WHITE PAPER
ON
DRUG ABUSE

September 1975

A REPORT TO THE PRESIDENT
FROM
THE DOMESTIC COUNCIL DRUG ABUSE
TASK FORCE

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THE VICE PRESIDENT
WASHINGTON

September 29, 1975

Dear Mr. President:

I am pleased to submit for your consideration the White Paper on Drug Abuse prepared at your request by the Domestic Council Drug Abuse Task Force. The White Paper documents the principal findings of the Task Force, assesses the current extent of drug abuse in America and presents a number of recommendations for improving the Federal government's overall program to reduce drug abuse.

Drug abuse is one of the most serious and most tragic problems this country faces. Its cost to the nation is staggering: counting narcotics-related crime, health care, drug program costs and addicts' lost productivity, estimates range upwards of $17 billion a year. In addition to these measurable costs, the nation bears an incalculable burden in terms of ruined lives, broken homes and divided communities.

The Task Force believes that the optimism about "winning the war on drugs" expressed so eloquently and confidently only a few years ago was premature. It urgently recommends that the federal government reaffirm its commitment to combatting drug abuse and that public officials and citizens alike accept the fact that a national commitment to this effort will be required if we are to ultimately succeed.

The Task Force submits this White Paper in the knowledge that it does not provide all of the answers to solving the drug abuse problem. The issues are complex and changing and the Federal effort represents only part of the nation's total response. However, I believe that the recommendations contained in the White Paper provide a solid base upon which a re-invigorated national effort can be built.

The Members of the Task Force, the contributors to the White Paper and I appreciate the opportunity to have participated in this vital undertaking.

Respectfully submitted,

Nelson A. Rockefeller

The President
The White House
Washington, D. C.

DOMESTIC COUNCIL DRUG ABUSE TASK FORCE

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PREFACE

Commencing in 1969, the Federal Government launched a major commitment toward eliminating the drug abuse problem in America. Sufficient progress had been made by late 1973 that Administration spokesmen, including, the former President, began to make cautious statements about "turning the corner on drug abuse." These statements were always accompanied by warnings that the data were not yet conclusive and that there was still a long way to go even if the corner had been turned. But, somehow, the qualifying statements were overlooked and the notion that we had "turned the corner on drug abuse" became accepted as fact by many in government and by most of the public and the press.

We now know that the very real progress which led to this confidence was, in the main, temporary and regional. In fact, at that very time, the underlying trends had already begun to turn up after having declined steadily for almost two years.

By the summer of 1974, Federal drug abuse program administrators began to realize that conditions were worsening and that the gains of prior years were being eroded. The deteriorating situation was confirmed over the next several months and, by early 1975, the Congress, the press and the public at large were becoming aware of the new and worrisome situation the Nation faced.

Deeply concerned over evidence indicating an increase in the availability and use of illicit drugs, President Ford, in April, called for a thorough appraisal of the nature and extent of drug abuse in America today. The President directed the Domestic Council, under the leadership of the Vice President, to undertake a priority review of the overall Federal effort in the prevention and treatment of drug abuse, to give him a frank assessment of our effectiveness, and to make recommendations concerning ways to make the Federal drug abuse program more effective in the future.

The specific objectives of the review were to:

- Assess the effectiveness of current drug programs and policies; and
- Determine if the Federal drug strategy, priorities and organizational structures are appropriate to meet current needs.

In addition, the review was to examine the need for, and structure of, a drug management and coordination mechanism in the Executive Office of the President.

To accomplish this mission, a task force, consisting of high-level representatives of twelve Federal departments and agencies having responsibilities in the drug abuse area, was created and charged with responsibility for preparing a comprehensive white paper on drug abuse which would be responsive to the President's concerns. As its first order of business, the task force established working groups to perform the analysis and to prepare initial drafts for its consideration. During the course of the review, more than 80 individuals from more than 20 different government organizations participated in work group activities. More than 30 other individuals, representing almost as many community organizations involved in the drug abuse area, also contributed valuable perspective and ideas.

The white paper does not attempt to evaluate each Federal drug agency or program in terms of its past performance or to compile a scorecard showing which agencies or programs produced the most impressive numbers of arrests, or seizures, or reformed addicts. It was the view of the task force that this type of statistical approach to evaluation is responsible, in large measure, for much of the ineffectiveness of our current efforts. Nor did the task force attempt to perform a management audit. Rather, the white paper seeks to review and assess the agencies and the programs in an operational context to see if they are rational (Do they make sense?), properly targeted (Are our objectives and priorities appropriate?), and reasonably structured to achieve their intended purposes (Can we expect them to accomplish what we created them to accomplish?).

The task force recognizes that, while this kind of analysis may not highlight where we have stumbled in the past, it will tell us where we should be headed in the future. The task force views the making of recommendations for improving the Federal drug program as its most important assignment.

Finally, the task force made every effort to reach unanimity on each recommendation, but this was not always possible given the widely disparate institutional and individual perspectives of its members. Accordingly, to provide the most useful document possible, the task force decided to work by consensus, identifying conflicts or differences of opinion where necessary. To ensure that all views were properly represented, however, members of the task force who did not share the majority view on any issue were invited to submit memoranda outlining points of disagreement. These memoranda are appended to, and made a part of, the white paper.

1. OVERVIEW:

A STRATEGY FOR CONTAINING DRUG ABUSE

The "drug problem" is not a recent phenomenon; the use of narcotics in the United States began prior to the Civil War. The fact that the earliest narcotics laws were passed over 60 years ago indicates that drugs have been a matter of national concern since the turn of the century.

Early efforts to deal with the problem focused on limiting the supply of drugs, first through taxation, then by prohibition and strict legal controls. The ever-increasing severity of Federal anti-narcotic laws reached a peak in the late-1950's with the passage of laws calling for life imprisonment and even death in certain cases.

The assumption behind this increasingly tough approach to the drug problem was that reducing the supply of illicit drugs would encourage drug-dependent individuals to detoxify and would keep drugs out of the hands of new users. Some did detoxify, but many did not, and the behavior and condition of those who did not detoxify continued to deteriorate. By the end of the 1950's there was general agreement that Federal policy was ineffective.

The belief that strict supply reduction by itself wasn't enough, coupled with the spread of drug use to new population groups, led to increasing experimentation with treatment for drug abusers during the 1960's. Finally, with the passage of the Drug Abuse Office and Treatment Act of 1972, Federal policy clearly called for a balanced response to the problem of drug abuse by adding a vigorous prevention and treatment component to the existing law enforcement efforts.

The Domestic Council Task Force on Drug Abuse strongly endorses the concept of a Federal program which balances the effort to control and, ultimately, reduce the supply of drugs with an effort to control and, ultimately, reduce the demand for drugs.[1] We believe

[1] The demand reduction program is intended to: (1) Dissuade the nonuser from experimenting with drugs; (2) deter the occasional user or experimenter from progressing to the abuse of drugs; (3) make treatment available for abusers of drugs who seek it; and (4) help the former abuser regain his place as a productive member of society.

that this concept should continue to be the cornerstone of the Federal strategy.

In addition to confirming the validity of this fundamental strategy, the past several years have taught us several lessons which are the basic themes upon which our specific recommendations are based.[2] This chapter discusses these basic themes, after first outlining the rationale for a balanced strategy.

NEED FOR A BALANCED PROGRAM

The fundamental objective of supply reduction efforts is to make drugs difficult to obtain, expensive, and risky to possess, sell or consume. The basic assumption is that if taking drugs is hazardous, inconvenient and expensive, fewer people will experiment with drugs, fewer who do experiment will advance to chronic, intensive use of drugs, and more of those who currently use drugs will abandon their use.

This assumption is well supported by historical evidence. Both in cases of individual drug use and in outbreaks of drug epidemics, the easy availability of the drugs themselves has been found to be a major factor. For example:

- Following the passage of the Harrison Act in 1914, which made opiates illegal for the first time, the number of opiate users in the United States was halved.
- An analysis of a Chicago heroin epidemic which began shortly after World War II, reached its peak in 1949, and declined in the early 1950's determined that: "The decline of this epidemic * * * (was) * * * most clearly associated with decreased quality and increased cost of heroin." [3]
- Immediately after World War II, an epidemic of amphetamine use swept Japan when this drug became readily available. A similar epidemic of amphetamine use occurred in Sweden in the early to mid-1960's. The Japanese experience is of particular interest because it developed in a country noted for low rates of alcoholism and other forms of excessive drug use.
- When relatively pure heroin at low cost became available to U.S. servicemen serving in Southeast Asia in 1970–71, use was

[2] These themes are in large part consistent with the basic findings of the National Commission on Marihuana and Drug Abuse, as well as those expressed in three issues of the *Federal Strategy for Drug Abuse and Drug Traffic Prevention* prepared by the Strategy Council on Drug Abuse. Thus, this white paper represents a gradual evolution of a consistent policy, rather than any abrupt departure.

[3] Hughes, Patrick H., et al. "The Natural History of a Heroin Epidemic," American Journal of Public Health, July, 1972.

widespread. When these same servicemen returned to the United States, where heroin is much more costly and much more hazardous to obtain, use dropped dramatically.

- During the period 1972–73, a shortage of heroin on the East Coast coincided with significant reductions in both the incidence and prevalence of heroin use on the East Coast.

Furthermore, most studies indicate that experimental users rarely search intensively to find drugs. In over 90 percent of the cases, they "happen on" drugs, or are introduced to drug use by a friend. This finding implies that if new users had to go beyond their normal contacts to find drugs, many would probably not use them.

In addition, several studies have shown that some people who began and enjoyed drug use, but eventually abandoned it, did so because drugs became expensive, inconvenient or dangerous to procure. A study of neophyte heroin users abandoned use in Los Angeles indicated that 55 percent did so because they lost their "connection." [4] Most did not make a concerted effort to establish a new connection The definitive survey of heroin users returning from Vietnam indicated that 60 percent of those abandoning use indicated inconvenience, cost, or fear of arrest and prosecution as reasons.[5]

Thus, successful supply reduction efforts can: (1) minimize the number of new users, (2) increase the number of old users who abandon use, and (3) decrease the consumption of current users.

These benefits are not attained without cost or limitations.

First, a supply reduction strategy is expensive. The Federal Government spends over $350 million on supply reduction efforts annually. Moreover, our efforts to encourage other countries to intensify their supply reduction efforts could in some instances have an effect on our bilateral relations.

Second, it is clear that there are significant adverse side effects of supply reduction efforts: young, casual users of drugs are stigmatized by arrest; the health of committed users is threatened by impure drugs; black markets are created and with them significant possibilities for corruption of public officials; and crime rates increase, as users attempt to meet the rising cost of scarce, illegal drugs.

Finally, no supply reduction effort can be completely effective. Even if we were willing to drastically restrict civil liberties—which we are not—or spend enormous sums on supply reduction efforts, some drugs would continue to flow into illicit markets. Further, supply reduction is not very effective in discouraging the casual illicit use of legitimate

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[4] Schasre, Robert, "Cessation Patterns Among Neophyte Users," International Journal of Addiction, Vol. I, No. 2, 1966.

[5] Robins, Lee, "The Vietnam Drug User Returns; Final Report," SAODAP, Sept., 1973.

drugs, since it is practically impossible to develop a system of controls that will prevent legitimate drugs from occasionally being available to illicit users.

Listing the costs and limitations of the supply reduction strategy is not meant to imply that supply reduction efforts are not justified; on the contrary, the task force believes that the effort to control availability through supply reduction should remain a central element of our strategy. But we must be mindful of the consequences of supply reduction efforts, so that we concentrate on ways of securing the benefits of supply reduction while ameliorating, to the extent possible, its adverse effects.

Balancing supply reduction efforts with complementary demand reduction efforts is one way to reduce the adverse costs of supply reduction, as well as being itself another avenue for reducing drug abuse. For example, the availability of treatment gives the drug user who finds drugs becoming scarce and expensive an alternative. The problems created for users by high prices, impure drugs, uncertain doses, arrests, and victimization by other drug users can be reduced by making a range of treatment easily available to users.

In fact, supply reduction and demand reduction are not only complementary in that one compensates for the limitations of the other, they are also interdependent, in that increases in the resources devoted to one activity will be most effective only if increased resources are simultaneously devoted to the other.

For example, reduced drug availability increases pressure on drug users to seek treatment. If law enforcement is intensified in a city, additional treatment capacity will be required to care for the increased number of addicts forced to seek treatment. A good illustration of this occurred during the East Coast heroin shortage of 1973, when the number of people seeking treatment grew by 42 percent.

Secondly, demand reduction efforts complement the limited but valuable prevention effects of supply reduction efforts. Programs to provide employment, counselling, and recreation may succeed in preventing experimentation with drugs among inner-city youth despite the difficulty of substantially decreasing the availability of drugs in those areas.

For many years, social and legal policy dichotomized drug use as either a "criminal" or "social" problem. The fact is that it is both at once, and that activities aimed at reducing supply (including law enforcement) and those aimed at reducing demand (prevention, treatment, and rehabilitation) are mutually supportive. Thus, a balanced program of supply and demand reduction should be the cornerstone of the Federal strategy to reduce drug abuse in America.

SUPPORTING THEMES

In addition to confirming the validity of the basic strategy of balancing mutually supportive supply reduction and demand reduction activities, the experiences of the past six years, in which the drug program has been a major priority of the Federal Government, have taught us important lessons. These lessons become general themes which underlie findings, conclusions, and recommendations contained in the chapters which follow. Together with the supply/demand balance, these themes form the basis for the comprehensive Federal strategy to combat drug abuse. They are:

1. *We must be realistic about what can be achieved and what the appropriate Federal role is in the war against drugs.* We should stop raising unrealistic expectations of total elimination of drug abuse from our society. At the same time, we should in no way signal tacit acceptance of drug abuse or a lessened commitment to continue aggressive efforts aimed at eliminating it entirely. The sobering fact is that some members of any society will seek escape from the stresses of life through drug use. Prevention, education, treatment, and rehabilitation will curtail their number, but will not eliminate drug use entirely. As long as there is demand, criminal drug traffickers will make some supply available, provided that the potential profits outweigh the risks of detection and punishment. Vigorous supply reduction efforts will reduce, but not eliminate, supply. And reduction in the supply of one drug may only cause abuse-prone individuals to turn to another substance.

   All of this indicates that, regrettably, we probably will always have a drug problem of some proportion. Therefore we must be prepared to continue our efforts and our commitment indefinitely, in order to contain the problem at a minimal level, and in order to minimize the adverse social costs of drug abuse.

   We must develop better measures of program progress than the "addict counts" or gross seizure and arrest statistics which have been used in the past, and we must educate the public to shift its focus to the more relevant trend, availability, and quality arrest data which are available.

   Further, we must be realistic about what the Federal Government can and cannot accomplish in this area. It *can* play a major role in limiting supplies of drugs, in maintaining a widespread treatment capacity, and in providing technical assistance, research, demonstration, and evaluation. It *can* take the lead in enlisting the cooperation of other nations of

the world in suppressing the production of illicit drugs. It *can* provide leadership in our domestic effort to reduce the levels of drug abuse, particularly if our national leaders clearly articulate their commitment to this effort.

We must recognize, however, that the Federal Government *cannot* single-handedly eliminate drug abuse or its effects on our society. Only through the combined efforts of the Federal, State and local governments, private individuals and businesses, and a variety of local organizations, working together, can we hope to ultimately succeed in this vital undertaking.

2. *Not all drug use is equally destructive, and we should give priority in our treatment and enforcement efforts to those drugs which pose the greater risk, as well as to compulsive users of drugs of any kind.* At any given level of consumption, different drugs pose different threats to the behavior and condition of users. Further, at high levels of consumption—particularly with intravenous injection—the effects are vastly increased. Public policy should be most concerned with those drugs which have the highest social cost.

   This does not suggest devoting *all* resources to the highest priority drugs, and *none* to lower priority drugs. All drugs are dangerous in varying degrees and should receive attention. But where resource constraints force a choice, those drugs with the potential for causing the highest social cost should be given priority.

3. *Supply reduction is broader than law enforcement and we should utilize a variety of supply reduction tools.* Federal supply reduction efforts should be targeted at all aspects of illicit production (or diversion from licit production) and distribution of drugs. The activities involved range from crop substitution and economic development to interdiction of illicit shipments and the removal of important traffickers from the supply system through long prison terms. More effective regulation and monitoring of the legitimate production and distribution of drugs such as amphetamines and barbiturates, which are also abused or used illicitly, is one reduction tool which should receive greater attention than it does now.

   Undertaking a comprehensive supply reduction program requires the cooperation of many foreign nations and the active participation of numerous Federal, State and local agencies. Full utilization of all resources should be encouraged, and closer cooperation fostered to ensure that all are contributing optimally to the overall supply reduction effort.

4. *Federal law enforcement efforts should focus on the development of major conspiracy cases against the leaders of high-level trafficking net-works, and should move away from "street-level" activities.* The most effective way to control and reduce supply is to immobilize large trafficking networks through the prosecution and conviction of their leaders. Since the leaders of trafficking organizations normally insulate themselves from overt illegal acts by delegating these acts to subordinates, conspiracy cases often are the only effective means for the law to reach them.

   To optimize the development of conspiracy cases, (1) higher priority should be placed on developing and analyzing operational intelligence, (2) the percentage of Federal agent time spent on "street-level" activities should decline, and (3) cooperation with border interdiction forces and with State and local police forces must be improved. This last item, improving cooperation with border interdiction and local police forces, is also important to insure that other vital law enforcement efforts continue to be adequately performed.
5. *The current treatment focus of demand reduction efforts should be supplemented with increased attention to prevention and vocational rehabilitation.* The bulk of Federal resources and attention have gone for treatment since the drug program was elevated to a high priority. In light of the acute need which existed at that time, this focus was clearly necessary.

   Yet, treatment is a response to a problem which has already developed. Given the difficulties of successful treatment, it is obvious that effective programs which prevent the problem before it develops are highly desirable. Similarly, vocational rehabilitation during and after treatment which enhances the probability that a former abuser will not return to drug use should be given priority. The task force believes both these areas should be important parts of the overall demand reduction program.
6. *Neither successful prevention or successful rehabilitation is drug specific; both should be closely integrated with other social programs.* The successful prevention models which exist have not been drug specific. That is, they have dealt with the broad range of adolescent problem behavior—drug use, alcoholism, truancy, and juvenile delinquency. Further, the more successful programs have been tailored to the specific problems and resources of a local community. Thus, prevention should be centered in broad range, community-based programs. The Federal role should be catalytic in nature, providing technical assistance, training, and limited seed money.

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Rehabilitation is a critical step in returning a drug user to a productive life. Individuals need help in developing or recovering skills which enable them to support themselves. Some need basic schooling, vocational counselling, and skills training; some need a form of supported work; and still others simply need a job. All of these services are provided by existing community manpower services; we must be sure that they are available to former drug users and stabilized patients in treatment.

In addition to these six programmatic themes, there are four themes related to effective management of the drug program at the Federal level which are woven into the task force's recommendations.

1. *Cabinet management should be strengthened, and direct White House involvement should be restricted.* A central theme of this Administration is that program management is properly a function of the Cabinet departments, and White House involvement should be restricted to participating in major policy decisions, maintaining oversight to ensure that the President's policies and directives are being effectively implemented, and assisting in interagency coordination.

   This theme meets the current needs of the drug program. During the past several years, a great deal of direct White House involvement was required to get the major drug agencies launched and to ensure that the Federal Government's commitment to the drug program was implemented. Now that these agencies have been in existence for several years, they are capable of assuming greater responsibility for program management and coordination.

2. *We must more effectively mobilize and utilize all the resources available in the Federal Government, State and local governments, and the private community.* While the task force endorses the "lead agency" concept, we believe that opportunities exist to more fully utilize the resources of the U.S. Customs Service and the FBI within an integrated Federal law enforcement program, and to utilize vocational rehabilitation services available in the Department of Labor as part of a comprehensive demand reduction program. Further, the Federal Government should take the lead in mobilizing the enormous potential resources available in State and local law enforcement agencies, and in State, local, and private prevention, treatment, and rehabilitation services. Only through full utilization of all available resources, and close cooperation among all involved agencies, can we hope to reduce the extent of drug abuse in America.

3. *There is a significant need to improve the efficiency and effectiveness with which the drug program is managed.* During the period of rapid growth in the drug program, there was little time for addressing management issues; rather, the focus was to launch a large drug program as rapidly as possible. Now that the program (and new agencies) have matured, it is time to consolidate the gains that have been made and to strengthen program management.

   Improvement is necessary in three areas:

   - Effectiveness of management within agencies.
   - Coordination between and among agencies.
   - Evaluation and follow-up of program and research results to determine their impact in reducing drug abuse in the United States.

4. *Significant progress can be made without requiring the commitment of substantial additional resources.* This is really the net result of implementing the preceding strategies and themes. In summary, a great deal of progress can be made in both supply and demand reduction efforts through better utilization and targeting of existing resources.

* * * * * * *

Before discussing specific recommendations for improving supply and demand reduction efforts, Chapter 2 examines the nature and extent of the drug problem in an effort to establish an understanding of the task which faces the Nation. Chapters 3 and 4 discuss the task force's evaluation of supply and demand reduction efforts, respectively, and present specific recommendations for improvement. Chapter 5 pulls the program together by discussing overall program management. The major conclusions and recommendations are summarized in Chapter 6.

2. ASSESSMENT OF THE CURRENT SITUATION

The cost of drug abuse to the nation is staggering. Counting narcotic-related crime, addicts' lost productivity, and treatment and prevention programs as major items, estimates range from a conservative $10 billion upwards to $17 billion a year; and there is no calculating the social toll in terms of lives ruined and homes broken. This chapter attempts to put this problem in perspective by discussing the current situation in detail. Then it draws on this assessment to make recommendations concerning Federal priorities.

The terms "drug abuse" and "drug problem" mean different things to different people. For the purposes of this assessment, "drug abuse" is defined as non-medical use of any drug in such a way that it adversely affects some aspect of the user's life; i.e., by inducing or contributing to criminal behavior, by leading to poor health, economic dependence, or incompetence in discharging family responsibilities, or by creating some other undesirable condition. Using this definition, the "drug problem" is the total effect on society of these adverse effects of non-medical use of drugs, not only the physical effects of drugs on the individuals using them.

Because we are unable to accurately measure the adverse effects of drug use, we frequently use the number of users as an indicator of the magnitude of the drug problem. In using estimates of the total number of users as a measure of the problem, we must keep several factors in mind:

1. *The magnitude of the drug abuse problem is related to the particular drug being used.* At any given level of consumption, different drugs pose radically different threats to the behavior and condition of users.
2. *The magnitude of the drug abuse problem is related to the frequency and quantity of consumption (or "use pattern").* At high levels of consumption—particularly with intravenous administration—the user's behavior and physical condition may deteriorate rapidly. For this user, a reduction in drug consumption is likely to significantly alter behavior and therefore impact on the drug problem.

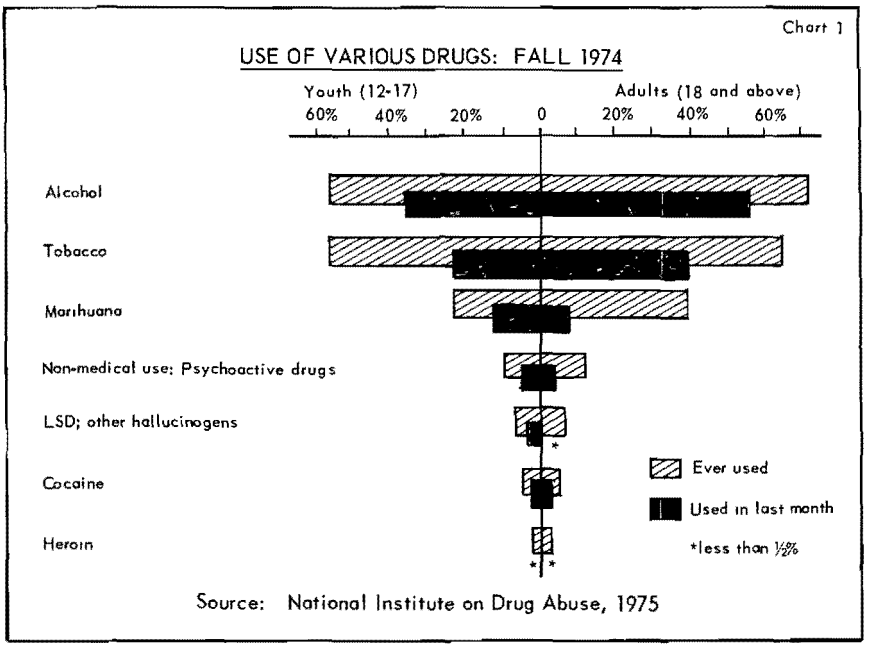
   On the other hand, at low levels of use, drugs are probable not particularly important in a user's daily life, so reducing his already low consumption is unlikely to have much impact on behavior or health. Thus, the largest portion of the drug

abuse problem (and the portion where efforts at reduction should be focused) is created by chronic, intensive users of drugs.

3. *These factors are interrelated.* The likelihood of advancing to chronic, intensive levels of consumption differs from drug to drug and from individual to individual. Users of dependence-producing drugs such as heroin are more likely to advance to high levels of use than are users of non-dependence-producing drugs such as marihuana.

Thus, in using estimates of numbers of drug users as an indicator of the drug abuse problem, it is important to distinguish among drugs being used, to recognize the variation of use patterns, and to predict how use patterns will change over time. These factors, much more than the absolute number of users, determine the magnitude of the drug abuse problem.

Chart 1 shows the results of the most recent national statistical sample of drug use taken in the Fall of 1974. It shows that a majority of both adults and youth have used alcohol and tobacco,[1] and that exposure to marihuana and non-medical use of so-called "dangerous



[1] See note concerning alcohol and nicotine on opposite page.

drugs" [2] is widespread. The dark bands show recent use and, because the adverse effects of drug use are associated with frequent, habitual use, are a better measure of the drug problem.

