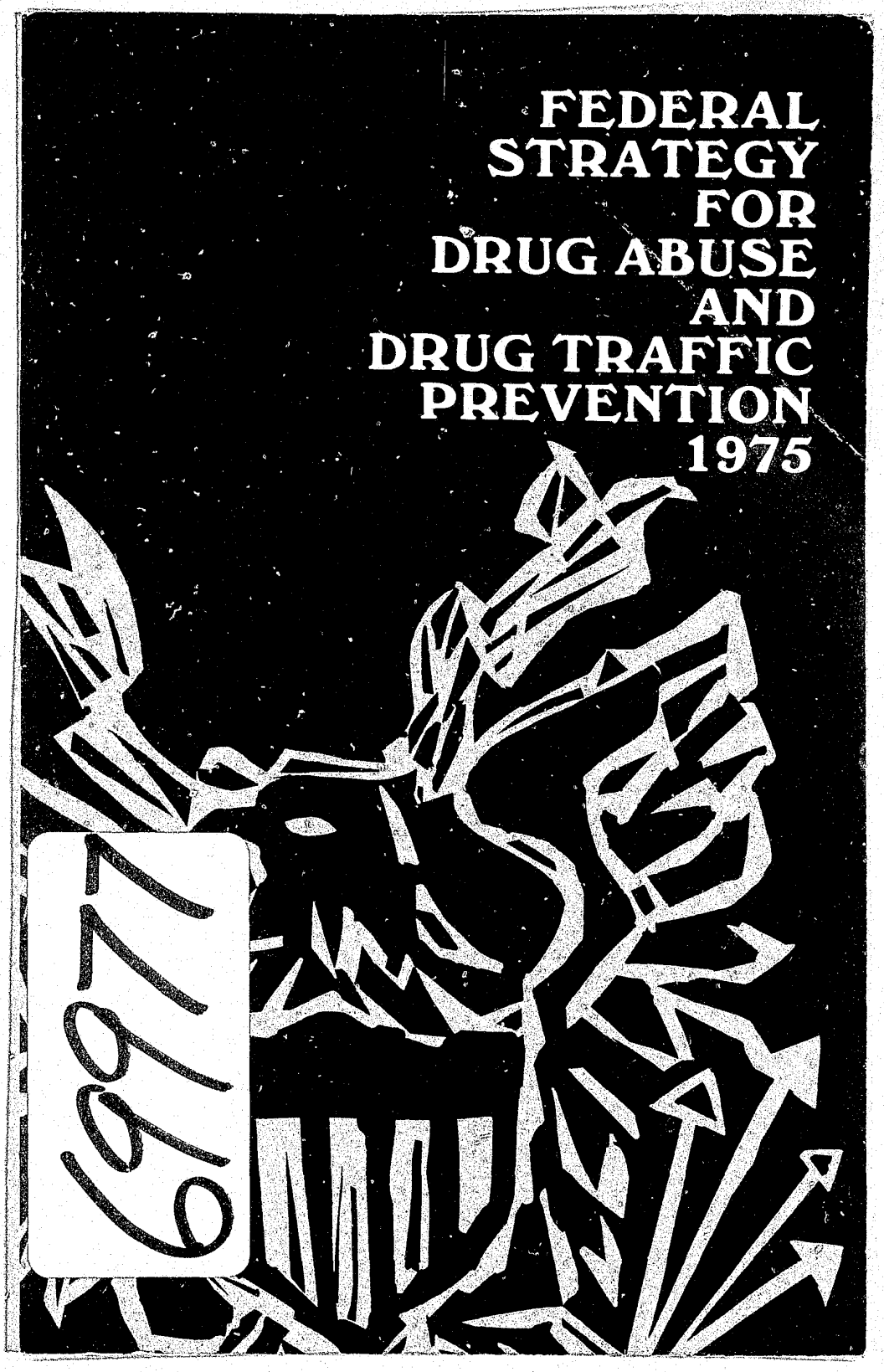
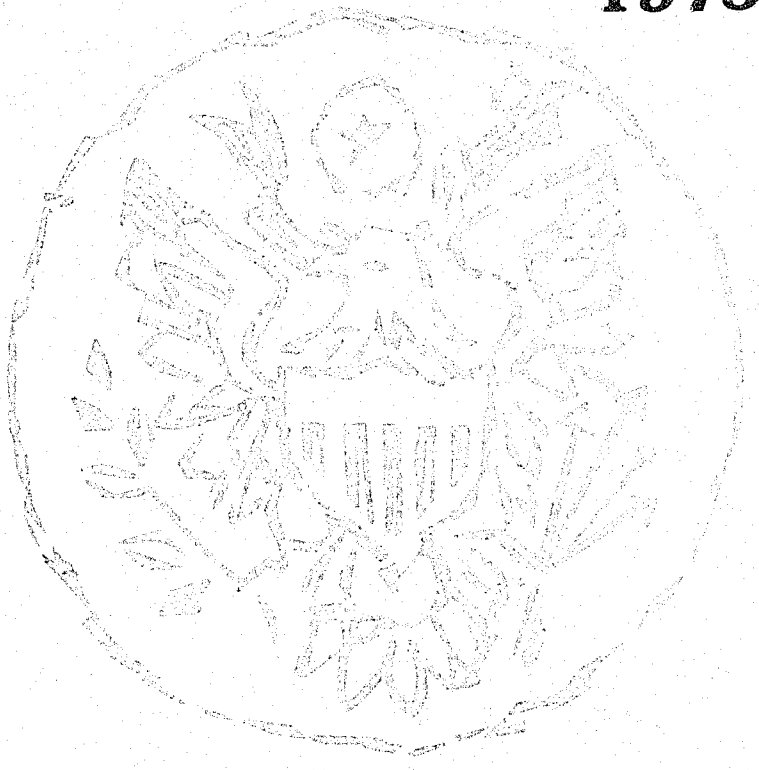


FEDERAL STRATEGY FOR DRUG ABUSE AND DRUG TRAFFIC PREVENTION 1975



Strategy Council on Drug Abuse
726 Jackson Place, N.W.
Washington, D.C. 20506

June 1, 1975

The President
The White House
Washington, D.C. 20500

Dear Mr. President:

The Strategy Council on Drug Abuse was established in the "Drug Abuse Office and Treatment Act of 1972" to develop a Federal Strategy for all drug abuse prevention activities of the Federal Government.

I have the privilege of submitting to you the *Federal Strategy for Drug Abuse and Drug Traffic Prevention 1975,* developed by the Council. This strategy continues to emphasize a balanced treatment, rehabilitation, education and law enforcement policy aimed at preventing drug abuse.

This third strategy is the last to be compiled by the Special Action Office for Drug Abuse Prevention, whose mandate expires June 30, 1975. The strategy reviews the accomplishments, continuing problems, and future plans of the Federal agencies dealing with the complex problem of drug abuse.

Faithfully yours,

Robert L DuPont M.D.

Robert L. DuPont, M.D.
Strategy Council on Drug Abuse

FEDERAL STRATEGY FOR DRUG ABUSE AND DRUG TRAFFIC PREVENTION

Prepared for the President
by
The Strategy Council
pursuant to
The Drug Abuse Office and Treatment
Act of 1972

Council Members

The Secretary of State

The Secretary of Defense

The Attorney General

The Secretary of Health, Education, and Welfare

Administrator of Veterans Affairs

The Director of the Special Action Office
for Drug Abuse Prevention

CONTENTS

I
INTRODUCTION: THE PROBLEM THE COMMITMENT

The Drug Abuse Office and Treatment Act of 1972 created the Special Action Office for Drug Abuse Prevention (SAODAP), and required the yearly publication of a Federal Strategy for Drug Abuse and Drug Traffic Prevention.

The Special Action Office is charged with developing policies that coordinate the activities of all Federal agencies which deal with drug abuse prevention and with communicating these policies to interested parties. The FEDERAL STRATEGY conveys the Federal Government's analysis of the nature of the drug abuse problem in the Nation and describes what is being done in response to that problem. It also identifies current Federal policy on drug abuse and drug traffic prevention and describes U.S. responses to drug abuse in the international, law enforcement, medical, and social areas.

The FEDERAL STRATEGY FOR DRUG ABUSE AND DRUG TRAFFIC PREVENTION 1975 provides background information on the contemporary situation, describes the current major concerns, and states intentions with respect to future actions. The FEDERAL STRATEGY then helps explain how our policies and accomplishments have evolved, how we are meeting current and expected needs, and what unfinished tasks need to be given high priorities.

Societal response to drug abuse is generally a mixture of social disapproval and governmental control. The response is mixed because drug abuse creates a multiplicity of issues to which government and society must respond. The role of certain drugs is sufficiently important medically, or is so ingrained in social or ceremonial usage, that outright prohibition is impossible. In any event no drug which has been used for pleasure has ever been eliminated from any society; as a practical matter the severest programs must have as their objective reducing levels of drug abuse.

FOCUS OF MAJOR FEDERAL AGENCIES INVOLVED IN
DRUG ABUSE AND DRUG TRAFFIC PREVENTION

SUPPLY REDUCTION	DEMAND REDUCTION	BOTH SUPPLY AND DEMAND REDUCTION
DEPARTMENT OF JUSTICE DRUG ENFORCEMENT ADMINISTRATION	SPECIAL ACTION OFFICE FOR DRUG ABUSE PREVENTION	DEPARTMENT OF STATE
DEPARTMENT OF THE TREASURY U. S. CUSTOMS SERVICE	DEPARTMENT OF HEALTH, EDUCATION AND WELFARE NATIONAL INSTITUTE ON DRUG ABUSE SOCIAL REHABILITATION SERVICES	DEPARTMENT OF JUSTICE LAW ENFORCEMENT ASSISTANCE ADMINISTRATION
	DEPARTMENT OF DEFENSE	
	VETERANS ADMINISTRATION	
	DEPARTMENT OF JUSTICE BUREAU OF PRISONS	

OPIUM: AN ILLUSTRATION

Opium (from which other drugs such as codeine, morphine, and heroin are derived) illustrates many of the ambivalent and complex aspects of drug regulation.

Science has developed synthetic substitutes for some, but not all of opium's uses. Widely used for pain relief and dysentery treatment, opium has a legitimate medical use both in this country and throughout the world. Opium and codeine have a history of medical usage and profiles of pharmacological effects which insure their use in medicine for the foreseeable future.

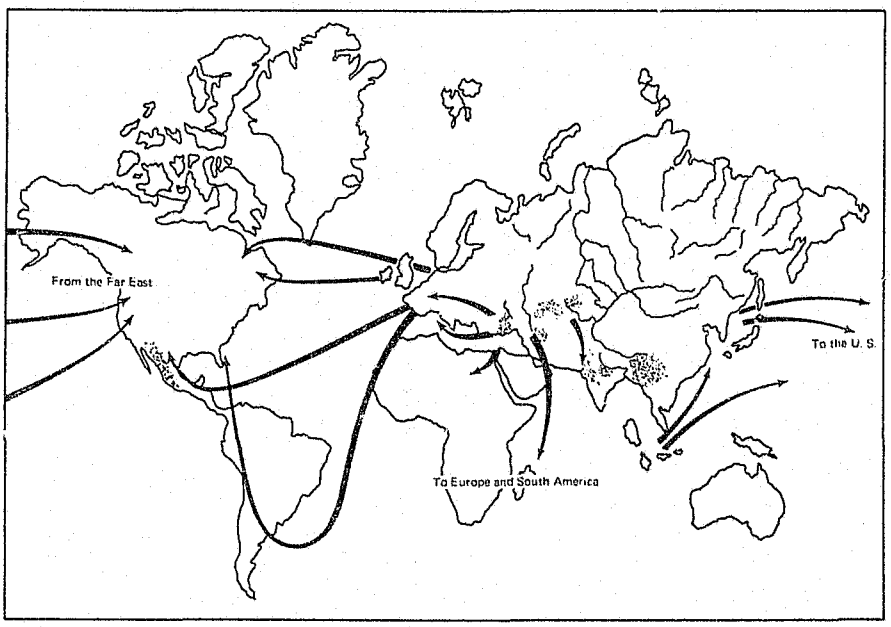
Opium is also smoked in the Orient for social and recreational purposes, a use which often does not appear to cause individual or social problems. There are, however, a number of individuals in Asia and the Orient who abuse opium to the extent that they become unable to function normally in society. In our own country the use of heroin (an illegal, highly potent derivative of opium) often causes serious individual or social problems.

The economic value of opium cultivation further complicates efforts to regulate it. About one-half of the world's opium poppies are grown illegally in remote areas of ethnic and cultural distinctiveness, far from the seat (and control) of central governments. The illicit demand for the drug gives the crop a cash value far exceeding that of any other crop, particularly for farmers and rural dwellers on marginal land. Thus, geographical and political realities combine to make eradication of illicit growing of opium poppies extremely difficult.

These problems, affecting control of a single drug of abuse, introduce several important aspects of the general problem of drug control.

- *First*, drug abuse is not a new problem. It has been a concern of societies for untold years and a concern of the Federal Government of the United States for over 100 years.

OPIUM GROWING AREAS & GENERAL TRAFFICKING ROUTES



- *Second*, the problem of drug abuse cannot be solved by any single, simple response. Single-track efforts have not, in the past, solved the problem.
- *Third*, although difficult, the problem of drug abuse is not unmanageable. The Federal Government is learning to develop balanced, interconnected responses aided by a better understanding of the scope of the problem.

The need to develop effective programs in a number of areas in countering drug abuse is one measure of the extent of the problem. No single program or set of programs in one area can adequately deal with a problem of the scope of drug abuse. Our efforts have had to spread across a variety of areas which are grouped for convenience into the following categories:

INTERNATIONAL COOPERATION. This category includes our efforts to prevent the production and processing of drugs abroad for illicit use in the United States, and the diversion of U.S. manufactured drugs to illicit uses overseas. Under the direction of the Cabinet Committee on International Narcotics Control, diplomatic efforts and technical assistance to foreign governments and to international bodies such as the United Nations and World Health Organization are undertaken with the recognition that drug abuse is a common problem, not a purely American one, and thus to elicit

support for drug abuse prevention and drug traffic prevention programs.

SUPPLY REDUCTION. This area covers the law enforcement efforts involved in cutting off the supply of drugs to the consumer. The efforts of the Drug Enforcement Administration, Customs Agents, and Immigration and Naturalization Service Agents are part of this effort.

LINKAGE BETWEEN CRIMINAL JUSTICE SYSTEM AND THE HEALTH DELIVERY SYSTEM. A number of pathways can be used to connect individuals involved in criminal justice activities (police, defense attorneys, prosecutors, judges, jailers) with those individuals delivering health-related services (prevention, education, treatment, rehabilitation). The goal of these linkages is to establish cooperative relationships between these many people so that both groups may do their jobs most efficiently.

DEMAND REDUCTION. Just as supply reduction seeks to reduce the availability of drugs, so demand reduction seeks to lower the number of people abusing drugs. Primary prevention efforts before drug abuse is established are coupled with treatment and rehabilitation for those who have experienced problems with drugs.

MANAGEMENT OF SCARCE RESOURCES. In any complex endeavor, such as dealing with drug abuse, considerable effort must be directed to reducing duplication by agencies working at the Federal level, assuring coverage of those concerns that are not within the exclusive province of any one agency, improving the division of labor between Federal and State and local agencies, and developing management and forecasting devices that will improve the ability to provide timely responses to changes in drug abuse patterns.

These five categories will supply the organizing device throughout much of this report. In Chapter IV we deal with past achievements in these five areas, demonstrating that the United States Government can take and has taken steps to limit and deter the abuse of drugs. In Chapter V the continuing problems that we currently face are discussed, and in Chapter VI plans for the future provision of a balanced, flexible response to the problem of drug abuse are presented in terms of these same five categories.

Before describing the accomplishments, continuing problems, and plans involving drug abuse and drug traffic prevention, a brief history of the United States Government's activities in responding to drug abuse is presented in Chapter II. Chapter III presents a tentative measure of the current costs to society of drug abuse. Chapters II and III then lay a foundation for understanding a complex and enduring problem that has significant consequences for the whole society.

II
HISTORY OF DRUG ABUSE: A LONG-TERM, CONTINUING, AND DYNAMIC PROBLEM

Drug abuse is not a new problem. For thousands of years people have used substances to alter moods, induce sleep, reduce pain, increase energy and alertness, to slip the bonds of reality, and to relax. The number of substances used is quite large; a chart on pages 86-87 groups the most common.

The mood-altering substance, or drug, that is selected for use is naturally important. There are different consequences from using alcohol, tobacco, or opiates. When used in ways that are acceptable to the society, drugs do not cause social or governmental concern. However, when drugs are abused, that is, used in a way that results in individual or social harm, societies intervene with a variety of measures to regulate their use.

The United States Government first considered action concerned with the problems of drug abuse in the late 1860's. The realization that many Civil War veterans had become dependent on morphine as a result of its use as a pain killer in treating their wounds spurred debate on the need for Federal laws.

1860 to 1920

During the Civil War, new discoveries in medical care had been rapidly implemented. Within a few years of its development, the hypodermic needle had made morphine readily available as a pain reliever. Because medical understanding of morphine's addictive properties had not kept pace with its use, morphine dependence, or addiction, was frequent and poorly understood. Treatment by physicians was thought to have produced at least half of the American opiate addicts during the 19th century.

Another drug abuse problem came to light at this same time with the realization that opium *drinkers* and *smokers* were far more

numerous than morphine *injectors*. The unrestricted supply of medicinal opium and the failure to label the opiate content of patent medicines led to the creation of many unsuspecting, opiate-dependent citizens.

Not until 1906, with enactment of the Pure Food and Drug Act, did Federal regulations require the labeling of the opiate content in medicines.

Subsequent laws passed by the Federal Government first restricted, and then completely prohibited, importation of the opium used in processing opium for smoking. Instead of banning the importation of smoking opium, Congress first doubled the tariff on it. The use of a high tariff ($300 per pound), intended to limit opium smoking, instead encouraged smuggling. Opium smokers either turned to illicit suppliers or changed to more concentrated forms of the opiate, such as heroin. Passage of the Harrison Narcotic Act in 1914 finally made the supplying of opiates of all kinds illegal except under medical supervision. Subsequent legal interpretations prohibited physicians from prescribing opiate drugs for maintenance of opiate-dependent individuals.

The intention of reformers in this period was to limit supply, first by taxation, then by prohibition or strict controls. They assumed that reduced supply would force drug-dependent persons into detoxification. Unfortunately, in those cases where detoxification failed, the individual turned to an alternative and illegal source of supply. These cases were not rare. While supply reduction did reduce the total number of people dependent on opiates, this benefit was gained at the cost of labeling as criminals those who continued to use the illegal supply system.

Throughout this period of reform (i.e., 1865 to 1920), the medical profession took small part in attempting to resolve the problems of drug abuse. Religious leaders and journalists lectured and wrote about the evils of drug abuse, and drew moral conclusions about its causes and cures. Medical knowledge of the consequences of drug dependence was not advanced, and no systematic research provided additional information. In fact, even the treatment efforts—limited to detoxification and symptomatic relief—were uncommon and uncoordinated.

Physicians were discouraged from involvement with drug abuse in this period by two factors:

- Court interpretations of the Harrison Narcotic Act subjected physicians to arrest if they maintained opiate-dependent patients, and
- The medical profession considered such maintenance as malpractice.

Physicians, lacking an accepted theory to explain addiction and faced with societal and governmental pressures not to treat addicts by

maintenance, were unable to assist law enforcement efforts by helping to reduce demand. Also physicians shared the general social disapproval and rejection of opiate-dependent individuals. Thus, even in the absence of legal restraint few physicians showed an interest in the problem of drug abuse. Perhaps because it struck close to home for them: many of these opiate-dependent individuals first took opiates under doctor's orders!

Thus, by 1919 the supply restriction approach was well developed and paramount. Hopes for an elimination of the drug abuse problem were kindled by these actions.

1920 to 1960

The decade after World War I did not see the elimination of the drug abuse problem. It is estimated that the number of opiate users was halved over the period 1890-1920. However, use and adverse social consequences of use were not eliminated. Indeed, a number of unintended consequences stemmed from the "supply-reduction alone" response. By passing strict laws for deterring use, legislators inadvertently encouraged the use of more concentrated, more harmful, and more easily hidden forms of the opiate. Means of administering the drugs were also changed from inhaling vapors and drinking small amounts of narcotics to injecting adulterated quantities directly into a vein. The use of contaminated equipment to prepare and inject the drug led to major infections among users. Medically, then, the changes brought about by Federal policy in these years were not desirable ones.

The typical opiate user at the turn of the century, before all supply became illegal, had been a middle-aged female who lived in a rural area. She took by mouth the opiates that she legally, if not openly, could then procure from a generally reliable supplier. Many of these opiate-dependent persons appeared to suffer few health consequences from the use of the drug. While they may have feared social disapproval of their dependence on opium, they broke no laws and had no difficultly acquiring sufficient opium. Many of these people led fairly normal middle-class lives.

In contrast, the typical opiate user in the 1920's was a young male, usually a minority-group member and a city dweller. He took, intravenously, the illicit heroin he had obtained from whatever source he could find. He experienced serious health problems as a result of this drug abuse.

The policy of relying on supply restriction alone proved inadequate. The increased risk caused prices for illicit drugs to rise, but some drug abusers were not deterred. Heroin addicts stole more goods and money to pay for their increasingly expensive habits and by the end of the 1950's the harshest penalties allowable had been levied on drug traffickers. The ever-increasing severity of Federal antinarcotic laws

ultimately led to mandatory minimum sentences and to penalties that included life imprisonment and the death sentence in 1956 (PL 84-728).

With a ready market for illegal drugs, criminal elements became active in meeting the demand. Illicit drug sales were big business, and organized crime took advantage of the opportunity to realize high profits. Bribery and corruption of law enforcement officials were constant problems.

In the case of alcohol prohibition, the unworkability of the law led to its repeal. In the case of the antinarcotic drug laws, a sense of futility and contempt for the laws emerged on the part of some citizens. These citizens saw the enriching of organized crime, the increasing crime rate among addicts, and the harmful health consequences of heroin abuse as proof of unsatisfactory public policy.

The Harrison Narcotic Act made many drug trafficking offenses Federal crimes and resulted in an increasing number of addicts in Federal prisons. In the late 1930's, the Federal Government built two treatment facilities with the intention of concentrating Federal treatment efforts there. While detoxification and inpatient care were provided, most patients left the hospital soon after detoxification. The programs remained very small and simply did not cure or arrest addiction. Of those who left, most relapsed to heroin dependence.

State hospital and prison programs showed the same lack of treatment success as did the initial Federal efforts. There was insufficient linkage between the criminal justice system and the rudimentary treatment programs and insufficient community-based treatment to achieve the level of success for which the sponsors of these programs hoped.

Part of this lack of success was attributed to restrictions on physicians, which subjected them to arrest if they maintained narcotic addicts. Some physicians had long felt that addiction was a medical problem, and that as doctors they should be allowed to treat addicts by using maintenance-level doses of opiates.

Laws that restricted the physicians' ability to treat narcotic-abusing patients did eliminate some very dangerous practices by physicians who essentially sold prescriptions, but at the price of producing some medical animosity toward law enforcement personnel and stifling the development of experience and knowledge about drug abuse. On the other hand, some law enforcement personnel thought that a few ethical physicians considered themselves beyond the law in arguing the primacy of their professional obligations. Those few physicians interested in treating addicts, and law enforcement personnel, therefore did not develop cooperative attitudes toward each other's responsibilities. This lack of accord seriously handicapped the integration of the medical and criminal justice efforts in drug abuse fields.

While narcotic abuse was of great concern, abuse of barbiturates and amphetamines also developed during this period. As new drugs became available for legitimate medical uses, there developed an increasing pattern of their abuse by persons taking advantage of the availability of the drugs to use them in nonmedically approved ways. Serious individual health and social consequences were soon recognized as stemming from barbiturate and amphetamine abuse. Abuse of "dangerous drugs," as they were later called, further complicated the problem of drug abuse by presenting a new group of abusers and new medical and social consequences of their abuse, such as traffic accidents and crimes of violence.

