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General Government Division

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September 29, 1993

The Honorable John Conyers, Jr.,
Chairman
The Honorable William S. Clinger, Jr.,
Ranking Minority Member
Committee on Government Operations
House of Representatives

As requested, we reviewed selected aspects of the operations of the Office of National Drug Control Policy focusing on (1) whether it should be reauthorized and (2) what lessons have been learned from the Office's past operations that could enhance its performance if it is reauthorized. Our report contains recommendations to Congress and a recommendation to the Secretary of Defense.

As agreed with the Committee, unless you publicly announce its contents earlier, we plan no further distribution of this report until 15 days from the date of this letter. At that time, we will send copies of this report to the Directors of the Office of National Drug Control Policy and the Office of Management and Budget; the Attorney General; and the Secretaries of Defense, Education, and Health and Human Services. We will make copies available to others upon request.

The major contributors to this report are listed in appendix IV. If you or your staff have any questions on this report, please call me on (202) 512-5156.

Henry R. Wray
Director, Administration
of Justice Issues

Executive Summary

Purpose

With the enactment of the Anti-Drug Abuse Act of 1988, Congress created the Office of National Drug Control Policy (ONDCP) to lead the nation's war on drugs. The 1988 act charged ONDCP with annually developing and coordinating the implementation of a national drug control strategy and authorized ONDCP for 5 years—until November 1993.

As part of the deliberations on whether ONDCP should be reauthorized, the Chairman and Ranking Minority Member of the House Committee on Government Operations requested GAO to assess ONDCP's implementation of its statutory responsibilities. At the Committee's request, GAO reviewed (1) the overall progress reported under the national drug control strategies and the measures of progress used by ONDCP, (2) ONDCP's efforts to coordinate implementation of national drug control strategies, (3) ONDCP's involvement in the collection of data used to direct policy and measure progress in the war on drugs, and (4) the drug budget certification process.

Background

The 1988 act created a management framework for ONDCP to use in planning a national drug control effort and keeping Congress informed so that effective drug control policy and funding decisions could be made.

The cornerstone of ONDCP's planning and policy direction efforts is the national drug control strategy. Under the 1988 act, ONDCP must (1) develop a national drug control strategy with short-and long-term objectives and annually revise and issue the strategy to take into account what has been learned and accomplished during the previous year, (2) develop an annual consolidated budget providing funding estimates for implementing the strategy, and (3) oversee and coordinate implementation of the strategy by federal agencies.

In developing the annual strategies, ONDCP concluded that to be effective, the drug war needed to be fought on two fronts—one front against casual or intermittent drug use and the second front against hard-core (chronic) drug use. The success of these strategies, according to ONDCP, should be based on reductions in drug use.

In its annual strategies, ONDCP continued the trend of funding programs associated with drug supply reduction efforts over programs associated with demand reduction efforts. Under ONDCP's first four annual strategies, covering fiscal years 1990 through 1993, about $9.8 billion was directed to international drug control programs and drug interdiction efforts,

$19.7 billion to domestic law enforcement, and $15.2 billion to treatment and prevention services.

As part of ONDCP's responsibility to develop consolidated drug control program budgets, the 1988 act prescribes a three-tiered budget review and certification process. The Director of ONDCP is required to certify that annual drug budget submissions to ONDCP from each "program manager, agency head, and department head" with drug control responsibilities are adequate to implement the objectives of the national drug control strategy.

Results in Brief

While ONDCP has reported a decline in drug use among casual users, there is no indication that progress has been made on the second front of the drug war—the fight against hard-core drug use. The data sources used by ONDCP do not effectively measure hard-core drug use, and the general indicators of hard-core use that do exist suggest that the problem is largely unchecked.

In GAO's view, one key challenge that faces ONDCP if it is reauthorized is to improve measures for assessing the progress being made under the national drug control strategies. In the past, these national drug control strategies have contained inadequate measures for assessing the contributions of component programs for reducing the nation's drug problems.

GAO also found that ONDCP and the federal drug control agencies need to work more cooperatively to develop, assess, and coordinate national drug control policy. In the past, frequent disagreements and conflict have, in GAO's opinion, strained working relationships between ONDCP and at least three federal departments—the Departments of Education (ED), Justice (DOJ), and Health and Human Services (HHS). In particular, ONDCP and HHS had major disagreements over the collection of drug data, and ONDCP threatened to withhold clearance of drug surveys to obtain HHS compliance with ONDCP requests. GAO recognizes that some disagreement and conflict may be unavoidable in view of ONDCP's responsibilities to monitor and oversee drug control efforts by federal agencies. Nevertheless, with respect to HHS, GAO does not believe that it is appropriate for ONDCP to assert approval authority over HHS data collection efforts. The 1988 act does not assign ONDCP this role.

The three-tiered budget review and certification process envisioned by the 1988 act has proved to be impractical. Because of staff constraints and

other factors, ONDCP has limited its reviews primarily to agency and departmental budgets and has only selectively certified program-level budgets.

The Department of Defense (DOD) submits its drug budget to ONDCP in accordance with the 1988 act. However, unlike other federal departments with drug control responsibilities, agencies within DOD do not prepare separate drug budgets, so DOD agencies cannot submit "agency" drug budgets to ONDCP for preliminary review. Thus, according to ONDCP, its ability to make budget comparisons among agencies is impaired.

Given the severity of the drug problem and the large number of federal, state, and local agencies working on the problem, GAO believes that there is a continuing need for a central planning agency to provide leadership and coordination for the nation's drug control efforts. Therefore, GAO believes that ONDCP should be reauthorized and is making a number of recommendations to enhance ONDCP's ability to execute drug policymaking and budget certification responsibilities.

GAO's Analysis

Progress Under the Strategy

According to ONDCP, the success of the strategy and national drug control effort should be judged on the basis of whether drug use is reduced. ONDCP has reported that a number of the strategy's objectives have been accomplished, pointing to a steady decline in reported drug use among casual users.

Similar progress has not been made with respect to hard-core drug use—the second front and the one that ONDCP sees as the most serious and difficult challenge in the drug war. Although ONDCP recognizes that more comprehensive data are needed to better understand the nature and magnitude of the problem, available indicators show that hard-core drug use is undiminished. For example, according to HHS data the number of frequent cocaine users has not significantly changed since the first estimates were made in 1985. Additionally, there is little indication of progress in reducing the availability of drugs or the level of drug-related violence and adverse health consequences, especially in the inner cities. (See pp. 24-38.)

Improved Measures Needed

GAO examined ONDCP's four annual strategies to determine the extent to which they provided an objective basis for measuring the success of the three major drug-control components that they funded. GAO found that although the strategies established broad goals for the components, they contained few performance indicators and little information on which to evaluate which components of the strategies are working, which are not, or how any particular component directly contributes to the overall goal of reducing drug use.

GAO recognizes that difficulties, such as the interrelated nature of the component programs and the clandestine nature of drug production, trafficking, and use, may preclude the development of precise performance measures. However, these difficulties should not stop antidrug policymakers from seeking the best measures for assessing what is being accomplished over the long term. Clearly, the better the measures established for assessing the component programs, the better decisionmaking can be focused on directing and redirecting drug policies, budgets, and operations. Centralizing these measures in the strategy would promote comprehensive decisionmaking on the numerous trade-offs and alternatives presented by various drug control options. (See pp. 44-46.)

Improved Working Relationships Needed

When interviewing ED, DOJ, and HHS officials, GAO heard numerous complaints and concerns about disagreements and conflict with ONDCP in 24 of the 28 interviews held. Officials from the three departments in some instances viewed ONDCP's oversight efforts as "micromanagement." However, DOD officials did not express concerns and complaints about disagreements with ONDCP. (See pp. 48-51.)

Major disagreements and conflicts developed between ONDCP and HHS over the collection and reporting of drug data. While HHS has had problems with ONDCP's involvement with the collection and reporting of drug data, ONDCP had strong concerns about HHS not meeting its data needs. According to ONDCP, HHS in the past had been unresponsive to ONDCP's needs for timely data for drug policy purposes. (See pp. 51-61.)

The 1988 act, as amended, vests HHS with responsibility for collecting data on the national incidence of various forms of substance abuse. According to HHS officials, in the past ONDCP has asserted the right to "clear" drug survey and other data collection instruments issued by HHS. For example, on one occasion ONDCP insisted on doubling the size of a HHS survey in order to obtain more reliable data on drug use among minorities, youths,

and urban groups. According to HHS officials, this change cost several million dollars but achieved only modest data improvements. (See pp. 52-54.)

Given ONDCP's responsibility for coordinating and overseeing federal antidrug efforts, GAO does not question ONDCP's right, or, indeed, its obligation, to consult with HHS and other agencies on the collection and development of drug-related data. However, GAO does not believe that it is appropriate for ONDCP to assert approval authority over HHS' drug data collection efforts. The 1988 act does not assign ONDCP this role. (See pp. 52-57.)

In addition, there is potential tension in having ONDCP control HHS' development and collection of drug-related data when ONDCP's success is judged in large part by the results of HHS data. This potential tension manifested itself several years ago when ONDCP reported a decline in frequent cocaine use on the basis of a misleading treatment of HHS data. (See pp. 57-59.)

GAO recognizes that disagreements over timeliness and quality of data are bound to occur given the demands placed on ONDCP by the 1988 act to report annually on drug control progress. Officials from both agencies agree that many of their disagreements in the data area result from the natural tension that exists between policy and research agencies. They also agree that their working relationship has improved and some data-sharing issues have been resolved as a result of the establishment of an HHS/ONDCP joint workgroup on data. (See p. 61.)

Certification of Drug Budgets

While the 1988 act requires ONDCP to review and certify three tiers of budgets from program managers, agencies, and departments, ONDCP has found the three-tier process impractical and has limited its reviews primarily to agency and departmental budgets. According to ONDCP, it does not have the necessary staff to review hundreds of submissions from program managers and program-level budgets are subject to considerable revision at the agency level. In 1992, ONDCP selectively reviewed and certified program manager budgets at two agencies. ONDCP believes that this selective approach to certifying drug budgets from program managers has merit. (See pp. 64-65.)

DOD submitted its fiscal year 1993 drug budget to ONDCP in December 1991 after it was approved by the Secretary of Defense and budget decisions

concerning budget resources and priorities had been made. In October 1992, DOD submitted its fiscal year 1994 drug budget to ONDCP, only 2 weeks before DOD had made its final budget decisions and several months after ONDCP received other departments' agency budgets. According to ONDCP budget officials, because ONDCP does not receive a DOD drug budget by August, it has not had the opportunity to make comparisons between DOD's drug budget and other preliminary federal drug budgets. (See pp. 66-68.)

ONDCP Should Be Reauthorized

The nation still faces a very serious drug problem. For example, according to preliminary Household Survey data for 1992, an estimated 11.4 million Americans still use illicit drugs, and drugs remain plentiful. In proposing to reauthorize ONDCP, the administration observed that "[f]ive years after its creation . . . more people are victims of violent crime and drug addiction than ever before." (See pp. 33-38 and 40.)

Given the severity of the drug problem and the large number of federal, state, and local agencies working on the problem, GAO believes there is a continuing need for a central planning agency to provide leadership and coordination for the nation's drug control efforts. (See pp. 38-40.)

In April 1993, the administration proposed reauthorizing ONDCP but at a significantly reduced staffing level (from 112 to 25). This restructuring, according to the administration, will refocus ONDCP on (1) policy development and (2) effective coordination of drug programs. With respect to budget certification responsibilities, ONDCP officials said that in the future their efforts would focus on broad budget issues. To these ends, GAO is making a number of recommendations to enhance ONDCP's ability to execute its policy and budget responsibilities. (See pp. 17 and 18, 47, and 69-70.)

Recommendations

GAO recommends that Congress reauthorize ONDCP for an additional finite period of time. GAO also recommends that ONDCP, in consultation with the drug control agencies, be directed to (1) develop additional measures to assess progress in reducing drug use (particularly among hard-core users), (2) develop performance measures to evaluate the contributions made by major components of current antidrug efforts and significant new initiatives, and (3) incorporate these measures in national drug control annual strategies.

GAO also recommends that Congress replace the current statutory language requiring review and certification of budget submissions from all program managers, agencies, and departments with a simple mandate that ONDCP review and certify drug control budgets at such stages and times as it considers appropriate. Additionally, GAO recommends that the Secretary of Defense direct that ONDCP be given a preliminary DOD drug budget by August of each year.

Agency Comments

GAO discussed the results of its work with officials from ONDCP, and pertinent aspects with DOD, DOJ, ED, and HHS officials. These officials generally agreed with the information in GAO's report.

ONDCP officials agreed with GAO's recommendations. ONDCP officials emphasized that budget certification was an important ONDCP responsibility, and obtaining flexibility to carry out selective certifications of drug budgets seemed reasonable given the reduction in ONDCP's staff. They also noted that they had begun preliminary discussions with a number of drug control experts to explore ways to develop program performance measures and to better measure hard-core drug use.

DOD officials concurred with GAO's recommendation to the Secretary of Defense and said that an August budget would be preliminary but would reflect the most accurate estimate of planned drug programs and funding available at that time.

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Abbreviations

ADAMHA	Alcohol, Drug Abuse and Mental Health Administration
ADMS	Alcohol, Drug, and Mental Health Service Block Grants
AID	Agency for International Development
CTAC	Counter-Drug Technology Assessment Center
DAWN	Drug Abuse Warning Network
DEA	Drug Enforcement Administration
DOD	Department of Defense
DOJ	Department of Justice
ED	Department of Education
FBI	Federal Bureau of Investigation
GAO	General Accounting Office
GGD	General Government Division
HHS	Department of Health and Human Services
HIDTA	High Intensity Drug Trafficking Areas
HRD	Human Resources Division
IMTEC	Information Management and Technology Division
IRS	Internal Revenue Service
LSD	Lysergic Acid Diethylamide
MSAs	Metropolitan Statistical Areas
NDATUS	National Drug and Alcoholism Treatment Unit Survey
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute for Drug Abuse
NSIAD	National Security and International Affairs Division
OCG	Office of the Comptroller General
OMB	Office of Management and Budget
ONDCP	Office of National Drug Control Policy
OSI	Office of Special Investigations
PEMD	Program Evaluation and Methodology Division
QRS	Quick Response Surveys
RCED	Resources, Community, and Economics Division
RFA	Request for Application
SES	Senior Executive Service
SAMSHA	Substance Abuse and Mental Health Services Administration

Introduction

Just 5 years ago, the nation's drug-related problems were considered to be so severe that a presidential study commission[1] concluded:

"The way in which we face the threat of drugs today may well determine the success or failure of our country in the future. As a people we have survived the Depression, civil and international war, and devastating disease; but now this country could dissolve, not because of an external threat, but because of our own failure to control illegal drug use."

Since then, federal antidrug efforts have escalated. For example, the annual federal drug control funding was increased from about $4.7 billion to about $12.2 billion from 1988 to 1993; the Office of National Drug Control Policy (ONDCP) was created in 1988 to plan and oversee the spending of those billions; and a national drug control strategy, primarily emphasizing a law enforcement orientation, was continued and intensified. Given the impending expiration of ONDCP's scheduled 5-year life and the experience gained over those 5 years, the issues before Congress are whether ONDCP should be reauthorized and what progress is being made to reduce the nation's drug problems.

Evolution of Federal Drug Control Policy

Drug-related problems have been a matter of national concern since the early 1900s when the first narcotics laws were passed. These early efforts focused primarily on reducing the supply of drugs, first through taxation, then by prohibition and strict legal control. The basic assumption behind this approach was that reducing the supply and availability of drugs would lead to a reduction in their use by encouraging drug-dependent individuals to detoxify and by keeping drugs out of the hands of users.

As drug use increased and spread to new markets during the 1960s, policymakers began to modify the law enforcement orientation of national drug control policy. With enactment of the Drug Abuse Office and Treatment Act of 1972, federal policy called for adding a vigorous demand reduction effort—drug treatment and prevention initiatives—to the existing law enforcement-led supply reduction effort.[2] The 1972 act established the National Institute for Drug Abuse (NIDA) to handle research, prevention efforts, treatment, training of professional and

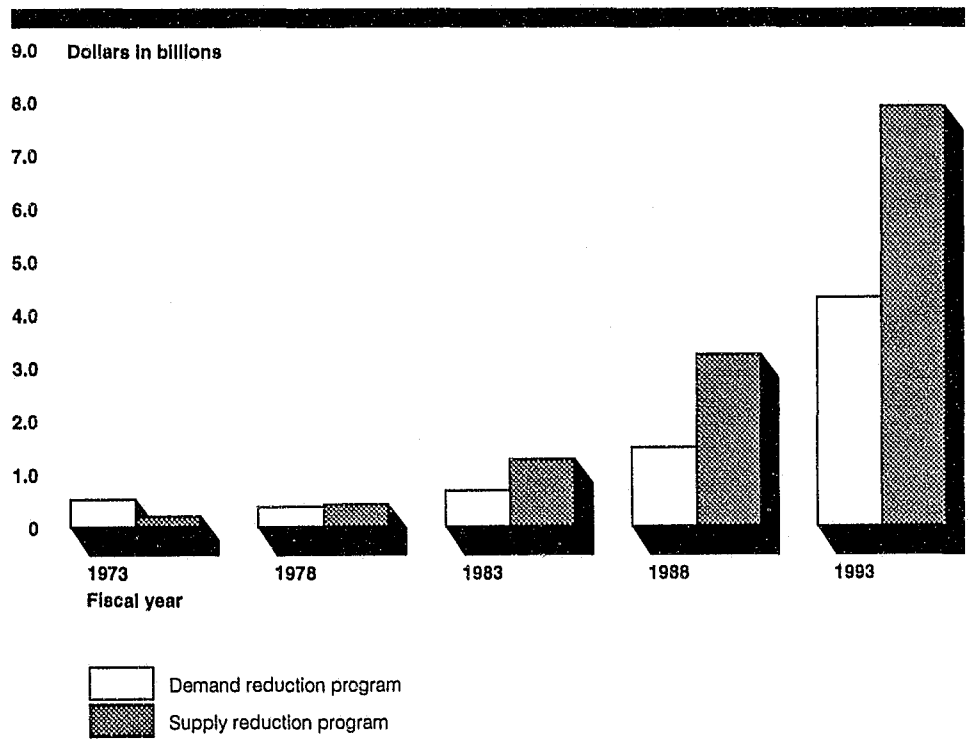
[1]The White House Conference for a Drug Free America, Final Report, June 1988.

[2]Supply reduction refers to any enforcement activity intended to reduce the supply or use of drugs, such as through international drug control initiatives, foreign and domestic drug enforcement intelligence, interdiction of drugs destined for the United States, and domestic law enforcement including enforcement directed at users. Demand reduction refers to any activity intended to reduce the demand for drugs such as through drug abuse treatment, education, prevention, research and rehabilitation.

paraprofessional personnel, and rehabilitation programs. While NIDA was spearheading the demand reduction effort, the Drug Enforcement Administration (DEA) and State Department were responsible for reducing drug availability by making drugs difficult to obtain; expensive; and risky to possess, sell, or consume.

By the late 1970s, the thrust of federal funding shifted back to emphasizing law enforcement-oriented supply reduction programs over demand reduction efforts. As shown in figure 1.1, supply reduction expenditures surpassed the treatment and prevention expenditures of the demand reduction effort around 1978, and the dollar gap between the two has widened substantially since that time.

Figure 1.1: National Drug Control Budget (Primary Components)



Source: Office of Management and Budget (OMB), National Drug Control Budget Summary 1992, Federal Strategy for Drug Abuse and Drug Trafficking Prevention 1974, and Annual Report on Federal Drug Programs 1980.

Congress passed the Anti-Drug Abuse Act of 1988[3] to, in part, provide leadership and accountability to address the nation's drug problems. The 1988 act (1) established ONDCP as an office in the Executive Office of the President and (2) created a management framework for ONDCP to use in planning a national drug control effort and keeping Congress informed so that appropriate drug control policy and funding decisions could be made. The 1988 act also included a sunset provision so that Congress could examine what it had created at the end of the 5-year period. ONDCP is scheduled to expire in November 1993 unless reauthorized.

