FEDERAL STRATEGY FOR DRUG ABUSE AND DRUG TRAFFIC PREVENTION

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

Council Members

The Secretary of State
The Secretary of Defense
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INTRODUCTION

The Drug Abuse Office and Treatment Act of 1972 created the Strategy Council on Drug Abuse and required that Council to publish annually a *Federal Strategy for Drug Abuse and Drug Traffic Prevention.* Since the last *Federal Strategy* was published in June 1975, a great deal has happened.

In response to the increasing availability and use of illicit drugs, President Ford, in May of 1975, directed the Domestic Council to undertake as thorough review and assessment of the Federal program to control drug abuse, to give him a frank assessment of its effectiveness, and to make recommendations concerning ways to make the Federal program more effective in the future. The Domestic Council Drug Abuse Task Force, created to discharge this responsibility, reported its findings and recommendations to the President in September 1975. That report, the *White Paper on Drug Abuse,* was endorsed by the President and has become the centerpiece of a revitalized Federal program to control drug abuse.

This *Federal Strategy for Drug Abuse and Drug Traffic Prevention 1976* attempts to place the events of the last eighteen months in perspective and to inform the nation of the future direction of the Federal program. It analyses the progress which has been made in combating drug abuse, it identifies and examines the "open agenda" of remaining problems and it charts a course which should guide Federal efforts in this area over the next several years. Specifically, Chapter I outlines the overall Federal strategy for dealing with the drug abuse problem and refines and extends several basic components of the strategy. Chapter 2 presents an assessment of the nature and extent of drug abuse in America, focusing particularly on the last three years. Chapter 3 summarizes the considerable progress which has been made in improving the Federal drug abuse program over the past eighteen months. Finally, Chapter 4 discusses the remaining problems and outlines the framework for dealing with them in the next several years.

The Strategy Council submits this document with full 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 what must be a national effort to deal with drug abuse. However, the *Federal Strategy* for 1976 represents a sound base upon which a truly national commitment to combating drug abuse can be built.

1. OVERVIEW: THE FEDERAL STRATEGY FOR CONTAINING DRUG ABUSE

Since 1970, the Federal strategy for containing the extent and impact of drug abuse in America has been developed, adjusted and refined in a succession of documents: these include the findings of the National Commission on Marihuana and Drug Abuse[1], three issues of the *Federal Strategy for Drug Abuse and Drug Traffic Prevention*[2] and, most recently, the *White Paper on Drug Abuse*[3], published just one year ago.

That strategy, as crystallized in the White Paper basically states that:

1. Total elimination of drug abuse is unlikely but governmental actions can contain the problem and limit its adverse effects. The Federal Government recognizes 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 abusing 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. Existing programs aimed at supply and demand reduction must be broadened. 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, early intervention 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

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[1] Published in two reports: (1) *Marihuana: A Signal of Misunderstanding*, March 1972; and (2) *Drug Use in America: Problem in Perspective*, March 1973.

[2] Published by the Strategy Council in March 1973, June 1974, and June 1975.

[3] Published by the Domestic Council Drug Abuse Task Force in October 1975.

are required. More attention should be paid to the setting of priorities, with Federal law enforcement efforts focused on high-level traffickers and Federal treatment resources focused on habitual users of high-risk drugs such as heroin, amphetamines and barbiturates.

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 strategy, as summarized above and as developed more fully in the White Paper, has not changed. Thus, the remainder of this chapter discusses, extends and amplifies the existing strategy, rather than breaking new ground. Specifically, five concepts which are at the heart of the Federal strategy for containing drug abuse are discussed. They are:

- The adverse effects of drug use represent the real cost to society, not drug use itself.
- The Federal program should balance supply and demand reduction efforts.
- Relative priority among drugs of abuse in both supply and demand reduction efforts should be based on the relative "social cost" and the risk to personal health.
- There should be greater efforts to assure full utilization of all available resources.
- Drug abuse occurs in the context of other social problems, not in isolation.

THE ADVERSE EFFECTS OF DRUG USE REPRESENT THE REAL COST TO SOCIETY

The term "drug problem" means different things to different people. To some, the use of drugs is itself a serious social problem. To others, the *effects* of the drug use constitute the problem and, so long as drug use does not lead to adverse effects on society, they believe that the government should not interfere with individual choices. Obviously, these concepts are closely interrelated and any definition of the drug problem must contain elements of each.

Over the past several years, most public officials have come to recognize that society is most concerned about the societal costs resulting from the adverse effects which drug use has on the lives of drug users and those who interact with them: by inducing or contributing to criminal behavior; by leading to poor health, economic dependence, or difficulty in discharging family responsibilities; by causing death; or by creating other undesirable conditions. Using this definition, the "drug problem" is the total effect on society of these adverse effects of the non-medical use of drugs, not only the effects of drugs on individuals using them.

Because we cannot always accurately and directly measure the adverse effects of drug use, we frequently use the number of users as an indicator of the magnitude of the drug problem.[4] In using estimates of the total number of users as a measure of the problem, three factors must be kept in mind:

1. The magnitude of the drug 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 probably not particularly important in a user's daily life, so reducing his already low consumption will have less impact on behavior or health.
3. These factors are interrelated. The likelihood of advancing to chronic, intensive 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 estimating the magnitude of the drug abuse problem, we cannot simply look at estimates of the total number of drug users. It is important to distinguish among the drugs being used, to recognized the variations in use patterns, and to assess how use patterns are likely to change over time. In terms of social cost, the most critical drug abuse problem commanding a priority on governmental efforts is created by chronic, intensive users of drugs who suffer or cause others to suffer adverse effects such as death, illness, job loss or drug-induced criminality. The total of these adverse effects determines the magnitude of the drug abuse problem.

THE FEDERAL PROGRAM SHOULD BALANCE SUPPLY AND DEMAND REDUCTION EFFORTS

The fundamental objective of early attempts at dealing with the drug problem focused on reducing the supply of illicit drugs; making them difficult to obtain, expensive, and risky to possess, sell or consume. The basic assumption was that if taking drugs is hazardous, inconvenient and expensive, fewer people would experiment with drugs, that few who did experiment would advance to chronic, intensive use, and that more of those currently using drugs would abandon their use. Evidence suggests that these effects do indeed occur; that when drug availability is reduced

[4] We are, however, currently working to improve and sharpen our ability to measure direct indicators of drug related problems.

through supply reduction efforts, a corresponding reduction in drug use occurs.[5]

These benefits are not obtained without cost or limitations, however. First, supply reduction is expensive. Second, there are significant adverse side-effects of supply reduction efforts: casual users of drugs are stigmatized by arrest; the health of committed users is threatened by impure drugs; black markets are sustained and with them significant possibilities for corruption of public officials; and some addicts are driven to commit more crime to meet the rising costs of scarce, illegal drugs. Finally, no supply reduction effort can be completely effective, at least within the constraints of this nation's commitment to the concept of civil liberty and with resources necessarily limited by the demands of other pressing social problems.

However, the supply reduction effort is complemented by a demand reduction effort designed to make treatment available as an alternative to the drug user who finds drugs scarce and costly, and to prevent as many individuals as possible from beginning drug use (or moving to compulsive use). Thus, many of these adverse effects of supply reduction can be reduced, and at the same time programs to provide employment, counseling, early intervention and recreational opportunities may succeed in preventing experimentation or increased drug usage among youth despite the difficulty of substantially decreasing the availability of drugs in certain areas. Therefore, a balanced program of supply and demand reduction is and will continue to be the cornerstone of the Federal Strategy to reduce drug abuse in America.

Reducing the demand for drugs is contingent upon (1) reducing availability; (2) developing more effective prevention programs; (3) interrupting the progression from experimentation to regular use; and (4) providing medical and social rehabilitation assistance for those with compulsive or addictive patterns of drug use.

To date, our efforts at prevention have had only limited success[6]; however, we have had considerable success in our treatment efforts. During the past year several important studies have been completed which indicate that treatment does, in fact, lead to substantial reduction in drug use, crime and other problems for patients while in treatment and for several years thereafter. The details of these studies are discussed at length in Chapter 3, but they are worth highlighting here: a 4-year follow-up of over 1,000 male heroin users showed a 93 percent reduction in daily opiate use and a 60 percent reduction in reliance on crime for financial support.

A final point which should be emphasized in this discussion is the fact that both supply reduction and demand reduction include a variety of activities, some of which need more emphasis. For example, Federal supply reduction efforts should be targeted at all aspects of the illicit production

[5] See Chapter 3 for a discussion of recent statistical evidence of this link between availability and use of drugs.

[6] New initiatives in this area will be discussed in Chapter 4.

and distribution of drugs. The activities involved range from crop eradication in illegal growing areas abroad, to interdiction of illicit shipments, to the removal of important traffickers from the supply system through arrest and imprisonment and through actions against their fiscal resources. The regulatory and compliance program, with its focus upon preventing diversion of legitimately produced drugs through effective regulation and the monitoring of production and distribution of such drugs, is one supply reduction tool which should receive increased attention.

In demand reduction, the current treatment focus should be supplemented with increased attention to prevention and vocational rehabilitation. Treatment is a response to a problem which has already developed. Given the difficulties of successful treatment, society better serves its citizens if it is able to prevent drug abuse. Thus, effective prevention and early intervention programs are highly desirable and should be pursued. Similarly, vocational rehabilitation during and after treatment should be given priority. Individuals need help in developing or recovering skills which enable them to support themselves: some need basic schooling, vocational counseling and skills training; some need a form of supportive work; and still others simply need a job. We must be sure such help is available to former drug users, stabilized patients in treatment and marginal users who are vulnerable to increasing their drug use, if we are to achieve long-term improvement in their behavior.

PRIORITY SHOULD BE GIVEN TO THE MOST DANGEROUS DRUGS

One of the major themes of the Federal strategy is that there should be more selectivity and targeting of Federal efforts. Federal policy calls for giving priority in both supply and demand reduction efforts to those drugs which inherently pose a greater risk to the individual and to society—heroin, and the so-called "dangerous drugs". Additionally, priority in law enforcement should be given to high-level traffickers of all illicit drugs, and priority in treatment should be given to compulsive users of drugs of any kind.

In determining the social cost of a particular drug, the following factors are considered:

- The likelihood that a user will become a compulsive user, either physically or psychologically dependent upon the drug.
- 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.
- The size of the core problem: the number of compulsive users who are currently suffering (or causing others to suffer) adverse consequences from the use of drugs.

A note of caution should be sounded concerning this concept of priorities. It 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. For example, within an overall program which gives priority to high risk drugs, there are organizational and regional units (such as the Drug Enforcement Administration's Miami office) or even entire agencies (such as the U.S. Coast Guard) which by the nature of their location or mission are most likely to make many seizures of lower priority drugs. This is not inconsistent with a policy of shifting the overall effort towards higher priority drugs.

Further, some investigative techniques are not easily targeted by drug or even by level of violator. Often the arrest of a lower level violator may lead to the subsequent arrest of higher level violators; and some smuggling networks trade in a variety of drugs, so the immobilization of a network financing and smuggling marihuana could remove an actual or potential heroin network. Thus, we must continue to devote resources on all aspects of the problem, but the overall effort should be shifted towards higher priority drugs.

Similarly, on the treatment side, there are individuals suffering serious physical and psychological effects from compulsive use of low priority drugs. These individuals need and should be provided treatment. And in the international program, some program elements such as crop eradication deal with the drug problem at such an important step of the illicit production and distribution process that efforts of this kind may be justified against all drugs.

Where resource constraints force a choice, however, the choice should be made for the higher priority drug, the higher level violator, and the compulsive user of drugs of any kind.

This concept is critical because these kinds of priority decisions are in fact beting made daily—often implicitly by individuals at the operational level—without regard to the inherent risks of the various drugs. For example, every time a law enforcement officer decides whether or not to pursue an investigation lead, he is making such a decision. Every time a specific research project is approved, a priority decision is made. When Customs officers are assigned to ports of entry such as Chicago or New York, a similar decision is being made.

The concept of "drug priorities" is intended to ensure that these implicit allocation decisions made by the individuals reflect a coherent policy based on the inherent costs to society of the different drugs. In Chapter 3 of this report, we will cite evidence of the implementation of this concept over the past year by both enforcement and treatment officials.

These priorities are not static, and should be subject to continuous review by program managers. As new evidence of the personal and social costs of drug use becomes available and use and abuse patterns change, it is necessary to modify these priorities, and reallocate resources accordingly. The Stragegy Council has undertaken such a review and has determined that the priorities established in the White Paper remain valid for the present.

FULL UTILIZATION OF AVAILABLE RESOURCES

Drug abuse is a national, indeed an international, problem. In order to combat it, it is critical that we more effectively mobilize and utilize all the resources available in the United States and overseas to deal with this problem. The Federal Government—the Congress, the Executive branch and the Judicial branch—State and local governments, and the private sector must work together in a new and far more aggressive attack against drugs.

Specifically, despite progress over the past two years, opportunities still exist to more fully utilize the resources of the U.S. Customs Service, the Internal Revenue Service, and the Federal Bureau of Investigation within an integrated Federal law enforcement program. Opportunities still exist to develop and use a broad spectrum of education, employment and vocational training services, many now available in the Department of Labor, as part of a comprehensive demand reduction program.

The primary responsibility for leadership and coordination of the total effort lies with the designated Cabinet departments and agencies. The lead agency concept places primary responsibility for law enforcement policy with the Department of Justice; for prevention, treatment and rehabilitation policy with the Department of Health, Education, and Welfare; and for international narcotic control policy with the Department of State. A Cabinet committee has been established in each of these areas under the leadership of the respective Cabinet officers, and working groups are addressing issues and coordinating activities across agency and departmental lines. One of the major tasks of each of these Cabinet committees is to enlist the support of all Federal organizations having something to contribute to a broad response to the drug problem.

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.

Most importantly, we must enlist the aid of communities and families in the fight against drug abuse. Studies by Presidential Commissions, Government agencies and private groups have concluded that the best defense against drug use, crime, and alienation is the family unit, and a community which makes an effort to reach out and include youth in meaningful and interesting activities. Strong, viable communities and families are the best way to make sure children learn the values necessary to avoid the trap of drug abuse; that they learn to respect others and themselves; and that they have healthy outlets for their energy. If families fail in these vital tasks, there is relatively little the government can do, no matter how well intentioned. The importance of the family and community in preventing drug abuse simply cannot be overemphasized.

THE RELATIONSHIP OF DRUG ABUSE TO OTHER SOCIAL PROBLEMS

Drug abuse does not occur in isolation. The profound changes which have occurred in the pattern of community and family life, together with the increased mobility of our population, have seriously weakened the influence of many traditional value systems on the behavior of youths and young adults. At the same time, new influences—particularly the visual media—send mixed and confusing signals to the young about drug use. Thus, while traditional institutions try to discourage drug use, the media advertises "chemical solutions" for a variety of problems, from illness, to drowsiness, or inability to sleep, to obesity.