By the end of the 1950's there was a general acknowledgment on the part of both the public and legislators that Federal policy was not working as well as had been hoped when the reform laws were passed. While the number of opiate-dependent people had been reduced, the behavior and condition of those who continued to use opiates had deteriorated. The frustrations of many citizens with the problems of drug abuse were augmented by a lack of any acceptable alternatives to then-current policies and by a belief that drug abuse was unmanageable—a problem that had no answers. Society's view was that drug abuse was a matter of individual preference. Treatment of drug abusers was thought by many to be useless and mere indulgence.

1960 to 1970

While public policy had been relying largely on supply reduction during the period from the 1920's to the 1960's, some experiments in treating narcotic addicts were being conducted by private citizens. By the late 1960's, there was some hope that the new treatment programs could be of great help in reducing the number of people who used drugs and in improving the behavior and condition of those who continued to use drugs.

Therapeutic communities first produced the "message" that heroin addiction could be cured: that is, people could be removed from a life centered on procuring the next fix and could do productive work while living within a strongly organized social group. The development of methadone maintenance programs produced a second hopeful note. When given a single daily dose of methadone, a synthetic substitute for opiates, many persons who had been dependent lost their craving for heroin. With the end of their physical dependence on heroin, additional counseling, training and education became practical. In well-run programs, criminal activity of the clients was reduced and constructive activities, such as schooling or work, begun. In general, individuals in methadone maintenance programs were able to realize much more of their individual potential than had earlier been thought possible.

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Both therapeutic community and methadone maintenance programs demonstrated the interest and ability of the medical and other professions in treating drug abuse. Both approaches also emphasized the vital role formerly addicted people could play in the rehabilitation process. The programs stimulated renewed public discussion of drug abuse just as the turbulence of the 1960's caused public concern to be focused on the rapidly escalating drug abuse problem.

Even in retrospect, the 1960's appear like a whirling confusion to many Americans. In that decade, acceptance of the *status quo* became less automatic for many citizens. Insofar as drug abuse was concerned, modes of treatment provided hope for a better future for both the drug abuser and the general public. Many more people became involved in working in what is known as drug abuse prevention (i.e., primary prevention, intervention, treatment, and rehabilitation). Public discussion of drug abuse problems was fanned by the rapid increase in drug use among young people and by the recognition that for some their use of drugs was a symbol of their rejection of some aspects of society.

The unprecedented amount of debate and concern reflected a public interest in drug abuse that approached near-panic status at times.

- The rising crime rate for stolen property coincided with an increase in heroin addiction from the mid-1960's through 1972. There were alarming rumors of hundreds of thousands of American military men returning home from Vietnam as heroin addicts.

- The well-publicized deaths of several users of LSD (lysergic acid diethylamide) and amphetamine caused dismay and alarm in middle-class families, members of society who had felt immune from a problem they had long associated with inner-city life.

- An inability to distinguish between different drugs (and their different effects on users) as well as frequent overreaction to drug experimentation led to public demands that something be done about drug abuse.

1970 to the Present

The crime rate, the deaths, the discussion, and the fear, all culminated in focusing national attention on drug abuse. The President and Congress realized that no single office had primary responsibility for coordinating the Federal drug abuse prevention effort. In his message to Congress of June 17, 1971, the President stated that the drug abuse problem in the United States had reached the dimension of a "national emergency" and that drug law enforcement must be

balanced by a "rational approach" to the reclamation of the drug abuser himself.

To achieve a coordinated Federal response, the Special Action Office for Drug Abuse Prevention was established in 1971. SAODAP was charged with coordinating the 14 Federal agencies engaged in research, prevention, training, education, treatment, and rehabilitation, aimed at reducing the demand for drugs.

With the enactment of the Drug Abuse Office and Treatment Act of 1972, Federal policy specifically called for a balanced response to the problems of drug abuse by including a vigorous prevention component. SAODAP was to:

> establish priorities and instill a sense of urgency in Federal and Federally supported drug abuse programs . . . develop overall Federal strategy for drug abuse prevention programs, set program goals, objectives and priorities, carry out programs through other Federal agencies, develop guidance and standards for operating agencies, and evaluate performance of all programs to determine where success is being achieved. It would extend its efforts into research, prevention, training, education, treatment, rehabilitation, and the development of necessary reports, statistics, and social indicators for use by all public and private groups.

Two more developments were involved in the movement by the Federal Government to a more comprehensive drug abuse and traffic prevention policy.

In August 1971, an intensified and coordinated international drug control effort was initiated with the establishment of the Cabinet Committee on International Narcotics Control, combining the efforts of the Departments of State, Justice, Defense, Treasury, and Agriculture, the U.S. Ambassador to the United Nations and the Director of the Central Intelligence Agency.

Supply reduction efforts were consolidated in July 1973, under the Drug Enforcement Administration (DEA), bringing drug law enforcement, intelligence, and regulatory actions into one agency. Additional legislation focused law enforcement efforts on the trafficker, and improved the credibility of laws restricting the supply of drugs.

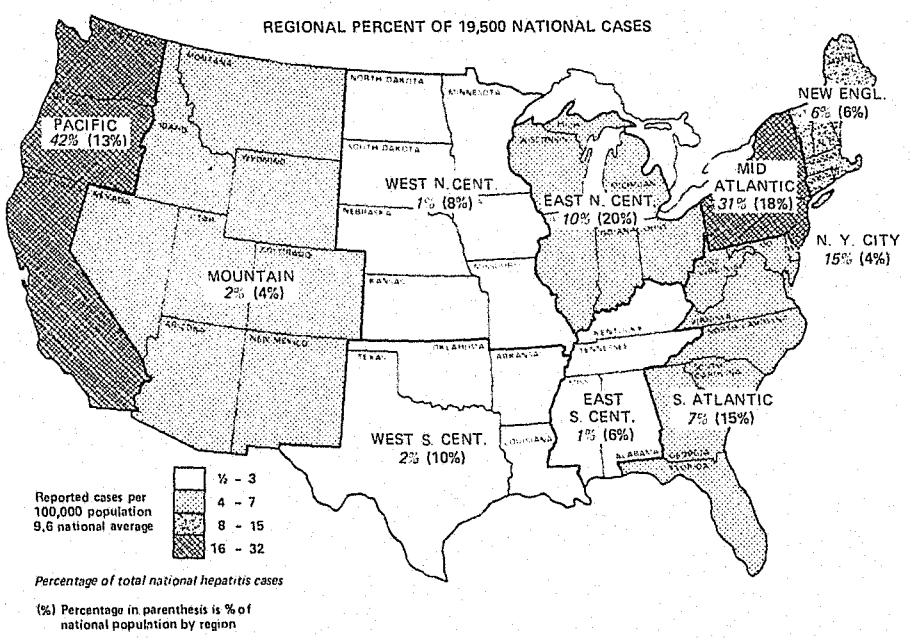
By 1974, a combination of both domestic and international supply reduction efforts sought to reduce the number of people who became heroin users and to increase the rate at which current heroin users abandoned their use. These efforts, coupled with extensive demand reduction programs to improve the condition and behavior of those who had used heroin, represented a major achievement of the balanced Federal approach.

The Present Situation

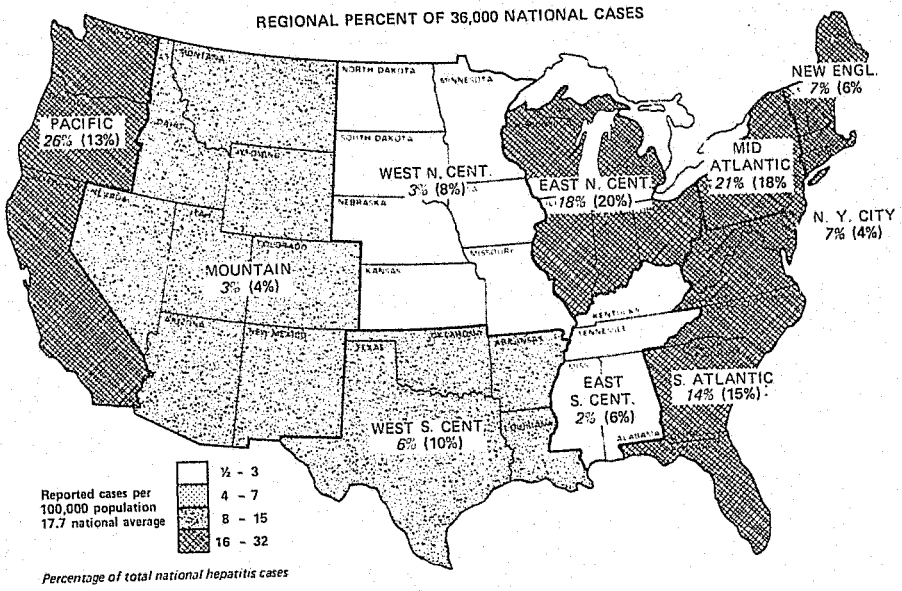
The multifront expansion of the Federal program has resulted in improved understanding of the extent of the drug abuse problem, in addition to more direct and immediately applicable results.

Recent studies have shown, for example, that there are virtually no cities anywhere in the United States that are free from the problem of heroin use. In testing the hypothesis that heroin use diffuses from large metropolitan areas to smaller cities, ten medium-sized cities were studied using a variety of available data. The findings suggested that heroin use has spread during the last decade from the largest to moderate and smaller sized cities in all sections of the country. Furthermore, data from the Center for Disease Control demonstrate that a form of hepatitis highly associated with heroin use has become much more widespread throughout the country, as the following maps show.

GEOGRAPHIC DISTRIBUTION OF DRUG-RELATED HEPATITIS - 1969



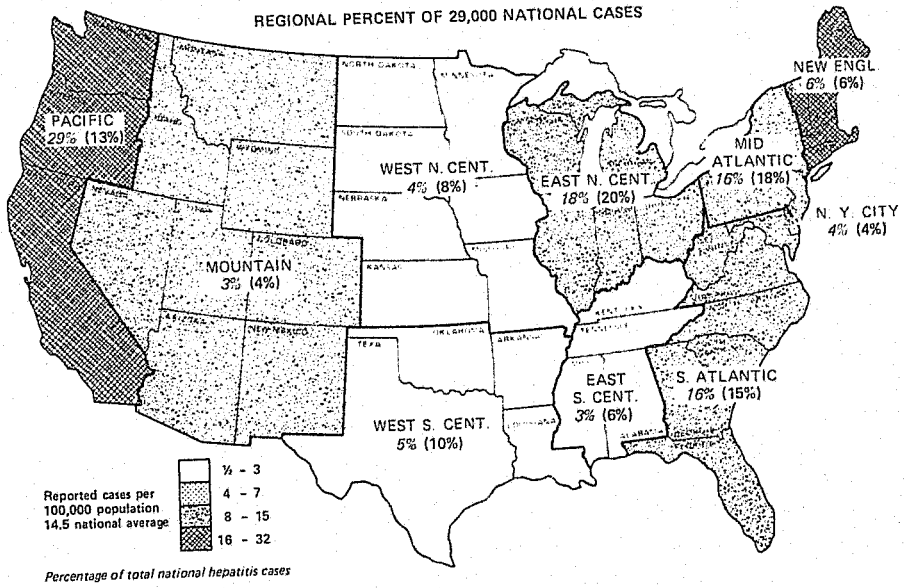
GEOGRAPHIC DISTRIBUTION OF DRUG-RELATED HEPATITIS - 1972



Percentage of total national hepatitis cases

(%) Percentage in parenthesis is % of national population by region

GEOGRAPHIC DISTRIBUTION OF DRUG-RELATED HEPATITIS - 1973



Percentage of total national hepatitis cases

(%) Percentage in parenthesis is % of national population by region

As the above studies and others show, the heroin problem has several aspects. There is, first, a continuing problem involving both new users and old users of heroin in the west and southern border states: 1974 saw a sharp increase in overdose deaths in Phoenix, Arizona, and San Francisco, California, for example. Second, there are signs in the east coast of former users in major metropolitan areas resuming prior use patterns. Third, rising rates of heroin use are involving new populations in the smaller cities and environs in new geographic areas, such as Jackson, Mississippi, Eugene, Oregon, and Des Moines, Iowa. Nationwide control of the heroin problem has not been achieved even though there have been some improvements, such as the very real heroin shortage on the east coast that did occur as a result of international cooperation and law enforcement efforts.

Continuing studies of the general problem of drug abuse have revealed changes in use patterns in other drugs beside heroin. A nationwide survey to follow one done by the National Commission on Marihuana and Drug Abuse in 1972 is presently being conducted. Several careful studies of limited population groups and selected areas of the Nation are already available and indicate some possible trends in general drug use. A nationwide sample of 18-year-old males taken originally in 1969 was repeated in 1974 with the same sample and using essentially the same method. The percent of those who had ever used marihuana, amphetamines, hallucinogens, and heroin was higher for this group when they were 23 years old than it had been for them when they were 18-year-olds.

It is well to remember that this 18-23 age group contains a large number of people who experimented once or twice with a drug. Another well-established survey has shown that many persons who experiment with drugs do not continue use. Having surveyed high school student use of drugs in a California county for seven years, this latter survey also reveals that the rate of increase in use of marihuana is slowing, LSD and heroin use are leveling off, and amphetamine and barbiturate use are decreasing at the high school level in that county.

Of considerable concern is the overall use pattern of drugs among youth. The California county high school survey indicates that students begin to use earlier and that females, who have used drugs less than males, are now closing that gap.

While the above surveys do not report drug abuse patterns for the entire Nation, they demonstrate that the problem of drug abuse is a continuing one. The U.S. Government has come to see the social costs of drug abuse as unendurably high and has decided to respond to the problem in a way to minimize damage both to the individual and the Nation.

III
SOCIAL COSTS: MEASURABLE AND UNMEASURABLE— DOLLARS AND LIVES

Drug abuse has been identified as a problem that is compounded by many interrelated problems of modern society—poor housing, poverty, crime, and lack of educational and job opportunities. But obviously it is also a problem indifferent to good housing, wealth, extensive educational opportunities, and job mobility. A more realistic view of what factors affect drug abuse would consider such things as leisure time, peer pressure, instant gratification, isolation, loneliness, low self-esteem, hate and indifference. The cost to society for dealing with the broad social problems is overwhelming. The cost to society for dealing with the immediate causes of drug abuse is staggering. Nonetheless, an attempt has been made to assess the value consequences of this problem which seriously affects individual as well as societal health and well-being.

Dollar costs of drug abuse have been conservatively estimated at $10 billion a year. The human costs to society of drug abuse are very high. More than 15,000 people a year lose their lives in drug-implicated circumstances. An analysis of the measurable and unmeasurable costs of drug abuse, though admittedly limited, gives an idea of the magnitude of the problem and of the impact of recent efforts to deal with it. Such an analysis contributes valuable information for making future decisions on how best to minimize the social costs of drug abuse.

UNMEASURABLE SOCIAL COSTS OF DRUG ABUSE

The intangible societal costs of drug abuse center in the effects of drugs on individual, family and community life; such costs are borne by both the user and nonuser of drugs. Although the costs of drug use to the individual in impaired physical and emotional functioning are often less drastic than death or hospitalization, they are nonetheless real. Drug abuse can affect normal self-regulating functions of the body, diet, quality of rest, and, thus, general physical health.

When using drugs becomes a substitute for interacting with other people or for the coping mechanisms that each individual employs, then the taking of drugs has significantly altered an individual's way of relating to his environment. In adolescence, the substitution of drug-using behavior for other kinds of learning experiences may diminish the maturation process or may allow drug-induced satisfaction to replace satisfaction achieved in more natural ways.

The effects of drug abuse on the family of the abuser can also be significant. Disruption of the daily routine of living and breakup of family life can result when the pressures caused by one family member's drug abuse problems become too intense. Drug-related changes in mood or behavior may put strains on a marriage and may affect the parent-child relationship by conveying attitudes about drug abuse and parental roles that are destructive. Drug abuse by adult family members is sometimes evidenced by an inability to assume personal responsibilities, and by child abuse and neglect. Alienation among family members caused by criminal prosecution for drug offenses places another undeniable strain on family life.

It is impossible to measure the total impact on society of drug abuse, yet the question of the interaction of drug abuse and society's values must be raised. The normative social order feels threatened by the prospect of widespread drug use, particularly when this use is concentrated in groups of young people and in individuals alienated from society. The linkage of drug abuse with violence and crime jeopardizes our sense of community, especially in metropolitan areas where there is increased public concern for personal safety both in the streets and homes. The angle from which drug abuse is viewed—whether as deviant behavior, irrational behavior, criminal behavior, or as evidence of failure of our culture to provide other means of coping with the pressures of life—significantly affects society's efforts to deal with the problem.

Because it is so complex a problem, efforts of society to reduce drug abuse have sometimes had unintended and undesirable consequences. When drug abuse suddenly mushroomed in the late 1960's, public demands for a prompt response encouraged the publication from a variety of sources, some of which were unsubstantiated, of reports of the harmful effects of drugs. Two consequences of a hastily conceived education program designed to frighten young people away from drug use were the reduction of credibility of official pronouncements regarding drug effects and the alienation of many of the very people who were the objects of the educational campaign. Accordingly, Federal information activities were recently redesigned to reflect better methods of disseminating the drug abuse prevention message.

The public's early simplistic reaction to the widespread use of marihuana resulted in social damage. Punishment at the user level overshadowed the recognition of marihuana use as a social problem.

Experience has shown us that a policy of criminal punishment for marihuana possession did not deter its use among millions of Americans. Instead, it resulted in damage to many young people by saddling them with criminal records at the beginning of their productive lives, and by reinforcing disrespect for the legal system. Subsequently, the Federal Government and almost all of the States reduced the penalty for possession of small amounts of marihuana from a felony to a misdemeanor and allowed juvenile first offenders to be dismissed without a criminal record.

The unintended costs to society are mentioned because they are an inevitable cost incurred when a concerted attempt is made to deal with a long-standing, pervasive problem such as drug abuse. It is a goal of the Federal Strategy to minimize all of the social costs of drug abuse, intangible and unintended, as well as those which can be measured.

MEASURABLE SOCIAL COSTS OF DRUG ABUSE

Although the problem has been recognized for a long time, it is only in the last few years that we have begun to accumulate data which enable us to assess some of the dollar costs of drug abuse. A recent study made for SAODAP, while admittedly not comprehensive, examines costs which can be assigned a dollar value by grouping them into five categories: property losses attributable to drug abuse, health costs, criminal justice system costs, lost productivity costs, and direct drug abuse prevention program costs. These five cost components are discussed briefly below.

PROPERTY LOSSES ATTRIBUTABLE TO DRUG ABUSE

The best-known area of drug-related social costs is the crimes committed to produce income to support heroin habits. This type of crime is increasing in 1975 in nearly all States and accounts for about two-thirds of all measurable drug abuse costs.

In order to estimate the amount of property loss due to income-producing crime, certain assumptions must be made about the number of heroin addicts and the means they use to finance their costly habit. Estimates of the number of heroin addicts range from 250,000 to 600,000; the number of these addicts who steal to support their habit is unknown. The daily cost of the habit depends upon the price and purity of the illicit heroin and thus also can only be estimated.

Given the risk of arrest and the uncertainty of supply, the number of days in which addicts are able to purchase heroin is also a factor. The cost of stealing to support a habit must take into account the fact that stolen goods must be sold at a fraction, variously estimated at one-fifth to one-third, of their retail value. In estimating the cost of drug-related

crimes only heroin use is considered. Based on conservative estimates of all these factors, the annual property loss due to drug-related property crime is set at $6.3 billion.

HEALTH COSTS

The economic costs of health-care consequences are measured in the SAODAP study in terms of the consumption of health services directly related to drug abuse. Estimates are made of the number of emergency-room visits caused by drug abuse and the cost of inpatient hospital care for individuals admitted for primarily drug-related problems. The number of mental hospital inpatient days devoted to treatment of diagnosed drug disorders is included as another cost factor. Many illnesses and accidents due to drug abuse are unreported. The estimates used here are projections made from data available in hospitals which use reliable reporting systems. Hospital costs are based on rates in short-term general hospitals and State and local mental hospitals rather than private institutions and, thus, are conservative. Based on these data, health resources costs totaled nearly $200 million a year.

CRIMINAL JUSTICE SYSTEM COSTS

Total criminal justice system costs related to drug abuse are estimated at $620 million a year, with over half of the State and local costs related to marihuana.

The ratio of drug arrests to total arrests for all causes is used in computing the proportion of police salary costs attributable to the arrest and case handling of drug-law offenses. The proportionate cost of prosecution, public defense, and court resources required in the processing of drug-law cases is estimated on a similar basis. Federal, State, and local correctional institution costs are based on the estimated average length of sentence for drug offenses, modified by reductions for parole and probation. Significant proportions of criminal justice system costs are directly related to policy decisions regarding the legal status of drugs such as heroin and marihuana.

LOST PRODUCTIVITY COSTS

Lost productivity costs measure earnings lost because of drug-related deaths, hospitalization of employed persons with drug-related medical problems, and drug-related absenteeism and unemployment. Productivity losses in the home and school environment are more difficult to measure than lost earnings of employed persons. Therefore

productivity losses resulting from drug abuse were calculated by SAODAP only on the basis of employed individuals and those seeking employment. The minimum wage was used in computation and no calculation was made for reduced efficiency on the job. The resulting productivity-loss estimate of $1.5 billion a year is felt to be very conservative.

DIRECT DRUG ABUSE PROGRAM COSTS

Direct program costs of drug abuse programs include treatment and rehabilitation of drug abusers, education and information efforts, training of personnel involved in treatment and drug law enforcement, research, planning, direction, and evaluation of program activities. Federal grants to the States are used to indicate a portion of State expenditures, and the Drug Abuse Council, a private foundation concerned with drug use and misuse, provided data on local drug abuse activities. Foundation data are used as indicators of private funding. The total direct program costs from Federal, State, local and private sources are estimated at $1.1 billion a year.

TOTAL DOLLARS

In summary, the measurable costs of drug abuse are estimated at $10 billion a year. This is a conservative estimate; using similar conservative assumptions the total could actually be as high as $17 billion, depending on the figures used to estimate property losses and other variables discussed. Remembering that drug abuse affects a relatively small percentage of society at this time, the cost in economic terms is high. Unless our programs in prevention, treatment, and supply reduction can reverse the upward trend in drug abuse, the cost will rise even further. If the $25-billion-a-year estimated cost of alcohol abuse and alcoholism by 7 percent of the adult population of this country is added, the combined dollar costs of alcohol and drug abuse can be conservatively estimated to total $35 billion a year.

While the cost in human terms is immeasurable, it is clearly unacceptable in a society committed to encouraging the highest development of human potential. The goal of the Federal Strategy is to minimize the societal and personal costs of drug abuse by reducing the harmful use of drugs. Programs to achieve that goal are described in the following chapter.

IV
ACHIEVEMENTS TO DATE

Since the expansion of the Federal effort in the early 1970's, the Federal Government better understands the nature of the drug abuse problem in America. Central to this increased understanding is the realization that we face a chronic problem that can flare into crisis proportions. If unchecked, and if conditions are favorable, drug abuse could spread through populations like a communicable disease.

Some examples may illustrate the explosive potential of the drug abuse problem:

- Of all males born in 1952 in the District of Columbia, 20 percent were treated for heroin use between 1970 and 1973; they were 17 years old in 1969 when the peak exposure to heroin abuse was reached in the Capital city.
- Of Army enlisted men in Vietnam, 44 percent tried a narcotic at the peak of drug availability; about 20 percent were addicted to heroin.
- There has been a tenfold increase over 8 years in the rate of drug-related hepatitis, a disease associated with the unsterile injection equipment frequently used by intravenous drug abusers.

The brief review of current trends in drug abuse presented in Chapter II has already shown how quickly the drug trafficking criminal can develop new supply routes after law enforcement efforts disrupt traditional ones. New users in new geographic areas and population groups (e.g., rural, small city residents, white females) demonstrate the need for continual monitoring of current trends in order for the Government to respond most appropriately.