NOTE CONCERNING ALCOHOL AND NICOTINE

Although alcohol and nicotine are the two most widely used drugs in the United States today, and are clearly psychoactive or mood-altering substances, their use and its consequences are not a central theme in this study. The task force excluded them from extensive consideration because public and social policy regarding these drugs is significantly different than that regarding the other drugs being discussed. Alcohol and nicotine are legally obtainable and socially acceptable drugs; with a few exceptions, the drugs considered in this report are not.

Clearly, alcohol and nicotine are bonafide substances of abuse whose use often create significant adverse social costs and consequences. As such, they should be dealt with along with other substances of abuse. The task force recognizes this interrelationship and encourages efforts to integrate all elements of substance abuse into broader health care programs, as is now being done in the Veterans Administration.

However, it must be remembered that the development of a discrete drug abuse health care delivery system was necessary because existing systems did not respond to the need of the hard-core narcotic addict and other chronic drug abusers. In part, this was due to a reluctance—not evident in the area of alcohol treatment of existing treatment units to treat what was considered to be a less desirable population of drug abusers.

Consequently, unlike alcohol, which has a greater historical basis of support and integration within community health care delivery systems, and which receives the vast majority of its financial support from non-Federal sources, other drugs of abuse required Federal intervention to provide needed treatment and prevention services. The Federal Government has taken a direct lead in the development and support of drug abuse prevention and treatment services which should ultimately be effectively and fully integrated into other community health systems. The task force supports those activities which are designed to better integrate the various programs developed to respond to the problems of substance abuse.

In this chapter, each of the principal illicit drugs is discussed in turn, with a summary of historical trends in use, availability, and supply, followed by a description of the current situation. Finally, the concluding section of this chapter examines the overall social cost of each drug, and recommends a priority for Federal efforts.

[2] The term "dangerous drugs" is commonly used to refer to the non-medical use of prescription or over-the-counter tranquilizers, barbiturates, and amphetamines and other stimulants.

A — PRINCIPAL DRUGS OF ABUSE

While it is convenient for the purposes of discussion to consider each of the drugs of abuse separately, in practice, these drugs are often used in combination. Even some heroin addicts do not use heroin exclusively. This multiple drug use occurs for a variety of reasons: beginning users often experiment with a variety of drugs singly and together in quest of novel experiences; experienced drug users sometimes use combinations of drugs for the more intense combined effect; and sometimes one drug is substituted for another which is unavailable.

These complicated patterns of drug use make it difficult to estimate the true scope of the drug problem. For example, estimates of the number of current abusers of different drugs are not necessarily additive, since a single individual may be counted in several groups.

Multiple drug abuse is not discussed in detail here because little reliable information is available about the combined effect of various drugs; however, research is in progress, as the matter is one of increasing Federal concern.

HEROIN

Heroin. The name itself evokes fear in most of us, and many consider heroin to be the drug problem. Most of the Federal effort in the drug abuse field has been directed at it. The concern is well founded; heroin is a very serious drug of abuse. But despite the attention it has received (and perhaps because of it) heroin remains one of the most misunderstood drugs and continues to be surrounded by many myths. Hopefully, this chapter will help dispel some of the myths and place the problem in its proper perspective.

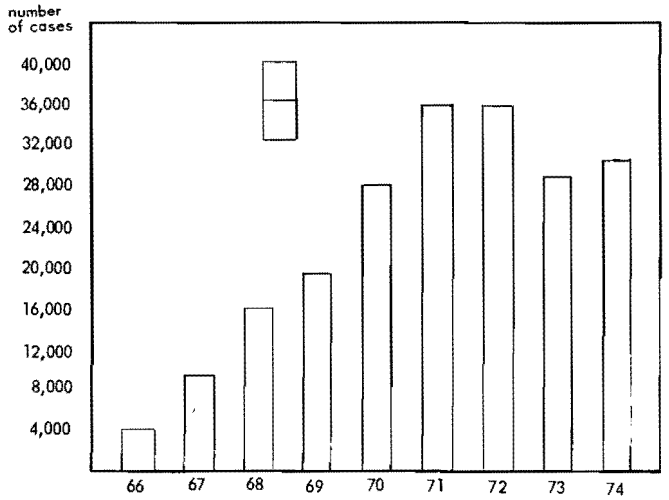
Historical Trends

In 1965, an epidemic of heroin use began in the United States. New use (or incidence) increased by a factor of 10 in less than seven years.[3] Both hepatitis data—important as an indicator because of the high rate of hepatitis among heroin users—and incidence data obtained from clients in treatment demonstrate this phenomenon (see charts 2 and 3).

[3] *Incidence* refers to the number of new users during a stated period of time; *Prevalence* refers to the total number of users at a particular point in time.

Chart 2

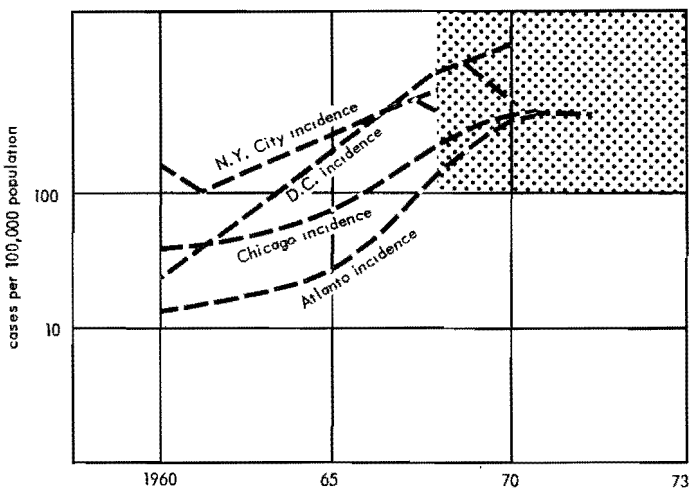
NARCOTIC RELATED HEPATITIS CASES



Source: Center for Disease Control, 1975

Chart 3

ESTIMATED INCIDENCES OF HEROIN USE



Source: National Institute on Drug Abuse, 1974

This widespread epidemic was composed of several smaller ones linked by a diffusion process which was surprisingly fast. The epidemic began among minority populations living in metropolitan areas on both coasts (e.g., New York City, Washington, D.C., Los Angeles, San Francisco). It spread quickly to other populations living in those same metropolitan areas, and then to other large metropolitan areas (e.g., Detroit, Boston, Miami, Phoenix). By about 1970, heroin use had begun to appear in smaller cities in the United States. Chart 4 shows the incidence of narcotic-related hepatitis among blacks and whites, and among men and women.

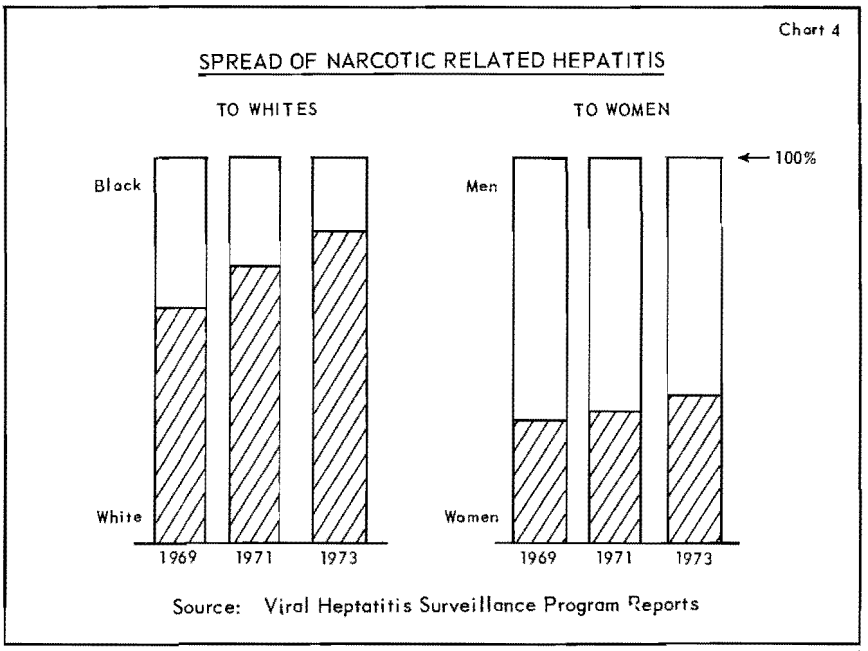


Chart 5 shows the spread of heroin use to new metropolitan areas derived from DAWN emergency room visits.[4]

[4] *Drug Abuse Warning Network* (DAWN), a data acquisition system which routinely collects information from emergency rooms, medical examiners' offices, and crisis centers indicating trends in drug abuse.

Chart 5

"AGE" OF HEROIN PROBLEM IN MAJOR CITIES

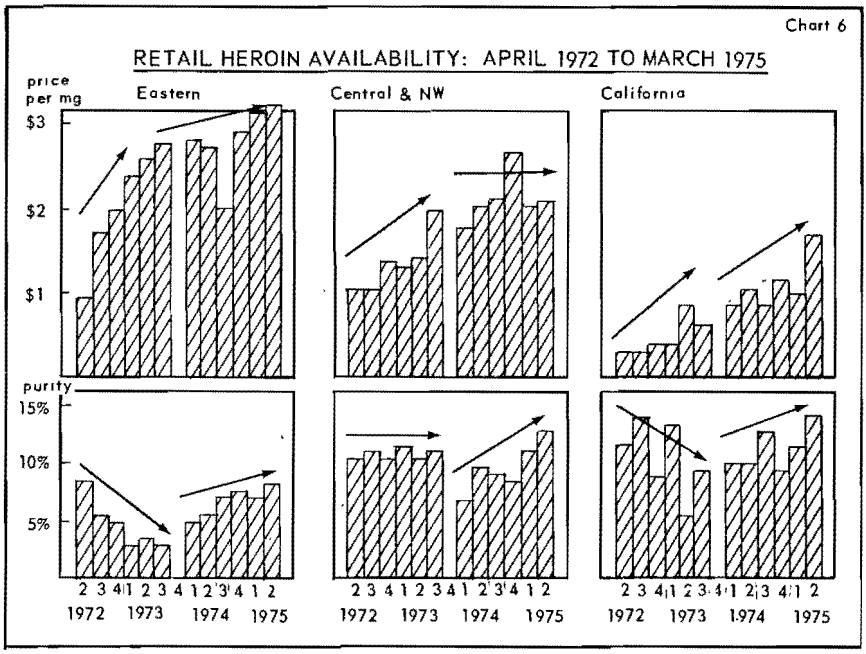
	% first Heroin use 1970-74
Los Angeles	27%
New York	33
Detroit	53
Boston	59
Minneapolis	60
Miami	75
Phoenix	75

Source: Derived from DAWN data

This sudden upsurge in heroin use sparked an intensified effort by the Federal Government to reduce the supply of heroin and to seek new methods of treating heroin addicts. In 1972, as a result of this effort, the upswing in incidence and prevalence of heroin use was interrupted, and there was a subsequent decline throughout 1973.

There are at least two interdependent factors which contributed to this decline in the magnitude of the heroin problem.

- The availability of a nationwide system of drug abuse treatment and rehabilitation services provided addicts with an alternative to street life and an opportunity to return to a more productive role in society.
- Law enforcement officials at all levels of government put unprecedented pressure on the distribution system. It became much more difficult, if not impossible, for an individual to secure drugs, and those which were available were of low purity. Central to the reduction in the supply of heroin was a combination of the Turkish opium ban, aggressive enforcement by the police of several European countries (particularly France) and several significant international conspiracy cases made by Federal enforcement agencies. These combined efforts produced a shortage of heroin on the East Coast, which was reflected in higher street prices and lower purity (see Chart 6).



The effects of these efforts were clear. In the cities on the East Coast where an estimated half of the users lived, heroin use declined significantly.

In Washington, D.C., for example, both incidence and prevalence declined significantly.[5] The decline in the number of new users was shown through dramatically reduced numbers of clients with a recent onset of heroin use coming into treatment. The decline in the total number of users was reflected in declining heroin overdose deaths and diminishing rates of detection of heroin among arrestees.

During the period of the East Coast heroin shortage, Mexico emerged as a major source country. Mexico's share of the U.S. illicit heroin market (measured by heroin removals from the U.S. market resulting either from seizures or undercover purchases) increased from about one-third to about three-fourths between 1972 and 1974.

[5] While it is sometimes misleading to use single cities as indicators of general trends in drug use, the experience of Washington, D.C., during this period of shortage illustrates developments in other East Coast cities, where a similar, but less dramatic, pattern existed.

At the same time, the share supplied by the French-Turkish connection fell from slightly more than half to less than 10 percent, as shown in the following table:

APPROXIMATE SHARE OF U.S. HEROIN MARKET

[In percent]

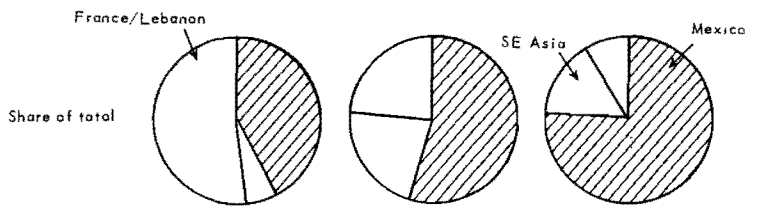
	1972	1973	1974
France/Lebanon—Certain 43 Probable 10	53	18	9
Southeast Asia	7	17	12
Mexico	38	63	77
Unknown	2	2	1

Note.—Estimates based on the Drug Enforcement Administration's Heroin Signature Program.

Mexico assumed this major importance not solely because traffickers operating in Mexico expanded their supply capabilities, but because other sources had disappeared and the total market had declined. In effect, Mexico became a large component of a reduced national market. By 1974, Mexico's supply capabilities had increased to a point where it was offsetting some of the reduced supply from France and Turkey. Thus, the task force estimates that the total supply available in 1974 was higher than in 1973, but still lower than in 1972.

Chart 7

SOURCES OF HEROIN



Source: DEA Signature Program

Current Situation

While data for 1975 are not as clear as the historical data, we can discuss several important features of the current situation.

1. There are several hundred thousand daily chronic users of heroin not currently in treatment.[6] These chronic users represent only a small percentage of those who have ever used heroin.
2. Incidence and prevalence of heroin use remain high on the West Coast and Southwest Border, areas which were not affected by the East Coast heroin shortage.
3. The East Coast heroin shortage appears to have leveled off and heroin is becoming more available. After increasing threefold over the period from June 1972 to March 1974, the price of heroin on the East Coast has remained steady. The rise in purity throughout 1974 combined with steady prices indicates increasing availability.
4. A number of cities which showed a decline in heroin use in 1972–1973 are now reporting an increase in prevalence based on rising numbers of heroin-related emergency room visits and heroin-related overdose deaths. These cities are also experiencing rising heroin purity. All these factors indicate a deteriorating situation.
5. A number of serious threats to supply reduction efforts exist which could, if left unchecked, increase the street availability of heroin. Illicit supplies from Mexico continue to pose a serious problem despite the commendable efforts of the Mexican Government. Illicit production in Southeast Asia remains the highest in the world, and the fact that new trafficking routes have been established to Northern European cities is worrisome. While it appears that Turkey is effectively controlling its current poppy crop, if such control diminishes the amount of heroin reaching the United States could increase.

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[6] The task force debated including a more precise estimate, but concluded that any number used would be imprecise, highly influenced by the estimating methodology, and subject to misinterpretation if compared to other estimates based on different methodologies. The simple fact is that it is neither possible nor particularly relevant to make a specific estimate of the number of addicts: not possible because of the imprecision of available estimating methodologies and the difficulty of defining precisely who is an addict; and not relevant because other data—trends in availability as measured by price and purity, patients in and waiting for treatment, drug related deaths, hepatitis cases, etc.—are better measures of whether things are getting better or worse. All of these measures indicate that significant improvement was made all through late 1972 and 1973, and that conditions have been gradually worsening since early 1974. While they have not yet returned to the levels of 1972, the trend is definitely upward.

6. The demand for treatment continues to grow and is geographically dispersed. Whether this growth in treatment demand is the result of an increasing pool of users, of users recycling back into treatment or the result of more effective outreach efforts by treatment agencies is not altogether clear. It is likely, however, that an increasing pool of users is responsible for at least some of the growth in demand for treatment.

These signs, taken together, are ominous. They indicate not only that the work of 1972–1974 is uncompleted, but that some of the significant gains that were achieved during this period have been lost and that new losses may accumulate unless our efforts in supply and demand reduction are intensified.

BARBITURATES, TRANQUILIZERS AND AMPHETAMINES

The various "dangerous drugs" present a special problem, for, unlike heroin, cocaine, and marihuana—which are totally illegal—these categories of drugs are frequently prescribed by doctors for valid medical purposes. The existence of this legal market vastly complicates control problems and, as a consequence, procurement in the illicit market has tended to be easy and inexpensive.

Historical Trends

At present, we are unable to track trends in the use and sources of these "dangerous drugs" as well as we can for heroin. However, it is clear that their use has increased rapidly in the United States during the last decade. Two different trends have led to this growth:

1. *These drugs are being prescribed more frequently and used more often in the general population.* Currently, about 25 percent of adult Americans have used one or more stimulants, sedatives or tranquilizers during the last year. Most of this use is under medical direction and controlled by prescription. But uncontrolled non-medical use of these drugs has grown sharply during this period of increasing usage. Currently, active non-medical use of these drugs is estimated to be 5 percent among the adult population, or 7 to 8 million Americans.
2. *Nonmedical use of prescription drugs has become widespread among youth (especially students)*, a trend which roughly duplicates the recent history of wholly illegal drugs. Not only are common substances such as amphetamines and barbiturates widely abused, but there has been a continuing stream of "fad" drugs. Since 1972, this unsupervised use by young people has apparently leveled off.

Both trends are apparent in a series of surveys of different portions of the population as shown in Chart 8.

Chart 8

TRENDS IN THE USE OF DANGEROUS DRUGS

BARBITURATES – SEDATIVES EVER USED	1968	1969	1970	1971	1972	1973	1974
National Sample of Adults	—	—	—	—	4%	—	4%
National Sample of Youths	—	—	—	—	3%	—	5%
Regional Sample of High School Graduates	—	—	16%	18%	15%	15%	14%
National Sample of High School Graduates	—	6%	9%	—	—	—	19%
BARBITURATES – SEDATIVES WITHIN LAST YEAR	**1968**	**1969**	**1970**	**1971**	**1972**	**1973**	**1974**
National Sample of Adults	—	—	—	—	—	—	1%
National Sample of Youths	—	—	—	—	—	—	3%
Regional Sample of High School Graduates	—	—	5%	6%	5%	5%	4%
National Sample of High School Graduates	—	3%	4%	—	—	—	6%
AMPHETAMINES – STIMULANTS EVER USED	**1968**	**1969**	**1970**	**1971**	**1972**	**1973**	**1974**
National Sample of Adults	—	—	—	—	5%	—	6%
National Sample of Youths	—	—	—	—	4%	—	5%
Regional Sample of High School Graduates	16%	20%	20%	23%	24%	20%	19%
National Sample of High School Graduates	—	9%	15%	—	—	—	32%
AMPHETAMINES – STIMULANTS WITHIN LAST YEAR	**1968**	**1969**	**1970**	**1971**	**1972**	**1973**	**1974**
National Sample of Adults	—	—	—	—	—	—	2%
National Sample of Youths	—	—	—	—	—	—	3%
Regional Sample of High School Graduates	6%	8%	7%	9%	10%	8%	7%
National Sample of High School Graduates	—	9%	13%	—	—	—	21%

These drugs are much more readily available in the illicit market than are wholly illicit drugs such as cocaine and heroin. This ready availability is reflected in the relatively low cost of a day-long "binge" with tranquilizers and amphetamines: less than $10, compared with $50–$100 per day for heroin or cocaine. The individual and social cost of dangerous drug abuse is, however, as high as that of almost any other abused substance.

There are three important sources of "dangerous drugs": (1) Diversion from legitimate domestic production and distribution; (2) illicit domestic production; and (3) illicit foreign production and smuggling.

It is possible to estimate the share of the illicit market from each source by looking for tell-tale "signatures" on seizures and undercover purchases made by law enforcement officials. (Signatures can be as complicated as a trace chemical due to faulty processing or as simple as a letter stamped on each tablet.) While these signatures are somewhat less developed than are the signatures for heroin, the estimating procedure provides the best available indicator of the relative market share of the various sources of "dangerous drugs."

Barbiturates are primarily a diversion problem, methamphetamines are primarily a problem of illicit production, and amphetamines are obtained from both sources.[7] The share of the illicit market for

[7] Chart 13 in chapter 3 illustrates relative market shares.

methamphetamines diverted from legitimate sources has decreased dramatically, and the share for amphetamines has decreased somewhat, both declines reflecting significant quota tightening by the Drug Enforcement Administration (DEA) under the Controlled Substances Act. At the same time, the share from legitimate sources for barbiturates has remained roughly constant.

Current Situation

Based on the survey data summarized in Chart 8, we can make the following general statements about the use of these drugs:

First, chronic, intensive, medically unsupervised use of amphetamines and barbiturates probably ranks with heroin use as a major social problem. Even if we restrict our attention to users "in trouble"—meaning those who regularly use a number of these drugs for non-medical purposes—a large group is involved.

Chart 9 illustrates how this estimate of users "in trouble" is derived. Assuming a substantial overlap among drugs, this chart shows that there are still more than one-half million regular, medically unsupervised users of different "dangerous drugs."

Chart 9

REGULAR USE OF DANGEROUS DRUGS

% of Population aged 14 or over

	Ever Used	Regular Use	Regular Non-Medical Use	Regular Non-Medical Multiple Drugs	Number of Users in trouble
Sedatives	5.7%	2.3%	0.3%	0.2%	270,000 300,000
Stimulants	3.1	1.8	0.7%	0.3	400,000 490,000
Tranquilizers	9.1	4.9	1.6%	0.3	400,000 490,000

Second, the problem could easily get worse. Serious individual and social consequences from drug use occur primarily among chronic, intensive users. Until recently, only a small fraction of all users of these drugs fell into this category.

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However, the probability of moving to a chronic, intensive use pattern is related to the age at which one began using drugs, as well as the number of different drugs used and the length of time since first use. We know that a large number of people: (1) Began using drugs in the early 1970's in their mid-teens; and (2) have used many different drugs. If many in this group follow the traditional pattern of falling into chronic use around age 20, the number of "in trouble" users of dangerous drugs will increase substantially.

COCAINE

Cocaine, though available for many years, is the new "in" drug, and the various implements and rituals associated with the use of cocaine have recently become subject to extensive commercial exploitation.

Historical Trends

Except for use in several highly publicized "in-groups" (e.g., musicians), cocaine use in this country was apparently insignificant as late as the early 1960's. Since then, however, use has increased rapidly, a trend which has received a great deal of attention in the press.

The increasing popularity of cocaine is reflected in law enforcement data. Since 1970, there has been a steady upward trend in the amount of cocaine seized en route to the United States from South America. DEA seizures and undercover purchases of cocaine have increased steadily in the last five years, both in the United States and internationally. Cocaine arrests by State and Federal agents have also risen sharply.

Virtually all of the cocaine entering the United States comes from South America and principally from Colombia, where the refining process is completed.[8]

Current Situation

Chart 1 showed that 4 percent of youths and 3 percent of adults have used cocaine at least once, and that 1 percent of each group used it in the month prior to the survey.

Rates of cocaine use vary greatly among specific groups within the general population. In a national survey conducted in 1972, 1.2 percent of junior high school students, 2.6 percent of senior high school students, and 10.4 percent of college students reported experience with cocaine. Almost half of those youths reported that their first use occurred recently—that is, during the previous twelve months.

[8] The finished cocaine is smuggled from Colombia into the United States by a variety of routes; direct, through Mexico, through the Caribbean, and even through Europe or Canada.

Additional studies indicate that as many as 16 percent of male high school graduates followed in a national sample had used cocaine at some time during the five years following graduation. There are other subpopulations in which use of cocaine is also high.

The data indicate that cocaine is used for the most part on an occasional basis (several times a month or less); usually in the company of others; and is likely to be taken in combination with alcohol, marihuana, or some other drug. Cocaine is not physically addictive.

About one percent of patients admitted to Federally funded treatment facilities reported cocaine as their primary drug of abuse; an additional 12 to 13 percent reported that they used cocaine in association with other drugs, mainly heroin. Thus, the data obtained from treatment programs and surveys generally reflect the fact that cocaine, as currently used, usually does not result in serious social consequences such as crime, hospital emergency room admissions, or death.[9] The implications of this conclusion are discussed later in this chapter.

In summary, although the rate of increase of first use of cocaine is alarming, significantly less is known about cocaine use in the United States than about the other drugs described in this assessment.

MARIHUANA[10]

Marihuana is the most widely used illicit drug, with an estimated 20 percent of Americans above the age of 11—25 to 30 million people—

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[9] The phrase "as currently used" is important. The effects of cocaine if used intensively—particularly if injected—are not well known, but recent laboratory studies with primates, as well as reports of the effects of chronic cocaine injection during the early 1900's suggest that violent and erratic behavior may result. For this reason, the apparently low current social cost must be viewed with caution; the social cost could be considerably higher if chronic use began to develop.

[10] A great deal of controversy exists about marihuana policy. On the one hand, recent research indicates that marihuana is far from harmless, and that chronic use can produce adverse psychological and physiological effects. Therefore, its use should be strongly discouraged as a matter of national policy.

However, in light of the widespread recreational use—and the relatively low social cost associated with this type of use—the Federal Government has been deemphasizing simple possession and use of marihuana in its law enforcement efforts for several years. For example, very few persons are arrested by Federal agents for simple possession and use; those who are charged with this offense normally are also being charged with some other, more serious offense as well. However, vigorous law enforcement aimed at major *traffickers* has been and should continue to be undertaken at the Federal level.