Establishment of a Management Framework

The management framework established by the 1988 act is a performance-based approach in that ONDCP was to (1) develop a strategic plan (the national drug control strategy) with short-and long-term objectives and costs; (2) annually issue the strategy to take into account what had been learned and accomplished during the previous year, such as progress made in achieving the objectives; and (3) annually report these results to the president and Congress. More specifically, ONDCP was to

- collaborate with the various drug control agencies to develop and annually issue a national drug control strategy to include short- and long-term objectives for both supply and demand reduction efforts and annually report the strategy to Congress and also use this strategy to establish policies that unite federal antidrug efforts with those of state and local governments and the private sector;
- develop and annually submit, with the president's budget proposal, a consolidated drug control program budget that addresses the supply and demand reduction efforts of all federal agencies covered by the national strategy[4] and, as part of the annual strategy, describe how the budget proposal is intended to implement the strategy as well as certify the sufficiency of the funding to implement the strategy;
- coordinate and oversee the implementation of national strategy policies, objectives, and priorities by federal drug control agencies; and
- evaluate the effectiveness of the previous year's drug control activities and, beginning with the second strategy, annually report that assessment to Congress.

[3]Hereafter referred to as the 1988 act.

[4]Hereafter, these agencies are referred to as drug control agencies.

ONDCP's Organizational Structure

To carry out the planning and coordination responsibilities of ONDCP, the 1988 act provided for four presidential appointees with Senate confirmation: a director, a deputy director for demand reduction, a deputy director for supply reduction, and an associate director for national drug control policy to head the Bureau of State and Local Affairs. The 1988 act, as amended by Public Law 101-510, also provided for the establishment of the Counter-Drug Technology Assessment Center (CTAC) within ONDCP, headed by a chief scientist who is appointed by the director of ONDCP. CTAC is to serve as the central counter-drug research and development center for the federal government.

ONDCP's Staffing and Budget

Located in the Executive Office of the President, ONDCP's staff includes political employees (presidential, Schedule C, and noncareer senior executive service (SES) appointees);[5] and career civil service employees. ONDCP also augments its staff with detailees from federal drug control agencies. Table 1.1 shows the number of ONDCP employees on board at year end from 1989 through October 1992.

Table 1.1: Number of Employees at ONDCP, 1989-1992

Calendar year ending December	Total employees
1989	76
1990	87
1991	88
1992 (October)	120

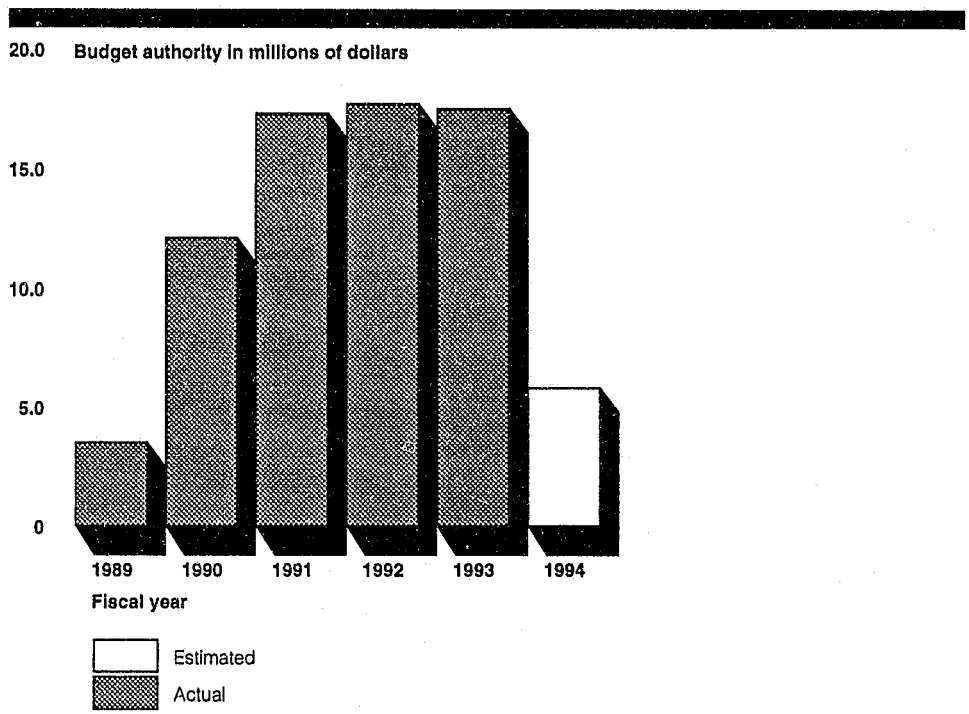
Sources: OPM and the Executive Office of the President.

Because of concerns about the high number of political appointees at ONDCP, Congress, in approving ONDCP's appropriation for fiscal year 1993 (P.L. 102-393), directed ONDCP to reduce its number of political appointees by at least 20 percent. Specifically, the law directed ONDCP to reduce by a minimum of 20 percent the number of noncareer SES and Schedule C positions on board as of September 30, 1992, by no later than September 30, 1993.

[5]Noncareer SES and Schedule C employees are appointed by the administration to support and advocate the president's political goals and policies. Noncareer SES appointees receive noncompetitive appointments to SES positions that normally involve advocating, formulating, and directing the programs and policies of the administration. Schedule C appointees receive noncompetitive appointments to positions graded GS/GM-15 or below that involve determining policy or that require a close, confidential relationship with the agency head or other key officials of the agency.

In April 1993, the administration proposed reauthorizing ONDCP but at a significantly reduced staffing level (from 112 to 25 full-time equivalent positions). According to the administration, this restructuring will refocus ONDCP on (1) policy development and (2) effective coordination of drug programs. As part of this staff reduction, ONDCP's fiscal year 1994 budget request for operations[6] decreased 66.9 percent—from $17.5 million in fiscal year 1993 to about $5.8 million for fiscal year 1994. Figure 1.2 shows ONDCP's budget for operations during fiscal years 1989 through 1994.

Figure 1.2: ONDCP's Budget for Operations During Fiscal Years 1989 Through 1984



Source: ONDCP.

[6]ONDCP's operating budget includes resources (budget authority) appropriated to ONDCP through its salaries and expenses account for operating expenses (such as personnel compensation, rental payments to the General Services Administration, and travel expenses) and nonappropriated gifts and donations from its gift fund account. The gift fund account is a trust fund into which all private gifts and donations made to ONDCP for the purpose of aiding or facilitating ONDCP's work are deposited. Although ONDCP's appropriations for salaries and expenses have included resources for High Intensity Drug Trafficking Areas (HIDTA) and CTAC research, these resources are not for ONDCP operations, and thus ONDCP does not include such resources as part of its operating budget summary.

ONDCP's Strategic Plan: a Law Enforcement Orientation

Since its inception, ONDCP has issued four annual national drug control strategies. Beginning with its second strategy, ONDCP, as required by the 1988 act, also issued annual national drug control strategy budget summaries as accompanying documents. These strategies and budgets, according to ONDCP, have set national drug control policy, guided the nation's antidrug efforts, increased funding for those efforts, and unified the wide range of antidrug agencies and programs spread throughout the government.

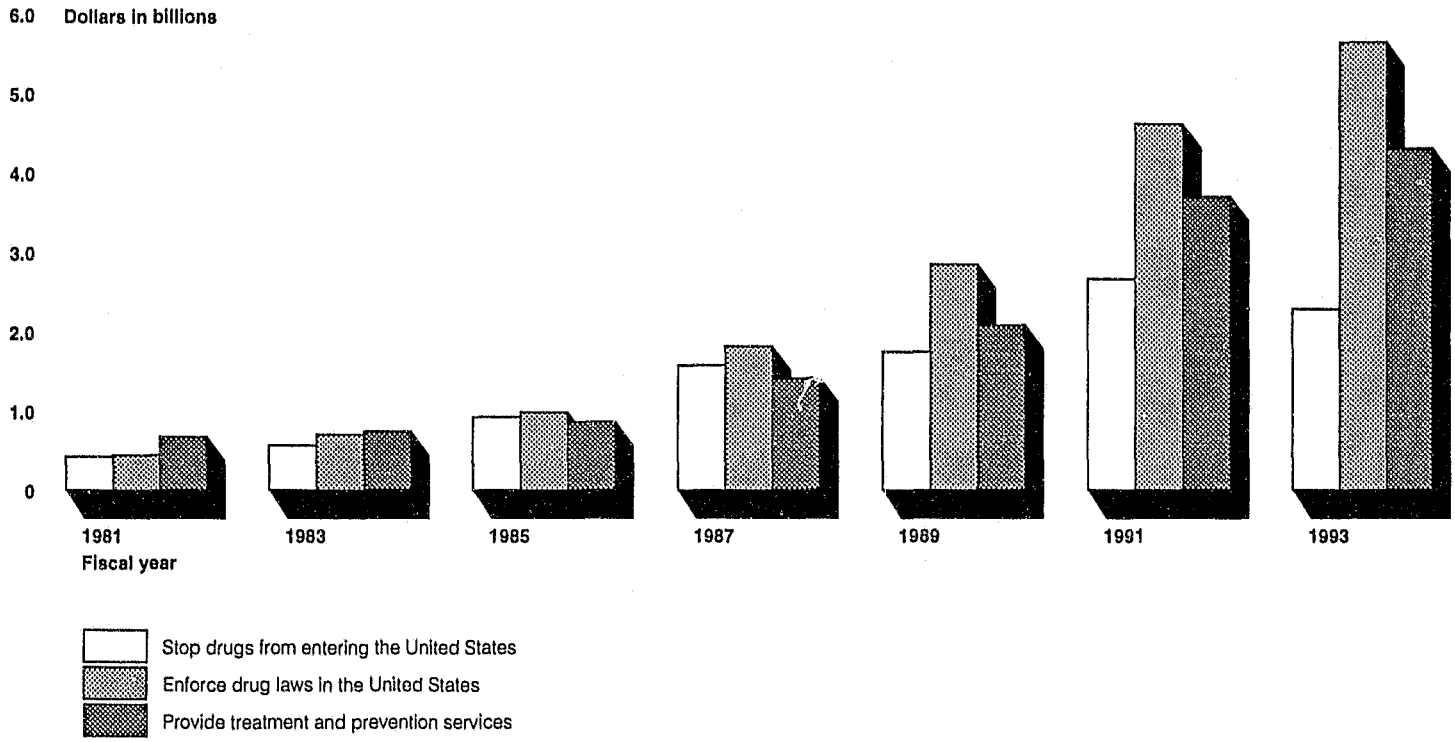
In developing the strategies, ONDCP concluded that to be effective, a drug war needed to be fought on two fronts—one front against casual or intermittent drug use and the second front against hard-core (chronic) drug use.

- Casual drug users are, according to ONDCP, largely responsible for the spread of drug use because such individuals impart a false message that a drug user can do well in school and/or maintain a career or family. Also, the fewer the number of casual users, the fewer will advance to become chronic/intensive drug users.
- Chronic drug users, according to ONDCP, are associated with crime; spread of HIV/AIDS; lost productivity; costly health care; and the destruction of families, neighborhoods, and communities. Today, this is the major front facing ONDCP and the one ONDCP considers to be the nation's most serious and difficult short-term challenge.

ONDCP continued the trend of funding programs associated with law enforcement-led drug supply reduction efforts over demand reduction efforts. As shown by figure 1.3, the three key program components of federal drug control funding involve the following:

- a supply reduction program comprising international and interdiction initiatives that are aimed at stopping drugs from entering the country,
- a domestic supply reduction program that is directed to enforcing domestic laws against drug trafficking and possession, and
- a domestic demand reduction program that provides for drug treatment and prevention services.

Figure 1.3: Federal Funding for Key Antidrug Program Components



Source: OMB.

According to ONDCP, although less of the drug control budget (32 percent) is directed toward activities labeled as demand reduction activities, many of the law enforcement efforts have an impact on demand. For example, arresting and punishing juveniles for illegal drug possession is expected to send a message to their friends and schoolmates to deter them from using drugs.

ONDCP also points out that while many drug supply reduction activities are intrinsically governmental functions most drug demand reduction efforts can and should be shared by schools, churches, and communities. Moreover, ONDCP believes that drug supply reduction activities are inherently expensive (patrol cars, aircraft, and prisons are all very costly);

however, many drug demand reduction activities rely less on capital outlays and more on community involvement and individual commitment. These factors in ONDCP's view, help to explain why larger amounts of federal funding are directed to drug supply reduction efforts rather than to demand reduction efforts.

Overall, ONDCP considers the national drug control strategy to be an integrated and balanced system where a change to one part would affect other parts of the system. Therefore, according to ONDCP, the integrated system would be most effective in reducing drug use when all aspects are receiving proper and balanced attention.

Objectives, Scope, and Methodology

As part of the decisionmaking on whether to reauthorize ONDCP, the Chairman and the Ranking Minority Member, House Committee on Government Operations, requested our assistance in assessing ONDCP's implementation of its statutory responsibilities. At the Committee's request, we reviewed (1) the overall progress reported under the national drug control strategies and the measures of progress used by ONDCP; (2) ONDCP's efforts to coordinate implementation of national drug control strategies; (3) ONDCP's drug budget certification process, including determining whether ONDCP is certifying drug budgets at the program manager level as required by the 1988 act and whether DOD submits its drug budget in accordance with the 1988 act; and (4) ONDCP's involvement with HHS in selected aspects of collecting and reporting drug data used to measure the progress in the war on drugs.

To meet these objectives, we adopted a two-tiered approach. The first tier involved assessing overall drug control efforts on the basis of four data sources: (1) the cumulative base of GAO published and ongoing work related to drug control, (2) the views of recognized drug control experts, (3) professional literature on drug control issues, and (4) the ONDCP promulgated national drug control strategies.

To help plan this first tier of work, representatives from all GAO units responsible for auditing different facets of the national drug control effort met in Washington, D.C., to discuss the results of their domestic and international audit work and future audit plans.[7] This audit work addressed the three major components of the drug war, i.e., international and interdiction; domestic law enforcement; and treatment and prevention

[7]Audit work had been performed in countries including: United States, Brazil, Bolivia, Colombia, Peru, Panama, Bahamas, Ecuador, Venezuela, Burma, Mexico, Pakistan, Thailand, Germany, United Kingdom, and Italy.

programs, as well as cross-cutting issues, such as the quality of drug use indicators and research. To further draw upon the cumulative base of institutional knowledge in the drug control area, the team leading this study obtained and reviewed over 200 GAO reports and testimonies dealing with drug abuse and drug control issues dating back to 1980 (see listing of these reports at the end of this report).

To obtain outside views on drug control issues, we convened a conference of experts knowledgeable about different components of the national drug control strategy. (See app. I for a listing of these experts and a brief synopsis of their backgrounds.) For their respective areas, each of these experts discussed the nature and magnitude of the drug problem, the anticipated future progress given current federal efforts and strategy, the implications of increasing or decreasing the strategy's emphasis in his or her area, and whether the existing drug control strategy should be modified or maintained.

We also conducted a computerized literature search, identified key reports and studies on drug control issues, and judgmentally selected and obtained more than 150 documents. In making this selection, efforts were made to ensure a diverse analytic base, not just proponents or opponents on any one particular issue. To help analyze this literature, a computerized database was established to capture, summarize, and organize pertinent information as each document was reviewed. In general, the use of such multiple data sources should help to ensure that any limitations in one data source would be mitigated by other sources.

The second tier of our approach focused on assessing ONDCP's involvement with other agencies, i.e., coordinating strategy implementation, certifying budget adequacy, and using agency data to measure progress in the drug war. To make these assessments, we did our work at ONDCP and four federal departments: DOD, HHS, ED, and DOJ. In addition to doing specific work at DOD and HHS as required by our objectives, we also did work at ED and DOJ because these departments administer major antidrug programs. The four departments we selected are responsible for a variety of essential antidrug programs (e.g., interdiction, domestic law enforcement, drug treatment, and prevention) and have sizeable shares of the total federal drug budget. Our overall approach consisted of

- interviewing ONDCP, DOD, HHS, ED, and DOJ drug control officials (60 interviews with 91 officials);

- collecting and analyzing relevant documents, including ONDCP's certifications of departmental and agency drug budgets; ONDCP and HHS internal documents including memoranda, correspondence, and press releases relating to selected aspects of ONDCP's involvement in the collection of drug treatment data and the collection and reporting of data from the National Household Survey on Drug Abuse; and HHS documents relating to ONDCP's involvement in reviewing HHS drug treatment and prevention grant programs;
- reviewing our earlier reports and testimonies relating to ONDCP and federal drug control agencies; and
- reviewing legislation and oversight hearings relating to ONDCP.

We discussed the results of our work with officials from ONDCP, and pertinent aspects of those results with DOD, DOJ, ED, and HHS officials. These officials included the Director, ONDCP; the Director, Program and Budget in the office of DOD's Coordinator for Drug Enforcement Policy and Support, Office of the Deputy Assistant Secretary of Defense; the Deputy Drug Coordinator, DOJ; the Staff Director, Drug Planning and Outreach Staff, Office of Elementary and Secondary Education, ED; and the Acting Deputy Director, Office of Applied Studies, Substance Abuse and Mental Health Services Administration, HHS. These officials generally agreed with the information in our report, and we have incorporated their comments where appropriate.

We did our work between September 1991 and July 1993 in accordance with generally accepted government auditing standards.

Overall Progress: a Mixed Assessment With Substantial Challenges Remaining

Despite advances made by ONDCP to establish an objective basis in the national drug control strategy for judging progress in the war on drugs and some positive results shown by related government surveys on drug-use trends, difficult challenges remain.

National Drug Control Strategy Sets Measures of Success as Objectives

According to ONDCP, the promulgation of its national drug control strategy was a landmark achievement. Each annual strategy not only proposed drug control budgets that resulted in Congress' substantially increasing funds in the three major components of drug control (i.e., stopping drugs from entering the country, enforcing laws against drug trafficking and possession domestically, and providing treatment and prevention service) but for the first time, according to ONDCP, committed the federal government to measure its progress by actual reductions in drug use instead of the number of arrests made, addicts treated, or drugs seized. Key sources of measurement information on drug use include the (1) National Household Survey on Drug Abuse, (2) National High School Senior Survey on Drug Abuse, and (3) Drug Abuse Warning Network (DAWN).[1]

Using these sources, ONDCP developed 2- and 10-year objectives in each annual strategy for reducing the supply of and demand for drugs. For example, the 1990 strategy set a 2-year objective that called for a 15-percent reduction in the number of people in the 1992 National Household Survey who reported any illicit drug use during the month preceding the survey as compared to those who reported using illicit drugs in the 1988 survey. The 10-year objective was set at a 55-percent reduction in the number of people who reported using illicit drugs from the 1988 survey. Also, a 2-year objective was set at a 60-percent reduction in the rate of increase in the number of individuals reporting weekly or more frequent cocaine use, while the 10-year objective called for an actual reduction of 60 percent in the number of users.

In each annual strategy, ONDCP adjusted the objectives to account for changes in conditions as indicated by the data it had available. Table 2.1 shows the 2- and 10-year objectives set by the January 1990 strategy and how those objectives were modified by the 1992 strategy.

[1]The National Household and National High School Senior surveys are periodic federally funded surveys to measure (1) the prevalence of drug use among the American household population aged 12 and over and (2) the prevalence and trends in drug use among American high school seniors. DAWN is a data collection system of participating hospitals and medical examiners who report on drug-related emergency room visits and deaths, respectively.

Table 2.1: National Drug Control Strategy 2-Year and 10-Year Objectives as Established in 1990 and Revised in 1992

	2-Year objectives		10-Year objectives		
Objectives	**1990 Strategy target**	**1992 Strategy target[a]**	**1990 Strategy target**	**1992 Strategy target[a]**	**Data source for assessing progress**
To reduce current overall drug use	15% reduction from 1988 levels	25% reduction from 1988 levels	55% reduction from 1988 levels	65% reduction from 1988 levels	National Household Survey
To reduce current adolescent drug use	15% reduction from 1988 levels	35% reduction from 1988 levels	55% reduction from 1988 levels	70% reduction from 1988 levels	National Household Survey
To reduce occasional cocaine use	15% reduction from 1988 levels	45% reduction from 1988 levels	55% reduction from 1988 levels	65% reduction from 1988 levels	National Household Survey
To reduce frequent cocaine use	60% reduction in rate of increase, 1985 to 1988	Reduction not specified	60% reduction from 1988 levels	Reduction not specified	National Household Survey
To reduce current adolescent cocaine use	30% reduction from 1988 levels	70% reduction from 1988 levels	55% reduction from 1988 levels	80% reduction from 1988 levels	National Household Survey
To reduce drug-related medical emergencies[b]	15% reduction from 1988 levels	10% reduction from 1990 levels	55% reduction from 1988 levels	45% reduction from 1990 levels	DAWN
To reduce drug availability[c]	15% reduction from prior year smuggling estimates	Reduction to be determined	60% reduction from prior year smuggling estimates	Reduction to be determined	Intelligence estimates
	15% reduction from 1988 availability estimates	10% reduction from 1991 availability estimates	60% reduction from 1988 availability estimates	35% reduction from 1991 availability estimates	National High School Senior Survey for 1990 strategy and National Household Survey for subsequent strategies
To reduce domestic marijuana production[d]	15% reduction from prior year estimates	Target to be determined	60% reduction from prior year estimates	Target to be determined	Intelligence estimates
To reduce student approval of drug use	20% reduction from 1988 levels	45% to 55% reduction from 1988 levels depending on drug[e]	60% reduction from 1988 levels	70% reduction from 1988 levels	National High School Senior Survey

[a]A tenth objective involving adolescent alcohol use was added by the 1992 strategy. The 2-year objective called for a 30-percent reduction from 1988 levels in the number of adolescents reporting any use of alcohol in the past month and a 10-year objective of a 50-percent reduction.