While there is cause for concern, there is also reason for optimism. We believe that balanced efforts can limit drug abuse. One very

important point is that social acceptance of drug abuse is still quite low. For example, drug abuse prevention efforts do not have to overcome a long-time attitude of national acceptance, as in the case of alcohol and tobacco. Another optimistic development in the recent past has been the stressing of naturalness and "doing your own thing." The resulting openness allows for alternative lifestyles to be offered to the potential drug abuser with less peer pressure to conform to group norms. Individuals can be deterred from adopting drug abuse lifestyles without forcing them into uncomfortable molds, and the growing rejection of "artificial" substances and experiences can be harnessed to reject drug abuse.

The great increase in public support for drug abuse prevention programs is most encouraging. Nearly a thousand local communities have begun a variety of programs designed to provide young people with rewarding alternatives to drug abuse.

Some fundamentally important tasks have been accomplished in all five categories of major concern set forth in Chapter I. They are discussed below.

INTERNATIONAL COOPERATION

Until we added vigorous diplomatic efforts, technical assistance, and health services to our activities in the law enforcement field, our drug abuse prevention efforts were inadequate responses to a problem that many foreign governments viewed as one the United States alone experienced. As we have expanded the character and scope of our international efforts, we have found increased recognition that drug abuse is a worldwide problem.

The struggle to curb drug abuse is international in two ways. The "Opium Illustration" (page 1) showed clearly how some drugs are grown or produced in a number of countries and abused in others. Heroin has reached this country from illicit opium production in Turkey, Burma, Thailand, Laos, and Mexico. Drug traffickers have also used variations in drug laws among nations to circumvent drug traffic prevention activities in the United States. One tactic has been to order controlled drugs from legitimate U.S. manufacturers to be delivered to an agent in a foreign country, where such drugs were not controlled, and then to smuggle the drugs back to the United States for illicit sale.

Actions

In mid-1971, the Department of State was assigned the primary responsibility for developing an intensified international narcotics control effort. The Cabinet Committee on International Narcotics Control, chaired by the Secretary of State, establishes priorities and guidelines and coordinates the international narcotics control efforts of the Departments of State, Justice, Defense, Treasury, and Agriculture,

the office of the U.S. Ambassador to the United Nations and the Central Intelligence Agency.

To assist foreign governments and international organizations in drug abuse prevention, the U.S. Government has provided $100 million over the past 4 years in grants. The funds are managed by the State Department's Senior Advisor on Narcotics Matters, who also serves as the Executive Director of the Cabinet Committee on International Narcotics Control. Most of the expenditures have been allocated for narcotics control programs in countries with significant current, or potential, involvement with illicit drugs. The major categories of grant assistance are training programs, equipment for foreign law enforcement personnel, and financial assistance for income substitution projects.

Some 40 countries have participated in DEA-led courses and seminars on drug enforcement in which 4,300 foreign law enforcement officers have had training both here and overseas. The International Police Academy has provided narcotics control instruction for 150 supervisors and management personnel from 30 countries. The U.S. Customs Service, in 1973 alone, trained more than 1,300 foreign custom officers and executives from 29 countries.

DEA'S overseas role is drug suppression. Since a large portion of the drugs which are illicitly abused in the United States originate in foreign nations (all of the heroin and cocaine, sizable quantities of dangerous drugs, and most of the hashish and marihuana), it is essential that DEA be present in those source countries as well as in the nations through which drugs transit on their way to the United States. DEA now has 174 agents stationed in 40 foreign countries.

Their mission is to encourage the suppression of illicit drug production and trafficking through those countries to the United States, and to assist foreign authorities in the suppression of drugs which are abused in their own nations.

Under the policy direction of the Cabinet Committee on International Narcotics Control, the DEA mission abroad is effected by close cooperation between DEA personnel and police and government officials in the host countries, as well as by DEA support and coordination with other U.S. representatives in those countries.

The specific DEA activities which support the mission consist of actual enforcement activity where permitted by the host country; enforcement assistance, advice and information sharing; training; technical advice; and efforts to lever the enforcement, legal, and political resources of those nations into the fight.

DEA agents work undercover in many foreign countries, sometimes at serious risk to their lives and safety. They assist foreign police in field operations, lending their expertise and presence in support of laboratory and drug seizures, raids, arrests, and the active collection of

drug-related intelligence. They share intelligence developed within the United States and in other parts of the world in an attempt to identify and immobilize major traffickers and organizations. They attempt to persuade police officers and other governmental officials of the seriousness of the problem and to encourage them to take affirmative action, for the sake of the world-wide community as well as the United States.

The effect of this cooperative effort is seen in the rise in the number of arrests made by the DEA and cooperating foreign agencies. A total of 281 cooperative drug arrests in FY 1971 grew to 1,325 in FY 1974.

The ban on Turkish opium poppy cultivation that took effect in the fall of 1972 did much to disrupt the flow of heroin to the east coast of the United States. The Turkish Government decision to ban poppy cultivation was supported by the United States, which pledged $35.7 million to compensate Turkey for the expected loss of export earnings based on legitimate uses and to help Turkish development agencies start projects offering new sources of income for former poppy growers. Some $15 million was paid before our aid ended when a new Turkish Government rescinded the ban on July 1, 1974.

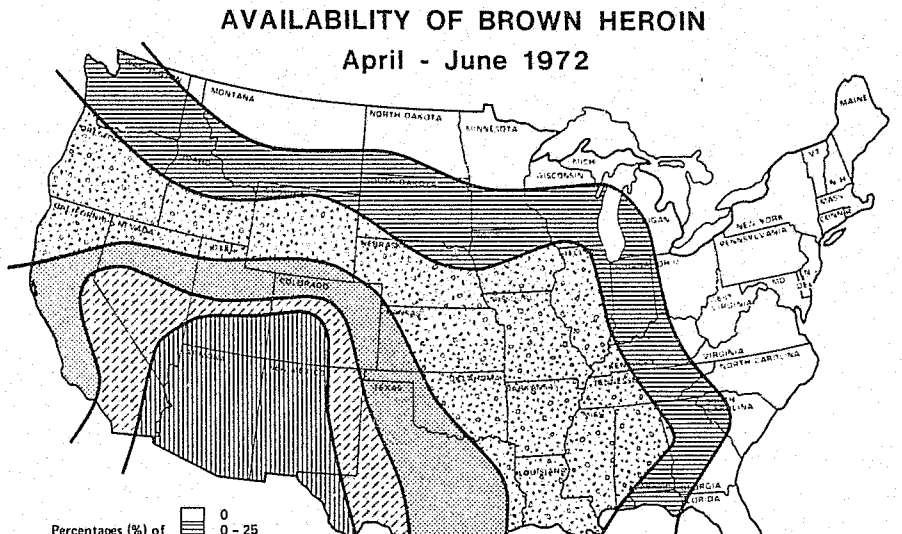
Our concern that the return to production might lead to an increase in illicit heroin shipments to the United States has been noted by the Turkish Government, which has pledged that it will not allow its resumption of poppy cultivation to injure other peoples.

New and substantial enforcement measures are being developed to police the prohibition on collecting opium gum, and Turkish authorities have been working closely with the United Nations' control officials. While we would vastly prefer that the ban on production had not been lifted, we hope that these measures and our continued vigilance will prevent a resumption of the flow of heroin from Turkey.

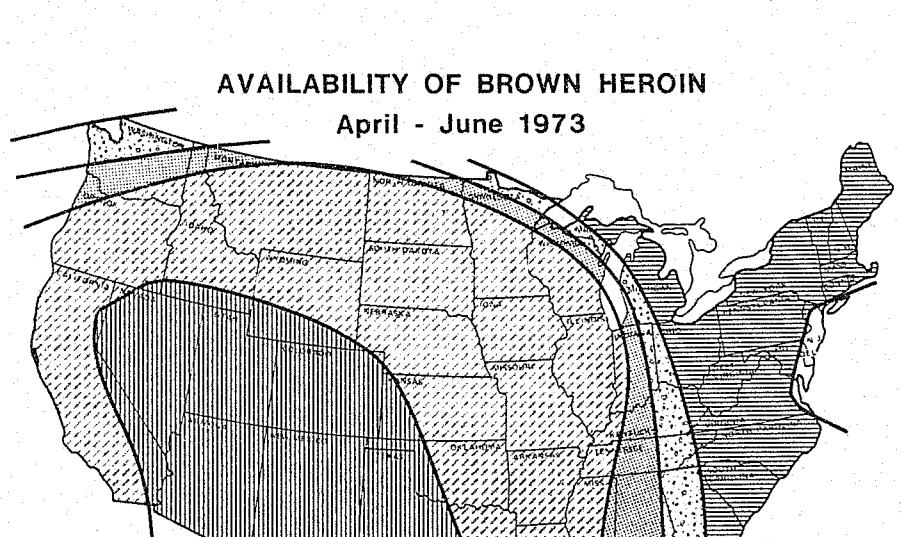
To achieve adequate control, the Turkish Government has adopted a method of harvesting poppies called "the poppy straw process." This process requires crushing equipment and a chemical process to extract the opiate. By requiring the harvesting of the whole poppy pod—rather than just the opium gum traditionally obtained by lancing the pod—the ability of traffickers to divert the opium may have been reduced.

While Turkey was the source of the bulk of heroin entering our country prior to 1972, Mexico became a significant source for the west coast and the border area. Suppliers in Mexico and the Golden Triangle of Southeast Asia sought to make up the deficiencies by increasing production and seeking new distribution routes. This shifting of supply patterns has meant that our international efforts have also shifted in emphasis. The following maps illustrate the distribution of heroin from these sources. Mexico has thus become the number-one-priority cooperative program.

AVAILABILITY OF BROWN HEROIN
April - June 1972



AVAILABILITY OF BROWN HEROIN
April - June 1973



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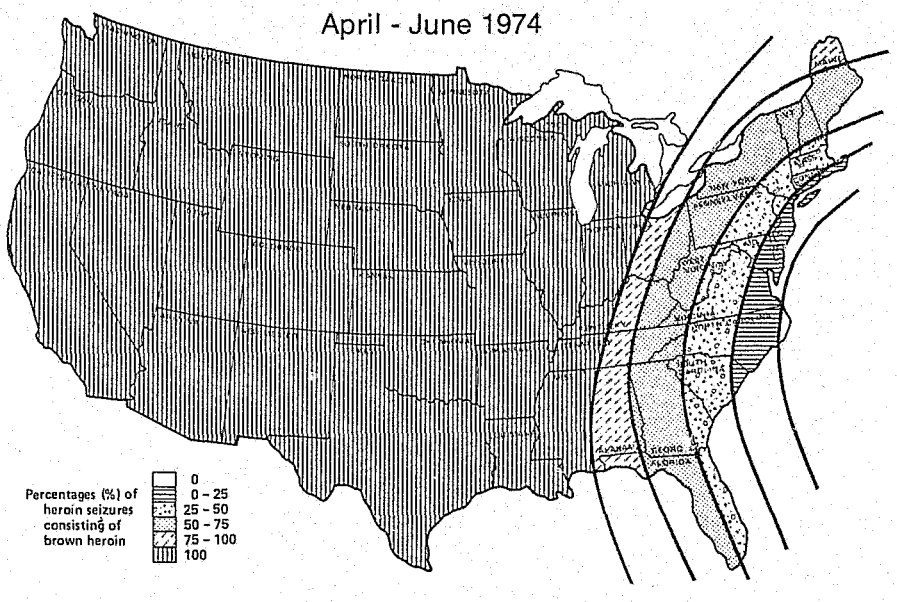
AVAILABILITY OF BROWN HEROIN

April - June 1974



By providing helicopters to the Mexican Government to assist it in its campaign to eradicate poppy growing in Mexico's western mountains and by strengthening controls on both sides of the border, there have been some reductions in illicit trafficking. However, a number of nations face major problems in cooperating. For example, Mexico's mountainous west makes interdiction and control of drug traffickers difficult; Burma and, to a lesser extent, Thailand, have insurgent groups which control or harass large areas of the mountainous opium-growing regions. These countries have limited resources of money and manpower with demands for their employment in ways that benefit their people directly and immediately. We and the producing countries cannot expect to see a high degree of success in our cooperative enforcement efforts until significant adjustments are made in the social attitudes and economic conditions in the opium-growing areas. The greatest hope lies in income substitution projects that effectively reduce illegal opium production.

The Special Action Office for Drug Abuse Prevention and the National Institute on Drug Abuse have provided assistance to foreign countries in prevention, treatment, rehabilitation, and research. Over 500 requests have been made for prevention materials, library materials, and technical assistance of a medical and social science character. Some 100 foreign nationals from 30 countries have received training in drug abuse prevention activities and have, in turn, contributed to our better understanding of the nature of our common problems.

There is also a multilateral dimension to our drug abuse programs. A United Nations Fund for Drug Abuse Control has been established to pool the various nations' contributions. As the leading proponent of the establishment of the Fund, the United States has contributed $14 million of the $18 million in total contributions. Some 37 countries have joined in contributing to the fund, thus indicating their awareness of the need for Fund programs. These programs include developing alternative economic opportunities for those who grow opium (Thailand); developing alternatives to cannabis production (Lebanon); and financing a worldwide study of drug dependence, which may well clarify the nature and extent of the common problem we seek to solve.

The difficult and lengthy process of producing multilateral narcotics legislation has shown some results. An amendment to the 1961 Single Convention on Narcotic Drugs, sponsored by the United States, has been ratified by 36 (including the United States) of the 40 countries necessary for its coming-into-force. The amendment would considerably strengthen controls over illicit production and international trafficking of narcotics. International controls over hallucinogens, amphetamines, barbiturates, and tranquilizers would be provided by the Convention on Psychotropic Substances, which has been ratified by 25 countries. The Convention was sent to the U.S. Senate in mid-1971 and still awaits approval.

With the elevation of drug abuse prevention to one of our principal foreign policy objectives, the U.S. Government began a difficult and lengthy process of improving cooperation among nations and tightening international cooperation in areas where different prorities, needs, capacities, and sensitivities make measurable progress difficult. Nonetheless, the achievements made are real ones and the lessons learned most valuable for shaping future policy. We have taken steps to limit the impact of drug abuse on our society by acquainting others with their role in it, by offering assistance to other nations in limiting drug abuse, and by adding health services, technical assistance, and vigorous diplomatic efforts to the existing law enforcement programs. These more balanced and more extensive efforts have produced a much greater recognition of drug abuse as an international problem and the beginning of an international commitment to deal with it.

SUPPLY REDUCTION

Supply reduction plays an important part in our drug abuse prevention strategy. Unless supplies of drugs with high abuse potential are reduced to low levels, the relative ease with which drugs can be obtained leads to experimentation and for some, serious abuse. Since many commonly prescribed drugs—such as barbiturates—are subject to misuse, supply reduction actions must deal not only with illegal drugs

like heroin but with legal over-the-counter and prescription drugs that are being wrongfully used.

The Comprehensive Drug Abuse Prevention and Control Act of 1970, commonly known as the Controlled Substances Act, authorized the Drug Enforcement Administration to establish controls over drugs which have abuse potential, and to draft regulations governing the distribution of these substances. DEA seeks to balance the need for sufficient quantities of drugs for legitimate medical uses with the reality that excess, unregulated supply encourages diversion and abuse. In the case of drugs such as heroin and the hallucinogens, for which no medical needs are established and whose abuse potential is high, supply reduction efforts are directed at reducing the amounts of those drugs to the lowest practical level.

There are a number of measures available to indicate significant reductions in the availability of drugs. For example, in late 1972 and the first half of 1973, the supply of heroin on the east coast was sharply reduced. One key measure was the price per gram of heroin at the retail level. During periods of reduced supply the cost of heroin goes up while the purity decreases. For example, from the second quarter of FY 1972 when the price was $510 and the purity was 7.4%, the combined efforts of the law enforcement agencies resulted in the price climbing to $1,320 and the purity decreasing to 4.9% in the first quarter of FY 1973.

The effect of such changes in availability does more than just make a heroin addict's habit more expensive. With reduced availability two important events occur.

First, experimentation by vulnerable nonusers is reduced and this, in turn, reduces the potential number of new abusers. While very few experimenters with heroin *seek* to become addicts, they frequently find themselves using more and more heroin in order to produce the desired effects and to avoid withdrawal symptoms.

Second, reduced drug availability increases pressure on the drug abuser to seek treatment. When supply is reduced and treatment simultaneously made available, additional drug abusers are drawn into treatment programs. During the east coast heroin shortage in FY 1973, for example, the number of individuals seeking treatment in the northeastern United States grew by 42 percent. Because more treatment programs had begun to operate and the reliability and efficacy of existing ones was further improved, we cannot attribute all of this increase to supply reduction activities alone. Nonetheless, reports from treatment staffs indicate that reduced availability of heroin was an important factor.

Other drugs have been successfully subjected to supply reduction programs. During the 1960's, the principal source of illicit barbiturates and amphetamines in the United States was diversion from domestic

manufacturers and distributors. Diversion included thefts from production lines, storage facilities, and shipments in transit; the writing of fraudulent orders, and, occasionally, criminal conspiracy between drug traffickers and individuals authorized to handle these dangerous drugs.

The Comprehensive Drug Abuse Prevention and Control Act of 1970 authorized the Bureau of Narcotics and Dangerous Drugs and its successor, the Drug Enforcement Administration, to develop increased controls over manufacturers (including production quotas) and distributors of controlled substances. By mid-1974, nearly all of the firms at the manufacturing and distributing levels (approximately 2,600) had been investigated for compliance with the Controlled Substances Act and manufacturer's production quotas assigned.

A measure of supply reduction can be found in drug-theft reports. If legitimate handlers deal with reduced amounts and comply with the security requirements of the Controlled Substances Act and if these provisions deter thieves, both the number of thefts and the amount stolen should decrease.

From mid-1972 until late 1973, total thefts of stimulants did drop from 9.8 million dosage units to 1.6 million dosage units. Thefts began rising at the retail level at the beginning of 1974, in part due to the effectiveness of controls at the wholesale level. An increase has apparently resulted in the number of thefts (with less quantity stolen) from retail pharmacies, where negligible security is required by the Controlled Substances Act and primary enforcement authority is left to the States. DEA is currently starting a pilot community action Pharmacy Theft Program aimed at reducing this increasing problem of pharmacy theft. All in all, however, in the last quarter of FY 1974 stimulant thefts were still three times smaller in volume than they had been 2 years earlier.

A major force in supply reduction is the recognition on the part of the pharmaceutical industry and the health professions of the need for diversion controls. Self-regulation and self-policing on the part of those involved is an important adjunct to Federal law enforcement directed at reducing diversion. The goal is to produce a supportive environment for rational prescribing and dispensing practices in medicine, dentistry, veterinary medicine, nursing, osteopathic medicine, pharmacy, and podiatric medicine. Working committees have been created by DEA with national pharmacy, pharmaceutical manufacturers, drug wholesalers, dental, medical, osteopathic, and veterinary medical associations.

These committees and DEA's liaison programs with all national professional associations, licensing boards, and professional schools are increasing awareness of the steps being taken to limit drug trafficking and are encouraging voluntary compliance. The working committees also serve as sounding boards to transmit the views of drug producers and professionals to the drug traffic prevention lead agency and thus improve the efficacy of relevant regulations.

At the State and local level, DEA has developed a liaison program with State governments which have licensing authority for legitimate controlled drug handlers at the retail level (pharmacists and practitioners). Evidence indicates that substantial retail diversion can fuel local outbreaks of drug abuse. Since State and local law enforcement agencies and regulating agencies are the only practical means of controlling retail diversion, DEA, through the Law Enforcement Assistance Administration (LEAA), established Diversion Investigative Units (DIUs) at the local level to investigate the diversion of licit drugs from retail and professional channels. The success of these units in the three States in which they were initially established has prompted other States to accept DIU programs in spite of reduced Federal funding. It is hoped that the program will continue to spread to the detriment of retail diversion in a large portion of the country.

LINKAGE BETWEEN THE CRIMINAL JUSTICE AND HEALTH DELIVERY SYSTEMS

It became apparent to many professionals in criminal justice and health care systems by the early 1960's that drug abuse is an individual's voluntary action and thus cannot be controlled solely by supply restriction and incarceration of drug offenders.

Judges, whose discretion in sentencing narcotic offenders was severely limited by the 1956 Narcotic Control Act, could see that institutionalization of drug offenders simply *delayed* their return to drugs without removing any of the causes of their dependency. The failure of punishment by imprisonment as a deterrent to drug use was also evident to many police and prison officials. Better understanding by physicians of the nature of drug dependency led to the realization that detoxification was only a single step in the treatment and rehabilitation process and not an end in itself. All these factors paved the way for better understanding and cooperation between criminal justice system and health care professionals.

The fact that drug possession and sale are criminal offenses, and that drug users are often involved in criminal activities to finance their drug habits, brings many drug abusers into contact with the law. Recognition that the criminal justice system could be a positive force for identification, treatment, and rehabilitation of drug offenders was first evidenced in the Narcotic Addict Rehabilitation Act of 1966 (NARA). Title II of NARA authorized the Attorney General and, by delegation, the Bureau of Prisons to provide institutional programs and community "aftercare" for certain narcotic-dependent offenders.

Since NARA's enactment, a more concerted effort has been made to break the cycle of drug abuse-crime-arrest-release-drug abuse-crime by using the criminal justice system as a focus for treatment and

rehabilitation of drug offenders. It is now established Federal policy that treatment and rehabilitation services will be provided to drug abusers who are Federal criminal offenders at *every* stage of the criminal justice process—the precommitment stage involving arrest and adjudication, the commitment stage involving imprisonment, and the postcommitment stage involving parole and release.

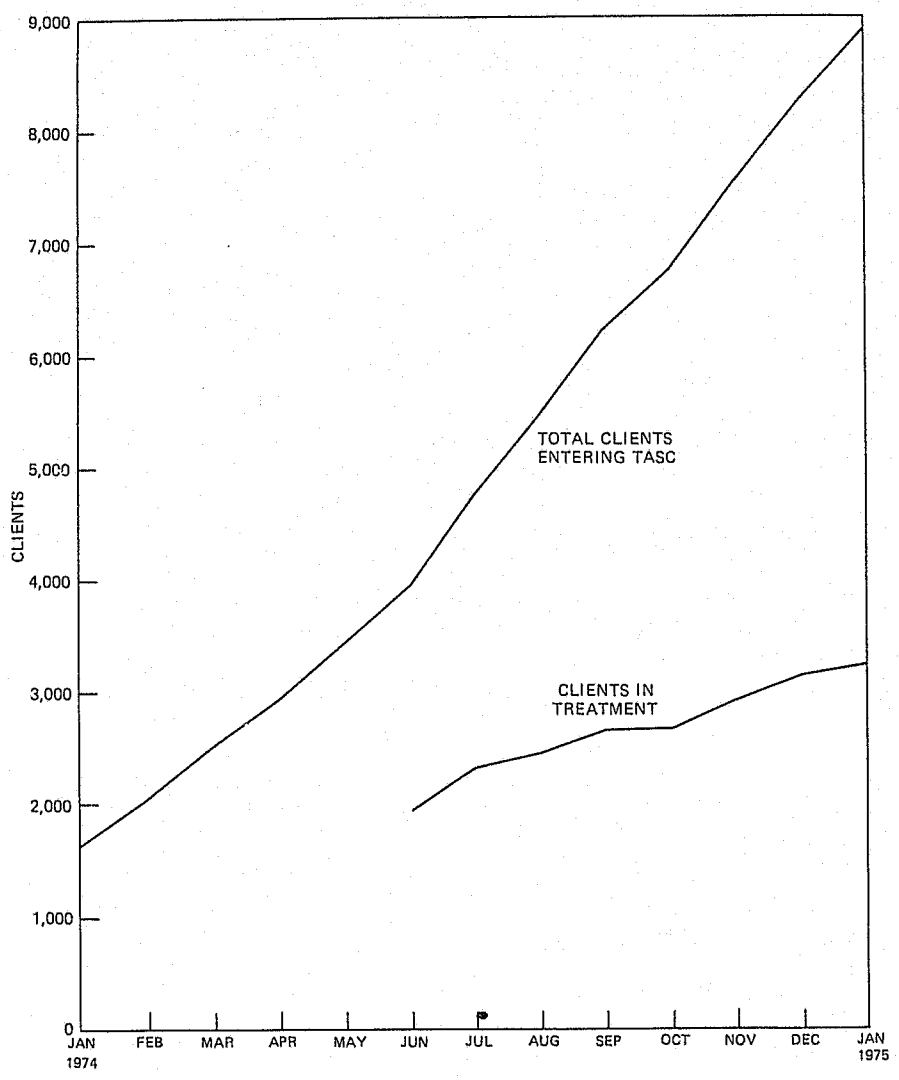
At the State and local levels, significant strides have been made in identifying drug abusers at the precommitment stage and, in many cases, diverting them into treatment programs in lieu of incarceration. The primary Federal mechanism for referral of pretrial or posttrial criminal offenders into community-based treatment programs is a program called Treatment Alternatives to Street Crime (TASC), developed by the Special Action Office and financed by LEAA. This program was designed as a flexible model which could be incorporated into the varying criminal and judicial systems found across the country.