Further, while drug abuse strikes all strata of our society, heroin addiction—the most feared—often afflicts those who have a variety of other social problems: poverty, unemployment, alienation, or lack of opportunity.

Understanding and acceptance of these simple facts has been slow in coming. All too often in the past we have tended to view drug abuse as an isolated phenomenon which could be dealt with independently of other problems and cured as one might cure a childhood infectious disease.

Over the past several years, however, there has been a growing awareness of the relationship between drug abuse and a variety of other social and personal problems with which we are afflicted. With this increasing awareness has come the understanding that drug abuse prevention and rehabilitation must be dealt with against the background of a broad range of problem behavior, including alcohol consumption, truancy, juvenile delinquency and unemployment; and the recognition that drug treatment facilities must have the capability to provide assistance (or refer to assistance) in a variety of "non-drug" areas including medical, familial, social and vocational.

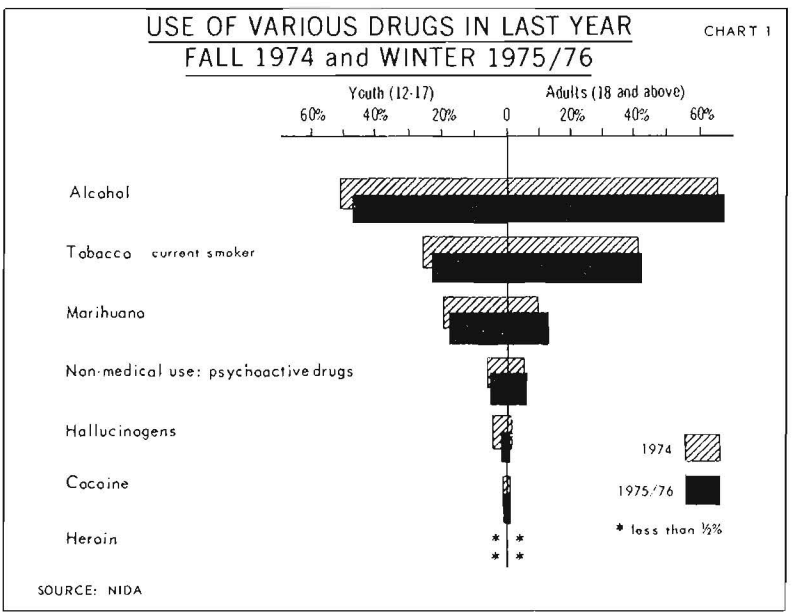
This discussion of the interrelationship of drug abuse with other social problems is not meant to imply that progress cannot be made on the drug abuse front without first solving the other problems. But it does imply that these other problems have an impact on the success of drug programs, and that drug programs must be designed in a way which is both consistent and coordinated with efforts to alleviate other social problems.

In sum, efforts to seek ways of more fully coordinating drug abuse prevention and law enforcement programs with other social, health and rehabilitative services are a growing part of the Federal strategy.

2. THE NATURE AND EXTENT OF DRUG ABUSE

Drug abuse remains at unacceptably high levels throughout the United States. Because of the illegal nature of most drug abuse, direct counts of the drug abusing population are difficult. However, on the basis of national surveys of drug use and analysis of other indicators of drug abuse trends, we are increasingly confident about our ability to describe the extent and trends of drug use in the country.

It is estimated that, in the past year, over 22 million have used marihuana; 7 million have used prescribed medication without medical supervision; 3 to 4 million have used cocaine; and over one-half million have used heroin.[1]



[1] These estimates are drawn from the most recent (Fall, Winter of 1975/76) national survey of drug use. The corresponding numbers for use at least once during lifetime: almost 139 million have used alcohol; about 37½ million have used marihuana; almost 19 million have used prescribed medication without medical supervision; almost 7 million have used cocaine and about 2 million have used heroin. The survey data are generally believed to accurately reflect drug use *except* for heroin. For some reasons, studies have shown the extent of heroin use to be consistently understated. Estimates made by other means of the number of Americans who have used heroin at least once in their lives have ranged as high as 2 to 4 million.

[2] It was the clear intent of the legislation calling for the preparation of this Strategy that it concentrate on those drugs covered by the Controlled Substances Act of 1970. Therefore, although acknowledging the high rates of use and the concomitant high social cost of alcohol and tobacco, this Strategy focuses on the scheduled drugs.

Chart I shows the results of the most recent national survey of drug use, taken in the winter of 1975/76 and compared to the previous survey taken in the fall of 1974. The chart shows use of different drugs during the twelve months preceding the survey by youths and adults. Notice that almost half of the youths and two-thirds of adults used alcohol within the past year (one-third of youths and more than one-half of adults within the past month). Further, almost one youth out of five and more than one adult out of ten had used marihuana within the past year. Non-medical use of so-called "dangerous drugs" was also widespread.[3]

In reviewing the survey numbers, it is important to remember that we are talking about hundreds of thousands of people. For example, one percent of youth aged 12-17 is equivalent to 250,000 people and one percent of adults is approximately one and one-half million people. Further, while these data indicate that the rising rates of use evident in the past have slowed, stopped, or even reversed for certain drugs, this dampening of previous upward trends in drug use should not be seized as evidence that the drug abuse problem is being solved.[4] We remain deeply concerned about these continuing high rates of use and their consequences. Additionally, we should not lose sight of the fact that these general trends often mask important changes in drug use among certain elements of the population or in certain geographic areas. In short, we must accept the fact that we are facing a chronic, persistent problem.

In Chapter 1, we discussed the concept that public policy should be most concerned with the adverse effects of drug abuse on the individual and society. Clearly, the adverse effects of the various drugs differ significantly and not all drug use contributes to these effects. Therefore, it is important to look not only at the number of users but at measures of direct social costs from drug abusing behavior as well.

The most graphic demonstration of the adverse effects of drug abuse is a "crisis" which results in death or in illness or injury severe enough to require emergency treatment in hospitals. Over the last two years, the National Institute on Drug Abuse (NIDA) and the Drug Enforcement Administration (DEA) have developed and refined a large-scale national drug abuse data collection system which collects data associated with drug abuse-related crises as reported by hospital emergency rooms and medical examiners in 24 of the largest metropolitan areas of the United States.[5]

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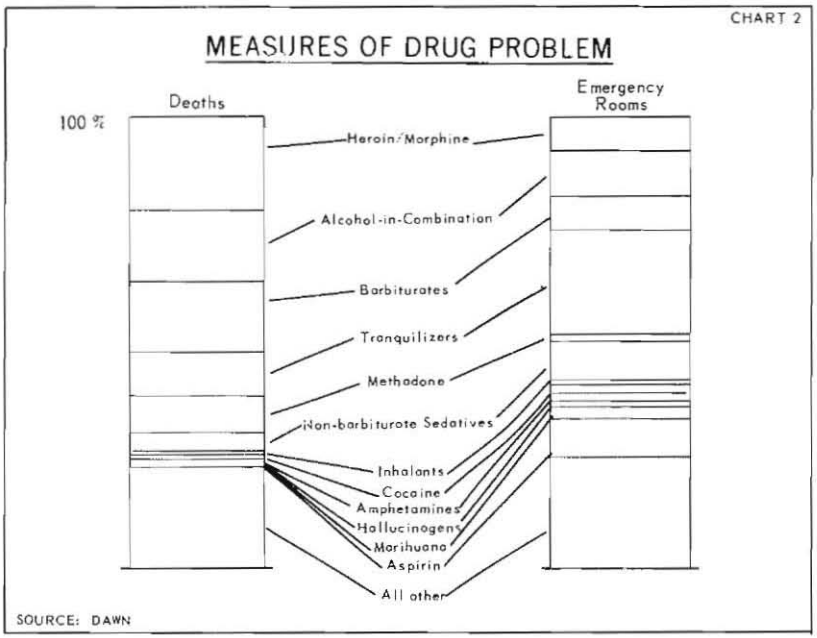
[3] The term "dangerous drugs" is commonly used to refer to the non-medical use of prescription or over-the-counter tranquilizers, depressants, and stimulants and other psychoactive drugs.

[4] The apparent decline in use by youths may be due to the "graduation" of a group with particularly high rates of drug use from the youth to the adult category since the last survey see discussion later in this chapter. However, a separate nationwide survey of high school seniors also showed a modest decline in the use of all drugs except alcohol and marihuana between 1975 and 1976.

[5] While the 24 metropolitan areas were not chosen randomly, they include most of the largest areas which together account for 31 percent of the total U.S. population. Thus, the aggregate data may be regarded as indicative of the situation across the United States, although they do not represent a random sample in the statistical sense.

This system is called the Drug Abuse Warning Network, or DAWN.

Chart 2 shows the distribution of "mentions" to DAWN by medical examiners and emergency room facilities during April through June 1976.[6]



Looking first at deaths, over half of all mentions are accounted for by heroin, alcohol in combination with some other drug[7] or barbiturates. On the other hand, cocaine, inhalants, amphetamines, hallucinogens, and cannabis each account for less than one percent of drug-related deaths.

When emergency room data are examined, we find that tranqualizers replace heroin as the leading drug mentioned, but the serious drugs reported by both systems are similar[8]; further, the least often mentioned are the same. These similarities in ranking indicate the basic validity of the assigned drug priorities. Even if mentions associated with a suicide attempt or gesture are eliminated from these data, the most serious drugs remain heroin, alcohol-in-combination, tranquilizers, barbiturates and non-barbiturate sedatives.

The remainder of this Chapter discusses each of the principal illicit drugs in turn, focusing especially on the past two years, the period for which data are most extensive and reliable.

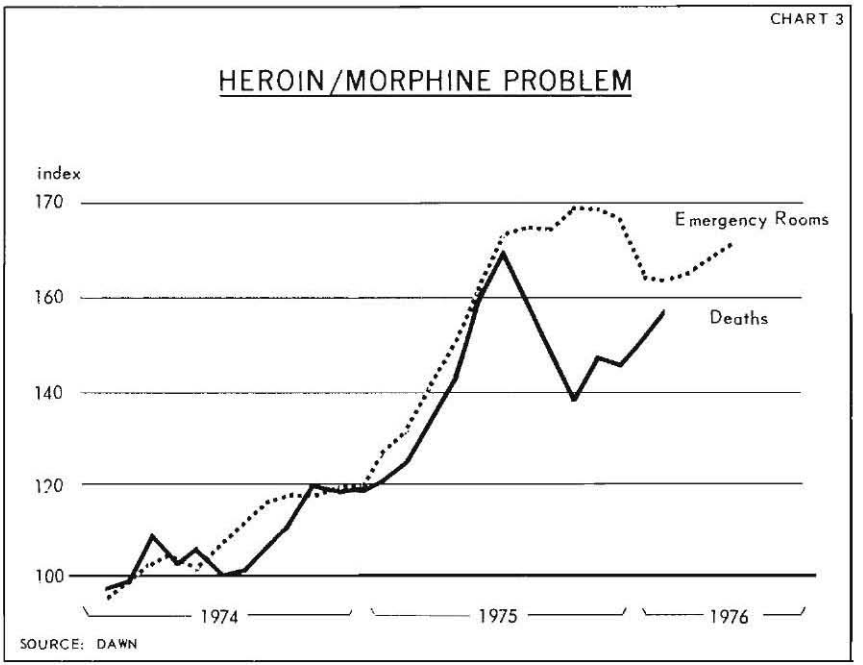
[6] A "mention" represents a substance abused by a patient which played a part in causing him to seek help. The patient may "mention" more than one drug during a single drug abuse crisis episode.

[7] The DAWN system now only records alcohol when its use is related to use of some other drug. We are currently investigating expansion of the system to include alcohol-drug mentions on the same basis mentions of other drugs are now made.

[8] Except for non-narcotic analgesics (e.g., aspirin), which rank relatively high in hospital emergency room mentions because of their widespread use among the general population.

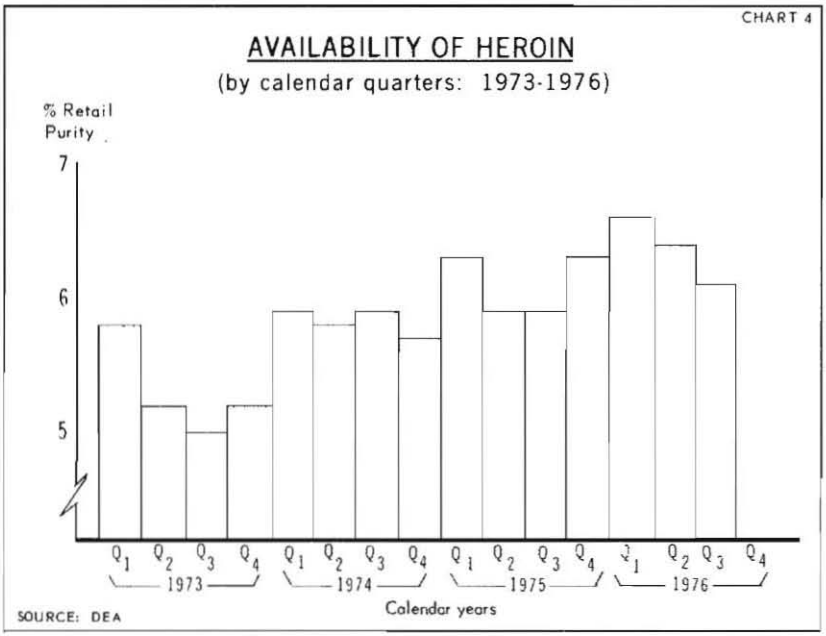
HEROIN

As noted in the *White Paper on Drug Abuse,* there was a decline in heroin use during 1972 and 1973 following imposition of a ban on poppy cultivation by Turkey and effective enforcement action against traditional trafficking networks by the French police. Shortly thereafter, heroin originating in Mexico began to flood the American market. Use of heroin turned upward again in early 1974 and continued to increase until the third calendar quarter of 1975. Since that time, there has been a general stabilization in the situation, with both the emergency room visits and overdose deaths remaining essentially flat or declining slightly, as shown in the following chart.



These charts of three-month moving averages are based on data from a consistently reporting panel of hospital emergency rooms and medical examiner facilities. This consistent reporting panel represents approximately 40 percent of the total DAWN system.

Availability of heroin measured by retail purity, as shown in the chart following, has followed essentially the same pattern, except that there is a slightly more detectable downturn in availability since January 1976. Hopefully, this indicates the beginning of a measureable result from the 1975 Mexican opium poppy eradication campaign, but the downturn must be sustained for several more months before we can be confident that this represents a real trend.



A closely related abuse problem which definitely appears to be lessening is death from the abuse of illegally obtained methadone. These deaths, which have predominated in New York City and have accounted for more deaths than heroin in that city in recent quarters, have declined by more than one-third since later 1973.

