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Drug Event, Philadelphia 9/12/91 [OA 8327]

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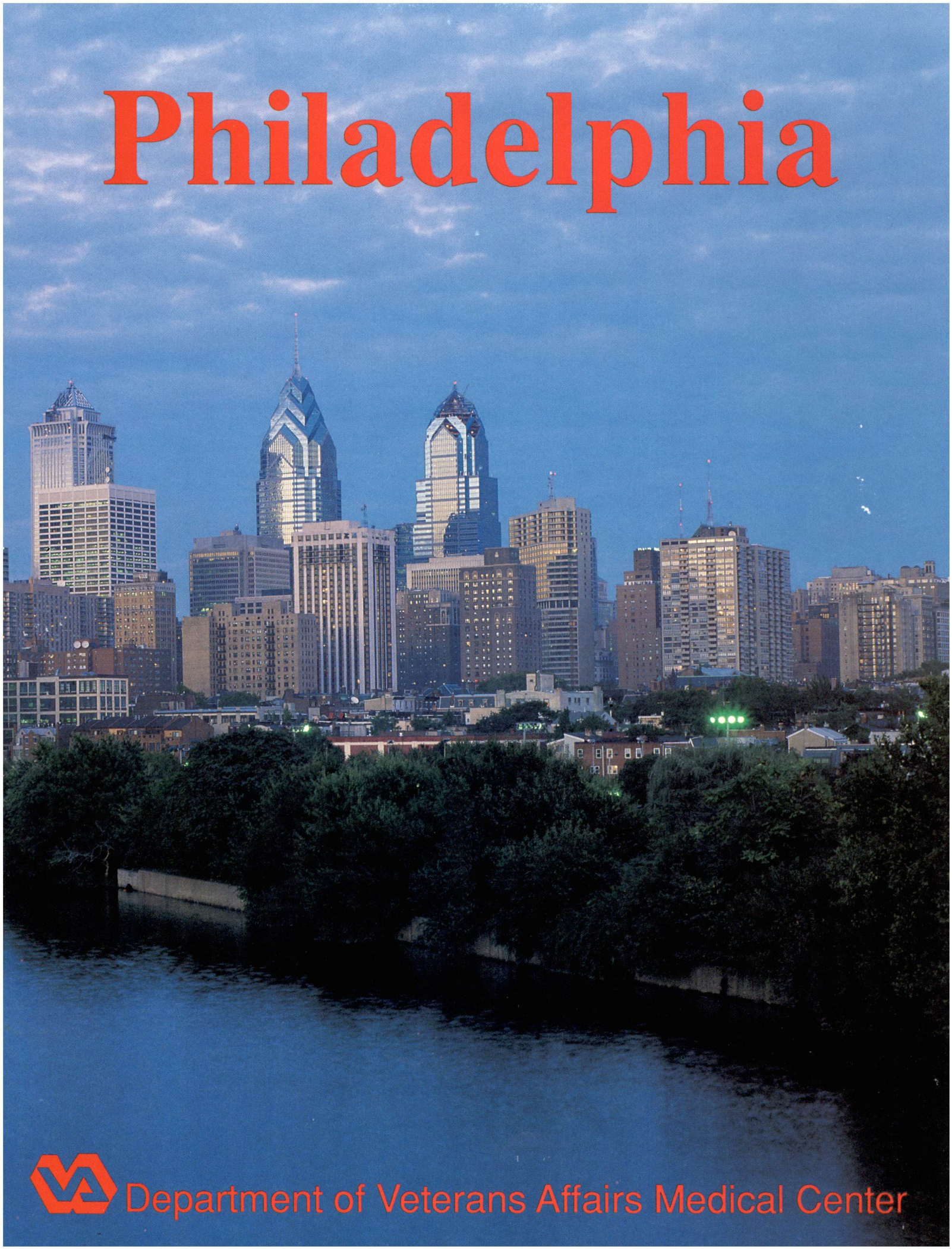

Philadelphia
Department of Veterans Affairs Medical Center

PHILADELPHIA: CITY OF BROTHERLY LOVE

Philadelphia, the City of Brotherly Love, is the fifth largest city in the United States. It has a population of a little more than 1.65 million. The metropolitan population is about 4.7 million. Pennsylvania has the fourth largest population (nearly 12 million) of all the states, exceeded only by California, New York, and Texas.

NEW YEAR'S DAY MUMMERS PARADE

HISTORICAL: Philadelphia was founded in 1682 by William Penn, an English Quaker. King Charles II granted Penn a parcel of land in the New World as payment for a debt the Crown owed Penn's father. The city grew rapidly, becoming the second largest English-speaking city in the world (London was the first) just before the American Revolution. Philadelphia was the Revolutionary War capitol, except for nine months of British occupation. The first Continental Congress met at Carpenter's Hall in 1774. The second Continental Congress met at the Pennsylvania State House, later renamed Independence Hall, and declared independence in 1776. In 1787, the Constitutional Convention met at Independence Hall and wrote the Constitution. Philadelphia served as the fledgling nation's capitol until 1800.

CLIMATE: The proximity of Delaware Bay has some effect on temperature conditions locally. Periods of extended cold weather are relatively rare and periods of abnormally high temperatures seldom last more than three or four days, although there are wide fluctuations in seasonal temperature. The average high temperature in July/August is 84 degrees, and the average low in January/February is 26 degrees.

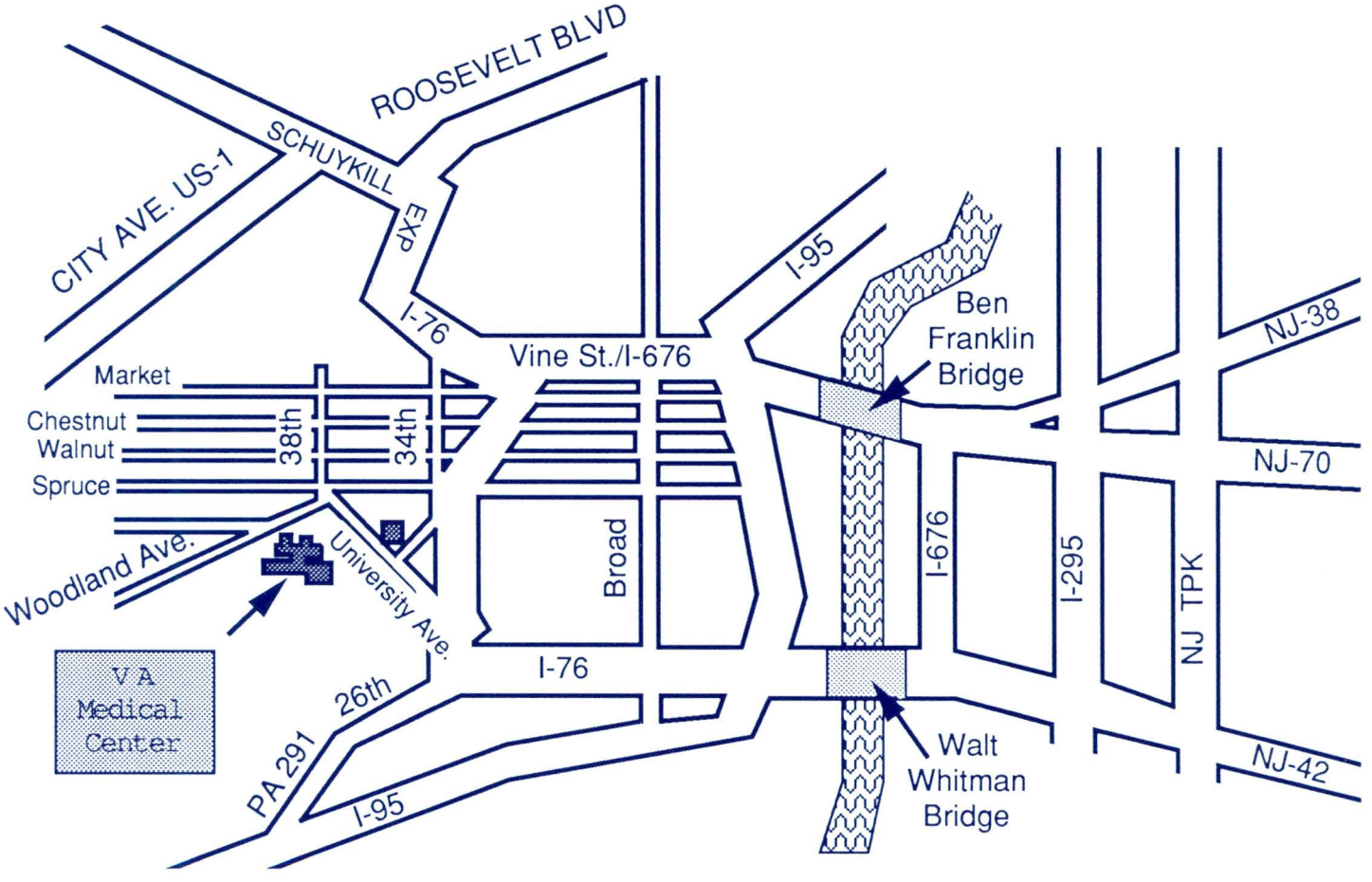
TRANSPORTATION: Philadelphia has fine transportation facilities which include service by more than 25 airlines; interurban, suburban, and interstate bus lines; limousine service to International Airport (Philadelphia) and John F. Kennedy Airport (New York); plus rail service (Amtrak), and a network of subways and commuter rail lines. Also, Philadelphia is served by the Pennsylvania Turnpike, I-95, and the New Jersey Turnpike. These highways and their connections enable motorists to reach the city conveniently and quickly.