The TASC model involved three basic components: (1) a screening unit which attempts to identify drug abusers entering the criminal justice system; (2) an intake unit to which eligible persons are referred for diagnosis of the drug problem involved and referral to an appropriate treatment program; and (3) a tracking unit to monitor the progress of TASC clients and assure their compliance with success/failure criteria of their respective programs, returning to the criminal justice system those who violate these criteria.

The TASC program encompasses all drug abusers, except those abusing only alcohol, and in addition to precommitment identification also monitors treatment for some parolees. In addition to treatment referral, several TASC programs have developed job development units to provide vocational training and job placement in the community for clients, providing a vital commitment between TASC and treatment communities.

Since its inception in 1972, TASC has demonstrated continued growth. Nineteen TASC projects are in operation and have referred over 8,800 drug offenders to treatment to date.

A recent evaluation of the first five TASC projects provides evidence of the success of the program. TASC has been successful as an outreach agent; 55 percent of all TASC clients studied were receiving drug treatment for the first time through TASC. Criminal recidivism rates for the clients studied ranged from 5.6 to 13.2 percent during the year of the study, compared to estimated national rates of 30 to 60 percent. Evidence further shows that TASC has been dealing with the "hard-core" addict population. Illegal drug usage among clients was one-fourth of the pre-TASC level. A major benefit of the program has been increased communication between treatment and criminal justice personnel, resulting in greater receptivity to treatment of drug-dependent persons by the criminal justice system.



TREATMENT ALTERNATIVES TO STREET CRIME GROWTH

The goal is to place at least one TASC project in every State having a significant drug problem. Consideration is also being given to expanding the scope of the program to divert juvenile and alcoholic offenders to appropriate treatment.

In addition to the TASC programs, many State and local governments provide drug treatment for criminal offenders in lieu of prosecution, or as a condition of probation or parole. SAODAP

encourages the development of criminal justice system programs at the State and local level.

The commitment stage of the criminal justice system involves drug treatment programs in Federal prisons and State and local correctional facilities.

The Bureau of Prisons, as the result of NARA, began operating institutional drug abuse treatment units in 1968, providing aftercare services to parolees. The legislative restrictions of NARA severely limited the number of drug offenders who could be treated under its provisions in Federal prisons.

In 1971, the Bureau of Prisons established "Drug Abuse Programs" in 16 Federal prisons and community care is being provided to a greater number of probationers, parolees, and drug offenders released from institutions. The Drug Abuse Programs in prisons all utilize some form of the therapeutic community model of drug treatment, and provide educational, vocational, and recreational programs.

The goal is to provide intensive treatment to all drug-dependent offenders willing to accept it but at present only about 30 percent of the drug-dependent population in Federal prisons is involved in treatment. In community care, practically all modalities are used as is appropriate for each patient.

DEMAND REDUCTION

Demand Reduction, which includes treatment, rehabilitation, primary prevention, and research, has been emphasized as a result of recent changes in the Federal response to drug abuse.

Treatment and Rehabilitation

As one illustration of this change, Federal support for the treatment and rehabilitation of drug abusers increased from $18 million in FY 1967 to $241.3 million in FY 1975. This level of funding produced a total of 95,000 treatment "slots," spaces in which 161,000 clients may be treated each year.

Readily available treatment not only meets known needs but frequently brings previously unidentified drug abusers forward voluntarily. The beneficial results of treatment promote more demand for treatment on the part of other individuals who also have drug abuse problems and are familiar with those who have been treated.

We have learned to offer a variety of treatment modes in order to deal effectively with all types of drug abuse problems. While formal evaluation programs are discussed in succeeding chapters, we already know that each established treatment mode furnishes an effective way to respond to some particular client's drug abuse problem. No

individual seeking treatment in the community-based treatment programs is forced into a particular type of treatment. Instead, each individual, after meetings with treatment personnel, has a personal treatment plan prepared.

For example, a client who has abused a variety of stimulants for a short time might be offered appropriate treatment in a therapeutic community or an outpatient counseling program. Another client who is addicted to heroin may profit most from a treatment program coupling methadone maintenance with counseling and skills training.

We recognize that there is no single answer to the complex set of problems surrounding the treatment of drug abusers and have therefore supported programs using drug-free treatment, chemotherapy and combinations of both types of approaches. The Federal Government's policy is to respect differences in approaches to treatment as well as the individual's right to decide whether or not treatment will be sought.

Detection and Treatment in the Military

Recognition that drug abuse is not restricted to the ghetto but occurs in every segment of society has been central to the establishment of effective demand reduction programs.

The military services form an important group in our society. This group is, simultaneously, most vulnerable to drug abuse problems because of the age and location of many of its members, and least able to afford the consequences of major impairments of its functioning due to widespread drug abuse. Clearly individuals whose consciousness or perception of reality has been altered by drugs can cause serious consequences in military organizations.

The Department of Defense thus became concerned when a high incidence rate of heroin abuse appeared among American servicemen stationed in Vietnam in late 1970 and early 1971. The military was given a mandate to identify drug abusers and to offer them treatment and rehabilitation services which would enhance their successful return to duty.

The first phase of the military response was the instituting of urinalysis screening and subsequent detoxification and treatment of servicemen needing such assistance. Soon afterwards the Department of Defense expanded its efforts by means of a combination information-education-prevention program based on the Drug Abuse Field Teams, and developed a Department of Defense Exemption Program, which allows a serviceman to voluntarily seek treatment without the threat of punitive action.

The results of these programs are impressive. As of September 1974, over 86,000 servicemen volunteered for military drug treatment. By July 1974, more than 74,000 urine samples had been confirmed as positive and the abusers referred to treatment. The conscious efforts

that have been made by the Department of Defense have demonstrated that a well-designed and carefully administered program can identify drug abusers early and channel them into treatment.

The Veterans Administration (VA) is charged with the provision of treatment for drug abuse to those individuals who are eligible for veterans benefits and request such treatment. In cooperation with the Department of Defense, a program has been developed to provide uninterrupted treatment to active-duty military drug abusers who are about to become veterans. These servicemen are transferred to VA treatment programs prior to their separation from the service and their transition to civilian status is, thereby, somewhat eased.

From all sources, including the cooperative VA-DOD program, the VA admitted to treatment over 21,000 drug-dependent veterans in FY 1974. While three-quarters of these clients were addicted to opiates, only 20 percent had had earlier treatment.

Community Acceptance And Support

Today the wide availability of successful treatment has changed the public appraisal of drug abusers as hopeless cases. While much more work needs to be done and many more individuals introduced to the successes that have been brought about, the public has begun to recognize that former drug abusers can be rehabilitated, can be reintegrated into society, and can hold jobs and lead normal social lives.

Rehabilitation and treatment must be linked closely, perhaps inseparably if both are to be effective. Rehabilitation and treatment are but two components of a total process designed to interrupt the destructive drug using behavior of individuals and to replace it with some order and direction which will allow former drug abusers to become productive, self-sufficient members of their community. To accomplish that part of the process identified as rehabilitation, services must be provided which help individuals develop or recover skills that enable them to support themselves and cope with life in nondestructive ways. Some people need basic schooling, vocational counseling, and skills training; some may need a form of supported work; and still others simply need a job.

An important part of demand reduction, then, is to furnish the former drug abuser with vocational rehabilitation programs that will support his efforts to regain control over his life. This need is not being met by the general Federal, State, and local providers of manpower services. General providers of manpower services have been directed by legislative and administrative mandates to consider other groups than former drug abusers as their priority targets. Drug abuse treatment and rehabilitation agencies have had to develop their own expertise in the provision of vocational rehabilitation services in a number of cases.

Treatment programs sponsored by the National Institute on Drug Abuse or the Special Action Office have been required to develop linkages with State and community vocational rehabilitation agencies to insure the delivery of vocational rehabilitation and manpower services to clients in treatment. As a normal part of their rehabilitation efforts, treatment programs will develop manpower capabilities where community manpower services are not available to their clients. No additional projects will be sponsored by treatment programs where the needs of former drug abusers are already being met by existing community manpower services.

The Special Action Office has worked with Federal manpower agencies to insure that ex-drug abusers are not disqualified for Federal civil service employment solely on the basis of prior drug use. Recent court cases have expanded public recognition of the suitability of many rehabilitated drug abusers to be employed in positions of public trust and responsibility on the State and local levels as well as the Federal.

We are finding answers to many of our questions about drug-related vocational rehabilitation projects by actual assistance to local community leaders in New York City, Philadelphia, Detroit, Boston, and the District of Columbia. Models suitable for application in other cities have been developed and are being evaluated. A variety of approaches are being tried in developing on-the-job training, institutional skills training in different settings, and pre- and post-employment counseling. In a move to add greater credibility to counseling efforts, ex-drug abusers are being trained for employment as vocational counselors in treatment programs.

Transitional supported employment—a new approach to the training and preparation of ex-abusers for the real world of work—is being tested in six additional cities after its initial development in New York City. Because finding jobs for ex-abusers is so important, four projects have been developed to test the effectiveness of independent job developers—independent in the sense that they work outside the treatment setting. These projects are currently being evaluated and manuals detailing what works will be distributed through the Vocational Rehabilitation Resource Libraries, the manpower libraries, and the National Clearinghouse for Drug Abuse Information.

These vocational rehabilitation programs are part of the overall long-range goal of prevention—in this case, seeking to prevent a relapse into drug abuse. We seek no preferential treatment for the ex-drug abuser. We do seek to remove barriers to employment and to manpower training that are based solely on an individual's past drug abuse.

Early detection offers improved potential for rehabilitation. The "return to duty" figures from the military drug treatment programs indicate that military rehabilitation succeeds more frequently than the average civilian program which encounters its clients generally after longer periods of drug use.

As both the Veterans Administration and the Department of Defense programs show, there is a need for the demand reduction activities of treatment and rehabilitation in every institution. The more and better treatment we offer, the more we find individuals who need and desire such treatment.

When our treatment and rehabilitation programs succeed, we have reduced the total demand for drugs. We recognize, however, that a more desirable approach than treatment and rehabilitation would be to prevent drug abuse before it even begins.

Primary Prevention

"Primary prevention" seeks to deter the development of patterns of drug abuse before *any* individual or social harm has been done. "Early intervention"—a related concept—seeks to identify those individuals whose abuse of drugs has just begun and to intervene in that pattern before *serious* harm is done.

While desirable, we have learned that prevention activities need to be undertaken with great care. Scare tactics can and have backfired by producing such unrealistic descriptions of the consequences of drug use that all cautions are discounted by the target audience.

To argue, for example, that "heroin addicts started out by smoking marihuana" implies a logical connection that is not accepted by most marihuana users. While they may not know any heroin addicts, the person considering smoking marihuana probably knows others who smoke it without progressing to other drugs. In seeking to prevent drug abuse by exaggerating the probable consequences of any drug use, a prevention program's credibility can be quickly destroyed.

Purely objective, scientific educational campaigns are not an answer either. They presume that providing scientific information will stop drug abuse. Experience indicates, however, that many potential drug abusers find the scientific approach irrelevant to their perspectives while others are not receptive due to its unfamiliar technical language. Scientific information may actually encourage a small number of people in its target audience to experiment with drugs as a result of their exposure to the information.

The confusing and sometimes counterproductive impact of prevention materials led to a moratorium on production of materials until guidelines could be produced. With the publication of "Federal Guidelines for the Production of Prevention Material" and the development of programs at the Office of Education and at the National Institute on Drug Abuse, a broad foundation has been laid for successful prevention programs.

An important answer the Federal Government has reached in laying this base is that primary prevention can be achieved by tailoring specific programs to a community's particular skills and problems. Because drug

abuse is a dynamic problem, varying from community to community and from time to time, the most effective way to respond in a particular community depends on the specific resources and situation in that community. Primary prevention must be locally based and carefully designed if it is to be effective. While Federal help in the form of offering model plans and financial and technical assistance is important, local communities must have an understanding of their problem and be prepared to make a commitment to respond.

There is no single answer to prevention, we have found, but there is a process that can offer help in a variety of ways. By offering a wide range of active alternatives to drug abuse, by being responsive to the needs of young people for opportunities to make changes for the better in the world, by facilitating development of a person able to live with his or her own self-perception, we can reduce the drug-abusing behavior of individuals and prevent drug-abuse patterns from developing fully.

Research

Much of what we have accomplished in prevention, treatment, and rehabilitation provides the first steps in demand reduction. We have demonstrated that some things can be done and that there is no reason to despair, but we cannot rest with having taken only first steps.

Just as we have institutionalized treatment, rehabilitation and prevention activities, so are we developing systematic research plans and capabilities, indicating what the most pressing research needs are and which agencies are expected to conduct such research.

Because of centralized funding and direction, research capabilities have been developed in both the Federal and private sectors helping to better understand the effects of drugs in individuals, to provide long-acting substitutes for methadone like L-Alpha Acetyl Methodol (LAAM), and to develop other improved treatment, prevention, and rehabilitation techniques.

The establishment of three research centers at major universities and the sponsorship, at 11 medical schools, of faculty members who teach and do research on drug abuse have newly alerted many scientists and physicians to the continuing need for fundamental research in the broad field of drug abuse.

Research in developing better treatment techniques for abusers of a variety of drugs (so-called "polydrug abusers") and on abusing combinations of alcohol and other drugs has progressed to the point where the first units are now in the field, delivering services in over 20 communities. While treating clients, they are also gathering useful evidence for treatment of future clients.

Research continues on the biological bases of drug dependency and addiction. Recent advances in our understanding of the action of

opiates in the brain, for example, add to basic understanding of the addictive process. Studies of the psychological correlates of drug abuse have produced a range of predictor variables which are likely to lead to more successful early intervention and prevention efforts. Research on marihuana has been greatly aided by Federal grants to develop standard dosage levels so that comparisons of one researcher's work with another's can be made. Long-term studies of the effect of marihuana's active ingredient on basic cell metabolism have also been undertaken with Federal support.

An illustration of the effect of systematic development of research capabilities in drug abuse prevention can be found in the bringing together of research materials, in the 1974 *Marihuana and Health* report, sufficient to raise caution flags about the supposed safety of marihuana use.

Demand Reduction Overview

Demand reduction activities will continue to require integrated action in prevention, treatment, rehabilitation, and applied and basic research.

As the drugs of abuse change, as the target populations change, as life, despite our complex efforts to simplify it, presents more problems, our demand reduction effort will change.

The general goal—to minimize the individual and social consequences of drug abuse by preventing abuse and treating and rehabilitating those who are not deterred—will remain constant.

MANAGEMENT OF SCARCE RESOURCES

Effective management is necessary to the success of the drug abuse and drug traffic prevention effort, including, as it does, Federal, State, and local agencies, private cooperating groups, and international organizations. Recognizing that there are considerable overlaps along with crucial gaps in the Federal agencies' activities in drug abuse prevention, SAODAP centralized the Federal organizational structures, reducing the number of Federal agencies involved in drug abuse prevention from 14 to 8 major actors.

This emphasis on *consolidation* and *coordination* at the Federal level, coupled with *decentralization* of those activities which can best be administered at State and local levels, provides for better use of the funds available.

Consolidation and Coordination: Law Enforcement

As earlier reported, the establishment of the Drug Enforcement Administration of the Department of Justice on July 1, 1973, brought

under one agency those Federal units primarily responsible for drug law enforcement.

Three Justice Department units were combined, and the drug investigation and intelligence functions of the U.S. Customs Service were transferred from the Secretary of the Treasury to the Attorney General. DEA has assumed responsibility for development of overall Federal drug law enforcement strategy and programs. The agency now has responsibility for coordination and cooperation with State and local law enforcement officials on joint drug enforcement efforts, for investigation and preparation for prosecution of all suspected violators of Federal drug trafficking laws, and for regulation of the manufacture and distribution of controlled substances.

Reorganization has reduced the organizational duplication of the separate organizations dealing with drug enforcement, has added the FBI's expertise in combating organized crime to the effort to control trafficking in illicit drugs, and increased the accountability of Federal drug law enforcement by placing a single administrator in charge. Under the policy guidance of the Cabinet Committee on International Narcotics Control, DEA deals with drug law enforcement officials of foreign governments and thereby has increased the efficiency of U.S. overseas efforts.

Consolidation and Coordination: Health Delivery System

In 1973, a new Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) was established in the Department of Health, Education, and Welfare.

One of six health agencies reporting to the Assistant Secretary for Health, ADAMHA is composed of three separate institutes: the National Institute on Drug Abuse (NIDA), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the National Institute on Mental Health (NIMH). The parallel organization of NIDA, NIAAA and NIMH allows closer coordination and cooperation among them regarding complementary programs. One example of this coordination is an experiment in combining alcohol abuse and drug abuse treatment programs in the same facility.

Many of SAODAP's supervisory and coordinating functions are being assumed by NIDA in preparation for the phasing out of the Special Action Office on June 30, 1975. The 1973 reorganization plan which established ADAMHA made NIDA the largest Federal drug abuse prevention effort, and gave it responsibility for conducting research, resource development, scientific and management information, forecasting, and technical assistance.

NIDA provides guidance to the States in their treatment and training efforts, and serves as a national resource in the development of

knowledge, the provision of technical assistance, and the gathering and dissemination of intelligence concerning the changing patterns of drug abuse.

NIDA's National Training System manages the National Drug Abuse Training Center, which produces training courses and models for regional training centers and State training support programs. The National Training System seeks to develop new and more effective approaches to training and education of drug abuse personnel.

More efficient use of funds for research, education, outreach, and the development and management of information systems is essential to improve coordination. Three clinical research centers have been created to integrate more closely both basic and applied research in drug abuse.

Coordination of Educational, Material and Informational Systems

Efforts to produce more effective educational materials resulted in a set of "Federal Guidelines for Drug Abuse Prevention Materials." These guidelines seek to prevent the release of harmful materials, and to reduce overlap and experimentation in all mass-produced materials which talk about drugs and drug effects.

All new drug abuse prevention materials must be pretested or evaluated and post-tested. Agencies that plan to produce or revise such materials must determine that they are consistent with Federal policy.

We have developed some basic management and forecasting devices to begin to identify and measure the incidence and prevalence of abused drugs so that we can better respond to changes in the types of drugs being abused.

NIDA's Integrated Drug Abuse Management Information Systems (IDAMIS) is the umbrella system which gathers and analyzes data produced by other information systems, such as the Client Oriented Data Acquisition Process (CODAP), the Drug Abuse Prevention Resource Units (DAPRU), and DEA's Drug Abuse Warning Network (DAWN).

CODAP is a system of data collection on the nature, extent, and severity of drug abuse as measured by data available from treatment programs.

DAWN, operated by DEA and partially funded by NIDA, is a system for collecting data on drug abuse trends from emergency rooms, crisis centers, and reports by medical examiners. Analysis of this information is useful in identifying areas where new or expanded treatment may be required, and in aiding law enforcement personnel by indicating where supplies of drugs may be increasing due to illicit traffic, or diversion, or over-prescription of licit drugs.

All these efforts to coordinate and consolidate drug abuse prevention efforts at the Federal level have also aided the States as they seek

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to provide better prevention, treatment, and training programs in their areas. The consolidation of Federal agencies involved in drug abuse particularly simplifies efforts by the States in seeking categorical and formula grants for their programs.

The results of research, of innovations in training and education, and of information collected by IDAMIS are being made increasingly available to the States through the National Clearinghouse for Drug Abuse Information, the monograph series of the Special Action Office, and IDARP—the Integrated Drug Abuse Reporting Process.

Decentralization

The law which established SAODAP also provided machinery for a decentralization of drug abuse prevention efforts to the States, the District of Columbia, and the territories of the United States.

Complying with the law, each State has submitted and had approved a plan for drug abuse prevention functions, and has established a "Single State Agency" (SSA) to prepare and administer the plan. In recognition of the diversity of State and local drug abuse problems, these SSA's are becoming a primary vehicle for implementation and management of operational programs related to prevention, treatment, rehabilitation, and training. They have responsibility for the accreditation of their training facilities, the licensing of agencies, and the certification of drug abuser workers.

NIDA, for its part, retains major responsibility for financial support, research, management and forecasting services, and provides guidance and technical assistance to the States when necessary to enable them to assume their enhanced role.

V
CONTINUING PROBLEMS— UNANSWERED AND UNANSWERABLE QUESTIONS

Many of our current activities are continuations of what we have already found to work while seeking ways to improve upon past performance. Other activities are new responses to new problems, or the testing of different responses to an old problem that has not been resolved in spite of past efforts. Hopeful advances are being made in the face of constraints and pressure of current economic difficulties.

Where appropriate, we have come to recognize that some questions have no satisfactory answers and that we must cope with this realization without succumbing to despair.

In this chapter, the five categorical divisions used in the preceding chapter will serve to structure comments on the continuing Federal response to drug abuse and drug traffic prevention needs.

INTERNATIONAL COOPERATION

The emergence of drug abuse and drug traffic prevention as major foreign policy goals in the 1970's showed our recognition that we could not do the job alone.

The major areas involved in achieving international cooperation include:

Provision of law enforcement and training, income substitution grants and prevention aids to foreign governments;

Exchange of narcotics intelligence;

Assistance in formulating international drug abuse policy, including treaty controls and grants to international organizations;

The delivery of drug abuse prevention programs to American citizens residing abroad.

A clear way to demonstrate the United States commitment to a balanced drug abuse program overseas is to assist taxpaying United States citizens currently residing in foreign countries. Many U.S. citizens overseas are United States Government employees or members of the U.S. military services and their dependents. Many of these families are stationed in locales where serious drug abuse problems already exist. Drugs may be produced locally and be readily available at very low prices. For many Americans, the difficulties of adapting to a new culture, their lack of foreign language skills and a shortage of familiar recreational and leisure-time activities have encouraged experimentation with drugs.

Cooperative efforts of the Special Action Office, the Department of State, and the Department of Defense have established several innovative demonstration programs designed to deal with this problem. A number of drug abuse treatment and prevention centers have been funded and these programs have received enthusiastic support from Americans overseas and the foreign communities in which they operate.

Just as is true domestically, however, unless the overseas local American community participates, the programs of prevention and treatment of drug abuse will be greatly hampered. While self-help is not at first a satisfactory answer to many Americans abroad who are experiencing drug abuse problems, our willingness to help them develop their own program often elicits their cooperation. The most manageable answer, then, is a grant or contract mechanism to a private, nonprofit, community-based organization. While Federal funds may be used to initiate these projects, a goal of complete local funding is essential.

Efforts to deal with our own citizens' drug abuse problems have frequently prompted a recognition on the part of the host country that a larger problem, involving the foreign country's own citizenry, exists. The recognition that the United States can offer help to other countries interested in responding to drug abuse problems has prompted many requests for assistance, advice, materials, training, and cooperative research. The bulk of these programs will be described in some detail in the Supply Reduction and Demand Reduction sections of this chapter.

International cooperation frequently provides the United States with new information, knowledge, and perspectives concerning developments in drug abuse patterns. The many foreign experts who visit the United States to learn about our programs and to share their knowledge with U.S. professionals doubtless gain a more complete understanding of our nation's efforts as a result of this exposure.

The Special Action Office has compiled an impressive group of consultants who are capable of working in foreign countries, are experienced in the problems of cross-cultural application of knowledge, and, frequently, are fluent in one or more foreign tongues. Requests for visits by such experts continue to come in at an increasing rate. The

Cabinet Committee on International Narcotics Control has agreed to support such technical assistance in those instances where it would appear to be a profitable portion of U.S. international cooperative efforts.