The task force endorses this moderate view and expects the lower priority that has been established for marihuana will also be reflected in our demand reduction efforts by the elimination of many non-compulsive marihuana users now in our treatment system.

having used it at least once. In short, marihuana has joined alcohol and tobacco as one of the most widely used drugs in the United States.

Historical Trends

National attention first focused on marihuana following reports of widespread use during the mid-1930's. Discussion culminated in legislation which imposed Federal criminal sanctions against both the distribution and use of marihuana. Although proscribed by Federal law, the use of marihuana continued during the ensuing years, but at relatively low levels. Marihuana use was most common among urban minority groups and Mexican-American workers in the Southwest during this period.

A significant increase in the use of marihuana began to occur during the mid-1960's when its use became associated with artistic and anti-establishment life-styles; use then rapidly spread across geographic, demographic, and social boundaries.

The sources of supply have traditionally been Mexico, the Caribbean and South America. They remain so today.[11]

Current Situation

Rates of marihuana use have been rising steadily over recent years as shown in chart 10.

Chart 10

TRENDS IN THE USE OF MARIHUANA

EVER USED

	1968	1969	1970	1971	1972	1973	1974
National Sample of Adults	—	—	—	15%	16%	—	19%
National Sample of Youths	—	—	—	14%	14%	—	23%
Regional Sample of High School Graduates	32%	40%	43%	50%	51%	55%	—
National Sample of High School Graduates	—	20%	35%	—	—	—	62%

CURRENTLY USED

	1968	1969	1970	1971	1972	1973	1974
National Sample of Adults	—	—	—	5%	8%	—	7%
National Sample of Youths	—	—	—	6%	7%	—	12%
Regional Sample of High School Graduates	18%	25%	25%	33%	35%	36%	38%
National Sample High School Graduates	—	6%	9%	—	—	—	21%

[11] In addition, there is an unknown but presumed small amount of domestic growth.

Current estimates suggest that up to 20 percent of the general population over the age of 11 has used marihuana at least once, and that use is encountered in nearly all population groups. Over 40 percent of those who have ever used marihuana are current users, and at least half of the current users use it at least once a week.

Rates of use may be considerably higher or considerably lower, depending on the segment of the population under study. The highest rates of use have been reported among so-called "hippies" and high school dropouts. There appears to be a slight preponderance of males among marihuana users, although this distribution varies considerably from study to study. Other findings which occur consistently include the following:

- Urban residents use at higher rates than rural residents;
- Use is greater among those with higher levels of education and income;
- Use is more frequent in the northeastern and western United States than in other regions.

A recent development which is cause for great concern is the increasing availability of the much more potent marihuana derivations—hashish, and other preparations of high THC (tetrahydrocannabinol) content. Unlike common forms of marihuana, these potent drugs are known to have serious physical and social effects on the user.

DAWN provides some interesting data on various drug crises attributed to marihuana. During the nine months between July 1973 and March 1974, marihuana comprised only one percent of all emergency room drug mentions, but 51 percent of all crisis center drug mentions. This distribution of mentions by facility type reflects the kind of acute psychological problems likely to occur in association with the use of marihuana, with panic reactions or "bad trips" predominating over the more life-threatening reactions which would lead to appearance in an emergency room.

From a treatment point of view, data show that approximately 17 percent of patients admitted to Federally funded drug treatment programs from January to April 1975, reported marihuana as their primary drug of abuse.[12] There is considerable controversy regarding the interpretation of these data for a number of reasons. The frequency of use reported by these "primary marihuana abusers" is less than once a week for nearly 45 percent of the patients. It seems clear that these people do not have a serious drug problem and should not be in treatment. Most likely, they were referred to treatment by the criminal justice system, by schools, or by parents who were concerned about

[12] This includes NIDA, VA, and DOD. When NIDA is viewed alone, the marihuana figure is 21 percent.

the marihuana use. But when treatment facilities are full, this is a poor utilization of resources and these occasional marihuana users should not be occupying treatment slots. (Chapter 4 will develop this concept further.)

OTHER DRUGS

In addition to these four major categories of drugs, Americans abuse a variety of other substances.

Hallucinogens [13]

Except for the use of peyote in the religious ceremonies of some American Indian tribes, the use of hallucinogens is a recent development in the United States.

Limited, nonmedical use of LSD began in California in the 1950's, but was greatly accelerated in the early 1960's as publicity associated with its use grew. In the early 1960's this drug was diverted from legitimate research sources, but by 1964 illegal manufacture of LSD was established. Today, virtually all LSD in the United States is produced illicitly and, because only very small amounts are needed to produce an effect, it is easily concealed.

Hallucinogen use is very different from most other drugs. Addiction, or even extended regular use is very unusual. These drugs are rarely used more than twice a week. Since a major reason people use these drugs is to experience unusual mental effects, most users stop taking these drugs entirely after the "trips" lose their novelty.

Surveys of hallucinogen use show that most who use do so less than once a month, and that weekly use is very rare. None of the surveys support conclusively the widespread belief that these drugs are not as popular as they once were, but there has been a definite decline in the number of hallucinogen-related medical problems.

Hallucinogens can cause a number of side effects, including panic reactions and long psychotic or depressive episodes. Most reactions are unpredictable and the negative side effects can occur after several "safe trips." The possibility of medical side effects such as chromosomal or genetic change has neither been thoroughly documented nor entirely eliminated.

Solvents and Inhalants

These are chemicals that are used for a variety of medical, industrial, and household purposes, and can also be inhaled to produce intoxication. The ingredients of these products are often unknown to the purchaser, abuser or doctor treating an adverse reaction.

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[13] LSD, (Lysergic Acid Diethylamide Tartrate), mescaline, psilocybin, peyote, etc.

Very little is known about the pharmacology of solvents. Partial tolerance may develop, and the effects of these substances are intensified when used with other depressants, especially alcohol.

Data on solvent use are sparse. The few available surveys indicate that about 7 percent of junior and senior high school students may have inhaled solvents once or twice and that about one percent of these experimenters continue to inhale periodically.

Volatile substance abuse occurs almost exclusively among the young, perhaps because solvents are often the most readily available intoxicants to children. Accordingly, maturing out of the inhalant habit is the general rule. Even heavy users will persist for only a few years, and then abandon solvent sniffing by their teens. (Many of these individuals, however, then begin the excessive use of alcohol, barbiturates or other substances.)

The fact that solvent inhalation lasts for such a short time for most users leads to the conclusion that it is primarily a reflection of the immaturity of those young people who become involved with it. Nonetheless, abuse must be monitored and action taken as appropriate. One simple action might be to use unpleasant additives in the manufacturing process. Further, the task force believes that the intervention efforts using peer groups discussed in chapter 4 will help some young people resist the pressure to experiment with these substances if and when the inhaling of solvents becomes temporarily popular among their friends.

B — DRUG PRIORITIES

One of the major themes of the Federal strategy discussed in chapter 1 was the importance of differentiating in terms of the particular drug of abuse, and the frequency and quantity of use. Implicit in that decision to differentiate is the assumption that public policy should be most concerned with those drugs which have the highest costs to both society and the user, and with those individuals who have chronic, highly intensive patterns of drug use.

In order to determine the social cost of a particular drug, we should consider the following factors:

- *The likelihood that a user will become a compulsive user, either physically or psychologically dependent on the drug:* closely linked to this concept is the ability of the drug to produce tolerance, requiring successively higher intake to achieve the same result.
- *Severity of adverse consequences of use, both to the individual and to society:* in terms of criminal behavior, health consequences, economic dependence and the like. (This is discussed in greater detail below.)

- *Size of the core problem:* the number of compulsive users who are currently suffering (or causing others to suffer) adverse consequences.

ADVERSE CONSEQUENCES TO THE INDIVIDUAL

The adverse consequences of drug use are of two types: consequences which are the direct result of drug use, and indirect consequences which are associated with drug use. *Direct* consequences include:

- *Illness or death:* Illness or death can occur from overdose, a severe toxic or allergic reaction to a drug, or from rapid withdrawal. In New York City, drug-related deaths are a major cause of death for males aged 15 to 25. Death due to drug abuse is often the result of ignorance—ignorance of possible contaminants in drugs, ignorance of the danger of using combinations of drugs, ignorance of the strength of the drug purchased and of techniques to determine nonlethal doses. If drug use affects reproductive organs, or when certain drugs are taken during pregnancy, a second generation may suffer casualties.
- *Acute behavioral effects:* The paranoia produced by intravenous injection of amphetamines can cause violent behavior and consequent criminal acts such as rape and homicide. Acute paranoia and extreme anxiety from the effects of hallucinogenics, and depression (in the withdrawal state) from stimulants such as amphetamines, are other examples of behavior effects.
- *Chronic behavioral impairment:* Adverse behavioral effects may also be chronic as with the inertia, apathy and depression associated with long-term heroin use. Also, impairment can be measured in things such as loss of productivity, health costs, welfare assistance, and criminal costs.
- *Intellectual Impairment:* Some evidence of intellectual impairment has been reported by clinicians on the West Coast. Specifically, mental status evaluations of chronic users of hallucinogens who stopped after two or more years revealed a clinical impression not unlike that of mild chronic brain disease.

Indirect consequences include:

- *Injury or death associated with impaired judgment:* Potent, mind-altering drugs such as LSD can affect judgment, which may for example, result in accidental death by succumbing to bizarre hallucinations, such as believing one can fly. Even a "mild" drug such as marihuana may distort preception and thus increase the risk of death in automobile accidents of either a driver or pedestrian.
- *Injury or death associated with conditions of use:* Poor nutrition and neglected hygiene stemming from the total focus of energy

on obtaining drugs can cause damage to vital organs. Transmission of viral hepatitis from shared needles is another medical problem of drug abusers. Young people in the drug culture are particularly susceptible to pneumonia. Infections associated with injections using unsterile needles may be fatal.

- *Developmental difficulties:* The potential for personality impairment due to drug use is an important consequence, but one difficult to assess. There are crisis periods in the course of every individual's development, but adolescence is a particularly vulnerable period because the individual seems inundated with crises. These crises provide an opportunity for growth, formation of new ideas, and the emergence of a healthier and more mature personality. The use of drugs as a means to deal with these crises may diminish, delay, or prevent this maturation process.
- *Barriers to social acceptance:* The public image of the drug user is extremely negative; thus, the user is often stigmatized, making it extremely difficult for a current or former drug user to find acceptance in society. Moreover, arrest and conviction for violation of drug laws results in the creation of a criminal record which may follow a user for the rest of his life.

ADVERSE CONSEQUENCES TO SOCIETY

Obviously the above adverse effects to individual drug users are society's loss, too. But there are also more directly measurable costs to society. A recent study estimated that the total measurable cost of drug abuse—direct program costs, health care costs, property losses attributable to drug-related theft, and lost productivity—was $10 billion to $17 billion per year.[14]

Still another way to look at the social cost of drug abuse—one which is of particular interest in this discussion of drug priorities because it can be broken down by drug—is to look at drug users' appearances in the various institutions we have established to deal with people in trouble.

Among the largest and most important of these institutions are the welfare system, the criminal justice system, and the health care delivery system. Drug users often appear in these institutions, and may be identified as users. If we assume that at least part of the reason for their appearance is drug use, the frequency of appearance provides one rough indicator of the magnitude of the social cost of drug abuse.

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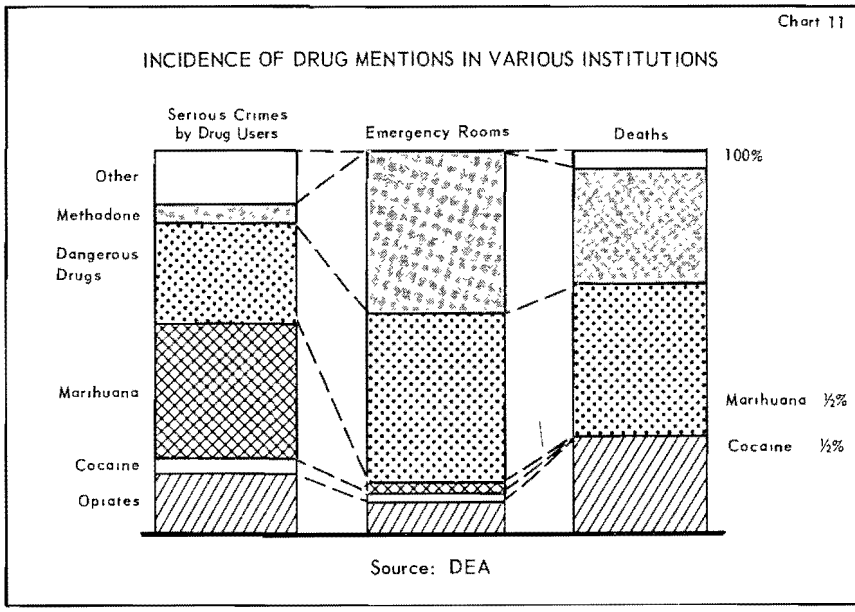
[14] Social Cost of Drug Abuse, Special Action Office for Drug Abuse Prevention, 1974: This excellent survey is summarized in the *Federal Strategy, 1975.*

Our capability to monitor these appearances is irregular and limited in scope, but some data exist. Chart 11 illustrates the fraction of drug users who had used various drugs prior to their appearance in three different places where people in trouble show up: the criminal justice system (serious crimes only);[15] emergency rooms and medical examiners' offices.



SUMMARY: DRUG PRIORITIES

Chart 12 ranks the various drugs according to the following criteria: (1) likelihood that a user will become physically or psychologically dependent; severity of adverse consequences, both (2) to the individual and (3) to society; and (4) size of the core problem.

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[15] The large proportion of marihuana mentioned is probably a reflection of its widespread use in society.

Chart 12

SUMMARY OF DRUG PRIORITIES

		DEPENDANCE LIABILITY	SEVERITY of CONSEQUENCES		SIZE OF CORE PROBLEM
			PERSONAL	SOCIAL	
HEROIN		HI	HI	HI	HI 400,000
AMPHETAMINES	NEEDLE	HI	HI	HI	HI 500,000
	ORAL	LOW	MED	MED	
BARBITURATES	MIXED	HI	HI	HI	MED 300,000
	ALONE	MED	HI	MED	
COCAINE		LOW	LOW	MED	LOW
MARIHUANA		LOW	LOW	LOW	LOW
HALLUCINOGENS		MED	MED	MED	LOW
INHALENTS		MED	HI	MED	LOW

Though the data are flawed and the rankings therefore imprecise, a clear pattern emerges.

- Heroin ranks high in all four categories;
- Amphetamines, particularly those injected intravenously, also rank high in all four categories;
- Mixed barbiturates rank high three out of four categories;
- Cocaine,[16] hallucinogens, and inhalants rank somewhat lower; and
- Marihuana is the least serious.

On the basis of this analysis, the task force recommends that priority in Federal efforts in both supply and demand reduction be directed toward those drugs which inherently pose a greater risk to the individual and to society—heroin, amphetamines (particularly when used intravenously), and mixed barbiturates—and toward compulsive users of drugs of any kind.

This ranking does not mean that *all* efforts should be devoted to the high priority drugs, and none to the others. Drug use is much too complicated and our knowledge too imprecise for that. Some attention must continue to be given to all drugs both to keep them from exploding into major problems and because there are individuals suffering severe medical problems from even a low priority drug, such as marihuana.

[16] This ranking is on the basis of current use patterns. As mentioned earlier, if intensive use patterns develop, cocaine could become a considerably more serious problem.

However, when resource constraints force a choice, the choice should be made in favor of the higher priority drugs. For example:

- In choosing whom to treat, we should encourage judges and other community officials not to overburden existing health facilities with casual users of marihuana who do not exhibit serious health consequences. (But, a person who is suffering adverse consequences because of intensive marihuana use should have treatment available.)
- In assigning an additional law enforcement agent, preference might be given to Mexico, which is an important source of both heroin and "dangerous drugs", rather than to Miami, where an agent is more likely to "make" a cocaine or marihuana case.

This drug priority strategy is essential to better targeting of limited resources and it will be further addressed in relation to supply and demand reduction activities in chapters 3 and 4. Further, the process of assessing the current social costs of drug abuse should be a continuing one, to ensure that resources are allocated on the basis of priorities which reflect current conditions and current knowledge.

3. SUPPLY REDUCTION

Chapter 1 summarized the basic objective of supply reduction efforts: to make obtaining drugs inconvenient, expensive, and risky, so that fewer people will experiment with drugs, fewer who do experiment will advance to chronic, intensive use, and more of those who currently use drugs will abandon their use and seek treatment. The effectiveness of supply reduction as a means of reducing drug abuse has been illustrated earlier and supply reduction will remain a basic part of the Federal strategy.[1]

Unfortunately, total elimination of illicit drug traffic is impossible. Participants at each level of the distribution network are replaceable, as are the drugs removed from the illicit pipeline through seizure. Sufficient resources are not available to eliminate all illicit drug traffic; nor would a free society tolerate the encroachment on civil liberties which such a policy would require. The realistic goal of supply reduction efforts, then, is to contain and disrupt the distribution system, and hopefully to reduce the quantity of drugs available for illicit use. From this perspective, supply reduction efforts must be selective, and scarce enforcement resources must be used in a way which will produce the greatest disruptive effects in the supply of those drugs which cause the most severe social consequences.

Allocation of resources should focus on two areas:

- *Highest priority drugs.* Chapter 2 discussed the risk associated with the use of various drugs and suggested that highest priority be given to those drugs causing the greatest social cost. Many supply reduction techniques cannot be focused on specific drugs, and some attention must be given to all drugs to keep them from exploding into larger problems; but when a choice is necessary, efforts should be devoted to reducing the illicit supply of high priority drugs.
- *Greatest disruption of distribution systems.* The total variety of supply reduction techniques—law enforcement, regulatory programs, crop eradication, etc.—must be weighed and resources concentrated on the combination of techniques which have the greatest overall impact on supply. Efforts should

[1] This benefit is not gained without costs and adverse effects—direct program costs, stigmatization of casual users through arrest, deteriorating health of continuing users, encouragement of black markets, crime to meet black market prices and the possibility of corruption. To partially offset these disadvantages, we recommend a complementary demand reduction effort, discussed in the next chapter.

focus on that portion of the supply system which appears to be most vulnerable at the time.

This concept of causing the greatest disruption of the distribution system has been useful in targeting efforts in the past. It has motivated agents to develop cases against financiers, chemists, and managers of major trafficking organizations; it has led the Cabinet Committee on International Narcotics Control (CCINC) to direct its primary attention to countries producing raw materials and harboring major traffickers; and it has resulted in greater emphasis on the regulatory program to combat the growing problem of retail diversion of amphetamines and barbiturates.

Identification of the most vulnerable parts of the illicit distribution system, and re-allocation of resources as necessary, should be a continuing activity of program managers. At various times, raw materials, processing facilities, inventories, wholesale distribution capacity, entrepreneurial skill, or capital will be in short supply. Any of these constraining factors which determine the capacity of the system should be the target of supply reduction efforts. For example, illicitly produced raw materials can be intercepted by locating and destroying lab facilities, or by arresting illicit chemists; distribution systems can be upset by aggressive investigative activity, interdiction efforts, and action by State and local authorities.

Strategic calculations about where to focus supply reduction efforts must recognize that major segments of both licit and illicit supply systems operate in foreign countries. For example, all of the opium used to produce heroin that is consumed in the United States is grown abroad; and a significant fraction of the processing facilities which supply methamphetamines and amphetamines are located in foreign countries. Thus, our strategy to control supply must often rely on foreign governments' capabilities to control drugs, and foreign commitment and capability may place an upper limit on this Nation's ability to control the supply of drugs at home.

Continued attention to this process of continually identifying the most vulnerable parts of the illicit distribution system—isolating current bottlenecks in terms of resources, capabilities, or activities in short supply—should be an on-going activity of program managers. Reallocation of resources should follow as necessary.

The balance of this chapter discusses the Federal supply reduction effort in five sections. Although these activities can be isolated for convenience in discussion, it is important to recognize that they are interdependent and mutually supportive, and that they must be

continually balanced against each other in designing the supply reduction program appropriate at a given time. They are:

- *Enforcement:* The enforcement program is designed to deter, immobilize, and inconvenience illicit producing and trafficking organizations, to discourage potential new trafficking organizations from forming, to reduce smuggling, and to remove drugs from the illicit market.
- *Intelligence:* The worldwide intelligence program provides information needed to make strategic and tactical decisions with respect to design of the overall supply reduction program, and deployment of enforcement resources.
- *International:* The purpose of the international program is to enlist the cooperation of foreign governments in worldwide drug control efforts, and to encourage those governments to intensify their efforts by providing them with training, technical assistance and material resources, and through suitable diplomatic initiatives.
- *Regulatory:* The regulatory program focuses on the diversion of legitimate domestic production to illegitimate use. Devices available to the Federal Government include scheduling drugs, establishing production quotas and auditing firms to ensure compliance with the security and recordkeeping provisions of the Controlled Substances Act.
- *Science and Technology:* Science and technology essentially serve a supporting role by increasing the effectiveness and efficiency of operating programs. This area includes not only engineering and hardware, but also operations research and program analysis.

ENFORCEMENT

Drug law enforcement is often assumed to *be* supply reduction, and vice versa. As discussed previously, that impression is not correct; law enforcement is but one of many activities which limit the supply of illicit drugs. Nonetheless drug law enforcement has been and probably will continue to be the single most important and most visible part of the overall supply reduction effort.

Reorganization Plan 2 of 1973 consolidated the principal drug investigative and intelligence resources in the Drug Enforcement Administration (DEA) for the purpose of ensuring optimal utilization and integration of these resources. While the task force did not undertake a comprehensive review of Reorganization Plan 2, all members

concur in the basic concept of an integrated drug law enforcement agency charged with lead responsibility.[2] DEA is that lead agency and has made considerable progress in its two-year existence.

The concept of a "lead agency," however, does not denigrate in any way the vital roles played by other agencies in the drug law enforcement effort. For example, Justice's Federal Bureau of Investigation (FBI) and Treasury's Internal Revenue Service (IRS) and Alcohol, Tobacco, and Firearms Bureau (ATF) have important supportive roles in investigation. The Central Intelligence Agency (CIA) has a vital supportive role with respect to intelligence regarding international trafficking. Treasury's U.S. Customs Service performs an invaluable interdiction function at our borders and ports of entry. The Immigration and Naturalization Service and Coast Guard provide valuable assistance. U.S. attorneys' offices prosecute Federal cases, and the courts try and sentence traffickers. The Federal Board of Parole determines when imprisoned traffickers are released. And, finally, 400,000 State and local police officers, partly financed by Justice's Law Enforcement Assistance Administration (LEAA), are the Nation's defense against local trafficking.

The drug law enforcement program must design a strategy which maximizes the contribution of each of these organizations to the overall objectives of disrupting illicit traffic and reducing the availability of drugs for illicit use. Before discussing the task force's recommendations for accomplishing these objectives, the three ways in which enforcement achieves supply reduction will be reviewed.

First, the arrest, prosecution and incarceration of traffickers and immobilization of trafficking organizations results in the elimination of some illicit supply capabilities. *Second*, the seizure of quantities of drugs and of equipment and materials needed to operate drug networks (such as vehicles, aircraft and other property used in smuggling), both directly and indirectly reduces illicit supplies of drugs and cripples or inconveniences the operations of illicit traffickers. *Third*, enforcement efforts have deterrent effects. Traffickers must operate cautiously: they must carefully screen customers, keep their markets small, and arrange elaborate strategies to hide the drugs. All of this caution reduces both the efficiency of trafficking activity and the total capability of the illicit supply system.

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[2] Reorganization Plan 2 is perhaps the most misunderstood and misinterpreted issue in drug law enforcement, and is therefore discussed more completely later in this chapter. There is fundamental agreement and acceptance of the central concept; the disagreement which exists revolves around the relatively narrow question of how DEA and Customs interact in performing their respective missions.

The following sections discuss the task force's findings and recommendations in four key areas which together determine the overall effectiveness of law enforcement efforts. They are:

- The development of enhanced capabilities to conduct conspiracy investigations and otherwise target enforcement resources at high-level violators.
- The effective immobilization of arrested or indicted traffickers.
- Interdiction; its role and interrelationship with investigation.
- Strengthening capabilities of State and local enforcement agencies, and improved cooperation between them and Federal investigative agencies.

Enhancing the Capability To Focus on Major Trafficking Organizations

To achieve maximum impact, supply reduction efforts must focus upon the prosecution and conviction of those high-level traffickers who direct major organizations, because immobilization of these leaders significantly reduces the organization's ability to move quantities of drugs for a considerable period of time.

Experience has shown that conspiracy cases are often the only way to apprehend high-level traffickers, since they purposely isolate themselves from all activities which would bring them into actual contact with drugs.[3] For example, DEA reports that almost half of the top violators it arrests are indicted on conspiracy charges. Use of conspiracy prosecutions is therefore one of the major tactical weapons which should be employed by enforcement personnel, prosecutors, and courts. Expansion of the use of conspiracy strategies will help to emphasize the importance of targeting enforcement resources at the leaders of trafficking organizations. Other strategies may, of course, be equally effective in certain cases. The important thing is to concentrate on top-level violators.

In the course of its work, the task force prepared very detailed recommendations for improving the Federal Government's ability to conduct conspiracy cases, and submitted them to the appropriate agencies. These detailed recommendations, which are only summarized and highlighted here, were in three broad areas:

- Building understanding and commitment to conspiracy strategy.
- Inducing cooperation of knowledgeable individuals.
- Developing long-term approaches to investigations.

[3] In high-level conspiracy cases, Federal efforts have a great advantage over State and local activity, since coordination of a variety of investigative techniques can best be achieved at the Federal level, and high-level cases usually involve interstate activity.

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First, it is essential to build understanding of and commitment to the conspiracy strategy among enforcement officials, prosecuting attorneys, judges, the Congress and the interested public.

Despite previous policy directives, it seems clear that current field practices in both investigating and prosecuting agencies often emphasize the quick arrest or conviction at the expense of vigorous pursuit of high-level violators. This orientation has proved resistant to change partly because of external incentives influencing the performance of the organizations, and partly because of internal personnel systems—those which recruit, train, evaluate, and reward individual agents.