DANGEROUS DRUGS

As shown in the charts above, the various dangerous drugs—barbiturates, tranquilizers, and amphetamines—rank behind only alcohol and marihuana in extent of use, and behind only heroin and alcohol in terms of the severity of effects upon individuals using them. These drugs present a special problem, for unlike heroin, cocaine and marihuana—which are totally illegal—these drugs are frequently prescribed by doctors for valid medical purposes. The existence of this legal market vastly complicates control problems. As a consequence procurement in both quasi-legal[9] and illegal markets has tended to be relatively easy and inexpensive.

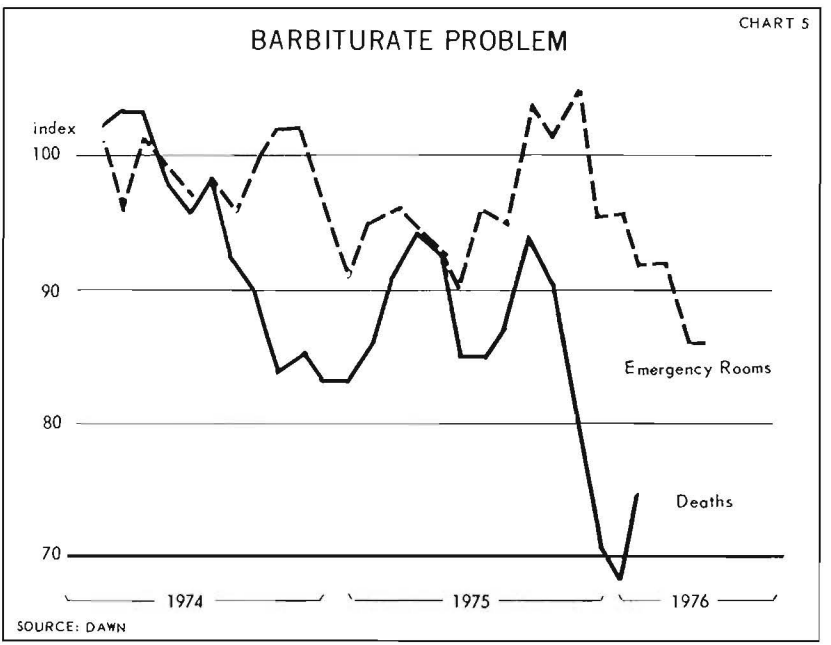
Tranquilizers, used in the past year by approximately two percent of the youths and adults surveyed, account for one-fourth of emergency room mentions—more than double any other drug. Although this category's contribution to deaths ranks considerably lower, the abuse of tranquilizers is clearly one of our most severe social problems. Both emergency room

[9] For example, from over-prescription, or when taken from a family member's medicine chest.

and medical examiner data from DAWN show a relatively stable pattern of mentions over the past two years. However, the most recent survey of drug use indicated a noticeable increase in non-medical use of tranquilizers by adults, particularly those in their twenties. Because of this increase as well as the continuing high level of problems caused by this class of drugs, we believe tranquilizer abuse trends should be closely monitored and corrective action taken, if necessary.

Chronic use of *barbiturates* also continues to rank with heroin and tranquilizers as a major social problem. Approximately three million Americans used these drugs without proper medical supervision in the past year; and barbiturates accounted for approximately 15 percent of DAWN medical examiner mentions (ranked third) and seven percent of emergency room mentions.

As shown in the chart below, there has been a definite decline in the number of barbiturate-involved deaths reported to DAWN and a somewhat less steep decline in barbiturate-related emergency room visits. This declining trend in abuse indicators probably is due to a combination of stricter scheduling, greater attention to compliance investigations, better medical treatment of barbiturate overdoses in emergency rooms and increased physician knowledge concerning the adverse side effects of excessive barbiturate prescription. It may also reflect substitution of other drugs for barbiturates by prescribing physicians.



Unsupervised use of *amphetamines,* while not as great a problem as is use of tranquilizers and barbiturates, remains serious because of their high use. In the last year, over half a million youths and 3½ million adults used

amphetamines without proper supervision, with adult use reflecting a fairly significant increase.

COCAINE

Cocaine, a stimulant with effects similar to those of amphetamines, presents a somewhat different control problem since most "street" cocaine originates from strictly illegal sources. Despite its illegality, however, the availability of cocaine has been gradually increasing over the past two years, due largely to increased production in coca-growing areas of Peru, Bolivia, and Ecuador. However, despite the common belief among law enforcement officials that cocaine use is increasing as well, the latest survey of drug-using behavior does not confirm any such increase.

As indicated in the charts summarizing DAWN data, cocaine mentions are a relatively minor portion of those drugs reported. However, program managers are convinced that cocaine continues to deserve a somewhat greater attention than seems indicated by those data in light of the incomplete knowledge we have as to its effects after continuing high use.

MARIHUANA

While marihuana is the most widely used illicit drug, its serious health consequences as reported to DAWN are two-thirds less frequent than are those for barbiturates, even though the number of youths using marihuana is almost ten times higher and the number of adults six times higher than those using barbiturates improperly. Both extent of use and health consequences have remained relatively stable for marihuana over the past year. This stability in both DAWN and survey data perhaps indicates that marihuana use is approaching a "saturation level" under current conditions.[10]

OTHER DRUGS

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

- *Hallucinogens such as LSD.* The hallucinogen problem, which reached serious levels several years ago, appears to be on a definite decline. Both the number of users and the adverse effects reported by DAWN declined in the last year. For example, 2.8 percent of youths and 1.1 percent of adults used hallucinogens in the year prior to the most recent survey; the corresponding numbers for the 1974 survey were 4.3 percent and 1.5 percent. Emergency room data show the same downward trend, a trend which began at least two years ago. However, this favorable trend does not signal a time to turn

[10] Current conditions include the continued legal prohibition on marihuana trafficking, possession, and use in most States. While early evidence from those States which have decriminalized it indicates very little change in the extent of marihuana use, more widespread decriminalization of marihuana possession and use could have an unknown impact on the extent of use.

attention away from hallucinogen abuse, since experience has demonstrated that "fad drugs" can change in popularity rapidly.

- *Inhalants such as paint and glue.* The abuse of inhalants is unique among all drugs reported in the national survey in that they are the only ones which are abused most heavily at the youngest end of the age spectrum: age 12–13. This concentration of inhalant abuse among the young is probably due to the fact that inhalants and solvents are the most readily available intoxicants to children. Even though most children mature out of the inhalant habit, its use should be monitored and action against abuse—such as using additives which produce an unpleasant odor in the manufacturing process of inhalants—should be taken where possible.

SPECIAL ANALYSIS: DRUG USE AMONG YOUNG ADULTS

One of the most striking and worrisome findings of the most recent survey of drug-using behavior is the extremely high use rates of young adults aged 18–25.

The chart below shows the percentage of youths, young adults, and other adults who have ever used a number of different drugs. It also shows the percentage who had used drugs in the 12 months prior to the survey, the same measure used in the general discussion earlier in this chapter.

	Ever Used			Used in Past Year		
	12-17	18-25	26+	12-17	18-25	26+
Marihuana	22.4%	52.9%	12.9%	18.4%	35.0%	5.4%
Amphetamines	4.4%	16.6%	5.6%	2.2%	8.8%	0.5%
Barbiturates	2.8%	11.9%	2.4%	1.1%	5.7%	0.5%
Tranquilizers	3.3%	9.1%	2.7%	1.8%	6.2%	0.8%
Cocaine	3.4%	13.4%	1.6%	2.3%	7.0%	*
Heroin	0.5%	3.9%	0.5%	*	0.6%	*

*Less than 0.5%

As shown, substantially greater proportions of young adults—from two to four or more times as many—report both exposure to and recent use of each of the major categories of drugs than do either the younger or older groups.[11] In fact, high rates of use among young adults are so much higher, than those of younger or older groups that the mere passage of one and one-half years since the last survey—permitting 16½ to 18 year olds then reported as youths to move into the "young adult" category—results in an apparent *decrease* in drug use among youths and an apparent *increase* in drug use among young adults (see Chart 1).

[11] Not surprisingly, drug-related deaths strike disproportionately at this group as well, ranking as one of the leading causes of death for both young men and young women.

Of these young adults, who were teenagers in the turbulent late 1960's and early 1970's when the heroin epidemic peaked, many represent an unfortunate legacy of that unhappy era. Whatever the reason for their high levels of drug use, it is clear that priority attention should be given to understanding and coping with the special problem of drug use by this group, lest it follow them through adulthood.

3. PROGRESS IN STRENGTHENING THE PROGRAM AGAINST DRUG ABUSE

Progress made in understanding the fundamental nature of drug abuse and in refining the Federal Strategy to minimize the cost of drug abuse to society was discussed in Chapter 1. Likewise, the progress made in controlling the spread of drug use and abuse to ever-increasing numbers of citizens was discussed in Chapter 2. This chapter summarizes the considerable progress made over the past 18 months in improving the operation of the Federal drug program and in putting it on a sound basis: progress which we hope to see reflected by a reduction in the basic indicators of drug use over the months to come.

This progress is discussed in six categories:

- Evaluating the impact of a balanced stragety.
- Targeting scarce resources on the most important part of the problem.
- Strengthening coordination and cooperation among Federal drug agencies.
- Broadening international cooperation.
- Improving the use and distribution of information.
- Securing effective removal of traffickers.

But first, a note of caution. While we take pride in these accomplishments, we recognize that much remains to be done. The fact that the extent and cost of drug abuse remain at high levels demands a continuing, long-term commitment to minimize the problem. In Chapter 4 we will discuss this commitment in terms of new initiatives and new approaches to the problem of reducing drug abuse.

EVALUATING THE IMPACT OF A BALANCED STRATEGY

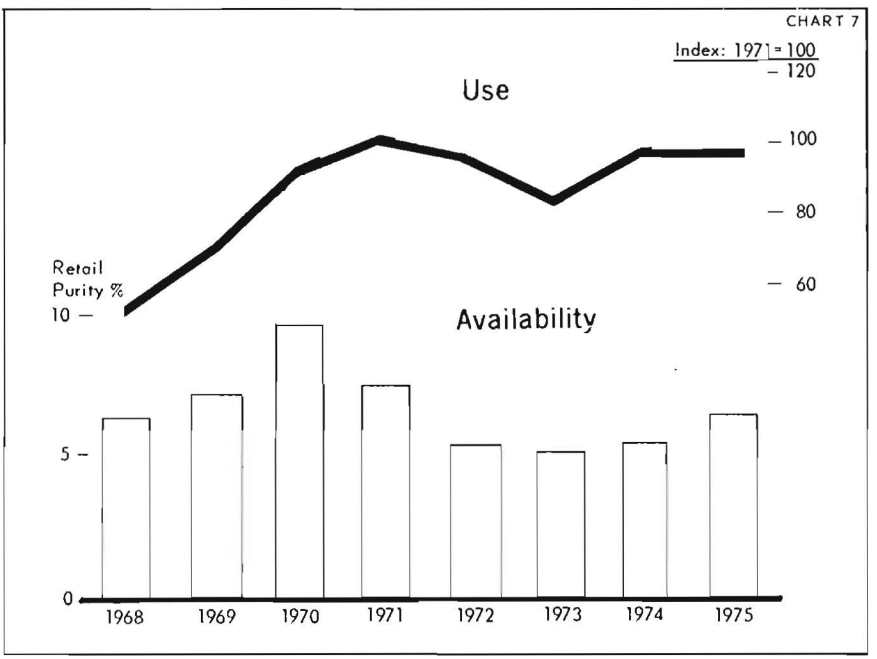
The concept of a balanced effort aimed at reducing the supply of illicit drugs while at the same time reducing the demand for those drugs has been the foundation of Federal drug policy for the past several years.

Central to this concept are the beliefs that: (1) reducing the availability of drugs will lead to a reduction in their use; and (2) treatment "works"—that is, it reduces drug use. Both of these beliefs were extensively discussed in the *White Paper on Drug Abuse*. This section describes some additional evidence developed over the past year.

Effect of Supply Reduction

The best single measure of the availability of heroin is its retail purity. The following chart shows this measure of availability since 1968 as a series of bars. As shown, average retail purity rose steadily to a peak of 9.6 percent in 1970, fell sharply in 1971 and 1972 (resulting from the elimination of Turkey as a major source of heroin), reached its low of 5.2 percent in 1973, and then gradually increased in 1974 and 1975 as Mexican brown heroin spread throughout the country.

To measure the extent of heroin use during the same period, four indicators of its use were converted into a single composite for display purposes—this is shown as a solid line above the availability bars so that direct comparisons can be made.[1]



[1] Since no single use indicator yet developed is totally reliable, four which are generally believed to reflect trends in use were selected, converted into indices with 1971 equal to 100, and averaged, giving them equal weight. The indicators used were: (1) narcotic-(primarily heroin) related deaths, (2) narcotic-related serum hepatitis cases (a good measure of new use); (3) State and local heroin and cocaine arrests (reported together, but predominately heroin), a reliable indicator on the assumption that no major changes were made in State and local priorities and procedures; and (4) property crime.

The heroin problem, as measured by the composite of the four problem indicators, rose throughout 1971, fell in 1972 and 1973, and rose again in 1974, and remained level during 1975.[2]

We believe that this chart represents an important piece of evidence in support of the statement that heroin use goes down when heroin availability goes down, and goes up when availability goes up.

Effect of Treatment

Also critical to the concept of a balanced Federal program is the belief that treatment "works", that it leads to a reduction in criminality and other socially costly behaviors. However, skeptics continue to question the value of drug treatment in view of the high rate of repeat drug use.

During the past year, several important studies have been released which indicate that treatment does indeed lead to substantial reductions in a patient's rate of drug use, crime, and other problem indicators, both while in treatment and several years after leaving treatment.

The most comprehensive study of post-treatment behavior of heroin addicts is just now beginning to report results of its analysis. Preliminary results seem to offer powerful evidence that treatment results in a significant decline in an addict's undesirable behavior. These results are based on detailed follow-up of a scientifically selected national sample of 1,078 male heroin users who entered treatment between June 1969 and June 1971. These individuals were contacted in 1974 and 1975 and interviewed concerning their current behavior.

The following chart summarizes the percentage of this group who manifested some undesirable activity or trait during the two months immediately preceding admission to treatment, and compares it to a two month period approximately four years after leaving treatment.

Follow-up Sample of 1078 Males
2 Months Pre-Treatment: 2 Month Period 4 Years Later
(expressed in percent)

	Pre-Treatment	Follow-up
Any illicit drug use	100	34
Any opiate use	90	23
Daily heroin use	75	5
Any non-opiate use	62	23
Daily or weekly non-opiate use	34	9
Any illegal support	50	17
Any part- or full-time employment	39	49

[2]Looking at the indicators individually, all four rose steadily to a peak in 1971, the first year availability fell. All but hepatitis dropped in 1972; hepatitis held at the 1971 level that year following extremely sharp increases in the prior two years; thus, holding steady represented a sharp reversal of the trend. In 1973, the four indicators were mixed as would be expected in the year during which the lowest availability was reached and the subsequent increase began. In 1972 all four rose, reflecting the general deterioration in the heroin situation. In 1974, property crime rose, but the other indicators all dropped slightly.