[b]Targets were revised because of changes in the number of drug-related emergency room episodes and data collection methods.

[c]Targets were withdrawn pending development of a more precise indicator of flow into the United States.

[d]New measures of domestic marijuana production to be developed because of the practice of revising prior year estimates as new intelligence emerges.

[e]Target set at 45 percent for occasional marijuana use, 55 percent for experimental use of cocaine, and 45 percent for regular cocaine use.

Indications of Success by Monitoring Drug-Use Measures

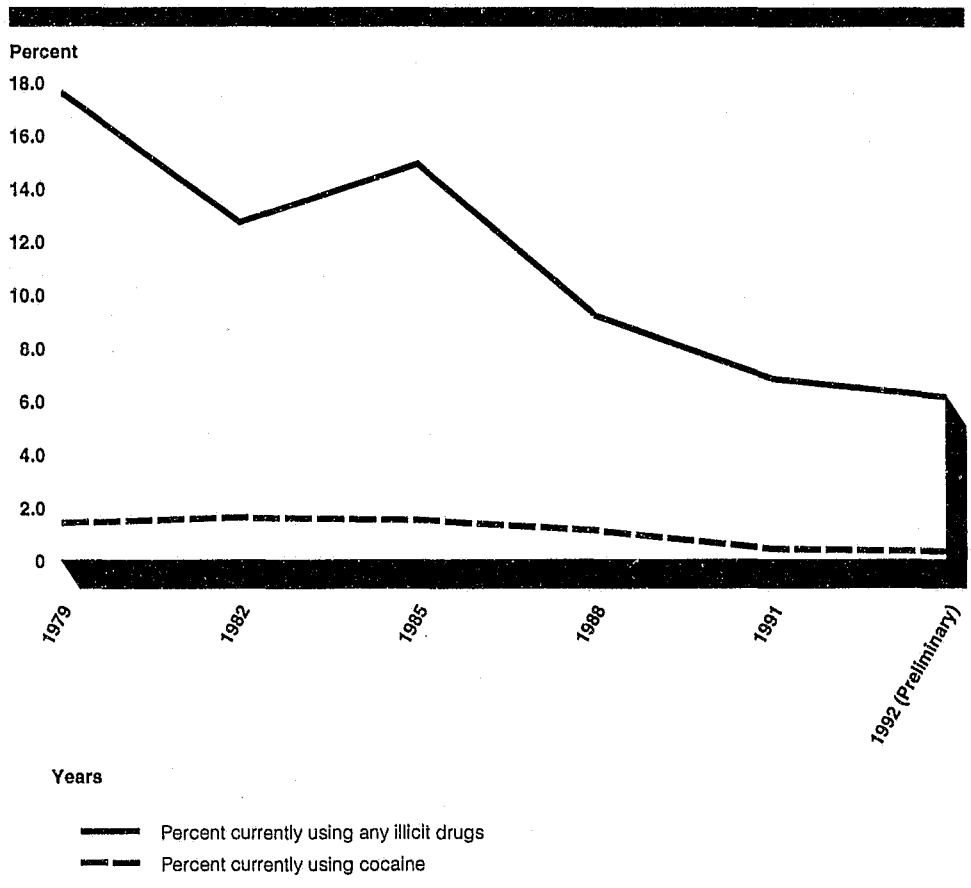
From inception, ONDCP chose to measure the success of the national drug control strategy in terms of the progress made in reducing drug use, instead of using such traditional indicators as the amount of drugs seized, the number of arrests, or the number of addicts treated. According to ONDCP, the success or failure of following the national drug control strategy should be determined on the basis of whether or not drug use declined. Given the progress made in achieving the drug-use objectives specified in the strategy, ONDCP believes the strategy has met this test.

As ONDCP specified in its 1992 strategy, the "war on drugs" consists of two fronts. The first front is against intermittent or "casual" drug use. The second is against "hard-core" (i.e., chronic and addicted) drug use. Controlling casual drug use is important in order to shutdown the pipeline to drug addiction and prevent the entry of new drug users, and, according to ONDCP's 1992 strategy, significant progress is being made on this front.[2] By 1992, five of the nine 2-year objectives set by the 1990 strategy had been met or exceeded. These objectives involved four of the five measures concerning changes in drug use (i.e., current adolescent drug use, occasional cocaine use, frequent cocaine use, and current adolescent cocaine use)[3] and a measure concerning changes in students' attitudes about drug use. Figures 2.1, 2.2, and 2.3 show the trends in the drug-use measures over the period 1979 through 1992, the year of the most recent data available.

[2]There are, however, some recent indications of possible regression. The HHS National High School Senior Survey on Drug Abuse, released in mid-April 1993, showed that while drug use continued to decline among high school seniors, there were modest but statistically significant increases in the number of the nation's eighth graders who used marijuana, cocaine, lysergic acid diethylamide (LSD), and other illicit substances. In the announcement of the survey results, the Acting Director of NIDA noted: "This recent cohort of students—whose average age is 13—may represent a reversal of previously improving conditions among teenagers."

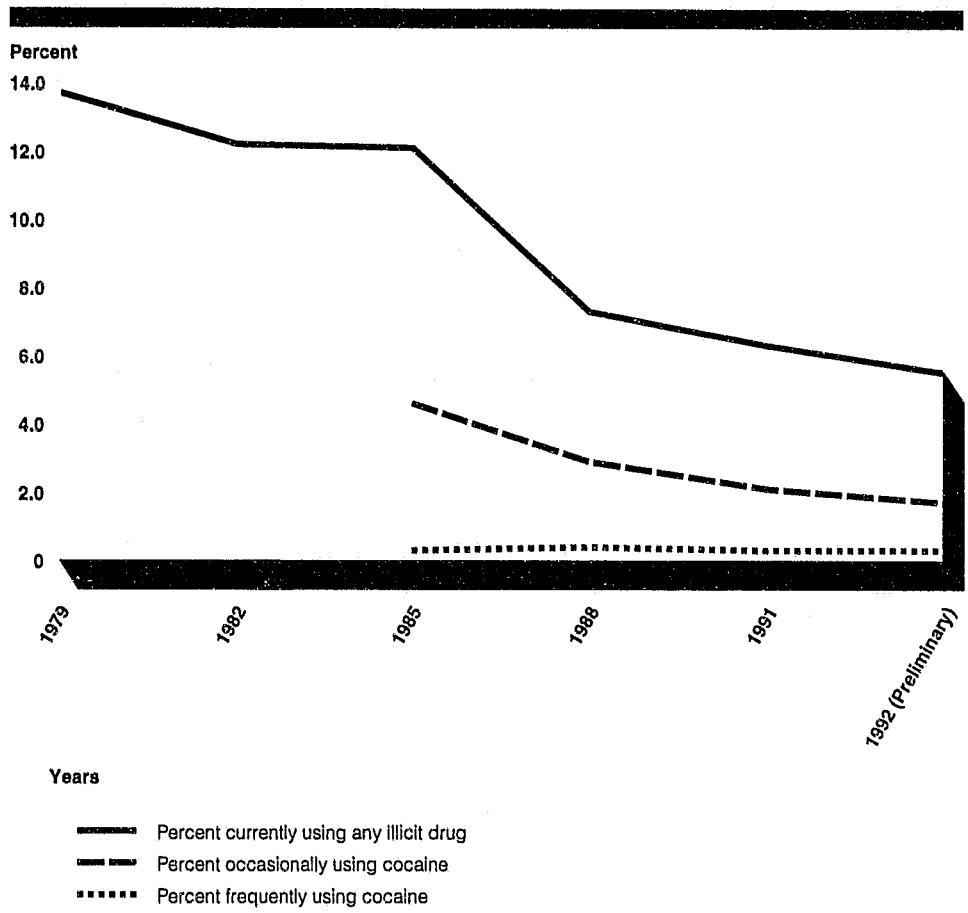
[3]The strategy defines "current use" as the use of an illicit substance within 1 month preceding the applicable survey, "occasional use" as use that occurred less than once per month during the year preceding the survey, "frequent use" as use that occurred weekly or more often during the year preceding the survey, and "adolescent use" as use by individuals 12 to 17 years of age.

Figure 2.1: Adolescent Illicit Drug-Use Trends



Source: National Household Survey.

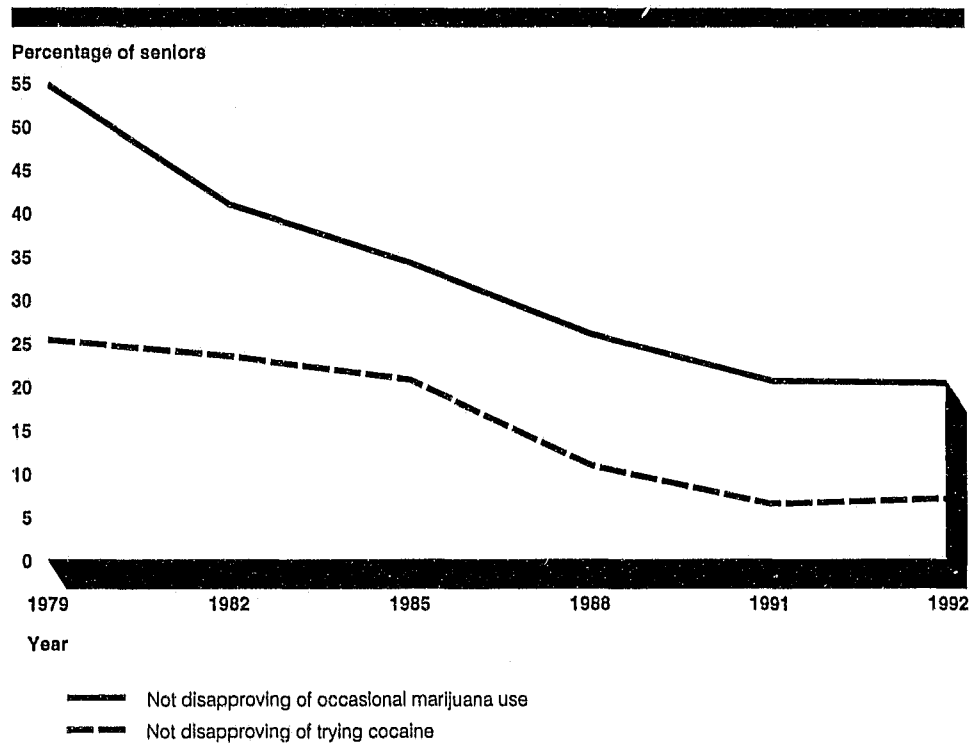
Figure 2.2: General Population Illicit Drug-Use Trends



Note: Data on occasional and frequent cocaine use were not collected until 1985.

Source: National Household Survey.

Figure 2.3: High School Seniors Not Disapproving of Drug Use



Note: Available data show a similar trend for the third-related measure (involving frequent cocaine use), but percentages are too small to effectively display.

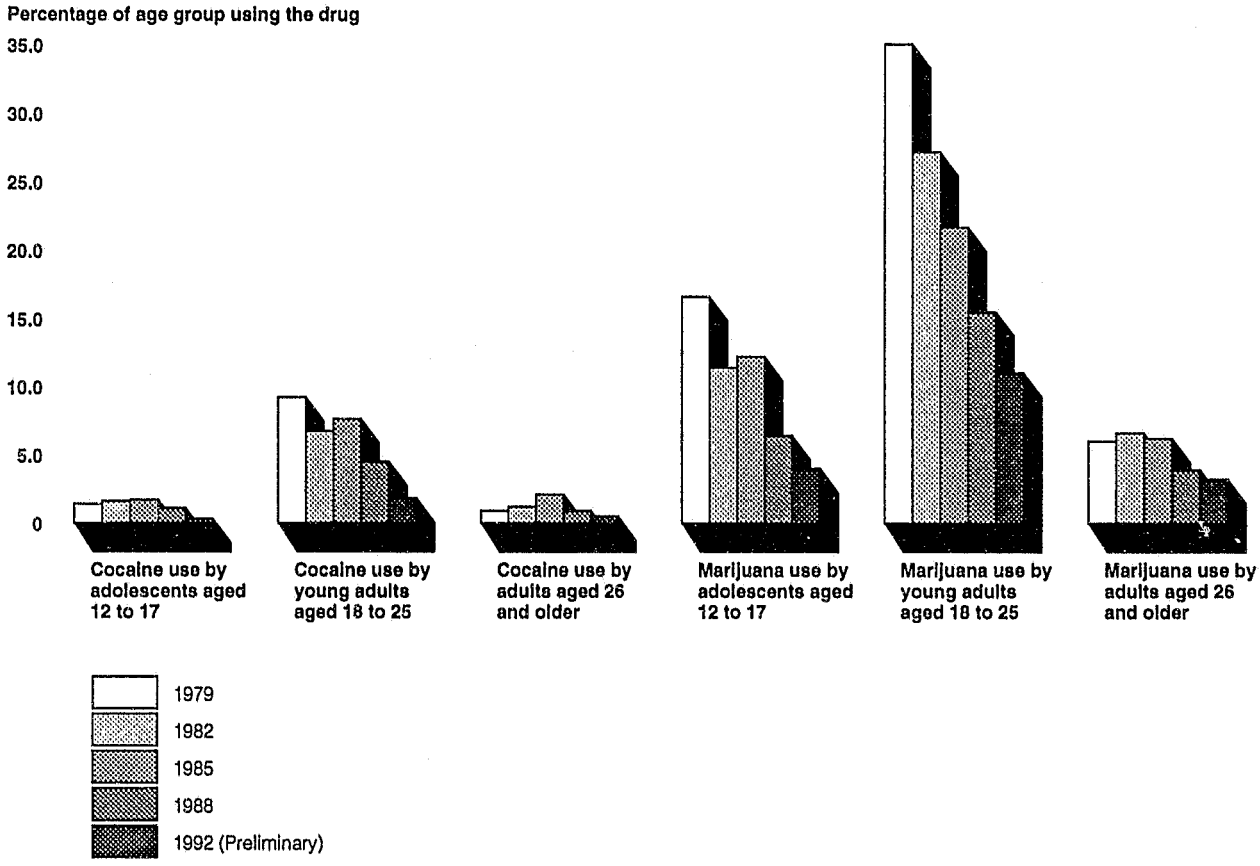
Source: National High School Senior Survey.

In general, the National Household Survey data indicate that the decreases in current drug use for both marijuana, the most commonly used illicit drug, and cocaine have occurred across all age groups (see fig. 2.4.). Reported marijuana use peaked among young adults aged 18 to 25 in the late 1970s.[4] The 1979 National Household Survey estimated that nationwide about one out of three young adults had used marijuana in the month preceding the survey. Reported marijuana usage then precipitously declined, while reports of relatively high cocaine use, i.e., high by historical trend data, continued until the mid 1980s. The use of either drug

[4]Although some may not be as concerned about marijuana use as compared to other drugs, such as cocaine, others see marijuana as a gateway drug to the use of other drugs. According to HHS, the use of cocaine is relatively rare among people who have never used marijuana (i.e., less than one-half of 1 percent), but the likelihood of using cocaine changes for those who have used marijuana. Among those who have used marijuana 200 or more times, 77 percent have tried cocaine. (See Drug Abuse and Drug Abuse Research: The Third Triennial Report to Congress, HHS, 1991.)

reported by persons who were older than 25 or younger than 18, while involving a much smaller proportion of the individuals in those age groups, tended to follow a similar pattern. However, according to HHS, the National Household Survey indicates there has been little apparent change from 1988 to 1992 in the use of cocaine by those 35 and older.

Figure 2.4: Current Use of Drugs



Source: National Household Survey.

In general, the reported current use of other drugs, such as heroin and hallucinogens (e.g., LSD), has been much less. According to National

Household Survey data, hallucinogen use among young adults aged 18 to 25 peaked at about 4 percent of the population in 1979, and as of 1992, hallucinogens were used by about 1.3 percent of that age group. The survey has also estimated that about .1 to .2 percent of young adults were current heroin users over the period 1988 through 1992.

During April 1992 appropriations hearings, the then ONDCP Director reflected on these and other achievements reached in reducing reported drug usage. While acknowledging that the drug war has not been won, he said

"I believe we have turned the corner in this battle. Among casual users, especially, we have made enormous strides. And, because every addict was at one time a casual user, this represents great progress from both a short and long term perspective."

Whether this progress will continue is far from certain. On the basis of data available since April 1992,[5] NIDA found that the long-term declines in overall drug use among some groups did not continue from 1991 into 1992. Between 1991 and 1992, according to NIDA, there was no statistically significant change in overall drug use among college students and high school graduates between the ages of 19 and 28. Moreover, among college students during that time, NIDA found that a statistically significant increase in the use of hallucinogens (including LSD) had occurred. Among secondary school students, NIDA found both a statistically significant increase in the prevalence of drug use (e.g., marijuana, crack, LSD, other hallucinogens, and stimulants) among eighth graders as well as a decrease in the number of eighth graders who disapproved of drug use (i.e., marijuana, crack, and cocaine).

The second front of the ONDCP-led war on drugs—the one against hard-core drug use—is the one that ONDCP considers to be its most serious and difficult challenge. According to the 1992 strategy

"...[about] 25 percent of drug users (those who are the most addicted users) consume about 75 percent of all the illegal drugs consumed in the United States and are the most resistant to anti-drug strategies. These heavy users are at the heart of the drug problem that we read about in our newspapers and see on television: open-air drug markets, crack houses, drug-exposed infants, abused and neglected children, gang violence, decaying neighborhoods, and drive-by shootings."

[5]Monitoring the Future Surveys, Institute for Social Research, University of Michigan, April 1993 and July 1993 releases.

As we discuss in the following section, given the limitations in the available data, it is difficult to assess progress on this second front. But the data that are available are not encouraging. According to HHS, the National Household Survey indicates that frequent cocaine use in 1992 was not significantly different than it was in 1985 (when data were first collected) or from 1988 (the base year ONDCP uses to measure progress). In addition, the most recent data on drug emergency room visits show that the problem has not declined from 1988 levels. In June 1993, according to the newly confirmed Director of ONDCP, the available data and his own observations indicate a continued increase in hard-core drug use, especially in the inner cities and among the disadvantaged. Given the Director's observations, the patterns of drug use indicated by the available but limited data, and ONDCP's finding that hard-core drug users consume the most drugs, we believe there is little basis for confidence that drug use—a measure for judging the success of the national strategy—has been significantly reduced in the aggregate.

Limitations in Using Existing Measures to Set Drug Policies and Priorities

We support the efforts ONDCP has taken to establish an objective basis for judging the progress of the national drug control effort. To date, however, the measures adopted by the strategy have not provided a great deal of insight into what ONDCP refers to as the second front in the drug war—the war against hard-core drug use. Apart from DAWN reports, which deal with the health consequences of drug abuse,[6] the principal data source used to develop and measure progress in dealing with drug usage (i.e., the National Household Survey) has not provided particularly reliable nor sufficient hard-core drug-use estimates for a number of reasons. These reasons include the following:

- The National Household Survey has not provided estimates on the number of drug dependent individuals. Rather, the survey measures frequency of use (e.g., the use of cocaine "once a week or more").[7] Thus, the level of drug dependency among the survey population is not clear from survey results.
- The National Household Survey, while targeting as much as 98 percent of Americans, has not surveyed populations most likely to be heavily involved with drugs, and therefore, may substantially underestimate the number of heavy users. More comprehensive approaches to measuring cocaine abuse indicate that the problem may be three or more times

[6]DAWN reports cover medical problems associated with both casual and habitual use.