HOUSING: Homes and apartments of all types and all price ranges are readily available within the commuting area, which encompasses the suburbs of Philadelphia and the neighboring communities of southern New Jersey. Tree-lined residential areas are located in the vicinity of the Medical Center within easy driving or walking distance.

EDUCATIONAL FACILITIES: All types of educational facilities are available (public, parochial, and private), with excellent opportunity for night study in nearly all fields. The city and suburban areas have more than 40 colleges and universities. Some of the most prominent are the University of Pennsylvania, Medical College of Pennsylvania, Temple University, Villanova University, LaSalle University, Drexel University, and St. Joseph's University.

HISTORICAL SITES AND CULTURAL CENTERS: There are many places in and around Independence National Historical Park. These include: Independence Hall, Liberty Bell Pavilion, Carpenter's Hall, Betsy Ross House, Congress Hall, Elfreth's Alley, Old City Hall, City Tavern, Philosophical Hall,

ART MUSEUM & WATER WORKS


ROOSEVELT BLVD
SCHUYKILL EXP
CITY AVE. US-1
I-76
Vine St./I-676
I-95
Ben Franklin Bridge
NJ-38
NJ-70
Market
Chestnut
Walnut
Spruce
38th
34th
Broad
I-676
I-295
NJ TPK
Woodland Ave.
University Ave.
VA Medical Center
26th
PA 291
I-76
I-95
Walt Whitman Bridge
NJ-42

THE MEDICAL CENTER

The Philadelphia Department of Veterans Affairs Medical Center consists of a medical facility and a 240-bed Nursing Home Care Unit. Approximately 2,000 full and part-time employees constitute a complete team of professional, technical, administrative, and support personnel for the Medical Center. The staff is supplemented by consultant and attending physicians and a large corps of volunteer workers from veterans, fraternal, and service organizations.

The 412-bed general medical and surgical facility is located in the "University City" section of West Philadelphia and is only a short distance from the main Philadelphia business district. Situated on 20 acres of land adjacent to the University of Pennsylvania campus, the Medical Center was the first authorized Rheumatology Center facility in the VA system. The Medical Center complex consists of a main nine-story building, a modern five-story general medical research building, a state-of-the-art clinical diagnostic addition, and a new two-story nursing home. The clinical addition was completed in 1991 and the Nursing Home became operational in June 1990. Although predominantly a general medical and surgical facility, concentrated psychiatric and neurological patient care is also provided.

The Medical Center's educational institution affiliations include two of the country's finest medical schools, the University of Pennsylvania School of Medicine and the Medical College of Pennsylvania. These schools play an active part in the functioning of the medical program and cooperate in directing and training approximately 125 residents in 20 specialty areas.

The Center is staffed and equipped to perform many highly specialized treatment procedures including cobalt therapy, cardiac surgery, hemodialysis, and advanced types of eye and ear surgery. Future plans include Magnetic Resonance Imaging (MRI) technology. In addition to modern and progressive medical, surgical, x-ray, and therapeutic equipment, there is a medical library, animal research facility, numerous active medical research programs, Nuclear Medicine Service, Medical Media Production Service, Rehabilitative Medicine Service, and Alcohol and Drug Dependence Treatment units.

THE MEDICAL CENTER EMPLOYEES WELCOME YOU

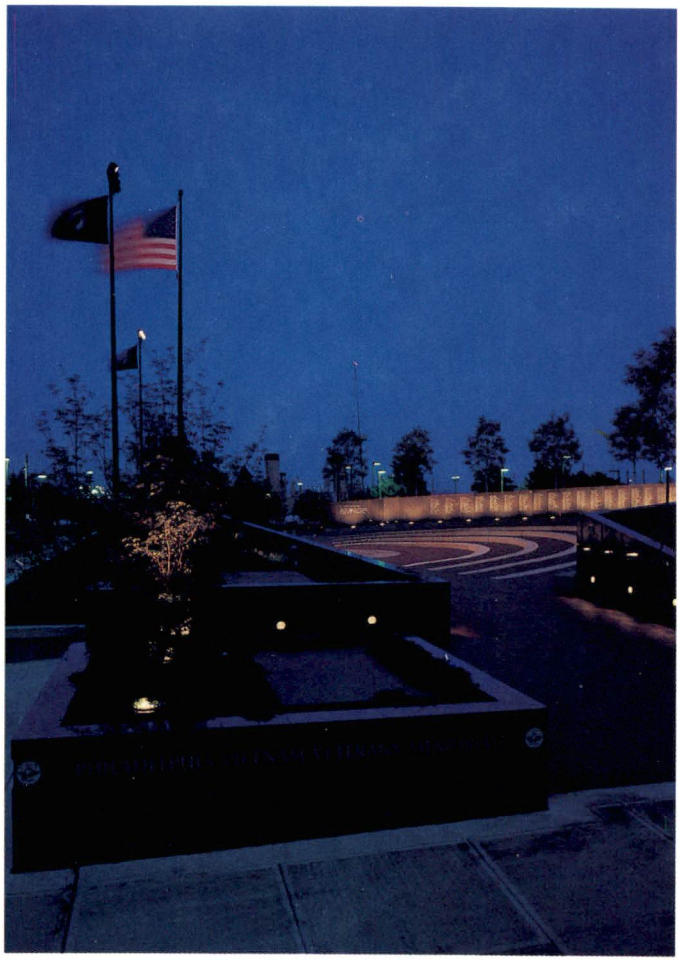
The 240-bed Nursing Home Care Unit is a short-term, skilled nursing facility located directly across University Avenue from the Medical Center. It is a two-story building containing four 60-bed units, each consisting of six private rooms and 27 double rooms.

The NHCU staff consists of VA staff physicians and nurse practitioners, assisted by registered and licensed practical nurses, and nursing assistants. There are also rehabilitation physicians and physical, occupational, and recreational therapists, along with dietitians, social workers, pharmacists, chaplains, and a variety of support personnel.

EMPLOYEE FACILITIES: Services provided for all employees include a credit union, a canteen furnishing both food and retail items, and a 530-space parking garage which is available on an individual and car pool basis. There is also an active Employee Association which sponsors many activities including ski trips, picnics, and a bowling league. Special parking areas are reserved for the handicapped and architectural barriers have been removed.

Franklin Court, Liberty Hall, Christ Church, Head House Square, Army-Navy Museum, Marine Corps Memorial Museum, Philadelphia Maritime Museum, Edgar Allan Poe House, the First Bank of the United States, and the Second Bank of the United States. A short distance away in the center of Philadelphia are the Philadelphia Museum of Art, Franklin Institute, Academy of Natural Sciences, Rodin Museum, and many other attractions. There are also many places of historical and cultural interest in the west, northwest (Germantown) areas of the city. Certified Historic buildings, dating from the 18th and 19th Centuries, number more than 70.

RECREATION: The 76ers, the Phillies, the Eagles, and the Flyers provide lively professional sports entertainment, and the area universities provide top-notch college athletics (especially in basketball where the teams of the Philadelphia "Big 5" play each other at the University of Pennsylvania "Palestra", an arena that is considered by many to be the best place in the country to watch a basketball game). Fairmount Park, the largest inner-city park in the world, contains bike paths, tennis courts, ball parks, picnic areas, and the scenic Schuylkill River. On the banks of the Schuylkill, one can find the famous "Boat House Row", a captivating area which is featured in numerous tourist publications. America"s first zoo exhibits more than 1,600 mammals, birds, and reptiles. The Philadelphia Orchestra is considered one of the leading symphony orchestras in the world. Also, the New Jersey seashore resorts (including Atlantic City), the Pocono mountain ski resorts, Baltimore, and New York City are all within a two-hour drive from Philadelphia. Washington, D.C., is only three hours away.



VIETNAM VETERANS MEMORIAL

GENERAL INFORMATION: Almost all religious denominations are represented by churches, including such famous ones as Christ Church, Old Saint Joseph's Church, and Old Swedes Church. The finest medical facilities are available with the city being serviced by more than 75 hospitals. All fraternal and service organi-zations have one or more branches in the city. Philadelphia has 42 radio stations (22 FM and 20 AM), and eight television stations, and three cable television systems. There are two major daily newspapers and more than 100 smaller daily and weekly independent newspapers.