This chart shows that, although some drug use persists, heavy drug use at the time of the follow-up interview is relatively low, reliance on illegal support (criminal income) is cut by more than 60 percent and there is a modest improvement in employment.[3]

Another follow-up study—one conducted on patients of the Narcotics Treatment Administration in Washington, D.C.—involving a smaller sample of individuals two years after treatment, shows similar results.

These advances in understanding the effects of major program elements and in validating basic assumptions on which the Federal strategy is based are extremely important. For example, in order to properly allocate Federal dollars in the future, it is critical that we know what works and what does not, for whom it works and under what conditions. This determination requires in-depth follow-up studies examining the extent of drug use following a change in availability or regulation, or the progress of clients during and after treatment. Identifying what programs work best remains the number one research and evaluation priority.

TARGETING SCARCE RESOURCES

A central theme of the Federal strategy is that there should be greater selectivity and targeting of Federal efforts in both supply and demand reduction, so that scarce resources are used where the problem is most severe and where the greatest impact can be made. Specifically, the strategy calls for concentrating Federal law enforcement efforts on high-level traffickers, and focusing Federal treatment resources on habitual users of high-risk drugs. In both supply and demand reduction, this concept suggests giving special priority to those drugs which inherently pose a greater risk to the individual and to society[4]—heroin, and the so-called dangerous drugs.

Great strides have been made by the various agencies, working independently *and* together, in implementing this concept. For example, a new *Drug Enforcement Administration (DEA) Strategy* has been issued which includes a mission statement focusing the agency's resources on the identification and investigation of key participants in major trafficking organizations.

Results both in terms of resource use and resulting arrests are impressive. The two charts on the following pages show the percentage change of FY 1976 over FY 1975 in two key measures of resource allocation:

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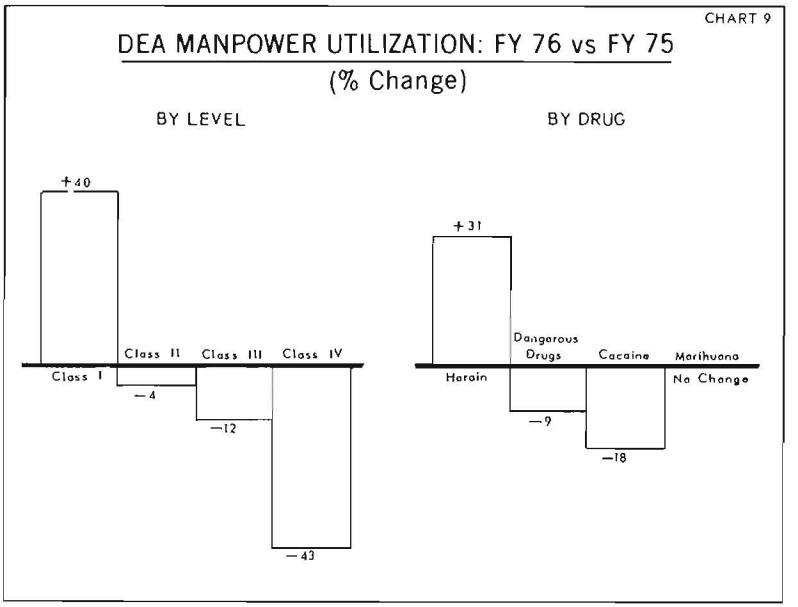
[3] Another interesting statistic is the one dealing with other treatment experiences: more than half of this group had been treated before their 1969-1971 admission; and three of five were enrolled in treatment programs between release from that treatment and the 1975 follow-up interview. This pattern of repeated treatment perhaps suggests that drug treatment "failures" are not that at all; but rather that each treatment experience gradually moves many drug abusers closer to abstinence.

[4] See Chapter I for a more complete discussion of this "drug priority" concept - its justifications, meaning, and limitations.



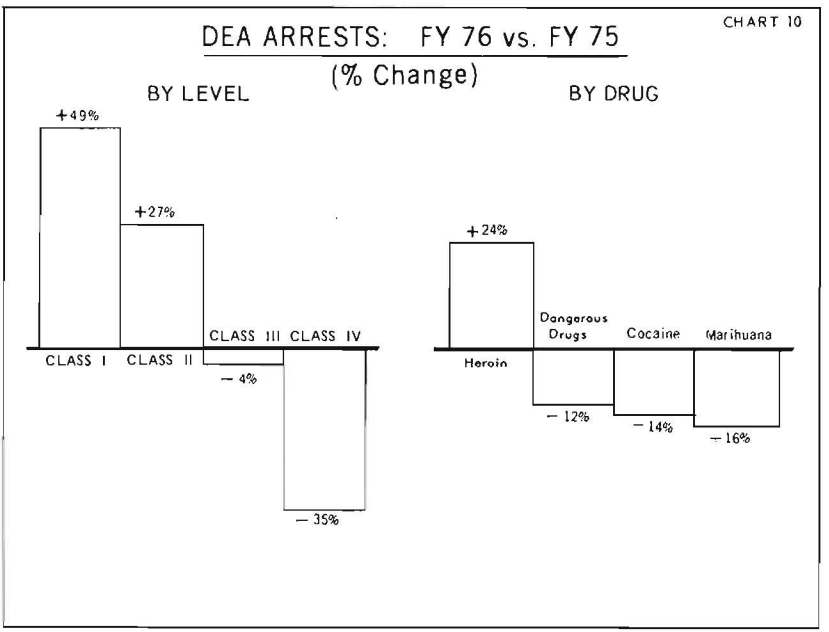
- *Manpower Utilization*—the number of man-hours devoted to cases of different types. While the total number of hours increased by only four percent, the number of hours devoted to the investigation of Class I—the highest level—violators increased 40 percent, and the number of hours devoted to heroin cases increased 31 percent.[5]
- *Arrests*—The total number of arrests increased by two percent, but the number of Class I arrests increased 49 percent, and the number of heroin arrests increased 24 percent.

Overall, major shifts have been made toward Class I and Class II violators and away from Class III and Class IV; toward heroin traffickers and away from cocaine and marihuana. Thus, even overall manpower only increased by four percent and the overall amount of PE/PI actually decreased by 13 percent, by shifting resources, DEA was able to devote almost half again as much manpower and slightly more PE/PI funds to the investigation of Class I violators. The result was a 49 percent increase in arrests of Class I violators.

To ensure that this refocusing of resources toward high-level traffickers and the more dangerous drugs continues, DEA has taken several internal management actions to help focus enforcement efforts on major drug traffickers. Its Office of Enforcement has been reorganized to promote the interregional cooperation required in complex conspiracy cases directed

[5]Evaluation of PE/PI expenditures—the expenditure of funds to purchase evidence (PE) or information (PI) needed in a drug investigation—shows a similar pattern.

against high-level violators. DEA agent evaluation forms have been revised to stress success in identifying and directing enforcement efforts against high-level violators and to encourage building interregional conspiracy cases rather than statistical arrest totals. The system of classifying drug arrests has been revised so that targeting of enforcement resources against high-level violaters is more selective and aimed at organizations capable of bringing large quantities of illegal drugs into a region on a continuing basis. Finally, guidelines have been issued to DEA agents overseas which emphasize concentration on major traffickers and organizations responsible for drugs destined for the United States.



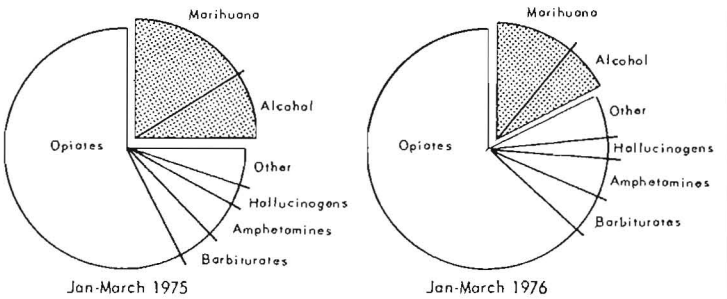
To focus even more attention on the problem of illicitly produced or diverted amphetamines and barbiturates, DEA has recently established an Office of Regulatory and Compliance Affairs. This office, which will be augmented by 16 new positions granted in the FY 1977 budget, should further concentrate efforts on the illegal diversion of controlled substances and ensure minimum leakage from the production of legitimate drugs.

Significant progress in targeting scarce resources where they will have the greatest impact in reducing drug abuse has also been made in the use of existing drug abuse treatment capacity. For example, the number of low priority drug users (such as casual marihuana users) in treatment programs has been reduced, thereby releasing badly needed treatment services for those with a greater need (heroin addicts, for example). The following chart compares the percentage of patients admitted to treatment funded by the National Institute on Drug Abuse (NIDA), the Veterans Administration (VA) and the Bureau of Prisons (BOP) who reported various drugs as their

primary drug of abuse during the period of January to March 1975, and January to March 1976.

CHART 11

PRIMARY DRUG OF ABUSE
PATIENTS ADMITTED TO FEDERAL TREATMENT



Source: Client Oriented Data Acquisition Process (CODAP)

Looking only at community treatment funded by NIDA, treatment for patients whose primary drug of abuse was marihuana, alcohol, or "no drug" was reduced by 57 percent between October 1975 and April 1976, freeing over 4,500 treatment slots for people with a greater need for treatment.[7]

Progress in restricting the use of expensive types of treatment has also been made. For example, in accord with *White Paper* recommendations:

- NIDA reduced the number of outpatient drug-free treatment slots by almost 6,000 between July 1975 and April 1976, a reduction of 14 percent;
- The Department of Defense reduced the number of people in its drug-free residential rehabilitative services by almost 800, a reduction of 25 percent;
- The Veterans Administration, excepting its pilot alcohol and drug dependence treatment program (which accepted all drug users regardless of primary drug of use), showed similar progress;

[6]This modest reduction is due to inclusion of alcoholics in a VA-sponsored pilot combined drug/alcohol abuse treatment evaluation project. Alcohol abuse continues to be our most serious drug problem. However, at the present time separate treatment centers are maintained for alcohol abusers, so patients whose primary drug of abuse is alcohol should be referred to those centers for treatment. The possibility of combining treatment for alcohol and other drug abusers is discussed in Chapter 4.

[7]In addition, funding for 7,000 additional community treatment slots is included in the FY 1977 budget request.

- The total number of patients treated in expensive in-patient hospital settings by NIDA, VA and Defense was reduced 19 percent.

Another way to improve the quality of care at a minimum cost involves greater utilization of paraprofessionals. The number of paraprofessional training courses provided by NIDA, VA and Defense has increased from 238 in 1975 to 346 this year, and the number of paraprofessionals trained increased by 59 percent, from 6157 to 9759. Also, the Departments of Defense and Health, Education, and Welfare and the Veterans Administration took the lead in incorporating drug abuse into professional education curricula, including the proposed curriculum for the new Defense Uniformed Services University of the Health Science Medical School and the Veterans Administration program for training medical students and residents in 18 university-affiliated Veterans Administration hospitals throughout the country.

STRENGTHENING COORDINATION AND COOPERATION AMONG FEDERAL DRUG AGENCIES

A major theme of the Federal strategy is that only with the full and efficient utilization of all available resources can we hope to contain the drug problem. Thus, major emphasis has been given to increasing the involvement of all agencies and to building mechanisms for coordinating their efforts.

There has been substantial progress in this area over the past 18 months. A major factor in the improved climate of cooperation was the need to work together to meet the President's request for a thorough review and assessment of the effectiveness of the Federal program to control drug abuse (an effort which led to the publication of the *White Paper on Drug Abuse).* During the course of that review, more than 80 individuals from over 20 different government organizations participated in work group activities. In reality, the Drug Abuse Task Force and its numerous working-level subcommittees never stopped working. On December 27, 1975, the President gave the Task Force the additional responsibility of preparing recommendations for dealing with the problem of drugs crossing our southern border, which served to keep the supply reduction groups meeting and working together. The demand reduction work groups were kept operating under the Office of Management and Budget's Office of Federal Drug Management in anticipation of the creation of the Cabinet Committee on Drug Abuse Prevention, recommended by the White Paper.

These temporary but effective coordinative mechanisms became the operating arms of two new Cabinet committees created by the President in April 1976 to ensure the coordination of all government resources which bear on the problem of drug abuse.[8] The President charged the newly

[8] The President announced the establishment of these two new Cabinet committees—one for drug law enforcement and the other for drug abuse prevention, treatment, and rehabilitation—in his Special Message to Congress on Drug Abuse of April 27, 1976.

formed Cabinet committees, together with the existing Cabinet Committee for International Narcotics Control, with integrating the efforts of seven Cabinet departments and seventeen agencies into an effective overall program directed against drug abuse. Specifically, he charged the new Cabinet committees with the following responsiblities:

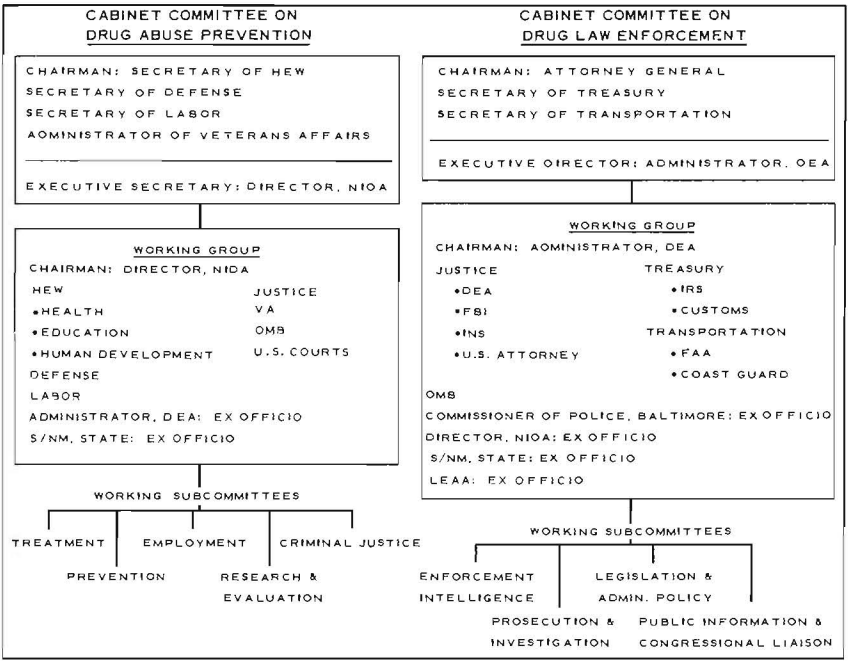
(1) To develop and implement the Federal strategy with respect to drug law enforcement (or drug treatment, rehabilitation, prevention and research);
(2) To assure proper coordination among Federal drug law enforcement (or treatment and rehabilitation) programs, including the collection, analysis and dissemination of information (or enforcement intelligence data);
(3) To assure that Federal enforcement resources (or prevention, treatment and rehabilitation) are effectively utilized;
(4) a. To assure proper coordination between the investigative and prosecutorial arms of the government
    b. To develop and monitor a plan for improving job opportunities for former addicts;
(5) To provide liaison between the Executive Branch and Congress, State and local governments and the public;
(6) To assure implementation of relevant recommendations contained in the Domestic Council's *White Paper on Drug Abuse;*
(7) To evaluate and make recommendations to improve Federal drug law enforcement (or treatment and rehabilitation) programs; and
(8) To report their progress to the President on October 1, 1976, and periodically thereafter.