[7]The survey also measures the frequency of marijuana use, but not use frequency of other drugs.

greater than indicated by the National Household Survey. Also, the survey has not estimated the frequency of heroin use.

- The National Household Survey has not provided good trend data on frequent drug use among the populations that it has surveyed. Given the small number of survey respondents who reported weekly or more frequent cocaine use, ONDCP has acknowledged that any monitoring of the number of individuals who reported frequent cocaine use from year to year or over several years is highly unreliable.

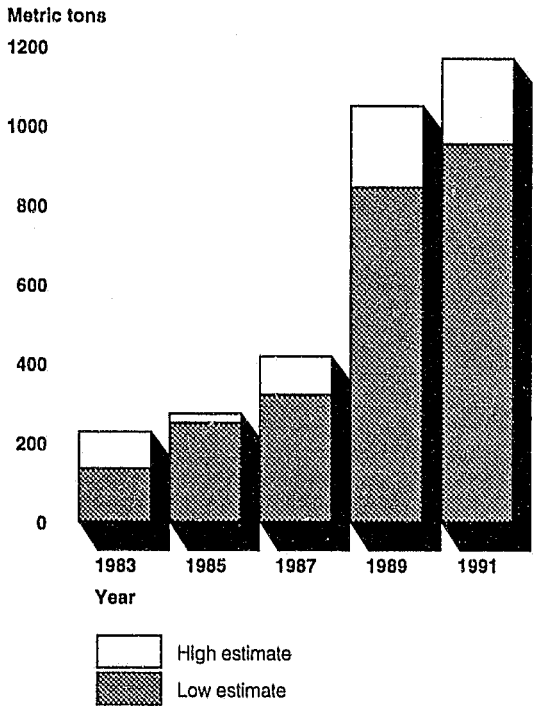
Since frequent or addictive drug use continues to represent the nation's most serious and difficult short-term challenge and a major front in the ONDCP-led war on drugs, we believe that ONDCP needs to search for additional measures for assessing progress against hard-core use of cocaine and other drugs, such as heroin. As we recommended in a previous report,[8] because of the shortcomings of National Household Survey data, the surveys should be cut back to a biennial schedule with savings available for more narrowly focused but more in-depth surveys of specific aspects of the drug problem. These in-depth surveys should address hard-core cocaine and heroin use patterns and trends and drug use by high-risk groups, such as transients, school dropouts, and juvenile offenders. Also, given the limitations of the survey's reliance on self-reports of drug use, we recommended that action be taken to validate those responses. In a discussion of these matters with us, ONDCP officials agreed that much more needed to be done to get a better understanding of hard-core drug use.

Serious Drug Problems Persist

Although data indicate that casual drug use has declined during the first 4 years under ONDCP's national drug control strategy, serious drug problems persist. For example, there is no indication that progress has been made in constraining the availability of drugs to drug users or potential users in this country. According to DEA intelligence officials, cocaine has been readily available in all major metropolitan areas. The results of federally sponsored surveys of high school students regarding the availability of drugs and intelligence estimates on foreign drug production capacity confirm that drugs are readily available (see figs. 2.5 and 2.6). Moreover, given the increased availability and purity of heroin, at a lower price structure, there is concern about a renewed increase in heroin use.

[8]Drug Use Measurement: Strengths, Limitations, and Recommendations for Improvement (GAO/PEMD-93-18, June 25, 1993).

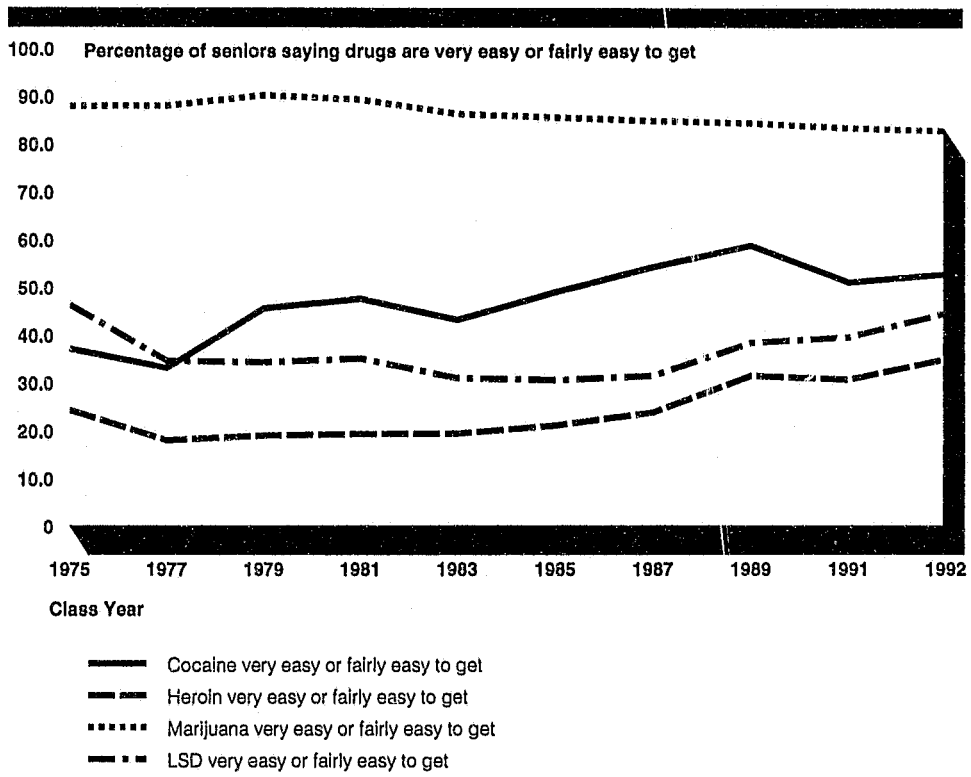
Figure 2.5: Intelligence Estimates on Foreign Cocaine Production Capacity



Note: Estimates for 1989 and 1991 are based on methodological refinements that take into consideration nonproducing immature coca plants and multiple harvests of mature plants.

Source: National Narcotics Intelligence Consumers Committee.

Figure 2.6: National High School Senior Perceptions of Drug Availability

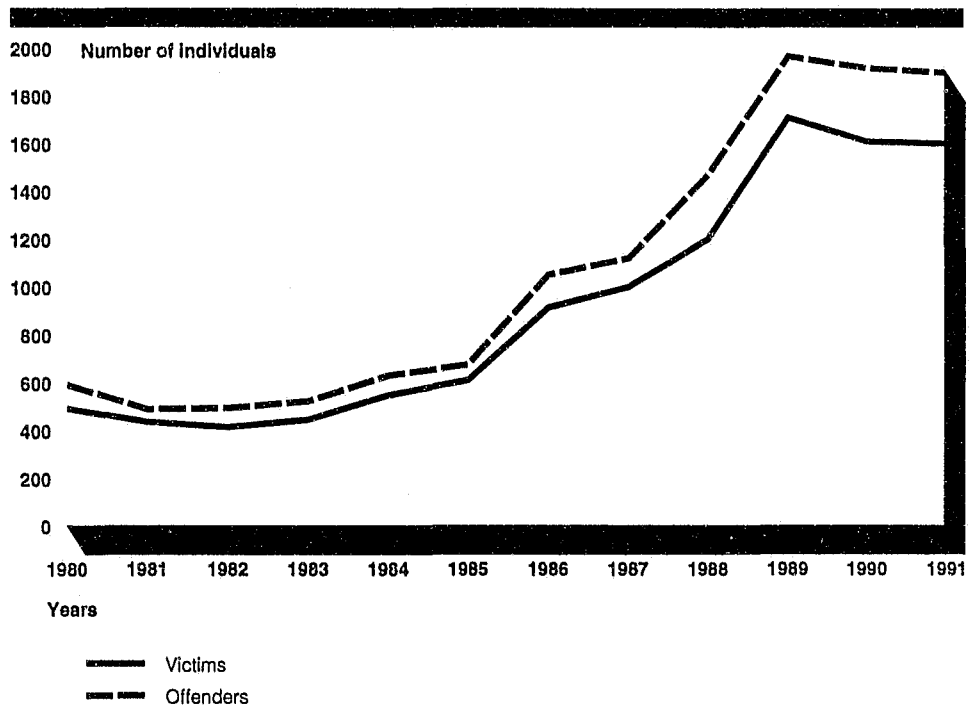


Source: National High School Senior Survey.

Apart from the indicators of drug availability, the continuing seriousness of the nation's drug problem is also evidenced by the level of drug-related crime and violence, particularly drug-related murders especially in the inner cities. Figure 2.7 shows the historically high level of drug-related homicides in recent years.[9] In cases of other drug-related criminal activity, the Bureau of Justice Statistics has estimated that one of every three convicted robbers or burglars committed the crime to get money for drugs, while one out of five inmates convicted of drug trafficking engaged in that illegal activity to get money for drugs. Also, according to recent arrest data, the percentage of arrestees testing positive for cocaine use during 1991 ranged as high as 75 percent in some cities, e.g., San Diego.

[9]The data represent that portion of total U.S. homicides for which information is available to categorize a homicide as involving narcotics and/or brawls due to the influence of narcotics.

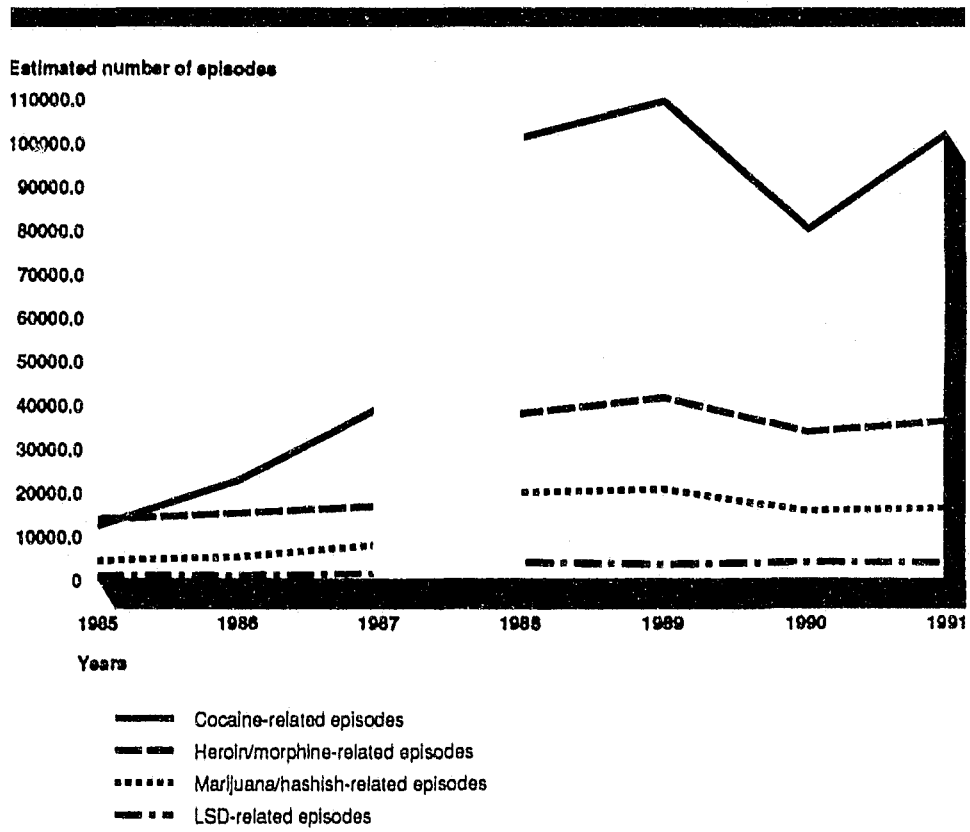
Figure 2.7: Drug-Related Homicides



Source: FBI.

An indication of the adverse health consequences of drug use—another measure of the seriousness of the problem—is available from DAWN reports. As indicated by figure 2.8, drug-related hospital emergency room visits to DAWN participating hospitals increased markedly in the mid-1980s. For example, cocaine emergencies increased about 3-fold from 1985 to 1987. Beginning in 1988, the year the DAWN reporting system was revised, DAWN began to estimate emergency room visits nationwide rather than just reporting participating hospital data. As a result of the new data, the severity of the problem has become more apparent.

Figure 2.8: Drug-Related Hospital Emergency Room Episodes



Note: DAWN data for 1988 and later periods represent national estimates, while prior data represent about 700 consistently reporting hospitals.

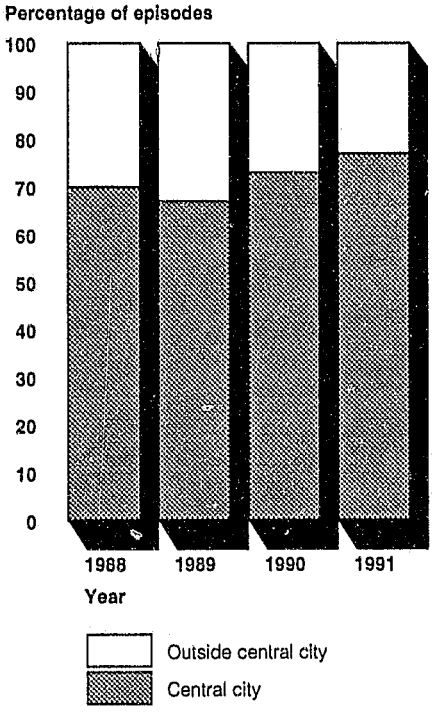
Source: DAWN.

The DAWN data (see fig. 2.9) also indicate that much of the stress on the nation's health delivery system attributable to drug use is concentrated in large central cities. For example, of the 21 metropolitan areas oversampled in DAWN in 1991, 77 percent of cocaine-related drug abuse problems were seen in hospital emergency rooms located in the central cities of those areas, and the remaining 23 percent at hospital emergency rooms in suburban portions of the areas.[10] Similarly, a RAND study of Detroit showed that city residents were three times as likely as suburban residents

[10]The DAWN sample size in other areas is not sufficient to make a central city versus outside central city comparison.

to visit hospital emergency rooms for drug-related causes and more likely to die of addiction-related causes.

Figure 2.9: Cocaine Abuse Emergency Room Episodes, Central City Vs. Outside Central City



Note: Data cover 21 metropolitan areas.

Source: DAWN.

GAO's Assessment of U.S. Antidrug Efforts

Over the past 10 years, we have evaluated various aspects of the three major U.S. antidrug efforts and the participation of federal, state, and local agencies in the national drug control strategy as promoted by ONDCP. Specifically, we have examined federal efforts to

- stop drugs from entering the country, including efforts to reduce source country production of illicit drugs, improve source country enforcement of antidrug laws, and interdict drug shipments destined for domestic distribution;

- reduce domestic demand for drugs, including efforts to match treatment programs with need, to improve treatment quality, establish drug prevention programs (in schools, communities, and workplaces), and improve treatment and prevention efforts through research and evaluation; and
- enforce domestic laws against drug possession and trafficking, including efforts to deter new and casual users, free current users, dismantle trafficking organizations, and stop street dealers.

In appendix II, we discuss these issues in detail as presented in reports that we have published over the past several years.

Our reports identify the immensity of the challenges facing the antidrug effort, challenges that range from helping foreign governments strengthen their economies and break their dependence on drug-related revenues to helping drug users (including prospective users) in this country turn away from what they may see as the allure of drugs. Moreover, given the apparent resourcefulness of the drug traffickers to adjust to the increased federal efforts, drugs are still plentiful today. In response, federal planners have begun to test new approaches, including those to address the continuing problems faced in the inner cities that have seemingly perpetuated the drug problem.

Accordingly, we see no diminishing of the need for an agency, such as ONDCP, to be tasked with overseeing and coordinating the multibillion dollar antidrug effort being carried out by over 50 federal drug control organizations. Over the years, we have found that one of the main reasons the government had not been more effective was the long-standing problem of fragmented drug control agency activities and we had therefore advocated strong leadership and central direction.[11] The following more recent reports show that much remains to be done.

- We found the need for strong central leadership to overcome longstanding information sharing problems, i.e., the information systems maintained by various law enforcement agencies were not sufficiently interoperable—the

[11]Gains Made in Controlling Illegal Drugs, Yet the Drug Trade Flourishes (GAO/GGD-80-4, Oct. 25, 1979), Federal Drug Interdiction Efforts Need Strong Central Oversight (GAO/GGD-83-52, June 13, 1983), National Drug Policy Board: Leadership Evolving, Greater Role in Developing Budgets Possible (GAO/GGD-88-24, Feb. 12, 1988), and Controlling Drug Abuse: A Status Report (GAO/GGD-88-39, Mar. 1, 1988).

automated systems could not work together to exchange information—to readily share important drug investigative information.[12]

- We found that five federal counternarcotics organizations had overlapping intelligence responsibilities and each were monitoring the movement of illegal drugs into Mexico by aircraft.[13] Each analysis repeated data such as the type of aircraft used, aircraft flight times, routes being followed, and potential landing sites. Similarly, we found that four federal intelligence centers each analyzed air traffic activity along the Southwest border and reported on aircraft types, routes, and suspected drugs being transported.[14]

- We found that both the Federal Bureau of Investigation (FBI) and DEA independently develop investigative strategies and priorities, operate separate intelligence systems, and use different systems for measuring effectiveness.[15]

Likewise, we see no diminishing of the need for an agency, such as ONDCP, to be tasked with the responsibility for setting the overall direction of the multibillion dollar strategy carried out by the various drug control agencies. As established in the executive office of the president, we see ONDCP as positioned to rise above the particular interests of any one federal drug control agency and use the national strategy to reorient federal efforts, as described in the following section, to meet the nation's continuing drug problem. In proposing to reauthorize ONDCP, the administration noted that "[5] years after its creation . . . more people are victims of violent crime and drug addition than ever before."

Reorientation of Law Enforcement Efforts and National Strategy

According to the National Institute of Justice, as the 1990s began, it had become clear to law enforcement officials that traditional law enforcement tactics were not effective in either ameliorating drug activity or reducing the concerns and fears of residents in drug affected neighborhoods. In turn, law enforcement agencies at all levels were prompted to seek alternative approaches. One of the more promising alternatives involves shifting police activities from a reactive-type mode (e.g., dispatching police in a squad car to respond to 911 emergency calls)

[12]War on Drugs: Information Management Poses Formidable Challenges (GAO/IMTEC-91-40, May 31, 1991).

[13]Drug Control: Inadequate Guidance Results in Duplicate Intelligence Production Efforts (GAO/NSIAD-92-153, Apr. 14, 1992).

[14]Drug Control: Coordination of Intelligence Activities (GAO/GGD-93-83BR, Apr. 2, 1993).

[15]Transition Series: Justice Issues (OCG-93-23TR, Dec. 1992) and Justice Department: Coordination Between DEA and FBI (GAO/GGD-90-59, Mar. 21, 1990).

to a more proactive mode (e.g., dealing with conditions that may spur criminal activity including drugs).

With the promulgation of the national drug control strategy in January 1992, ONDCP recognized the need to coordinate law enforcement resources with those of social service and economic development agencies to change conditions in neighborhoods and communities that had fostered the drug trade. Specifically, ONDCP highlighted the "Weed and Seed" program as a new, multiagency initiative designed to help reclaim and rejuvenate embattled neighborhoods and communities by linking drug law enforcement efforts with social services. The proposed $124 million drug control program was based on the premise that a partnership of federal, state, and local governments, community organizations and citizens, and business and nonprofit organizations is essential to create safe urban neighborhoods.[16]

In short, the strategy has begun to recognize the need to deal with societal conditions that may predispose individuals to use drugs or become dealers. Although conclusive evidence is not available on the importance of particular factors in placing individuals at risk and which specific government programs should be adopted, there is a general body of research that tends to support the need for a drug policy that is oriented toward dealing with societal factors that contribute to the nation's drug problem.[17]

Also, crime statistics and concerns of many criminal justice experts point to the need to help those who may be least able to afford the consequences of drug involvement—poor, inner city minority residents, and especially juveniles. For example, FBI crime statistics indicate that

- the rate of arrests for drug violations in the nation's central cities is about twice that of the rest of the country (see fig. 2.10); and
- the rate of arrests for black juveniles is over five times higher than that of white juveniles, yet just a few years ago, the difference in arrest rates were not so pronounced (see fig. 2.11).