Thus, more than policy exhortation is required. Leaders of the agencies involved in suppressing illegal drug traffic must publicly support the long-term conspiracy strategy, seek support for it, and be willing to accept possibly unfair criticism when sheer numbers of arrests decline. Within each organization, leaders must make the necessary shifts of resources and adjustments to the incentive and rating systems which will get agents "off the streets," and curtail the arrest of low-level employees in trafficking organizations. In particular, new measures of effectiveness must be developed which encourage building conspiracy cases rather than rewarding managers and agents on the basis of numbers of arrests.

Commitment to high-level conspiracy cases is equally necessary in the prosecuting function. Conspiracy investigations are difficult for prosecutors—they absorb time and result in relatively high rates of acquittal and reversal. In addition, rapid turnover among prosecuting attorneys works against developing skills in this area. The 19 Controlled Substance Units inaugurated by the Attorney General this year offer a potential solution to these problems, provided that these specialists are not diverted from drug conspiracy prosecutions to other work.[4]

Judicial support for conspiracy prosecutions has been less than enthusiastic. Conspiracy trials are time-consuming and complicated, and courts have expressed some legitimate concerns regarding the misuse of conspiracy laws by law enforcement agencies. On the other hand, the task force believes that the courts will be more responsive

[4] In addition, better coordination in enforcement and prosecution of conspiracy cases is imperative. Exploiting the full potential of a complex conspiracy case requires complete responsiveness of agents and prosecutors to each other's needs. Prosecutors should advise the enforcement agency as to the kinds of evidence needed to support conspiracy and other drug violations. Similarly, enforcement and prosecution should be coordinated in case disposition; e.g., questions of whether to grant informal immunity, transfer a case to a local jurisdiction, utilize a grand jury, or to enter into plea bargaining are ones in which investigative agencies should have a say.

to this important law enforcement tool if repeatedly made aware of the fact that high-level drug traffickers seldom become involved with actual drug transactions, making conspiracy investigations the only possible avenue of prosecution.

Finally, support for this conspiracy emphasis by Congressional committees with oversight and budget responsibility must be developed, or law enforcement agencies will continue to feel compelled to generate seizure and arrest statistics, the traditional measures of success.

The *second* area for improvement is by inducing the cooperation of persons with knowledge of drug conspiracies. Due to the nature of illicit drug trafficking, only a few individuals working inside the organization have knowledge of drug distribution networks.

In developing conspiracy cases these are the people who can provide the most valuable leads. Cooperation can be induced by a wide variety of legal devices. These include decisions to grant formal or informal immunity,[5] postponing sentencing until defendants have delivered on their promise to cooperate, making cooperation a condition of probation, explicitly recognizing cooperation as a factor in parole decisions, and maintaining adequate protection of cooperating individuals by the U.S. Marshals Service.

The *third* way we can improve our capability to conduct conspiracy investigations is by developing long-term approaches to investigation. Since productive leads and cooperating individuals are scarce commodities, they must be preserved, if possible, by keeping these individuals out of court. This can be done by developing other evidence, or by using the border search authority of the Customs Service to arrest a known drug smuggler. In maintaining long-term sources of information, great care must be taken to avoid putting the cooperating individual in a position in which he is forced to actually participate in an illegal act.

Immobilizing Drug Traffickers

Gathering sufficient evidence to prosecute a trafficker does not guarantee his immobilization. He may be operating in a foreign country, out of reach of effective prosecution and sentencing. Even in the United States, indictment and arrest do not guarantee immobilization; these events merely begin a long criminal justice process during most of which the trafficker may be free to continue operating. At the end of this process, incarceration may be relatively short.

[5] As tools to secure cooperation, grants of immunity can be effective. Yet they should be used sparingly. The Justice Department has recently reviewed the process of granting immunity with an eye toward tightening procedures.

This failure to immobilize traffickers against whom a substantial case has been developed is very costly—costly in terms of wasted investigative resources, weakened deterrent, and reduced public trust in the criminal justice system. Consequently, the task force believes that efforts to more effectively immobilize indicated traffickers are vitally important.

The United States has two broad options for denying traffickers safe havens in foreign countries. First, U.S. enforcement officials can cooperate with foreign law enforcement officials in developing cases to be tried in foreign countries. [6] In some countries—for example, France and Mexico—laws permit evidence gathered in the United States for violations committed here to be used in prosecuting a trafficker in the foreign country's courts. Second, we can indict the foreign trafficker and then seek jurisdiction through extradition or expulsion. Both of these devices should be used to the maxium extent possible and the task force recommends that a permanent DEA-Justice-State committee be established under the CCINC to coordinate the extradition and expulsion program.

For traffickers operating within the United States, simply arresting them has not proven to be an effective means of immobilization. Traffickers usually raise bail quickly and often immediately resume trafficking when released. Thus, attention should be paid to ways to keep traffickers from operating before conviction or while on appeal, and we should of course seek ways to increase the rate of conviction, and the period of incarceration which follows.

The task force's major recommendations regarding sentencing and parole of drug traffickers include:

- Requiring minimum mandatory sentences for persons convicted of high-level trafficking in narcotics and "dangerous drugs." [7]
- Requiring mandatory consecutive sentencing rather than concurrent sentencing for persons who are arrested and con-

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[6] It is worth noting that our success in encouraging other countries to deny safe havens depends significantly on our willingness to deal severely with people we arrest in the United States. Foreign governments have noticed and complained about our lenient treatment of couriers from their countries arrested in the United States. They have also noticed the short prison terms for major domestic violators. Consequently, some doubt our determination to control drug abuse. Thus there is an important interdependence between the program to deny safe havens to overseas traffickers, and the program to effectively control traffickers arrested in the United States.

[7] In this regard, the task force specifically endorses the President's proposal for mandatory minimum sentences for persons trafficking in hard drugs and suggests that consideration be given to expanding the proposal to include major traffickers in barbiturates and amphetamines.

victed for narcotics trafficking while on bail from another trafficking offense. This kind of selective deterrent aimed at offenses committed while on bail should help reduce the high rate of continued drug trafficking.[8]

- Undertaking major efforts to educate judges regarding the likelihood of repeated trafficking offsenses, and encouraging them to carefully weigh the danger to the community a trafficker represents if released.
- Submitting written recommendations from prosecutors to the parole board regarding parole decisions on high-level violators. At minimum, prosecutors should submit written requests to keep high-level traffickers incarcerated. This policy should ultimately result in explicit revisions of parole guidelines in order to defer parole for high-level traffickers.
- Revoking parole and cancellation of all "good time" already served, in the event that a paroled offender is re-arrested on narcotics trafficking charges.

Indirect pressures can also be used to supplement direct prosecution attacks on drug traffickers. Efforts can be aimed at confiscating contraband drugs, damaging the trafficking network's capacity to finance its operations, and seizing vehicles, passports, and licenses (e.g., pilots') necessary to remain in the drug trade.

Targeting on the seizure of contraband by itself would not be an effective supply reduction strategy. The amounts seized are too small and the drugs themselves too easily replaced. Nonetheless, increased seizures of drugs in quantity could have a substantial impact on trafficking organizations. Toward this end, the development of improved technical equipment to detect drugs, especially easily concealed narcotic drugs, should be given high priority. Further, the detection of drugs will always remain useful for the leads and evidence that detection produces.

By focusing on the trafficker's fiscal resources the government can reduce the flow of drugs in two ways. First, high-level operators, usually well insulated from narcotics charges, can often be convicted for tax evasion. Second, since trafficking organizations require large sums of money to conduct their business, they are vulnerable to any action that reduces their working capital.

The IRS has conducted an extremely successful program that identifies suspected narcotics traffickers susceptible to criminal and

[8] A recent DEA study showed that 45 percent of a group of traffickers on bail were implicated in post-arrest trafficking.

civil tax enforcement actions. Recently, the program has been assigned a low priority because of IRS concern about possible abuses. The task force is confident that safeguards against abuse can be developed, and strongly recommends re-emphasizing this program. The IRS should give special attention to enforcement of income tax laws involving suspected or convicted narcotics traffickers.

Drug enforcement agents should be further encouraged to recognize promising leads for tax investigation purposes, and to refer them to the IRS. Even when tax cases cannot be made, information regarding financial transactions may be valuable in proving other violations by drug dealers. For example, the Customs Service enforces a law requiring reports of international transportation of currency; drug dealers have to violate this law regularly.

International agreements to increase investigative access to information in financial institutions should also be pursued.

All of these indirect methods of immobilizing trafficking networks can be very powerful tools in the overall supply reduction strategy. However, the great discretion these tools provide law enforcement officials requires that extreme care be devoted to developing appropriate guidelines and procedures for their use, to ensure that constitutionally guaranteed civil liberties and fundamental rights of privacy are not impinged upon.

Interdiction; Its Role and Interrelationship with Investigation

The Customs Service and the Immigration and Naturalization Service perform a valuable interdiction role along our borders and at ports of entry. Interdiction has an effect on the overall supply reduction effort in three ways. *First*, such activity results in the arrest of persons and the seizure of drugs. *Second*, the presence of a uniformed interdiction force which can search persons and cargo at the border has a strong deterrent effect: some potential traffickers will be dissuaded, and others will be forced to adopt more expensive and vulnerable methods of smuggling. *Third.* interdiction efforts will often discover narcotics trafficking activities that were previously unknown to investigators, thus adding to the investigation data base.

The last two of these three functions—deterrence and discovery of previously unknown distribution systems—are most effective if the interdiction efforts are random. If interdiction focuses too narrowly on certain locations, types of people, and types of activity, then a sophisticated trafficker will simply "beat the system" by doing the unexpected. On the other hand, the first objective—arrest and seizures—is best accomplished if interdiction concentrates its efforts on individuals, activities, and places which have a known potential for trafficking on the basis of current information. Thus, there is a need for both random and targeted interdiction efforts.

Under Reorganization Plan 2, a distinction is drawn between investigative functions and interdiction functions with respect to

narcotics enforcement efforts. The investigative function was given to DEA; the interdiction function continues to be performed by the Customs Service. Unfortunately, the distinction between interdiction and investigation was not precise in the legislation. This ambiguity has led to jurisdictional disputes among enforcement agencies, and the resulting interagency rivalry and lack of coordination have hampered supply reduction efforts.

The extent of the jurisdictional dispute is often viewed out of context and, frankly, out of proportion. The actual issues in question are relatively small. This is not to say that real differences do not exist—they do—nor that the effects of the disputes are minor—they are not.

However, to put the differences in their proper perspective, we should first outline the considerable areas of agreement which exist. They are:

1. The central concept of Reorganization Plan No. 2 of 1973—that of creating a lead agency for drug law enforcement which integrates most investigative and intelligence activities—is sound, and DEA is that lead agency.
2. The development of conspiracy cases should be a major element of drug law enforcement. Both border arrests and undercover purchases are useful ways of penetrating trafficking organizations to initiate conspiracy investigations, as are a number of other techniques. All should be used.
3. Interdiction of drugs at the border and ports of entry is an important component of the overall supply reduction strategy because of (1) the deterrent effect, (2) the potential for penetration of trafficking organizations, and (3) the possible removal of large quantities of drugs. The importance of this function is enhanced by the unique search authority of Customs.
4. Prior information is useful in performing the third of those objectives; namely, removing quantities of drugs from the market. While the vast majority of Customs border arrests and seizures always have been accomplished without prior information, both before and after Reorganization Plan No. 2, the most significant seizures have in the past been made based on prior information.
5. To date, DEA has not provided intelligence to the Customs Service relating to the modus operandi of smugglers, or regarding specific individuals, in sufficient quantity. A greater exchange of information is necessary.

The task force believes that these basic points should form the framework for resolution of outstanding jurisdictional issues and better overall coordination. The specific jurisdictional issues to be

resolved center on the extent of Customs activities in performing the interdiction role assigned by Reorganization Plan No. 2. They include:

- Development of prior information.[9]
- Jurisdiction over air interdiction and the use of transponders in suspected aircraft.
- Maintenance of intelligence information systems.
- Liaison with foreign customs agencies on narcotics matters.
- Laboratory analysis of narcotic seizures.
- Debriefing of persons arrested at the border on narcotics smuggling charges, to enable appropriate followup investigations.

These issues are founded on sincere differences of opinion regarding how best to utilize the unique capabilities of each agency in reducing the overall supply of drugs. But prompt resolution is essential; continued failure to resolve these issues hinders the effectiveness of the entire program to reduce the flow of drugs.

The task force feels that the two agencies have a basis upon which to achieve agreement for better operational coordination. Their respective efforts are complementary elements of an overall program, and are not mutually exclusive. DEA and Customs must set aside their institutional interests and work together if the Nation is to have the most effective drug enforcement effort.

The task force is encouraged by recent progress which has been made in meetings between the Commissioner of Customs and the Acting Administrator of DEA. Nonetheless, the task force recommends that the President direct the Attorney General and the Secretary of the Treasury to undertake resolution of these issues within the next three months. If these issues cannot be, or have not been resolved at the agency or department level by December 31, 1975, the task force recommends that the Attorney General and the Secretary of the Treasury report their final recommendations for resolution of the matter to the President.

The time has come for these issues to be resolved and solutions implemented.

Strengthening Capabilities of State and Local Police

The last area for improving the overall law enforcement effort is the strengthening of linkages between Federal law enforcement agencies and the more than 400,000 State and local police.

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[9] In this, the most contentious of these issues, DEA has recently established a special section within its Office of Intelligence to concentrate entirely on creating intelligence information for use by Customs—smuggler's methods of operation, individuals who are suspected traffickers but not currently the subject of ongoing covert investigations, license plates of vehicles involved in narcotics, etc. Further, Customs has repeatedly been invited to participate as a full partner in the recently established El Paso Intelligence Center, which is designed expressly to improve intelligence exchange at the U.S.-Mexican border.

These police have an important independent effect on supply reduction objectives, since they are solely responsible for directing efforts against local drug dealers. Local law enforcement officials can disrupt stable distribution patterns and force dealers to be extremely cautious in approaching new, unknown, and as yet untrusted users. In addition, State and local enforcement agencies produce defendants in drug cases who may prove to be valuable leads in developing significant conspiracy cases.

The Federal Government seeks to strengthen State and local enforcement agencies and co-operate with them through several mechanisms. First, LEAA block and discretionary grants support State and local drug enforcement along with other enforcement activities. Second, LEAA and DEA jointly fund State and local officers involved in joint enforcement efforts. Third, DEA provides a variety of services to State and local agencies; for example, they train State and local officials in up-to-date narcotics investigation techniques; process State and local drug evidence in DEA laboratories; and disseminate intelligence to State and local agencies.

All of these efforts should be continued and expanded.

INTELLIGENCE

The intelligence function is an integral part of the overall supply reduction program. Good strategic intelligence on trends in drug abuse, general levels of availability, sources of drugs, and capability of other governments to control drugs is essential. This information is a key to making resource allocation decisions among the various components of the overall drug program, and for evaluating the effectiveness of both supply and demand reduction programs. Operational and tactical intelligence are vital in targeting enforcement resources; without them enforcement efforts would be targeted on a more random basis, with a resultant reduction in efficiency and effectiveness. Further, tactical intelligence often leads to the development of strategic intelligence.

Significant progress has been made in establishing a national narcotics intelligence system since the formation of DEA in 1973. However, the overall narcotics intelligence function has generally suffered from:

- *Counterproductive competition within and among enforcement agencies.* There is ample evidence that competitive attitudes within and among enforcement agencies have impeded an optimal production and flow of operational intelligence. In order to base enforcement action on something more than random inspections and informants' initiatives, all intelligence producers must be made to recognize that they serve many users.

- *Insufficient funding during the internal resource allocation process.* This is particularly true with regard to intelligence analysis capability.

The following sections discuss highlights of the task force's analysis of the intelligence function, looking first at operational and tactical intelligence and then at strategic intelligence. In each, the four phases in the production of finished intelligence will be reviewed: collection, collation (or data base management), analysis and dissemination.

Operational and Tactical Intelligence

The collection of operational intelligence is currently one of the most effective components of the intelligence system. The reason is simple: enforcement agents are the primary collectors and they have been in place for a long time. However, this component can be made even stronger by:

- Encouraging the cooperation of defendants, as discussed earlier in the section on conspiracy cases.
- Including questions during debriefings which may produce information useful to another agency or may develop historical material useful in conspiracy cases. We suggest that a new investigative report form be devised with the participation of representatives of all user agencies; it would reflect priority operational intelligence questions and would compel the interrogator to cover a broader range of subjects than his individual investigation might dictate.
- Expanding DEA's narcotics intelligence capability in a way which closely integrates it with enforcement activities.

The analysis of operational and tactical intelligence depends on the adequacy of three factors: (1) Analytic resources; (2) manual and automated information filing systems; and (3) a proper flow of information to the intelligence analysts—all of which are currently inadequate. Inadequate analysis can only be overcome by increasing the number of intelligence analysts in DEA and attracting the best available talent for this function. The problem of inadequate information storage and retrieval capability is complicated by the existence of four separate automatic data processing (ADP) systems. The task force recommends that an analysis of all these systems be conducted, perhaps by OMB, with a view toward integration or at least improved interface.

Competitive attitudes within and among enforcement agencies have had a negative impact on the sharing and use of operational intelligence. Perhaps this is caused by the inordinate attention paid to agency seizures totals, which causes one agency not to pass informa-

tion to another. Another problem centers on the behavior of users of intelligence; they must be compelled to observe all restrictions concerning its further dissemination. Failure to impose discipline in this regard leads to reluctance on the part of the agency producing sensitive intelligence to share it. Other potential impediments to the dissemination of operational intelligence are the Privacy Act, and the Freedom of Information Act.

The Central Intelligence Agency plays a vital role in the overseas collection of intelligence dealing with international narcotics trafficking. While its principal focus is on strategic intelligence, valuable tactical and operational intelligence is also collected.

Strategic Intelligence

Strategic intelligence about trends in drug abuse, levels of availability, sources of drugs, characteristics of illicit production and distribution systems, and capacities of foreign governments to control drug supplies is important in making broad resources allocation decisions, and in selecting which supply or demand reduction programs to emphasize. Accordingly, this intelligence should be routinely available to all organizations involved in the drug program, as appropriate to their particular responsibilities and functions.

As the agency responsible for the development of a national narcotics intelligence system, DEA has made significant progress in some areas. The development of chemical signatures to identify sources of drugs, and the use of hepatitis and emergency room episodes as indicators of trends in drug abuse are examples. However, DEA is currently inadequately equipped to supply the full range of strategic intelligence requirements, mostly due to the lack of sufficient strategic intelligence analysts. The task force recommends that greater resources be committed to this area. In addition, the users of this intelligence—in many cases members of this task force—must do a better job in identifying specific strategic intelligence requirements. The Intelligence Estimate Board recently established by DEA should help in this regard, as should the Foreign Intelligence Subcommittee of the CCINC.

The task force believes that the CCINC must provide greater leadership in the area of foreign narcotics strategic intelligence. The Central Intelligence Agency, the State Department, the Department of Defense, and DEA all have important roles to play in the collection and analysis of information, and the CCINC is the appropriate interagency coordinative mechanism.

INTERNATIONAL [10]

No matter how hard we fight the problem of drug abuse at home, we cannot make really significant progress unless we succeed in gaining cooperation from foreign governments, because many of the serious drugs of abuse originate in foreign countries.[11]

Thus, our capability to deal with supplies of drugs available in the United States depends strongly on the interest and capability of foreign governments in drug control. In order to encourage the greatest possible commitment from other governments to this joint problem, the task force believes that narcotics control should be discussed at the highest levels, to adequately communicate our deep concern over international drug trafficking and our commitment to control it. President Ford recently said:

> All nations of the world—friend and adversary alike—must understand that America considers the illicit export of opium to this country a threat to our national security * * * Secretary Kissinger and I intend to make sure that they do (understand).

The task force applauds this statement, and urges that it be reflected in the agenda of all high-level bilateral discussions; between heads of State, foreign ministers, finance ministers, justice ministers, and any other officials who play a part in the drug program. These discussions should deal not only with illicit opium, but with other drugs as well.

The key objectives of the international program are to gain the support of other nations for narcotics control, and to strengthen narcotics control efforts and capabilities within foreign governments. These objectives can be achieved through internationalization of the drug program, cooperative enforcement and enforcement assistance, and control of raw materials—each of which is discussed below. A final section deals with the special problem of Mexico.

Internationalization of the Drug Program

In many countries, drug abuse is still seen as principally an American problem. Many countries are unaware of the extent of their own drug abuse. Poorer nations find it difficult to justify the allocation of scarce resources to deal with drug abuse in the face of so many other

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[10] The international program is operated under the general policy guidance of the Cabinet Committee on International Narcotics Control (CCINC), which is chaired by the Secretary of State. Other members include the Attorney General, the Secretaries of Treasury, Defense, and Agriculture, the U.S. Ambassador to the United Nations, and the Director of the CIA. The Executive Director of the CCINC is the Senior Advisor to the Secretary of State and Coordinator for Narcotics Control Matters. Other key working-level organizations are the Agency for International Development, United States Information Agency, National Institute on Drug Abuse, and the Office of Management and Budget.

[11] Not all abused drugs are of foreign origin; of course, we have problems with U.S. manufactured amphetamines, barbiturates and other mood-altering drugs.

pressing needs. Some producing countries lack sufficient administrative control over opium-growing areas within their boundaries to effectively participate in drug control programs.

Still, there are several things the United States Government can do to raise the level of concern of foreign governments. The United States should intensify diplomatic efforts at the highest level of government to assure that other "victim" nations express their concern over violation of international treaty obligations in multilateral forums and in bilateral contacts. In addition, the United States should continue to participate in building institutions that promote international awareness of drug abuse. Such mechanisms include the signing of formal drug control and regulatory treaties and the support and encouragement of international efforts to study and reduce drug abuse. Chapter 4 will describe cooperative assistance in determining the extent of drug abuse in a foreign nation.

International treaties complement U.S. efforts to control drug abuse and have formalized the drug concerns of other nations. The Single Convention on Narcotic Drugs of 1961 is the basic treaty now in force for controlling narcotic substances. The international machinery established by the Single Convention has a mixed record. It has worked well in limiting legal production of narcotic drugs to amounts needed for medical and scientific use.[12] It has been less successful in getting countries to fulfill their treaty commitments to root out illegal production and trafficking.

Accordingly, in 1972 a United Nations Conference prepared a Protocol to Amend the Single Convention. The Protocol strengthens the authority of the International Narcotics Control Board (INCB), the control organ of the Single Convention. In addition, the Protocol strengthens provisions used to estimate production, manufacturing and consumption requirements. By July 1975 a total of 40 countries[13]—including the United States—had ratified or acceded to the Protocol, and it came into force on August 8, 1975.

The impact of the Amending Protocol can be significant:

- The INCB for the first time has authority to require reduction of opium poppy cultivation and opium production in countries shown to be sources of illicit traffic.

[12] Further, the U.N. has been closely monitoring worldwide developments in regard to the supply of and demand for codeine and other opium derivatives, which have been in short supply for two years. The task force recommends that the ad hoc Opium Policy Task Force continue to provide similar oversight of the American situation until the period of limited supplies is past. Additionally, the Task Force recommends that the Opium Policy Task Force accelerate its evaluation of the potential of Papaver Bracteatum as a substitute for morphine-based Papaver Somniferum in the production of codeine.

[13] Unfortunately, with the exception of Thailand, none of the important opium-producing countries has yet ratified or acceded to the Protocol. An important part of our program is to urge other nations to do so.

- The international control system will intensify its efforts against illicit narcotics traffic through access to better information, on-the-spot examinations, and publicity of control violations or non-cooperation at the highest levels of the United Nations.
- The United States will have, along with other "victim" countries, significantly greater ability to extradite and thus prosecute narcotics traffickers who have taken refuge in other nations.
- For the first time under a narcotics control treaty, the control organ will have authority to recommend technical and financial assistance to help cooperating governments carry out their treaty obligations.
- Also for the first time in international narcotics control, the nations undertook an obligation to drug abuse prevention and education, by adding the treatment, rehabilitation and social reintegration of drug abusers to law enforcement efforts, as was done in the United States with the passage of the Drug Abuse Office and Treatment Act of 1972.

Even with the Amending Protocol, however, the Single Convention is not without problems. The INCB remains dependent upon the cooperation and ability of the parties to the treaty to furnish it with timely and accurate statistics. An even more serious problem is that the INCB must depend upon the willingness and ability of cooperating governments to respect and enforce the Board's decisions. Finally, it must be recognized that governments unable to enforce their own national narcotics laws are not likely to be able to enforce the INCB rulings.

Another important international treaty is the Convention on Psychotropic Substances of 1971. It provides a system for the international control of psychotropics similar to that which the Single Convention provides for narcotic drugs.[14] Although the United States played a major role in the preparation of this treaty, Congress has not yet passed the enabling legislation and the Senate has not yet ratified it. U.S. ratification of the Psychotropic Convention would demonstrate willingness to control production of substances manufactured here in much the same manner as we ask other governments to control production of narcotics covered by the Single Convention.

[14] The Convention sets up various procedures for the control of psychotropic substances. Manufacturing, distributing, and trading in psychotropic substances must be licensed and the drugs may be dispensed only by an authorized prescription. Warning labels must be used. The Convention also requires that records be kept by the manufacturer, the distributor and the dispenser and provides for a system of inspection. For the more dangerous substances, both export and import authorizations are required. The Convention also calls for measures of prevention and education and for treatment, rehabilitation, and social reintegration of drug-dependent persons. It provides for coordinated action against illicit traffic, punishment of violations of the Convention, and extradition of offenders.

Consequently, the task force strongly recommends the prompt passage of enabling legislation and ratification of this treaty.