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September 3, 1991

TO: **DAQOGWBH**

FROM: **QOGWBH**

SUBJECT: **DOING DRUGS ...**

Ola! Welcome back. (Check E-mail to find out how much I missed you.)

Some specific questions on the drug event:

1. Can you get copies of media coverage, commentary, etc. following the President's 1/31/91 briefing on Drug Control Strategy (specifically reaction to increase in Federal drug treatment spending).

J.H. OMB 2. What is status of this drug budget (proposed $11.7 billion, 11% increase over last year)?

ONDCP 3. Has Congress supported/impeded the President's proposal?

Joe McHugh 467-9850 will fax

ONDCP 4. Specifically, what does the President's proposal cover for drug treatment spending?

5. Quotes from experts on Administration's drug treatment proposals, and track record.

Budget → Drugs
Janet Hale x8120

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10TH STORY of Level 1 printed in FULL format.

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February 2, 1991

SECTION: LEGAL AFFAIRS; Vol. 23, No. 5; Pg. 267

LENGTH: 3862 words

HEADLINE: Rethinking Drugs

BYLINE: BY W. JOHN MOORE

HIGHLIGHT:
New reports on cocaine use prompt White House officials to assert that tough enforcement is paying off; congressional skeptics have their doubts. Other experts are urging a brand new strategy aimed at cocaine addicts.

BODY:
In his 1989 inaugural address, George Bush vowed to end the nattional "scourge" of illegal drugs. Not 24 months later, in mid-December, an upbeat President declared that his Administration was fulfilling that promise. "Our hard work is paying off," he told White house reporters. "Virtually every piece of information we have tells us that drug use trends are heading in the right direction -- down."

What encouraged the President and the government's drug warriors was the latest batch of statistics on illicit drug use. Many of the figures were compiled by the National Institute on Drug Abuse (NIDA), a unit of the Health and Human Services Department. Casual use of all drugs declined last year among every age group, according to the NIDA study. Cocaine use slumped even more. The number of weekly cocaine users dropped. Emergency room visits attributed to cocaine use were also down. (For a detailed look at recent drug statistics, see box, p. 269.)

Earlier figures totaled up by the Justice Department showed that the percentage of prisoners who tested positive for cocaine was no longer increasing. Even cocaine-caused deaths were said to have reached a plateau in many cities. And another NIDA-sponsored study, the National High School Senior Survey, whose results were released on Jan. 24, showed drug use among high school seniors dropped to the lowest level in 15 years.

The Bush Administration has avoided talk of victory in the $ 10.6 billion war on drugs. "We will not rest until the day of the dealer is over, forever," Bush said in his Jan. 29 State of the Union address.

But in press briefings, Bush Administration officials have spread the news of the findings as proof that their antidrug strategy is paying off. "These numbers are undeniably encouraging," John T. Walters, acting director of the two-year-old Office of National Drug Control Policy, said on Dec. 19.

On Capitol Hill, some Democrats attacked the Administration assessments as overly rosy. Other Democrats focused on the bad news in the NIDA study -- which was based on a survey of 9,259 households -- including the stable use of "crack cocaine" and the increasing number of daily cocaine users. A Senate Judiciary

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Committee report, released on Dec. 19, found almost four times more weekly cocaine users. More drug addicts were missed than counted in the NIDA survey, the committee said. "These figures show that America's hard-core drug problem is getting worse, not better," committee chairman Joseph R. Biden Jr., D-Del., said. He complained that the "new [NIDA] drug totals are the perfect fuel for our folly -- a soothing reassurance that the difficult drug dilemma is on the way to resolution."

In the meantime, private drug policy experts have argued that the implications of the drug data are being ignored by politicians. Both Biden and NIDA are right. Rather than providing fuel for further partisan bickering, these experts say, the new numbers should produce a dramatic shift in drug policy.

"An epidemic has run its course," said Peter Reuter, co-director of the RAND Corp.'s drug policy research center in Washington. "It doesn't mean that the problem is over. But it is a different problem now. What you do have to worry about is how you manage the problems of people who have become dependent on drugs."

He and other authorities say what's needed is a well-financed initiative that targets hard-core drug users and the long list of problems that often accompany addiction, ranging from crime to the surge in babies born damaged by cocaine.

"I'm glad yuppies curtailed their drug use. But if we don't deal with the other problem of hard-ore drug users, we're just kidding ourselves," said Bruce Mendelson, director of data analysis and evaluation for Colorado's Alcohol and Drug Abuse Division.

"It's a mistake to determine national drug strategy on the basis of what is happening to the middle-class drug user," Eric D. Wish, director of the Center for Substance Abuse Research at the University of Maryland (College Park), said in an interview. "We have a continuing problem with the most dysfunctional drug abusers in the country. And we need to focus on them even in the face of a decline in drug use among the general population."

In fact, some drug statistics suggest that the number of cocaine users is down but the volume of cocaine consumption is up. "What the data tell us is the level of the epidemic but not the intensity of the epidemic," cautioned James N. Hall, executive director of Up Front, a Miami-based national drug information center. "The drug problem is creating more-serious consequences despite the fact that we have fewer users."

THANKS, NANCY

The Reagan and Bush Administrations' approaches to drugs emphasized enforcement -- detecting users, particularly through testing, and punishing dealers with long prison sentences. Skeptics in the drug policy community maintain that the Bush antidrug initiatives were mostly irrelevant, noting that consumption figures were already declining before such punitive measures as mandatory prison sentences for drug sellers and increased interdiction efforts were adopted. Prevention and education -- including Nancy Reagan's much maligned "Just Say No" campaign -- probably influenced more people not to use drugs.

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Even successful prevention and education programs may prove less successful with hard-core users, drug experts cautioned. Almost everyone agrees that more and better treatment programs are needed. But even increased government spending on treatment, although helpful, is unlikely to help much until careful evaluations make clear which kinds of programs work. Moreover, finding communities that will accept treatment centers has become a growing problem.

Charles B. Rangel, D-N.Y., chairman of the House Select Committee on narcotics Abuse and Control, says federal drug strategy should focus on the causes of drug use, such as a lack of good schools and jobs. "They have not overemphasized the middle-class constituency; they have ignored the root causes of drugs in the poorer communities," he said.

What help will be given to hardcore drug users, particularly those in the inner city, remains uncertain. "The danger exists that as drug use declines in the middle class, this residual group of drug users will become a national scapegoat, subject to extremely harsh societal reactions or, alternatively, become a neglected group that society has written off," Wish wrote in a recent paper on national drug policy in the 1990s.

For example, 300,000 drug-addicted babies were born in 1990, most of them in poor urban neighborhoods. "It looks like the old story -- problems tend to become invisible when white America perceives them as primarily affecting African-Americans," John E. Jacob, head of the New York City-based National Urban League, wrote recently in a year-end assessment of conditions in black America.

There already are some signs that the war on drugs has produced more casualties among blacks. A December USA Today survey found that nationally, 41 per cent of those arrested on drug charges in 1989 were black. But blacks are only 15 per cent of the drug using population, experts say. According to the Correctional Association of New York, there are more blacks age 18-24 in New York's prisons (24,000) than in a all the state's colleges and universities (23,000).

GOOD NEWS

All indicators reveal that the drug crisis had ebbed if not ended among middle-class Americans of all ages. The new NIDA study showed the number of monthly drug users down by 44 per cent in the past five years. The figure was even more dramatic for cocaine. From 1985-90, the number of Americans regularly using cocaine dropped by 72 per cent. Cocaine-related visits to hospital emergency rooms declined by 32 per cent from the third quarter of 1989 to the first quarter of 1990, according to NIDA report released last August. Less than half of all high school seniors have ever used illegal drugs, the Jan. 24 high school survey found.

"The survey data are quiet clear in showing a substantial downturn in the number of people actively using drugs," said Lloyd D. Johnston, program director at the University of Michigan's Institute for Social Research in Ann Arbor, which prepared the NIDA study. "Fewer people are using drugs and more people are quitting."

Moreover, the decline in U.S. drug use is remarkable given the worldwide rise in cocaine consumption described in a Jan. 9 report by the U.N. International

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Narcotics Control Board. Although the data are not perfect, Reuter said, the combination of NIDA studies, the high school senior survey, emergency room admissions figures and the results of prisoner drug tests all offer evidence of dramatic change. "There seems to be strong evidence that the problem is receding in terms of the number of people who are users of drugs and, secondly, heavy users of dangerous drugs," he said.

State and local findings seem to confirm this trend. In Dade County, Fla., for example, where Miami is located, reports of cocaine emergency room treatments dropped by 50 per cent from 1987-90. Cocaine-caused deaths declined from 53 in 1986 to 15 during the first 10 months of 1990, according to Dade County medical examiner.

From the President on down, Administration officials have voiced cautious optimism that the drug scourge is being contained, as the national and local figures suggest.