Bilateral sharing has led to increased appreciation of the international aspects of drug abuse. This heightened understanding in turn makes the third area of concern—development of international drug policy—a significantly more fruitful area for negotiation. The Cabinet Committee on International Narcotics Control has been able to develop a coordinated Federal Government policy for both law enforcement and drug abuse prevention activities in dealing with foreign governments and international organizations.

The improved climate for communicating interests and concerns with respect to drug abuse results in greater cooperation and more effective programs. Nonetheless, the dynamism of drug abuse forces those seeking to prevent it to remain unsatisfied with present levels of cooperation and to seek ways to improve the speed and scope of our responses to new patterns of drug abuse. By providing leadership by example and by offering assistance to Americans and others overseas, we are supplying some answers while acknowledging that although we have learned much, we expect to learn more about drug abuse and drug traffic prevention.

Improved international cooperation has, and continues to assist in many ways; nowhere more importantly than in supply reduction.

SUPPLY REDUCTION

Although important reductions in the supply of narcotics and dangerous drugs have been achieved, there is widespread recognition that more extensive, sophisticated, and coordinated efforts are needed if the availability of abuse-prone drugs is to be sufficiently restricted. The sharp reductions in east coast heroin traffic and illicit diversion of dangerous drugs, for example, have been countered by drug traffickers' producing new routes and new organizations. The decentralization, smaller-sized amounts, and multiple sources of supply that replace the relatively centralized, wholesale European connection for heroin have made detection and seizures more difficult. The achievements in reducing licit dangerous drug availability have similarly been countered by traffickers in those drugs.

The answer to supply reduction, then, is the by-now-all-too-familiar one of hard, detailed, comprehensive planning and coordination of the various law enforcement personnel involved. There are neither easy nor permanent answers that will allow us to view the problem of drug supply as finally solved. Improved international cooperation has allowed more long-range interruptions in the supply of drugs. In accord with CCINC established policies, DEA's oversea role involves extensive

cooperative suppression activities in those foreign areas which are the sources for most of the drugs abused in the United States. Thus, DEA has developed extensive programs of assistance and cooperation with those foreign countries which are involved as intermediaries in production or shipping by illicit drug suppliers.

These programs consist of cooperative enforcement and intelligence activities as well as the DEA training of foreign police officials and officers previously mentioned. The programs are aimed at (1) identifying illegal drug activities and major traffickers and trafficking organizations; (2) developing information which can be acted upon to disrupt these activities and obtaining evidence which can be used to prosecute the people involved; and (3) increasing the awareness and interest of foreign countries in prosecuting drug traffickers and increasing the capabilities of their enforcement people to respond to illicit drug activity.

In addition to these operational and institution-building activities, DEA will continue to expend effort and resources (in close cooperation with Country Teams and the Department of State) to persuade foreign officials of the necessity for more stringent laws in relation to drug offenders. DEA will also seek more effective legal relationships between countries, most particularly in the area of extradition of drug traffickers.

DEA will increase emphasis in all of the above areas in FY 1975. The number of foreign police officers to be trained will, for example, be increased to 2,400. They will be trained in 36 "in-country" training schools and in nine U.S. training programs. Additional DEA agents will be assigned overseas, and offices will be opened in countries or areas where they did not previously exist. In essence, DEA will continue to expand its integrated foreign suppression activities.

The U.S. Custom Service also plays a role in the training of foreign officers in border-control activities which emphasize interdiction techniques, border surveillance, cargo control, and search and seizure methods in relation to contraband of all types.

U.S.–MEXICO COOPERATIVE PROGRAMS

Mexico is now a primary source for heroin appearing throughout the United States, except the Eastern Seaboard. Mexico's 2,000-mile border with the United States and the large volume of traffic that crosses that border make drug traffic control difficult. By high level cooperation, however, U.S. and Mexican customs agents have developed an extensive and compatible radio network, the stationing of narcotic-detecting dogs at Mexico City airport, and a private aircraft and boat monitoring system to control smuggling into the United States.

Mexico is of prime importance to DEA in its responsibility to control narcotic and dangerous drug traffic. This general drug control

assignment goes beyond U.S. Customs' responsibility for stopping all contraband and smugglers from entering the United States. DEA's tasks encompass reducing the supply of illicit drugs entering the United States from foreign sources, training foreign narcotic officers, and establishing import quotas for controlled drugs.

DEA has identified Mexico as the number-one priority in its law enforcement effort and has focused on supplying personnel and support facilities for a cooperative program with the Mexican government to reduce drug availability. DEA has increased by 100 the number of agents along the Mexican-U.S. border this year (FY 1975) and is completing an inter-regional information and analysis center at El Paso for quicker response and better coordination.

Because European heroin trafficking had dropped between 1972-1974 as a result of the Turkish poppy cultivation ban, agents could be reassigned to the Mexican border area to react to the increased problem there. With the resumption of poppy cultivation in Turkey, however, DEA must be prepared to counteract the following possible developments: (1) an immediate increase in heroin traffic as stockpiles are sold off in anticipation that Turkish opium might once again be available for processing into heroin; and (2) illicit diversion of opium, despite all precautions, and a consequent resumption of European heroin trafficking.

Customs, Immigration, and DEA all rely upon extensive telecommunications systems, rapid data processing, and the use of electronic devices to detect and disrupt drug-trafficking routes. The increased expertise of drug traffickers and their prevalence in more areas require increasingly sophisticated detection techniques and more extensive undercover and intelligence work. DEA's advanced technology program is designed to supply new and improved equipment, materials, instruments, systems, and mathematical models.

In the less than two years since DEA was created to centralize in one agency the responsibility for all drug investigative and intelligence activity at the Federal level, considerable success has been achieved in coordinating the activities of DEA and the inspection and patrol activities of the U.S. Customs Service and the Immigration and Naturalization Service at ports and borders.

There has not been sufficient time to date to effect total coordination of the investigative and intelligence functions with the patrol function. It is anticipated that this will be accomplished in 1975 through the execution of additional interagency agreements designed to correct those areas where lack of functional clarity still exists.

Domestic United States

Supply reduction efforts, of course, extend into the purely domestic sector. DEA participates in a number of activities to reduce

drug trafficking. First priority is a continuation, within the country, of its international and border-based efforts against heroin and cocaine, both of which originate exclusively from abroad. In second rank of the enforcement priority is the effort directed at such nonnarcotic dangerous drugs as hallucinogens, amphetamines, and barbiturates. Within the dangerous drugs category, DEA is primarily concerned with barbiturates.

Current data indicate that the number of chronic, intensive, medically unsupervised abusers of barbiturates is probably greater than the number of chronic, intensive users of heroin. Moreover, intensive barbiturate abusers frequently exhibit violent behavior and suffer serious health consequences from their abuse. While amphetamines, methamphetamines, and hallucinogens also have serious problems associated with their abuse, the extent of the problems they present is of less immediate significance than that associated with barbiturate abuse. A gauge of the extent of the dangerous drug problem on the domestic level is seen in the 41,474,145 dosage units of dangerous drugs confiscated by all Federal agents in FY 1974.

Research into the health consequences of hashish and marihuana is ongoing but has not yet developed conclusive answers. Available health data demonstrate that marihuana is not harmless. It remains Federal policy to take appropriate actions to reduce the availability of marihuana and related products. DEA targets on the ton and multiton shipments of marihuana and large-volume transactions of related materials. Consequently, action directed at these targets will continue as DEA's third level of enforcement priority.

In FY 1974, DEA domestic seizures of marihuana totaled over 115,000 pounds, U.S. Customs and INS border seizures were 696,000 pounds, and DEA/foreign cooperative seizures totaled 335,000 pounds. The seized marihuana would produce over 733 million dosage units or more than three dosage units for every man, woman, and child in the Nation.

In addition to the domestic enforcement responsibilities and priorities described above, DEA has drug control and drug regulation functions under the Controlled Substances Act. Drug control functions are to determine whether or not new drugs shall be placed under controls that will restrict their availability, how restrictive these controls should be, and what changes should be made regarding presently controlled drugs. Scheduling decisions are a joint effort of HEW's Food and Drug Administration and DEA and are reached on the basis of whether or not the drug has a legitimate medical use and its relative abuse potential. The less needed and more dangerous a drug is, the tighter the controls on it.

While all of the methods have not been fully developed, DEA has begun to produce consistent methodologies for gauging the abuse

potential of drugs as an aid to its drug control decisions. These methodologies will supply baselines against which new drugs can be measured and hopefully answer some basic questions that will allow prompter, more accurate control decisions on new drugs.

When a drug is a controlled substance, an important activity of DEA is regulation of its distribution. With 400,000 registrants who handle controlled drugs, DEA clearly has a large regulatory task. It has primary responsibility for monitoring the manufacturers and wholesale handlers of controlled substances. In cooperation with the Law Enforcement Assistance Administration, DEA has developed a program (page 30) to combat diversion of retail-level prescription drugs at State and local levels. These Diversion Investigative Units provide support and acquaint the States with their responsibility to monitor legitimate drug handlers licensed by the State. Since retail-level diversion by even a small number of doctors or pharmacists has led to local epidemics of drug abuse, these efforts are important. For example, with only three States involved to date, 10 million dosage units of dangerous drugs were seized under the DIU program.

"Passing the Buck"

A continuing problem experienced by those seeking to reduce the supply of drugs, and one to which there is again no simple, single answer, is the frequently encountered view that supply reduction is someone else's problem. At the international level, the national level, and State and local levels, the view that drug trafficking control efforts should really be focused at a different level is still voiced. The foreign response to requests for cooperation may be "get your own house in order first."

At the national level, the attitude often expressed is that foreign governments should "stop the shipping" of illicit drugs to us. At the local level, one hears that drug control is "a Federal matter."

Obviously, educational efforts on the part of those involved in drug trafficking control to show the shared nature of responsibility have worked to a degree, as evidenced by the greater international cooperation just discussed and the signing of agreements by DEA with 45 States of the United States, in which the States agree to assume responsibility for control of drugs at the retail level while DEA handles control at all other levels.

Some gains have been made in increasing the appreciation of drug control as a common and pervasive problem, but the United States cannot be satisfied until such appreciation is much more widespread and efforts to combat it more coordinated.

Intelligence sharing among several law enforcement agencies as is occurring in the New York City area, the use of Federal drug analysis laboratories by State and local authorities, and help in the training

process of State and local police units—all are ways to improve coordination and communication, and to increase efficiency throughout the Nation. Given the scarcity of resources and the size of the drug abuse problem, DEA seeks to deflect State and local government units from making large numbers of retail marihuana arrests. Since marihuana arrests are increasing by more than 30 percent per year in most of the States, there is a real danger of swamping local criminal justice systems with these lower priority arrests. In view of the fact that most local marihuana enforcement activity is not associated with increases in heroin and other higher priority enforcement activity, DEA's Task Force Program, partially funded by LEAA, seeks to refocus State and local efforts on high-priority drug abuse trafficking, including large-volume trafficking in marihuana. Such refocusing would avoid needlessly stigmatizing many casual users of marihuana while increasing heroin-related enforcement activity.

LINKAGE BETWEEN CRIMINAL JUSTICE AND HEALTH DELIVERY SYSTEMS

The evolution of a cooperative relationship between criminal justice and health professionals regarding drug abuse prevention and treatment was discussed in Chapter IV (page 30). Continuing objectives in achieving more effective linkage between these two systems include expansion of TASC (discussed in detail on page 31) at the State and local level, the development of a Federal counterpart to TASC for those arrested for Federal crimes, and coping with the need for treatment services to several thousand local jails where humane detoxification should be available.

The National Institute for Drug Abuse (NIDA) established a Criminal Justice Branch in its Division of Community Assistance (DCA) to facilitate continued development of a mutually beneficial relationship between the treatment community and criminal justice personnel. The Criminal Justice Branch has primary responsibility for the conduct of all NIDA programs and operations involved in the treatment and rehabilitation of drug-related delinquent and criminal offenders at all levels of the criminal justice system—Federal, State, and local—and at all stages of the correctional process—from precommitment to institutionalization to post-commitment. The Branch works closely with LEAA State Planning Agencies and NIDA Single State Agencies as well as with professional organizations and relevant interest groups.

TASC is our most notable effort in the *precommitment* diversion to drug treatment and rehabilitation programs of drug offenders whose criminal offense involves State or local law enforcement systems. A Task Force in SAODAP is exploring, with the Justice Department, the feasibility of a Federal pretrial program aimed at establishing structured

identification, referral to treatment, and tracking efforts for drug dependent offenders similar to the TASC program at the State and local level.

Involvement of juvenile offenders in precommitment diversion programs is receiving increased attention as a result of passage of the Juvenile Justice and Delinquency Prevention Act of 1974. The Act points out the inadequacy of present treatment and rehabilitation programs for juvenile drug offenders and provides impetus for treating juvenile drug offenders who come in contact with the criminal justice system. One answer to meeting the needs of juvenile drug abusers may be found in a pilot TASC project for juvenile offenders which became operational in Boston in January 1975.

The Bureau of Prisons (BOP) is committed to developing new programs for drug offenders at the *commitment* stage of the law enforcement process. The Bureau recognizes that its drug-abusing population is continuing to rise from an estimated 24 percent of the Federal prison population at the beginning of FY 1974 to 31.5 percent by the end of FY 1974. Of that drug-using population, about 75 percent used narcotics primarily, another indication that heroin incidence continues to be of major concern.

Through research and analysis of its present programs, BOP hopes to develop new programs which can serve as models for State and local correctional facilities. Additionally, LEAA has undertaken a study of State and local drug treatment needs and resources in city and county jails throughout the country. The survey will assess the quantity and quality of services now offered as a first step toward improving institutional treatment of drug offenders and guaranteeing prompt medical detoxification of arrestees.

The *post-commitment* stage in the law enforcement process, involving parole and release, is often integrated into precommitment and institutional programs. The treatment and rehabilitation of drug abusers is a lengthy process, and the continuation of treatment for criminal offenders into community-based programs offering educational, vocational and guidance counseling is essential.

The Bureau of Prisons offers "aftercare" services to an increasing number of releasees and probationers. By mid-1974, there were almost 2,700 offenders in community care programs, some 1,100 of whom were probationers. In order to provide "aftercare" services, BOP contracts directly with drug abuse programs, family service agencies, and mental health clinics in the releasee's home community. This brings local professional and paraprofessional personnel into a working relationship with prison staff and U.S. Probation Officers to promote increased understanding of the problems of releasees, probationers, and parolees. In some cases, drug-dependent offenders in the Federal prison system are released under supervision from BOP institutions without having been in an "incare" Drug Abuse Program during incarceration.

This release of untreated offenders, though involving only about 500 offenders in FY 1974, is another illustration of the need for quality community-based treatment and rehabilitation programs for drug-dependent persons released from jails and prisons.

Prevention programs of the Drug Enforcement Administration provide continuous communication between law enforcement and the health community to reduce chronic, illegitimate use of dangerous drugs. In addition to the activities of DEA's Diversion Investigative Units, discussed earlier, DEA is increasing its control over production of drugs regulated under the Controlled Substances Act, so that over-supply of these drugs, especially amphetamines and barbiturates, does not encourage their misuse.

Since DEA has little authority to monitor legitimate controlled-drug handlers at the retail level, State licensing authority, where the legal responsibility rests, is being upgraded to attain adequate and uniform drug regulation of retail concerns throughout the Nation. This is being accomplished by liaison and cooperation with State licensing boards, through persuasion and education of pharmacists and practitioners, and through the activities of DIU's.

Some mention must be made of the doctor-patient relationship and the responsibility of the patient regarding the use of prescribed drugs. Physicians are being made increasingly aware of the dangers of overprescription and indiscriminate use of drugs. The ultimate responsibility, of course, remains with the patient. If he visits one doctor after another, collecting prescriptions and self-administering them without regard to, or knowledge of, their potential danger, no amount of regulation by government can save him from overdosing, from acquiring drug dependency, or from other harmful consequences.

The linkage between law enforcement and health delivery systems has as its goal the prevention of indiscriminate and illegal drug use. The ultimate responsibility for minimizing the individual consequences of drug abuse lies with the individual himself.

DEMAND REDUCTION

When efforts were first begun to provide an extensive Federal presence in demand reduction activities, a high priority was basic treatment of heroin addicts. Very shortly after treatment programs designed to serve inner city heroin addicts were initiated, the need for additional and improved services in the broad field of demand reduction activities was realized. Having supplied some answers on a crash basis, the focus of demand reduction efforts is now necessarily broadening to do a more complete job.

We are seeking to improve the quality of our answers on the effects and consequences of drug use, on the most effective primary prevention

and early intervention techniques, on achieving true rehabilitation and societal reintegration of former drug abusers and we are seeking ways to transfer these improved techniques to those working in demand reduction activities.

Research

An interdisciplinary approach has proved most productive in enhancing our present understanding of the problems of drug abuse and improving means of reducing demand for drugs. When applied studies were undertaken in efforts to modify drug-abusing behavior, we found that some basic assumptions could no longer be made. Basic research into the biological, psychological, and sociocultural origins, epidemiology, and history of drug abuse revealed that multiple causal factors are frequently involved. For example, whether or not an individual actually experiments with a drug like heroin will be determined largely by socio-environmental factors such as drug availability, peer pressure, existence or absence of alternative sources of gratification, and so on.

To understand why some experimenters progress beyond initial use requires neurophysiological research. To understand why some forms of treatment succeed in ending drug abuse requires knowledge of psychosocial factors. Thus, research which seeks to determine the origin and patterns of drug-abusing behavior is a complex process involving many different disciplines.

Research into the basic mechanisms of action of the various abused drugs has not been adequately supported for a long enough time to produce satisfactory answers. Isolation of those parts of the brain tissue that serve as the opiate receptors, for example, is only a recent advance in our understanding of the action of opiates in the brain. Research at the biochemical, intracellular, cellular, organ, and organism levels has produced a number of disparate findings that have yet to be welded into a single conceptual framework.

The basic behavioral and social learning principles that underlie drug seeking, dependence and abuse liability, and the addictive process are now being studied. For example, despite detoxification and withdrawal from a drug, when a former drug abuser returns to his original environment many of the things he sees and hears there produce a classical conditioned response to seek drugs again.

Knowledge of these basic principles helps us to understand why treatment fails; and to begin investigating behavior modification techniques to improve the probability of treatment success.

Earlier studies of the role of the family, peer pressures, and groups of particular concern, such as ethnic groups and high school youth, have resulted in a range of predictor variables, useful in predicting which groups are more likely to become seriously involved with drugs than others. Specific primary prevention and early intervention techniques can then be aimed at these high risk groups. While

predictor-variable research is still underway, it offers prospects of more effective delivery of primary prevention and early intervention services.

Research on cigarette smoking offers a useful analogy for general drug research. It was not until large-scale studies, involving thousands of people over long periods of time, were made that many of the most serious risks associated with cigarette smoking became evident.

Similarly, drug abuse research has not generally been directed at groups other than young, healthy adults, traditionally studied for relatively brief periods. Only recently have research efforts been directed toward those in poorer health, or pre-adolescents, or older persons.

Abuse of *combinations* of drugs by all groups is another area of contemporary research where there are, as yet, few satisfactory answers. There is already evidence that the use of marihuana combined with alcohol, and the use of both barbiturates and alcohol is more hazardous than using any one of these drugs alone. Much more needs to be done in the combination-drug-use and long-term-use areas before satisfactory basic knowledge is available.

The National Institute on Drug Abuse finances research designed to improve the demand reduction efforts of the Federal Government. One of its chief additional responsibilities beyond research funding has been to improve the usefulness of ongoing and planned research by explicitly providing for comprehensiveness and comparability. Gauging the extent of drug abuse, for example, has proven very difficult and shortcomings of surveys, data collection, and analysis classifications have been many. NIDA has developed a conceptual matrix to guide its research and to provide comparability standards for future official surveys.

Other Federal agencies, in addition to NIDA, are developing important answers to demand reduction problems. DOD's experience with its extensive urinalysis program has produced important innovations in the development of lower-cost techniques and in finding chemicals more effective in detecting drug use. DOD has shared these findings and comprehensive drug abuse data it has gathered with other agencies. The VA also is participating with NIDA in long-term experiments with LAAM, a possible improvement over methadone because it need be administered only one-third as often.

Primary Prevention

Primary prevention in drug abuse was defined by practitioners this past year as a constructive process designed to prevent or reduce physical, mental, emotional, or social impairment resulting from the abuse of chemical substances, and to promote personal and social growth to full human potential. This broad definition demonstrates the vast scope of primary prevention programs. Research described in previous sections may allow better focused primary prevention efforts

in the future by identifying precisely those most in need of it. However, as the situation stands now, we do not know the reasons why the majority who do not abuse drugs choose not to do so. We must cast a broad primary prevention net to minimize the individual and social costs of drug abuse.

Earlier editions of the FEDERAL STRATEGY reflected the great concern of the Federal Government with treatment aspects of demand reduction. The developing and managing of large numbers of treatment facilities was of primary concern. State drug abuse plans, reporting systems, financial management systems and guidelines all emphasized treatment. Understanding and attacking the root causes of drug abuse through primary prevention and early intervention efforts simply were not given the same priority as providing treatment to drug abusers.

Much of the earlier emphasis was due to the acute need for treatment. The lack of emphasis given to primary prevention stemmed in part also from the inability of any group to offer a convincing model for widespread deployment, such as the methadone maintenance and therapeutic community models offered in treatment programs.

In addition, division existed within the ranks of those interested in primary prevention. Two groups offered differing, extreme approaches: "educators," who saw a need for factual materials on the effects of drugs, and "societals," who saw drug-abusing behavior as a result of the general social problems of depersonalization, unresponsive institutions, racial, sexual and age discrimination, alienation, and anomie.

With no centralized program to evaluate and assist primary prevention efforts and with an uncoordinated, ill-defined proliferation of efforts at the Federal, State, and local levels, many promising and successful programs went unnoticed. Funding agencies also became more reluctant to finance primary prevention programs because of the lack of general agreement as to what was beneficial, needed, and effective.

Within the past year, the Special Action Office for Drug Abuse Prevention and National Institute on Drug Abuse have developed a perspective that emphasizes the role of primary prevention as one of providing community-based, socially acceptable alternatives to drug-taking behavior. Both agencies have assumed responsibility for developing the national role in such an effort. The Office of Education (in HEW) assists by alerting school systems and educators to the need for, and means of, drug-abuse prevention.

The varied causes of drug abuse and the great variety of approaches to providing alternatives make obvious the Federal Government's inability to do this job alone. Solutions, we have learned, must be found at the most personal level possible.

Individual families, local neighborhoods and communities, local institutions and businesses are ultimately responsible for developing

ways to deal with their particular problems. Local and State governments assist these grassroots efforts by allocating resources, developing ways to provide support, and coordinating efforts.

The Federal role has been defined as providing: basic guidelines for the development and management of primary prevention efforts; model prevention programs that have proven effective on specific problems; materials for use by local level programs, ranging from dissemination of successful practices, films, pamphlets, to evaluation plans; training programs; and technical assistance in developing and operating local programs. States will provide regulatory and credentialing actions to help certify local programs in supporting communities.

With the Federal role in primary prevention freshly defined, a number of activities have already supplied some answers to the problem of effective prevention techniques. Technical assistance is being provided; some 40 demonstration grants are testing prevention programs for minorities, rural populations, inner-city youth, and families; special materials are being produced for and by minority groups to meet their needs; national primary prevention standards are being developed by nationwide collaborative efforts. An effort, called "the National Search," has begun to identify the most successful existing primary prevention programs throughout the country, and to elicit from youth proposals for new efforts.

Prevention, then, is receiving an increased share of attention but it remains handicapped by the vast and changing character of the problem and the lack of well-established and widely recognized parameters within which efforts will be focused. While increased attention, support, and recognition of primary prevention activities have emerged, a sense of dissatisfaction with the field's definition, organization, and structure persists.

Treatment and Rehabilitation

The Federal Government has made a substantial contribution to meeting the demand for treatment. The present commitment of the Federal Government is to provide a nationwide level of 95,000 treatment slots. These slots are funded by NIDA and SAODAP. The Bureau of Prisons, Veterans Administration, and Department of Defense provide additional treatment slots to their specific clientele and these additional treatment slots are not included in the 95,000 figure. The extent of the Federal contribution to general treatment is reviewed periodically and the appropriateness of the size and distribution of the effort reassessed. For example, analysis of the distribution of the 95,000 slots in the FY 1975 budget revealed that the initial allocation of the Federal slots was not congruent with specific community needs. Some communities at first received an excess of unused capacity; others received insufficient capacity to meet demonstrated need.