Through the initiative of the United States, the United Nations Fund for Drug Abuse Control (UNFDAC) was established to provide voluntary contributions to enable the United Nations and its narcotics organizations to increase their narcotics control assistance to member governments. The fund has helped energize the entire U.N. drug program. It has also been useful in calling attention to the fact that drug abuse is truly a worldwide problem, not one which affects only the United States. Moreover, the Fund has served as an essential supplement to U.S. efforts in those countries which prefer to receive assistance from multilateral rather than bilateral sources.

To date, the United States has contributed four-fifths of the financial support of the Fund, and there is justifiable concern in Congress about the high proportion of the Fund's resources provided by American taxpayers. The task force believes that a more aggressive and imaginative fundraising program directed to the leaders of other governments would be likely to generate greater financial support from them. While it is expected that other governments will progressively carry a greater load, the Fund's work in priority areas such as Turkey is so directly important to U.S. drug supply reduction efforts that it is in our national interest to continue support for the Fund.

The task force believes that the United States should continue to support and actively participate in other important international organizations dealing with drug control. These include Interpol, the international criminal police organization, and the Customs Cooperation Council, an international organization of representatives from the Customs services of 76 member nations.

Cooperative Enforcement and Enforcement Assistance

Once enhanced international interest in drug control is aroused, the problem of translating that concern into effective operational programs still remains. The key to solving this problem is the development of strong drug control organizations within foreign countries. Strengthening foreign enforcement organizations depends on three interrelated components: the provision of technical and equipment assistance, formal training of foreign enforcement officials, and assistance through cooperative enforcement efforts with U.S. agents stationed overseas.

U.S. *technical and equipment assistance* and support to foreign enforcement agencies accompanied by a political commitment on the part of the host government, and careful bilateral planning, can contribute significantly to better narcotics control. In many instances such assistance is absolutely essential to the development of foreign narcotics control capability.

Formal training of enforcement officials is another important component of the program to strengthen foreign enforcement organizations. Since the establishment of the CCINC, the Drug Enforcement

Administration and the U.S. Customs Service have provided training in the United States and overseas for over 9,000 foreign enforcement officials. Such training has taught many foreign officials the necessary skills to suppress illicit narcotics production and trafficking, has motivated them to become more effective in conducting enforcement operations, and has encouraged greater cooperation between them and American enforcement officials.

Under CCINC auspices, an evaluation was recently made of DEA and Customs training programs. It highlighted the need to closely integrate training into the other elements of narcotics assistance programs so that training will contribute to the more basic objective of developing self-sustaining, highly skilled foreign narcotics control units.

Direct assistance to foreign officials through cooperative enforcement activities is a third component of this program. The Drug Enforcement Administration presently has more than 200 agents in over forty foreign countries. The primary task of U.S. narcotics agents abroad is to assist their foreign counterparts in preventing illicit supplies of narcotics and dangerous drugs from reaching the U.S. market. In addition to the reduction in narcotics flow, these joint efforts provide "on-the-job training," for foreign officials in advanced anti-drug trafficking techniques. This cooperative activity has contributed to reducing the illicit traffic affecting the United States. For example, it played a major role in immobilizing the heavy illicit heroin traffic from Turkey and France which had such a serious impact on the United States. Currently, DEA agents are working with Mexican Federal agents to control the problem which has developed there.

The task force believes that additional emphasis on the collection, analysis and utilization of overseas operational intelligence is needed. By providing additional training to U.S. agents abroad in intelligence collection needs and techniques, intelligence could be a more effective tool in deterring the flow of drugs to the United States. Finally, U.S. narcotics agents abroad should concentrate their activities on international trafficking channels, particularly those believed to be headed for the United States, and should avoid becoming involved in inconsequential local arrests and seizures.

Control of Raw Materials

The basic factors to consider in the control of raw materials used in making drugs are controls over legitimate production, and illicit crop destruction and crop substitution programs.

The medical need for opium-derived drugs requires some poppy cultivation. The problem is to control diversion from these legal crops. Past strategy has attempted to concentrate legitimate poppy cultivation in countries with the capability to control diversion, and to strengthen the control capabilities in other producing countries. As a result, India, which has a successful control system, has been a

major legal producer of opium. When Turkey decided to re-enter the licit market, the U.N. made a major effort to assist in the strengthening of control systems. Consequently, Turkey has shifted its harvesting methods from poppy incision to harvesting by the "poppy straw process." This program promises much more effective control of diversion from legitimate poppy cultivation.

Illicit cultivation of opium poppies, coca leaves and marihuana can be attacked through crop destruction or substitution programs. Because of different political, economic and cultural factors in each source country, no general approach can apply. In Thailand, for example, although opium has been outlawed for more than fifteen years, Thai hill tribes have cultivated the crop for centuries. Thus, any serious program to suppress illicit crop production by the Government of Thailand must be undertaken in conjunction with income substitution in the affected areas to create new economic alternatives so that the hill tribes will not turn to banditry or insurgency. An important consideration in the use of crop destruction as a tool in narcotics control is that the elimination of crops at the source in one or two significant countries of supply is not, alone, a solution to the problem. The base materials for illicit drug traffic—whether opium, coca, or cannabis—can be cultivated in a large number of countries, so crop eradication can only be a short-term measure to control drug availability in one specific area.

The task force recognizes that efforts to eliminate illicit cultivation will have limited success as long as there are no viable economic alternatives for growers. Thus, we endorse efforts to develop alternative sources of income. For example, in Turkey our agricultural experts have developed a winter lentil, winter safflower, and hardier oat, wheat, and barley varieties to replace the poppy crop.[15] The United States should continue to explore ways to effect crop substitution in cooperation with foreign countries and the U.N. Such projects increase the possibility of a long-term solution to the problem of illicit supply.[16] While crop replacement projects involve an element of uncertainty, in the final analysis they may constitute the only feasible alternatives to moving to strong controls or the elimination of production, two methods which by themselves are likely to be unacceptable to the producing country.

Since full implementation of a crop substitution project over a large area is likely to be expensive, the task force believes that efforts should be made at the beginning of any such project to enlist other

[15] It is interesting to note that the Turkish government has decided to continue these projects with its own funds, despite its decision to allow renewed cultivation of opium poppies.

[16] Since new crops are unlikely to provide the same income *illicit* poppy cultivation provided, effective enforcement of a poppy-growing prohibition must accompany development of these projects.

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financial sponsors, such as the various international financial institutions.

Mexico: Major Source of Supply

Mexico is currently the top priority country in the international narcotics control program, since drugs are both produced in and trans shipped through Mexico. The Mexican narcotics situation is complicated by such factors as its proxinity to the U.S. market, the size and topography of the country, and the relatively unpatrolled 2,000 miles of common border. All of these factors are exacerbated by the problem of insufficient trained personnel within Mexico.

Since 1969, there has been growing cooperation between the United States and Mexico in suppressing narcotics abuse. President Echeverria has assigned high priority to the Mexican anti-drug campaign, and in May and June 1975, a review of the past year's narcotics control program in Mexico resulted in the Mexican Government's decision to increase dramatically its effort to eliminate illicit cultivation of opium and marihuana by expanding crop destruction operations and committing more personnel to the task.

The United States agreed to support the Mexican effort by providing additional equipment for crop destruction. DEA and Customs are also taking strenuous steps to intensify their own efforts to cope with this problem.

Even though joint U.S.-Mexican efforts within the past year far exceeded those of previous years, the amount of heroin and other illicit substances crossing our common border is not decreasing.

Thus, these efforts must be further improved on both sides of the border. The task force recommends that a program be developed for more effective border control, and that Customs, DEA and the U.S. Border Patrol vastly improve their coordination of activities along the border, including joint task force operations. The task force also recommends that the CCINC be instructed to discuss further cooperative programs with the government of Mexico.

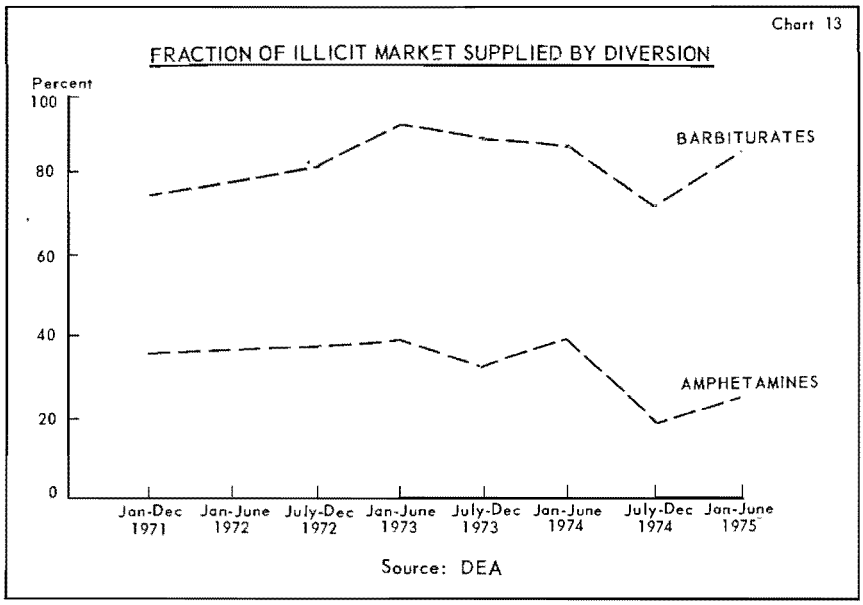
REGULATORY AND COMPLIANCE

In Chapter 2, we observed that the abuse of "dangerous drugs" such as amphetamines and barbiturates ranks with heroin as a severe social problem. Of course, only a small fraction of the people using these drugs use them chronically and without medical supervision. However, this small fraction of the total users amounts to a large absolute number of abusers. Estimates are that there are several hundred thousand people using these drugs in a manner which leads to a high personal and social cost, which is roughly comparable to the number of heroin addicts.[17]

[17] Chapter 2 discusses this concept. Basically, a user is likely to be "in trouble" if he uses these drugs intensively, in combination with other drugs, and without medical supervision.

The regulatory and compliance program plays a vital role in the strategy to control the illicit supply of these drugs. By its very nature, this program is targeted exclusively at drugs which have legitimate medical uses as well as abuse potential. Therefore, two objectives must be carefully balanced: we must keep legitimately produced "dangerous drugs" out of illicit markets, and at the same time preserve a legitimate market in which drugs are inexpensive and readily available.

Moreover, the regulatory and compliance program is targeted only at that portion of the supply of these drugs which is diverted from legitimate domestic manufacture; to deal with illicit production and smuggling, we must rely on a criminal enforcement program similar to that used to reduce supplies of opium, cocaine, and marihuana. The chart below shows that drug diversion accounts for a major share of the illicit market.



Diversion from legitimate domestic production can occur at a variety of different points and in a variety of ways. Drugs can be diverted at the production stage, the wholesale distribution stage, the retail distribution stage, the dispensing stage, or at the sub-retail level (e.g., medicine cabinets). This diversion can occur as a result of thefts, accidental losses, fraudulent purchases, or illicit sales.

The regulatory program attempts to minimize this diversion by (1) using the authority of the Controlled Substances Act of 1970, and (2) by controlling retail diversion.

Controlled Substances Act

The Controlled Substances Act of 1970 provides the statutory authority to regulate drugs which have abuse potential. The Act provides for:

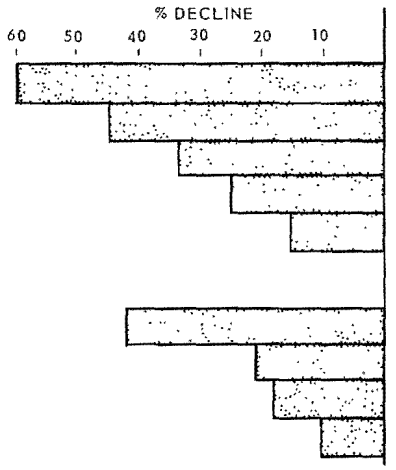
- The scheduling of drugs into five abuse classifications;
- The imposition of manufacturing quotas on Schedule II drugs (highest level of abusable drug with legitimate medical use);
- Auditing firms to determine compliance with the manufacturing, reporting, and security requirements of the Act.

DEA and the Food and Drug Administration (FDA) in HEW share responsibility for scheduling drugs. Scheduling decisions are made by balancing a drug's abuse potential with its medical value. Higher drug schedules correspond to increasing abuse potential and lower legitimate medical need, and require tighter restrictions on production, distribution, and use.

An evaluation of recent scheduling decisions indicates that scheduling does reduce abuse of dangerous drugs without significantly increasing the cost of these drugs to legitimate users. The chart below shows the decline in abuse as measured by DAWN mentions of five stimulants and four depressants following their scheduling in 1973. The average decline is 35 percent.

Chart 14

DECLINE IN DAWN MENTIONS AFTER SCHEDULING IN MID-1973



	STIMULANTS	Schedule
	Benzphetamine	III
	Diethlypropion	IV
	Chlorphentermine	III
	Phendimetrazine	III
	Phentermine	IV
	DEPRESSANTS	
	Methaqualone	II
	Pentobarbitol	III
	Secobarbitol	III
	Amobarbital	III

Source: DEA

During the same period, the retail price of these same drugs in the legal market either remained steady or rose only a few percent. These data indicate that the regulatory system can reduce abuse without substantially affecting the prices in legitimate markets.

The scheduling procedure should be quick (to avoid the spread of abuse); accurate (to insure appropriate trade-offs between preventing abuse and insuring availability for legitimate medical use); and consistent (to avoid legal problems with drug firms). The major obstacle to an effective drug scheduling process has been the difficulty of making reliable assessments of the abuse potential of a drug. However, research currently being conducted by DEA, NIDA and FDA should provide in the near future techniques for quickly and accurately gauging the relative abuse potential of various drugs.

In summary, the scheduling system appears to be working effectively.

DEA and FDA are also required to establish production quotas for Schedule II drugs, based on an estimate of "legitimate medical need" for the drugs. These quotas aim at preventing overproduction of legitimate drugs, thereby reducing the likelihood of diversion.

In practice, the quota system proves difficult to administer and cannot alone prevent the diversion of legitimate drugs. The government must utilize quotas in concert with other regulatory controls to ensure that manufactured drugs are distributed only to those who need them. Since the government is responsible for ensuring the availability of drugs to legitimate users, and since it cannot guarantee appropriate distribution, the quota-estimating procedure must make fairly liberal allowances for inventory and manufacturing needs. This problem of determining production limits is further compounded by inadequate and unreliable projections of demand provided by FDA.

Thus, the realistic function of quotas is to dampen market promotion and prevent overstocking. At best, the quotas limit inventories (sometimes significantly reducing them as with amphetamines) thereby reducing the amount lost when thefts occur and perhaps inhibiting promotional activities by drug companies.

Finally, the Controlled Substances Act requires Federal licensing of all firms that handle scheduled drugs. In addition, the Act imposes an elaborate set of security and recordkeeping requirements on licensed firms. The security requirements help prevent thefts, and the recordkeeping requirements help prevent accidental losses and deter illicit sales.

To insure compliance with these provisions of the Act, DEA investigates licensed firms. The major sanction available to DEA

to induce compliance is its ability to deny or revoke a firm's license to handle scheduled drugs.[18]

The program to control diversion at the wholesale level has been generally effective, but improvements can be made in its efficiency. For example, existing automated information systems can be used to reduce the amount of time required to complete an inspection of a legitimate firm. Information about local trends in abuse, legitimate drugs that appear in illicit markets, the size of existing firms, thefts reported by specific firms, and records of previous inspections can be combined to permit the pinpoint targeting of compliance investigations. The personnel system for compliance investigators (e.g., recruitment, selection, training and evaluation of the investigators) can be strengthened to insure high quality investigations. These three improvements would increase the efficiency and effectiveness of the regulatory program.

Controlling Retail Diversion

Retail diversion is a large and growing problem, as evidenced by the fact that thefts from retail pharmacies have increased sharply in the last two years. Also, a number of recent surveys have indicated that fraudulent prescriptions are not difficult to obtain and are readily filled.[19] The predominance of retail diversion is evidenced by an examination of drugs available in the illicit market; the distribution of brands is parallel to the distribution of brands in legal markets. If wholesale diversion were the major source of supply, the distribution of brands in the illicit market would be skewed in some manner.

The Federal Government has very little regulatory authority at the retail level. Most of the authority in this area is reserved to States. The Federal role primarily involves giving technical, financial and informational assistance to the States. A major obstacle to effective control at the retail level is the sheer number of registrants: there are over half a million.

Since the Federal Government is dependent on State capabilities in seeking to control retail diversion, the most important recommendation of the task force regarding retail diversion is to launch a systematic

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[18] The Federal Government can *revoke* a registrant's license only if the registrant loses his State license, is convicted of a felony, or lies on his application form. Since these criteria are fairly narrow, the revocation sanction is rarely used. However, the Federal Government can *reject* a license renewal application from producers and wholesale distributors for "failing to operate in the public interest." This power does not, however, extend to retail distributors and dispensers. The reissue of a retail distributor's license can be denied only on the same narrow grounds that allow revocation. Thus, the Federal Government's authority is broader at the wholesale level than at the retail level.

[19] A recent DEA study showed that a random sample of pharmacists presented with fraudulent prescriptions filled them in about half of the instances.

effort to upgrade State regulatory capabilities. The other major components of a program to control retail diversion are efforts aimed at improving physicians' prescribing practices and experimental programs to curb pharmacy thefts. Each is described briefly below.

Key elements of the program to *upgrade State regulatory capabilities* include:

- A State assessment program which evaluates current State capabilities, and monitors improvements.
- Expansion of the LEAA supported Diversion Investigation Units which fund joint efforts to control retail diversion.
- Training of State investigators through formal DEA operated schools and by cooperative retail investigations.

Key elements of the program to *improve physicians' prescribing practices* include

- Development of prescribing guidelines by joint FDA, NIDA, DEA and medical society committees.
- NIDA sponsored programs within medical schools to disseminate information on proper prescribing practices and appropriate scheduling procedures.
- Continuation of FDA efforts to educate physicians about proper prescribing practices through labeling and other means.
- NIDA sponsored technical assistance to medical societies regarding peer review of prescribing activities, especially through Professional Standard Review Organizations.

Finally, development of a program to *curb pharmacy thefts* should be given high priority since pharmacies account for over 80 percent of all drugs stolen through the licit distribution system. A pilot program in St. Louis, in which pharmacies took anti-burglary precautions and police gave high priority to pharmacy thefts had promising results, and may form the basis for development of an LEAA experimentation program in other selected cities.

SCIENCE AND TECHNOLOGY

The science and technology function is an important support element of the overall supply reduction program. If successful, the science and technology program will increase the overall effectiveness of other program elements both directly, for example, by providing a better device for tracking suspect vehicles, or by allowing better assignment of interdiction forces through statistical analysis and operations research; and indirectly, perhaps through extracting useful information as to source from a drug sample.

The key in achieving the most from science and technology expenditures is to closely integrate its planning with the objectives and strategies of the ultimate users of the technology, whether in law enforce-

ment, intelligence, regulation of legitimate production, or crop control. Science and technology planned in conjunction with the ultimate user can thus be a vital part of the overall supply reduction effort. For example, the need for a way to identify opium poppy fields over a wide area led to the development of "Compass Trip," an aerial detection system based on multi-spectral photography. Use of this system permitted more effective deployment of ground forces involved in crop destruction, as well as providing a mechanism for subsequently determining the effectiveness of the crop destruction effort.

Based on an assessment of technology needs from the perspective of the overall supply reduction program, the task force recommends that high priority be given to projects in the following areas:

1. *Limit the flow of drugs entering the United States by interdiction at the port of entry or between ports.* Better equipment, such as X-ray systems, thermal viewers and electronic detectors of drug vapor are needed for facilitating border interception efforts. Aircraft equipped with electronic sensors and advanced communications equipment, high-speed boats, and sophisticated ground radar, sensors and monitors are other examples of the type of equipment needed.

   We should also develop better methods for tracking suspect land vehicles, aircraft and boats by improving the use of beacon devices and tracking systems.
2. *Improve U.S. drug intelligence and information systems.* Science and technology can assist intelligence efforts by developing advanced computer technology and management information systems to improve the storage, retrieval and analysis of data. For example, systems have been developed to monitor changes in patterns of drug abuse through analysis of hepatitis data.
3. *Improve communications systems and support equipment for enforcement officers.* The effectiveness and safety of agents could be increased by the use of devices such as miniaturized alarm systems, and night vision and video-recording systems for monitoring drug distribution operations. Advanced communications systems would also facilitate the coordination of various agents' activities. Better tracking devices would enhance an agent's ability to maintain surveillance.
4. *Assign experienced scientists, engineers and technicians to provide direct technical and scientific support for enforcement and intelligence operations in the field.* A closer relationship between technical specialists and enforcement officers would provide each group with a better appreciation of the others' role in the overall supply reduction effort.

5. *Selective local destruction of drug crops.* Development of better means of locating crops and developing poppy-specific herbicides would improve our ability to control poppy cultivation, for example.
6. *Determine the country of origin of illicit drugs by analysis of seized samples.* Trace elements in drugs such as opium, morphine base and heroin can be used to identify their country of origin. Such information has both strategic and diplomatic value.
7. *Determine the source of the diversion of licit drugs into illicit markets.* The deliberate incorporation of trace elements into legitimately produced drugs would aid in pinpointing the location of the diversion effort.

Changes in year-to-year program funding prove particularly disruptive to technology development. Long-term commitments of money and scientific and technical talent are essential in meeting the program objectives described here. Thus, to the degree possible, funding and staffing of science and technology activities should remain relatively steady from year to year.

4. DEMAND REDUCTION

If the supply reduction effort discussed in the last chapter is successful, illicit drugs will become more expensive, will be more difficult to find, and buying them will be hazardous. As a result, fewer people will use drugs illicitly, and those who do may reduce their consumption.

However, some drugs will continue to be available in the illicit market in varying quantities, since supply reduction efforts cannot be completely successful. Thus, some people will continue to use drugs and others will experiment with them and perhaps become habitual users.

In Chapter 1, we noted that complementary demand and supply reduction programs improve the effectiveness of the overall effort to combat drug abuse. This chapter analyzes the components of the Federal program to reduce the demand for drugs.

Most of the early efforts in the demand reduction area were directed toward providing treatment to drug users. This emphasis on providing care for those in need was appropriate because of the acute nature of the problem and the national responsibility to provide treatment to those who seek it certainly continues.

Nonetheless, we now realize that "cures" are difficult to attain. This is especially true if we define cure as total abstinence from drugs. Relapse rates are high, and many narcotic addicts require treatment again and again.[1] Even treatment which does not result in permanent abstinence is worthwhile from society's point of view, since for the period of treatment plus some time beyond, most addicts' lives are stabilized and most are better able to function as valuable members of society. Perhaps the addict is able to hold a job, or returns to school, or becomes a more reliable family member. Certainly, treatment—even if not completely successful—is useful.

But treatment alone is not enough. Once someone reaches the point at which he needs treatment, a serious problem has already developed and permanent improvement is extremely difficult. It is far better to prevent the problem before it develops.

Therefore, the task force believes that greater emphasis must be placed on education and prevention efforts that promote the healthy growth of individuals and discourage the use of drugs as a way to solve (or avoid) problems. Experiences to date indicate that broad-based, community-based programs which meet the developmental

[1] Experience shows that individual addicts who return to treatment exhibit more progress the second time; more again the third; and so on.

needs of children and youth are the most effective, and future emphasis should be placed on this type of prevention and education program.

At the same time that greater emphasis is being placed on prevention efforts, it is also important that greater attention be paid to drug users by existing rehabilitation programs in order to provide them with marketable skills and jobs. Positive changes in an addict's life and self-esteem are needed to keep him from returning to drug use. A job can do as much to accomplish this as anything else.

Detailed recommendations for improving demand reduction efforts are only highlighted here. Many others developed in the course of the review have already been implemented in whole or in part. The balance of this chapter summarizes the most important findings, conclusions, and recommendations of the task force under six headings:

- Education and Prevention.
- Treatment.
- Vocational Rehabilitation.
- Interface with the Criminal Justice System.
- Research, Demonstration, and Evaluation.
- International Demand Reduction.

EDUCATION AND PREVENTION

Illicit drugs are likely to remain available for a long time. And, despite our efforts to treat and rehabilitate drug users, we now understand that once a person begins to abuse drugs, long-term rehabilitation is both expensive and difficult. These sobering facts have convinced many experts that supply reduction efforts, even when coupled with treatment and rehabilitation, are not enough, and that ultimately the drug problem can only be contained through effective education and prevention efforts.

There has been common agreement on the long-term desirability of expanding efforts in the education and prevention field for some time. However, only recently has experience begun to indicate how that expansion should be implemented and what roles the Federal, State and local governments and the private sector should play.

One conclusion well supported by experience is that drug abuse does not occur in isolation, so programs which address the broad developmental needs of children and youth are the most effective in preventing and reducing drug abuse and other forms of self-destructive behavior such as truancy, alcoholism, and juvenile delinquence.[2] The

[2] Although recognizing that drug abuse is not confined to youth, current education and prevention efforts concentrate on youth from early childhood through late adolescence. Adults of all ages and roles will be involved in these efforts, but as a group they will not be the target of a specific effort.

most successful drug abuse education and prevention programs are those that take into account all the problems affecting young people and do not focus exclusively on drug abuse.

Another lesson learned from experience is that in all programs where prevention efforts have been successful, the local community has been a vital part of program planning, management and financial support. In some communities the schools are the focal point of prevention activities; in others, churches; in still others, neighborhood "rap" centers. Communities have generally been very receptive to the development of prevention activities, and over 1,000 communities have responded to the opportunity to receive training to help them create the opportunities for personal and social growth for their youth which prevent or reduce destructive drug use. This community interest is evidenced by the number of Office of Education Mini-Grant Projects [3] and NIDA funded demonstrations currently underway.[4]

We have also learned valuable lessons from programs which have proven unsuccessful. Early experiments with drug education using scare tactics aimed at youth and children did not work. In fact, they may have been counterproductive by stimulating curiosity about drugs. Future Federal media efforts aimed at this audience should:

- provide basic information about drugs and their effects, not in a "scare" sense, but with an objective presentation of "best information"; and
- emphasize successful and productive lifestyles of non-drug users.

