccupied both law enforcement and treatment officials.[17] One of the many surprising aspects of the modern drug abuse epidemic was that heroin use, an end-stage drug habit, increased sharply in the very early stages of the modern American drug epidemic, peaking in 1971, long before marijuana and cocaine use reached their peaks in 1978 and 1987, respectively.[18] In the United States from about 1910 to about 1977, serious drug abuse was equated all but universally with heroin addiction.[19]

14. McGlothlin, Anglin, and Wilson, *Narcotic Addiction and Crime*.

15. U.S., Department of Health and Human Services, *Drug Abuse and Drug Abuse Research: The Third Triennial Report to Congress from the Secretary, Department of Health and Human Services*, DHHS pub. no. (ADM) 91-1704 (Rockville, MD: Department of Health and Human Services, National Institute on Drug Abuse, 1991).

16. John A. O'Donnell et al., *Young Men and Drugs—A Nationwide Survey*, DHEW pub. no. (ADM) 76-311 (Washington, DC: Superintendent of Documents, U.S. Government Printing Office, 1976).

17. Musto, *American Disease*.

18. Robert L. DuPont, "Prevention of Adolescent Chemical Dependence," *Pediatric Clinics of North America*, 34:1-11 (1987).

19. National Commission on Marihuana and Drug Abuse, *Drug Use in America*.

These experiences in the evolution of the national response to drug abuse shaped the Tripwire proposal.[20] This brief review of the history of the early years of the drug abuse epidemic makes clear that heroin was the drug that mattered most and that urine testing and compulsory treatment, including both civil commitment and the use of the criminal justice system, were at the center of drug abuse policy.[21] It is also important to recall that these early efforts to respond to the drug abuse epidemic focused on crime and poverty areas of large cities.

As the nation's heroin problems worsened in the early 1970s and the opposition to the war in Vietnam intensified, it became commonplace to blame the returning veterans for the heroin addiction problems in the nation's cities. The single most dramatic example of research at the highest scientific level affecting national drug abuse policy in a highly politicized area was the study by Lee N. Robins of returning servicemen.[22] Dr. Robins, not surprisingly, found that the rates of heroin use by servicemen while in Vietnam vastly exceeded the rates for a carefully matched control group of young men. What was revolutionary in her results was the finding that three years after their release from military service, whether they had received drug abuse treatment or not, the rates of heroin use for subjects who had served in Vietnam were not significantly different from those of the matched control group who had never served in the military or gone to Vietnam. This finding, which was so convincing that it left no room for doubt, effectively ended that highly political explanation for America's heroin epidemic.

Robins found that 88 percent of the servicemen who had been addicted to heroin while in Vietnam had not been addicted at any time during the three years after their return. Furthermore, even among those who reported heroin addiction during their first year back in the United States after leaving Vietnam, 70 percent were not addicted at any time during the following two years. These stunning findings went to the heart of two other common misconceptions in the drug abuse field: (1) that most people who were once addicted to heroin stayed addicted for the rest of their lives; and (2) that the only way to end heroin addiction was by using drug abuse treatment.[23] This study raised

20. Robert L. DuPont, "Operation Tripwire: A New Proposal Focused on Criminal Heroin Addicts" (Paper delivered at the convention of the Federal Bar Association, Washington, DC, 1 Oct. 1977).

21. McGlothlin, Anglin, and Wilson, *Narcotic Addiction and Crime*; William H. McGlothlin, "Criminal Justice Clients," in *Handbook on Drug Abuse*, ed. DuPont, Goldstein, and O'Donnell, pp. 203-9; William H. McGlothlin, M. Douglas Anglin, and B. D. Wilson, *An Evaluation of the California Civil Addict Program* (Rockville, MD: National Clearinghouse on Drug Abuse Information, 1977).

22. Lee N. Robins, *The Vietnam Drug User Returns* (Rockville, MD: National Clearinghouse on Drug Abuse Information, 1974); idem, "Addict Careers," in *Handbook on Drug Abuse*, ed. DuPont, Goldstein, and O'Donnell, pp. 325-36.

23. Lee N. Robins et al., "Vietnam Veterans Three Years after Vietnam: How Our Study Changed Our View of Heroin," in *Problems of Drug Dependence*, ed. L. Harris (Richmond, VA: Committee on Problems of Drug Dependence, 1977).

serious questions about the relevance of these assumptions for other populations and for the policies based on them. This historic and influential study by Dr. Robins required the active leadership of the White House drug czar because it involved timely and substantial funding for the nation's top longitudinal epidemiological researchers and the active participation of major government agencies, including the understandably skittish Department of Defense and Veterans Administration.

In the formative years of the contemporary federal drug abuse prevention program, the link between drug use and serious crime was a controversial issue. While the first focus of national concern about drugs was on heroin addiction and related inner-city crime, the drug issue rapidly evolved to focus on the unprecedented rises in marijuana use within the far larger middle class. Pot smoking was not obviously crime related. In the 1970s there was a broadly based effort to normalize the use of marijuana, seeking to treat it similarly to alcohol and tobacco. For this pro-pot movement to prosper, it was essential to unhook illicit drug use and crime except to the extent that marijuana sale and use were themselves criminal offenses. In the logic of those years, the application of criminal penalties to marijuana use was seen as a miscarriage of justice.