But some critics say the proclamations of victory are premature. Other analysts, who scoff at the notion that the Administration's policies can be credited for the decline in drug use among middle-class Americans, argue that the downward trends began in the mid-1980s, before Bush became President. "They were wise in selecting their goals because they could not miss," said Karst J. Besteman, director of the Substance Abuse Center at the nonprofit Institutes for Behavior Resources in Washington. "The trends were all moving in a faster direction than were their goals."

Herbert D. Kleber, deputy director for demand reduction in the Office of National Drug Control Policy, conceded that drug epidemics always end as more and more users realize the consequences of their deadly habits. "What isn't inevitable is the speed at which that happens," he added. "The citizen response and the governmental response are absolutely critical."

The Administration deserves credit for publicizing the dangers of drugs and increasing the resources available for attacking the problem, Kleber said. "It would be a dangerous assumption to say that if we just folded our bags and went away, the drug problem would, too."

HELPING THE HARD CORE

Much of the dispute over the status of the war on drugs involves numbers, particularly the number of addicts. NIDA's recent household survey pegged the number of weekly cocaine users at 662,000, down form the 1988 estimate of 862,000. (A person who uses cocaine at least once a week is said to addicted). Although many drug policy experts say they believe that heavy cocaine use is declining, even some Administration officcials have distanced themselves from NIDA's weekly users total. In an interview, for example, Kleber noted the problems with the household survey numbers. "We have tended to agree with the [National Academy of Sciences] Institute of Medicine study," he said; that group puts the number of cocaine addicts at 1.5 million-2.5 million.

The Senate Judiciary Committee's study said that from May 1989 to December 1990, the number of hardcore users had increased from 2.2 million-2.4 million. "The Administration's undercount misleads the American public and lulls the country into a false sense of security about how far we have come" in stamping out drug abuse, Biden said at a Dec. 19 news conference.

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The NIDA figures may be inaccurate for a host of reasons, skeptical experts say. For one thing, the institute's household survey asked people to voluntarily fill in detailed questionnaires; approximately 18 per cent of those contacted refused to participate. "Are people going to admit to drug use when there is a law enforcement crackdown going on?" asked William Butynski, executive director of the Washington-based National Association of State Alcohol and Drug Abuse Directors.

A bigger problem is that both the household and high school senior surveys don't include several fast-growing segments of the drug using population. For example, the high school senior survey doesn't include dropouts. The NIDA household survey, which claims to account for 98 per cent of the U.S. population, excludes college students living in dormitories, the homeless and prison inmates.

The result, some authorities say, is a tilt that reflects middle-class reductions in drug use while ignoring growing drug use among those left uncounted in surveys. "As the social status of users falls," the errors in the NIDA survey increase, because "the 2 per cent of the population not in the household survey contains a larger fraction" of drug consumers, said Mark A. R. Kleiman, a drug researcher at Harvard University's John F. Kennedy School of Government.

Research conducted by the Justice Department's National Institute of Justice (NIJ) on drug use among prisoners in 23 major cities found that this population of users is far larger and consumes more cocaine, crack and heroin than previously believed. "What the studies did was to provide the first estimates of the undercounting that was occurring," said the University of Maryland's Wish, who devised the NIJ study. According to Wish, the estimated number of weekly cocaine users among those arrested each year in the nation's largest cities ranges from 978,000-1.3 million people, far higher than NIDA's estimate for all frequent cocaine users.

"If our estimates are correct, the majority of the frequent cocaine users in the United States are persons with limited education, few job skills, unstable families, few social skills and a pattern of breaking the law and using drugs," Wish has written. "Their drug use is but one part of a constellation of deviant behaviors and disadvantaged backgrounds."

SWITCHING STRATEGIES

For many drug policy analysts, numbers that show a decline in casual use but a surge in consumption means that there should be a replotting of the nation's drug strategy.

"From here on out, if the government believes the data that they present to the public, they have got to make some adjustment," said the Substance Abuse Center's Besteman.

The RAND Corp.'s Reuter compares what he fears may be the drug problem of the future with the heroin epidemic in the mid-1970s, when a tiny fraction of the population consumed vast quantities of drugs. "An aging cohort of urban males with expensive drug dependencies will be the source of an enormous volume of crime and disease," he predicted.

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Some experts believe the Administration's emphasis on reducing the supply of drugs has become less important. Rangel and John Conyers Jr., D-Mich., chairman of the House Government operations Committee, say they favor equally dividing the available antidrug money between the demand side of the equation, which includes education, prevention and treatment, and the supply side, which is primarily interdiction and enforcement. Roughly 70 per cent of the federal funds are now targeted at cutting off drug supplies.

Although tougher street-level enforcement has its advocates, others say that approach produces more problems than successes. Some older addicts might be scared by tougher enforcement efforts and decide to seek treatment, but others are likely to commit more crimes, especially property crimes, to pay for an increasingly expensive habit as drugs become scarcer, according to this line of thinking. Still others are likely to turn to a combination of drugs and alcohol, which often produces even more violence, said Arnold S. Trebach, president of the Drug Policy Foundation, a Washington-based group that advocates drug legalization. "Nothing in the criminal justice system shows that tougher law enforcement would reduce over-all cocaine use."

The criminal justice system could be a gateway to treatment, according to Wish. Prisoners in urban jails who are cocaine users could be ushered into treatment facilities at a fraction of the cost of imprisonment, he said.

Some cities and states are taking such steps. In Nevada, for instance, with the help of federal grant money, north Las Vegas police have hired treatment expert for each of the city's police stations, according to Liz Breshears, chief of the Bureau of Alcohol and Drug Abuse in the Nevada Human Resources Department.

Federal administrators maintain that treatment hasn't been neglected. Since the start of the Bush Administration, the government's priorities have been "the pregnant addict, the crack user, the high-risk user," Kleber said. "Don't confuse the philosophic rhetoric with where the funds went. The emphasis may have been on user accountability, drug-free workplaces and all of those things that try to impact on the so-called casual user, but the large-scale treatment money wasn't designated for that group." From 1987-90, public treatment slots climbed from approximately 800,000 to 1.5 million, according to the Office of National Drug Control Policy.

Demand for places in treatment centers is soaring. The good news is that more users of illicit drugs are seeking treatment. The bad news is that the growing demand reflects the dimensions of the problem. "If you look at the demand at the front door of treatment centers, you would not know that drug abuse has gone down," said Mark R. Bencivengo, coordinator for municipal drug abuse programs in Philadelphia. His office gets 275 requests a week for treatment, and yet the city has only enough money for 370 beds in residential treatment facilities and a certain number of slots in outpatient clinics, he said.

Paying for treatment is just one problem facing state and local governments. Enlarging treatment centers may not be the best way to measure progress, especially if the quality of treatment goes down. A recent study by the Institute of Medicine found that from 1980-88, the amount of money spent per person in public treatment programs dropped. "Basically, what we did in the 1980s was greatly increase the number of people treated but lower the quality

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of the treatment," Reuter said. "Most treatment experts would say it is less people through treatment than to prove them with services that are worth a damn."

Drug policy official Kleber agrees that there's a need for accountability in drug treatment programs. But he blames Capitol Hill for at least part of the problem, noting that Congress has repeatedly failed to approve legislation that would link federal money to requirements that states be held accountable for the quality of drug treatment plans.

In any event, a growing problem for treatment centers is neighborhood opposition. The Office of National Drug Control Policy is reviewing the extent to which Washington can or should get involved in local siting decisions. In the meantime, the Justice Department has brought suits in federal court, using antidiscrimination provisions in the fairhousing statutes. Missouri Gov. John D. Ashcroft has pushed legislation requiring that treatment facilities be permitted in any areas zoned commercial or industrial unless community leaders can find an alternative site.

Just finding a suitable building in a big city is difficult enough, Bencivengo said. Competition for buildings even from community and government organizations can be fierce, he added. And neighborhood groups seek to block the move in may instances, usually by invoking zoning restrictions. "Trying to put recovering substance abusers with AIDS in a neighborhood," Bencivengo said. "It's a political hot potato," with powerful political constituencies fighting often "disenfranchised" ex-drug users.

ROOT CAUSES

Treatment also may prove less successful with hard-core users, particularly those who are unemployed and uneducated. Many of these addicts may live in areas where crime is rampant and economic prospects bleak. The chances that a 30-day treatment plan will take if the user returns to his old environment are much lower than the prospects for a middle-class drug abuser, Colorado's Mendelson said.

"If you bring in a patient with double pneumonia, treat him and then kick him out of the hospital without any clothes on, what the hell is the good of the treatment?" Rangel asked. Rangel has introduced legislation that would establish the first federal commission in decades to investigate the underlying causes of drug abuse.

Rangel complained that inaccurate portrayals of the nation's drug problem as mostly a problem of the black underclass are unlikely to galvanize much political support. "This Administration and the Reagan Administration are afraid of entitlements. And they are afraid of the government getting involved in a new program that deals with the ills of the urban communities."