Additional media efforts should be directed at parents, teachers, police, clergy, and others whose relations with drug-prone youths have a major influence on whether or not they decide to use drugs.

In the general area of community-based prevention, the Federal role should be catalytic in nature; specifically:

- To provide training and technical assistance to local communities which enable them to define their problems and mobilize

[3] The Mini-Grant program is an attempt by the Office of Education to involve concerned people in local communities and school systems in the planning and execution of programs dealing with youth problems. Selected teachers, parents, police, and other concerned residents are trained in organizational skills so they can successfully establish and fund programs defined by the community as important in assisting with the problems of youth. Approximately 1,500 local drug abuse prevention programs have been established by these core groups, and another 2,500 "influenced" by them.

[4] The NIDA program provides over 40 communities with funds to be used in the development of innovative prevention program techniques that might serve as models for replication in other locations. A wide variety of community and school-based initiatives are presently being supported, including peer-counselling, interpersonal communications and problem solving skills, career education, and planned alternatives programs.

their resources in support of effective education and prevention programs;

- To provide materials and guidebooks for use by local programs;
- To provide limited seed money for particularly critical programs and creative new programs;
- To rigorously evaluate existing programs; and
- To make the results of these evaluations widely available for use by States and local communities in designing or improving their own programs.

The task force does not anticipate (or recommend) major Federal grants in support of these local projects.

Federal efforts to deal with the wide variety of youth problems are now scattered across numerous agencies. The task force believes that it is critically important to coordinate and integrate their efforts more closely. The agencies involved include:

- Law Enforcement Assistance Administration (Justice)
- Drug Enforcement Administration's Prevention Section (Justice)
- Runaway and Truancy Programs (Health, Education and Welfare)
- Office of Education (HEW)
- National Institute on Drug Abuse (HEW)
- National Institute on Alcohol Abuse and Alcoholism (HEW)
- National Institute of Mental Health (HEW)
- Dependent School System (Department of Defense)
- Social and Rehabilitation Service (HEW)
- Veterans Administration
- Extension Service—4–H Youth Program (Department of Agriculture)

Representatives of these agencies should form a permanent functional subcommittee under the Cabinet Committee for Drug Abuse Prevention (CCDAP).[5] The subcommittee's first responsibility should be to develop a government-wide prevention plan which will address all dysfunctional behavior in youth regardless of the particular form it takes. This plan should be submitted to the Secretary of HEW, as Chairman of CCDAP, by March 31, 1976.

In summary, education and prevention should play a more important role in the national program than they have in the past. The task force recognizes that drug abuse does not occur in isolation and that drug abuse prevention programs involve many of the same elements which are required to prevent other kinds of self-destructive behavior. Accordingly, the task force believes that these drug abuse prevention efforts should be integrated into an overall Federal, State, local,

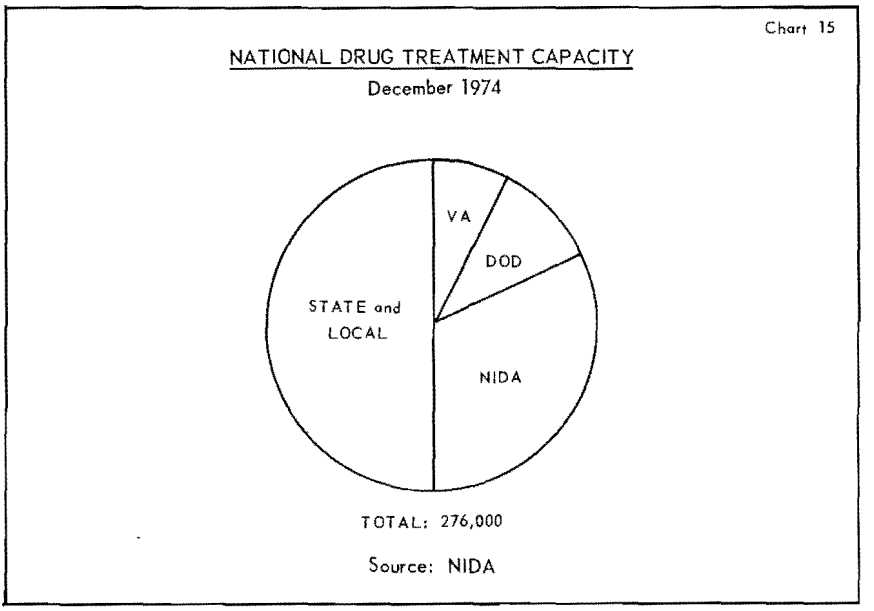
[5] See chapter 5.

and private program for dealing with all behavioral problems among youth as soon as possible. Finally, the role of the Federal Government in this area should be catalytic and supportive; the major effort and funding should come from local communities.

TREATMENT

As mentioned earlier, the main thrust of the Federal demand reduction effort to date has been in treatment. Reflecting this priority, the budget for Federally funded treatment services grew from $18 million in 1966 to $350 million in 1975.

Progress in establishing a sizeable treatment capacity has been impressive. As shown in Chart 15 below, national capacity exists to treat over one quarter of a million drug abusers at one time. Since the average length of time an individual remains in treatment is seven months, this treatment system could potentially treat over 450,000 drug abusers in a given year.



Yet even this doesn't seem to be enough. Waiting lists began to form again early in 1975, after being almost nonexistent for 15 months. No longer can NIDA shift unused treatment slots to more hard-pressed areas as was done throughout 1974, since no significant excess Federally supported capacity exists anywhere. The number of identified drug abusers among persons arrested is climbing. Nearly everyone from the treatment community contacted in the course of the study named "limited treatment capacity" as the single most important issue in drug abuse treatment and rehabilitation.

Treatment capacity should be increased to fill unmet treatment demand when necessary because of the high social cost associated with compulsive drug use. But there are also ways to increase the effective capacity of (or reduce the effective demand on) the existing system, and to increase the efficiency of treatment. Both types of improvement should be made before increasing static capacity. The task force recommendations regarding treatment are discussed below in four sections:

- Treatment priority.
- Treatment types (or "modalities").
- Quality of care.
- Supplemental funding.

Treatment Priority

In chapter 2, we said that priority should be given to those drugs and patterns of use which have the highest social costs. We said that the highest social costs were associated with the *compulsive use* of those drugs with high dependence liability. Drugs in the highest risk category are:

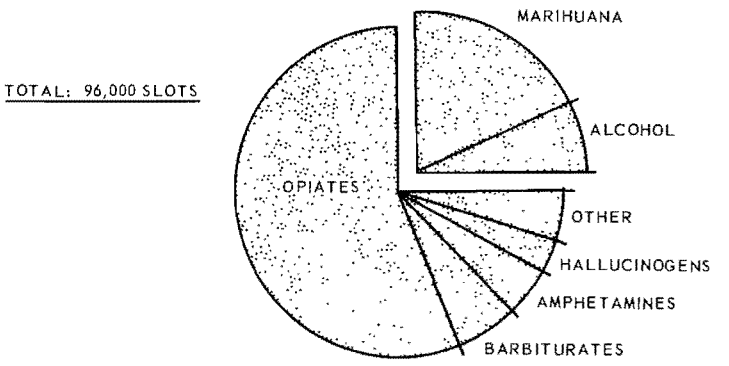
- Heroin
- Barbiturates, particularly when mixed with other drugs
- Amphetamines, particularly when administered intravenously

Other drugs of abuse, such as cocaine or marihuana, present a somewhat lesser but not insignificant risk, particularly if used in a compulsive manner.

Chart 16 below shows the percentage of patients admitted to treat-

Chart 16

PRIMARY DRUG OF ABUSE



Source: CODAP

ment funded by NIDA, VA, and the Bureau of Prisions between January and April 1975 who reported various drugs as their primary drug of abuse.[6]

Marihuana, the second most prevalent drug, is not one identified as having a high priority. The third most prevalent is alcohol for which separate treatment centers exist. The task force recognizes that some individuals are indeed suffering severe adverse consequences because of compulsive use of these drugs and need treatment. But to the extent possible, services in drug treatment centers should first be provided to abusers of opiates, barbiturates, and amphetamines.

The task force also recognizes that many drug treatment centers face the problem of receiving inappropriate referrals of casual or recreational marihuana users from the courts for "treatment" as an alternative to jail. This places both the client and treatment center in a difficult position. The task force recommends that NIDA, in conjunction with the Department of Justice, establish and distribute guidelines for appropriate judicial referral for drug treatment services. Further, the task force urges the expanded use of community mental health centers (CMHC's) to provide alternate community treatment. The success of CMHC's in providing drug and alcohol treatment, particularly in rural areas, is sound evidence that these resources can and should be used to a greater extent than at present.

In summary, all agencies involved in drug treatment should develop operating plans which give preference to abusers of high-risk drugs or compulsive abusers of any drug, to the extent possible, and should refer users of low-risk drugs to other social services.[7] Agencies such as VA and DOD which are required to provide treatment to users of lower priority drugs should do so in the most cost-effective way possible. The work group has made recommendations to the Assistant Secretary for Health, HEW, which give NIDA the authority to ensure that Federally funded Community Mental Health Centers make

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[6] Unfortunately, we do not have complete data concerning the 120,000 non-Federal slots. However, we believe that the pattern shown here closely approximates that for non-Federal slots as well.

[7] Options for implementing a policy of giving treatment priority to users of high-risk drugs are somewhat limited for some agencies. For example, Veteran Administration legislation mandates treatment for all eligible veterans who request it, regardless of their particular drug of abuse. Nonetheless, even in these situations some leverage exists through choosing to provide less costly types of treatment to users of lower priority drugs, and reserving the most expensive treatment for those using high-risk drugs.

services available to drug users.[8] If only half of the NIDA funded slots currently occupied by marihuana and alcohol abusers could be recovered, 12,000 Federal slots would be avialable to treat users of more serious drugs.

Treatment Types

Another way to increase the effective capacity of existing treatment programs is to utilize the most cost-effective type of treatment for each patient. There are a variety of treatment types including:

- *Methadone maintenance,* which provides the medication to satisfy the craving for narcotics in dependent individuals so that they can take advantage of rehabilitation services and maintain a more normal lifestyle.
- *Detoxification,* which gradually eliminates a patient's physiological dependence on a drug.
- *Drug-free treatment,* which provides counselling and structured activities to help the individual regain his place in society.

Each of these, in turn, are offered in a variety of settings, which have radically different costs.

	Average yearly cost per patient
• Hospital (inpatient)	$21,800
• Prison	9,000
• Residential, including half-way houses and therapeutic communities	4,500
• Day care	2,200
• Outpatient	1,700

To give an indication of the use of these various treatment types and settings, Chart 17 shows the percentage of patients entering NIDA treatment programs between January 1 and March 31, 1975, in each type and setting. For example, Chart 17 shows that 8 percent of the patients entered hospitals for detoxification, while 42 percent were drug-free outpatients.

Since hospital treatment costs more than twenty times as much as outpatient services, we recommend that the latter form of treatment

[8] Specifically, NIDA should be given the means to ensure that Community Mental Health Centers provide the full range of drug abuse services as mandated by Section 401(A) of PL. 92–255; and NIDA should be authorized to approve or disapprove all requests for waivers by CMHC's as they relate to this legislation.

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Chart 17

TYPES OF TREATMENT AND SETTINGS

TREATMENT SETTING	TYPE OF TREATMENT			
	Methadone Maintenance	Detoxification	Drug Free	TOTAL
• Prison	—	—	3	3
• Hospital	—	8	3	11
• Residential	—	2	12	14
• Day Care	—	—	4	4
• Outpatient	15	10	42	67
TOTAL	15	20	64	100%

be utilized whenever possible. For example, opiate detoxification can usually be accomplished on an outpatient basis, and should be.

In general, inpatient detoxification should only be used when drug abusers are physically dependent on a drug, and when life-threatening medical, surgical, psychiatric, or obstetrical complications justify hospitalization. Another instance in which this option should be considered would be mixed addictions such as opiates and barbiturates requiring two separate withdrawal regimens.

On the other hand, the possibility of effectively treating compulsive abusers of high-risk drugs in outpatient drug-free slots is highly questionable. People abusing opiates and barbiturates generally need either medication or the structure and supervision provided in a day care or a residential program. The use of outpatient drug-free slots for low priority drug users should be curtailed, and such funds used to provide effective treatment services for high priority drug users.[9]

Quality of Care

Improving the quality of care will also constructively affect the balance between treatment capacity and demand. To the degree that we improve treatment effectiveness, the relapse rate—the percentage of treated drug users requiring further treatment—should decline,

[9] For example, the 31% of NIDA's outpatient drug-free slots currently used for marihuana users, and the 17% currently used for people who claim no drug use at all.

thereby reducing the effective demand for treatment services in a relatively short period of time.

During the past year, NIDA has initiated a number of major programs to improve the quality of care in drug treatment programs. These include publication of the Federal Funding Criteria and various "How To" manuals, provision of technical assistance training for both professionals and paraprofessionals, ongoing program review and development of accreditation standards under the auspices of the Joint Commission on Accreditation of Hospitals.

In addition to those steps which have already been taken, the task force has recommended several specific actions to the Director of NIDA, the Assistant Secretary for Health, HEW, and other appropriate officials. These actions, many of which are already being implemented as a result of being highlighted by the task force, are summarized below.

1. *Switching from methadone to LAAM, a long acting substitute for. methadone, in treating opiate-dependent persons as soon as its safety and efficacy have been determined.* Because patients will only be required to come to the clinic three times a week, LAAM should reduce diversion, cost, and interference with patients' work schedules.
2. *Publishing revisions to regulations governing methadone immediately.* These regulations will facilitate entrance into treatment and will allow more reasonable surveillance, establish a more equitable patient termination procedure, and allow the use of physicians' assistants where medically and legally appropriate to substitute for certain current physician time requirements.
3. *Accelerating skill training for paraprofessionals.*
4. *Resolving jurisdictional and organizational problems between DEA, NIDA and FDA.* Most of these deal with overlapping responsibilities for setting and monitoring compliance with treatment standards. The task force recommends that this be made NIDA's responsibility.
5. *Incorporating drug abuse into the required curricula of medical schools and schools of social work, psychology, and vocational rehabilitation.* Drug abuse problems have generally been on the periphery of health training, and medical schools seem unwilling to incorporate the subject into their curricula; of 115 U.S. medical schools, fewer than 5 require course work in drug dependency and less than 20 offer it as an elective. Some progress has been made; for example, licensing and accreditation examinations for health personnel are being revised to include specific references to drug abuse knowledge

and related skills. However, more must be done and the task force recommends that HEW develop a specific plan in this regard.

Supplemental Funding

The Federal Government funds drug treatment services by sharing costs with local programs on a gradually declining Federal share basis for a period of several years. Part of the philosophy of this type of funding is having the Federal Government provide the financial assistance and expertise to initiate treatment programs, with the Federal role gradually declining to allow State and local agencies to pick up larger shares of the costs of these programs. However, many programs are now finding it difficult to meet even their proportionate matching share of funding.

HEW's policy is to move away from grants for specific programs (categorical grants) toward reliance on payments by outside agencies such as insurance companies, Medicaid, and social services funds (third-party payments) for services provided clients. While this policy is sound in the case of most medical and social services, there are at present many serious limitations to garnering third-party payments for drug abuse treatment. These include:

- *Client Eligibility.* A large percentage of clients in drug abuse treatment do not qualify under major third-party programs (i.e., Medicaid and social service funding) due to stringent eligibility requirements related to age, sex, income and disability.
- *Lack of Coverage.* Less than one-third of the treatment clients are employed at the time of admission, and of those employed, many do not have health insurance coverage. Those clients who are insured are likely to have plans that exclude out-of-hospital benefits, thereby eliminating the majority of cost-effective drug abuse treatment services. Furthermore, many insurers view drug addiction as a self-inflicted or chronic problem and will not provide coverage.
- *Provider Status.* The Medicaid program is administered differently in each State. Since clinical services are optional under Medicaid, community-based treatment clinics are eligible for reimbursement only in States which have such plans. An additional constraint is the lack of licensing and accreditation standards for drug abuse programs, necessary for inclusion under most insurance plans.

- *Rate Structure.* Most payment programs are not obligated to pay the full cost of services, resulting in a gap between costs and reimbursement.

Because of these limitations, third-party payments are not realistic as a major source of funding for drug abuse treatment services at this time. The changes required for drug abuse coverage would be massive, including changes in Medicaid and social service statutes, changes in the implementation of the Medicaid program, and comprehensive revamping of private insurance policies. However, drug programs have not adequately tried to capture third-party and social service reimbursements for those clients who *are* eligible.

Under current legislative and regulatory provisions, third-party payments cannot be expected to replace Federal funding for drug abuse treatment and rehabilitation, but they can be an important supplement. For example, third-party payments can be used as a secondary funding mechanism for programs to meet a portion of their local matching requirements.

Rather than jeopardize treatment programs which are already finding it difficult to obtain local matching requirements, the task force recommends that the Federal share of categorical program support not be reduced below 60 percent. This cost-sharing rate of 60 percent Federal/40 percent local should be maintained until it can be determined that local governments and private donors are able to assume greater fiscal responsibility.

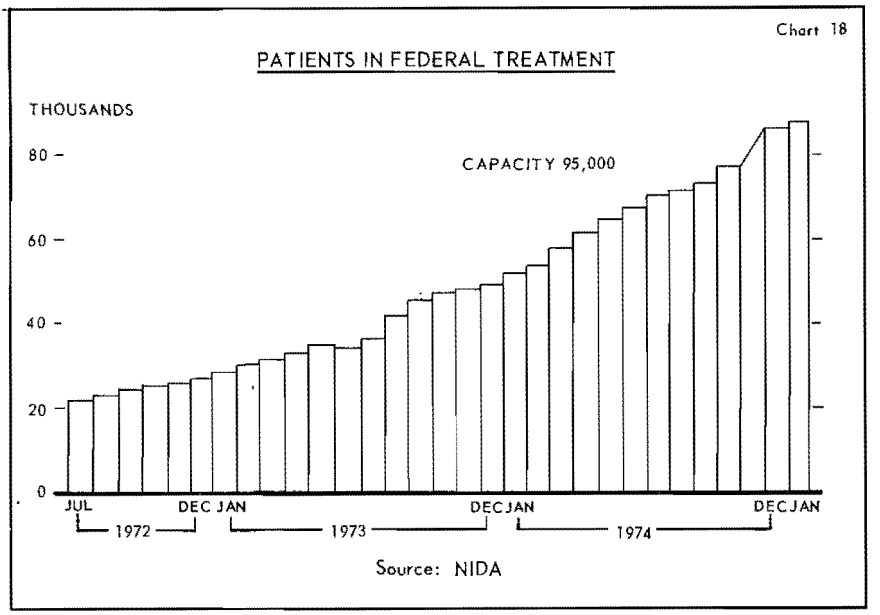
In the long term it is critical that drug abuse treatment services be incorporated into the general health services system. However, it is impractical to do so at this time. Nonetheless, the task force believes that we must continue to pursue the goal of including drug abuse services in national health insurance and other programs designed to meet the overall health needs of Americans.

Current and Projected Treatment Demand

Many of the steps recommended above will have a significant impact on the treatment capacity required in the future. For example, the identification of barbiturates and ampehtamines as drugs whose abuse warrants high treatment priority will tend to increase treatment demand. On the other hand, many under-utilized slots can be freed through more careful screening of marihuana and alcohol abusers.

It appears, nonetheless, that current capacity is inadequate to meet the existing demand. NIDA treatment utilization has increased

rapidly over the past 18 months and is now operating at or above effective capacity as shown in Chart 18 below.[10]



Initially, treatment programs were funded on the basis of "best guesses" of the demand for treatment in an area. However, during 1974 a full inventory of treatment utilization was made and a massive shifting of slots occurred from areas of underutilization to areas where there was unmet treatment demand.[11] This resulted in a better geographic distribution as well as full slot utilization. Today, because almost all treatment facilities are operating at a capacity level, only marginal geographic shifts in treatment location are possible.

Thus, there is a shortage of treatment resources at the present time. This existing unmet treatment demand comes from several sources:

	Approximate Number
• Patients currently on NIDA waiting lists	4, 400
• The treatment alternatives to street crime program (TASC) (It is anticipated that the TASC program will generate this unmet treatment demand of 4,500 slots annually)	4, 500
• Bureau of Prisons parolees (U.S. Probation Service estimates an additional 3,000 potential clients for the already fully utilized community care programs.)	3, 000

[10] Effective capacity is below 100 percent because a few slots will be empty at scattered sites, lowering the utilization rate.

[11] Over 15,000 slots were shifted during 1974

In addition, further demands are likely, since NIDA treatment utilization has grown by approximately 3,000 patients per month during the past year. That rate has slowed in recent months, but it is reasonable to expect some additional demand from communities.

Non-Federal sources are unlikely to meet all of this increased demand for treatment. Local programs are already experiencing difficulty in meeting their increasingly proportionate share of funding through the categorical grant process. State and local sources now fund about one-half of all treatment slots, and these sources are finding it difficult to increase their investment in drug abuse treatment. And, given the many legislative and programmatic constraints outlined in the supplemental funding section, third-party payments cannot make a substantial contribution to treatment funding at the present time.

Therefore, the Federal Government should be prepared to fund additional community treatment capacity. The exact number of additional slots required will not be known until the interrelated effects of the recommendations discussed above are assessed, but it is imperative that the number be determined as soon as possible. The task force recommends that CCDAP[12] undertake a high priority analysis of treatment capacity, and submit a recommendation to the President by December 1, 1975, in order to be considered in FY 1977 budget deliberations.

VOCATIONAL REHABILITATION

Vocational rehabilitation is a critical part of the treatment process, since society's objective of altering the drug-using lifestyle of a former addict is clearly linked to his ability to find and hold a job. A job not only enables one to be self-supporting, it enhances the dignity and self-reliance that people need to be responsible members of society.

Treatment services targeted at interrupting the abuse of drugs are an important first step. To complete the process and insure against the likelihood of return to drug use we must provide the abuser with the emotional stability and technical skills he needs for survival. At present, the rehabilitation needs of drug abusers are not being adequately met. For example, CODAP[3] data for the period ending September 30, 1974, indicated that 30 percent of clients in treatment were employed full-time; 5 percent employed part-time; 4 percent were in training programs, and 12 percent were in education programs. But, 49 percent of clients in treatment were not involved in any form of employment, educational or training activity at all.

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[12] See chapter 5.

[3] Client Oriented Data Acquisition administered by NIDA.

A further example of the lack of success in rehabilitation is depicted in Chart 19 below, which shows the vocational status of patients entering treatment and leaving treatment from January 1 to March 31, 1975.

Chart 19

EMPLOYMENT AND EDUCATION STATUS OF CLIENTS

% of Clients

Activity	Employed Full-Time	Employed Part-Time	In School	In Skill Development	None of the Named Activities
when admitted	19.64	5.23	20.67	3.84	56.13
when discharged	20.26	6.10	17.61	4.40	58.06

(Source: CODAP Report June 1975)

These data are imprecise since they deal with different groups of people. But the story they tell is distressing: there may be no discernable improvement in the employment and educational status of patients during their period of treatment. Either the treatment system, or the rehabilitation system, or both have missed an important opportunity.

Treatment programs themselves are usually not equipped to provide clients with the skills, training, and educational services needed to prepare for employment. These rehabilitation services have not been built into the treatment system, since they are available through State and local rehabilitation programs. However, the availability of such services depends upon the willingness of local and Federally funded rehabilitation programs to provide services to drug users, and the willingness of private and public employers to hire them. Unfortunately, in far too many cases, this cooperation is lacking.

To encourage more effective cooperation and collaboration between drug abuse treatment programs and the rehabilitation and employment service agencies, the task force recommends the following:

1. Establish a vocational rehabilitation subcommittee under CCDAP[14] with representation from the Department of Labor, Rehabilitation Services Administration (RSA), Veterans Administration, Social and Rehabilitation Service, and NIDA to develop a strategy to review current program regulations and guidelines, State plans, and special initiatives of relevance to the long-term rehabilitation of drug abusers. This subcommittee should (1) develop joint research and demonstration projects to improve the delivery of rehabilitation and employment services to drug abusers, and (2) develop strategies for involving the private sector in the employment and rehabilitation of drug abusers.
2. Establish and implement a DHEW policy that RSA, in cooperation with NIDA, will formally encourage State vocational rehabilitation agencies to provide rehabilitation services to drug abusers. While the legislation and regulations governing State vocational rehabilitation programs clearly state that no individuals or groups may be excluded because of their disability, the fact is that in RSA no current emphasis is placed on the provision of services to drug abusers. The regulation which states that no individual or group may be excluded because of their disability should be strictly enforced enforced in connection with drug abusers.
3. Encourage drug abuse Single States Agencies and treatment programs to seek cooperative agreements with manpower and vocational rehabilitation agencies by strengthening the drug abuse State plan regulations to require substantive joint activity. Emphasis should be placed on establishing mechanisms to provide for referral of clients requiring employment oriented services and on requiring joint State and local planning to provide a full range of services to drug abusers.
4. NIDA and the Department of Labor should review all regulations to ensure that they do not impede the provision of rehabilitation services to drug abusers. This applies to the NIDA confidentiality regulations as well as vocational rehabilitation regulations.

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[14] Cabinet Committee for Drug Abuse Prevention, discussed in chapter 5.

INTERFACE WITH THE CRIMINAL JUSTICE SYSTEM

Studies have repeatedly shown that most high priority drug users have a history of repeated involvement with the criminal justice system. This involvement may be an arrest for possession or for a "habit-supporting" crime such as larceny. Or, it may be for offenses entirely unrelated to drug use. Whatever the reason, these arrested drug users are prime candidates for treatment since the arrest and subsequent criminal justice procedure provides an opportunity to detect and monitor their drug-using behavior, and to encourage their participation in a treatment program. Therefore, development of systematic linkages between the treatment and criminal justice system is critical.