In the early 1970s, the most effective form of drug treatment appeared to be methadone maintenance for heroin addiction. In the 1975 federal drug strategy, attempting to respond to the already waning public support for government-sponsored drug programs, there was a commitment to accommodating the conflicting forces then shaping federal policy by refocusing federal efforts on those aspects of illicit drug use that created the greatest social costs.[24] This meant focusing on overdose deaths and serious crime and ignoring marijuana and cocaine. The latter were then widely considered to be soft drugs, in contrast to heroin, the prototypical hard drug. The heart of this strategy was to focus on crime and heroin addiction, the bedrock of the support for the federal drug program.[25] A central programmatic expression of this strategy was Operation Tripwire, proposed 1 October 1977 by the director of the National Institute on Drug Abuse, Robert L. DuPont, in a speech at the annual meeting of the Federal Bar Association in Washington, D.C.

The larger objective of the Tripwire proposal was to help heroin addicts themselves overcome their deadly habit by using the power of the criminal justice system. The proposal established a systematic link between the criminal justice system and drug abuse treatment. Tripwire was also designed to relieve the crushing cost to the criminal justice system caused by the heroin epidemic, and, even more important, it was intended to help reclaim families and communities being torn apart by

24. Strategy Council on Drug Abuse, *Federal Strategy for Drug Abuse*.

25. James F. Maddux, "History of the Hospital Treatment Programs, 1935-74," in *Symposium on Drug Addiction and the U.S. Public Health Service*, DHHS pub. no. (ADM) 77-434, ed. W. R. Martin and H. Isbell (Washington, DC: Government Printing Office, 1978), pp. 217-50.

the crime and sickness directly caused by heroin addiction.

THE ORIGINAL OPERATION TRIPWIRE PROPOSAL

The Tripwire proposal can be divided into three areas: screening, supervision, and the consequences for positive drug tests. The screening area had two parts. First, all parolees and probationers, regardless of their conviction offense or history of drug or alcohol abuse, would have their urine tested for heroin use on an unannounced basis "once or twice a year." Second, all offenders released from incarceration would be given physical examinations looking for track marks indicating past intravenous drug use, and they would be interviewed and their records reviewed for evidence of past heroin use.

In terms of supervision, offenders identified by either means, routine screening or screening at release from a correctional institution, as having a history of heroin use would be subject to regular urine monitoring, with clean urines being a requirement for continued freedom in the community. They would all be subject to monthly or more frequent unannounced drug testing.

As to consequences for positive drug tests, offenders producing a positive drug test for heroin while under routine CJS supervision would be placed in more intensive supervision with "weekly or more frequent urine tests." If a second urine drug test were positive, the offenders would be required to enter treatment but would be left free to select the modality of treatment they preferred. Repeated failure of the drug test while under supervision would lead to "prompt reincarceration" that would be for "three to six months," followed by release to the community with continued intensive supervision including regular unannounced urine tests. The Operation Tripwire proposal noted that, based on the Vaillant and Robins findings, "some heroin addicted offenders will be able to refrain from regular heroin use as a result of close supervision, even without treatment."

A pilot phase for Operation Tripwire was envisioned with the ultimate cost of the program projected to be about $12-$14 million a year. The Tripwire program was to be initially funded cooperatively by NIDA and the Department of Justice and operated by single state agencies for drug abuse prevention.

CONTROVERSIES SURROUNDING TRIPWIRE

Tripwire never got started. The argument that dominated the proposal focused not on the vital practical implementation issues—which are the focus today of proposals to extend the use of drug testing in the criminal justice system—but on the fundamental assumptions that heroin use caused crime, that close supervision with strict consequences could reduce heroin use, and that reducing heroin use would lead to reduced criminal activity. These conclusions, now largely taken for granted, were hotly debated in 1977 with many influential academics at the time ex-

pressing skepticism and even hostility on all three points.[26] Tripwire could go nowhere if these fundamental assumptions were not accepted.[27]

In an attempt to diffuse some of the controversies that arose in reaction to the original proposal, a scaled-down pilot project, Paroled Addicts in Treatment for Heroin, was developed. A recent review[28] of the link between the criminal justice system and drug abuse treatment has refocused on the long-neglected Tripwire and Paroled Addicts in Treatment for Heroin proposals:

> In October 1977 Robert L. DuPont, then Director of the National Institute on Drug Abuse, presented a paper titled "Operation Trip-Wire: A New Proposal Focused on Criminal Heroin Addicts" to the Federal Bar Association Convention. . . .[29] Using the findings of McGlothlin and colleagues, . . .[30] he proposed setting up a "tripwire" in the form of urine testing that would identify daily heroin users who were on probation and parole. If an addicted probationer or parolee did not stop his or her daily drug use, the user would be referred to compulsory drug abuse treatment; if treatment was refused or daily heroin use maintained, the addict would be reincarcerated. Even though the proposal was changed to a research study called Paroled Addicts in Treatment for Heroin (PATH), the study never got under way because of the controversy. Criticism focused on three areas: (1) the image problem created when a health agency proposed a mechanism for behavioral control using the criminal justice system, (2) the violation of probationers' civil rights when tested, and (3) the inadequacy of the urine testing technology. . . .[31] However, in spite of the controversy, practitioners and researchers interested in the relationship between drugs and crime supported the PATH concept, not only because of their clinical experience but also because of the large number of crimes committed by addicts.[32]

The Tripwire proposal fell on deaf ears in the criminal justice system, the drug abuse treatment community, and the federal government. The heroin epidemic that had so rattled the country at the end of the 1960s was clearly diminishing by 1977.[33] The Special Action Office for Drug Abuse Prevention was closed in 1975 as the initial political focus on the drug problem waned. While there

26. National Commission on Marihuana and Drug Abuse, *Drug Use in America*.

27. For a friendlier review of the thinking about drugs and crime at the time of the original Tripwire proposal, see William H. McGlothlin, "Drugs and Crime," in *Handbook on Drug Abuse*, ed. DuPont, Goldstein, and O'Donnell, pp. 357-64.

28. Carl G. Leukefeld, "Opportunities for Enhancing Drug Abuse Treatment with Criminal Justice Authority," in *Improving Drug Abuse Treatment*, DHHS pub. no. (ADM) 91-1754 ed. Roy W. Pickens, Carl G. Leukefeld, and Charles R. Schuster (Washington, DC: Government Printing Office, 1991), pp. 328-37.

29. DuPont, "Operation Trip-Wire."

30. McGlothlin, Anglin, and Wilson, *Evaluation of the California Civil Addict Program*.

31. Carl G. Leukefeld, "The Clinical Connection: Drugs and Crime," *International Journal of the Addictions*, 20(6,7):1049-64 (1985).

32. John C. Ball et al., "The Criminality of Heroin Addicts: When Addicted and When Off Opiates," in *The Drugs-Crime Connection*, Sage Annual Reviews of Drug and Alcohol Abuse, vol. 5, ed. James A. Inciardi (Beverly Hills, CA: Sage, 1981), pp. 39-65; David N. Nurco et al., "A Comparison by Ethnic Group and City of the Criminal Activities of Narcotic Addicts," *Journal of Nervous and Mental Disease*, 174:112-16 (1986).

33. Mark H. Greene and Robert L. DuPont, "The Epidemiology of Drug Abuse," *American Journal of Public Health*, pt. 2, 64:1-56 (1974).

has been a White House drug czar every year since 1971, SAODAP was unique. It was a large office with substantial funding. SAODAP was a home for researchers; it was not a political operation but a social policy laboratory. Later drug chiefs lacked the scientific staff and the budget that SAODAP, thanks to the vision of Jerome Jaffe and others who developed the office in 1971, had.

By 1977, crime rates had fallen, as had budgets in both the criminal justice system and the drug abuse field. A logical response to a program that was working, as the original federal heroin addiction program clearly was in 1977, would have been to increase its support. This is precisely the opposite of the way the political process worked. As soon as there was even the slightest evidence that the country had turned the corner on heroin addiction, the support from both political parties for any effort to deal with the drug problem virtually vanished.[34]

This political thinking is similar to what psychiatrists call primary process thinking, the primitive thinking associated with dreams and with psychosis. If something is growing, it is out of control and justifies almost any action. If the problem is shrinking, then it not only does not justify action, but it is treated as if it does not exist. In this maladaptive thinking, the size and importance of the problem are ignored while only the change in the size of the problem is considered to be important. Unfortunately, much media-driven political thinking about health and social problems has these same qualities.

The ebb and flow of support for public funding of drug abuse prevention bears eloquent and painful witness to primary process thinking at work in the contemporary United States. When the heroin problem was worsening in the late 1960s and early 1970s, there appeared to be almost no limits to federal funding for antidrug efforts. As soon as the heroin indicators turned down in the mid-1970s, the public support virtually evaporated. More recently, when the cocaine problem dramatically worsened during the crack epidemic in the late 1980s, an even larger run-up of public funding occurred. As soon as the cocaine indicators began to fall, the political and media support for public funding or antidrug efforts eroded.

On a more purely political front, the new administration that came into Washington in 1977 was devoted to decriminalizing marijuana use. It took a remarkably benign view of cocaine use. Reform in 1977 meant including drug addiction as a handicapping illness under federal law in order to protect the drug addict from discrimination. This attitude was part of a generally permissive approach to illicit drug use in the government at that time. There was more concern for preventing authorities, including those in the criminal justice system, from infringing on the rights of convicted criminal offenders than there was for reducing their criminal activity.[35] Tripwire was 6 years too late to catch the political

34. Robert L. DuPont, "The Future of Drug Abuse Prevention," in *Handbook on Drug Abuse*, ed. DuPont, Goldstein, and O'Donnell, pp. 447-52.