In addition to the above ongoing responsibilities, the Chairmen of the Cabinet committees were directed to work closely to develop plans for improving the coordination between law enforcement and drug abuse prevention, treatment and rehabilitation programs.

The new Cabinet committees are now quite active, both at the Cabinet committee level and in their working groups and functional subcommittees (see chart below for the structure of the two committees).

This *Federal Strategy 1976* is evidence of the work of those Cabinet committees since most of it is drawn from their respective October 1 progress reports to the President.

Important progress in improving interagency coordination and cooperation has been made between individual agencies, as well. For example, at the time the White Paper was released, the greatest need for improved interagency cooperation involved the Drug Enforcement Administration and the U.S. Customs Service. Reorganization Plan No. 2 of 1973 drew a distinction between investigative and interdiction functions with respect to narcotics enforcement. The investigative function was given to DEA and the interdiction function left with the Customs Service. Unfortunately, the distinction between interdiction and investigation was not made clear in the



Reorganization Plan. This ambiguity led to jurisdictional disputes between the agencies.

The most valuable contribution the White Paper made toward the resolution of these disputes was to focus the debate on a relatively narrow set of issues, and to point out the considerable areas of agreement which existed, but which were often overlooked. Since the White Paper's release, the working relationship between DEA and the Customs Service has improved markedly. Among other things:

- Last December, the U.S. Customs Service and DEA signed and implemented a Memorandum of Understanding which outlines operating guidelines for improving coordination between those agencies, thus signalling an end to the rivalry which had hindered Federal drug law enforcement efforts for more than ten years. These guidelines were discussed by top DEA and Customs officials in joint session in February 1976 to ensure clear understanding of them.
- To respond to Customs' complaint that DEA was not providing useable tactical intelligence in sufficient quantity, DEA established a capability within its intelligence branch to work specifically on Customs requirements. In addition, Customs has made provisions for assigning three intelligence analysts to DEA headquarters to ensure that DEA personnel are sensitive to Customs' intelligence requirements, and that all relevant information is relayed to them. Customs has also assigned personnel to the interagency El Paso Intelligence Center and to DEA's Detroit office. The resulting flow

of information from DEA to Customs has increased sharply since the Memorandum of Understanding was signed, from a few hundred specific items per month to over one thousand per month.

- Finally, in June 1976 DEA and Customs agreed on a procedure which permits Customs to debrief persons arrested for drug smuggling at the border if DEA declines to do so.

A similar Memorandum of Understanding between Customs and the Immigration and Naturalization Service (INS) was signed in April 1975 and the U.S. Coast Guard will soon be executing Memoranda of Understanding with Customs and DEA.

The Immigration and Naturalization Service, the U.S. Coast Guard, the Federal Aviation Administration (FAA) and the Bureau of Alcohol, Tobacco and Firearms (ATF), as well as DEA and Customs, are working together at the El Paso Intelligence Center. An Interagency Drug Intelligence Group with representatives of several of these agencies has been meeting since mid-June to monitor the movement of brown heroin. Further, DEA, in coordination with the Cabinet Committee on Drug Law Enforcement, has established two pilot Field Intelligence Exchange Groups in Chicago and Miami. The objective of these groups is to maximize prosecutions against key high-level traffickers and financiers by coordinating the local intelligence resources of Federal agencies and State and city law enforcement organizations.

BROADENING INTERNATIONAL COOPERATION

In his April 27 message to the Congress on drug abuse President Ford said:

"No matter how hard we fight the problem of drug abuse at home, we cannot make really significant progress without the continued cooperation of foreign governments. This is because most dangerous narcotics are produced in foreign countries. Thus, our capability to deal with supplies of drugs available in the United States depends largely on the interest and capability of foreign governments in controlling the production and shipment of illicit drugs.

" . . . We must now intensify diplomatic efforts at all levels in order to encourage the greatest possible commitment from other governments to this international problem. We must continue to provide technical and equipment assistance through cooperative enforcement efforts with U.S. agents stationed overseas, all aimed at strengthening drug control organizations within foreign countries. And we must continue to participate in building institutions and a system of international treaties which can provide a legal framework for an international response to this international problem.

"I have spoken personally to Presidents Echeverria of Mexico and Lopez-Michelsen of Colombia and with Prime Minister Demirel of

Turkey in an effort to strengthen cooperation among all nations involved in the fight against illicit drug traffic . . .

"And I am confident that our joint efforts will bring about a real reduction in drug trafficking into the United States."

Mexico has been the top priority country in the international narcotics control program for the past several years since it has become the dominant U.S. source of heroin. Mexico is also a major source of marihuana and an important transshipment route for cocaine. During the past year, President Ford, Secretary Kissinger and Attorney General Levi have all underlined in their talks with the President, President-elect and the Attorney General of Mexico the great importance we attach to Mexico's narcotics control efforts.[9] Further we have continued to provide substantial amounts of material assistance, primarily aircraft, to Mexican narcotics agents.[10]

Probably the most important single development in the international narcotics control area over the past 18 months was the decision last year by the Mexican Government to move from manual destruction of poppy plants to use of environmentally safe herbicides.[11] Previously, soldiers were moved by helicopter into the poppy fields in the high Sierra Madre mountains to knock the plants down with sticks—a system as laborious, slow, and inefficient as it sounds.

Using the vastly more efficient aerial spraying method, the Mexican Government reports that it destroyed over 20,000 poppy fields in the campaign which ended in April 1976, more than four times the number of fields destroyed in any previous campaign. While many of the fields were undoubtedly harvested before being destroyed, and many were replanted, this represents a major achievement which should significant reduce the amount of Mexican heroin available in the U.S.[12] As noted in Chapter 2, we believe the decline in purity of brown heroin since June 1976 portends this reduction but only time can confirm that trend.

Lasting effectiveness of the eradication campaign and complementary U.S. enforcement efforts will require continuation, at the same or higher levels, of the strenuous efforts both governments are now making. A new Mexican administration will be inaugurated in December, three months after the resumption of intensified poppy eradication efforts this fall. President-elect Lopez-Portillo stated in his September 24, 1976 meeting

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[9] President-elect Lopez-Portillo assumes office on December 1, 1976.

[10] Following the provision of $15.8 million in assistance in FY 1975, the U.S. Government will provide $14.5 million in FY 1976 including the transition quarter, and an additional $8.1 million is programmed for FY 1977. This represents more than one-fourth of the total international narcotics assistance program.

[11] These short-acting herbicides used were selected by the Mexican government from among those used routinely in Mexican agriculture.

[12] At the same time the Mexican Government has stepped up its eradication campaign, DEA has intensified enforcement attacks on major traffickers of Mexican heroin, both in the U.S. and in Mexico, through sharing intelligence and joint prosecutions.

with President Ford that his administration will continue and even seek to increase, his predecessor's efforts. This is critical, because even a brief slowdown during the transition between presidential administrations could allow a significant amount of opium to be harvested, since substantial acreage reaches maturity in late fall.

Another important joint Mexican-U.S. program implemented over the past year is called JANUS—a special program to prosecute Mexican national traffickers in Mexico based on testimony taken in the U.S.

Significant progress can also be noted in the cases of two other opium producing countries—one, the former major U.S. source; the other a major potential source.

- *Turkey:* In the 1960's and early 1970's, opium diverted from Turkey's licit crop and processed into heroin in Marseilles accounted for more than half of the heroin in the United States. Because of its concern about the diversion, the Turkish Government banned all opium production following the 1971-1972 crop year, a ban which was rescinded under intense domestic political pressure in 1974. However, the poppy crop now is strictly monitored and harvested by the more controllable poppy straw method: to date, Turkish, United Nations and U.S. experts have not detected significant diversion to illicit markets from the 1974-75 or the 1975-76 poppy straw crop.

- *Burma:* Burma produces the largest quantity of illicit opium in the world, estimated at 450 metric tons annually.[13] Recognizing that most of the insurgent groups and independent warlords that infest its northern states finance their operations with the proceeds of opium trafficking, the Burmese Government has dramatically stepped up its destruction of illicit poppy fields and raids on trafficking caravans, using U.S. supplied helicopters for mobility.[14] During the 1975-76 growing season the Burmese Government destroyed and/or forced out of operation 17 laboratories and refineries, intercepted nine large drug caravans and destroyed approximately 18,000 acres of opium poppies. These efforts reduced significantly the amount of heroin that would have been available for export from Burma.

Another drug of abuse which is grown and processed overseas is cocaine. Coca production is narrowly limited geographically, with coca leaves grown primarily in Bolivia and Peru, and processing into cocaine taking place mainly in Colombia. Thus, if supplies can be reduced in those three

[13] To put this volume in perspective, the annual U.S. illicit demand is estimated at 5-7 tons of heroin, equivalent to 60-80 tons of Southeast Asian opium.

[14] Our narcotics control expenditures in Burma for FY 1976 were $13.3 million, following less than $1 million in FY 1975. A FY 1977 budget request for $2.9 million is to support a spare parts and maintenance program for U.S. helicopters and furnish any additional required aircraft.

countries, the total amount of cocaine available can be severely limited, since there are not ready alternative sources. Just such an opportunity to make major inroads into coca production, refining, and trafficking appears to be developing. In September 1975, President Lopez-Michelsen of Colombia and President Ford discussed the increasing cocaine problem. Following that meeting, President Ford directed that we expand our assistance to Colombian efforts to interdict the growing cocaine traffic. In response, U.S. narcotics assistance provided to Colombia increased from approximately half a million dollars in FY 1975 to almost $5 million in FY 1976 for a comprehensive package of aircraft, communications equipment and other needed equipment.

In June 1976 President Banzer of Bolivia and Secretary Kissinger met and laid the groundwork for an expanded assistance program in Bolivia which will:

- Expedite and expand research and pilot efforts now underway to determine the feasibility of alternative sources of income for the traditional coca growers;[15]
- Develop a mechanism to enforce control over coca growing (new growers should now be stopped from growing and traditional growers should be subjected to control when alternative sources of income become available); and
- Strengthen Bolivian enforcement capabilities against drug traffickers.

Subsequently Peru, the other major source of coca, has offered to work with us as well, and negotiations are now underway to develop a joint program.

The difficulties posed by a program of bringing coca production under control in those countries by combining alternative income for coca growers with the adoption of a parallel crop control and enforcement effort cannot be minimized. Not only must we identify viable alternate sources of income in these remote areas, we must also develop means of marketing the products. Moreover, long-entrenched lifestyles must change. But the price of failing to try is clearly greater than the funds involved.

Questions have been asked about these "cocaine initiatives" in light of the fact that cocaine is a lower priority drug than heroin or the "dangerous drugs." However, the drug priority concept does not mean that *all* efforts should be devoted only to the opiates, barbiturates and amphetamines which have higher social costs. Attention must be given to all drugs to keep them from expanding into major problems.

[15] President Ford has approved potential funding over five years with up to $45 million of Agency for International Development (AID) concessional loan funds for agricultural assistance to poor farmers in the coca-growing areas of Bolivia beginning in 1979, and up to $8 million in additional narcotics control funds to strengthen enforcement. U.S. loan funds will only be utilized provided viable programs can be developed and the Bolivian government moves forward with enforcement and control measures. We plan also to encourage Bolivia to seek additional assistance for this effort from international financial institutions.

The percentage of our international program directed against cocaine—even with the new programs now projected for Bolivia and Peru—some $5 to $7 million per year over five years from an annual budget that has averaged in the upper thirty millions—is well below the percentage directed against heroin. Therefore, the programs envisaged for Bolivia, Peru and Colombia regarding cocaine are consistent with the concept of drug priorities. In Chapter 4 we discuss the need to monitor these programs with a view toward assessing how they fit within an overall international strategy

Another area in which progress has been made over the past 18 months is that of developing a more comprehensive and strict system of international treaties and national laws to control drug production and trafficking. For example, the Convention on Psychotropic Substances of 1971 came into force in August 1976 upon ratification by forty countries.

While the fact that the Convention came into force is salutary, with the exception of France it has not been ratified by any of the major producers of psychotropic substances, which severely weakens its effectiveness. Prominent among the holdouts is the United States, though the Convention was sent to the Senate over five years ago and the President has repeatedly called for passage of domestic enabling legislation, most recently in his drug abuse message to the Congress of April 27, 1976.[16]

Further, a number of prominent drug producing or trafficking countries have strengthened internal control in the past year. These include:

- *Singapore.* In December 1975, the Government of Singapore passed legislation providing for the death penalty for trafficking in morphine or heroin, and the ultimate sentence has already been imposed. Evidence suggests that traffickers are now less willing to use Singapore as a transit route.
- *Holland.* Over the past few years, Amsterdam has become a major point of entry for Southeast Asian heroin destined for Western Europe. In August 1976 the Dutch Parliament passed legislation which simultaneously increased the penalties for trafficking and decreased them for simple possession.

Additionally, the U.S. Customs Service has concluded treaties with counterpart organizations in Mexico and Austria during the past year to increase cooperation in the suppression of customs offenses, including the smuggling of narcotics and other contraband.

Finally, in order to stimulate greater international demand reduction activity, the Cabinet Committee on International Narcotics Control recently revised its guidelines in this area and disseminated them to all United States diplomatic missions abroad. These guidelines should result

[16] "The delay in U.S. ratification of the Convention has been an embarrassment to us. Moreover, it has made it extremely difficult for us to urge other countries to tighten controls on natural-based narcotic substances, when we appear unwilling to extend international controls to amphetamines, barbiturates and other psychotropic drugs which are produced here in the United States."

in greater attention to the modest but important program which has been launched over the past several years to encourage other nations to look more closely at their domestic drug abuse problems. By bringing their own drug abuse problems to the attention of other countries, we can stimulate closer cooperation among nations in a truly global effort to control illicit drug trafficking.

IMPROVING THE USE AND DISTRIBUTION OF INFORMATION

The collection and sharing of information regarding all aspects of the drug abuse program are crucial to its success. For example, information on the effects of drug use is central to any public education process. Data on the extent of drug use, the availability of illicit drugs and the resultant social costs are critical in making broad resource allocation decisions and in evaluating the overall effectiveness of our programs. Strategic intelligence on trends in drug abuse, levels of price and availability, sources of drugs, and capabilities of other governments to control drugs are essential for more detailed resource allocation decisions. Data on the effect of different types of treatment on abusers of different drugs, both during and after treatment, are vital to determining what type of treatment works best for whom. In short, information should serve as the foundation for both short- and long-term program management.