Asked whether an antidrug program that was aimed solely at hard-core users could lose popular support, Kleber acknowledged the possibility that "if the country feels that the problem is concentrated among the poor and the disadvantaged . . . we will [not] be able to get the national consensus toward spending the resources that we need." Though the percentage of cocaine abusers in the underclass is high, he said, "the sheer numbers are much higher among the middle class."

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Other analysts predicted that broad support for antidrug efforts will continue if for no other reason than the connection in the public's mind between drug use and crime.

Additional enforcement poses other problems. With minorities constituting a high percentage of those imprisoned, said Ethan Nadelmann, a Princeton University drug policy expert, harsh drug law have disenfranchised a quarter of all black males age 18-25.

And in Miami, no longer a cocaine capital, new programs are starting to help hard-core users of all economic classes. According to Up Front's Hall, the city's cocaine epidemic peaked in the summer of 1986. Since then, Miami and surrounding Dade County have devised a comprehensive community-based anti-drug strategy that Hall called reasonably successful. "If the patient had a temperature of 108 degrees, it is down to 103," he said.

Miami uses its criminal justice system to direct drug users into recently expanded treatment centers. At the same time, Miami and Dade County governments, working with private industry, established an addiction services board to coordinate antidrug efforts. Enforcement efforts have not been ignored; a heavy emphasis was put on halting street sales.

The results have been downward trends in virtually all drug statistics. But Hall, noting the increase in infant deaths caused by maternal cocaine abuse, cautioned against optimism. "We're just shaving the iceberg."

GRAPHIC: Picture 1, Herbert D. Kleber of drug policy office, There's greater awareness of drugs' effects.; Picture 2, Sen. Joseph R. Biden Jr., D-Del., The "hard-core drug problem is getting worse."; Picture 3, Peter Reuter of the RAND Corp., Epidemic is over, but not the problems.; Pictures 1 through 3, Richard A. Bloom

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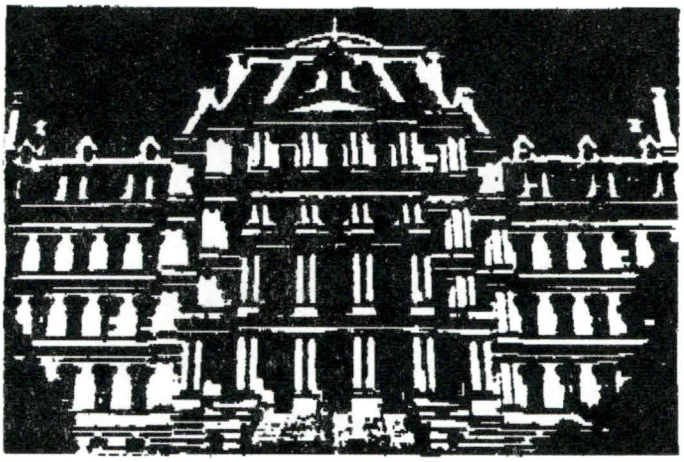

FACSIMILE TRANSMITTAL SHEET

Number of Pages including cover 4

Date: 9/4/91

To: Carol Blymire

Fax Number: 456-6218

Office Number: 7750

Comments: Attached drug tables per your request.

Economics and Government

From: Janet Hale

Fax Number: (202) 395-4639

Office Number: (202) 395-3120

FEDERAL DRUG CONTROL PROGRAM BY AGENCY

(BA & Outlays in Millions)

22-Aug-91
01:23 PM

OMB Drug Team

Federal Drug Control Program Accounts		1990 Actual	1991 Approp.	1992 REVISED President's Budget	1992 House Floor	1992 Senate
ACTION	BA	10.5	10.9	11.1	10.0	10.9
	OL	10.5	10.9	11.1	10.0	
AGRICULTURE	BA	6.7	16.2	15.0	15.4	15.8
	OL	6.2	15.2	14.0	14.3	
DEFENSE	BA	799.1	1,105.3	1,158.6	1,156.0	NA
	OL	559.3	738.5	981.5	980.5	
EDUCATION	BA	602.8	679.1	713.4	693.5	722.1
	OL	506.4	661.8	699.0	677.3	
EXEC. OFFICE OF THE PRESIDENT						
Office of National Drug Control Policy – S&E & Gifts	BA	12.1	17.6	20.2	20.1	19.1
	OL	12.0	14.4	19.2	19.1	
High Intensity Drug Trafficking Areas (HIDTA)	BA	25.0	82.0	50.0	50.0	85.0
	OL	11.3	75.2	58.0	58.0	
Special Forfeiture Fund	BA	(115.0)	(46.0) /1	(77.0) /3	(77.0) /3	(67.0)
	OL	(73.6)	(78.1)	(65.2)	(65.2)	
TOTAL, EXOP	BA	37.1	105.6 /2	70.2	70.1	114.1
	OL	23.3	89.6	77.2	77.1	
HEALTH & HUMAN SERVICES						
ADAMHA	BA	1,168.3	1,370.5	1,477.8	1,357.7	1,386.4
	OL	787.3	1,203.7	1,351.7	1,320.0	
Health Care Financing Administration	BA	170.0	190.0	201.5	201.5	201.5
	OL	170.0	190.0	201.5	201.5	
Other HHS	BA	104.7	136.6	156.7	148.3	156.7
	OL	60.4	132.0	137.2	130.3	
TOTAL,HHS	BA	1,443.0	1,697.1	1,836.0	1,707.5	1,744.6
	OL	1,017.7	1,525.7	1,690.4	1,651.8	
HUD	BA	106.5	150.0	165.0	165.0	165.0
	OL	3.8	49.2	129.4	129.4	
INTERIOR	BA	29.4	38.2	47.8	47.9	47.4
	OL	25.9	35.9	43.5	43.3	

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22-Aug-91
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(BA & Outlays in Millions)

OMB Drug Team

Federal Drug Control Program Accounts		1990 Actual	1991 Approp.	1992 REVISED President's Budget	1992 House Floor	1992 Senate [illegible]	F
JUSTICE							
Bureau of Prisons	BA	967.7	243.3	315.7	286.4	xx	
Buildings & Facilities	OL	96.8	554.3	583.8	601.9		
Other, Prisons	BA	599.2	790.9	1,068.2	1,005.0	xx	
	OL	553.4	753.5	1,049.5	992.7		
Total Prisons	BA	1,566.9	1,034.2	1,383.9	1,291.4	1,301.9	—
	OL	650.2	1,307.8	1,633.3	1,594.6		
DEA	BA	558.4	694.3	748.0	706.3	740.7	
	OL	540.0	637.3	690.0	659.0		
FBI	BA	138.7	175.0	226.4	214.7	222.0	
	OL	138.1	168.9	192.0	181.0		
Forfeiture Fund	BA	333.3	372.0	382.5	382.5	382.5	
	OL	283.0	320.2	328.7	328.7		
INS	BA	120.2	138.3	161.4	151.6	165.2	
	OL	96.2	135.7	157.6	147.1		
Office of Justice Programs							
State & Local Drug Grants	BA	444.7	492.0	492.0	492.0	xx	
	OL	180.3	321.5	331.5	331.5		
Other OJP	BA	41.5	42.6	33.7	42.3	xx	
	OL	61.3	41.9	38.6	44.1		
Total Office of Justice Programs	BA	486.2	534.6	525.7	534.3	540.9	—
	OL	241.6	353.4	370.0	375.6		
Organized Crime Drug Enforcement Task Forces	BA	214.9	334.9	402.0	363.4	380.3	
	OL	165.5	320.9	363.3	334.6		
Support of Prisoners	BA	112.0	135.1	159.7	152.7	156.9	
	OL	67.2	125.9	153.0	147.0		
U.S. Attorneys	BA	126.8	181.5	200.8	185.7	185.6	
	OL	112.5	175.3	196.8	183.6		
U.S. Marshals	BA	158.0	201.9	233.4	210.2	209.9	
	OL	142.2	197.5	225.8	208.2		
Other Justice (Criminal & Tax	BA	12.6	19.0	21.3	19.7	19.6	

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22-Aug-91
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(BA & Outlays in Millions)

OMB Drug Team

Federal Drug Control Program Accounts		1990 Actual	1991 Approp.	1992 REVISED President's Budget	1992 House Floor	1992 Senate Floor	
Divisions & INTERPOL)	OL	11.1	18.2	21.3	19.8		
TOTAL, JUSTICE	BA	3,828.0	3,820.9	4,445.0	4,212.5	4,295	
	OL	2,447.5	3,761.1	4,331.9	4,179.2		
LABOR	BA	46.0	74.5	79.2	85.0	80.2	
	OL	46.9	47.4	79.0	84.9		
STATE							
International [Function 150]	BA	307.3	462.5	611.7	570.0	NA	
	OL	157.3	269.9	404.5	371.2		
TRANSPORTATION							
Coast Guard	BA	665.2	718.6	704.1	661.9	NA	
	OL	630.3	716.1	698.0	655.7		
Other Transportation (FAA/NHTSA)	BA	23.7	36.4	43.8	42.1	NA	
	OL	21.3	33.7	39.5	37.8		
TOTAL TRANSPORTATION	BA	688.9	755.0	747.9	704.0		
	OL	651.6	749.8	737.5	693.5		
TREASURY							
Customs Service	BA	664.9	605.6	663.7	647.3	719.4	
	OL	548.8	620.6	671.4	657.6		
Other Treasury (BATF, FLETC, USSS, FINCEN, & IRS)	BA	241.9	295.2	287.7	297.5	303.9	
	OL	237.8	289.8	285.8	296.9		
TOTAL TREASURY	BA	906.8	900.6	951.5	944.8	1,023.3	
	OL	786.6	910.4	957.2	954.5		
U.S. COURTS	BA	258.1	337.0	424.4	411.0	410.2	
	OL	259.3	316.7	398.4	385.9		
VETERANS AFFAIRS	BA	305.6	368.2	546.0	546.0	546.0	
	OL	300.3	361.3	537.8	537.8		
GRAND TOTAL	BA	9,375.8	10,521.2	11,822.8	11,338.7		
	OL	6,802.7	9,543.4	11,092.5	10,790.7		

/1 Special Forfeiture Fund value includes $40 million to various agencies for uncontrollable overtime and $6 million for ONDCP.