35. Musto, *American Disease*.

winds that propelled the drug abuse field when heroin addiction was public enemy number one and 10 years too soon to catch the even more potent political winds of the crack epidemic.

In late 1977, the head of the Department of Health, Education and Welfare asked for the resignations of all institute directors in the Alcohol, Drug Abuse, and Mental Health Administration, including the director of NIDA who had a few months earlier proposed Operation Tripwire in the belief that it was the most important new idea in the drug abuse field at the time. Here was an idea that could build on the solid foundations of the previous decades of drug abuse research and contribute significantly to bringing to an end the drug plague in America's cities. A few months after the secretary of health, education, and welfare received the resignation of the NIDA director, the President sacked this secretary, showing once again the short life span of those who swim with sharks.

The drug field took a dramatic turn in the decade after Tripwire was proposed. Innovation shifted away from publicly funded drug abuse treatment as many of the brilliant young leaders left the field entirely. The Parents' Movement, focusing on marijuana use by middle-class teenagers, took hold beginning in 1976 in Atlanta, Georgia. The Parents' Movement became, by the end of the decade, the engine driving the entire drug abuse effort. This was a movement that was not centered on heroin use or on publicly funded treatment. It was a movement that saw experts in the drug abuse field, including researchers, as preoccupied with heroin addiction and as dangerously permissive on the use of marijuana. Because the leaders of the Parents' Movement controlled the political process, drug czars after 1980 had to pass the political litmus test of this movement to be selected by the White House.[36]

Meanwhile, a quiet revolution was taking place in drug abuse treatment. As local, state, and federal funding fell for public treatment programs, which had been dominated since the late 1960s by methadone treatment and therapeutic communities, the initiative for innovation shifted to the private sector. The Minnesota Model was developed in the 1970s and was widely applied throughout the nation in the 1980s. This was a privately funded 28-day residential treatment program using the disease concept of addiction and relying heavily on the 12-step programs based on Alcoholics Anonymous.[37] This movement revolutionized drug abuse treatment, making it far more successful than it had ever been before. Like the Parents' Movement, the Minnesota Model was largely unconnected to governmental activities, to research, or to the urban underclass.[38]

36. Robert L. DuPont, "Commentary: NIDA's Role in Applied Research," in *Drugs in the Workplace: Research and Evaluation Data*, DHHS pub. no. (ADM) 91-1730 ed. Steven W. Gust et al. (Washington, DC: Government Printing Office, 1991), 2:225-30.

37. U.S., White House, Office of National Drug Control Policy, *Understanding Drug Treatment* (Washington, DC: Government Printing Office, 1990).

38. Robert L. DuPont and John P. McGovern, ed., "A Bridge to Recovery—An Intro-

TRIPWIRE IN THE 1990s

The striking and completely unpredicted rise in the use of cocaine in the early 1980s, followed by the devastating impact of the crack cocaine epidemic in the United States in 1986 and 1987, occurred when the political climate had changed dramatically from that of the early 1970s. The prison population and crime rate, which had declined or stabilized in the 1970s, rose menacingly in the late 1980s. Attitudes toward drugs in general and toward marijuana and cocaine in particular, after the impact of the Parents' Movement, became progressively harder. Support for legalization, or even for decriminalization, had peaked in 1978 and was on a long-term downward trend characteristic of the end of drug epidemics. The national attention on illicit drug use focused not on heroin, as it had from the late 1960s until about 1977, or on marijuana, as it had from 1977 until 1985, but on cocaine.

Each of the two times there has been a large increase in the public attention to the drug issue, first from about 1969 to 1972 and then from 1986 to 1990, there was a flurry of media attention to the alternative option to the policy of prohibition of illegal drug use. This alternative approach calls for the legalization of currently illicit drugs. In both of these episodes, there was little popular support for the legalization of drugs, but the media and certain relatively small but excessively vocal segments of the intellectual community found these ideas attractive. A few highly visible attorneys, economists, and some politically liberal academics have been attracted to the idea of legalizing drugs as have, somewhat paradoxically, a few conservative market-oriented opinion leaders. Television coverage, especially during these two episodes of intense national focus on illicit drug use, gave the appearance that there was wide and growing support for the legalization of drugs. Polls taken for the last thirty years have made clear that there has never been substantial support for making drugs such as cocaine and marijuana, to say nothing of heroin, phencyclidine (PCP), and LSD, as freely available as we now make alcohol and tobacco. These same polls show that the support for legalization has declined steadily for over a decade.

Those who favor legalization of currently illegal drugs have had the most success when their audience was young people and when the drug was marijuana, the illegal drug that came closest to being legalized in the United States during the last twenty years. The percentage of American high school seniors who believed marijuana use should be entirely legal peaked in 1977 at 33.6 percent and fell steadily thereafter to 16.6 percent in 1989.[39] A statewide telephone poll conducted in Maryland in the fall of 1990 is typical of the findings among American adults. In this

duction to 12-Step Programs" (Manuscript, Institute of Behavior and Health, 1991).