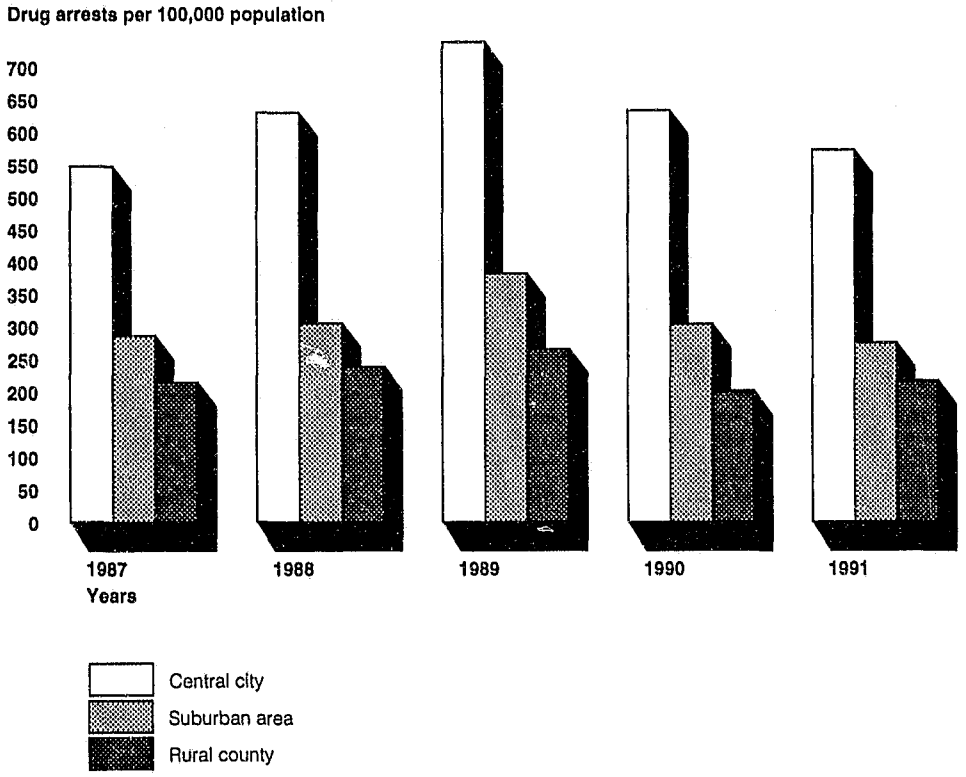
[16]Initial demonstration sites included: Atlanta, Boston, Charleston, Chicago, Denver, District of Columbia, Fort Worth, Kansas City, Los Angeles, Madison, Omaha, Philadelphia, Pittsburgh, Richmond, San Antonio, San Diego, Seattle, Trenton and Wilmington.

[17]For example, see Drug Abuse and Drug Abuse Research: The Third Triennial Report to Congress, HHS, 1991, Delinquents and Drugs: What the Evidence Suggests About Prevention and Treatment Programming, D. Hawkens, D. Lishner, J. Jenson, and R. Catalano, in Youth at High Risk for Substance Abuse, NIDA Monograph 1987, and Patterns of Substance Use and Delinquency Among Inner City Adolescents, Urban Institute, July 1989.

In this regard, a committee of the American Bar Association has supported a drug control strategy that addresses the problems that contribute to drug use in our society—chronic unemployment, deficient public education, inadequate housing and health services, dysfunctional family structures, and deficient foster care systems.[18] According to the committee, relying on law enforcement to achieve demand reduction is costly and inefficient given the questionable deterrent value of criminal sanctions in reaching hard-core addicts and the feasibility of using the criminal justice system as the primary avenue for treatment.

[18]Responding to the Problem of Drug Abuse: Strategies for the Criminal Justice System, Report of an Ad Hoc Committee of the Criminal Justice Section of the American Bar Association, January 9, 1992.

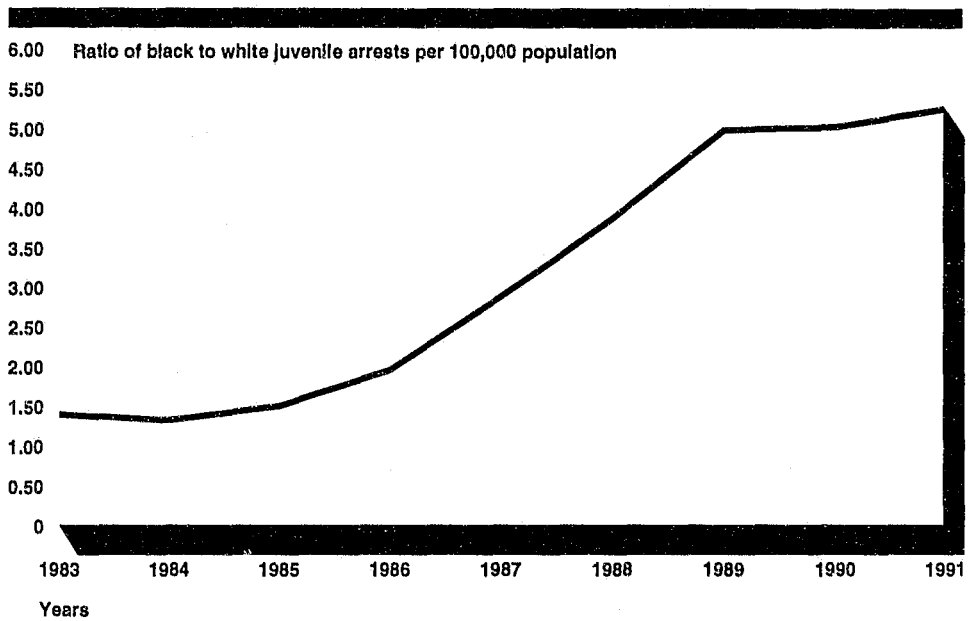
Figure 2.10: Drug Abuse Arrest Data



Note: In general, central cities are defined as those with a population of more than 50,000 in metropolitan statistical areas (MSA). Because of the source data, the central city numbers include non-MSA cities involving about 9 percent of the population.

Source: FBI Uniform Crime Reports.

Figure 2.11: Juvenile Drug Arrest Rates



Source: FBI Uniform Crime Reports and Statistical Abstract of the United States.

Broad Goals Established for Assessing Antidrug Efforts

As we discussed in chapter 1, Congress mandated the development of annual national drug control strategies as the cornerstone of a management framework for ONDCP to use (1) in planning a national antidrug effort and (2) for keeping Congress informed so that appropriate drug control policy and funding decisions could be made. Accordingly, we reviewed ONDCP's four national drug control strategies to determine the extent to which they provided an objective basis for measuring the success of the three major drug control programs funded under the strategies. Those major programs involve

- stopping drugs from entering the country (to which about 19 percent, or $2.3 billion, of fiscal year 1993 funding was directed);
- enforcing domestic laws against drug trafficking and possession (to which about 46 percent, or $5.6 billion, of fiscal year 1993 funding was directed), and
- delivering drug treatment and prevention services (to which about 35 percent, or $4.3 billion, of fiscal year 1993 was directed).

We found that although the national strategies established broad goals for these major programs, the goals were not designed to provide a basis for judging the contributions made by the programs or their constituent activities to reducing the nation's drug problem. For example, according to the strategy, the primary goal of interdiction is to deny smugglers the use of air, land, and maritime routes to the United States. According to some law enforcement officials, to make a difference drug seizures would need to amount to as much as 75 percent of available supply. Yet, available ONDCP data for the past few years indicate that U.S. and foreign governments seized about one-fifth to one-third of the potentially available cocaine produced worldwide and, according to intelligence estimates, the flow of cocaine to the United States has not been diminished. However, the national drug control strategy has not specified the kinds of measures needed to assess the contribution that the interdiction effort is making to deliver on the strategy's overall goal to reduce drug use.

We recognize that setting measurable standards for drug control programs as a means for assessing performance is not easy and has eluded managers for years. In part, this difficulty is attributable to

- the clandestine nature of drug production, trafficking, and use, which limits the quality and quantity of data that can be accumulated; and
- the interrelated nature of antidrug efforts, which make it difficult to isolate the full impact of a single program.

Accordingly, the challenge facing a central planning agency, such as ONDCP, is to work with the drug control agencies to develop a set of indicators for judging the contributions made by antidrug programs funded under the strategy. Although difficulties, such as the interrelated nature of programs, may preclude the development of "perfect" or "precise" performance measures, in our opinion, these difficulties should not stop antidrug policymakers from developing the best alternative measures—measures that could provide general indicators of what is being accomplished over the long term.

Conclusion

There has been a steady decline in reported drug use among casual users, but similar progress has not been made concerning hard core drug use, the second front in the drug war and the one that ONDCP sees as the most serious and difficult challenge. Although ONDCP recognizes that more comprehensive data are needed to better understand the nature and

magnitude of the problem, available indicators show that hard core drug use is undiminished. In addition, there is little indication of progress in reducing the availability of drugs or the level of drug-related violence and adverse health consequences, especially in the inner cities.

Given these factors and the large number of federal, state, and local law enforcement and social service agencies that need to coordinate their activities to work on the drug problem, we believe there is a continuing need for the drug control planning and oversight functions the 1988 act required of ONDCP. As mandated by the 1988 act, the national drug control strategy was to serve as the cornerstone of a management framework for planning a national drug control effort, overseeing that effort, and keeping Congress informed so that appropriate drug control policy and funding decisions could be made.

We support that management framework and the concepts that it embraces—requiring the establishment of objectives for drug supply and demand reduction activities and the monitoring of progress towards those objectives—for a number of reasons. In our view, the better the measures established for assessing these activities, the more informed decisionmakers can be as to whether or not drug policies, budgets, or operations need to be modified. Given the persistent and changing nature of the nation's drug problem, the priorities of past strategies will not necessarily continue to guide future drug control efforts, e.g., the recent reorientation of law enforcement to provide a closer link to social service and economic development as a means for better dealing with community drug problems. Moreover, centralizing these measures in the strategy promotes comprehensive decisionmaking that takes into consideration the numerous alternatives and trade-offs presented by the various drug control options.

We also agree with ONDCP that objectives and measurements that focus on reducing drug use are important in assessing progress in the war on drugs. However, we believe there are two fundamental problems with relying so heavily on such "bottom line" objectives and measures. First, measuring drug use is extremely difficult. The National Household Survey, which has provided the basic measure of drug use, does not effectively reach the most serious part of the problem—hard-core drug use. The survey, while useful, has other methodological limitations as well, such as relying exclusively on self-reporting. Second, measures of actual drug use, even if substantially enhanced, will not provide decisionmakers with the

information they need to assess and as necessary, adjust or redirect drug control efforts.

Recommendations

We recommend that Congress reauthorize ONDCP for an additional finite period of time and include in reauthorization legislation a direction that ONDCP in consultation with the drug control agencies (1) develop additional measures to assess progress in reducing drug use (particularly among hard-core users), (2) develop performance measures to evaluate the contributions made by major components of current antidrug efforts and significant new initiatives, and (3) incorporate these measures into future drug control strategies.

Agency Comments

On August 31, 1993, we met and discussed the results of our work with the Director and other officials of ONDCP. These officials agreed with the thrust of our recommendations and noted that they had begun preliminary discussions with a number of drug control experts to explore ways to develop program performance measures and to better measure hard-core drug use.

ONDCP's Coordinating Efforts: Disagreements and Conflict Over Drug Data and Other Issues

ONDCP established mechanisms for overseeing and coordinating implementation of national drug control strategies by federal control agencies. However, these mechanisms and the interactions among ONDCP and three federal departments—ED, HHS, and DOJ—led to disagreements and conflict. In some instances, officials from these departments viewed ONDCP's oversight efforts as "micromanagement." When interviewing HHS, DOJ, and ED officials, we heard numerous complaints and concerns about disagreements and conflicts with ONDCP in 24 of 28 interviews held. However, such complaints and concerns were not expressed by DOD officials we interviewed. In particular, ONDCP and HHS had major disagreements over the collection and reporting of drug data. We recognize that some disagreement and conflict may be unavoidable in view of ONDCP's responsibilities to monitor and oversee drug control efforts by federal agencies. In discussions about this report, ONDCP officials indicated that in the past there was friction between ONDCP and other agencies; however, efforts have been taken to address the problems.

Good working relationships will be particularly important to ONDCP's future success if it is downsized as proposed. ONDCP and HHS have taken steps to address their data problems and to improve working relationships. Similarly, ED officials said that the need for a drug coordinating office exists, and they look forward to working with the "new ONDCP."

Micromanagement Concerns

ONDCP developed a number of mechanisms to exercise its overall authority to oversee implementation of the national strategy. These mechanisms included reviewing drug-related materials and information before they were finalized by the agencies and requiring agencies to develop plans, subject to ONDCP approval, for implementing the strategy.

Differences Over ONDCP's Review of Agency Documents

ONDCP requested draft drug-related materials and reports from various agencies for review and coordination before final agency action. For example, ONDCP requested HHS to supply it with all proposed drug-related legislation and testimony; drug-related reports, including statistical reports, congressionally mandated reports, and evaluations; and press releases and speeches. According to ONDCP, its review of drug-related materials and reports before final agency action was necessary for coordination purposes to ensure that drug-related initiatives were implemented effectively and in accord with the president's national drug control strategy.

ONDCP also developed a procedure for reviewing federal agencies' drug-related data collection forms and documents as part of the Office of Management and Budget's (OMB) review under the Paperwork Reduction Act of 1980 and for reviewing all draft drug-related regulatory actions pursuant to pertinent executive orders. Although ONDCP has no approval authority over HHS drug-related data collection instruments under this review procedure, it makes comments and recommendations for OMB's consideration.

As part of its review of federal agency draft drug-related documents, ONDCP reviewed HHS' Requests for Applications (RFAs)[1] for drug treatment and prevention grant programs. According to HHS officials, ONDCP's review of these RFAs for three grant programs and disagreements that resulted from these reviews were a serious source of conflict between ONDCP and HHS. Within HHS, the former Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA)[2] was the agency responsible for administering HHS' drug treatment and prevention programs.

According to the Acting Administrator of ADAMHA, ONDCP exercised a high degree of oversight and micromanagement over ADAMHA. In his view, at the time of our interview in February 1992, the relationship between ONDCP and federal agencies had improved over time but enormous conflict still existed. In a March 11, 1992, memorandum to HHS' Assistant Secretary for Health, the Acting Administrator said:

"I reluctantly must inform you about a serious problem we are having in trying to implement new drug abuse programs. In fact, the process of clearing Requests for Applications (RFAs) through ONDCP has deteriorated to the point that it is seriously threatening our ability to provide adequate notice to applicants, to conduct peer review, and to make award decisions in a timely and responsible manner. I believe it would be irresponsible of me not to inform you of these issues at this time . . . and . . . we believe their [ONDCP's] micromanagement has gone too far, and is jeopardizing the Administration's demand reduction efforts."

[1]For the purposes of this report, an RFA is an announcement seeking grant applications and listing requirements for the grant.

[2]As of October 1, 1992, ADAMHA and its components were reorganized into a new health services agency called the Substance Abuse and Mental Health Services Administration (SAMHSA) within the Public Health Service of HHS. At the time of our review, NIDA was a component agency of ADAMHA and was responsible for drug data collection and epidemiological studies. As part of the reorganization, NIDA's responsibilities for most epidemiological studies and drug data collection, such as the National Household Survey, were given to the Office of Applied Studies in the newly created SAMHSA. NIDA and the other research institutes in the former ADAMHA became components of the National Institutes of Health. Because much of our review was done before the reorganization, sections of this report refer to NIDA as the agency responsible for drug data collection.

For example, according to ADAMHA officials, on one RFA they were concerned about the level of detail at which ONDCP was proposing changes, delays in ONDCP's review, ONDCP's insistence on making changes to the RFA after ONDCP had approved it and HHS had issued it publicly, and ONDCP's lack of understanding of the legal requirements to which HHS must adhere.

On the other hand, ONDCP's Director, Office of Planning, Budget and Administration, told us that HHS made modifications to two of the three grant programs under dispute. These modifications, according to the Director, were not consistent with the national drug control strategy.

Implementation Plan Disagreements

On the basis of each national drug control strategy, ONDCP annually tasked federal drug control agencies with developing numerous plans for implementing objectives relating to specific drug control programs and initiatives. The development of these implementation plans, according to the Director of ONDCP, "is the critical step in turning the words of the National Drug Control Strategy into programs that reduce drug use in this country."

According to ONDCP, it identified about 400 objectives from its 4 annual national drug control strategies that were issued from September 1989 through January 1992. ONDCP assigned each objective to a lead drug control agency, which developed an implementation plan, subject to ONDCP's approval, for completing each of its assigned objectives.

To monitor progress, ONDCP required written progress reports or held periodic meetings with the federal drug control agencies. The agencies reported to ONDCP on how many objectives had been completed, how many were on schedule, and what progress had been made.

ED, DOJ, and HHS officials disagreed about the utility of ONDCP's requirement that agencies develop implementation plans for objectives identified in national drug control strategies. According to these officials, ONDCP's requirement and the process it used to implement the requirement were burdensome and of little value. For example, DOJ officials pointed out that ONDCP identified far too many objectives (about 400) for development of implementation plans and that the objectives were frequently of a program and procedural nature rather than policy oriented. DOJ and HHS officials viewed the implementation plans as micromanagement by ONDCP. In contrast, ONDCP viewed its requirement for the development and monitoring of agency implementation plans as a function of its

responsibilities to oversee and coordinate implementation of national drug control strategies.

Prospects for Improving Working Relations and Oversight

It is difficult to determine whether ONDCP was in fact micromanaging or aggressively carrying out its legislatively mandated responsibility. What is clear is that HHS and DOJ perceived instances of micromanagement by ONDCP. Similarly, ED officials expressed concerns about strained working relationships and conflict with ONDCP. For example, in December 1992, ED's Assistant Secretary for Elementary and Secondary Education said that a certain "arrogance and antagonism" pervaded ONDCP. In general, ED's concern about conflict with ONDCP was not inconsistent with the views of a number of other agency officials.

While ED's past relationship with ONDCP could be characterized as strained, ED officials said the need for a drug coordinating office exists. Further, these officials said they are optimistic that the working relationship with ONDCP will improve, and they plan to take steps to help improve that relationship.

In our opinion, the lessening of friction between ONDCP and federal drug control agencies should not be brought about through elimination of ONDCP's oversight responsibilities. However, as discussed in chapter 2, we believe that ONDCP needs to focus its efforts on developing performance measurements to evaluate major antidrug efforts.

Disagreements Between ONDCP and HHS Over Drug Data Issues

Disagreements between ONDCP and HHS over timeliness and quality of drug data have been a problem for the two agencies and have also contributed to strained working relationships. Problems over data have resulted primarily from ONDCP's review and involvement with HHS' drug-related survey collections and friction over the collection and reporting of drug data for policy versus research purposes. In two instances ONDCP insisted that HHS make changes to a major drug use survey despite the warnings of HHS officials about the benefits, cost, and timing of such changes. In another instance ONDCP's and OMB's changes to an HHS drug treatment survey over the objections of HHS officials led to the collection of flawed data. Further, ONDCP publicly reported a decline in frequent cocaine use that was misleading.

While HHS has had problems with ONDCP's involvement with the collection and reporting of drug data, ONDCP had strong concerns about HHS not

meeting its data needs. According to ONDCP, HHS has been unresponsive to ONDCP's needs for timely data for drug policy purposes.

We recognize that disagreements over timeliness and quality of data are bound to occur given the demands placed on ONDCP by the 1988 act to report annually on drug control progress. Also, officials from both agencies agree that many of their disagreements in the data area result from the natural tension that exists between policy and research agencies. They also agree that their working relationship has improved, and some data-sharing issues have been resolved as a result of the recently established HHS/ONDCP joint workgroup on data. We believe that the HHS/ONDCP joint workgroup on data is an appropriate mechanism through which ONDCP and HHS can continue to work to improve federal drug data.

ONDCP Pressured NIDA to Expand Household Survey Sample Size

The 1988 act, as amended, vests HHS with responsibility for collecting data on the national incidence of various forms of substance abuse. The act also requires ONDCP to submit with its annual strategy an evaluation of the effectiveness of drug control during the previous year.

ONDCP works extensively with HHS to ensure that adequate data are available for developing and directing federal drug policy and for measuring annual progress in the war on drugs. As part of this process, ONDCP reviews HHS drug data collection instruments such as those used to collect data for drug surveys. At the time of our review NIDA, a component of ADAMHA within HHS, was responsible for various drug abuse surveys.

According to HHS officials, as part of its review of the plans for the 1990 National Household Survey on Drug Abuse, ONDCP pressured NIDA to more than double the survey sample size. The National Household Survey is the only national survey of drug abuse in the general population, and although the survey has limitations, it has been used as a basis for understanding the extent of drug abuse in household populations in the United States.