NIDA sought to remedy this—to match more closely the treatment and rehabilitation slots with the need—by reducing funding to those programs which had unused capacity (utilization rates lower than 85 percent) and allocating the money saved to programs with unmet needs for treatment. The reallocation of monies combined with increased demand for treatment has increased the percentage of filled Federally funded community-based treatment slots from 55 percent in February 1974 to 74 percent in July 1974; and to 90 percent by November 1974. It was expected to reach 100 percent in March 1975.

NIDA has also established clearer priorities for funding new treatment and rehabilitation programs, giving greatest weight to opiate-abuse treatment and rehabilitation programs in communities where there is both demonstrated need and no Federally funded treatment.

Despite these efforts to do the most with available resources, many areas are not receiving as much treatment and rehabilitation moneys as they need. The drug-abusing population desiring treatment has expanded into new geographic areas, and into new population groups in some cases, while Federal monies from phased-out programs that previously treated drug abusers (such as programs funded by Model Cities grants from the Department of Housing and Urban Development) have run out.

NIDA is seeking to find answers to the problem of unmet needs in a period of economic uncertainty. Since direct grant and contract funding by the Federal Government for drug abuse treatment programs has been gradually reduced during the last year, NIDA is developing means to obtain additional funding support from third parties, such as general health insurers, health maintenance organizations, and industrial concerns.

The objective underlying increasing third-party payments is to integrate drug abuse treatment and rehabilitation programs in the general health care delivery system. The ultimate goal is to have drug abuse covered in a fashion similar to coverage for mental illness, alcoholism, or diabetes. This will be discussed in more detail in the next chapter.

NIDA is currently developing demonstration projects designed to assist treatment programs to obtain those third-party payments to which they are already entitled. Three basic projects are: to identify the major obstacles to obtaining third-party payments and develop models for action by the Federal Government, State, and local agencies; to develop a model drug-abuse-treatment delivery system within a health maintenance organization and to demonstrate how third-party payments can be secured for employees in industrial concerns.

While this activity offers hope for the future, other aspects of NIDA's treatment and rehabilitation efforts are affecting present

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operations directly. NIDA's major effort in improving the quality of care offered by treatment programs requires all drug treatment programs to reach certain levels of program performance. These levels are achievable with minimal assistance from the Federal Government.

The Federal Funding Criteria for Treatment Services are designed to upgrade the quality of drug treatment service delivered by federally funded programs. These Criteria specify only the minimum standards, such as the elements of appropriate service to be provided at a cost level which maximizes treatment capability. Detailed "how to" manuals for each treatment modality are available to help implement the use of the Criteria.

Technical assistance is available for any program having difficulty complying with the funding criteria. The Single State Agencies and emerging State licensing systems, along with the professional and paraprofessional members of the drug abuse treatment community, have considerable leeway in developing State treatment-delivery standards above the minimums. However, in spite of the early emphasis on treatment in the demand reduction efforts, and the recent publication of the Federal Funding Criteria and "how to" manuals, treatment personnel would be the first to express dissatisfaction with "answers" received to date. Demonstration projects are currently attempting to provide more complete answers to treatment questions by seeking to:

- identify the fundamental elements of treatment, measure their effectiveness, determine the causal factors, and indicate where they can be strengthened;
- develop and test empirical indicators of treatment success, such as recidivism rates, reduction in drug use and criminal behavior and social, physical, and psychological status;
- identify and test treatment modes that have worked in other rehabilitation fields, such as the behavioral contracting use in helping individuals reenter the school system;
- test the feasibility and cost effectiveness of establishing treatment programs in traditional hospitals, as well as in such nontraditional settings as alternate schools;
- establish new treatment models for reaching minority groups (Indians, Mexican-Americans, etc.) and other specific populations such as women, rural persons, and youth;
- build a collaborative network linking individuals engaged in similar activities and thereby, better identify issues, form strategies and construct better research methodologies and designs.

While NIDA is the lead Federal agency in providing treatment and rehabilitation, other Federal Government agencies supply similar services to their specific clientele.

The Department of Defense at the beginning of FY 1975 was treating over 17,000 service personnel, at over 550 worldwide locations. Granted that the extent of involvement with drugs varied and detection was generally early due to the urinalysis program, the military services have been returning to duty about 50 percent of those who received treatment and rehabilitation services.

Such a success rate compares favorably with existing civilian programs and stimulates questions as to why the military succeeds so often. Is military success due to high standards for service entry and to early identification of the drug abuser? Does the military have better treatment programs? Do the very clear standards and expectations of the military, its discipline and emphasis on teamwork, as well as the guarantee of employment, make a difference in rehabilitation? Or are the types of drugs being used by military clients significantly different and more amenable to treatment than drugs used by civilian treatment clients?

The Veterans Administration in FY 1974 provided treatment to a total of 21,000 veterans with drug problems. VA treatment is concentrated in 53 drug treatment facilities in areas having the highest incidence of drug abuse. These facilities provide short-term detoxification, counseling, extended care in therapeutic communities, and continuing care in outpatient and satellite clinics.

The Veterans Administration, in concert with the Special Action Office, is seeking answers to the question of whether alcohol- and drug-dependent patients can be treated in the same setting. Ten Drug Dependence Treatment Centers are participating in the project as combined treatment facilities using the same modalities and approaches and following common guidelines. Comparison groups, in which alcoholics and drug abusers are being treated separately and in usual manner for each, will allow some gauging of the effectiveness of the combined treatment programs compared with the separate treatment programs.

The Veterans Administration has recently expanded its programs to provide better rehabilitation services to all of its treatment clients and to inform other veterans of the available services. Additional staff will provide for personal counseling and planning with each veteran, helping him to find a job, and/or school or training programs. The staff will also acquaint the community with the employment abilities of the former drug abuser.

Some veterans who have had drug problems will be hired by the VA to bring into treatment other veterans with existing drug problems. Through publicity, speeches and participation in community activities, through visits to block parties, street corners, parks, and other places where drug-abusing veterans may be found, the veteran with a problem with drugs will be made aware of the VA treatment and rehabilitation services.

The Bureau of Prisons has 1,700 offenders in its drug abuse program within Federal prisons. The BOP estimates that inmates who have some history of drug abuse account for about one-third of all prisoners. The BOP can treat about 1,700 of its drug-dependent population of 6,300, or 29 percent of the offenders in the overall population. An additional 2,600 offenders are treated after release from prison in community care programs.

While the BOP program has been increasing in size, the percentage of the prison population with a history of drug abuse has been growing as well: from 21 percent in December 1972 to 35 percent of the entering group of prisoners in June 1974. With the ability to select those most suitable for treatment among the many eligible, BOP has compiled high rates of success.

Only 25 percent of those receiving community care after release are reported each quarter as having at least one "positive" urinalysis for drug abuse. Only 5 percent of the community-care clients each quarter are deemed program "failures." About 60 percent of the community-care clients are employed and 60 percent of these are employed in their own skill areas. While some periodic abuse of drugs exists, actual addiction is not common, even though three-quarters have had some history of opiate use.

However, all of these treatment and rehabilitation services supplied by the Federal Government are inadequate measures if the public and employers fail to recognize successfully rehabilitated former drug abusers as potentially productive citizens who should be given a chance. We need to acknowledge, as a people, that there is no satisfactory, long-run answer to drug abuse treatment and rehabilitation unless we reintegrate or, in some cases, integrate for the first time, the rehabilitated into the community. A Task Force on increasing community support for drug abuse treatment, rehabilitation, education, and employment efforts is currently addressing that problem. The Task Force, a joint effort of the Special Action Office, the National League of Cities, and the United States Council of Mayors, is attempting to strengthen some 20 communities' support for programs and to promote public acceptance of the idea of the rehabilitated former drug abuser. Long-held stereotypes do not just disappear when faced with the facts. Only persistent efforts to bring about public actions that demonstrate both acceptance and the workability of such acceptance will reduce the blinding power of old labels.

MANAGEMENT OF SCARCE RESOURCES

Chapter IV introduced the principles guiding the Federal Government in its efforts to use wisely the limited money and manpower allocated to drug abuse and drug traffic prevention. Those principles

are: consolidation of the Federal agencies working on drug abuse matters, decentralization to the States and local levels of governments of matters they are best equipped to deal with, and coordination of the total drug abuse and drug traffic prevention activities at all levels of government.

Information systems such as CODAP and DAWN (see page 41) are already producing useful data which are being applied to current problems. We are now capable of producing data and have baseline figures that enable tentative assessments of which programs should be maintained, where some of the failings of our programs are, and where new needs and opportunities may be first appearing. We can recognize success early, can identify problems with these new management approaches, and thereby promote the most efficient means of dealing with drug abuse.

DAWN is an example of a cooperative effort by DEA and NIDA to provide information about drug abuse trends throughout the Nation. Based on representative population centers' reports, DAWN enables DEA to spot new drugs or new patterns of abuse and respond appropriately to the law enforcement aspects. NIDA is able to use the DAWN data in estimating incidence and prevalence of particular patterns of drug abuse. When fully developed, programs to predict future treatment needs may use DAWN data.

Based on exhaustive pretests conducted during the summer of 1974, CODAP, NIDA's own program for generating aggregate management reports concerning federally funded treatment programs, has recently been revised to produce more accurate and meaningful information. Since client identifying data are not included in this reporting system, it ensures client confidentiality and data security. The revised CODAP, which became operational on a national level November 1, 1974, offers the advantage of more reliable reports on treatment programs.

Treatment programs are ideal places on which to focus management skills because of the extent of Federal support. In FY 1975, Federal support for the treatment of drug abusers totaled approximately $198.2 million. Thus, Drug Abuse Treatment Program Review is an important management process. Many of the persons and agencies responsible for instituting treatment programs did so without having had previous drug-treatment experience. The sense of urgency and crisis reaction in the new program often made training and technical assistance irregular. Programs began accepting clients before comprehensive management, fiscal, and programmatic policies were fully developed. Then, as needs became apparent, *ad hoc* procedures were often instituted and rapidly became "the way it's done."

The Drug Treatment Program Review Project validates proper management and expenditure of Federal funds; it helps evaluate the

management efficiency of selected programs, identifies strengths and weaknesses of particular programs in order to provide technical assistance, communicates successes to other programs, and terminates the programs unable to meet minimum standards.

In conjunction with the Federal Funding Criteria which provide managers with a detailed matrix of costs of treatment programs, such reviews do much to assure wise and effective expenditure of Federal funds in community-based programs.

Such management practices become ever more important when demand for services rises but, because of pressing national economic constraints, additional financial support is not presently available. Management efforts simply have to be applied to a number of areas where no one feels reductions are satisfactory answers. A priority system for admission to treatment will certainly be needed if present trends continue. While no one *in treatment* will be terminated due to excess demand, such excess of demand over availability of slots will require admission first of those who need treatment the most and who can best profit from it.

We are charged with balancing our concern for high-quality treatment with the need to do nothing extraneous. In deciding on the use of paraprofessionals, for example, in lieu of scarcer and more expensive professionals, we must continually assess the true function to be performed, the relative effectiveness of one over the other, and the long-run vs. short-run advantages and disadvantages of each choice.

The Veterans Administration Pilot Program offers an excellent example of such balancing efforts to do the most with limited resources. One Drug Dependence Treatment Center has a program that frees hospital space during the day, seeks to resocialize the former drug abuser by activities in a home-like surrounding, yet meets the requirements of applicable laws and regulations (designed to protect traditional hospital patients) by providing a hospital bed for the veteran upon his return to the hospital each evening. While seeking to have the law changed to further increase both the effectiveness and economy of the new program, the Veterans Administration is already demonstrating its advantages.

The Veterans Administration plans to expand this effort further by establishing Halfway Houses which will dissociate the recovering drug abusing patient from the hospital and will permit him to live in the community during his last few weeks of treatment and rehabilitation.

The military services have also been seeking ways to reduce their costs and improve their performance. For example, the DOD urinalysis program, which has performed 5.5 million urinalyses, has reduced costs nearly 20 percent through a new testing procedure. The use of paraprofessionals in treatment, rehabilitation, and multilevel education programs has also proved cost effective in the military context.

For all Federal agencies, an extensive research plan is currently being reviewed. The plan assigns responsibilities for drug abuse research to specific agencies and states current needs in the research area. This plan will facilitate coordination and cooperation by communicating "who is to do what" to others who may have related research interests.

There is much more to be done in the management field; the following chapter deals with our specific intentions in that regard. Even though the institutions charged with managing a coordinated, comprehensive, national response to problems of drug abuse are still quite new and the guiding principle of decentralization to the State and local level makes some types of management more difficult, a basic foundation has been laid upon which better managed programs are building.

VI
FUTURE PLANS AND ACTIVITIES

The Federal policies in drug abuse and drug traffic prevention reflect the distance we have to go as well as the way we have come. A large number of continuing problems are being addressed by our present policies, some more directly than others. One being met directly is a most serious continuing problem, the lack of knowledge as to what underlies drug-abusing behavior. What human processes are involved? And, how can drug abuse best be prevented? We do know, after all, that following the best treatment and rehabilitation experiences we can provide, our client is a former drug abuser and that status is not a uniformly good one.

An area of continuing problems that we cannot deal with as directly as the fundamental research discussed above is being dealt with indirectly, however. To some extent our actions to end the rejection of the former drug abuser by rehabilitating and reintegrating him into society are resulting in increased public acceptance of drug abuse prevention.

We are helping individuals to function in our society, whether drug-free or not, and are moving in a generally forward manner toward accepting drug abuse as a problem the society can and has to live with. Our intolerance of the addict's addiction; our impatience with those individuals whom we think should "know better" than to abuse drugs, yet do; and our invidious ranking of abusers of alcohol as socially more acceptable than abusers of barbiturates, are all gradually being seen from more informed and experienced perspectives.

Improvements have been made, but our general ambivalence as to what position society should take on the legal drugs—alcohol and nicotine in particular—continues.

Medical schools seem unwilling to take drug abuse seriously and to make drug dependency a recognized part of the medical school curricula. Of 115 U.S. medical schools, fewer than 5 require course

work in drug dependency and less than 20 offer an elective in alcoholism and/or drug abuse.

Some of our treatment programs fail to offer a humane treatment setting due to staff prejudices against drug abusers. Many jails fail to provide humane detoxification for drug abusers. A continuing problem exists in society's reluctance to accept methadone maintenance programs despite the very real benefits such programs impart to both the client and society at large.

All of these problems reflect the very human resistance to change we all share. What stops us from despairing, of course, about the intractable nature of man is precisely his counterbalancing ability *to change* and his demonstrated capacity for increasing his sensitivity and compassion.

While acknowledging that much remains to be done, a productive four years have elapsed since a health and social service dimension and an extensive international effort were added to the existing law enforcement effort. A broad, coherent foundation for policymaking has been created with the establishment of the tripartite law enforcement, international, and health and social service efforts.

The commitment by the Federal Government is to pursue a balanced policy of demand and supply reduction, to undertake systematic and institutionalized programs, and to monitor, understand, forecast, and plan for prevention of drug abuse and drug trafficking. No longer need crises flare up as a result of changes in drug abuse patterns without adequate prior warning; no longer need *ad hoc* policy responses be necessary in a very complicated field. While not yet having achieved mastery over so formidable a problem, the Nation has devised a system for affecting the process of drug abuse without having to wait for a sense of national crisis and emergency. Provisions for review and change have been adopted and the Federal level of management and coordination has been appropriately adjusted.

We intend to continue to provide a balanced governmental response to the problem of drug abuse. The balance will be seen in simultaneous efforts to reduce drug availability as well as reducing the demand for drugs. Our efforts will extend from international to State and local cooperative efforts and our objective will be to meet society's needs while helping individuals who have a problem with drugs.

INTERNATIONAL COOPERATION

The balance of diplomatic, law enforcement, and demand reduction activities that is present policy will continue. Through such a blend of activities, we have already appreciably increased awareness and cooperation on the part of other nations. We must continue our three-fold efforts to communicate the fact that drug abuse is not only our

problem but theirs as well. Increased recognition of the common problem has brought additional efforts to deal with it. Renewed efforts to demonstrate how the United States can help others with their drug abuse problems should produce further cooperative efforts.

We know, of course, that there are many problems facing other nations. Some nations' very survival is threatened by domestic divisive forces, others suffer food shortages, lack roads and means of communication, or have a hundred high-priority items that may outrank drug abuse and drug traffic prevention. But most nations are responsible citizens of the world who, we feel, seek to be good neighbors. By offering assistance and demonstrating how it would be in their interest to cooperate further, by showing how cooperative programs are benefiting others, and by their own experience with the first stages of cooperative programs with us, we expect to further increase the extent of international recognition of the problem and to strengthen their desire to cooperate with the United States in dealing with the problem of drug abuse prevention.

Our emphasis will be on:

- disruption of trafficking efforts through cooperative efforts between DEA and foreign officials;
- equipment grants for law enforcement;
- exchange of intelligence and know-how;
- training by DEA and Customs;
- crop/income substitution assistance;
- technical assistance to treatment programs, such as NIDA's sending skilled practitioners abroad;
- cooperation in research projects.

Our cooperation will not be limited to bilateral efforts. We shall continue to cooperate with the United Nations' multilateral efforts to prevent drug abuse. The United Nations provides a major forum in which our attempts to further common efforts may be heard and in which a dialogue may develop. The expertise of the specialized subcommittees dealing with drug abuse matters has given us unique perspectives on the problems of other countries in addition to proposals for appropriate solutions to some of these problems. We expect the United Nations to play a major role in developing international drug abuse prevention policies.

We expect no easy breakthroughs in this aspect of our total response to drug abuse. Winning the support of other nations and the people of other nations who are most directly involved in drug abuse prevention is a lengthy, difficult process. Suspicions must be allayed by repeated demonstrations of the sincerity of the United States in these efforts. Real progress will only be measured over the years.

SUPPLY REDUCTION

The resurgence of heroin abuse and the increasing expertise of suppliers of dangerous drugs call for expanded efforts in already proven programs. To deal with its number-one-priority, Mexico, DEA will expand its presence in that country and help to design and support eradication, intelligence, enforcement, and training programs mounted by the Mexican Government. In addition, DEA will improve its enforcement efforts on our southwest border by further developing an inter-regional intelligence center at El Paso, by securing improved operational agreements with Customs and the Immigration and Naturalization Service on custody of prisoners and evidence, and by increasing efforts to combat air smugglers in the area.

To deal with the situation presented by the resumption of Turkish poppy growing, DEA will contribute to diplomatic initiatives by offering technical advice on securing poppy fields against diversion. DEA also will document the extent of diversion using chemical analysis of heroin samples to determine their origin.

Should diversion occur despite the efforts of the Turkish Government, it will be met by expanding the scope of DEA support for Turkish enforcement activities and by seeking more effective cooperation with local police units in expected recipient areas.

While small-time pushers are frequently easier to arrest and prosecute, DEA intends to concentrate on higher-level traffickers in order to disrupt drug trafficking networks more effectively. The crossing of district and regional boundaries will be facilitated. Cases will be more fully developed to include more and higher-level defendants and the quality of evidence presented to the prosecutor will be of higher quality. Close adherence to defendants' constitutional rights will be continued in spirit as well as in law.

To achieve these improvements, DEA is relying on full-scale use of regional intelligence conspiracy units, the development of regional technical units responsible for maintaining equipment able to document events in a case, assistance to agents in the effective use of this equipment, and, through applied research, development of improved aids to surveillance.

A third area of effort will be to raise the level of resources of other enforcement units, both here and abroad. Encouraging other police departments to devote additional resources to drug law enforcement, sharing intelligence and informants, and using the large manpower resources of patrol units to support DEA investigations will enable DEA to increase the overall impact of the enforcement efforts. DEA will accordingly: (1) increase its foreign programs in cooperating areas where drugs destined for the United States are either grown, processed, or transshipped; and (2) implement operating agreements with

Customs and the Immigration and Naturalization Service that will conserve DEA's manpower in border areas.

DEA recognizes that dangerous drugs pose an increasing problem and that additional efforts to reduce their availability are needed. A four-pronged attack on dangerous drugs is designed to increase the effectiveness of DEA's program to reduce the availability of barbiturates, amphetamines, methamphetamines, and hallucinogens.

An expanded criminal investigation program will be aimed at the higher level producers and smugglers of dangerous drugs. DEA will seek to reduce diversion from licensed manufacturers and wholesale distributors by more effective targeting of compliance investigations, holding companies to more stringent standards, and using manufacturing quotas more effectively. At the retail level, expanded efforts of the Diversion Investigation Units will be combined with other programs designed to check illicit availability. Efforts will be made to reduce the amount of time needed to alter the controls on drugs after an abuse problem becomes apparent. All these steps will both respond to the current flow of dangerous drugs and establish procedures useful in long-run programs of drug control.

A final area of DEA emphasis is in its headquarters intelligence functions. Demands on intelligence have increased as DEA efforts spread from an emphasis on the Near East-European area to an extensive effort in Latin America and Asia. Accompanying the increase in geographic coverage has been the increasing sophistication and numbers of illicit drug traffickers. To counter the expanded responsibilities, DEA will:

First, improve and enlarge the intelligence data base by using the input of new agents and sources and by requiring ongoing units to produce more regular and comprehensive debriefings of informants, its own agents, and other enforcement units.

Second, better organize the data base to make it more easily accessible and responsive to new needs.

Third, use the data base to provide DEA agents with better and interregional level tactical/operational intelligence for case-making purposes and to provide agency management with strategic intelligence for use in monitoring enforcement effectiveness and changes in trafficking, which information will be used in allocating agents and resources to specific geographic areas.

The U.S. Customs Service plans to continue to meet its responsibility to interdict the flow of illegal narcotics and dangerous drugs through its CCINC-directed training and advisory programs for foreign customs officers; its 1,200-man Customs Patrol (whose capabilities are being stepped up by extensive use of sensing and recording equipment to monitor remote smuggling locations), increased use of the Treasury's

computerized information system, and effective participation in the Customs Cooperation Council whose 75 member nations are developing new, coordinated enforcement procedures and techniques.

LINKAGE BETWEEN THE CRIMINAL JUSTICE AND HEALTH DELIVERY SYSTEMS

When tracing the history of the Federal response to drug abuse problems in Chapter II, we noted that following the passage of the Harrison Narcotic Act in 1914 there was conflict between law enforcement personnel charged with enforcing the law and physicians who sought to treat opium addicts.

That conflict between the law enforcement officer, sworn to uphold the laws, and the doctor, sworn to uphold the ethics of the Hippocratic oath, continues to color relations between the criminal justice system and the health delivery system even today. To deny that the problem of lack of cooperation exists simply delays dealing with it. What *has* been accomplished in achieving cooperation, however, shows that real progress is being made and that much more can be done.

Much of what has been done by the Federal Government in drug abuse and drug traffic prevention, of course, has been an overall linking of related programs to one another in order to function more effectively.

A balanced governmental response to the problem of interaction of criminal justice and health delivery systems requires a three-pronged effort to: (1) reduce drug availability under the provision of the Controlled Substances Act; (2) provide health services to individuals who come in contact with the criminal justice system; and (3) safeguard confidentiality of treatment for persons attempting to change their drug-abusing lifestyles.

The Controlled Substances Act (CSA) of 1970 placed the majority of psychoactive substances of abuse on a schedule which determines their degree of control—ranging from substances regulated only as to their purity, potency, and labeling to those which can be legitimately used only for research purposes. The Attorney General, who has ultimate responsibility for control decisions of drugs currently on the market, receives a scientific and medical evaluation of the drug from Health, Education, and Welfare before making a scheduling decision. Thus, his decision can reflect a comprehensive evaluation of the medical and social implications of the drug's use.

The Food and Drug Administration of HEW is responsible for determining the abuse potential of new drugs. FDA and DEA work closely in deciding the degree of control necessary for new drugs, and research is underway to improve their methods for gauging abuse potential of drugs.