/2 Includes $6 million from Special Forfeiture Fund for ONDCP.

/3 Special Forfeiture Fund values are not directly reflected in total. $31.0 million are contained in ADAMHA and $46.0 million in Prisons, Buildings & Facilities.

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NOTES ON DRUGS:

CENTER ITSELF:

Sept. 12, Thursday, 4 -- drug treatment facility at VA Hospital -- focus on Admin. view on drug treatment -- accountability and results (this is the type of facility we talk about in our Nat. Drug Strategy)

--mostly outpatient; also in; also on-site research

--Dr. O'Brien, then Martinez; Dr. O'B. introduce President (Charles O'Brien, head of psychiatry)

ONDCP:

--1989 Strategy -- #1 priority under drug treatment -- increase federal funds for treatment in order to expand the number of treatment slots and the range of treatment methods availble;

--same source: if we fail to provide help, drug users will continue not only to destroy their own lives, but to endanger the lives of unborn children, commit crimes against others, and siphone nergy from the American ecnomy.

TREATMENT FACT SHEET (8/29):

--(based on FY '92 proposal): in last three years (since FY '89), federal funding for treatment capacity increased $855.8 million -- 85% increase; # persons served from 1.5 to 2.25 million -- if state, local and other sources had continued to increase their support at same rate as fed. budget increases, overall treatment capacity would have increased to serve additional 675,000 (nearly 3/4 million more)

--CONGRESS: FY '91 -- we requested additional $100 m. for ADMS block grant to be used only for drug-rleated programs -- instead, Congress app. only $76 m. for entire ADMS block grant, for drugs, alcohol and mental health -- so only $20 m., 1/5 our reqyuest, could go to drug treatment -- estimate means 200,000 fewer people could be treated

--FY 1992: overall increase of $171 m. for treamtnet (including $99 m. for Capacity Expansion Program, CEP -- created to supplement funds received by the states from ADMS block grant program in order to increase the number of drug treatment slots in shortage areas -- this increase we propose will mean we can serve an additional 200,000 --

--DLONGRESS: Senate authorized CEP but has as yet provided no funding; House provided only $31 m. (1/3 request), but hasn't authorized program;

--CONG. funding falls far short of request -- House would cut 300,000 people from our budget -- Senate 200,000

BENNETT:

--"When drug treatment is done right, it works. When treatment succeeds, addiction's horrible grip on individuals -- and their families and neighborhoods -- is looseneed. I have always believed that effective drug treatment **must** be an integral part of any successful national drug control strategy. And the more I've seen and learned about good drug treatment, the more convinced I've become.

--need sense of individual responsibilitiesy

--there are casualties in this war -- just look no further than your own door to see there are casualties in this war

--realize also that success at staying off drugs depends on the environment to which a recovering addict returns -- that's why effective local law enforcement, strong families, strong neighborhoods, good schools and good churches are critical in making, and keeping, a community free of drugs -- and in helping good treatment work. Treatment cannot succeed in a vacuum -- it certainly won't work in a drug-ridden society.

--they are a danger not only to themselves but also to everyone with whom they come in contact

--until barely 25 years ago, only 2 prison-hospitals publicly funded for drug treatment and research -- today, over 5,000

--is a great source of hope in our battle because is focused on relieving most stubborn part of the problem -- compulseive, destrcutvie, dangerous drug use -- associated with wide tvariety of santi-socieal behavior that imposes enorous costs on American society -- violent crime, loss of employment, broken families, accidents, drug-addi cted babies, premature death;

--it can work -- can turn many drug addicted people into productive ctiziens -- but we cannot be satifised with our current rates of success -- challenge we face is to imporove the quality of treatment, identify which sorts work best with whom, increase recovery rates, learn more about what works and why -- well-planned drug treatment system that insists on accountability, coordination, and results;

--is crucial part of broad strategy --

O'BRIEN MEMO:

--ok -- records show that over the past 4 years, using the largest federal expensidutre in this area ever made available, the tide has begun to turn -- more substance abusers are in treatment now

--develop effective treatments for those trapped in addiction

--this Admin. leading the drive to fund new treatment programs and upgrade the quality of existing programs -- this group for 3 years received research funds from war on drugs --

--this program -- example of program that combines the best in treatment with innovative and rigorous research and training professionals -- exactly what we were talking about in our DCS

--20 years old, back when few treatments available for substance abuse -- very few scientific studies indicating what was effective -- from beginning, treatment and research went hand in hand; as a result of scientific approach, provided outstanding care and developed new information about nature of addiction -- benefited patients all over the country

--these treatments can work -- studies show reductions of more than 70% in drug use; 3 times more likely to be employed; 1/4 as likely to commit crimes

--explore combinining -- for instance, shows probation combined with treatment more than 3 x as effective in reducing re-arrest reates

OMB:

1991 approp. -- total federal drug control program by agency: $10.5 billion; 1992, over $11 billion

ONDCP TPs:

--number one goal of our anti-ddrug efforts is to reduce the number of people using drugs and prevent others from trying for first time

--Fed. drug budget -- our number one domestic initiative -- since entered office, total spending from $6 b. to nearly $11.7 in three years, if enact budget; in treatment and prevention, doubled from 1.6 to 3.2 billion

----concentrating on targeting areas for money -- and partnerships --

--coming up on 2nd anniv. of NDCS -- clear we've made remarkable progress as a nation -- Am. people deserve a lot of credit for individual and collective efforts -- significant declines in drug use and increasing intolerance to drug use is creating a safer, more productive America

--but much more needs to be done --

FROM NEXTUS:

--1992 BUDGET PROPOSAL: drug war budget -- $11.7 b. for drug war (compared to $10.5 billion); 11% increase -- one of the largest in overall budget;

---3rd National Drug Control Strategy --

--new proposaed drug treatment program would funnel $100 million to areas that show a need for treatment funding -- (get details) -- expansion of drug abuse facilities

--balanced approach to drug abuse -- treatment, prvention and la enforcement

--last February's proposal, greatly exapnd drug treatment -- even when under pressure to hold line on federal budget, proposed 11 % spending cincrease in war on drugs --

--budget request will add 10%, $156 million, to treatment program (square this with $100 m. above) -- if states kick in their share, up to 200,000 more addicts will be cared for

--and prevention programs;

--drug treatment, $1.7 billion, up 10 percent; drug prevention and education, $1.5 billion, up 5 percent

--Congress in 1990 axed $250 million from Bush's request

--when Bush took office, spending on anti-drug programs was $6.4 billion

--unswerving commitment to the issue

--our hard work is paying off -- virtually every piece of information we have tells us that drug use trends are heading in the right direction -- down

--now have succeded with interediction, shifting focus -- to the problems of people who have become dependent on drugs

--hard-core drug users -- target -- dysfunctional drug users
--we need more and better treatment programs -- but also have to focus on causes of drug use -- the root cause --
--300,000 drug-addicted babies born in 1990
--DRUG addicts lead to crime and disease
--from 1987-90, public treatment slots climbed from 800,000 to 1.5 million
--since start of admin., our priorities have been the pregnant addict, the crack user, the hihg-risk user -- that's where our large-scale treatment money was desciged for
--good news -- more users of illicit drugs seeking treatment
-- need for accountability in drug treatment programs -- but Capitol Hill responsible for at least part of the problem -- "has repeatedly failed to approve legislation that would link federal money to requirements that states to bheld accountable for quality of drug treatment plans"
--compounding hard-core users -- unempoyment, uneducation - bleak economic prospects --

HOLD?

Hold

<Susan Hepner>

You know, there's really nothing I can tell you about treating the victims of drugs. You're the ones who can tell me. You're the ones who live every day ~~the stories I hear about -- the anguishing stories of~~ the fight for human life and dignity.