39. Lloyd D. Johnston, Patrick M. O'Malley, and Jerald G. Bachman. *Trends in Drug Use and Associated Factors among American High School Students, College Students, and Young Adults: 1975-1989* (Ann Arbor, MI: University of Michigan, Institute for Social Research, 1991), p. 144.

survey, 15.0 percent of the 968 respondents answered "yes" to the question, "Should adults be able to possess small quantities of marijuana for personal use without legal penalty?" "No" was the answer of 82.3 percent while 2.7 percent said they had no opinion on this question. The question in this poll was phrased to elicit the maximum support for the concept of legalization of drugs, as it focused on private marijuana use by adults.[40]

In the heroin phase of the American drug epidemic, the public policy score was kept by counting overdose deaths. That is how the nation kept track of whether we were winning or losing the war on drugs. In the marijuana phase, the score was kept by monitoring the percentage of high school seniors who smoked marijuana daily. The cocaine phase of the contemporary drug epidemic was scored by counting the rates of murder and of the births of cocaine-addicted babies. The tragic increase in the use of marijuana and cocaine that occurred after the mid-1970s made clear the dangers of defining some illicit drug use as soft or trivial. It was precisely the policy position that focused on heroin addiction and rejected marijuana and cocaine use as serious drug problems, which had seemed so forward-looking in 1975, that set the stage for marijuana and cocaine to become the primary epidemic drugs of the following 15 years.[41]

40. "Poll Finds Most Marylanders against Drug Legalization," *CESAR Reports*, 1:1 (Spring 1991).

41. Strategy Council on Drug Abuse, *Federal Strategy for Drug Abuse*.

In 1981, there was a tragic crash on the aircraft carrier *Nimitz*. Investigation subsequently showed that nearly half of all sailors on the ship had recently used marijuana, cocaine, or other illicit drugs. This led to a new initiative in the military, labeled Zero Tolerance, focused on regular, random drug testing of all service personnel. This effort led to prompt and profound reductions in drug use in the military. The civilian labor force followed suit with drug testing in the workplace.[42] These efforts captured the initiative in the private sector and the focus on marijuana and cocaine, the two illicit gateway drugs.[43] These new initiatives in the civilian workplace were associated with improvements in drug-testing technology and a new level of standardization in the urine drug-testing process.[44] The new testing technology and processes were far cheaper, far more accurate, and far more sensitive than the testing that was available in 1977, when Tripwire was proposed.

42. Robert L. DuPont, "Never Trust Anyone under 40: What Employers Should Know about Drugs in the Workplace," *Policy Review*, 48:52-57 (Spring 1989); idem, "Drugs in the American Workplace: Conflict and Opportunity, Part I: Epidemiology of Drugs at Work," *Social Pharmacology*, 3:133-46, (1989); idem, "Drugs in the American Workplace: Conflict and Opportunity, Part II: Controversies in Workplace Drug Use Prevention," ibid., 3147-64 (1989).

43. Robert L. DuPont, *Getting Tough on Gateway Drugs: A Guide for the Family* (Washington, DC: American Psychiatric Press, 1984).

44. U.S., Department of Health and Human Services, "Mandatory Guidelines for Federal Workplace Drug Testing Programs," *Federal Register*, 11 Apr. 1988, pp. 11979-89.

In 1987, the first new national data system since the original SAODAP programs was begun when the Drug Use Forecasting (DUF) system began testing booked arrestees. Today there are 24 DUF sites across the United States. This historic program not only for the first time peeled back the curtain of denial from the criminal justice system about the full extent of current illicit drug use among arrestees, but it provided a new window on the extent of drug use in the underclass that had been systematically undercounted by earlier national drug use surveys.[45] Unlike the surveys of households and high school students which had, until DUF, been the basis for the way the nation estimated the number as well as the trends of users of various illicit drugs, the DUF system included not only self-report of drug use but also urine testing. The following section describes the DUF program and the search for a powerful sponsor to launch the first new national drug use monitoring program in the United States in twenty years.

Development of the DUF program

The National Institute of Justice initiated the DUF program in 1987. Findings from a number of research projects had suggested that following drug use trends of criminals was a valuable indicator of illicit drug use in the population at large. The influential work of John C. Ball and David N. Nurco had demonstrated that heroin addicts in Baltimore committed six times as many crimes while using the drug frequently than when they used the drug infrequently.[46] McGlothlin and Anglin's careful study of persons admitted to the California Civil Addict Program also documented the association between drug use and crime rates. These studies showed that criminals were at very high risk of using illicit drugs.[47]

In 1983, the National Institute of Justice funded two research studies on drug-testing programs for arrestees. The first project evaluated the existing program in Washington, D.C., which was begun in 1970. All persons arrested in the District of Columbia and charged with a criminal offense had their urine tested for drugs of abuse. The court used the test results at arraignment to determine who should be sent to urine-monitoring or drug abuse treatment programs during the period of pretrial release. The research study was designed to assess the impact of the drug-testing program on the criminal justice system and the arrestee's pretrial misbehavior.[48]

The second study funded by the National Institute of Justice was de-

45. Eric D. Wish, "U.S. Drug Policy in the 1900s: Insights from New Data from Arrestees," *International Journal of the Addictions*, 25(3A):377-409 (1990-91); Eric D. Wish and Bernard A. Gropper, "Drug Testing by the Criminal Justice System: Methods, Research, and Applications," in *Drugs and Crime*, ed. Michael Tonry and James Q. Wilson (Chicago: University of Chicago Press, 1990), 13:321-91.