Over the past several years, the volume of information available to drug program managers has increased greatly. Progress in analyzing this information and in distributing it in a timely and useful way to potential users—ranging from the public to other enforcement agencies—has not kept pace.

We have made modest progress over the past 18 months, in analyzing available data and in sharing information more widely. For example, the Client Oriented Data Acquisition Process (CODAP) and DAWN provide data on the extent of drug use, the impact of such drug use in terms of deaths and hospital emergency room visits, the characteristics of drug users entering treatment and the impact of treatment on those users. This information is now available on a quarterly basis to program managers, health professionals, regulatory officials and the general public.

Further, the National Institute on Drug Abuse has undertaken to periodically publish a *Heroin Indicators Trend Report* which synthesizes these and other data to determine trends in availability and use.

Intelligence, often thought of as an exotic art somehow unconnected with the rest of the drug program, is merely the use of information from a variety of sources to provide a picture of what is happening, so managers can target resources appropriately. The White Paper found that the overall narcotics intelligence function generally suffered from:

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

- Counterproductive competition within and among enforcement agencies. There was evidence that competitive attitudes within and among enforcement agencies impeded the production and flow of operational intelligence.

To respond to the inadequacy of funds, additional resources have been allocated to intelligence activities in both DEA and Customs.[17] A unit will be established for long-range intelligence planning in DEA, and DEA headquarters' strategic intelligence capability will be expanded. Further, DEA has implemented several internal management changes in both headquarters and field intelligence operations, as well as stressing the responsibility of agents to collect and report intelligence to meet multi-agency needs. For example:

- DEA has scheduled six intelligence collection and reporting training schools for Special Agents beginning in November 1976.
- All regional intelligence offices, foreign and domestic will have functional reporting responsibilities to the headquarters Office of Intelligence.
- Existing agency and management evaluation forms will be revised to include intelligence collection and reporting as an important factor to be considered in the evaluation of all agents for supervisory positions.
- The curricula for DEA's supervisors' school and mid-level management school will be revised to place greater emphasis on intelligence collection and reporting.
- DEA field managers will be scheduled for intelligence management training and review either in the three-week school or in abbreviated sessions designed to highlight its curriculum.

As these changes are implemented, the intelligence support provided to other agencies should improve, thus increasing interagency cooperation and sharing. In addition, several multi-agency efforts to ensure full participation in information sharing by drug law enforcement agencies have been launched. These initiatives are intended to provide an exchange of information on local, regional, and national levels. They are:

- *El Paso Intelligence Center (EPIC):* This interagency group, located in the southwestern border area, receives and disseminates information on trafficking and illegal alien activity along the southern border. The EPIC staff includes operational personnel from DEA, Customs, INS, Coast Guard, FAA, and ATF.
- *Interagency Drug Intelligence Group (IDIG):* This interagency intelligence group, at DEA headquarters in Washington, combines DEA, Customs and INS personnel efforts in analysis and

[17]Specifically, a total of 59 new positions for FY 1977 are being allocated within DEA for regional, strategic and operational intelligence. Customs has added 21 intelligence positions.

dissemination of intelligence relating to a priority drug target, heroin from Mexico.

- *Unified Intelligence Division (UID):* A joint city-State-DEA intelligence unit has been in operation for over two years in the New York City metropolitan area, with membership from a broad range of Federal, State and local drug law enforcement agencies operating in that area. The UID has a small central staff housed within the DEA regional office and analyzes and disseminates intelligence information for the area.
- *Field Intelligence Exhange Group (FIEG):* The Cabinet Committee on Drug Law Enforcement has proposed that interagency groups be formed in 19 major cities to focus intelligence resources upon selected major trafficker targets. On August 20, 1976 pilot efforts to test this concept were begun in Chicago and Miami. Agencies participating include DEA, Customs, IRS, the U.S. Attorney's Office, INS, Coast Guard, FBI, Secret Service, ATF and representatives of State and local law enforcement.

Despite this progress, much more needs to be done. Plans to further improve the dissemination of information are discussed in the next chapter.

SECURING EFFECTIVE REMOVAL OF TRAFFICKERS

Earlier, we discussed the progress being made in focusing Federal law enforcement resources on the arrest of major traffickers. Much of the progress we have made in improving our ability to apprehend these traffickers will be lost, however, unless major changes are made in the way our criminal justice system deals with drug traffickers after arrest.

To deal with the failure to immobilize traffickers against whom substantial cases have been develop, President Ford proposed legislation in his April 27, 1976 special message which would:

1. Require minimum mandatory prison sentences for persons convicted of high-level trafficking in heroin and similar narcotic drugs. These minimum sentences—three years for a first offense relating to an opiate and six years for an offense following a previous conviction or for selling an opiate to a person under 21 years of age—are intended to ensure that drug traffickers know that they will go to jail upon conviction.
2. Enable judges to deny bail in the absence of compelling circumstances for certain categories of notorious drug defendants. These defendants include those persons previously convicted of an opiate felony, persons on parole, probation, or other conditional release, non-resident aliens or persons in possession of illegal passports at the time of arrest, and persons convicted of having been fugitives.
3. Raise the value of property used to smuggle drugs which can be seized by administrative as opposed to judicial action from $2,500

to $10,000 and extend this forfeiture provision to include cash or other personal property found in the possession of a narcotics violator.

4. Make meaningful an existing provision which requires that any person planning to transport an amount exceeding $5,000 file a report, and that the report be filed prior to departure.
5. Reduce the opportunities for unloading of contraband by requiring owners or masters of small, privately owned boats to report their arrival to the U.S. Customs Service immediately, instead of within 24 hours.

Enactment of this legislation would represent a major contribution to the Federal anti-narcotics effort. Securing enactment is thus one of the highest priority "open agenda" items discussed in Chapter 4.

The problem of fugitives is significant: currently there are 2,547 Federal fugitives charged with drug-related offenses. Of these, 345 are Class 1 major traffickers. To help deal with this problem, the FBI will utilize resources available to them to assist DEA in apprehending major drug fugitives. In addition, the Department of State, the Immigration and Naturalization Service, U.S. Customs and the Criminal Division of the Department of Justice are developing plans for coordinating the controlled re-entry of drug law fugitives into the United States. These plans will include a review of existing extradition treaties with an eye toward strengthening them as necessary.

Finally, to attack the financial resources necessary for narcotics traffickers' illegal transactions, in his April 27, 1976 Special Message on Drug Abuse the President directed the Secretary of the Treasury to work with the Commissioner of the Internal Revenue Service, in consultation with the Attorney General and the Administrator of the Drug Enforcement Administration, to develop a tax enforcement program aimed at key traffickers. To begin implementing that directive, the Administrator of DEA and the Commissioner of the Internal Revenue Service have signed a Memorandum of Understanding providing for exchange of information on major drug violators who may be guilty of tax evasion. So far, the names of 375 Class 1 drug violators have been sent to IRS field officials so that tax investigations can begin if warranted.

In June 1976, a U.S.-sponsored resolution urging governments to make the financing of narcotics traffickers a punishable offense and to exchange information that would be helpful in identifying persons committing such offenses, was adopted unanimously by the United Nations Economic and Social Council. Action to this end should prove to be a significant step toward improved cooperation in narcotics investigations.

In addition, the recently concluded U.S.-Swiss Mutual Assistance Treaty on Criminal Matters, which becomes effective in January 1977, should

[18]There is a great likelihood that these individuals are routinely committing tax offenses, since they pay no taxes on their illegal income.

expedite the exchange of information concerning persons engaged in criminal activities, including alleged drug traffickers, even while the case is still in the investigatory stage. Exploratory discussions have been held or are underway in a number of countries with a view toward entering into mutual assistance agreements for exchanging information to disrupt the financing of international crimes.

To provide specialized prosecutorial support to the program aimed at incarcerating major drug traffickers, the Attorney General has devoted greater resources to more extensive enforcement of the conspiracy laws of the United States. There are presently special controlled substances prosecution units in operation in the offices of 19 U.S. Attorneys throughout the country. The U.S. Attorneys were alloted additional personnel to staff these units so that prosecutors would be in a position to devote full time to major cases. In addition, DEA has established a headquarters staff to support conspiracy cases and has put greater emphasis on its Central Tactical Units which specialize in the development of major conspiracies. Both the Criminal Division of the Department of Justice and DEA monitor the activities of the prosecution units and conduct seminars to train attorneys and agents. In addition, DEA has a conspiracy investigation course for agents which is now being expanded to train personnel in the domestic regional offices.

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It should be clear from this discussion that we believe a great deal of progress has been made over the past 18 months in revitalizing and refocusing the Federal drug abuse program and putting it on a sound basis, but there is more we must do. This is the subject of the next chapter: "The Open Agenda."

4. THE OPEN AGENDA

As indicated in the previous chapter, we have made progress in the past 18 months, particularly in the fuller utilization of Federal resources. Nonetheless, much remains to be done in all of the areas discussed there.

Specifically, Federal enforcement efforts can still be more narrowly focused on high-level, interstate and international traffickers. The Internal Revenue Service, the Federal Bureau of Investigation and State and local law enforcement organizations can all contribute more to an overall enforcement program. We can do much more to encourage other nations to join us in this truly international struggle. We need to secure passage of new legislation aimed at improving our ability to put major traffickers in prison and at closing loopholes in the law which allow them to continue to prey on our young. And we need to enlist State and local vocational training services; and State, local and private organizations in a broad prevention effort.

This chapter discusses the additional need for priority action in nine areas:

- Development of a national prevention strategy.
- Expansion of treatment linkages with both Federal and State and local criminal justice systems, other State and local community services, and alcohol treatment.
- Broadening of the program against amphetamine and barbiturate use.
- Removal of offenders from drug trafficking by improving post-arrest prosecution and incarceration, and by attacking the financial resources of traffickers.
- Improvement in intelligence support.
- Action to strengthen State and local law enforcement.
- Outlining of an overall framework for evaluating specific international programs.
- Review of sanctions imposed for possession offense.
- Development and use of new knowledge.

Much of this "open agenda" is not entirely new and some of it has been called for explicitly before. These items remain on the open agenda because progress in implementing them has been slow or inadequate, program managers have been unable to mobilize the resources from organizations which are outside their control, Congress has failed to act on proposed legislation or simply because they need continuing emphasis. All are important to the success of the Federal strategy. The fact that action on them has been called for before but not achieved should not deter us from renewing our efforts in these critical areas.

DEVELOPMENT OF A NATIONAL PREVENTION STRATEGY

Nearly every major review of the Federal drug program has concluded that greater emphasis must be placed on education and prevention efforts aimed at discouraging the use of drugs.[1] Yet, despite this general agreement about the importance of giving greater attention to prevention, progress has been limited. There is only now emerging a general agreement concerning what constitutes prevention, what prevention approaches work best and what the Federal role should be in this area.

In the past the Federal Government has supported a variety of well-intentioned programs which were aimed at "preventing" drug abuse. The results of most such programs have been questioned, however, and there is no strong evidence which clearly demonstrates that prevention programs work. In response to this apparent conflict between the need to do more in the area and the paucity of knowledge as to what works, the Executive Branch and the Congress have been extremely cautious in committing resources to prevention programs, resulting in only modest financial support for these activities.

In order to overcome this dilemma, we believe that a high priority effort, including additional funds for demonstrations, should be made to develop a comprehensive National strategy which, in specific terms, discusses what works and what doesn't and which outlines the appropriate Federal role in the prevention effort. Accordingly, the Cabinet Committee for Drug Abuse Prevention, Treatment and Rehabilitation has undertaken an action agenda which will first catalogue existing prevention programs, evaluate each of these to determine if they work and, if so, for what kinds of individuals in what kinds of environments. They will also point out where new knowledge is required and recommend a program for developing such knowledge. At each stage, attention will be given to developing interim products which can be of immediate use to community-based prevention sponsors.

Since we do know that initial experimentation and much subsequent heavy drug use occur during adolescence, services and strategies should be directed at population groups within the age span of 8 to 18. We also know that programs must be developed that are able to operate across a continuum ranging from those unlikely to get involved in drugs to those at highest risk. Programs must also include four essential components: information, education, alternatives and intervention. Adults involved with the youth (for example, parents, teachers, counselors) and friends should be viewed as key secondary target groups.

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[1] For example, the White Paper said: " . . . 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."

A number of community institutions—the family, school, church, recreation programs and the media—have an impact on the growth and development of children. The role of each of these institutions in preventing drug abuse should be emphasized. Opportunities for doing so should be evaluated and the best incorporated in an overall prevention strategy.

Another area of drug abuse prevention which deserves greater attention is early identification and intervention. This requires early attention to children who have problems with alcohol or drug use in their early teen years. Schools, family, health and counselling centers, welfare agencies and other institutions linked to the daily lives of children and families should be sensitized to both identifying and appropriately dealing with such behavior so that it doesn't progress and become more serious.

Prevention research efforts should focus on determining conditions which precede drug abuse. These efforts should include studies of non-drug use and drug-free communities to identify factors contributing to and promoting non-drug use. A great deal of research has already been done on these factors and the Federal Government should now broaden its efforts to collect and synthesize this existing knowledge. To this end, it is important to maintain a close liaison with those involved in child and adolescent research in order to take advantage of learning which might have implications for drug abuse prevention.

Finally, the Federal Government should encourage and facilitate an evaluation of the effectiveness of prevention models. In the past, information provided by prevention projects varied so much that direct comparison of various programs was difficult. Therefore, clear statements of program objectives must be developed and disseminated which pose common criteria for program reporting and evaluation. This will allow communities to better determine the impact of their programs.

EXPANSION OF TREATMENT LINKAGES

While some progress has been made in developing systematic linkages between the Federally-funded treatment system and other existing systems dealing with individuals in trouble, more is needed. Specifically, greater cooperation and expanded linkages are required between the Federally-funded treatment system and:

- the criminal justice system (both Federal, and State and local);
- State and local community services; and
- organizations dealing with alcohol abuse.

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 simple drug possession or for a "habit-supporting" felony such as robbery or it may be for offenses entirely

unrelated to drug use. Whatever the reason, these arrested drug users are prime candidates for treatment since their arrest and subsequent handling in the criminal justice system provide an opportunity to detect and monitor drug-using behavior and to encourage participation in a treatment program, where appropriate. Thus, development of systematic linkages between the treatment and criminal justice system is critical.

The Federal Government has taken an important step in providing referral services to offenders who come into contact with the criminal justice system at the State level. A Law Enforcement Assistance Administration (LEAA) funded program called Treatment Alternatives to Street Crime (TASC) identifies and refers narcotic-involved offenders to drug abuse treatment in 38 cities throughout the United States. About 26,000 clients have been referred to treatment since the program began, and there are 5,200 clients currently in treatment. Results to date have been dramatic—the average recidivism rate has been cut in half—and the program has been enthusiastically received by the law enforcement officials, the courts and communities alike.