The Controlled Substances Act provided for annual registration of all legitimate handlers of controlled substances, and gave to DEA the responsibility for determining which new drugs should be placed under control, and what the degree of control of individual drugs should be. Control decisions are made on the basis of whether or not the drug has a legitimate medical use and on its relative abuse potential.

Following passage of the Act, DEA began a regulatory program of visiting every licensed manufacturer and wholesale distributor of controlled drugs. The firms were informed of their responsibilities under the Act and the importance of voluntary compliance was stressed. By the end of FY 1975, all firms will have been visited at least once, enabling DEA to focus regulatory investigations on firms with the greatest potential for diversion of frequently abused drugs, and to apply tougher sanctions for violations of the CSA, in the knowledge that now "noncompliance through ignorance" will be indefensible. Regulatory inspections of manufacturers and wholesale distributors of controlled substances are also made by FDA and pertinent information is exchanged between the agencies.

Regulation of controlled substances at the retail level requires voluntary compliance on the part of physicians and other health professionals. Following an increasing trend toward self-regulation through physicians' peer review committees, a pilot project for self-regulation and voluntary compliance with CSA regulations was initiated in three States in FY 1974. This program will be expanded in the future. It emphasizes the role of State and local associations and societies, professional schools, and State regulating boards.

The second area of interface between the criminal justice and health delivery systems involves the treatment and rehabilitation of drug abusers. Cooperation with regard to drug abusers who come in contact with the criminal justice system has been discussed earlier in this report at some length. The Department of Justice is implementing a special pilot program in five judicial districts to identify drug-dependent arrestees, refer them to treatment, and monitor their progress while in treatment. The pilots will be established in 1975 in the Boston, Atlanta, Detroit, San Antonio, and Arizona judicial districts. They will be administered by the Department of Justice in coordination with the District Courts, the U.S. Attorneys, the Administrative Office of U.S. Courts (Probation Division) and the Bureau of Prisons. The Federal criminal justice system's responsiveness to the need for treatment of drug-dependent offenders and the provision of additional alternatives to U.S. Attorneys and Federal courts in the disposition of cases involving drug abusers, will both be increased by this program.

One further instance of cooperation between criminal justice and health personnel resulted from an amendment to the Controlled Substances Act (effective in early FY 1975) which requires methadone

programs to be registered with DEA, as well as with FDA, and to be visited by DEA annually to insure appropriate control over the drugs administered by the programs.

In order to safeguard the interests of clients in methadone programs, DEA and the health services personnel involved in the programs have reached an agreement that no program under investigation by DEA will be shut down without a conference with health providers.

Protecting the confidentiality of patient records—the third area of interaction between criminal justice and health systems—is vital to successful treatment and rehabilitation of the drug abuser. Confidentiality safeguards were written into the Act which established SAODAP in 1972. These safeguards are being revised jointly by HEW and SAODAP to serve the best interests of patients in all drug abuse programs and, now, also in alcohol abuse treatment programs. The scope of confidentiality regulations is being widened to include any program which directly or indirectly receives Federal funds, and to make sure that Federal disclosure regulations may not be superseded by State laws.

While protection of confidentiality of patient records remains the highest priority, provision is being made to allow access to those records with the written consent of the patient, for purposes beneficial to him. The matter of voluntary disclosure of information in a client's record is a delicate one which must balance both the judgments of treatment personnel and requirements of the criminal justice system. Information in patient records may be disclosed without the patient's consent only in cases of extreme medical emergency, or in answer to a court order. Medical researchers, auditors and investigators from DEA and FDA, however, will not be precluded by these requirements from pursuing legitimate investigations in their respective fields as long as the anonymity of the patient is preserved.

These new regulations, expanding and clarifying the confidentiality provisions outlined in P.L. 92-255, are still under review to insure that the best interests of the patient can be served with due regard for protection of society in general.

DEMAND REDUCTION

Our policy of a balanced governmental response to the problem of drug abuse also applies within the demand reduction area. New emphasis on primary prevention will be balanced by improvements in treatment standards. Research will continue to seek both basic causes of drug abuse and the most effective primary prevention techniques. This balance of efforts within the demand reduction area should lead to better answers—answers that are both more helpful to individuals and more workable in terms of society's needs.

As experience with drug abuse demand reduction mounts, early hopes to find general-purpose programs have faded. Instead, the needs for specialized responses to particular groups and problems and extension of services to new groups are increasingly appreciated.

Programs in the Military

The Department of Defense Drug Abuse Control Program's primary goal is to return rehabilitated drug abusers to duty and to prevent future abuse. It has recently included in that program goal an increase in treatment services for its civilian employees and for military dependents.

Two examples of the treatment services for dependents are the Frankfurt Youth Health Center (West Germany) and the Bangkok Youth Treatment Center (Thailand).

The Frankfurt Center is a DOD and Special Action Office joint project, providing drug treatment and other health services to adolescent military dependents. The successes of the Frankfurt project are such that it is serving as a model for further implementation of dependent treatment services.

The Bangkok Center, a cooperative effort of DOD, the Department of State, and the Special Action Office, provides drug treatment services to adolescent American dependents.

The many civilians working with the military both at home and abroad are being helped by more extensive referral and treatment services for both drug and alcohol abuse.

The decision to resume the involuntary urinalysis program within DOD is widely hailed as contributing to drug abuse prevention. It came after considerable examination of the impact on DOD of the decision by the United States Court of Military Appeals in the case of *United States v. Ruiz*. The ruling prohibits a less than honorable discharge if it is based solely on evidence obtained through involuntary testing. In the Court's view the order to provide an involuntary urine sample for use in characterizing a military member's discharge as less than honorable, constituted a violation of the self-incrimination provision of Article 31 of the Uniform Code of Military Justice. The DOD urinalysis program was reinstituted within the constraints of the *Ruiz* decision after determining that there still remained an unacceptably high number of drug abusers in the Armed Forces and the urinalysis program was an effective means of combating the problem. The interest of society in limiting the harmful effects of drug abuse in the military services is upheld while the decision of the Court protecting individual rights is complied with.

The military services also maintain confidentiality of the records of drug abusers, limiting access to those treatment and chain-of-command personnel who have a need to know. The Department of Defense is developing a humane and rational approach that may serve as a model

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for meeting human needs within the Federal Government. Clearly, if a balance can be struck by the military services between their particular needs and responsibilities in a most vital area and the needs and rights of service personnel, other Federal agencies can do as much to meet the needs of their personnel.

Rural Programs

NIDA is responding to the special needs of rural areas for demand reduction services. Rural problems are caused by: the diffusion of certain forms of drug abuse from large, coastal cities to smaller, interior ones; the development of particular patterns of abuse among rural youth and the elderly; the residence in rural areas of minorities, such as Indians and Mexican-Americans having a history of drug-related problems; and scattered populations faced by high transportation costs and scarce medical services.

A Rural Task Force is charged with developing rural drug abuse prevention, treatment, and rehabilitation programs. A Rural Drug Abuse Conference held in December 1974 served as a forum for selected Single State Agency heads and clinicians to discuss rural drug abuse programs. It helped to identify those areas of Federal policy which inhibit the effectiveness of rural programs, defined elements essential to rural efforts, and suggested changes in Federal policy to make it more responsive to rural needs.

NIDA and the Special Action Office are presently developing plans to respond to the most pressing needs of rural programs. For example, treatment by health and counseling professionals is required under Federal treatment standards in order to assure high-quality care. Yet the requirement of a physical exam for all drug treatment clients in rural areas can be both costly and frustrating. It is frequently hard and expensive to reach a physician and the examination may reveal serious health problems that drug abuse programs cannot handle. Frequently there is no appropriate agency to which to refer the client in such cases.

The National Health Service Corps and the Agricultural Extension Service Corps offer two important Federal sources for supplying the much-needed skills of medical and counseling services in rural areas. The Special Action Office and NIDA are working to achieve better coordination of their rural efforts with these services.

Patterns of dangerous drug and multiple drug abuse including alcohol are frequently encountered in rural areas. However, drug abuse prevention programs, unequipped to deal with these specific problems, are often the only social service agency available to many rural dwellers. Better coordination of the rural efforts of NIDA, the National Institute of Alcohol Abuse and Alcoholism, and the National Institute of Mental Health is an early concern of the Rural Task Force Project.

Actions to improve the rural situation which NIDA can take on its own include: allowing more flexibility in applying the Federal Funding

Criteria in rural areas; asking the States to develop a comprehensive rural strategy as part of each State's yearly plan; instituting a collaborative relationship among Single State Agencies and program directors concerned with rural programs; and developing model rural programs after evaluating existing ones.

The Special Action Office and NIDA, in developing the plans for rural areas, are well aware that in those areas there exists a very difficult problem of lack of popular support for drug abuse prevention, treatment and rehabilitation. Ignorance about what can be done about drug abuse is widespread and there is a pronounced lack of interest in learning more. There is a considerable tendency to view drug abuse as "not a problem here." The task of community education is time-consuming and expensive. Although there is no easy solution available, efforts will continue because such support is indispensable to a successful long-run effort.

Prevention Policies

The new emphasis on prevention in demand reduction has already begun (details were discussed in Chapter V). The overal focus on NIDA's prevention activities, however, will be on providing technical assistance, developing resources, analyzing the impact of, and evaluating, existing programs. Essentially, NIDA is to perform as a facilitator and broker. Knowing the need for community-based programs, NIDA will seek to link community service programs, such as Boys Clubs, Girl Scouts, 4-H, and YMCA with prevention activities. Prevention should become more achievable by placing prevention activities in a setting that makes the best use of the relatively rare skills of experienced youth counselors, and by deemphasizing "drug education," while stressing instead alternatives, intelligent choices, and personal value development.

Some 14 Federal agencies, including DEA, the Office of Education, and the Departments of Agriculture and Housing and Urban Development, are involved in primary prevention programs. A major remaining task is achieving the maximum possible coordination of these drug abuse prevention efforts. While drug abuse prevention guideline materials have been developed, the fast pace of events in community-based programs requires further coordinating efforts at the Federal level. Most simply put, the Federal Government's policy is to evaluate what we have, test new solutions, and support effective demonstration programs.

To support effective programs, we are developing evaluation instruments that will make empirically-derived evaluation a possibility, thus adding an important dimension to judgment. By presenting reports on the actual impact of successful prevention programs in communities, we shall hopefully increase the support of that segment of society

which has been skeptical of the usefulness of prevention programs and has legitimately asked for better evidence of our claims that prevention works. By supplying technical assistance to prevention programs, more community programs will be enabled and encouraged to do more in drug abuse prevention.

Training and Manpower

Three major policy decisions define and govern NIDA's role in training and manpower programs. The agency is to:

1. Deemphasize the Federal role in the actual delivery of services, and emphasize technical assistance, training assistance, research, and resource development.
2. Help States develop capacity and capability to manage and operate programs and services related to drug abuse treatment, rehabilitation, research, and training through the development of the Single State Agencies.
3. Help develop the accreditation and licensing of drug abuse programs, and the accompanying credentialing of drug abuse workers by States.

These policy decisions are designed to advance the principle of decentralizing to the States the maximum possible responsibility, retaining only those functions that require Federal centralization.

NIDA aims to have the training capacity of the Single State Agencies (SSA's) in place by the beginning of FY 1976. The SSA's will be supported by NIDA through technical assistance, research, and development efforts. During FY 1976, the chief objective in the training and manpower area will be to assure completion by the States of licensing and accreditation of facilities and programs and the credentialing of drug abuse workers.

The National Training System (NTS), consisting of the National Training Center, regional training centers, and State training support programs, will play a leading role in accomplishing the accreditation program.

NIDA plans to develop validated training courses adaptable by State agency training programs; design training modes for rural areas to be used at the national, regional, and State levels of training; develop criteria and assessment instruments to assign qualifying credits for work experience of drug abuse workers; train evaluation and research personnel, and develop methods of training evaluators; and establish a training resource and information exchange system in selected resource centers throughout the Nation.

An important program activity of the National Training System is to update the knowledge and skills of professionals and paraprofessionals presently involved in treatment and rehabilitation. Centers for

professional education include Baylor University Medical School and Downstate Medical Center of New York. The University of California at Los Angeles Medical School is proposed as a third center.

These centers will develop model courses and curricula content in drug abuse and alcoholism that may be included in other medical school curricula. They also will help coordinate the activities of career teaching fellows who are developing physician training models, expand the attention paid to drug abuse treatment and rehabilitation in the continuing education programs required by State licensing authorities, and organize and conduct conferences, workshops, and seminars in drug abuse for professional groups such as the American Medical Association.

Clinical Research

Most of the ongoing clinical research (see page 53) deals with long-term and shorter studies of the safety and efficacy of methadone, LAAM, narcotic antagonists, combinations of methadone and narcotic antagonists, and lithium, which is used to block the intoxicated feeling produced by drinking alcohol.

The major concern is to investigate the possible complications and benefits that stem from using these and other pharmaceutical substances in the treatment of drug abuse.

The Demand Reduction Future

While much remains to be done in demand reduction, the scope of what is being sought, and the thoughtfulness of the seekers are reassuring. What is particularly important is the emphasis on increasing the quality, responsiveness, and adequacy of the demand reduction activity.

It is essential to realize that quality should not be sacrificed for false economies and that only by investing steadily are complex social program goals fully realized. The Federal concern in the area of Management of Scarce Resources, which follows, is built around this same understanding. Its whole intention is to cut waste in order to extend capacity and provide resources of the highest standard where most needed.

MANAGEMENT OF SCARCE RESOURCES

The Federal effort in drug abuse and drug traffic prevention has been sizable and distinctive. It has developed programs that draw foreign cooperation, has centralized drug law enforcement, and coordinated health and social welfare activities. A specialized sector of the Federal Government was created to deal quickly with the manifold program.

Very soon, however, certain other governmental and social developments made reorganization of the reorganization obviously inevitable. The public grew aware of the relationship of some aspects of drug abuse to other social problems such as alcoholism and mental health. The Administration developed decentralizing plans to shift additional responsibilities and revenues to the States. And, finally, there is the growing consensus that some form of National Health Insurance is close at hand and that in future years it will include coverage of the medical and rehabilitative aspects of drug abuse treatment.

These factors have combined to require a restatement of the FEDERAL STRATEGY with respect to the management and financing of drug abuse programs. A division of labor between the Federal level and that of the States and localities is central to the FEDERAL STRATEGY. The States and localities will manage prevention and treatment services in their area, while research, limited resource development, and technical assistance efforts will remain basically a Federal responsibility.

The desired role of the Federal government in its partnership with the States and localities is one of facilitator, provider, and coordinator of some of the needed resources and offering assistance, knowledge, and alternatives in support of the common effort.

The States, for their part, have the responsibility to treat drug abuse clients, with relatively few Federal restrictions on what they can do. Federal Funding Criteria and Drug Abuse Treatment Program Review projects do establish minimum standards for treatment and rehabilitation programs, but beyond these standards considerable latitude remains. These standards reflect both the Federal Government's responsibility to its taxpayers and the professional responsibilities of Federal drug abuse prevention managers to see that quality care is provided. Credentialing, accreditation, and licensing programs have been developed to assure quality care.

Since States, in the U.S. Federal system, retain power over licensing and regulating the bulk of drug abuse treatment and rehabilitation matters, Federal efforts are restricted to encouraging and supporting such efforts.

Financing

There is another major reason, besides quality of care, for such credentialing activities, and that is the improved position credentials give programs in obtaining payments from private insurers, health maintenance organizations, and other so-called "third parties."

Many managers of treatment programs view third-party payment procedures as impossibly complex. Because it can take 6 to 9 months to be reimbursed, they regard it as "too little, too late" and do not "bother" with it.

The FEDERAL STRATEGY, however, is to attempt to make a virtue out of the inevitable in this problem of third-party payments.

First, programs are now being developed to work out the best ways for treatment programs to begin to garner the third-party payments to which they are already entitled.

Second, the National Training System will provide training to State and local programs in how to cope with the requirements of claim filing and record keeping.

Third, credentialing efforts have already begun so that model standards and requirements will soon be at hand.

Fourth, in the transition process to full use of third-party payments, the Federal Government pledges to provide interim financing until third-party reimbursements are regularized.

State and local officials in drug abuse prevention are to be supported by the Federal Government in entering this new financing relationship, a relationship which has considerable virtue. Any sort of reimbursement-for-services-system will make it possible to plan more confidently and to base budgets upon actual services provided. As the present NIDA support system is structured, a State or local program can lose funds it planned on if its client caseload declines, or if other programs have a relatively higher caseload than it has. While such allocation decisions are required by the overall Federal responsibility to spend where the need is greatest, the disruptions that can be caused by such reallocations are serious. The more a program can rely on third-party payments, the more control it will have over its budgeting and planning.

Federal categorical grants and other forms of funding of specific drug abuse services are expected to continue. Changes in both Federal laws that were not specifically focused on drug abuse and in funding criteria that nonetheless often helped drug abuse programs in the past, have further limited opportunities to receive funding from general programs. For example, those programs authorized by the Comprehensive Manpower Training Act of 1974 now focus on other target groups for rehabilitation than the drug abusers it previously supported. Budget changes in the Social Security funds have also caused retrenchment in planned support. By bolstering the ability to obtain third-party payments, programs in States and localities may be able to replace these lost funding sources.

Preparing for National Health Insurance

The President's moratorium on new Federal programs, except in energy, enables more comprehensive preparation for future National Health Insurance (NIH) proposals. HEW's Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) has established a Task Force consisting of representatives from each of its member institutes:

alcohol, drug abuse, and mental health. The Task Force will generate input for National Health Insurance Policy, assure that coverage for substance abuse and mental health problems receive similar emphasis, and give the three institutes more visibility and a louder voice in influencing decisions than each individual institute would have.

Since many of the issues facing the institutes are similar, their combined efforts in resolving problems will be complementary. In addressing coverage of drug abuse treatment under National Health Insurance, several major issues must be considered. The Special Action Office has made its concerns known to ADAMHA in the areas of eligibility requirements, coverage, and certification of providers. These issues are listed below together with the current Special Action Office position on each.

Eligibility Requirements

It is the Special Action Office position that a drug abuser should not receive special consideration with respect to eligibility for coverage under National Health Insurance by virtue of his abuse of drugs.

National Health Insurance is expected to cover individuals that are either working or are medically indigent. Most drug abusers will fall into these two categories. On the other hand, some who change jobs frequently or have not built-up tenure, may not be eligible for National Health Insurance in either category. Additional arrangements will have to be made to assure drug abuse treatment services are made available to those not eligible under NHI.

Extent of Coverage

No discriminatory restrictions should be placed on benefits for drug abuse treatment. Full benefits should be provided, consistent with coverage provided for other medical services.

The drug abuser should additionally be offered a full range of services which are compatible with the unique requirements of drug abuse treatment.

Unique Requirements of Drug Abuse Treatment

Comprehensive drug abuse treatment involves a broad range of services, both medical and nonmedical, as well as a broad array of service providers, many of whom are nonprofessional. Furthermore, drug abuse treatment does not fall neatly into any one well-established structure because various treatment options are required to provide the optimum care for each individual drug abuser.

Examples of some of these unique requirements are:

- Long term outpatient care for those patients on methadone maintenance;

- Residential and halfway house care for those patients in a drug-free modality;
- Counseling and vocational guidance.

Thus, drug abuse treatment cannot be fully accommodated within the traditional medical model for health insurance reimbursement. The Comprehensive Community Care Centers envisioned in the National Health Insurance concept must be defined broadly enough to provide typical drug abuse treatment services, many of which fall within a social or human service model rather than a medical model. Indeed, emphasis on a medical model may foster less effective and more expensive treatment methods.

Certification of Providers

As noted above, many drug abuse workers are nonprofessional and lack formal credentials; thus, assessment and verification of credentials is important if National Health Insurance or another third-party payment system is to reimburse these people for services.

A study is underway to study existing certification systems and develop a model system for credentialing drug abuse workers. The States will play the most significant role in this endeavor and will be expected to provide for the licensing of drug abuse treatment and rehabilitation facilities. More than one-half of the States have already enacted licensing legislation and many other States have legislation pending.

The Special Action Office and the National Institute on Drug Abuse efforts in support of this activity include: (1) the development of guidelines which reflect established levels of program performance in an effort to upgrade the quality of services, and (2) development of "maximally achievable" standards by the Joint Commission on Accreditation of Hospitals (JCAH) which cover four types of drug abuse facilities:

- comprehensive rehabilitation projects
- emergency services
- short-term detoxification
- assessment and referral services.

Transition

The National Institute on Drug Abuse is preparing a transition plan which will outline the move toward partial funding of drug abuse treatment under National Health Insurance and other third-party payment plans.

Provision will be made for continuation of categorical grants and contracts for:

- treatment for drug abusers who do not meet eligibility requirements of National Health Insurance or other third-party payment plans
- education and prevention projects
- training
- research

Direct Federal operations will be continued in planning, direction, coordination, evaluation, and research. Development and operation of data systems will be continued to support research, evaluation, project management, and long range policy decisions.

Local Funds

Faced with national economic problems and a moratorium on new Federal programs, except in energy, fewer noncategorical, unspecialized resources will be available from the Federal Government in future years. In addition to garnering third-party payments from insurers and Federal sources, drug abuse prevention programs are encouraged to seek other funding from State and local sources. Funds from revenue sharing that can be spent by local governments are an illustration of one type of such possible financial aid.

Program Management

A number of improvements in managing the national drug abuse prevention effort are underway, or will be shortly. One is aimed at increasing the States' effectiveness in their own planning and management. Major help in this endeavor is provided by the State block grants NIDA makes. In FY 1976, the amount of money given to States to use as they see fit in drug abuse prevention is expected to be $35 million. The funding will be accompanied by encouragement for the States themselves to decentralize appropriate planning and management functions to their own regions and localities. Program-management assistance and self-evaluation packages from NIDA to the States are being prepared. For example, IDARP, the Integrated Drug Abuse Reporting Process, aids States in developing their own management information systems, by supplying operating systems, computer software, and personnel. Each State can then create a management information system which furnishes both data required for Federal management needs and data for managing programs within the State.

A second area of action focuses on removing Federal obstacles to State and local efficiency of management. It is Federal policy that variance among State activities will be supported as long as it is consistent with minimum quality of care standards. The Federal

Government must be constantly alert to inadvertent limitations on such diversity. Some States, for example, have achieved a unity of sorts in planning, programming, and budgeting for drug abuse, alcohol abuse and alcoholism, and mental health. However, budgeting and planning criteria of the three Federal agencies under ADAMHA that deal with those areas have not been made uniform. Those States that are ahead of the Federal Government in this regard have to step back to comply with the three different sets of requirements.

We intend to speed up the coordination of our differing requirements so that we do not refute, by example, our words of encouragement to State and local programs to go further in their coordination.

The Federal allocation cycle is being improved by a variety of techniques to restrain the swings in allocations that have occurred, so that State and local programs may plan more efficiently.

The Federal communication effort with the States and localities can have significant management consequences. Better plans, capable of wider support by those who will ultimately use them, are being developed by encouraging greater participation by States and localities in the drawing up of new models and programs, such as the current rural drug abuse effort.

If we communicate the reasons policy changes are necessary and then develop those changes in cooperation with the State and local programs, support for the new policies will certainly be more easily obtained. A significant illustration of the importance of communication arises in the Federal Government's need for data generated by State and local programs. We must show how the data are to be used and justify the investment in State and local time required to get the information.

A third level of management concern is within the Federal Government itself. Coordinating the various agencies involved in demand reduction has been the responsibility of the Special Action Office, whose statutory authorization expires on June 30, 1975. A task force of the White House's Domestic Council is conducting a review of Federal drug abuse prevention policy and formulating plans for future high-level coordination.

An atmosphere conducive to more intelligent public policy has been created by the actions and debates of the last 4 years. A sobering element of that atmosphere is the realization of the necessarily tentative, flexible, qualified, and limited character of specific policies in drug abuse and drug traffic prevention.

The debate has provoked a widespread interchange among a growing community of involved people, which helps to improve the Nation's response to the problem. While complete agreement on all specific policies does not seem achievable, *the drug abuse community has developed a consensus that the national goal is to minimize the individual and social costs of drug abuse.*

If this goal is much more widely shared now than 4 years ago, so, too, is an appreciation of the need for long-term, patient, and reflective policies to achieve it.