46. Ball et al., "Criminality of Heroin Addicts."

47. McGlothlin, Anglin, and Wilson, *Evaluation of the California Civil Addict Program*.

48. Mary A. Toborg et al., *Assessment of Pretrial Urine Testing in the District of Columbia* (Washington, DC: Department of Justice, National Institute of Justice, 1989).

signed to set up a drug-testing program for arrestees processed in Manhattan Central Booking. Because no pretrial drug-testing program was operating in New York City, the testing had to be set up as part of a confidential research study. The urine test results were retained and analyzed solely by the researchers. The primary focus of the research was on the ability of drug use at arrest to predict pretrial misbehavior.[49]

These two studies produced startling results. More than one-half—54 percent—of the booked arrestees in Washington, D.C., and Manhattan in 1984 tested positive for a drug at arrest.[50] These findings showed the high level of recent drug use, especially of cocaine, among persons arrested for a variety of crimes. The results were used to prepare testimony before the President's Panel on Organized Crime in 1984 to show that cocaine had become a common street drug in Manhattan.[51] Of equal importance was the finding that it was feasible to obtain voluntary urine specimens from arrestees being processed in a hectic urban booking facility—Manhattan—as part of a research study.

In an auspicious happenstance, Eric D. Wish, the director of the Manhattan pretrial testing research project, on an airplane discussed with James K. Stewart, director of the National Institute of Justice, the possibility of establishing a national system of tracking drug use by arrestees by obtaining periodic, voluntary, and anonymous interviews and urine specimens from new samples of booked arrestees in the largest cities of the United States. The discussion with Stewart came after a succession of similar discussions with staff of other federal agencies. Only Stewart, however, was willing to support the project and to provide the continuing leadership needed to implement a new national drug monitoring program. In November 1986, Eric Wish became a visiting fellow at NIJ to help design and establish what was to become the Drug Use Forecasting program.

As was found in the study of arrestees in Manhattan, a majority of the arrestees in each DUF city were willing to provide a voluntary and anonymous interview and urine specimen to the DUF interviewers. In every major city where the DUF program was initiated, 50 percent or more of the booked arrestees tested positive for at least one drug. In most cities, cocaine was the most prevalent drug, sometimes found in 60 percent or more of the arrestees. In no other segment of the population, except perhaps for persons admitted to drug treatment programs, were such

49. Eric D. Wish, Mary Cuadrado, and Stephen Magura, "Drug Abuse as a Predictor of Pretrial Failure-to-Appear in Arrestees in Manhattan" (Final report submitted to U.S., Department of Justice, National Institute of Justice, Jan. 1988); Douglas A. Smith, Eric D. Wish, and G. R. Jarjoura, "Drug Use and Pretrial Misconduct in New York City," *Journal of Quantitative Criminology*, 5:101-26 (1989).

50. Eric D. Wish, Mary A. Toborg, and John P. Bellassai, "Identifying Drug Users and Monitoring Them during Conditional Release" (National Institute of Justice Briefing Paper, Department of Justice, National Institute of Justice, 1988).

51. Eric D. Wish, "Cocaine Use in Arrestees in New York City, Washington, D.C.," in *Report to the President and the Attorney General: America's Habit: Drug Abuse, Drug Trafficking and Organized Crime* (Washington, DC: Government Printing Office, 1986).

high rates of drug use found by urinalysis.

The tremendous amount of drug use found in arrestees, together with the fact that two to four times more drug use was found in arrestees by urinalysis than through their voluntary and anonymous self-reports of drug use, showed the magnitude of the drug problem in offenders that was going undetected by traditional criminal justice assessments.

The national response

There was a growing recognition by policymakers that drug testing should become a routine and universal function of the criminal justice system. Testing could be used to identify illicit drug users at arrest as well as to monitor persons released to the community before trial and after conviction. The endorsement of this approach is best exemplified by the requirement of the policy plan for 1990 of the White House Office of National Drug Control Policy that the states of the nation begin to plan for the establishment of urine testing in all segments of the criminal justice system.[52] Thus it had taken almost 15 years for policymakers to begin to realize the benefits of the strategy envisioned by the Operation Tripwire proposal in 1977.