Ideally this linkage would encompass everyone who comes into contact with Federal or State criminal justice systems for any significant period of time and would operate from the time of arrest until final discharge from the correctional system. Current programs begin to meet this requirement, but are limited in scope and geographic coverage. Further, relationships between treatment and criminal justice agencies have often been impeded by procedural obstacles, mutually shared suspicions and inadequate coordination.

The Federal Government currently sponsors programs to improve these linkages for both Federal and State offenders. Below, the task force recommends new initiatives for both Federal and State offenders.

Federal Offenders: Pre-Trial

While there are no existing programs which screen people entering the Federal criminal justice system for drug abuse, the recently passed Speedy Trial Act of 1975 (STA) may provide the vehicle to develop an identification and referral program.

Title III of the STA provides for the establishment of pre-trial service agencies on a demonstration basis in ten Federal judicial districts. In these pilot projects, all arrestees are to be routinely screened to determine if they have a history of drug abuse or are currently using drugs. Recommendations are to be made to the judicial officer, who can place the defendant under supervision of the pre-trial services officer. This pre-trial services officer then can assist the defendant in securing any necessary drug treatment, employment help, medical or legal services.

The Speedy Trial Act is an important step in the right direction, but it has some limitations. While mandatory urinalysis for all offenders may not be feasible, the program should develop an effica-

cious means of identifying drug-abusing criminal offenders and referring them for treatment services. Further, activity under STA applies only to those arraigned and pending trial, and does not deal with others who voluntarily or involuntarily come in contact with the system through investigation or arrest and release. Finally, the ten cities pilot provides no assurance that programs will be developed in all Federal judicial districts.

If the results of the first ten pilot projects are good, the task force recommends prompt expansion of the program.

Prisoners and Parolees

The Bureau of Prisons (BOP) provides drug-free inpatient treatment to certain opiate-dependent offenders. The incare program consists of 21 treatment units in 16 Federal correctional facilities throughout the United States, currently accommodating approximately 2,000 prisoners. The Bureau also contracts for community care programs for Federal parolees and probationers.

Once Federal offenders are released from prison they are supervised by the U.S. Probation Office, an agency of the judicial branch of government. Persons who could benefit from drug treatment may be referred to community treatment programs either on a voluntary basis, or as a condition of parole. When drug treatment services are required, these services are paid for by the Bureau of Prisons even though the U.S. Probation Office by law must maintain supervision, responsibility and primary contact with the treatment organization.

This cumbersome arrangement should be modified to improve the administration of payments for treatment services for parolees and probationers. The task force therefore recommends that funds and responsibilities be transferred from BOP to the U.S. Probation Service, and that the U.S. Probation Service be made pay agent for treatment services for Federal parolees and probationers.

Another problem area with Federal parolees is the apparent resistance of the courts and BOP to the use of methadone maintenance. Ninety-five percent of drug using prisoners are opiate abusers, yet only two percent of those persons who get treatment while on parole receive methadone. The need to have access to a wide variety of treatment approaches has been established, and methadone maintenance has proven useful in treating opiate addiction. Therefore, the task force recommends that the courts and BOP accept methadone maintenance as a proper treatment alternative.

State Offenders

Many drug-using offenders come into contact with the criminal justice system at the State level. The main Federal role in these cases is to encourage the State and local law enforcement agencies to utilize treatment processes in conjunction with or in lieu of prosecution and jail, and to provide assistance for this purpose. The task force recommends that priority in Federally funded treatment be given to criminal justice offenders who desire to participate. Further, the task force strongly encourages State and local governments to develop more comprehensive criminal justice treatment programs, drawing upon existing models. It is further recommended that NIDA encourage Single State Agencies and State Planning Agencies to develop joint programs providing greater cooperation in this area.

At the present time, the major Federally sponsored program for referring State and local criminal offenders to community based treatment programs is Treatment Alternatives to Street Crime (TASC). Its goal is to decrease the incidence of drug-related crimes with their attendant cost to the community by interrupting the drug-driven cycle of street crime—arrest—jail by providing treatment. TASC identifies drug abusers in the criminal justice system, refers them to proper treatment, and monitors their progress.

TASC has established projects in 26 major metropolitan areas, with 4,000 clients presently in treatment; over 15,000 have been referred since August 1972. Of the clients referred under TASC, over half were receiving drug treatment for the first time.

Under present policy each TASC project may receive a maximum of two or three years of LEAA discretionary funding. After this period, each project must seek local and/or State continuation funding. One project has completed its LEAA funding period and is being funded by State block grant funds. Three additional projects whose Federal support ends in January 1976 will be continued by non-Federal funding. It is anticipated that most of the remaining Federally funded TASC projects will secure State and/or local funds despite the present economic situation.

The task force recommends that the TASC project be expanded to include any jurisdiction with a population of 200,000 or more that can satisfactorily demonstrate eligibility. The task force also recommends that TASC funding over the next several years be maintained at its present level of approximately $4 million per year. As older projects complete their period of Federal funding, monies will be available for new starts. Increased efforts should also be undertaken to secure continued funding of all successful TASC projects from LEAA State Planning Agencies.

Summary

Current programs for Federal offenders are limited in scope (i.e., focusing primarily on parolees) and geographic coverage, and are functioning under obsolete legislation.[15] Moreover, there is presently no comprehensive Federal guidance for State and local agencies who seek to establish programs more flexible than TASC. Development of comprehensive programs for providing drug treatment to all criminal offenders who need it should be given the highest priority.

Accordingly, the task force recommends that an interdepartmental committee on the drug user and the criminal justice system be established under the Cabinet Committee on Drug Abuse Prevention. This committee should:

- Develop alternative models for treatment in lieu of and in conjunction with criminal justice processing from the time of arrest through final discharge.
- Develop minimum standards on these matters as guidelines to be employed in connection with the funding of State and local programs by both LEAA and NIDA.
- Draft new legislation for the treatment of Federal offenders encompassing the entire process from arrest through final disposition; this legislation would replace NARA and other obsolete legislation and would provide a model for parallel State and local efforts.

A progress report should be completed by March 31, 1976.

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[15] The Narcotic Addict Rehabilitation Act of 1966 (NARA) is outmoded. For example, under Title I, persons charged with certain Federal offenses are eligible for civil commitment in lieu of prosecution. However, this cumbersome procedure has been infrequently invoked since its enactment, and has become obsolete in terms of contemporary treatment approaches.

Title III of NARA provides Federally funded treatment for persons who voluntarily present themselves to the U.S. Attorney and request these services. Often such persons "voluntarily" request such commitment in return for dismissal of criminal charges by local prosecutors. The task force recommends that Title III be terminated. Title III provided treatment at a time when there was no established network of community based treatment services in the country. However, today NIDA has established a nationwide treatment network through funding of staffing grants, drug abuse service project grants, State-wide service contracts and formula grants, and currently maintains 95,000 treatment slots.

Thus, there no longer exists the basic need for Title III of NARA. In fact, utilization of Title III slots has showed a dramatic decrease from almost 2,000 clients in 1971 to 265 clients for the same period in 1975. The money saved from the more expensive NARA slots ($2,940 per slot for NARA vs. $1,640 for NIDA) could be used by NIDA to supplement grants in those treatment areas that do not have room for additional clients.

RESEARCH, DEMONSTRATION AND EVALUATION

Since 1971, drug abuse research has received increasing priority, with higher levels of resources available and major national capability created in the field. Funding over the past five years has totaled $243 million, as shown below.

Funding (millions of dollars)

	1971	1972	1973	1974	1975	Total
NIDA	14.3	28.6	39.3	54.2	48.4	184.8
OE	4.2	4.6	3.0	0.2	0.5	12.5
DEA	na	3.7	3.3	7.8	5.7	20.5
VA	0.3	0.6	2.0	1.0	1.3	5.2
DOD	0.0	3.4	6.6	4.8	4.9	19.7
Total	18.8	40.9	54.2	68.0	60.8	242.7

This research program has led to significant advances in our understanding of drug abuse, particularly in methods of detecting drugs, in measuring the extent of drug abuse and the abuse potential of various drugs, and in the pharmacology of methadone and other chemotherapeutic alternatives for treating narcotic addiction.

In developing a research strategy for the future, two principal areas should be addressed:

- Research priorities; and
- Research management

Research Priorities

There currently is no broad agreement on Federal priorities for research. Yet, the need for greater attention to evaluating the relative effectiveness of different drug abuse prevention, treatment, and rehabilitation approaches is obvious. In order to properly allocate Federal dollars in the future, it is critical that we know what works and what doesn't, for whom it works and under what conditions. This determination requires in-depth follow-up studies on the progress of clients during and after treatment. Identifying what prevention and treatment programs work best should be the number one research priority.

Other high priority areas for research and evaluation include determining:

- What causes a person to turn to drugs: what leads certain individuals into serious drug abuse problems while others avoid them.
- What treatment systems seem to do better in terms of decreasing drug use, decreasing crime, increasing employment, etc.

- What effect different treatment systems have on the behavior of clients, as contrasted with their pre-treatment behavior.
- How the behavior of clients changes during treatment and after release into society.
- Whether characteristics of a clients' profile at admission can be predictors of probable success in one type of treatment vs. another type.
- What treatment methods work best for each type of client. Clients could then be immediately referred to a particular modality based on the information compiled in their client profile studies.

Research Management

Because of the rapid expansion of research activities and the differences between individual agency missions, there is no mechanism for coordinating research across the various Federal programs, no systematic long-range planning to derive the maximum benefit from research activities, and little dissemination of available results between Federal agencies. Since all Federal research is aimed at basically the same objective, there is obviously a need to integrate and coordinate the overall Federal research, demonstration and evaluation (RD&E) effort.[6]

To insure that the required coordination among agencies involved in RD&E is achieved, a single agency must have overall responsibility for Federal RD&E planning. The obvious choice is NIDA, since NIDA is the major funding source of Federal RD&E in drug abuse, with a FY 1975 budget representing over 80 percent of the entire Federal effort. NIDA is involved in all areas of basic research in drug abuse, and has a strong capability in applied research, demonstration and evaluation. Because of the predominant size of its research program, we recommend that NIDA first formulate an overall plan for RD&E in consultation with other agencies involved in the RD&E function. Then other agencies should develop their specific plans in a way that supplements, rather than duplicates, NIDA's program.

Further, in order to coordinate the development of an integrated RD&E program, the task force recommends that an interagency research committee be established under CCDAP. The committee should be composed of the heads of research activities at NIDA, the Office of Education (HEW), the National Institute of Mental Health (HEW), the Drug Enforcement Administration, the Department of Defense and the Veterans Administration.

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[6] This does not negate the need for specific research efforts by agencies which are targeted toward a given population or agency activity, such as Department of Defense research focusing on the drug problems of servicemen.

INTERNATIONAL DEMAND REDUCTION

During the past few years, the Federal Government has markedly increased its participation and support of international drug abuse demand reduction programs.

Further action is required in three major areas of international demand reduction:

- *Providing drug abuse prevention and treatment services for official American citizens residing abroad.* The Department of State should continue to be the agency with primary responsibility for providing treatment services for official Americans and their dependents living abroad in the high-risk areas of drug abuse. In performing this mission, the Department of State should seek technical assistance and advice from NIDA. Programs run by the United States overseas provide additional benefits by serving as on-site demonstration projects for various types of treatment, by facilitating the exchange of information, and by displaying the most up-to-date approaches to drug abuse demand reduction for host country professionals and government officials.
- *Providing advice and technical assistance to foreign governments and international organizations.* Under the CCINC aegis, NIDA should provide teams of consultants to those countries which request U.S. assistance in developing demand reduction plans and programs.
- *Formulating general international drug abuse prevention and treatment policy.* The Treatment Subcommittee of the CCINC should be activated to improve this function and a NIDA representative made Chairman.

The following specific objectives should be pursued by the United States in its effort to reduce domestic drug abuse through prevention programs among foreign governments. We should:

- Assist foreign governments to estimate the scope of drug abuse problems in their country.
- Assist foreign governments in developing programs offering alternatives to drug abuse.
- Encourage and assist foreign governments to undertake and share the results of research on the extent, causes, treatment and prevention of drug abuse.
- Call to the attention of appropriate foreign governments their obligations under Article 38 (as amended) of the Single Convention on Narcotic Drugs, which requires international coordination of demand reduction activities.
- Continue to support the United Nations Fund for Drug Abuse Control and strengthen our bilateral efforts, both to respond to

requests from other governments and to stimulate selectively those requests which will further U.S. interests.

In summary, cooperative demand reduction programs serve to bring to the attention of other countries their own drug abuse problems. This recognition that drug abuse is a problem which affects all nations will help to encourage international cooperation in reducing drug abuse.

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5. PROGRAM MANAGEMENT

The Federal program to control drug abuse is composed of activities as diverse as any in government: crop substitution in the mountains of northern Thailand; drug treatment centers in over 2,000 locations; research on the pharmacology of drugs; cooperative law enforcement with police forces in over 40 foreign countries; Defense Department urinalysis testing; and patrolling thousands of miles of border to prevent illicit smuggling—to name just a few. In fact, the Federal effort to simultaneously reduce the supply of and demand for illicit drugs involves seven Cabinet departments and seventeen agencies.[1]

Clearly, strong coordinative mechanisms are necessary to ensure the efforts of these departments and agencies are integrated into an effective overall program, and that the approach adopted in each is consistent with the President's priorities. This need was quickly recognized when drug abuse first became a high priority program in the early 1970's. A variety of permanent and temporary offices were created to provide policy guidance, program oversight, and interagency coordination of the rapidly expanding program. These included:

- The Cabinet Committee on International Narcotics Control (CCINC), created in 1971 to coordinate the international control program.
- The Special Action Office for Drug Abuse Prevention (SAODAP), created in 1971[2] to oversee and coordinate the development of a comprehensive treatment and prevention program to balance the existing law enforcement program.
- The designation of the head of the Justice Department's Office of Drug Abuse Law Enforcement (ODALE) as Special Consultant to the President for Narcotics Affairs in 1972.
- The creation of a special drug abuse staff within the Domestic Council.

As the drug program matured, many of these temporary offices were replaced with more traditional and stable structures. By mid-

[1] Departments of State, Defense, HEW, Justice, Treasury, Labor and Agriculture; AID, CIA, Veterans Administration; NIDA, FDA, Social Rehabilitation Service, Rehabilitation Services Administration, and Office of Education in HEW DEA, LEAA, Immigration and Naturalization Service, and Bureau of Prisons in Justice; Customs, and Internal Revenue Service in Treasury; and OMB, NSC and the Domestic Council in the Executive Office of the President.

[2] By Executive Order: Legislation followed in 1972.

1973, the specialized Domestic Council staff had evolved into a small office in the Office of Management and Budget (OMB), and the executive directorship of CCINC had been transferred to the State Department's Senior Advisor for Narcotic Matters (S/NM). In July 1973, ODALE was merged with the Bureau of Narcotics and Dangerous Drugs, the Office of National Narcotics Intelligence, and with U.S. Customs Service officers involved in drug investigations to create a new Drug Enforcement Administration (DEA) in the Department of Justice; and the Attorney General was given overall responsibility for drug law enforcement. Finally, by early 1974, the permanent successor to SAODAP—the National Institute on Drug Abuse (NIDA)—was established in HEW. Over the next 18 months, NIDA gradually assumed most of SAODAP's functions, allowing SAODAP to expire as scheduled on June 30, 1975.

Thus, a steady decrease in direct Executive Office involvement paralleled the assumption of authority by the lead agencies in the drug field: NIDA for prevention and treatment; DEA for law enforcement; and the State Department Office of the Senior Advisor (S/NM) for international activities. The Administration's goal was to develop effective management within each of the three segments of the Federal drug program and, as their management capacity increased, to gradually reduce direct Executive Office involvement.

The task force strongly endorses this concept, but recognizes the continuing need for program oversight and limited interagency coordination at the Executive Office level. The recommendations which follow are designed to strengthen the management capabilities of the lead agencies concerned with drug abuse, and to provide better coordination of the overall drug abuse prevention effort.

The task force recommends four basic actions: (1) Revitalization of the Strategy Council on Drug Abuse to provide overall policy guidance; (2) creation of a Cabinet Committee for Drug Abuse Prevention with an active subcommittee structure to continue the coordination of prevention and treatment activities formerly provided by SAODAP; (3) continuation of a small staff in the Office of Management and Budget to provide assistance to the Strategy Council and the Executive Office; and (4) development of an integrated data analysis capability. Each of these recommendations is discussed below.

REVITALIZATION OF THE STRATEGY COUNCIL

The Strategy Council on Drug Abuse was established in 1972 to develop an annual strategy statement which would provide an assessment of the drug abuse problem in the United States, a plan for a comprehensive Federal response, and an analysis of the major pro-

grams conducted in drug abuse prevention and drug traffic prevention.[3] In addition to continuing to develop the *Federal Strategy*,[4] the task force recommends that the Council's responsibilities be expanded to include the following functions:

- To offer a forum for policymakers which spans both drug abuse supply and demand activities, in order to resolve major policy issues.
- To provide coordination between supply and demand reduction programs, and to ensure that resources are allocated in a manner which strikes the optimal balance between these complementary aspects of the program.
- To advise the President, Vice President, and other key Executive Office personnel on the status of drug abuse in the United States.
- To monitor progress in implementing task force recommendations as presented in this white paper, and to report progress to the President by March 31, 1976.

In order to ensure that the Strategy Council is sufficiently broad in its outlook (i.e., able to maintain a perspective which balances supply and demand reduction activities, and to integrate drug abuse with other national goals and programs), the task force recommends that the Assistant to the President for Domestic Affairs be added to the Council and designated as Chairman.

Further, the task force recommends that the Secretary of the Treasury also be added to the Strategy Council, in view of the important roles played by the U.S. Customs Service and the Internal Revenue Service in the overall drug program.

CREATION OF A CABINET COMMITTEE ON DRUG ABUSE PREVENTION

Coordination among agencies involved in drug abuse demand reduction was the responsibility of SAODAP prior to its expiration. A consistent theme which emerged in each of the functional working groups on the demand side of the task force review was that the need to coordinate Federal drug abuse prevention activities remained, and that interagency coordination should in fact be strengthened beyond that which had existed under SAODAP.

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[3] Membership includes the Secretary of State, the Secretary of Defense, the Attorney General, the Secretary of Health, Education, and Welfare, and the Administrator of Veterans Affairs.

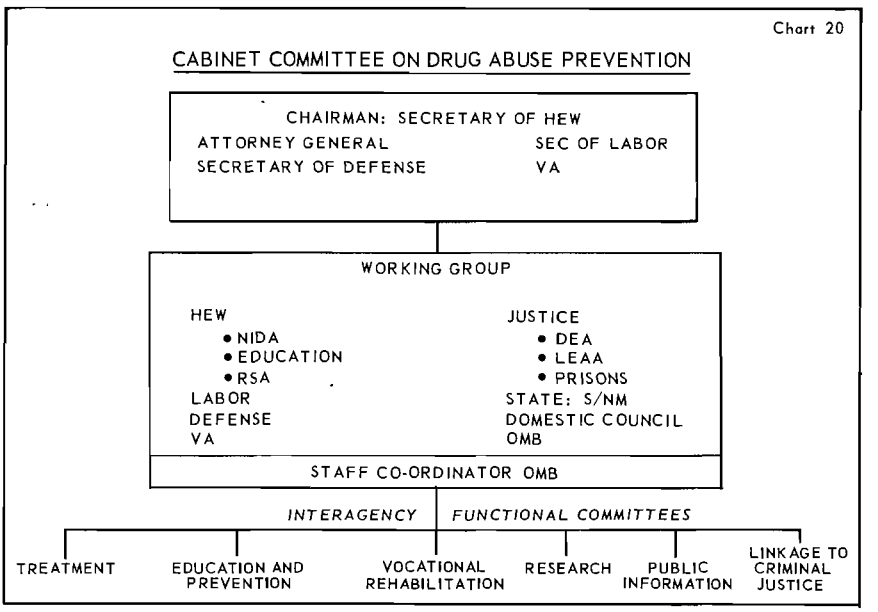
[4] In the past, publication dates have varied. The task force recommends that in the future the document should be published on June 30. To facilitate preparation of the book, the Council may require departments and agencies engaged in the drug program to submit information and reports necessary to assure a comprehensive document.

To meet this need, the task force recommends that a new Cabinet Committee on Drug Abuse Prevention (CCDAP) be created, and that the Secretary of the Department of Health, Education and Welfare be named Chairman. We believe that this recommendation is fully consistent with the President's often-stated goals of lodging operating responsibility in the appropriate Cabinet departments, and of holding Cabinet officers responsible for improving the Federal Government's response to critical national problems. The membership of the CCDAP should include:

- The Secretary of HEW, Chairman.
- The Secretary of Defense.
- The Secretary of Labor.
- Administrator, Veterans Administration.
- The Attorney General.

The task force further recommends that the Secretary of HEW appoint an Executive Director of CCDAP who would serve as chairman of an assistant secretary level working group. Finally, the task force recommends the creation of a series of interagency functional groups to provide detailed coordination below the level of the working group.[5]

Chart 20 illustrates one possible structure for CCDAP.



[5] The task force's model is the CCINC, which has been quite successful in providing interagency coordination of the international program.

CCDAP should be charged with the following responsibilities:

- Prepare annually a government-wide assessment of drug abuse demand program requirements in treatment, rehabilitation, research, demonstration, evaluation, and information systems, to be submitted to the President.
- Maintain and publish semi-annually a report on the status of drug abuse in the United States.
- Provide overall policy direction for, and coordination of, Federal drug education and prevention, treatment, vocational rehabilitation, research, and training programs.

The Executive Director of CCDAP should be given the following responsibilities:

- Act as public spokesman for the Federal Government on overall drug abuse prevention programs and the status of drug abuse;[6]
- Provide leadership in planning and coordinating drug abuse prevention with other Federal programs;
- Encourage departments and agencies whose primary mission is not drug-related to place high priority on drug abuse prevention and treatment needs of their constituencies.
- Advise the Secretary of HEW on drug abuse prevention programs, policies and priorities.

The creation of this Cabinet Committee will give HEW, Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), and NIDA the organizational strength and authority to provide the interdepartmental and interagency coordination needed to maintain the progress which has been made n drug abuse treatment and prevention.

In addition, the task force has proposed a number of internal organization and management changes to strengthen NIDA's ability to carry out its expanded responsibilities. Among the most important are (1) assignment of a full time legal counsel; (2) establishment of an Office of Communications and Public Affairs; (3) delegation of greater authority by ADAMHA and HEW; and (4) improvements in contract and grant procedures.

The task force recommends that DEA continue its corresponding lead agency role regarding law enforcement and regulatory programs, as designated by Executive Order No. 11727. In the course of this review, the task force noted several opportunities to improve DEA's ability to fill this lead agency role through improvements in internal management; these have been discussed with the Administrator and the Deputy Attorney General. However, since the task force has already recommended that the Attorney General and the Secretary

[6] Individual agency heads would continue to speak for their own specialized programs.

of the Treasury report to the President by December 31, 1975, concerning their recommended program for improving coordination of drug law enforcement activities, the task force has not recommended a specific coordinating mechanism for supply reduction activities.

CONTINUATION OF A SMALL EXECUTIVE OFFICE STAFF

The actions already discussed will play an important role in helping assure greater policy guidance and interagency coordination. Nonetheless, the task force believes that there is a continuing need for a limited Executive Office staff for some period of time to provide coordination and policy guidance during this transition period. Accordingly, the task force recommends that an Executive Office staff, consisting of 3 to 5 professionals, be maintained in OMB. Its functions should include:

- Oversight and limited coordination of the three major aspects of the drug program—law enforcement, treatment and prevention, and international control.
- Staff support to the Strategy Council, the Domestic Council, OMB, the National Security Council, and others in the Executive Office of the President.
- Selective management assistance to the drug agencies.
- Assistance and advice on drug abuse management and budget issues to the Director and Deputy Director of OMB.

This Executive Office staff should also work with, and provide staff assistance to, other interagency drug coordinating structures which are or will be in place, including: the CCINC, the CCDAP, DEA and NIDA.

The task force recommends that as many of the responsibilities of this office as possible gradually be shifted to the departments, agencies, and Cabinet committees, in order to avoid institutionalizing direct Executive Office involvement in this area.

DEVELOPMENT OF INTEGRATED DATA CAPABILITY

A major requirement for managing the drug program is the development of a systematic data base to serve as a foundation for both long-range and short-range program management decisions. While the information needs of senior managers are diverse and vary from agency to agency, there are elements which, when integrated, can be useful to all. Some progress has been made in identifying and integrating these elements over the past several years, but much more work is required to meet the overall needs of the drug program.

Accordingly, the task force recommends that an interagency information-sharing mechanism be established under the aegis of the

Strategy Council.[7] This mechanism would improve Federal drug abuse program management by increasing the sharing, analyses, and coordination of drug abuse information. For example, data collected by law enforcement agencies (e.g., on the availability of various drugs) is needed by managers on the demand reduction side to accurately program resources, and treatment trend information can be useful to law enforcement managers by indicating new patterns of use. In developing an information-sharing mechanism, each agency should continue to provide for its own objectives and program responsibilities; therefore, it is not practical to develop a single Federal data system in the drug abuse area. However, a periodic report to Federal policymakers consisting of selected data and analyses from all agencies will allow them to manage from an overall Federal perspective.

The task force is confident that if the recommendations discussed in this chapter are successfully implemented they will ensure a more effective and efficient Federal drug control effort in the future. Furthermore, the task force feels confident that prompt action on these management recommendations will make possible a more rapid implementation of the policy and program recommendations presented earlier.

[7] Membership should include: DHEW (FDA, NIAAA, NIDA, NIMH); DOD; DOJ (BOP, DEA, LEAA); OMB, Treasury (Customs); and VA, S/NM.

6. RECOMMENDATION SUMMARY

In the preceding chapters, the Domestic Council Drug Review Task Force has: (1) presented its assessment of the nature and extent of the drug abuse problem in the United States today; (2) evaluated current programs and policies designed to deal with drug abuse; and (3) made recommendations for improving the effectiveness of the drug program in the future.