~~But~~ you're also the ones who ~~make the advances~~ -- one individual soul at a time. Yours are the faces seen by eyes ~~that have become~~ clear of drugs ~~for the first time in years~~. Yours ~~is~~ are the hands ~~and the words and the presence~~ that give ~~sustenance~~, ~~strength and hope~~.

You're our front-line army, doing daily battle against an enemy more ~~devious, cunning, and~~ evil than we've ever faced on battlefields ~~anywhere~~.

--phoenix; resurrection; rebirth; fiends; scourge; plague

--plague of a winter of our souls

We cannot continue with generations born into despair, growing up with numbness, finding love and direction in a needle or a vial. Our greatest challenge as a society is to act before it is too late. Drug abuse is a symptom. While we must, of course, do everything we can to treat the symptom -- we must eradicate the disease. (Petersmeyer quote)

If I could leave one gift to the American people -- if..... it would be the return to an inner moral compass -- one nurtured

by the family, valued by society -- a moral compass giving meaning, sharing caring, etc., etc.

We must value life. Every life. For its potential and its meaning. Each life lost to the scourge of drugs devalues each American life. (More)

Our society must change. While we value individual rights -- and always must, because that's ou unique legacy as a nation -- look at what "individual" has come to mean. It means individual purpose is individual pleasure. Privilege. An isolated "I". But what a lost, lonely world it would be if we were all (image), alone. We are not -- and we cannot be. We are (image) -- interdependent --- we must realize that we can't make it without each other. We've lost some crucial connections -- communitieis -- religious, cities,(keep going with Moyers, p. 120)
Think of our interdependency. The breakfast, the clothes, the trnasportation, etc. We're part of a cycle -- we're just one piece -- and without any of the other pieces, that breaks down. And it's all interwoven -- responsibility -- if one piece falls ...
Why has the modern society -- which has the tools to be the (?) soceity of human history -- instead become a society devoted to personal pleasure, immediate gratification. The satisfaction of earning pleasure, of finding pleasure in the small details of being alive, of finding pleasure through sharing

We are giving our children everything -- everything, perhaps, except conscience. The depth of feeling that comes with giving, serving.

September 3, 1991

MEMORANDUM FOR QOGWBH

FROM: DQOGWBH DQOGWBH

SUBJECT: DRUG EVENT, PHILADELPHIA

This event occurs Thursday, September 12, at 4 -- the speech should start at about 4:45 -- at the drug treatment facility at the VA Hospital. The speech should focus on the Administration's view on drug treatment. This is apparently the type of facility that we talk about in our National Drug Strategy. We should stress accountability and results.

The event will be of an academic atmosphere -- POTUS will speak to doctors and other professionals from the hospital. He needs to talk about the drug treatment aspect, because it's a part of the Strategy he's often been accused of ignoring.

Remarks are expected to be 8-10 minutes at the most. The room is small, so the text will be on cards. The treatment program is mostly outpatient, although they do have an inpatient ward. They also conduct on-site research.

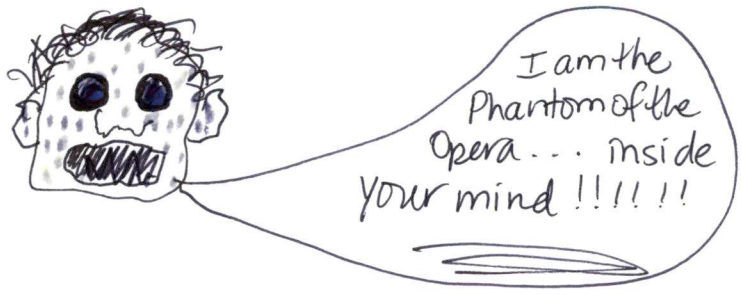
Upon arrival, there will be a briefing with POTUS and Dr. O'Brien, and then a briefing with 6 patients, 6 doctors, and POTUS before the speech takes place.

When they get to the room where the speech will occur, Dr. O'Brien will introduce Martinez, who will give brief remarks (3 minutes), and then Dr. O'Brien will introduce the President.

Contacts are as follows: Dan Casse, Cabinet Affairs, x2800; Charles O'Brien, head of psychiatry, 215-222-3200 ext. 132; Herb Cleeber, ONDCP, at 467-9600.

Enclosed is some background info provided by Dr. O'Brien. I think it'll be helpful, although I honestly didn't finish reading through it. I got your memo, and will start working on those questions first thing Wednesday morning.

Hope you enjoyed Phantom!!!!!!!!!



TREATMENT FACT SHEET

1. Overall Treatment Funding and Capacity

	1989	1990	1991	1992
Overall National Estimates:				
--Slots	556,000	678,052	725,236	796,885
--Persons Served	1,556,800	1,898,646	2,030,661	2,231,000
--Federal Funding	1,002.1 M	1,438.9 M	1,686.8 M	1,857.9 M

- Federal funding for treatment capacity has increased by over three-quarter of a billion ($855.8 million) since FY 1989, reflecting an 85 percent increase in funding.

- If State, local, third parties and other sources have continued to increase their support of treatment services at the same rate as Federal budget increases, we estimate that overall treatment capacity will have increased to serve an additional 675,000 persons, bringing overall capacity up to 2.2 million persons.

2. Relative Impact of the FY 1991 Appropriation

- The President requested an additional $100 million for the ADMS block grant to be used only for drug-related programs. Instead, Congress appropriated only $76 million for the ADMS block grant, to be used for drugs, alcohol and mental health programs. Only about $20 million could be targeted for drug treatment.

- We estimate that Congressional budget action may well have resulted in approximately 200,000 fewer persons being treated.

3. The President's FY 1992 Request

- The President's FY 1992 Budget contains an overall increase of $171 million for treatment, including $99 million for the Capacity Expansion Program (CEP). This new program was created to supplement the funds received by the States from the ADMS block grant program in order to increase the number of drug treatment slots in shortage areas.

- We estimate that the increase in treatment funding proposed by the President will result in an increase of 71,650 slots to serve an additional 200,000 persons nationwide.

- The Senate has passed authorizing legislation for CEP but has provided no funding yet for this program. The House has provided only $31 million for the CEP but has not passed legislation to authorize the program.

- Overall, Congressional funding falls far short of the President's FY 1992 request.

-- The House appropriation bill contains funding for a total capacity of 1.9 million persons, 300,000 persons less than the President's budget.

-- The Senate appropriation bill contains funding for a total capacity of 2.0 million persons, 200,000 persons less than the President's budget.

THE WHITE HOUSE

Office of the Press Secretary

Embargoed For Release Until 9:00 P.M. EDT
September 5, 1989

FACT SHEET

NATIONAL DRUG CONTROL STRATEGY

The National Drug Control Strategy describes a coordinated and comprehensive plan of attack involving all basic anti-drug initiatives and agencies. The Strategy recommends the largest dollar increase in the history of the drug war -- nearly $2.2 billion, 39 percent above the Fiscal 1989 level. Throughout, the Strategy emphasizes the principle of user accountability -- in law enforcement efforts focused on individual users; in decisions regarding sentencing and parole; in school, college, and university policies regarding the use of drugs by students and employees; in the workplace; and in treatment.

The Strategy also calls for increased efforts in cocaine source countries and a more active international campaign by the United States to engage other nations in the fight against drugs. Interdiction efforts will be better targeted on key individuals in the drug organizations and on high-value shipments.

Another major priority is increasing the capacity of the drug treatment system and making it more accountable for results. Significant emphasis is also given to providing increased support for prevention and education efforts aimed at helping young people and others resist and reject drugs.

The Strategy embodies the following elements:

<u>Expand the criminal justice system</u>

- Provide funds for larger police forces, and increased numbers of jails, prosecutors, and courts.
- Develop alternatives for incarceration such as boot camps to free up jail and prison space.
- Require drug testing of prisoners, parolees, and arrestees.

Hold users, whether casual or heavy users, accountable for their actions

Undertake a vigorous program to eradicate domestically-grown marijuana

Mobilize communities in the war on drugs

- Emphasize community-level prevention of drug use before it starts.
- Require schools and colleges to implement firm drug-free policies in order to receive Federal funds.
- Clean up and secure public housing.

Expand drug-free workplace policies

- Promote drug-free workplace policies in the private sector.
- Recommend testing for job applicants and employers in safety and sensitive positions.
- Aggressively implement Executive Order 12564 to assure drug-free workplace plans and policies within the Federal government.

Expand treatment and target services to improve the number of individuals served and the effectiveness of treatment

- Hold Federally-funded treatment programs accountable for their effectiveness by establishing performance criteria.
- Require drug testing in treatment programs receiving Federal funds.
- Explore expanded use of "civil commitment" whereby addicts are sent by the courts to residential treatment facilities.
- Improve drug treatment services for pregnant women.

Place heavier emphasis on targeted international efforts closer to production and trafficking sources

- Elevate the drug issue as a foreign policy priority.
- Dismantle drug trafficking organizations.
- Reduce trafficking profits by focusing increased efforts on money laundering.