In 1988, the Office of National Drug Control Policy was the new White House drug office and was under the leadership of the most visible drug czar the nation had ever had, William Bennett. Like the early 1970s, when the first White House drug office, SAODAP, was created, the bonanza of money and political support to deal with drugs was short-lived. Today, the second director of the Office of National Drug Control Policy, Governor Bob Martinez, faces, as did the second head of SAODAP, Robert L. DuPont, the demoralizing problems of declining political and budgetary support. Of the nation's eight drug czars, the first four held office during the heroin phase, the next two during the marijuana phase and the Parents' Movement, and the most recent two czars during the cocaine or, more accurately, the crack phase of the nation's drug abuse epidemic. The first six were all health care professionals and researchers. The last two are the first drug czars to be politicians with no prior experience in drug abuse treatment, prevention, or research.

As the 1980s ended, the nation's prisons were bursting under the load of incarcerated offenders. Whatever the politics of longer sentences and more efficient criminal justice processing, the long-term costs of drugs and crime were unsustainable at the local, state, and national levels. It became fashionable once again to look for new ideas that could cut the cost of the vicious cycle of drugs and crime.

An updated Tripwire proposal would cover all illicit drugs and take advantage of the new immunoassay drug tests to do far more testing than was done in the past. The application of the new drug-testing technology to hair, instead of urine, would offer the opportunity to extend the surveil-

52. U.S., White House, Office of National Drug Control Policy, *National Drug Control Strategy* (Washington, DC: Government Printing Office, 1990).

lance window from the 1-3 days provided by urine for most drugs to 90 days as provided by hair.[53] An updated Tripwire would also involve wider use of the 12-step programs that have revolutionized the private sector drug treatment field in the last decade.

The Tripwire proposal calls for universal, routine, and frequent tests for illicit drug use, with incarceration being the swift response to continued drug use. Treatment must be linked to the CJS not as a way of covering up continued use of drugs but as a way of helping offenders stop their drug use. The testing program needs to be universal because of the great power of denial. The period of incarceration need not be prolonged, but it must be repeated as often as the offender returns to illicit drug use. There is a powerful resistance to drug testing on one hand and reincarceration as a predictable response to positive drug tests on the other. Nevertheless, only a systematic approach, such as Tripwire, can help the majority of criminal offenders, their families, and their communities who are now being destroyed by drug abuse.

IMPLICATIONS OF TRIPWIRE FOR DRUG ABUSE RESEARCH AND PUBLIC POLICY

Science and policy are always uneasy allies. Neither is a certain beacon for navigation through complex and controversial issues. This has been true with every aspect of the connection between criminal justice and drug abuse. There have always been scientists, and policy experts, on all sides of every subject, and this is true today of drug testing for conditionally released offenders.

Tripwire was a solid idea that fit well with the needs of the time. It built on an extensive body of research and on the initial federal efforts in the drug abuse field. It focused on the most socially disruptive segment of the illicit-drug-using population and on those with the greatest need. Tripwire used the knowledge that most heavy users only stop illicit drug use when they have compelling reasons to stop and when those reasons are applied repeatedly over a long period of time.[54] Tripwire also harnessed the powerful political process unleashed by the downturn in political support for drug abuse as the first evidence of the drop in heroin trends became apparent.

So what went wrong? Why was Tripwire not adopted in 1977, and why in 1992 does it seem like a good, new idea for some time in the future? A combination of unfortunate developments undermined the potential support for Tripwire. Within the criminal justice system in the late 1970s there was little enthusiasm for drug testing, which used a new and unfamiliar technology. There was a well-established inertia for doing things as they had always been done. Most people in the criminal justice system thought they knew who was using drugs and what to do about it. Drugs were seen as a relatively un-

53. See Tom Mieczkowski, "New Approaches in Drug Testing: A Review of Hair Analysis," this issue of *The Annals* of the American Academy of Political and Social Science.

54. Vaillant, "20 Year Followup of New York Narcotic Addicts."

important part of the crime problem. Therefore, most CJS leaders at that time did not perceive a need for a new and potentially expensive program based on urine testing and compulsory mechanisms for reincarceration of drug-using offenders to ensure that they stopped illicit drug use. Within drug treatment, there was then a growing interest in outpatient, nonmethadone treatment for abusers of drugs other than heroin. Methadone maintenance treatment for heroin addicts had been a controversial treatment that generated little political support, especially within the drug treatment community. Nonmethadone treatments did not work well with these difficult patients, so many in the drug-free treatment community were eager to stop treating criminal heroin addicts and to start treating occasional marijuana and cocaine users, or what were called at the time "polydrug abusers."

More directly, the fall of 1977 saw the election of Jimmy Carter as president and his appointment of a new secretary of health, education, and welfare, Joseph Califano. Califano wanted new heads of all his institutes. The incumbent head of NIDA, who conceived the Tripwire proposal, was a holdover from the Ford administration in Califano's mind. Califano got rid of the heads of the mental health and alcohol institutes in the summer of 1978, before he axed the director of NIDA, the most visible patron of the Tripwire idea.