To obtain more reliable data on drug users, particularly minorities, youth, and urban groups, ONDCP wanted NIDA to expand the survey sample size from approximately 8,800 individuals in the previous 1988 survey to 20,000 for the 1990 survey. According to two senior level ONDCP officials, ONDCP arbitrarily selected the increase in the sample size and could not scientifically justify its basis for more than doubling the sample size. ONDCP's Director, Office of Planning, Budget and Administration, told us

that doubling the sample size of any survey would certainly improve the quality of the survey.

Although ONDCP insisted on the doubling of the survey sample size, the Director of NIDA recommended in a January 11, 1990, memorandum to the Administrator of ADAMHA against the expansion of the National Household Survey sample size because it would "not provide the data necessary to provide a valid, defensible response to ONDCP's desire for better data on drug users. . ." The Director further commented:

"We [NIDA and ADAMHA] also have a primary responsibility to our own scientific credibility and responsible utilization of taxpayer dollars. The modest gain that doubling the sample size would give in precision of data among non-minority populations is insufficient to justify perhaps $3 million of additional funds."

NIDA officials were also concerned about the timing of ONDCP's request. ONDCP requested the increase in sample size about 2 months before the survey interviewers were to begin their field work. At that point, according to the Director of NIDA, the only way the survey sample size could have been increased was by increasing the selection probability within households already selected to be screened. In other words, more interviews would be done in the selected households rather than including additional households in the survey. This would not increase the number of geographic areas within the sample. Further, because minorities were already significantly oversampled, the degree to which their numbers could be further increased within the same geographic areas was limited. Therefore, more than doubling the sample size would not respond to ONDCP's need for additional information about minority populations, younger age groups' drug usage patterns and trends, and inner-city/urban drug use prevalence.

According to the Acting Administrator of ADAMHA, ONDCP threatened to refuse to clear other surveys unless the Household Survey sample size was increased. Unable to convince ONDCP that the increase would not provide more reliable data on drug users and that a variety of in-house analyses and outside studies could be used to obtain the data, NIDA increased the sample size from approximately 8,800 in 1988 to 20,000 in 1990.

In discussing this matter with ONDCP, an ONDCP official said that with limited oversight authority over federal agencies, ONDCP threatens to withhold clearance of drug surveys in order to obtain agencies' compliance with ONDCP requests. The official also said ONDCP now agrees

with HHS' recommendation to create other surveys or studies to collect data on specific populations, such as minorities and younger age groups. However, the 1988 act requires annual drug abuse surveys of the general population,[3] and the Household Survey is the only survey available for collecting such data. Consequently, the Household Survey must be used to collect drug abuse data needed for the strategy until other surveys or studies can be developed by ONDCP and HHS and approved by OMB.

Given ONDCP's responsibility for coordinating and overseeing federal antidrug efforts, we believe it is ONDCP's right and, indeed, its obligation, to consult with HHS and other agencies on the collection and development of drug-related data. Therefore, we do not question the appropriateness of ONDCP's intentions for expanding the survey to obtain more reliable data on minorities, youths, and urban groups. However, we do not believe it is appropriate for ONDCP to assert approval authority over HHS' drug data collection efforts. The act creating ONDCP does not assign it this role.

In our view, rather than arbitrarily more than doubling the survey sample size over the objections of ADAMHA and NIDA officials, ONDCP should have worked with NIDA to determine whether the data needed by ONDCP could be collected through the Household Survey and what the sample size should be.

ONDCP Set Stringent Schedule for Survey Results

As requested by ONDCP, NIDA releases preliminary Household Survey data to ONDCP about 5 to 6 months after the data collection is complete, which is a significantly more stringent schedule than NIDA had in the past prior to ONDCP's involvement. According to NIDA's Acting Director of Epidemiology and Prevention Research, as a result of the time frames established by ONDCP, there is a greater chance for error in the preliminary analysis of the survey data.

An error in analysis did occur in the 1991 Household Survey. ONDCP and NIDA discovered that an inappropriate procedure had been used to adjust for missing data for "frequency of use." The procedure resulted in overestimation of use for some drugs, most notably frequent cocaine use in those age 35 and older. Consequently, ONDCP released its January 1992 national drug control strategy with erroneous 1991 Household Survey data provided by NIDA. Corrected data would have yielded interpretations by ONDCP different from those published in the strategy.

[3]Specifically, the 1988 act amends part A of title V of the Public Health Service Act to require that survey data be collected each year on the national prevalence of substance abuse, including "the extent of alcohol and drug abuse among high school students and among the general population."

Following the release of the January 1992 strategy, the procedure causing overestimation of some drug use was revised, and the estimates were corrected and distributed in an errata sheet to recipients of the Household Survey reports. In a memorandum dated May 22, 1992, to HHS' Counsel to the Secretary for Drug Abuse Policy, the Acting Director of NIDA noted:

"Given the stringent schedules within which the contractor and NIDA must labor to provide data . . . to ONDCP and to conduct a December press release, such inconsistencies can always occur. When a complex national survey is conducted . . . it is extremely difficult to produce a complete error-free data file within 6 months after field work ends."

In an effort to prevent these types of errors, NIDA has implemented additional quality control checks on editing and imputation done on future Household Survey data. According to NIDA's Acting Director, the best course of action would be to lengthen the time between data collection and release of the data outside NIDA. However, this action would not allow NIDA to fully meet ONDCP's data needs for development of an annual national drug control strategy.

ONDCP agrees in principle on the need to release high-quality products that are as close to completion as possible. However, according to ONDCP officials, ONDCP does not have any flexibility in changing the time frame for collecting the Household Survey data. In an April 21, 1992, ONDCP memorandum to HHS, ONDCP noted that it cannot approve any schedule for release of data that "undermines the development of the President's National Drug Control Strategy."

Disagreement Over Drug Treatment Survey Resulted in Flawed Data

Another source of tension between NIDA and ONDCP resulted from the 1990 and 1991 National Drug and Alcoholism Treatment Unit Survey (NDATUS). NDATUS provides annual information on the client utilization rates of treatment centers in 56 states and territories. In 1990, NIDA and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) submitted their proposed NDATUS form to ONDCP and OMB for review. The most noted characteristic of the form was that it contained a single matrix for reporting both drug abuse and alcoholism clients. NIDA and NIAAA developed the single-matrix form with the assistance of the treatment community in response to the treatment community's inability to separate the collection of drug and alcohol client data.

As a result of the ONDCP and OMB review, NIDA and NIAAA were asked to expand the four-page NDATUS form into a six-page form with two additional

matrices. In an attempt to collect better data on drug treatment, ONDCP and OMB believed the additional matrices would produce data on clients being treated for problems associated with drug abuse only or alcoholism only. NIDA and NIAAA strongly objected to ONDCP's and OMB's proposed modification because they believed the form would not yield the information ONDCP wanted to obtain. NIDA's previous experience with multiple-matrix NDATUS forms indicated that most treatment centers did not have the ability to separately identify their client capacity for alcoholism versus drug abuse clients. Furthermore, according to treatment providers, most clients have drug and alcohol addictions, and it is virtually impossible to distinguish between drug abuse and alcoholism as a primary diagnosis.

NIDA cautioned ONDCP that the use of a multiple-matrix form would result in flawed data. Nevertheless, according to NIDA officials, NIDA used the multiple-matrix form because ONDCP threatened to withhold clearance of NIDA's other data collection instruments if it was not used. According to a NIDA official, ONDCP pressured NIDA at the last minute to change the NDATUS form.

After the 1990 NDATUS was administered, NIDA's review of the 1990 data showed that changes in the form had resulted in invalid data being reported. According to NIDA, the 1990 NDATUS form resulted in a significant backlash from a number of states and treatment providers. NIDA said it received numerous phone calls and letters from approximately 30 states indicating the difficulty they experienced with the 1990 form and their support for a single-matrix form. Many providers, according to NIDA, (1) arbitrarily split their caseload between the drug abuse and alcoholism only matrix, (2) reported their entire caseload on the combined matrix used for reporting clients with drug abuse and alcoholism addictions, or (3) tripled their reported capacity by reporting the same capacity on all three matrices. According to NIDA, because the 1990 NDATUS form produced distorted client data, the 1990 data can only be aggregated and cannot be used, as intended by ONDCP and OMB, to isolate the number of individuals being treated for alcoholism only, drug abuse only, or both.

Despite the problems with the 1990 NDATUS data, the following year ONDCP recommended to OMB approval of the 1991 NDATUS form on the condition that the 1990 form be used again to collect the data. HHS explained in a memorandum to OMB that "misinterpretation of data and use of data that are seriously distorted by reporting practices do not form a valid basis for budget and policy decisions." According to HHS officials, ONDCP's

enthusiasm for continued use of the 1990 form was based on its "use of the numbers [data] without a complete understanding of and appreciation of the distortions that they contain." While OMB initially agreed with ONDCP, HHS made a successful appeal to OMB and did not use the 1990 multiple-matrix form for 1991.

As discussed above, we do not question ONDCP's right to consult with HHS and other agencies on the development of drug-related data, nor do we question its right to consult with and provide its views to OMB in conjunction with that agency's forms clearance process. However, we believe that it is not appropriate for ONDCP to assert approval authority over HHS drug data collection instruments since the act does not assign it this role.

Furthermore, as illustrated in the next section, there is potential tension in having ONDCP control HHS' development and collection of drug-related data when ONDCP's success is judged in large part by the results of HHS data.

ONDCP's Reporting of the 1990 Household Survey Data Was Misleading

As part of the annual national drug control strategy, ONDCP reports drug use indicators, such as the Household Survey and the High School Senior Survey, to assess and report its progress in achieving its annual strategy goals and objectives. Because drug use data are used to assess the progress of the national drug control strategy, which affects drug policy and funding decisions, the data should be reported as accurately and objectively as possible. We noted one instance in which ONDCP reported data in a misleading manner. Although we recognize that this instance may not reflect ONDCP's usual practice for reporting data, we believe that it is important to note because if the data are not reported correctly, strategy and budget priorities for the nation's antidrug efforts could be misdirected.

While the 1988 and 1990 Household Surveys on Drug Abuse showed that the estimated number of frequent cocaine users nationally was 862,000 in 1988 and 662,000 in 1990, HHS' NIDA and ONDCP reported this information quite differently. NIDA's and ONDCP's recognition of the Surveys' limitations and interpretation and reporting of the Surveys' results were as follows.

NIDA determined that the decrease between the 1988 and 1990 Surveys was not statistically significant[4] and stated in its summary of the 1990 Household Survey data released to the public in December 1990 that

[4]At a minimum, NIDA determines whether its Household Survey results are statistically significant at the .05 significance level; the estimate of the decrease in frequent cocaine use was significant only at the .30 significance level.

"While the number of past year and past month cocaine users [current users] has decreased significantly since the peak year of 1985, frequent or more intense use [use on a weekly basis] has not decreased."

By contrast, the Acting Director of ONDCP stated in his press release on the 1990 Survey results:

"We also sought to break and halt the alarming increase in rates of frequent cocaine use, for obvious reasons. The 1990 Survey demonstrates that this goal, too, has been achieved and exceeded—much faster, in fact, than I believe anyone could reasonably have expected."

The Acting Director acknowledged the Survey's limitations in measuring hard-core drug use, but he did not refer to the problem of lack of statistical significance of the Survey's findings or to NIDA's statement that frequent cocaine use had not decreased.

According to ONDCP's Director, Office of Planning, Budget and Administration, HHS cleared ONDCP's press release. However, according to NIDA officials, HHS briefed ONDCP on the 1990 Household Survey results, explaining which results were statistically significant, and tried to persuade ONDCP not to report data that was not statistically significant.

Subsequently, ONDCP reported in its February 1991 National Drug Control Strategy that the frequent cocaine use data may not be statistically significant. However, the strategy noted that "it appears that recent dramatic increases in frequent cocaine use have not only been halted, but abruptly reversed," and the survey indicates "progress against frequent cocaine use far exceeding that originally anticipated."

In commenting on this matter, ONDCP's Director, Office of Planning, Budget and Administration, said HHS reports data that are significant at the 95-percent confidence level. The Director said if ONDCP used the 95-percent standard to report data, ONDCP would never be able to report change in drug use. The Director also noted that ONDCP does not rely solely on statistically significant data to make policy decisions.

Our review of the press releases for the 1990 Household Survey data and our analysis of the data indicated that ONDCP's interpretation and characterization of the survey results were misleading. (See app. III for our detailed comments on ONDCP's reporting of the 1990 frequent cocaine use data.)

Recently, in its June 1993 report on the results of the 1992 Household Survey, HHS said:

"Frequent use of cocaine, defined as use on a weekly basis during the past year, remained unchanged between 1991 and 1992 at about 640,000 users (0.3 percent of the population). Since this measure of frequent cocaine use was first estimated in 1985, no significant increases or decreases have occurred. It should be noted that these estimates are subject to large sampling error and potentially large nonsampling error."

While we recognize that ONDCP has to make policy decisions using the best available data, we believe that ONDCP should report data with the appropriate caveats so as not to misdirect the nation's antidrug efforts or mislead the public. We also believe that although ONDCP did include some caveats about the limitations of the Household Survey in its December press release and in its February 1991 strategy, its bottom line statements about the decline in frequent cocaine use were misleading.

HHS' Special Projects Group Did Not Meet ONDCP's Expectations for Timely Data

While HHS had problems with ONDCP's involvement in the collection and reporting of data, ONDCP officials told us that HHS was unresponsive to many of ONDCP's data requests. Because ONDCP perceived HHS as unresponsive to its data requests, it encouraged HHS to establish the special projects group to do quick response surveys (QRS). HHS established the QRS mechanism with the intent of responding to ONDCP's need for quick, policy-relevant data.

ONDCP issued its first QRS request to HHS in July 1991, asking for a quick assessment of whether indications of increased heroin use were evident in the emergency rooms included in the Drug Abuse Warning Network survey (DAWN). According to an HHS official, HHS was not timely in providing the requested information. HHS completed part of the study in November 1991 and briefed ONDCP staff on the results in January 1992. However, according to an ONDCP official, the briefing did not meet ONDCP's needs because HHS did not allow ONDCP to publicly release the data. Furthermore, ONDCP did not receive a report that could be released publicly until November 1992, more than a year after its request. Because HHS did not meet ONDCP's time frames, ONDCP hired a private contractor to collect the heroin data needed within its time frame.

According to ONDCP, delays with the first QRS project and difficulty in obtaining any written material from verbal briefings caused ONDCP to view the QRS system with some skepticism. Further, ONDCP experienced similar

delays in most QRS projects. According to ONDCP, HHS' unresponsiveness on many data issues complicated ONDCP's internal planning for data and other research and made it difficult for ONDCP to deal with policy issues that were data-dependent for resolution.

Because the QRS studies were not working as ONDCP intended, ONDCP suggested that HHS consider abandoning the effort. An ONDCP memorandum to HHS dated March 12, 1992, noted:

"Although the heroin study is first-rate . . . the other items [other QRS requests] are generally no longer of interest to us [ONDCP]. The idea was to try to get at least a quick-and-dirty notion of what recent data or other information revealed was going on in these areas. The time has passed when the information would have been helpful for policy purposes."

HHS sent ONDCP a memorandum pointing out that it had made a "substantial investment of time, personnel, and resources in this [QRS] effort." The memorandum noted that a quick response capability is absolutely necessary to adequately advise policy makers on national drug control policy. HHS initially resisted but subsequently abandoned the special projects group.

HHS is making efforts to provide ONDCP with timely data. In April 1992, the Acting Administrator of the former ADAMHA sent a memorandum to ONDCP noting that ADAMHA intended to be responsive to the data needs of the administration. The Acting Administrator noted that "ADAMHA will undertake appropriate internal measures and controls to ensure our responsiveness" to ONDCP's data requests. Further, the Acting Administrator stated that she intended to institute procedures to ensure that ADAMHA understands ONDCP interests, including written requests from ONDCP, follow-up meetings, final agreement on due dates, and monthly status reports. We believe that such actions will assist HHS and ONDCP in building mutual understanding about ONDCP's data needs and HHS' ability to meet them. In commenting on this matter, the Director of ONDCP's Office of Planning said HHS was unresponsive to ONDCP's data requests in past years but has made great improvement recently.

ONDCP's Interagency Data Committee Has Done Little to Improve Federal Drug Data

In April 1990, ONDCP established and chaired an interagency data committee to improve federal data influencing drug policy, but it has done little to lead the committee in accomplishing its mission. The data committee—one of many ONDCP coordinating committees established to coordinate and oversee implementation of the strategy objectives—has

been inactive and ineffective. The data committee was specifically designed to guide improvements in the relevance, timeliness, and usefulness of drug-related data collection, research studies, and evaluations. The committee was composed of high-level officials from several departments, including the Departments of Education, Health and Human Services, Justice, Labor, and Transportation. According to NIDA's Acting Director, Division of Epidemiology and Prevention Research, an active data committee with the correct leadership would help to resolve much of the tension that exists between ONDCP and HHS.

Since its establishment in April 1990, the committee has met only four times. The last committee meeting was held in October 1990. During that time, the data committee inventoried and developed recommendations to improve drug-related data and evaluations, identified gaps and flaws in current drug-related data systems, and selected priorities for its working groups. The working groups provided ONDCP with implementation plans for their selected priorities, but ONDCP did not respond to them. According to ONDCP, it infrequently monitored the progress of the working groups and did not provide any guidance or direction.

Improvements in Data Area Through HHS/ONDCP Joint Workgroup on Data

In May 1992, an ONDCP-established joint workgroup on data first met to discuss data issues concerning ONDCP and HHS. The HHS/ONDCP workgroup, which meets monthly, differs from the formal data committee in that it comprises only HHS and ONDCP staff. According to HHS and ONDCP officials, ONDCP's relationship with HHS has improved, and many of the data-sharing problems have been solved as a result of the workgroup. In an August 25, 1992, memorandum to ONDCP's Director, the Secretary of HHS noted that "the joint HHS/ONDCP workgroup has already improved our efforts in data sharing between the agencies, and will be doing more in the coming months."

In commenting on the data problems, the Acting Deputy Director of the Office of Applied Studies within SAMHSA (ADAMHA's successor) said the Office has implemented several programs that are directly responsive to the problems. For example, the Office of Applied Studies has already taken steps to improve its release of data. According to the Acting Deputy Director, the Office is committed to releasing data in accordance with the best professional practices. The timing of data releases from the Office of Applied Studies will depend on professional judgement with regard to the quality and accuracy of the data.

Conclusions

ONDCP's interactions with federal drug control agencies has often resulted in disagreement and conflict. Some disagreement and conflict between ONDCP and federal drug control agencies may be unavoidable in view of ONDCP's responsibilities to monitor and oversee drug control efforts by federal agencies. Nevertheless, given the number and consistency of agency complaints at three of the four departments in our review, it is apparent that working relationships between ONDCP and federal drug control agencies have been strained. Better working relationships will be particularly important to ONDCP's future success if it is downsized as proposed. With fewer resources, we believe ONDCP will have to rely more on federal agencies to accomplish its responsibilities to oversee and coordinate implementation of drug policy.

ONDCP's involvement with HHS in the collection and reporting of drug data has been a major problem for the two agencies and disagreements between them, in our opinion, have contributed to strained working relationships. However, in the past year, both HHS and ONDCP have made efforts to address their data problems and have taken steps to improve their working relationship. Yet, both agencies agree that more needs to be done to develop new measures of abuse in targeted populations and to ensure that accurate, objective, and timely data are available for measuring progress and establishing policy in the war on drugs.

We recognize that if ONDCP is charged in the future with developing measurements for assessing progress in reducing hard-core drug use and developing measures for assessing the performance of major antidrug components, as we recommend in chapter 2, it will need to work closely and cooperatively with HHS and other drug control agencies to identify the best data available to make the assessments and the mechanisms for collecting such data. However, we do not believe it is appropriate for ONDCP to assert approval authority over the agencies' drug data collection efforts.

Drug Budget Certification

As part of ONDCP's responsibility to develop annual consolidated national drug control budgets, the 1988 act requires ONDCP's director to review and certify in writing that annual drug budget submissions from each "program manager, agency head, and department head" with drug control responsibilities are adequate to implement the objectives of the national drug control strategy.[1] ONDCP has used its budget certification authority to increase several agencies' drug budgets by threatening decertification and has decertified two agencies' drug budgets. While DOD submits its drug budget in accordance with the 1988 act, ONDCP has been forced to make "last minute" certifications of DOD's drug budget, and its ability to make budget comparison among federal agencies has been impaired. While the 1988 act requires ONDCP to certify drug budgets of program managers, ONDCP has decided to use this authority on a limited, selective basis.