While each recommendation is important in itself, it is the combined effect of all taken together that will produce a major improvement in the overall program to reduce drug abuse. Viewed as a whole, these recommendations underline and expand the themes discussed in Chapter 1; namely:

1. Total elimination of drug abuse is unlikely, but governmental actions can contain the problem and limit its adverse effects. We recognize that drug abuse is a long-term problem and requires a long-term commitment.
2. All drugs are not equally dangerous, and all drug use is not equally destructive. Enforcement efforts should therefore concentrate on drugs which have a high addiction potential, and treatment programs should give priority to those individuals using high-risk drugs, and to compulsive users of any drugs.
3. Efforts to reduce the supply of and the demand for drugs are complementary and interdependent, and Federal programs should continue to be based on a balance between these two concepts.
4. We must broaden existing programs aimed at supply and demand reduction. In supply reduction, greater emphasis should be given to regulatory and compliance activities aimed at curtailing diversion from legitimate production, and a higher priority should be given to increasing international cooperation in preventing the illicit production of drugs. In demand reduction, increased attention should be given to prevention and vocational rehabilitation.
5. Program management must be improved to ensure the maximum return from resources committed to drug programs. Better interagency coordination and stronger intra-agency management are required, with more attention paid to the setting of priorities.

6. The Federal Government should provide leadership in the national drug abuse prevention effort, but it cannot do the job alone. The support and cooperation of State and local governments, private businesses and community organizations are essential if we are to contain drug abuse and minimize its costs to the individual and society.

The major recommendations made throughout the white paper are listed below for easy reference.

DRUG PRIORITIES: CHAPTER 2

1. The task force recommends that when resource constraints force a choice, priority in both supply and demand reduction should be directed toward those drugs which inherently pose a greater risk—heroin, amphetamines (particularly when used intravenously), and mixed barbiturates.

2. The task force recommends that priority in treatment also be given to compulsive users of drugs of any kind.

SUPPLY REDUCTION: CHAPTER 3

1. The task force recommends that a continuous process of identifying the most vulnerable segments of the illicit distribution system be launched, and that resources be continually reallocated to focus on the most vulnerable portion of the system.

Enforcement

1. The task force, while endorsing the concept of a lead agency in drug law enforcement recommends that the law enforcement strategy be designed to fully utilize the resource of all organizations involved in law enforcement.

2. The task force recommends that Federal law enforcement efforts focus on major trafficking organizations and particularly on the leaders of those organizations.

3. The task force recommends that greater attention be given to development of conspiracy cases, which often are the only way to apprehend high-level traffickers. Detailed recommendations for accomplishing this are made in three areas: (1) Building understanding and commitment to conspiracy strategy; (2) inducing cooperation of knowledgeable individuals; (3) and developing long-term approaches to investigations.

4. The task force recommends that personnel systems which recruit, train, evaluate, and reward individual agents be adjusted so that they emphasize conspiracy investigations rather than simply the number of arrests.

5. The task force recommends that the Controlled Substances Units inaugurated by the Attorney General be continued and not diverted to other activities.

6. The task force endorses the President's proposal for mandatory minimum sentences for persons trafficking in hard drugs, and suggests that consideration be given to expanding the proposal to include traffickers of barbiturates and amphetaminies.

7. The task force recommends mandatory consecutive sentencing rather than concurrent sentencing for persons who are arrested and convicted for narcotics trafficking while on bail from another trafficking offense.

8. The task force recommends revoking parole in the event that a paroled offender is re-arrested on narcotics trafficking charges.

9. The task force recommends that the Internal Revenue Service reemphasize its program of prosecuting drug traffickers for violation of income tax laws under strict guidelines and procedures.

10. The task force recommends that the President direct the Attorney General and the Secretary of the Treasury to settle jurisdictional disputes between DEA and Customs by December 31, 1975, or to report their recommendations for resolution of the matter to the President on that date.

11. The task force recommends continuation and expansion of LEAA and DEA activities aimed at strengthening State and local law enforcement agencies.

Intelligence

1. The task force recommends that a new investigative report form be devised, with a number of questions aimed at eliciting information useful to other agencies.

2. The task force recommends an analysis of the four automatic data processing systems involved in intelligence activities, with an eye to either integrating or better coordinating them.

3. The task force recommends that DEA devote more resources to the analysis of intelligence, both strategic and tactical.

4. The task force recommends that the CIA's role should continue to be focused on the collection of strategic intelligence.

5. The task force recommends that users of strategic intelligence under the guidence of CCINC identify specific startegic intelligence requirements.

International

1. The task force recommends that a higher priority be given to development of international cooperation in preventing illicit production of drugs, and that special attention be given to Mexico as the major source country for U.S. markets.

2. The task force recommends that the U.S. government intensify diplomatic efforts to heighten other governments' concern over violations of international treaty obligations; and continue participation in institutions that promote international awareness of drug abuse.

3. The task force recommends the prompt ratification of the Convention on Psychotropic Substances of 1971.

4. The task force recommends continued support for the United Nations Fund for Drug Abuse Control, but urges that the Fund be encouraged to initiate a more aggressive fund-raising program.

5. The task force recommends continued support and participation in Interpol, and the Customs Cooperation Council.

6. The task force recommends that additional emphasis be placed on the collection, analysis, and utilization of overseas operational intelligence, and recommends that U.S. agents stationed overseas concentrate their activities on international trafficking channels believed to be headed for the United States.

7. The task force recommends that continued attention be given to crop substitution as a means of reducing the supply of raw materials used in making drugs, and believes that this should be one of the major focuses of the U.N. Funds' efforts.

8. The task force recommends creating a permanent DEA/Justice/State Committee under the Cabinet Committee on International Narcotics Control to coordinate efforts to seek U.S. jurisdiction over foreign drug traffickers through extradition or expulsion.

9. The task force recommends that the Opium Policy Task Force accelerate its evaluation of Papaver bracteatum as a substitute for morphine-based Papaver Somniferum in the production of codeine.

Regulatory and Compliance

1. The task force recommends several specific actions which will improve the program to control diversion at the wholesale level.

2. The task force recommends a major effort to upgrade the regulatory capabilities of States regarding retail diversion of drugs.

3. The task force recommends a program to improve the prescribing practices of physicians.

4. The task force recommends development by LEAA of pilot programs designed to curb pharmacy thefts.

Science and Technology

1. The task force recommends a specific set of priorities for the research effort; highest among these are projects aimed at providing better equipment for use in border interdiction, improving intelligence information systems, and better support and communication equipment for enforcement officers.

2. The task force recommends that research program funding be kept relatively steady from year to year to enable long-range planning and development.

DEMAND REDUCTION: CHAPTER 4

1. The task force recommends that greater emphasis be placed on education and prevention efforts that promote the healthy growth of individuals and discourage the use of drugs.

2. The task force recommends that greater attention to patients in drug treatment and former drug users be paid by the vocational rehabilitation system in order to provide them with marketable skills for jobs.

Education and Prevention

1. The task force recommends that education and prevention programs address the broad developmental needs of children and youth, and be community based.

2. The task force recommends that Federal media efforts provide basic information about drugs, and emphasize successful and productive lifestyles of non-drug users, rather than using scare tactics.

3. The task force recommends that the Federal role in community based prevention be catalytic in nature; specifically, to provide training and technical assistance to local communities, to provide materials and guidebooks to local programs, to provide limited seed money, to evaluate existing programs, and to make the results of these evaluations available for use by other States and communities.

4. The task force recommends that an overall national program for integrating Federal, State, local and private programs for dealing with all behavioral problems in youth be developed, and identifies eleven separate government programs which should be included in this overall review.

Treatment

1. The task force recommends that agencies involved in drug abuse treatment give treatment priority to abusers of the following high-risk categories of drugs: heroin, barbiturates (especially when mixed with other drugs), and amphetamines (particularly when administered intravenously). Priority should also be given to compulsive users of drugs of any kind.

2. The task force recommends that NIDA be given the authority to assure that users of lower priority drugs can obtain treatment, when available, at Community Mental Health Centers, in accord with Section 401A of the Drug Abuse Office and Treatment Act of 1972.

3. The task force recommends that hospital treatment for drug abuse should be severely restricted in order to reduce overall costs, and outlines specific guidelines for its use.

4. The task force recommends that the use of outpatient drug-free treatment for compulsive users of high-risk drugs be restricted, and these people treated in a more structured environment. The use of outpatient drug-free treatment for casual users of lower-risk drugs should also be restricted, and the funds thus freed used to provide more effective services for high priority drug users.

5. The task force recommends that LAAM, rather than methadone, be used as a medication for opiate-dependent persons as soon as its safety and efficacy have been determined.

6. The task force recommends that the Food and Drug Administration (FDA) methadone regulations be published immediately.

7. The task force recommends that training courses to increase skills of paraprofessionals be expanded.

8. The task force recommends prompt resolution of existing jurisdictional and organizational problems between DEA, NIDA and FDA by the Assistant Secretary for Health, HEW.

9. The task force recommends that drug abuse treatment be part of the required curricula of medical schools and schools of social work, psychology, and vocational rehabilitation.

10. The task force recommends that categorical funding for drug treatment programs be stabilized so that cost sharing is at a maximum rate of 60 percent Federal and 40 percent local until local governments or community organizations are able to assume fiscal responsibility above this level.

11. The task force recommends that long-term efforts be initiated to incorporate drug abuse treatment services into the general health care delivery system.

12. The task force recommends that the Federal Government be prepared to fund additional community treatment capacity, if necessary, and recommends that the specific need be identified by December 1, 1975.

Vocational Rehabilitation

1. The task force recommends that NIDA and the Department of Labor review all regulations to ensure that they do not impede the provision of vocational rehabilitation services to drug abusers. This applies to the NIDA confidentiality regulations as well as vocational rehabilitation regulations.

2. The task force recommends that the Rehabilitation Services Administration (RSA) instruct State vocational rehabilitation agencies that the regulation which states that no individual or group may be excluded because of their disability will be strictly enforced in connection with drug abusers.

3. The task force recommends that NIDA encourage Single State Agencies to develop cooperative agreements with manpower and vocational rehabilitation services in their areas.

4. The task force recommends that NIDA and RSA develop joint research and demonstration projects to improve the delivery of rehabilitation and employment services to drug abusers.

Criminal Justice System

1. The task force recommends that treating criminal offenders who abuse drugs be given the highest priority. The Department of Justice and HEW should establish a permanent working group charged with seeking ways to expand the interface between the criminal justice and drug treatment systems. This criminal justice working group should publish a semi-annual report that addresses the progress made in implementing the recommendations discussed in the white paper with further recommendations for future initiatives. The first report would be due in March 1976.

2. The task force recommends that the pilot pre-trial service projects, to be established in ten Federal judicial districts as a result of the Speedy Trial Act of 1975, routinely screen all arrestees to determine if they have a history of drug abuse or are currently using drugs. The results of these ten pilot pre-trial services projects should be evaluated as soon as possible.

3. The task force recommends that funding for the Treatment Alternatives to Street Crime (TASC) program be maintained at its present level of approximately $4 million per year, and the program be expanded to include any jurisdiction with a population of over 200,000 which can demonstrate eligibility.

4. The task force recommends that funds and responsibilities be transferred from the Bureau of Prisons to the U.S. Probation Office so that USPO can contract for and administer treatment services for Federal parolees and probationers.

5. The task force recommends that the U.S. courts and the Bureau of Prisons alter their policy regarding drug-free treatment and accept methadone maintenance as a proper treatment alternative for parolees and probationers.

6. The task force recommends that Title III of the Narcotic Addict Rehabilitation Act of 1966 be terminated, and the budgetary savings diverted to NIDA to supplement grants in treatment areas which have prospective clients or waiting lists.

Research, Demonstration, and Evaluation

1. The task force recommends that priorities in research be established for follow-up studies on the progress of clients after leaving

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treatment, and to determine relative effectiveness of different prevention, treatment, and rehabilitation approaches.

2. The task force recommends that NIDA formulate a plan for research, demonstration, and evaluation in consultation with other agencies involved in RD&E; those agencies should then develop their specific plans to supplement rather than duplicate NIDA's plan.

PROGRAM MANAGEMENT; CHAPTER 5

1. The task force recommends that the Strategy Council on Drug Abuse be given additional responsibilities to provide coordination between supply and demand reduction programs, and that the Assistant to the President for Domestic Affairs be made a member and designated as Chairman. The task force also recommends that the Secretary of the Treasury be added to the Strategy Council.

2. The task force recommends the creation of a Cabinet Committee on Drug Abuse Prevention chaired by the Secretary of the Department of HEW to provide coordination among agencies involved in drug abuse demand reduction activities. Membership of the CCDAP should include the Secretary of HEW, the Secretary of Defense, the Secretary of Labor, Administrator of the Veterans Administration, and the Attorney General.

3. The task force recommends that the Secretary of HEW appoint an executive director of the CCDAP who will serve as chairman of an Assistant Secretary level work group. This work group should be supported by a series of interagency functional groups which would provide detailed coordination in specific areas; e.g., treatment, education, prevention and research.

4. The task force recommends CCDAP be charged with preparing annually a government-wide assessment of drug abuse demand program requirements, and with publishing semi-annually a report on the status of drug abuse in the United States.

5. The task force recommends that DEA continue its corresponding lead agency role regarding law enforcement and regulatory programs, as designated by Executive Order No. 11727.

6. The task force recommends continuing a small Executive Office staff, located in the Office of Management and Budget, to provide assistance and advice to the White House staff, the Strategy Council, and OMB. The task force recommends that the responsibilities of the Office gradually be shifted to the departments, agencies and Cabinet Committees.

7. The task force recommends the creation of an interagency executive committee to improve the sharing, analysis, and coordination of drug abuse information at the Federal level.

APPENDIX

Comments of Department of the Treasury/U.S. Customs Service

Comments of Drug Enforcement Administration

Treasury/Customs Service Addendum to Domestic Council White Paper

The Domestic Council White Paper on Drug Abuse is a monumental effort and a valuable addition to assist the efforts of the United States Government to counteract a recent increased trend in narcotics trafficking and consumption. We nevertheless feel it desirable to indicate Treasury-Customs disagreement with some of the major conclusions in the law enforcement sections of the report. The conclusions which we address ourselves to in this addendum relate principally to the structural restrictions placed upon U.S. Customs Service by Reorganization Plan No. 2, but also address themselves to some degree to our relations with foreign countries in the effort to control drug trafficking.

Nothing in this addendum should be construed as criticism of any agency of Government. We believe that the present cooperation between the Drug Enforcement Administration and Customs is better than it ever has been, and may be as good as it can be *considering the prohibitions imposed upon Customs and the organizational imperatives of Reorganization Plan No. 2.* We feel that there will not be maximum coordination among agencies with enforcement or supply reduction roles as long as the Customs Service is prevented organizationally from realizing its full potential as an interdictor of drugs at the land and sea borders of the United States.

After more than two years of experience with the single agency investigation concept, it appears to us that the complete exclusion of Customs from intelligence gathering and investigative activities relating to narcotics smuggling has been counter-productive to the ovrrall national narcotics enforcement effort. The current failure to pursue conspiratorial leads resulting from border seizures and arrests and the under-utilization of intelligence and investigative resources has created a major gap in a comprehensive narcotics enforcement program. The full utilization of Customs intelligence and investigative resources would be a positive step in bringing Federal narcotics enforcement effectiveness to its highest possible level.

In assessing what U.S. strategy should be, we must be flexible enough to adopt changes where necessary to assure utilization of all available U.S. resources and to give the U.S. Government maximum flexibility in obtaining foreign government cooperation for improving our overall effort. Together these steps could give the U.S. a greater chance to exercise real leadership in the global effort and promote our own interests.

Treasury, together with Customs, urges the following:

1. The lead agency concept under Reorganization Plan No. 2 should not be the basis for denying the U.S. Government diplomatic flexibility should special circumstances in certain countries dictate the marshalling of additional and available resources.

   What is needed is clear acceptance of agency roles and missions, full utilization of existing resources, skills, and statutory and regulatory authority to accomplish not only individual agency mission but to support each other's mission. Just as the Drug Enforcement Administration and other agencies have good relations with counterpart police officers in foreign countries, so the Customs Service has particularly close relations with its counterpart Customs Services in virtually every country, most of which are members of the Customs Cooperation Council. Since these foreign Customs Services are the principal repositories of information about smugglers in their countries, and since they generally prefer to deal with U.S. Customs

rather than any other U.S. agency in the exchange of intelligence regarding narcotics, it would be most productive for the U.S. Customs Service to collect intelligence abroad on all types of smuggling, including narcotics. A limited additional number of Customs agents assigned overseas to investigate and collect intelligence on narcotics could contribute materially to enhanced enforcement capabilities at U.S. ports and borders.

2. The most effective and efficient means of interdicting the drug traffic is to seize the high-value, concentrated narcotics at the borders of the United States. The statutory authority of search and seizure possessed by the U.S. Customs Service is broader than that of any U.S. enforcement agency. Effective drug interdiction at the borders is dependent upon the gathering of intelligence abroad concerning potential shipments and the application of all enforcement tools to accomplish the actual seizures at the border.
3. Overseas both in manpower and funding may have limited impact in reducing the long-term availability of drugs in the U.S. so long as the world opium supply far exceeds demand. It is unrealistic to expect that the U.S. Government alone can effectively reduce the supply of illicit drugs from abroad by overseas effort in the foreseeable future. While the U.S. can provide the leadership, as important will be the efforts by the countries themselves to improve their anti-narcotics capabilities. We should a) advance the concept that recipient countries should become totally self-sustaining in the anti-narcotics programs now funded by the U.S.; and b) move toward the goal of "de-Americanizing" the overseas effort as rapidly as possible.
4. It appears essential that the scope of U.S. efforts in Mexico be broadened to encompass as many branches of the Government of Mexico as possible by utilizing incentives for favorable Mexican action. Action to that end should also contribute to greater flexibility in moving against funds used to finance drug trafficking. Reciprocal strengthening of U.S. enforcement efforts along the Southwest border is required as a clear sign of U.S. commitment to substantial drug supply reduction.
5. While assigning a high priority to treatment efforts may be required and beneficial, the United States can suffer only tragic consequences by practicing selective law enforcement. Enforcement must be even-handed and comprehensive to be effective and corruption-free. To diminish efforts against marijuana and cocaine can only erode further respect for law and law enforcement officers. Certainly, the fact that the United States is experiencing the highest level of contraband smuggling since Prohibition is an indication of the involvement of organized criminal elements utilizing the derived illicit profits for additional criminal activity. During the past 90 days, there have been seizures of 13 tons, 18 tons, 43 tons and 6 tons of marijuana and dozens of seizures exceeding one and two tons. These smuggling ventures have been by boat, airplane and every conceivable means. There is an unprecedented volume and scope of contraband smuggling activity which should not be ignored or de-emphasized by Federal law enforcement agencies.

Comments of the Drug Enforcement Administration

SUPPLY REDUCTION STRATEGY AND THE ROLE OF PRINCIPAL FEDERAL AGENCIES

As the White Paper correctly observes, the principal component of the Federal Government's supply reduction strategy is the law enforcement effort and related functions. The necessity of this activity is easily grasped by the public at large, but the successful pursuit of a strategic enforcement policy, the complexity of the factors involved, and the appropriate roles of the various Federal agencies is a matter poorly understood by those not directly involved. The White Paper has dealt with many of these issues and illuminated important strategy and policy considerations. There are, however, additional facets which are worthy of expression and which form the basis of this comment.

Basically, Federal enforcement efforts are divided into three distinct functional areas. These are interrelated by virtue of the single mission which each seeks to serve, but otherwise dissimilar in the sense that they represent a clear division of labor required for the efficient use of resources.

I. Investigation.

The first and most important effort is the aggressive investigation and apprehension of those individuals directly responsible for the organization of this illicit commerce. The activity of these persons, which spans continents and cultures, makes possible the maintenance of an illicit drug traffic with a continuity and volume which could not otherwise be sustained. Their identification and apprehension can form a strategic blow to the traffic, sharply reducing the continued availability of drugs.

In order to ensure that Federal investigative efforts are in fact targeted in this strategic fashion, it is necessary that a single agency with the total conceptual grasp of the problem be able to cull through the vast amount of intelligence and leads developed by itself and other Federal, state, and local agencies. Moreover, since much of the traffic in drugs is of international scope, it is necessary that this agency establish and maintain functional offices abroad in order to make possible the penetration of criminal organizations at both ends of the flow of traffic. It is at the foreign source and the domestic points of delivery where the greatest opportunities for penetration exist. Customarily, several weeks or more of advanced planning will be required in the foreign country to obtain the financial backing, to recruit couriers, and to plan for the concealment and smuggling of the contraband goods. This provides a number of opportunities for undercover penetration and surveillance by foreign police assisted by their U.S. counterparts.

By the same token, similar opportunities exist simultaneously within the United States, where those violators destined to receive the illicit drug shipment are reaching out for customers and co-conspirators to facilitate their eventual distribution.

Again, it is clear on the basis of reason as well as reference to past experience that a single agency must have total purview of the investigatory effort on both sides of the U.S. border in order to: (1) ensure appropriate targeting of investigatory resources, (2) achieve coordinated cooperation of both foreign and domestic investigatory efforts, and (3) make tactical decisions as to most favorable time, place, and circumstances to culminate the investigation with arrests, indictments, and seizures. This mission has been entrusted by the President and the Congress

to the Drug Enforcement Administration, an agency of the Department of Justice created by Reorganization Plan No. 2 of 1973. It was the clear intention of the Congress and the President to create a single agency to pursue this particular form of the Government's effort.

A. History of Reorganization Plan No. 2.

Prior to its creation, this single function was fragmented between the Bureau of Narcotics and Dangerous Drugs and the United States Customs Service. This represented a counterproductive division which had existed at least since the founding of the Federal Bureau of Narcotics in 1930 and had often resulted in operational and jurisdictional disputes of a destructive nature. These problems were thoroughly documented in both the Senate and House reports and hearings in the Spring of 1973. Moreover, many years of experience had proven that the nature of these conflicts were such as to require a final and absolute organizational solution. It was in the light of this history and the demonstrated need to put an end to three decades of bureaucratic conflict that Reorganization Plan No. 2 was conceived and approved.

In Chapter No. 3, entitled "Supply Reduction," the White Paper references continuing disputes between the Drug Enforcement Administration and the U.S. Customs Service. These disputes are primarily concerned with the techniques for establishing working cooperation in the field and the exchange of intelligence between the two agencies. They are in some sense a residue of the jurisdictional conflicts of past decades. In our own opinion, these have been exacerbated in recent months because of the Customs Service's dissatisfaction with the jurisdictional determinations expressed in the Reorganization Plan and its hope of returning to the previous state of affairs as a result of the present study and similar inquiries being conducted by a Senate Subcommittee.

But both common sense and existing law mandate the continued centralization of investigative responsibility within a single agency to ensure the kind of total coordination which the President and the Congress desire and the use of enforcement resources in a strategic fashion on the basis of strategic standards.

The central point which we wish to emphasize here is that the plan itself contains no ambiguity but provides clear principles for the allocation of specific responsibilities on the basis of whether their essential nature relates to investigative activity as opposed to search and seizure functions to be performed by uniformed personnel.

II. Interdiction.

The second most important enforcement effort within the total Federal strategy is the interdiction of the flow of illicit drugs at the United States ports and borders. This function is allocated to the U.S. Customs Service and the Border Patrol of the Immigration and Naturalization Service. It is performed in a manner entirely unlike that of the investigatory function and is designed to achieve different but related objectives. These duties were expressly reserved to the Customs Service by Reorganization Plan No. 2 of 1973 in recognition of the importance of this task as a part of the Federal supply reduction effort. This effort will be most effectively served if the management of the Customs Service will concentrate its emphasis on this task rather than seeking to develop a secondary duplication of existing investigatory efforts.

III. Government-wide Support.

The third element of the Federal drug enforcement effort consists of the supporting efforts of various Federal agencies in accordance with the role appropriate to each. In other words, although Reorganization Plan No. 2 established a principal

agency for the investigation of and collection of intelligence concerning the illicit drug traffic, it recognized that other agencies such as the FBI, IRS, ATF, and CIA could make unique contributions as a spin-off of the pursuit of their particular missions.

Additionally, non-enforcement agencies of the Federal Government frequently provide support which, although ancillary to their principal mission, is indispensable to a successful supply reduction strategy. For example, the Department of State has provided the diplomatic initiative necessary to procure the interests of foreign nations and to lay the ground work for the cooperation of DEA agents with their foreign counterparts. The CIA, as was noted in the White Paper, plays a valuable role in the collection of strategic intelligence in many foreign countries. The Department of Agriculture continues to provide valuable technical assistance in programs which envision crop substitution and eradication. The Federal Aviation Administration participates in DEA's El Paso Intelligence Center for developing intelligence concerning the traffic in drugs across the US/Mexican border. Finally, the Food and Drug Administration, as has been stated, participates in and supports many of the regulatory decisions designed to reduce the diversion of legitimate drugs.

IV. Conclusion.

DEA has established liaison and cooperation with each of these agencies and departments of government. Each provides a unique type of expertise not duplicated within DEA itself and in no sense representing discordant jurisdictional ambiguities. Thus, where the statutory divisions of labor are recognized and taken advantage of, the basis exists for establishing a team effort in which each can assist in achieving the Government's ultimate objectives. The DEA is committed to absolute cooperation and fulfillment of its role within the concept of interdepartmental teamwork called for by the White Paper. It is also committed by virtue of both policy and practice now in force to increasing the targeting of investigative resources at the major violators and organizations responsible for much of the traffic in illicit drugs. It is DEA's view that the perception of the correct supply reduction strategy as briefly summarized in this comment will clarify the understanding of the appropriate roles which each agency should play in the overall Federal effort. This understanding is the key to the elimination of the kinds of counterproductive and often petty bureaucratic tensions which have sometimes occurred.

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