Tripwire did not fit the more permissive approach to drugs of the Carter administration. Carter and his White House drug czar were supporting the decriminalization of marijuana. They were also tolerant of the recreational use of cocaine. A tough approach to criminal heroin addicts did not find favor with either Carter or Califano. Since the Tripwire proposal lacked a powerful political constituency and came at a time when the media had grown tired of drug stories, the Tripwire idea died at birth. The drug budget in those years was shrinking, not expanding, so a new and potentially expensive idea was not quickly adopted. This same situation is occurring today as the drug budgets are looked at increasingly to reduce costs rather than to add new programs. The fact that Tripwire promised to cut costs in the CJS profoundly over the long haul held little appeal to executive and legislative staffs attuned to the impact of a proposal on the current year's budget. In the late 1970s, after the exaggerated claims for social programs in the 1960s, they had grown cynical about promises of long-term returns on social program investments.

Can Tripwire now be revived in a new, updated form? Earlier experience suggests this will be a difficult sale, regardless of the research evidence that this targeted approach within the criminal justice system is the right thing to do from many points of view, including both budgetary and humanitarian concerns. There are today, as there were in 1977, many good reasons to support the Tripwire idea. It helps those drug abusers who are the neediest and those creating the highest social costs. A revived Tripwire would be especially beneficial to the communities hardest hit by the current drug

epidemic, the poorest urban communities. A revived Tripwire offers the best hope of cutting the size of CJS populations, including those in expensive jails and prisons. Tripwire harnesses the newly improved technology and lowered cost of drug testing. Especially were a new Tripwire to be linked to hair testing, with the latter's 90-day surveillance window, compared to the 3-day window for urine testing, it could be a powerful new weapon in the war against drugs.

But the resistance to the Tripwire concepts are many and enduring. There are two primary reasons for pessimism, the first being the lack of high-level sponsorship. The Tripwire idea would have to be picked up by the drug czar or even the President to be certain of getting a trial. Alternatively, the secretary of health and human services or the attorney general could provide effective sponsorship, and the heads of the National Institute on Drug Abuse and the National Institute of Justice could be effective parents as well. Lower-level sponsorship is unlikely to move the largely immobile bureaucracies in either the criminal justice or the drug abuse fields. Congressional sponsorship of a new Tripwire would be useful but a double-edged sword at any time, given the inescapable conflicts between the legislative and executive branches of government. These conflicts are virtually insurmountable when the two branches of government are controlled by different political parties. If a powerful Democratic committee chairperson were to pick up the Tripwire idea during the administration of a Republican President, it would meet with little enthusiasm and much resistance from all executive branch officials.

One possible solution to this dismal problem can be gleaned from the experience of SAODAP twenty years ago. Under the leadership of Jerome Jaffe, a scientist with impeccable credentials, that agency made great strides in the use of research to guide national drug policy. Perhaps a return to the tradition of appointing scientists experienced in substance abuse research to lead the country's drug policy agency would help promote new, more effective ideas. Such a person could marshal the resources to launch a revised Tripwire program and other innovative programs.

The experience with Jerome Jaffe at SAODAP and with James K. Stewart at the National Institute of Justice, as well as with many other leaders who initiated major new programs in the drug and crime field, demonstrates that successful leaders may or may not be scientists but must be open to the lessons of science and then have the personal qualities necessary to organize these lessons into coherent, practical programs. Successful leaders identify personally with these new programs and carry them through the long, painful, and uncertain gauntlet of politics, budget review, and bureaucratic resistance to become, ultimately, the new foundation on which future innovation can be built. Such leaders are rare and precious in this and in other fields. Whether scientists themselves or not, it is clear today that leaders are most likely to succeed when they marshal a convincing body of scientific evidence and a substantial number of scientific leaders to help them

build, sell, and sustain their new programs.

The second major barrier to the implementation of a new Tripwire proposal, after the lack of high-level sponsorship, is budgetary constraints. In times of generally rising government spending, promising new ideas are swept up quickly and enthusiastically. When the overall budget is constrained, as the federal budget has been for over a decade now, new ideas are hard to fund. The ubiquitous naysayers in the bureaucracy have an easy time stopping new ideas when they ally themselves with the powerful forces of fiscal restraint.

So what hope is there for the basic Tripwire idea of universal, systematic drug testing of all criminal justice subjects and for continued illicit drug use to be linked to incarceration? Surely, the Tripwire idea needs to be refined and pilot tests conducted. The Tripwire idea needs to be widely discussed in the professional literature with an openness to the public media. During such an incubation period, the Tripwire idea must wait for a high-level patron who will adopt it as his or her own idea, for a time when there is a receptiveness to the link between drugs and crime, and for a willingness to spend additional money on the new program. Such a moment may be a few months off, or many years.

It is probable that the basic Tripwire concepts will be adopted into wide practice within a decade, even without a major programmatic initiative. The last 15 years have seen growing use of urine tests for nonmedical drug use within the criminal justice system. The question, in our view, is less whether the Tripwire ideas will be widely adopted than how and when drug testing will become a matter of routine and universal practice within the criminal justice system. Science is a useful precondition for such an adoption, but it is not a sufficient basis for it to occur. For Tripwire, or any other research-based programmatic idea, to become a reality it will require a confluence of political, media, and economic forces far beyond mere science.