If ONDCP is reauthorized with fewer staff as proposed, Congress should consider giving ONDCP flexibility to certify drug budgets as it deems necessary. In addition, to provide ONDCP with sufficient time to review DOD's drug budget and make budget comparisons among agencies, DOD should provide ONDCP with its drug budget earlier.

ONDCP's Drug Budget Certification Authority

The 1988 act makes the director of ONDCP responsible for developing and presenting to the president and Congress a consolidated national drug control budget proposal.[2] As part of this responsibility, the 1988 act requires a three-tier drug budget certification process whereby ONDCP is to receive drug budget submissions from each program manager (tier 1), agency head (tier 2), and department head (tier 3) with drug control responsibilities. The 1988 act requires program managers, agency heads, and department heads to submit their respective budgets to ONDCP at the same time they submit them to their superiors and before submission to the Office of Management and Budget (OMB). The director of ONDCP must certify in writing that drug budget submissions to ONDCP are adequate to implement the objectives of the national drug control strategy for the budget request year.

ONDCP requires federal drug control agencies to follow a detailed process in developing their budget proposals. ONDCP provides each agency with

[1]ONDCP certifies that drug budgets are adequate or inadequate to implement the objectives of the national drug control strategy. For the purposes of this report, we refer to ONDCP certifications that budgets are inadequate as "decertifications."

[2]We reviewed and reported on ONDCP's efforts to develop a consolidated federal drug budget in Developing a Federal Drug Budget: Implementing the Anti-Drug Abuse Act of 1988 (GAO/GGD-90-104, Aug. 23, 1990).

program and budget guidance for the drug-related portions of their budgets. The guidance consists of specific funding priorities and further budget and policy suggestions. Annually, ONDCP also develops national drug control budget submission requirements that it sends to all federal drug control agencies and departments. These requirements include identifying programs, agencies, and departments that are to submit budgets; dates the budgets are due to ONDCP; and specific information required.

ONDCP Selectively Certifies Drug Budgets of Program Managers

As discussed above, the 1988 act envisions a three-tiered budget review and certification process, requiring drug budget submissions from program managers, agency heads, and department heads. Because of resource limitations and other factors, this three-tiered process has proven to be impractical, and ONDCP has limited its budget reviews primarily to agency and department budgets. ONDCP did not require the submissions of any program-level budget as part of its review of fiscal year 1992 and 1993 budgets and only selectively required budgets from program managers when reviewing fiscal year 1994 budgets.

ONDCP's limited review of program manager budgets is due in part to staff constraints and the fact that program-level budgets are numerous and subject to considerable change. ONDCP in its national drug control budget submission requirements for the fiscal year 1992 and 1993 drug budgets requested drug budgets from all departments and agencies with drug control responsibilities but did not request drug budgets from any program managers. ONDCP did not require program manager drug budgets because, according to an ONDCP official, (1) ONDCP does not have the staff necessary to review hundreds of program manager drug budgets; (2) since the 1988 act does not define program manager, any definition developed by ONDCP would require weeks to months of negotiations between ONDCP and the affected agencies and departments; and (3) generally agency reviews of program-level budget submissions eliminate excessive requests or requests contrary to policy.

In February 1992, unlike previous years, ONDCP in its national drug control budget submission requirements for the fiscal year 1994 drug budget requested drug budgets from program managers from two selected agencies along with the drug budgets from all agencies and departments with drug control responsibilities. ONDCP requested fiscal year 1994 drug budgets for four programs within the Internal Revenue Service (IRS) and ADAMHA. ONDCP became aware of the need to review program budgets at

these agencies through routine discussions with program managers. ONDCP believes that this selective approach to certifying drug budgets from program managers has merit.

Budget Certification Process Has Resulted in Increase in Federal Drug Budget

While ONDCP certifies agency drug budgets, ONDCP's Budget Director said that the review process, at times, lacks precise criteria. The Director said that the process is both an art and a science. For example, the Director noted that ONDCP has worked with some demand reduction agencies to develop minimum levels of budget growth needed to support the national drug control strategy. In contrast, the Director said that supply reduction agencies frequently submit budgets that are more than adequate to implement the strategy.

Since its inception, ONDCP has twice decertified agency drug budget submissions. ONDCP threatened decertification by sending letters to federal agencies and departments marked "draft" stating that the agencies' and departments' drug budgets were not adequate to implement the objectives of the national drug control strategy. When the agencies or departments increased their budgets to address ONDCP's concerns, ONDCP certified their budgets.

In 1990, as part of its review of drug budgets for fiscal year 1992, ONDCP sent decertification letters marked "draft" to the departments of Veterans Affairs and Housing and Urban Development. As a result of the threat of decertification, the two departments increased their drug budgets, and ONDCP subsequently certified them as adequate. Similarly in 1991, ONDCP sent decertification letters marked "draft" to five departments[3] as part of its review of drug budgets for fiscal year 1993. As a result of the threat of decertification, the five departments increased their drug budgets, and ONDCP subsequently certified them as adequate. In total, the five departments increased their fiscal year 1993 drug budgets by $105.3 million.

In 1991, ONDCP decertified IRS' fiscal year 1993 drug budget, stating that IRS' overall drug budget was not adequate to implement the objectives of the national drug control strategy. The Department of the Treasury subsequently increased IRS' drug budget by almost $15 million and 100 full-time equivalent employees. The following quote from a November 25,

[3]The five departments were ED, HHS, and the departments of Housing and Urban Development, the Treasury, and Veterans Affairs.

1991, Treasury Department letter to ONDCP shows the impact of ONDCP's drug budget certification authority:

"We [the Department of the Treasury] also recognize the importance of expanding IRS involvement in the war on drugs. Consequently, in response to the concerns expressed in your [ONDCP] letter, we will revise our FY 1993 budget request to OMB to include an additional initiative for Criminal Investigation positions designated for anti-narcotics activities."

In 1992, unlike previous years, ONDCP did not threaten any agencies or departments with draft decertification letters but did issue one formal decertification for the fiscal year 1994 drug budget cycle. ONDCP decertified ADAMHA's fiscal year 1994 budget submission for several budgetary and policy reasons. For example, ONDCP noted that ADAMHA's requested funding for one of its block grant programs was not keeping pace with inflation.

Because of the change in the administration, ONDCP, in the fall of 1992, stopped its certifications of fiscal year 1994 drug budgets after completing certifications of agency drug budgets. According to ONDCP's Budget Director, ONDCP generally did not certify drug budgets at the department level in the fall of 1992 because ONDCP was awaiting budget and policy guidance from the new administration.

ONDCP Needs Earlier DOD Drug Budget Submission

Unlike agencies and components in other federal departments with drug control responsibilities, DOD agencies and components do not develop "agency" drug budgets. Instead, DOD develops a single department drug budget based on budget information provided by DOD agencies and components such as the Army, Navy, and Air Force and submits this budget in accordance with the 1988 act. Because DOD does not develop agency drug budgets and ONDCP does not receive a DOD drug budget by August when needed, ONDCP's ability to make cross-cutting comparisons between DOD's drug budget and other federal drug budgets is impaired.

According to an ONDCP budget official, federal departments generally submit their drug budgets to ONDCP between September and October. Prior to that time, federal drug control agencies within the departments, except for DOD, submit their drug budgets to ONDCP as early as May and no later than August. These agency drug budgets are preliminary budgets that have not been approved by cabinet-level, department officers. According to ONDCP's Budget Director, ONDCP's review and certification of agency budgets provides it with the opportunity to recommend changes, identify

policy concerns, and make cross-cutting comparisons of agency drug budgets before final department budget submissions. ONDCP's review of agency drug budgets in the summer of each year provides the opportunity for ONDCP recommendations to be included in department drug budgets reviewed in the fall of each year.

According to ONDCP and DOD budget officials, DOD submitted its fiscal year 1993 drug budget to ONDCP for review and certification in December 1991, after the budget had been approved by the Secretary of Defense. When the Secretary approved the DOD drug budget, according to ONDCP officials, decisions concerning budget resources and priorities had been made, leaving little opportunity for ONDCP to recommend any changes. Further, as discussed next, ONDCP had to make a "last minute, very rushed effort" to certify DOD's drug budget in 1991. As a result, according to an ONDCP budget official, ONDCP has little influence over DOD's drug budget.

Seeking a more timely review of DOD's drug budget for fiscal year 1994, ONDCP requested that DOD submit earlier versions of its drug budgets. ONDCP made its request in an April 9, 1992, letter from ONDCP's Budget Director to DOD's Deputy Assistant Secretary for Drug Enforcement Policy. The following comments from the letter indicate ONDCP's rationale for requesting earlier versions of the budget.

"As you know, we are required by 21 U.S.C. 1502 to review and certify the Department of Defense's (DOD's) drug budget to ensure that it is adequate to implement the objectives of the National Drug Control Strategy. In the past, your office provided us with its fall submission to the Office of Management and Budget. This has resulted in a last minute, very rushed, effort by our staff to certify the Department's drug budget. To improve on this situation, and to more faithfully comply with the requirements of the law, this year we are expanding our budget review role to include an examination of the budget submissions developed by the DOD components.

"We request that your office forward the drug-related budgets of the various DOD components to the Office of National Drug Control Policy (ONDCP) at the time they are received by your office.

"I believe this will serve the interests of both DOD and ONDCP. We will have an opportunity to carefully consider the Department's drug initiatives for the coming year. Similarly, the Department will have the opportunity to discuss our concerns earlier in the process."

In May 1992, ONDCP budget officials met with DOD officials to discuss the timing of DOD's drug budget submission to ONDCP. According to ONDCP and

DOD budget officials, DOD agreed to provide its department fiscal year 1994 drug budget to ONDCP in August 1992, before approval by the Secretary of Defense.

Although DOD made a good effort to provide a drug budget to ONDCP earlier, ONDCP did not receive it until October 1992. According to a DOD budget official, because of congressional issues DOD had to deal with when developing its fiscal year 1994 budget, DOD did not have enough meaningful information to give ONDCP in August. However, unlike the previous year's submission, DOD provided its fiscal year 1994 budget to ONDCP about 2 weeks before the Secretary of Defense approved the budget. While ONDCP had little time to review DOD's lengthy drug budget, it was able to highlight some concerns in its certification letter to DOD.

DOD budget officials pointed out that DOD had made efforts to provide ONDCP with timely information on its drug budget. These officials noted that DOD had briefed ONDCP on its drug budget prior to formal submission of the budget to ONDCP. However, according to ONDCP's Budget Director, the briefings did not provide ONDCP with the details needed to review and certify DOD's drug budget. DOD budget officials also pointed out that DOD develops a biennial budget that gives ONDCP early access to DOD's preliminary second year budget. The budget figures in the second year budget, however, are estimates that are subject to amendment. According to DOD budget officials, the second year budget has always been amended, though not significantly.

Conclusions

ONDCP has used its budget certification authority to increase several agencies' drug budgets by threatening decertification and has decertified two agencies' drug budgets that, according to ONDCP, were not adequate to implement the objectives of the national drug control strategy. In addition, ONDCP, citing resource limitations and other factors, has decided to review and certify drug budgets developed by program managers on a limited, selective basis. Given the large number of drug budgets developed by program managers and the proposed reduction in ONDCP's staff, ONDCP's selective approach appears to be reasonable.

While DOD submits its drug budget to ONDCP in accordance with the 1988 act, unlike other federal departments with drug control responsibilities, DOD agencies and components do not prepare "agency" drug budgets. Rather, DOD prepares a single "department" drug budget that it provides to ONDCP later in the year shortly before or after approval by the Secretary of

Defense. As such, DOD agencies cannot submit "agency" drug budgets to ONDCP by August, when ONDCP certifies other agencies' preliminary federal drug budgets and makes comparisons among them to facilitate coordination of national drug policy. Other federal drug control departments submit their agency drug budgets to ONDCP as early as May and no later than August.

Before 1992, DOD submitted drug budgets to ONDCP that were approved by the Secretary of Defense, leaving ONDCP little opportunity to recommend changes affecting budget priorities and resources. Further, ONDCP had been forced to make rushed reviews of DOD's drug budgets.

Because DOD cannot provide ONDCP with DOD agency drug budgets, ONDCP needs a preliminary DOD department drug budget by August, when it has received other preliminary budgets from drug control agencies. To accomplish this, DOD may need to accelerate its drug budget development process and/or provide a more preliminary drug budget to ONDCP.

Recommendation to Congress

If ONDCP is reauthorized, we recommend that Congress replace the current statutory language requiring review and certification of budget submissions from all program managers, agencies, and departments with a simple mandate that ONDCP review and certify drug control budgets at such stages and times as it considers appropriate. Affording ONDCP greater flexibility in its budget certification reviews is, in our view, particularly important if ONDCP's staff is to be greatly reduced.

Recommendation to the Secretary of Defense

Without a preliminary DOD drug budget received by August of each year, ONDCP's ability to thoroughly review DOD's drug budget and make budget comparisons among agencies is impaired. If ONDCP is reauthorized and continues to have drug budget certification authority, we recommend that the Secretary of Defense direct that ONDCP be given a preliminary DOD drug budget by August of each year.

Agency Comments

On February 18, 1993, we discussed our recommendation to the Secretary of Defense with officials in the Office of the DOD Coordinator for Drug Enforcement Policy and Support. These officials, including the Director, Program and Budget, who is responsible for the formulation of DOD's drug budget, concurred with the recommendation. The DOD officials emphasized that an August budget submission, while an accurate estimate

of planned drug programs and funding at that time, would be preliminary. The officials also reiterated that DOD does not develop agency drug budgets and has made efforts to provide ONDCP with timely drug budget information in previous years.

On August 31, 1993, we met with the Director and other officials of ONDCP and discussed the results of our work. These officials agreed with our recommendations. They emphasized that budget certification was an important ONDCP responsibility and obtaining flexibility to carry out selective certifications of drug budgets seemed reasonable, given the reduction in ONDCP's staff. They also said that in the future their efforts would focus on broad budget issues. The ONDCP officials also agreed with our recommendation to the Secretary of Defense that DOD provide its drug budget to ONDCP by August of each year.

April 1992 Drug Control Symposium Panel Members

The advisory group was impaneled to provide GAO insights into the drug war from experienced individuals representing a diversity of perspectives inherent to establishing and carrying out a national drug control strategy. Following is a list of panel members and the perspective each represents.

Interdiction	Mr. Peter Reuter, Codirector, Drug Policy Research Center, RAND Corporation
Federal Law Enforcement	Mr. Robert Stutman, Robert Stutman & Associates, Inc., (former head of the New York Office, Drug Enforcement Administration)
Local Law Enforcement	Mr. Ruben Ortega, Chief Executive Officer, Phoenix Institute of Technology (former Phoenix Chief of Police; member of the President's Drug Advisory Council; and as of Fall 1992, Salt Lake City Chief of Police)
International	Ms. Ann Wrobleski, Senior Vice President, The Jefferson Group (former Assistant Secretary of State for International Narcotics Matters)
Defense Department	Major General Arnold Schlossberg (U.S. Army, retired), President, National Insurance Crime Bureau (former Deputy Assistant Secretary for Drug Policy and Support, Department of Defense)
Treatment	Dr. Herbert Kleber, Director of Division on Substance Abuse, Columbia University (former Director of Demand Reduction, Office of National Drug Control Policy)
Prevention	Ms. Linda Doctor, Project Director, Prevention Services, The Circle, Inc., (former Director of Massachusetts' Prevention Services and as of May 1992, Director, Division of Prevention: Youth, Adult and Elderly Health, Massachusetts Department of Public Health)
Community Organizations	Mr. Alvin Brooks, Founder and President, Ad Hoc Group Against Crime, Kansas City, Missouri, and former member of the President's Drug Advisory Council
Alternatives	Mr. Eric Sterling, President, The Criminal Justice Policy Foundation (former congressional committee counsel)

GAO's Assessment of U.S. Antidrug Efforts

Stopping Drugs From Entering the Country

Source Country Production

Recent data on the number of acres of coca leaf under cultivation in Bolivia and Peru—cultivation that accounts for about 90 percent of the crop worldwide—indicate that since 1989 cultivation has leveled off at about 440,000 acres. However, according to intelligence estimates, this cultivation level could sustain as much as 15 percent more cocaine production than in 1989. Because the land under coca cultivation had been increasing at an annual average of about 10 percent since 1980, U.S. State Department officials believe the leveling off in production is significant. Given the substantial economic dependence on coca leaf production, a major challenge facing the Agency for International Development (AID) is to help the coca producing nations reduce that economic dependency.[1] Complicating this challenge are limitations on what AID can do given the resources available[2] and other restrictions, such as U.S. Department of Agriculture opposition to AID's promotion of alternative crops because of the potential for increased competition with domestically produced agricultural products.[3]

Source Country Enforcement

Effective antidrug enforcement depends, in part, on the political will of the foreign government to ensure that action is taken against drug trafficking activities. However, our reviews have found that source country governments have not always been able to maintain effective control over military and police units involved in drug control activities, coordinate military and police antidrug activities, and control airports necessary for drug smuggling. Other factors inhibiting source country governments' actions against drug traffickers include political instability caused by active insurgent groups, political corruption, limited resources, economies

[1]The Drug War: Observations on Counternarcotics Programs in Colombia and Peru (GAO/T-NSIAD-92-2, Oct. 23, 1991).

[2]Foreign Aid: Problems and Issues Affecting Economic Assistance (GAO/NSIAD-89-61BR, Dec. 30, 1988).

[3]Drug Policy and Agriculture: U.S. Trade Impacts of Alternative Crops to Andean Coca (GAO/NSIAD-92-12, Oct. 28, 1991).

heavily dependent on coca leaf production,[4] and the priority assigned to antidrug efforts.[5]

Shortcomings in U.S. program management have also added to the uncertainty of international program effectiveness. Although U.S. officials have been working to improve program management, we found that the United States did not have a reliable system for evaluating the effectiveness of counternarcotic aid programs, nor had it established the management oversight needed to execute large counternarcotics assistance programs.[6] Yet the challenges facing U.S. assistance programs are immense. For example, in June 1992, the Assistant Secretary of State for International Narcotics Matters announced that poppy cultivation in Colombia had increased from earlier estimates of about 5,700 acres to about 37,000 to 49,000 acres. According to U.S. officials, the heroin produced from the poppy cultivation is destined for the United States, and Colombia had replaced Mexico as the primary supplier of heroin to the United States. Moreover, these officials do not believe Colombia has the resources to simultaneously sustain enforcement against both cocaine and opium poppy and have noted that Colombia has passed up cocaine targets because of the priority placed on eradicating opium poppy cultivation.[7]

Interdiction

Over the years, we have reported on the limitations of relying on interdiction programs to resolve the nation's drug problems. In our 1989 air interdiction report, we noted that although the interdiction efforts resulted in the seizure of substantial amounts of drugs, given the foreign production capacity the overall availability of drugs to U.S. consumers had not been diminished.[8] We believed that authorizing additional funds for the air interdiction programs may not be the most effective use of limited resources since such programs do not address both the supply of or demand for illegal drugs.

[4]The Drug War: Observations on Counternarcotics Programs in Colombia and Peru (GAO/T-NSIAD-92-2, Oct. 23, 1991, and GAO/T-NSIAD-92-9, Feb. 20, 1992).

[5]The Drug War: Extent of Problems in Brazil, Ecuador, and Venezuela (GAO/NSIAD-92-226, June 5, 1992).

[6]Drug War: Observations on Counternarcotics Aid to Colombia (GAO/NSIAD-91-296, Sept. 30, 1991, and GAO/T-NSIAD-92-02, Oct. 23, 1991); Drug Control: Enforcement Efforts in Burma Are Not Effective (GAO/NSIAD-89-197, Sept. 11, 1989); Foreign Aid: Problems and Issues Affecting Economic Assistance (GAO/NSIAD-89-61BR, Dec. 30, 1988); and Drug Control: U.S. Supported Efforts in Colombia and Bolivia (GAO/NSIAD-89-24, Nov. 1, 1988).

[7]The Drug War: Colombia Is Undertaking Anti-Drug Programs but Impact Is Uncertain (GAO/NSIAD-93-158, Aug. 10, 1993).

[8]Drug Smuggling: Capabilities for Interdicting Private Aircraft Are Limited and Costly (GAO/GGD-89-93, June 9, 1989).