The Federal effort in drug abuse prevention marks a watershed in our history. We have moved from an unreflective rejection of the drug abuser which, in many cases, wasted the talents and lives of these citizens, to a national commitment to treat and rehabilitate those whom we did not prevent from abusing drugs.

This concerned reaching out to help those in need while at the same time making our community a more humane and decent place to live, reasserts both the American respect for human dignity and the best aspects of community concern.

The Federal Government will continue its efforts—described throughout this report—to clarify national objectives, ask better questions, address the feasible outcomes of policies in drug abuse, and manage well our balanced efforts in these fields.

We face a dynamic problem complicated by national economic difficulties; we, nonetheless, feel confident that as a people we can cope.

APPENDIX

The following charts use these abbreviations

BA – budget authority
OBL – obligations
OUTL – outlays

SOME COMMONLY ABUSED DRUGS

CLASS	DRUG TYPE	NAME	EFFECTS*	MEDICAL USES
Depressants (substances which lower the rate of muscular or nervous activity)	alcohol	beer, distilled spirits, wine	chronic use can cause psychological and physical dependence; excessive use is damaging to liver and brain and can cause death; alcohol use is a major factor in traffic accidents; simultaneous use of alcohol and barbiturates is dangerous because of narrow margin between maximum effect and lethal dose	to improve appetite and digestion as a skin disinfectant solvent for other drugs and medications
	narcotics	codeine, Demerol, heroin, methadone, morphine, opium, Percodan, Dilaudid	besides relief of pain, produces relaxation, euphoria, relief of anxiety; tolerance develops rapidly; highly addictive, especially when injected intravenously	codeine—for cough in general, as analgesic (painkiller) as treatment for diarrhea
	sedative/hypnotics	chloral hydrate, Doriden, Nembutal, Phenobarbital, Quaalude, Seconal	produce relaxation, drowsiness, and decreased alertness; tolerance develops with continued use; narrow band between toxic effect and overdose levels; chronic use of barbiturates can result in physical and psychological dependence, and medically unsupervised withdrawal can be fatal; danger of overdose is increased when barbiturates are used with alcohol, tranquilizers and other drugs	for insomnia, tension, and epileptic seizures
	tranquilizers	Librium, Valium, Miltown/Equanil	relief of anxiety and tension, drowsiness; less powerful and therefore less dangerous than sedative/hypnotics, but with similar danger of dependence, unsupervised withdrawal, and use with other non-narcotic depressants	for tension, anxiety as muscle relaxants as treatment of alcohol and barbiturate withdrawal
Psychedelics (an imprecise class of substances believed to be capable of causing the expansion or heightening of consciousness)	cannabis	marihuana, hashish, THC	marihuana produces in some individuals mood changes and alteration in sensory and time perception; can cause euphoria and drowsiness, impair short-term memory processes and have a detrimental effect on driving performance; in high doses can induce psychosis; hashish and THC are more concentrated forms of cannabis	
	hallucinogens	DMT, LSD, Mescaline, nutmeg, Psilocybin, STP	can produce in normal persons the perception of sights and/or sounds not actually present; expectations of user can affect individual reaction	(outside U.S.) LSD used in psychotherapy
Stimulants (substances which temporarily increase the activity of some vital process or organ of the body)	amphetamines	Benzedrine, Dexedrine, methamphetamine	produce a feeling of increased alertness, euphoria, sometimes restlessness and insomnia; continued use can result in tolerance and psychological dependence; prolonged high-dose injection can produce paranoid psychosis	for depression, excessive fatigue, narcolepsy for children's behavior disorders for short-term treatment of obesity

	caffeine	coffee, chocolate, cola, No-Doz, tea	increased alertness, restlessness, insomnia, upset stomach; heavy use causes tolerance and psychological dependence	for oversedation and headache related drugs are used as cardiac stimulants, diuretics, and in treatment of asthma
	cocaine		increased alertness; tolerance develops with continued use and psychological dependence can result; prolonged high-dose use can cause paranoid psychosis	as a local anesthetic
	non-amphetamine stimulants	Ritalin	*similar to those of amphetamines*	*for anxiety or oversedation* for children's behavior disorders for mild depression
Others	inhalants and solvents	aerosols (freon), chloroform, amyl nitrite, nitrous oxide, gasoline, benzene, airplane glue, paint	vary from pain relief to hallucination or intoxication similar to that produced by alcohol; use of large amounts can cause stupor and death; continued excessive use can damage liver, kidneys, bone-marrow, brain	amyl nitrite—for dilation of cardiac blood vessels *nitrous oxide—as a surgical anesthesia*
	nicotine	cigarettes, cigars, chewing tobacco, pipe tobacco, snuff	can act as stimulant, depressant, or tranquilizer; can cause headache, loss of appetite, nausea; continued use causes tolerance, leads to strong psychological dependence; long-term and excessive use causes impaired breathing, is a factor in heart and lung diseases and cancer, and can result in death; cigarette smoking is the chief cause of lung cancer	

*Effects of drugs vary with amount taken, frequency of use, and expectations of the user.

BUDGET CHARTS

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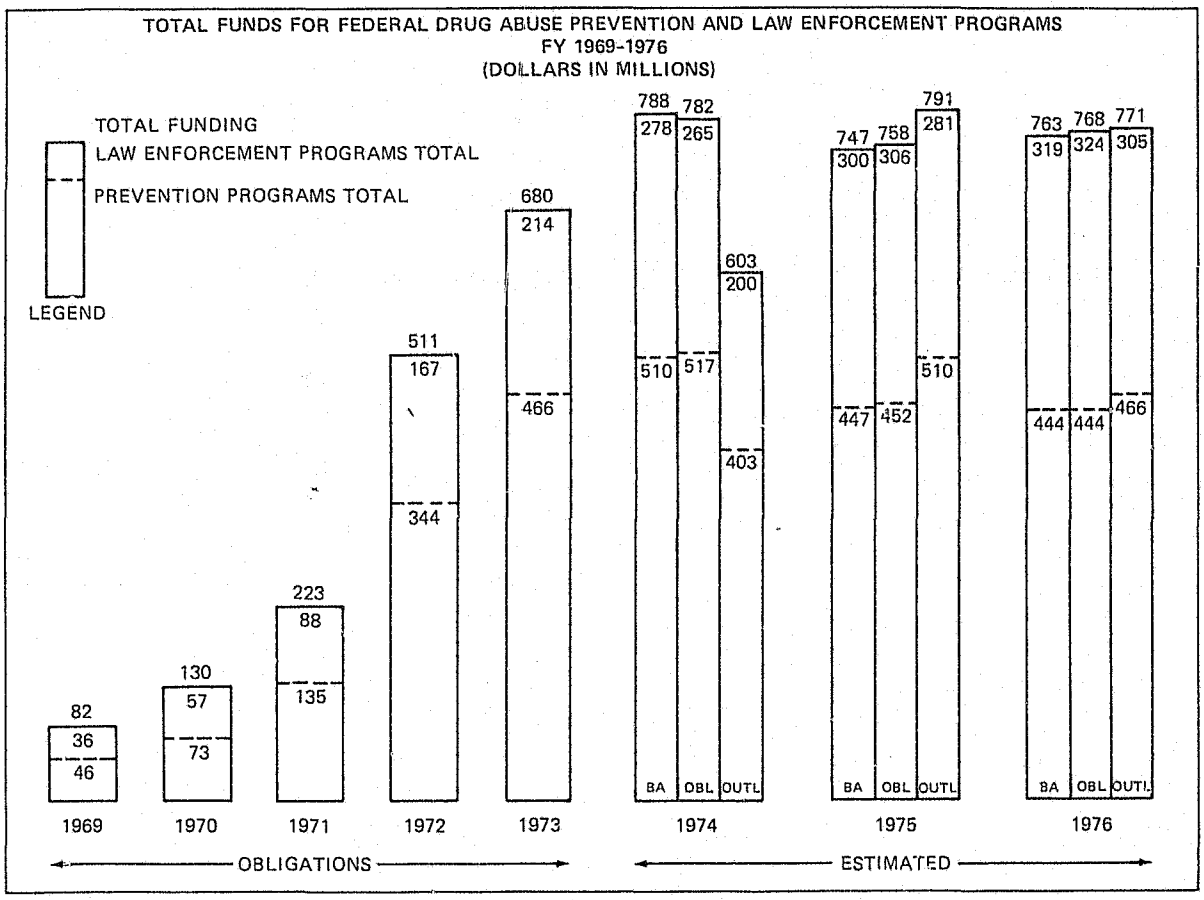


DRUG ABUSE PREVENTION PROGRAMS FY 1969-76

(DOLLARS IN MILLIONS)

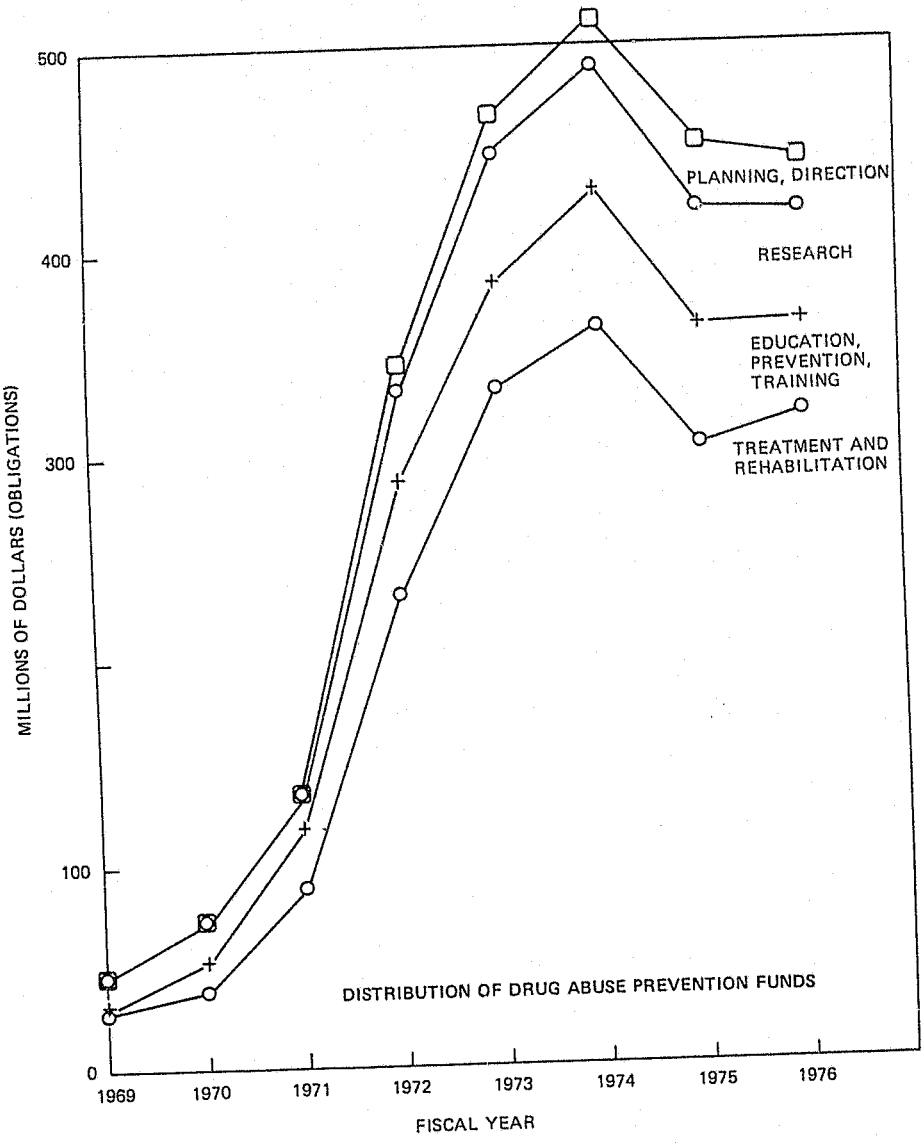
AGENCY	FY69	FY70	FY71	FY72	FY73	FY 1974			FY 1975			FY 1976		
						BA	OBL	OUTL	BA	OBL	OUTL	BA	OBL	OUTL
SAODAP	0	0	0	1.5	39.9	51.0	27.3	21.5	13.0	13.0	45.5	0	0	8.6
HEW														
NIDA	37.2	40.5	56.2	116.7	204.5	244.1	273.0	168.1	211.0	211.0	231.7	221.8	221.8	226.5
NIMH	N/A	N/A	N/A	N/A	N/A	4.5	4.5	3.2	5.2	5.2	4.7	4.2	4.2	4.4
NIH	N/A	N/A	N/A	N/A	N/A	3.3	3.3	3.1	3.0	3.0	3.0	3.2	3.2	3.2
OE	0.2	3.4	5.4	13.0	11.9	5.7	5.7	7.7	0	0	0.5	0	0	2.0
SRS	N/A	N/A	3.6	58.0	53.0	54.0	54.0	54.0	59.0	59.0	59.0	63.0	63.0	63.0
OHD	1.2	2.5	4.5	5.4	8.8	9.0	9.0	9.4	9.3	9.3	9.7	7.4	7.4	7.2
OEO	2.2	4.9	12.8	18.0	(23.0)**	0	0	0	0	0	0	0	0	0
VA	0.6	0.8	1.1	16.2	27.7	30.3	30.3	30.3	32.3	32.3	32.3	33.2	33.2	33.2
JUSTICE														
BOP	0.5	1.1	1.4	1.9	3.4	10.2	10.2	8.8	11.6	11.6	11.8	11.8	11.8	12.2
LEAA***	1.1	12.8	36.8	31.9	27.5	21.7	21.7	19.9	27.3	27.3	24.4	22.5	22.5	23.8
DEA	1.5	2.0	2.1	2.7	2.6	2.7	2.6	2.5	2.9	2.9	2.8	2.9	2.9	2.8
DOD	0.1	0.1	1.1	58.7	73.0	68.6	68.6	68.6	67.5	67.5	67.5	67.9	67.9	67.9
STATE	0	0	0	1.0	1.0	0.9	0.9	0.6	0.7	0.7	0.7	0.8	0.8	0.6
CSC	*	*	*	*	*	0.2	0.2	0.2	0.5	0.5	0.5	0.5	0.5	0.5
DOL	0	0	0.2	0.6	0.5	1.5	1.5	1.5	1.0	1.0	1.0	1.7	1.7	1.7
DOC	0	0	0	0	1.5	*	*	0.5	*	*	0.2	0	0	0
HUD	1.4	4.1	8.7	13.0	6.3	0	1.6	10.3	0	4.4	6.2	0	0	5.1
DOT	0	0	0	0.8	0.9	0.6	0.6	0.6	0.7	0.7	0.7	0.9	0.9	0.8
USDA	0	0	0	2.5	1.9	1.6	1.8	1.8	1.6	1.6	1.6	1.6	1.6	1.6
ACTION	N/A	N/A	N/A	N/A	N/A	0.5	0.5	0.4	0.5	0.5	0.6	0.4	0.4	0.4
TOTAL	46.0	72.4	135.2	344.4	465.8	510.4	517.3	403.0	447.1	451.5	510.4	443.8	443.8	465.5

* LESS THAN $100,000

** INCLUDED IN NIDA

***INCLUDES TASC FUNDING OF $4.9M/1972; $2.3M/1973; $1.9M/1974; $5.8M/1975; AND $3.7M/1976. DOES NOT INCLUDE LAW ENFORCEMENT FUNDING.

N/A - ESTIMATE NOT AVAILABLE


500
400
300
100
0
MILLIONS OF DOLLARS (OBLIGATIONS)
PLANNING, DIRECTION
RESEARCH
EDUCATION, PREVENTION, TRAINING
TREATMENT AND REHABILITATION
DISTRIBUTION OF DRUG ABUSE PREVENTION FUNDS
1969
1970
1971
1972
1973
1974
1975
1976
FISCAL YEAR

DRUG LAW ENFORCEMENT PROGRAM FUNDING FY 1969-76

– EXCLUDES DRUG ABUSE PREVENTION ACTIVITIES –

(DOLLARS IN MILLIONS)

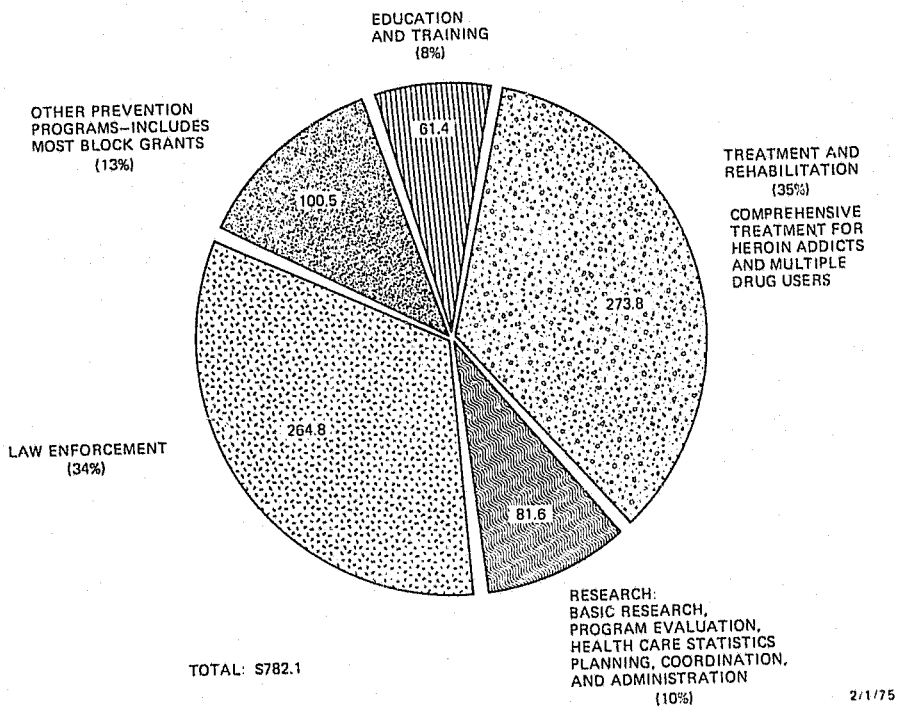
AGENCY	FY69	FY70	FY71	FY72	FY73	FY 1974			FY 1975			FY 1976		
						BA	OBL	OUTL	BA	OBL	OUTL	BA	OBL	OUTL
DEA	18.5	27.8	41.2	63.3	69.7	109.8	112.1	95.1	132.8	139.4	133.6	147.9	152.0	150.1
LEAA** & OTHER JUSTICE	0.4	4.5	12.4	23.0	30.2	67.3	67.3	44.6	62.2	62.2	54.3	64.7	64.7	53.2
STATE	0	0	4.4	20.7	42.7	42.5	27.1	5.2	42.5	42.5	26.8	42.5	42.5	37.8
IRS	0	0	0	10.1	16.9	21.8	21.8	21.3	20.0	20.0	20.0	20.0	20.0	19.8
CUSTOMS	17.0	24.8	30.2	46.9	52.5	34.6	34.6	31.4	40.5	40.5	44.3	42.6	42.6	42.3
USDA	0	0	0	2.1	1.5	1.6	1.6	1.6	1.5	1.5	1.5	1.5	1.5	1.5
DOT	0	0	0	0.4	0.4	*	*	*	*	*	*	*	*	*
DOD-CIVIL	0	0	0	0	0.2	0.3	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.4
TOTAL***	35.9	57.1	88.2	166.5	214.1	277.9	264.8	199.5	299.9	306.5	280.9	319.6	323.7	305.1

* LESS THAN $100,000

** DOES NOT INCLUDE TREATMENT ALTERNATIVES TO STREET CRIME (TASC) FUNDING; SEE LEAA PREVENTION PROGRAMS.

***DOES NOT INCLUDE DOD-MILITARY OR U. S. POSTAL SERVICE

1974 FUNDING OF FEDERAL DRUG ABUSE PROGRAMS
(OBLIGATIONS IN $ MILLIONS)



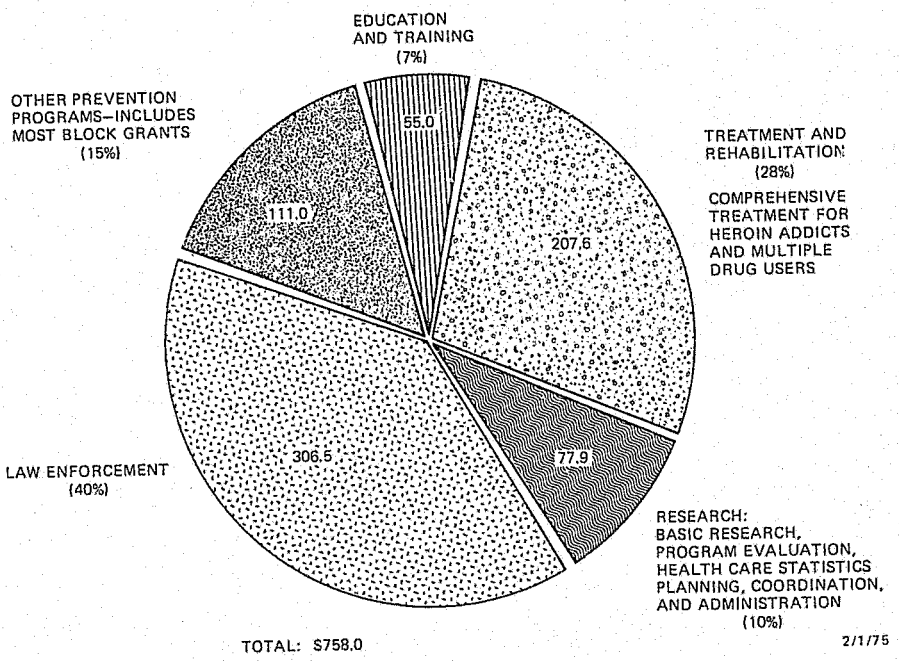
TOTAL: $782.1

2/1/75

CONTINUED

1 OF 2

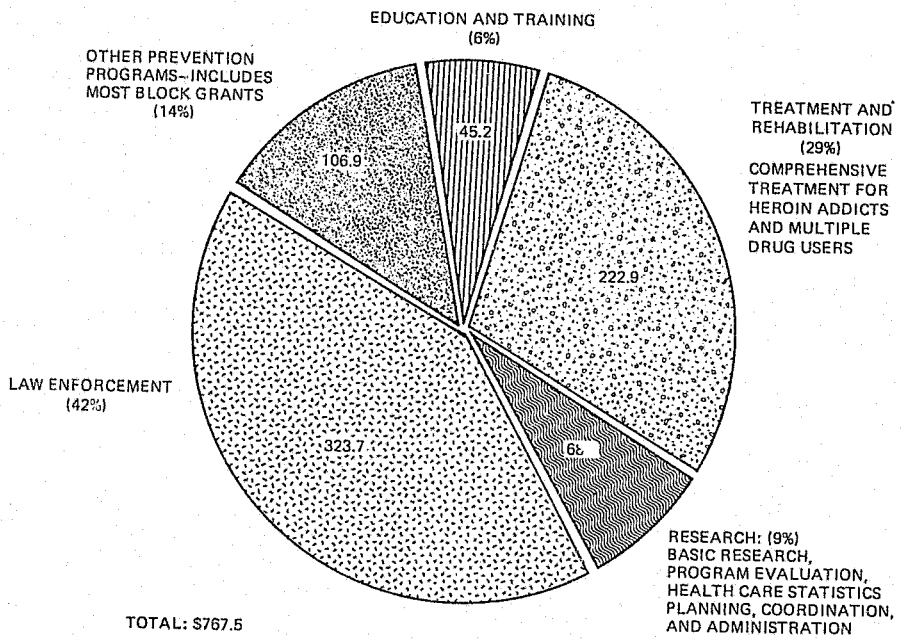
1975 FUNDING OF FEDERAL DRUG ABUSE PROGRAMS
(OBLIGATIONS IN $ MILLIONS)



TOTAL: $758.0

2/1/75

1976 FUNDING OF FEDERAL DRUG ABUSE PROGRAMS
(OBLIGATIONS IN $ MILLIONS)



TOTAL: $767.5

2/1/75

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U.S. GOVERNMENT PRINTING OFFICE : 1975 O - 576-504

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