TASC should be expanded as rapidly as possible to encompass any jurisdiction with a population of 200,000 or more that can demonstrate eligibility. As older projects complete their period of Federal funding, monies will be available for new starts. As the start-up funding provided by LEAA runs out for each TASC project, the local government should be prepared to provide funding support from either LEAA block grants or other sources: none of these projects should be allowed to lapse. If the additional client load caused by TASC referrals exceeds existing community treatment capacity, increasing that capacity should be given high priority.

Federal offenders with histories of drug dependency who are in the community under either pre-trial or post-conviction supervised release are highly vulnerable to relapse and criminal behavior to support their addiction. Thus, a TASC-like program applied to Federal probationers could have a similar positive impact on recidivism rates in this high risk category of released offenders.

Currently, the only program which provides this identification and referral system for Federal offenders is the pre-trial services pilot project directed by the Chief Justice of the United States. Mandated under the Speedy Trial Act of 1974, the pilot is being implemented in 10 major Federal judicial districts to screen all defendents brought before the Federal courts to determine present and past drug use, especially heroin use.[2] Each defendant is routinely questioned as to present and past drug use. Present or past drug treatment for opiate and non-opiate use is determined and recommendations for continued or initial treatment are made to the judicial officer. Treatment needs are determined by the pre-trial services officer as a result of the initial bail interview and by follow-up

[2]New York City, Brooklyn, Philadelphia, Baltimore, Atlanta, Detroit, Chicago, Kansas City, Dallas, and Los Angeles.

field verification of interview data. All ten agencies have been operational since February 1976 and well over 4,500 defendants have been interviewed, with approximately one-third having been released on pre-trial supervision.

This project is important because it begins to fill an important gap in referral services for drug abusers within the Federal criminal justice system. Presently, Federal referral efforts begin only after sentencing and even these pre-incarceration efforts are limited. Most Federal referral activities occur when an individual is about to be released from prison. The ten-cities pilot will enable the Federal Government to develop a more comprehensive capability to identify and refer for treatment and other appropriate services those people entering the criminal justice system who need such help. As soon as preliminary favorable results of the first ten pilot projects are substantiated, the program should be expanded.

Attention must also be given to providing proper treatment to those in prison or on parole. LEAA legislation required that by October 1, 1976, all convicted offenders incarcerated or on a supervised release program receive drug or alcohol treatment, if warranted. Earlier surveys of State prison systems have indicated that such services have been lacking. A priority assessment of the actual delivery of required services has been undertaken to determine if significant corrective action is needed. Currently, programs for Federal offenders are operating under antiquated legislation, the Narcotic Addict Rehabilitation Act of 1966 (NARA). We should repeal Titles I, II and III of the Narcotic Addict Rehabilitation Act, substituting legislation for Title II which will identify drug-dependent inmates and provide institutional and aftercare supervision.

While the number of heroin-using clients referred to treatment by the criminal justice system should increase, the number of casual or recreational marihuana users referred for "treatment" as an alternative to jail should decrease in order to reserve limited treatment capacity for those who need it more. To accomplish this, the National Institute on Drug Abuse (NIDA) and the Department of Justice have begun to develop a referral training package for judges, prosecutors and probation and parole officers which could be used at all levels of operations, i.e., Federal, State and local jurisdictions. Further, the Cabinet Committee on Drug Abuse Prevention (CCDAP) has adopted the establishment of guidelines for judicial referral as an issue to be incorporated into their activities.

State and Local Community Services

The federal Government has traditionally been responsible for a greater share of the funding for drug abuse treatment than for most other health services, including alcohol and mental health. This was necessary since traditional health and mental health providers were reluctant to initiate drug abuse treatment activities.

Over the past four years State and local governments have assumed an

increasing share of this funding. However, they now appear to be unable to assume any additional responsibility. Indeed, some States and localities have had difficulty this past year in meeting their present matching requirements. The National Association of State Drug Abuse Program Coordinators has urged "that the level of Federal support for drug abuse services be fixed at 80% of the true program cost", which they assess at 20% more than current allowances, "without reducing the current nationwide base of 102,000 NIDA-supported treatment slots." This concern underscores the real problem that States face in meeting their financial commitments in the drug abuse area, and suggests that the current policy of stabilizing the cost-sharing at 60 percent Federal and 40 percent non-Federal is too low as assessed by the States. The importance of maintaining or increasing the Federal contribution to community-based treatment cannot be overstated: it is vital to the continuing viability of a community service delivery strategy.

A related problem to the one of funding is that of system stability. Time and again, State and local officials have stressed the need to have a greater understanding of what the Federal treatment position will be over a 3-to-5 year period in order to adjust their own plans. Thus, we should attempt to define a Federal strategy for treatment which covers several years. Such a treatment strategy should indicate what the Federal objective is—for example, to provide treatment services to all who seek them; or to provide detoxification services on demand and fund only a certain number or broader treatment slots—the approximate level of resources to be expected and what services we expect the States to provide.

Finally, there is a need for community-based treatment to expand its interface with the total community health and social service providers to ensure that the drug abusing client receives the services he needs. Obviously, more than just treatment services are needed if rehabilitation is to occur. For example, employment and related training are essential to the rehabilitation of the drug involved offender. Since the drug abuse treatment system is not specially funded to provide employment and training services, better ways of assuring access to programs in the community that do provide such services are essential. However, many of the existing Federal programs which provide skills training or employment assistance currently exclude drug abusers or narrowly limit their participation.[3]

Because employment and related training and job development activities are essential to the rehabilitation of the drug involved offender, and current services lacking, we must establish ways of improving drug offenders' employability and employment opportunities. Over the next six months,

[3] Under the Comprehensive Employment and Training Act authority to conduct skills training and employment assistance programs has been delegated to prime sponsors—political jurisdictions of 100,000 or more. Consequently, determinations as to whether drug abusers should be targeted for special assistance is dependent upon local initiatives and policy determinations.

the cabinet Committee on Drug Abuse Prevention, Treatment and Rehabilitation will undertake to ensure that drug abusers will not be denied access to existing Federal manpower or rehabilitation programs. Specific activities will be directed at reviewing guidelines, regulations and plans for vocational rehabilitation and employment programs at both Federal and State levels; developing cooperative activities and projects in these areas; and developing a strategy for greater involvement of the private sector in employment programs.

Finally, we reaffirm the long-term goal of incorporating drug abuse services into the general health service system and including drug abuse services in national health insurance and other payment programs. While it is difficult to do so, we have made some progress in collecting third-party payments and we will continue to do more. But we should not abandon categorical support of drug abuse treatment services, since existing third-party payment schemes can at best cover only a portion of the required service.

Alcohol Treatment

Alcohol is the most widely used drug in the United States today, and its abuse is related to more deaths and injuries than any other drug. Yet very little has been done to integrate the community-based activities dealing with the problem of alcohol abuse and the abuse of other drugs.[4] At the least, there are opportunities for more fully integrating alcohol research with other research on the causes of addiction.

Further, even though efforts have begun to exchange programmatic information between NIDA, the National Insitute on Alcohol Abuse and Alcoholism and the National Institute on Mental Health—the three institutes which comprise the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA)—a need remains for increased inter-institute sharing of a broad system of information, including coordination of planning and research data, to provide timely influence on policy decisions by the institutes. At a time of increasing Congressional emphasis on cost containment, we must improve the efficiency of ADAMHA.

The case for partial integration of treatment services is not as clear, but the CCDAP should review and evaluate data on the clinical experiments that combine drug and alcohol abuse treatment to measure how well this approach works. Where possible, specific recommendations regarding further combined demonstrations or research should be made.

BROADENING OF THE PROGRAM AGAINST AMPHETAMINE AND BARBITURATE ABUSE

In Chapter 2, we observed that the abuse of "dangerous drugs" such as tranquilizers, amphetamines and barbiturates ranks with heroin as a severe

[4] However, the Veterans Administration and the Department of Defense have been moving toward integration for several years.

social problem. Estimates are that there are several hundred thousand people using these drugs in a manner which leads to a high personal and social cost, a figure roughly comparable to the number of heroin addicts.[5]

However, the complexities of the problem confronting the Federal Government with regard to dangerous drugs are much different and in some ways more difficult to correct than are those of heroin abuse:

- Since many of these drugs have legitimate medical uses as well as abuse potential, two objectives must be carefully balance; 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.
- The existence of this licit distribution system vastly complicates the control problem, since much of the illicit supply begins as legitimate production and is diverted at a variety of levels.
- The legitimate retail distribution is "controlled" by independent doctors and pharmacists, some of whom do not exercise adequate standards of control.
- Once distributed, the drugs essentially are under the control of the individual recipient.

The regulatory program which has been established under the authority of the Controlled Substances Act of 1970 does a reasonably effective job of controlling production and distribution at the manufacturing and wholesale stage through a system of schedules, quotas, registration and investigations.[6] But the Federal Government's ability to affect this problem at the retail and user level is severely constrained, both by the geographic dispersion and large number of registered retail distributors (over 500,000) and by the impact of doctors, pharmaceutical manufacturers and pharmacists on drug-using behavior.

Therefore, the Administrator of DEA has established a special task force chaired by the DEA Office of Regulatory Affairs with membership from DEA, the Food and Drug Administration, NIDA, FTC, DoD, CPSC and regulatory boards to:

- Review the problem in depth and make specific recommendations for enhancing the overall program.
- Develop specific proposals, such as increased training or the creation of more Diversion Investigation Units, which will assist and thus increase the effectiveness of State and local authorities in combating retail diversion.

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[5] Basically, a user is likely to be in need of specialized assistance if he uses these drugs intensively, in combination with other drugs, and without medical supervision.

[6] For example, the abuse of several scheduled drugs, barbiturates in particular, has decreased between FY 1975 and FY 1976 through the introduction of quotas, tight security and record-keeping. The recent creation of a separate Office of Regulatory Affairs within DEA and the assignment of additional manpower should lead to further improvements.

- Develop cooperative alliances with professional associations so that drug control prevention and self-regulation programs such as the promulgation of prescribing guidelines can be instituted. This will impact on some of the social as well as regulatory consequences of drug abuse. Improper prescribing practices as well as poor communications between the professionals and the regulatory agencies will also be addressed.
- Follow up on the recently completed Federally funded study of State licensing boards and professional associations to assess how its recommendations can be implemented.
- Review the unrestricted international trade in dangerous drugs and monitor other nations' experiences with new drugs of abuse.

REMOVAL OF OFFENDERS FROM DRUG TRAFFICKING

It has become all too clear that gathering sufficient evidence to prosecute a trafficker does not guarantee his or her removal from further trafficking. A trafficker may be operating in a foreign country, out of reach of effective U.S. prosecution, trial and sentencing. If they remain in the United States, indictment and arrest do not guarantee immobilization; they merely begin a long criminal justice process during most of which the trafficker is free to continue operating. At the end of this process incarceration may be relatively short.[7]

This failure to immobilize traffickers against whom a substantial case has been developed is very costly; in terms of wasted investigative resources and lowered morale, in terms of weakening the deterrent value of the law, and in terms of reduced public trust in the criminal justice system. Consequently, efforts to more effectively immobilize indicated traffickers are vitally important.

The open agenda for improving performance in this area is discussed in two parts:

- Improving post-arrest handling in the criminal justice system.
- Attacking the financial resources of traffickers.

Post-arrest Handling by Criminal Justice System

Now that Federal law enforcement agencies are demonstrating the ability to shift their focus to high-level violators, we must make significant changes in the way the criminal justice system handles major traffickers after arrest to capitalize on this progress.

One necessary step is to enact better laws. The President proposed legislation in his April 27 Special Message on Drug Abuse which, among other things, is aimed at improving our ability to put major traffickers in prison.

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[7] Nationally, 55 percent of convicted Federal narcotics offenders received sentences of either less than three years of imprisonment, or probation. (FY 1975 data)

These proposals are now before the Congress. They should receive bipartisan support and swift passage. Enactment of these proposals will represent a major contribution to the national anti-narcotics effort.

Increased attention to the problem of prosecution of major traffickers is also needed. The establishment of Controlled Substances Units (special drug prosecution units) in the United States Attorneys' offices in 19 cities has helped to focus prosecution resources on cases involving major traffickers. But all too often, limited prosecutorial resources have forced these units to be diverted to lower level drug cases, or even to non-drug cases. We understand that this diversion reflects competing needs for the services of experience prosecutors who normally staff these units, but they nonetheless hurt the drug program.

We believe that there needs to be greater commitment of experienced attorneys to these units. Specifically, we recommend that all existing Controlled Substances Units be staffed with experienced prosecutors and further that the United States Attorneys' offices which do not have Controlled Substances Units select one or more experienced prosecutors to work with DEA on major cases. Additional DEA conspiracy units should be developed and DEA should ensure close working relationships between designated agents and prosecutors' offices in all major cities. Training DEA agents in conspiracy techniques, already increased substantially, should be further expanded and U.S. Attorneys should receive regular briefings by DEA personnel on the drug traffic in their geographic areas.

Finally, there also is a pressing need to increase the number of United States magistrates and Federal judges. We specifically endorse the recommendations concerning Federal judges and magistrates made by the President in his June 17, 1976 message to the Congress on crime.

Financial Resources of Traffickers

By focusing on traffickers' fiscal resources the government can reduce the flow of drugs in two ways. First, high-level violators, usually well insulated from narcotics charges, can often be convicted for evading the taxes due on their illicit income. Second, since trafficking organizations require large sums of money to conduct their business, they are vulnerable to actions that reduce their working capital.

Thus, the Internal Revenue Service (IRS) has a major role that it can and must play in drug enforcement. In accordance with the Presidential directive to develop a tax enforcement program aimed at high-level drug traffickers, DEA and the IRS signed a Memorandum of Understanding on July 27 which provides for the sharing of information concerning suspected tax violations by major narcotics violators. Since signing the memorandum, DEA has provided IRS with an initial listing of 375 names of high-level violators and meetings have been conducted in the field between DEA and IRS officials. All of this represents a good start: now the IRS must devote sufficient resources to ensure effective enforcement of the tax laws

against high-level drug traffickers. If additional resources are necessary, they should be provided.

In addition to action by the IRS, there are other measures which can be taken to deprive the trafficker of fiscal resources needed in his trade, or to use financial aspects of his operations to build a criminal case. They include the following:

- Enact the provisions of the President's proposed drug legislation which would: (1) raise the value of property used to smuggle drugs which can be seized by administrative, as opposed to judicial action (from $2,500 to $10,000), and extend this forfeiture provision to include cash or other personal property found in the possession of a narcotics violator; and (2) make operative the current provision requiring a report whenever more than $5,000 is being exported.
- Pursue negotiations to bring about mutual assistance agreements with other countries for increased investigative access to information which could help disrupt the financing of narcotics trafficking.
- Expand the DEA financial intelligence project, which analyzes financial flow to and from a suspected violator to build a prosecutable case.
- Expand training in financial intelligence. The sophisticated methods used by higher-level traffickers to move money and conceal profits require an equally sophisticated form of investigation. DEA's National Training Institute should work with the IRS to devise training courses for our analysts and agents in financial investigative techniques.