Similarly, in reporting on planned expansion of interdiction capabilities into the Caribbean, we concluded that known radar limitations and inefficient apprehension activities allowed smugglers to avoid detection. Moreover, we believe the planned changes—expanding radar systems and establishing a helicopter base—would not eliminate system problems and would be expensive.[9] Likewise, in 1993 we reported on the ease with which drug traffickers in Mexico changed their trafficking routes to effectively counter U.S.-supported Mexican air interdiction operations.[10]

With the increased role of and funding for DOD, we also examined the contribution DOD was making in improving the effectiveness of interdiction activities. DOD was assigned lead agency responsibility for the detection and monitoring phases of the interdiction process—leaving interception and apprehension to the law enforcement agencies such as DEA.

We found that although DOD had given detection and monitoring a high priority, bringing with it a vast array of aircraft, radars, and other assets that enabled DOD to expand surveillance capability over drug trafficking activities, DOD's detection and monitoring efforts had not had a significant impact on the national goal of reducing the supply of cocaine entering the United States. We also noted that the enormous drug profits made interdiction losses relatively inconsequential to drug traffickers and the resourcefulness of drug traffickers to avoid detection contributed to the continuing domestic availability of cocaine supplies.[11] Regarding other key systems that DOD supports in the drug control effort, we found that

- overall guidance on intelligence collection, analysis, and reporting had been lacking and had resulted in duplication of intelligence production efforts within and among DOD and civilian drug control agencies[12] and
- communications network requirements to link DOD with other drug control agencies had not been fully developed.[13]

[9]Drug Control: Anti-Drug Efforts in the Bahamas (GAO/GGD-90-42, Mar. 8, 1990).

[10]Drug Control: Revised Drug Interdiction Approach Is Needed in Mexico (GAO/NSIAD-93-152, May 10, 1993).

[11]Drug Control: Impact of DOD's Detection and Monitoring on Cocaine Flow (GAO/NSIAD-91-297, Sept. 19, 1991).

[12]Drug Control: Inadequate Guidance Results in Duplicate Intelligence Production Efforts (GAO/NSIAD-92-153, Apr. 14, 1992); and Drug Control: Coordination of Intelligence Activities (GAO/GGD-93-83BR, Apr. 2, 1993).

[13]Drug Control: Communications Network Funding and Requirements Uncertain (GAO/NSIAD-92-29, Dec. 31, 1991).

Providing Treatment and Prevention Services

Matching Treatment Availability With Need

Our past work has shown that continued attention needs to be directed toward matching treatment availability with need. For example, in April 1990 we reported that one-third of the clinics we reviewed in three states did not meet the 7-day HHS goal set for prompt treatment of intravenous drug users, with some waiting more than 3 months.[14] Also, in a series of reports assessing the ability of the treatment system to meet the critical treatment needs of pregnant women, we found that drug treatment services for drug-addicted pregnant women were insufficient or inadequate to meet demand.[15] The barriers restricting treatment opportunities included the lack of adequate treatment capacity and appropriate services among treatment centers for pregnant women, resistance to placing treatment centers in various communities, transportation problems, and the women's fear of criminal prosecution if they identified themselves as drug users. Additionally, we have reported that although Medicaid benefits could help covered individuals with drug addiction and related problems, barriers such as insufficient state funds, provider reluctance to accept some clients, and federal policies limiting reimbursement limited the ability of the states to use Medicaid as a treatment resource. In turn, some states made little use of the Medicaid option.[16]

Improving Treatment Quality

Even for long-established treatment protocols, such as methadone maintenance for heroin addicts, we have found that a number of treatment facilities were not effectively treating the addiction.[17] We recommended that treatment funds be closely monitored (e.g., performance standards established) so that the results of federal investment could be

[14]Drug Treatment: Some Clinics Not Meeting Goal of Prompt Treatment for Intravenous Drug Users (GAO/HRD-90-80BR, Apr. 30, 1990).

[15]ADMS Block Grant: Women's Set-Aside Does Not Assure Drug Treatment for Women (GAO/T-HRD-91-37, June 20, 1991, and GAO/HRD-91-80, May 6, 1991); and Drug-Exposed Infants: A Nation at Risk (GAO/T-HRD-90-46, June 28, 1990, and GAO/HRD-90-138, June 28, 1990).

[16]Substance Abuse Treatment: Medicaid Allows Some Services but Generally Limits Coverage (GAO/HRD-91-92, June 13, 1991).

[17]Methadone Maintenance: Some Treatment Programs Are Not Effective; Greater Federal Oversight Needed (GAO/HRD-90-104, Mar. 22, 1990, and GAO/T-HRD-90-19, Mar. 23, 1990).

determined.[18] Also, to ensure that treatment reaches pregnant drug users and mothers with young children, we recommended that accountability measures be established with respect to women's set-asides in the existing drug abuse block grant program.[19]

The passage of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Reorganization Act of 1992 should advance the development of the accountability framework envisioned in our report. The act conditions the receipt of funding by a state on HHS receiving an assessment of the incidence and prevalence of drug abuse, current prevention and treatment services to deal with such drug problems, and other requirements.

Drug Prevention in Schools

Federal financial assistance (about $624 million during fiscal year 1992) has helped the nation's school districts establish or expand drug education and prevention programs. Our survey of students and principals in six school districts indicated that they believed drug and alcohol abuse among school-age children would be worse without the federally funded programs.[20] However, not much more was known at the local, state, or national level about the effectiveness of the various programs and curricula in reducing or preventing drug abuse among students. Until better information becomes available on what are effective programs, it will be difficult to assess the level at which the federal assistance should be continued. Thus, how well the Department of Education implements the recently enacted statutory requirements for states to periodically evaluate and report on the effectiveness of state and local drug and alcohol abuse education programs, together with other research and evaluation findings (see p. 78 for discussion), will be critical to making decisions on how much should be committed to what kinds of prevention programs. Also affecting such decisions are the results of our evaluations of comprehensive prevention programs for youth, which are summarized in the next section.

Community and Workplace Prevention

We agree with ONDCP concerning the need to promote active community and workplace prevention efforts, but we are troubled that limited

[18]ADMS Block Grant Program: Drug Treatment Services Could Be Improved by New Accountability Program (GAO/HRD-92-27, Oct. 17, 1991); and GAO/HRD-90-104 and GAO/T-HRD-90-19.

[19]ADMS Block Grant: Women's Set-Aside Does Not Assure Drug Treatment For Pregnant Women (GAO/HRD-91-80, May 6, 1991).

[20]Drug Education: School-Based Programs Seen as Useful but Impact Unknown (GAO/HRD-91-27, Nov. 28, 1990).

information is available to indicate what kinds of prevention programs would be successful.[21] We have, however, identified characteristics shared by certain comprehensive prevention programs for youths that seem to indicate which programs hold promise and believe these factors deserve further trial and experimentation by others designing community prevention efforts.[22] Without effectiveness data, however, we did not recommend specific funding except for further national evaluation and dissemination of materials under development that can assist in program evaluation, a significant concern discussed in the following section.

Improving Treatment and Prevention Through Research and Evaluation

We have reviewed the research sponsored by key federal agencies over the past 2 decades.[23] Effective responses to the problem of drug abuse depend on understanding the fundamental biological and social causes of drug abuse and measuring the success of efforts that have been tried already. To the degree that important topics are not studied, government and private agencies lack the knowledge base for informed action to prevent and treat drug abuse.

Judging the adequacy of the nation's research effort—whether the right studies, enough studies, or good quality studies have been done—poses evaluation challenges. Federal agencies keep few data consistently that describe the research they support, let alone data from which to draw conclusions about the studies' merits or their contributions toward informed action on the drug abuse problem.

Nonetheless, given the modest funding commitment to research and evaluation and the lack of definitive research findings, coupled with the continuing need for informed drug control initiatives, we concluded that it was time for national drug policymakers to review whether the budget commitment to research and evaluation is appropriate and to set broad priorities as to what direction it should take.

[21]Drug Abuse Prevention: Federal Efforts to Identify Exemplary Programs Need Stronger Design (GAO/PEMD-91-15, Aug. 22, 1991); and Community Based Drug Prevention: Comprehensive Evaluations of Efforts Are Needed (GAO/GGD-93-75, Mar. 24, 1993).

[22]Adolescent Drug Use Prevention: Common Features of Promising Community Programs (GAO/PEMD-92-2, Jan. 16, 1992).

[23]Drug Abuse Research: Federal Funding and Future Needs (GAO/PEMD-92-5, Jan. 14, 1992, and GAO/T-PEMD-91-14, Sept. 25, 1991); and Drug Abuse: Research on Treatment May Not address Current Needs (GAO/HRD-90-114, Sept. 12, 1990, and GAO/T-HRD-91-56, Oct. 10, 1990).

Enforcing Laws Against Drug Trafficking and Possession Domestically

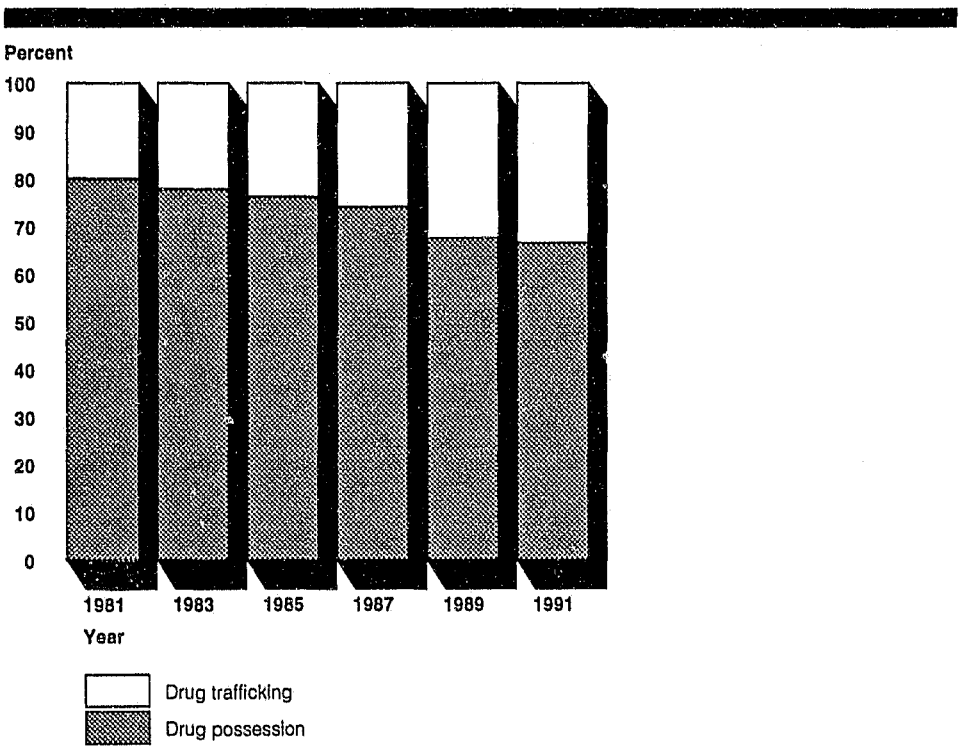
Deterring New and Casual Users

Using the criminal justice system to hold users accountable for their illegal behavior, a major underpinning of the national strategy, is a daunting task. According to ONDCP, to achieve deterrence there must be clear consequences and punishment for possessing and/or using drugs. Yet, we reported that increased drug arrests had substantially burdened correctional facilities, probation and parole offices, and substance abuse centers.[24] All eight cities that we studied had taken actions to cope with the overcrowding, including increased use of plea bargaining, parole, probation, early release from jails and prisons, and downgrading certain offenses to misdemeanors. Moreover, there is a recognized difficulty in matching criminal justice sanctions to some drug possession violations. As we reported in April 1992, a newly established criminal justice sanction established to deter drug possession and use—denial of access to federal benefits—had not been generally accepted as a worthwhile sanction.[25] Against this backdrop, analysis of national data trends indicates that law enforcement has reduced the relative emphasis previously directed to drug possession (see fig. II.1).

[24]The War on Drugs: Arrests Burdening Local Criminal Justice Systems (GAO/GGD-91-40, Apr. 3, 1991).

[25]Drug Control: Difficulties in Denying Federal Benefits to Convicted Drug Offenders (GAO/GGD-92-56, Apr. 21, 1992).

Figure II.1: Proportion of Drug Arrests Related to Possession and Trafficking Offenses



Source: Bureau of Justice Statistics.

Freeing Current Users

Largely as a consequence of drug trafficking and use and aggressive drug law enforcement efforts, the federal and state corrections-supervised population—offenders imprisoned, jailed, and on probation or parole—has increased about 44 percent since 1985 to about 4.3 million in 1990. The inmate population increase has strained federal and state prison capacity to treat drug abuse. Given our work that is described next, upwards of 70 percent of inmates may have a substance abuse problem needing treatment. Also, about one-half of all probationers have had a drug abuse problem, and drug abusers were more likely than nonabusers to be rearrested.[26]

[26]Recidivism of Felons on Probation, 1986-1989, Bureau of Justice Statistics Special Report, February 1992.

Our 1991 reports[27] indicated that about 530,000 of the 740,000 federal and state prison inmates may have substance abuse problems. However, only about 20 percent were receiving treatment, and there was no guarantee of after-care, which was determined to be an important component of an effective treatment regimen. Likewise, our review of the criminal justice system's ability to identify, monitor, and refer offenders to treatment indicated that much more needs to be done.[28]

Focusing on Trafficking Organizations

One way to dismantle trafficking organizations is to mobilize a coordinated federal, state, and local law enforcement attack in the areas of the country that are recognized as the points of entry for illicit drugs that are used throughout the country. Since 1990, Congress has appropriated $279 million to assist a coordinated effort in five gateway areas referred to as HIDTAs. This $279 million is in addition to about $6 billion of federal antidrug funds directed to supply and demand reduction efforts in these areas during the period.

Our reviews of how the high-intensity funds were distributed showed that the effort lacked a clear focus of what was to be accomplished.[29] Accordingly, in January 1992, ONDCP established an objective for the high-intensity areas to compile a list of the most important trafficking organizations and develop a strategic plan for dismantling each organization. We believe this objective is needed to help better focus the federal law enforcement effort onto leaders of the trafficking organizations. Available data indicated that a small percentage of drug offenders convicted in federal court are organizers, managers, or leaders of the criminal activity that led to the conviction.[30]

[27]Drug Treatment: Despite New Strategy, Few Federal Inmates Receive Treatment (GAO/HRD-91-116, Sept. 16, 1991); and Drug Treatment: State Prisons Face Challenges in Providing Services (GAO/HRD-91-128, Sept. 20, 1991).

[28]Drug Control: Treatment Alternatives Program for Drug Offenders Needs Stronger Emphasis (GAO/GGD-93-61, Feb. 11, 1993).

[29]Drug Enforcement: Improving Management of Assistance to High Intensity Drug Trafficking Areas (GAO/T-GGD-91-53, July 25, 1991); and Drug Enforcement: Assistance to State and Local Law Enforcement Agencies in High Intensity Drug Trafficking Areas (GAO/T-GGD-92-37, May 6, 1992).

[30]GAO observation based on a random sample of U.S. Sentencing Commission files on 859 defendants convicted of a drug offense in 8 federal judicial districts during February, May, September, and October 1990. In that sample, 7 percent of the convicted defendants were found by the courts to be organizers, managers, or leaders of the criminal activity.

We have also identified shortcomings in the federal system established to support money laundering investigations.[31] An effective antimoney laundering campaign could substantially reduce the profitability of drug crime by making it difficult, if not impossible, for criminals to spend or disguise the proceeds of illegal activities. To do so, in part, requires a federal effort to ensure that businesses and financial institutions report large cash transactions to the federal government and that those reports are used to maximum advantage in targeting investigations to those who are most likely to be involved in money laundering activities. Our reviews of the federal effort showed that the processing of some civil penalty referral cases had not been timely, with some cases remaining inactive for excessive periods and causing some cases to be closed because of statute of limitations requirements. Regarding the use of reports to identify drug traffickers, we found that because of information disclosure prohibitions, some reports were not being used to the extent that they otherwise could (e.g., the reports were not routinely shared with state enforcement agencies).

We also found that efforts to control precursor chemicals (e.g., the chemicals needed by drug traffickers to convert coca leaves to cocaine) have not been fully successful.[32] Although domestic efforts had reduced the amount of U.S. precursor chemical exports to South America cocaine producing countries, European exports had increased.

Focusing on Street Dealers

Until the mid-1980s, traditional federal, state, and local narcotics enforcement efforts were focused more toward drug activity at the mid- and upper-levels of wholesale distribution than to retail street sales.[33] In general, local police agencies employed specialized narcotics units staffed by undercover personnel to make "buys" from mid- and upper-level dealers and then effect arrests.

[31]Money Laundering: Treasury Civil Case Processing of Bank Secrecy Act Violations (GAO/GGD-92-46, Feb. 6, 1992); Money Laundering: The Use of Cash Transaction Reports By Federal Law Enforcement Agencies (GAO/GGD-91-125, Sept. 25, 1991); Money Laundering: Treasury's Financial Crimes Enforcement Network (GAO/GGD-91-53, Mar. 18, 1991); Money Laundering: The U.S. Government Is Responding to the Problem (GAO/NSIAD-91-130, May 16, 1991); and Money Laundering: State Efforts to Fight It Are Increasing but More Federal Help Is Needed (GAO/GGD-93-1, Oct. 15, 1992).

[32]Drug Control: Implementation of the Chemical Diversion and Trafficking Act of 1988 (GAO/GGD-91-56BR, Apr. 3, 1991).

[33]Gains Made in Controlling Illegal Drugs, Yet the Drug Trade Flourishes (GAO/GGD-80-4, Oct. 25, 1979); and Searching for Answers, National Institute of Justice, July 1992.

Beginning in the mid-1980s, the crack cocaine epidemic spurred local police agencies to respond more directly to street-level retail sales. In turn, the number of arrests climbed dramatically.[34] In New York City, for example, arrests rose 70 percent from 1985 to 1987 and doubled in the 2 years from 1986 to 1988 (also see figure II.1, which shows the increasing nationwide focus on trafficking). According to Justice evaluations, however, wholesale dealers were seldom arrested and arrested street-level sellers were rapidly replaced by others. This has led to a rethinking of how police departments should respond to the drug problem.[35]

[34]The War on Drugs: Arrests Burdening Local Criminal Justice Systems (GAO/GGD-91-40, Apr. 3, 1991).

[35]Searching for Answers, National Institute of Justice, July 1992.

GAO's Comments on ONDCP's Reporting of the 1990 Household Survey Data on Frequent Cocaine Use

ONDCP reported in the 1991 national drug control strategy and its press release for the 1990 Household Survey data that the estimated number of frequent cocaine users nationally declined 23 percent, from 862,000 in 1988 to 662,000 in 1990. ONDCP reported these estimates at the .30 level of significance.

Traditionally, .05 or less significance levels are considered to be statistically significant. A .05 significance level indicates that there is a 5-percent probability that a statement that there is a difference between two measures will be untrue. In reporting that there was a 23-percent decline in the number of frequent cocaine users from 1988 to 1990, ONDCP accepted the risk that there is a .30 probability (30-percent likelihood) that its statement is untrue. It is not common practice to use significance test results that allow for such a high probability of error.

One factor that contributed to this problem relates to the very small number of respondents who reported frequent cocaine usage. Only 0.3 percent of the 9,259 respondents in 1990 fell into this category and 0.4 percent of the 8,814 respondents in 1988 reported frequent cocaine usage. The impact of the small proportion of respondents is also reflected in the width of the confidence intervals reported by the National Institute on Drug Abuse (NIDA). Table III.1 shows the 95-percent confidence intervals as reported by NIDA.

Table III.1: Total Frequency of Cocaine Use Once a Week or More

Year	Population estimate	Lower limit[a]	Upper limit[a]
1988	862,000	620,000	1,173,000
1990	662,000	464,000	943,000

[a]Computed at 95-percent confidence level.

Source: National Household Survey on Drug Abuse: Population Estimates for 1988, and National Household Survey on Drug Abuse: Population Estimates for 1990, NIDA.

When computing these confidence limits NIDA used a Taylor Series approximation procedure to compensate for the small number of respondents. The confidence intervals are wider than are usually desirable. For 1988 there is about a 553,000 range within which the true value for the population is estimated to fall, and for 1990 the range is 479,000.

The wide confidence interval computed by NIDA and the .30 significance level reported by ONDCP both illustrate a lack of sufficient evidence upon

which to make any definitive statement about changes in the number of frequent cocaine users.

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