IMPROVEMENT IN INTELLIGENCE SUPPORT

Despite the progress made in the past year, the narcotics intelligence function remains weak. Improvements are critically needed because the availability of good strategic and tactical intelligence is the key to proper resource allocation. For example, strategic intelligence on trends in drug abuse, levels of price and availability, sources of drugs and capabilities of other governments to control drugs is essential for resource allocation decisions within and across agencies and for evaluating the impact of supply reduction efforts. Operational and tactical intelligence is essential for targeting enforcement efforts, screening possible leads and for insuring the maximum development of those leads.

Over the next several months, the Enforcement Intelligence Subcommittee of the CCDLE will focus on improving four critical functional phases of the intelligence process:

- Establishment of agency requirements for intelligence information and the assignment of collection tasks against those requirements.
- Collection of intelligence information from domestic and foreign sources and reporting of the information.

- Analysis and dissemination of intelligence.
- Linkage between domestic and foreign intelligence.

To meet the needs of participating agencies, the subcommittee will develop and disseminate a set of multiagency requirements. Further, to ensure that the information needed by each agency is accurate and fully attuned to the changing environment, it may be advisable to establish a Requirements Management Group with the principal function of updating and disseminating intelligence requirements to ensure adequate reporting.

The investigator/agent in the field should be the principal resource for the collection and reporting of tactical narcotics intelligence information. Law enforcement managers must reorient the agent force to serve not only enforcement, but strategic intelligence and multiagency needs as well. DEA must become accustomed to collecting and reporting information beyond the immediate scope of a specific case. To help accomplish this, DEA has scheduled six intelligence collecting and reporting training schools for its Special Agents beginning in November 1976. Within DEA, intelligence and enforcement activities must be more closely coordinated for more efficient collection, analysis and utilization of intelligence.[8]

Efficient use of intelligence data is dependent on analysis and dissemination. Recognizing this need, additional resources for intelligence analysis have been provided for both DEA and Customs, but more may be required. This is particularly true with regard to domestic strategic intelligence.

The international nature of the production and traffic in illicit drugs requires the use and careful coordination of both domestic law enforcement intelligence resources and foreign intelligence resources. The fact that two Cabinet Committees—International Narcotics Control and Drug Law Enforcement—have overlapping responsibilities in the area, plus the legal prohibition of any domestic involvement of the CIA (one of the major contributors to the *international* narcotics intelligence effort) makes coordination both difficult and essential. To address this coordination problem, the Working Group of the Cabinet Committee on International Narcotics Control (CCINC) has established a special task force to examine difficulties impeding effective interagency relationships abroad. The Enforcement Intelligence Subcommittee of the CCDLE is working closely with this task force. One concern of this group is to assure that appropriate foreign intelligence is available for domestic drug enforcement, while all proper legal requirements and related policies are implemented and observed.

[8] As discussed in Chapter 3, several individual agency steps have also been taken to improve the collection and dissemination of intelligence information. Recently DEA and Customs concluded an agreement that provides that Customs may debrief those narcotics defendants not debriefed by DEA, so that more intelligence supporting interdiction and investigative efforts can be gathered and analyzed. In addition, Customs and DEA have agreed that Customs officers should gather narcotics related information from the international Customs community. Further, a number of interagency intelligence sharing mechanisms at the local and national level have also been established.

ACTION TO STRENGTHEN STATE AND LOCAL ENFORCEMENT

An inevitable result of directing Federal drug law enforcement activities against major drug traffickers is even greater reliance on State and local enforcement to investigate and prosecute the remaining drug offenses. As DEA moves away from prosecution of lower-level violators, additional resources must be found to enable local jurisdictions to handle those investigations. Further, Federal prosecutors are becoming increasingly selective as to which cases they will accept, so there will be increasing pressure on local prosecutors to take those drug cases declined by Federal prosecutors. These increased pressures on State and local law enforcement resources will in turn increase demands on already congested State and local courts and correctional facilities.

There is little evidence that State and local police and prosecutors have the resources to handle this additional burden. In fact, over the past few years many States and most major metropolitan areas have actually reduced the funding of enforcement programs, drug law enforcement particularly. Rare is the major police department whose drug enforcement program has been able to acquire increased resources to meet its increasing needs during the past few years. Further, many promising State and local programs originally funded through LEAA start-up funding were terminated because State and local jurisdictions have chosen not to absorb these programs in their budgets.

The paradox is that, while we are depending more and more on State and local involvement in drug law enforcement, State and local authorities are allocating fewer and fewer resources to combatting drug abuse.

Cooperative efforts, such as the establishment of a Unified Intelligence Division in New York to coordinate intelligence sharing among Federal, State and local enforcement officials, as well as two pilot projects in Chicago and Miami, help. So do the training programs run by DEA: during last year alone, DEA trained 3,331 local police officers in narcotics enforcement. The availability of Federal resources is an important factor in assisting State and local law enforcement. In FY 1975, $29 million in LEAA grants for drug law enforcement were made, bringing the 6-year total in this area to $133 million.[9]

All of these activities should be expanded. For while we have a responsibility to enforce the Federal statutes, we also have a responsibility to work more closely with local police to develop joint investigations and to focus on traffickers who are bringing drugs through interregional, interstate and international boundaries to local jurisdictions.

State and local governments have a great responsibility, as well. Under our Federal system, the responsibility for enforcing the law against most

[9] In addition, the budget for FY 1977 provides for continuation of the DEA task force program which capitalizes on joint Federal and local enforcement efforts, and continued training and laboratory support for State and local officers.

violations is specifically reserved for State and local jurisdiction. They simply cannot expect the Federal Government to continually shoulder a greater and greater share of the responsibility and funding for these vital programs. We understand resources are scarce, but the drug abuse program certainly deserves a special priority as long as the problem persists.

OUTLINING OF AN OVERALL FRAMEWORK FOR EVALUATING SPECIFIC INTERNATIONAL PROGRAMS

The 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 those foreign governments.

To achieve these objectives, we have undertaken efforts in a wide variety of areas. In addition to diplomatic efforts, we have fostered the development of international control organizations and have participated in the formulation of international treaties to assist in illicit drug control. We have provided technical and equipment assistance to foreign enforcement organizations, direct cooperative enforcement assistance through U.S. agents stationed overseas, and training of enforcement officials. We have assisted in the eradication of illicit crops, and in the development of alternative source of income for traditionally grown illicit crops. We have encouraged the extradition and expulsion to the United States of indicted traffickers, the exchange of evidence to permit prosecution of traffickers in the foreign countries in which they are operating, and more recently, have assisted in assessing the extent of a nation's drug problem and advised regarding the establishment of treatment systems.

In all of this, we have attempted to provide corrective action as close to the source as possible, since it becomes more and more difficult to deal with illicit drugs as they move further into the distribution network.

As we continue to gain experience with all of these techniques, we must also continue to assess the contribution each makes to the overall program, and at what cost, so that the priorities we set among techniques, as well as among individual country programs, are sound and consistent with overall Federal policy. Naturally, any such overall framework must leave considerable flexibility for responding to individual opportunities, and must take into consideration realistic constraints on what can be done imposed by the sometimes limited capacity of the host govenment and overall foreign policy objectives.

Two particular areas in which careful consideration and integration into an overall strategy are needed are:

- *Use of foreign assistance funds for extensive income substitution projects.* Recently, we have undertaken an ambitious income substitution pilot project in Bolivia. Similar programs are being negotiated for Peru and Pakistan. The problems which must be resolved if these programs are to be successful are many and

difficult. Illegal traffickers are able to outbid renumeration from legal production; hence, licensing procedures must not only be developed but enforced. Also, the areas in question are remote from markets and the tradition of poppy or coca growing is embedded in the cultures of the peoples in question. These programs should be monitored closely to assess the feasibility of developing alternative sources of income for those who currently product illicit drug crops.

- *Activities of narcotics control personnel abroad.* Our narcotics control personnel abroad now include 287 persons from the Drug Enforcement Administration assigned to our Embassies and Consulates, an increase from 91 in 1971. Operating under the policy guidelines of the CCINC and the direction of the ambassadors under whom they serve, DEA agents are the principal liaison contact for the U.S. Government with foreign agencies concerned with enforcement of drug laws. Their principal duties are liaison in enforcement and in the development and exchange of narcotics intelligence.

  The latest guidelines for DEA operations in foreign countries, dated July 30, 1976, reflected the Congressional concern written into the National Security Assistance and Arms Control Act of 1976 that U.S. officers not participate in direct police arrest action abroad. This Congressional action expressed a desire, congruent with the policy direction the Cabinet committee and DEA have for some time been following, to move DEA agents abroad away from operational activities and toward a liaison and intelligence collection and exchange role. These new guidelines should be closely monitored.

Finally, an international program to encourage the prosecution of foreign traffickers abroad where possible should be expanded. Such judicial cooperation requires methods for exchanging evidence consistent with our own judicial procedures. Foreign cooperation in the prosecution of traffickers relieves docket congestion in U.S. courts and manifests the spirit of cooperation in the broadest sense.

REVIEW OF SANCTIONS IMPOSED FOR POSSESSION OFFENSE

No strategy or policy should remain static. Its effectiveness and validity should be continually assessed as new information and experiences are developed. The *White Paper on Drug Abuse* filled just such a role for most of the drug program but did not completely address one component of the Federal strategy—the question of what sanction to impose for possession of small quantities of illicit drugs for personal use. This is a particularly difficult question with regard to marihuana.

There is no longer a question that marihuana is harmful and that chronic use can produce adverse psychological and physiological effects. Therefore, the Council is unanimous in its belief that Federal policy ought to strongly

discourage its use. The question, however, is how do we most effectively accomplish this with the least cost to society.

In light of the widespread recreational use of marihuana and the relatively low social cost associated with this type of use, an increasing number of people have begun to question the appropriateness of applying a criminal sanction against marihuana users. Without doubt, the threat of a criminal sanction will discourage some potential users. On the other hand, society pays a relatively high price for this form of deterrence: high in terms of stigmatizing casual users with criminal records; high in terms of diverting limited criminal justice resources from other, more serious matters; and high in terms of contributing to an atmosphere which nurtures disrespect for the law.

A number of States and foreign governments have begun to experiment with a variety of alternative approaches to discouraging marihuana use.[10] We believe the Federal Government should carefully assess the experience of these States and foreign governments with a view toward building an empirical data base that would enable policymakers at all levels to weigh the costs versus the benefits of the various alternatives. We should know, for example, how "decriminalization" of possession of marihuana has affected the number of users, the frequency of use and public attitudes in jurisdictions which have decriminalized, and how it has impacted on the criminal justice system within those jurisdictions. Additionally, the Federal Government should give particular attention to identifying the likely international implications of a shift in U.S. policy, in that a number of Latin American governments have expressed concern about this prospect, interpreting it as a signal of generally lowered concern about drug abuse.[11]

The recommendation for this kind of analysis should not be construed as a call for decriminalization of marihuana or of any other drug. It is not. But we must attempt to identify and quantify the costs and benefits of alternative approaches to discouraging drug use to ensure that we are pursuing our policies in the most effective manner.

DEVELOPMENT AND USE OF NEW KNOWLEDGE

Much of the discussion in the *Federal Strategy* concerns how we can maximize the effectiveness of our current programs by instituting greater management efficiency, setting priorities, and identifying targets of greatest opportunity in order to focus major efforts on them. However, all of these

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[10] For example, in the U.S., Alaska, California, Colorado, Maine, Minnesota, Ohio, Oregon and South Dakota, and overseas, Italy, the Netherlands and Colombia are experimenting with different versions of reduced penalities for marihuana possession.

[11] An international consideration which has sometimes been erroneously raised is the effect of decriminalization on our obligations under the Single Convention on Narcotic Drugs. Simply put, that Convention says that marihuana possession must be illegal, but leaves the sanction to the signator country's discretion. The Convention does require continued attention to trafficking.

concepts, valuable though they may be, have an overriding limitation: the current state of our knowledge. In the long-term, the degree to which we can realize major progress in addressing the problem of drug abuse is dependent on the rate at which we can increase our use and analysis of current information, as well as how successful we are in developing new knowledge and understanding of the phenomenon of drug abuse.

For example, while progress has been made in the development and utilization of drug abuse indicators over the past two years, the capacity of the Federal Government to conduct sophisticated analysis of this data and information is very modest. Both DEA and NIDA must devote greater attention and resources to more complete analyses of the information and data they are generating in increasing quantities. Grants and contracts in this area should clearly require that analysis be an integral part of the effort and the resultant data should be made widely available to avoid duplication by others. Expensive information-gathering systems will become difficult to justify if the capacity to analyze the data is not significantly enhanced.

Drug abuse research also has a basic and essential role to play in any attempt to get at the basic causes and longer range solutions to the problem. Research is required to:

1. Increase our understanding of the social and individual causes and consequences of drug abuse. For example, we still know very little about why some individuals when exposed to a particular drug either turn away from it, experiment with it or become severely dependent on it.
2. Increase our knowledge about the long-term effects of drugs such as cocaine. This knowledge is important in both our treatment and law enforcement efforts, and is essential to our ability to develop informed and rational public policy.
3. Assess the exact relationship between drug use and crime. While public officials almost uniformly believe that a strong relationship exists, research has not proven any *causal* relationship.
4. Improve treatment systems through the development of longer acting opiate maintenance and of narcotic antagonists. LAAM (L-alpha-acetyl methadol) is a methadone-like drug which has the significant advantage over methadone of spreading its action more evenly and over a longer period of time. By helping to eliminate the need for frequent clinic visits, the drug promises to permit the addict to lead a more normal life and to virtually eliminate the problem of illegal diversion and accidental poisoning created by the previous need to take medication home. Narcotic antagonists, which are not themselves addictive, show promise of providing an effective pharmacological device for breaking the cycle of addiction by preventing the reinforcing action of a narcotic from occurring while an individual is on the drug. Very promising early clinical trials have lead to the undertaking of large-scale studies on both types of drugs.

5. Continue basic research on the pharmacology of drug use. The findings during this past year of the existence of naturally occurring opiate-like substances in the brain grew directly out of Federally funded basic drug research of the past five years. This is one of the most effective areas of all biomedical research. It holds out the promise of major breakthroughs in understanding drug dependence, the development of new treatments for drug abusers, the development of new medical treatment agents for pain and a wide variety of mental disorders.

The outcome and especially the long-term implications of any given research are often difficult to anticipate. What might begin as a curious observation may turn out to be the key to much-improved treatment and prevention. A close look must be given to increasing the modest amounts of support which are presently being given to research with a clear understanding that the key to long-term diminution of drug abuse lies with a better understanding of the basic nature and extent of drug abuse. It is important that the Federal effort be broad enough to encompass both basic and applied research and flexible enough to respond to newly emergent problems and opportunities.

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