Take a fresh approach to interdiction

- Create interagency and interdisciplinary teams to analyze and target smuggling modes, methods, and routes.
- Target key individuals and high-value shipments.
- Enhance border interdiction systems, operations, and activities.

Improve the quality of research, information, and technological capabilities available for drug control efforts

- Establish a Federal Drug Control Research and Development Committee.
- Develop a more current and flexible information base.

Improve coordination of Federal anti-drug policy and intelligence support

- Establish interagency working groups chaired by the Office of National Drug Control Policy to coordinate supply and demand reduction efforts.

- Establish an interagency working group chaired by the Office of National Drug Control Policy to develop plans for an intelligence center to unite U.S. drug-related analytical capabilities, and to improve intelligence capabilities.

Recommend a $2.2 billion increase in drug funding to $7.9 billion in 1990. The major changes over 1989 are shown on the following chart:

Drug Resources, Fiscal Year 1990

Budget Authority (Millions of Dollars)

	FY1989 Enacted	Feb 9 Budget FY1990*	Feb 9 Budget Plus Drug Portion of Crime Bill**	Drug Strategy Sep FY1990**	FY89-FY90 % Increase	FY89-FY90 $ Increase
Corrections	734	894	1,601	1,601	118%	867
International	250	306	306	449	80%	199
State and Local Grants	150	150	156	350	133%	200
Judiciary	209	242	250	250	20%	41
Other Law Enforcement	2,779	3,018	3,058	3,113	12%	334
Prevention/Education	943	1,041	1,041	1,176	25%	233
Treatment	604	735	735	925	53%	321
Total	5,669	6,386	7,147	7,864	39%	2,195

* These columns include resources for the U.S. Court and make other minor adjustments to the figures presented in the "Building a Better America" document issued in February, 1989.

** These columns include the "drug portion" ($0.8 billion) of the President's $1.2 billion crime initiative announced in May, 1989. The Administration supports enactment of the crime initiative (The Comprehensive Crime Control Act of 1989) in its entirety.

The drug portion of prison construction is based on the projected share of drug offenders in Federal prison at the time the construction is completed. This new methodology reflects more accurately the likely impact of drug offenses. For consistency with prior years, the historical prison construction numbers have been adjusted to reflect this new methodology.

National Drug Control Strategy

Executive Summary

September 1989

National Drug Control Strategy

Executive Summary

Most Americans believe that illegal drugs represent the gravest present threat to our national well-being. The evidence reinforces this concern:

Crime. Fear of drugs and attendant crime are at an all-time high. Rates of drug-related homicide continue to rise — sometimes alarmingly — in cities across the country.

Health. The number of drug-related emergency hospital admissions increased by 121 percent between 1985 and 1988, as many as 100,000 babies are born each year to mothers who use drugs, and intravenous drug use is now the single largest source of new AIDS virus infections.

The Economy. A U.S. Chamber of Commerce estimate puts annual gross illegal drug sales at $110 billion — more than our total gross agricultural income, and more than double the profits enjoyed by the Fortune 500 companies combined.

Overseas. In many foreign nations the drug trade and drug inspired violence and corruption are causing serious social, economic, and political disruption. Trafficking threatens stability and democratic institutions.

However, there is also some positive news. Recently, the National Institute of Drug Abuse (NIDA) released the results of its National Household Survey on Drug Abuse — the first such national study since 1985. The survey found the number of Americans using any illegal drug on a "current" basis (i.e., at least once in the 30-day period preceding the survey) has dropped 37 percent: from 23 million in 1985 to 14.5 million last year.

The survey tells us that, despite the persistent widespread availability of illegal drugs, millions of Americans who once used them regularly appear to have given them up altogether. This and other surveys indicate that many others — young people for the most part — have chosen not to try drugs in the first place.

But the NIDA survey also found that "frequent" use of cocaine in any form (i.e., the number of respondents who report ingesting the drug one or more times each week) is up a shocking 33 percent since 1985. One word probably explains much of the intensifying drug-related chaos that we see every day: ***crack***.

There are really two drug wars to be fought. The first is against "casual" use of drugs, and that is being won. The other, much more difficult war is against addiction to cocaine, by far the most common dangerous drug of abuse. On this second front, increasingly located in our cities, the war is being lost — badly.

To win the drug war it is important first to come to terms with the drug problem in its essence: drug use. Drug use must be reduced, but it is necessary to be scrupulously honest about the difficulties that are faced and set reasonable goals and objectives. In addition, there must be created something that has never existed before: a comprehensive, fully integrated national drug control strategy — a strategy with particular emphasis on attacking the use of crack cocaine.

The Strategy lays out a coordinated plan of attack involving all basic anti-drug initiatives and agencies. Following the Introduction, seven chapters examine the "fronts" on which the drug war must be waged: Criminal Justice; Treatment; Education, Community Action, and the Workplace; International Initiatives; Interdiction; Research; and Intelligence. Each chapter is preceded by a summary of the recommendations contained therein.

Several Appendices are included within the Strategy. Quantified goals and measures of success, as required by Section 1005(b) of the Anti-Drug Abuse Act of 1988, are set forth in Appendix A. Also included are implementation plans (Appendix B), recommended State anti-drug legislation (Appendix C), high-intensity drug trafficking areas (Appendix D), a plan for improved automatic data processing and management among Federal drug agencies (Appendix E), and a list of individuals consulted in writing the Strategy (Appendix F).

Several fundamental themes underlie the Strategy, including:

- society has been too permissive of drug use;

- better coordination and management of government efforts is needed;

- State and local governments should adopt Federal principles of accountability as a model in developing their anti-drug strategies; and

- efforts should focus heavily on certain aspects of the problem, such as cocaine.

This is a truly national strategy. It calls upon all sectors of American society — private (individuals, educators, philanthropic organizations, businesses, the media, and religious, cultural, and community organizations) and public (Federal, State, and local governments) — to combat the drug problem.

What follows is a summary of the key priorities of the National Drug Control Strategy.

I. CRIMINAL JUSTICE

Overview

The absence of a significant risk of punishment for illegal drug activity is perhaps the single greatest hindrance to drug reduction efforts. More predictable, severe sanctions provided by the criminal justice system will be one of the most powerful forms of drug prevention. They will make it increasingly difficult to engage in any drug activity with impunity.

In order to be an effective deterrent, the criminal justice system must expand to accommodate more people at every point, from arrest through prosecution, release, and final supervision. This means more law enforcement officers, prosecutors, judges, courtrooms, and jails.

Priorities

- Increased Federal funding to States and localities for street-level drug law enforcement.

- Federal funding to States for planning, developing, and implementing alternative sentencing programs for nonviolent drug offenders, including house arrest and boot camps.

- Increased Federal funding for Federal law enforcement activities (including courts, prisons, prosecutors, and law enforcement officers); and additional resources targeted on Federal money laundering investigations.

- Vigorous prosecution of and increased fines for all misdemeanor State drug offenses.

- Expanded programs to eradicate the domestic marijuana crop.

- Adoption by the States of drug-testing programs throughout their criminal justice systems: for arrestees, prisoners, parolees, and those out on bail. Adoption of such programs will be a condition for receipt of Federal criminal justice funds.

- Funding through the Department of Housing and Urban Development to establish security systems for public housing projects, including tenant identification cards, guards, and security fences.

- Establishment of a Supply Reduction Working Group, chaired by the Office of National Drug Control Policy, to carry out the statutory requirement to "coordinate and oversee the implementation by National Drug Control Program agencies of the policies, objectives, and priorities" defined in the National Drug Control Strategy. This group will consider supply-related drug policy issues that are interdepartmental in nature. It will not deal with operational decisions or have line authority or responsibility.

- Revision of Federal drug agency personnel evaluation systems, where appropriate, to add a criterion for career advancement and reward that emphasizes cooperation among employees within and across various agencies.

- Strong encouragement for States to adopt policies revoking the drivers licenses of those convicted of a drug offense and recommendation of model drivers license revocation legislation to the States.

II. DRUG TREATMENT

Overview

Effective treatment is an important part of the overall strategy to reduce drug use. Millions of Americans need help to stop using drugs. Responsible and compassionate public policy requires that our nation's drug treatment capacity be increased.

Priorities

- Increased Federal funds for treatment in order to expand the number of treatment slots and the range of treatment methods available.

- Greater State, local, and individual treatment program accountability for effectiveness. Submission of State plans for treatment resource allocation and systemic improvements will be a condition for receipt of Federal treatment funds.

- Improved coordination among local treatment facilities so that treatment resources and availability match community needs, and so that drug users are referred to the most appropriate treatment provider.

- Improved coordination between treatment facilities and social, health, and employment agencies in order better to assist those drug-dependent persons who need services in addition to treatment. Under some circumstances, treatment facilities will be assisted in the development of their own programs in these areas.

- Increased funding of outreach programs and early treatment for expectant mothers who use drugs.

- State and private insurance company coverage of outpatient and other less intensive forms of treatment for drug use. A thorough review of Federal policy will be conducted to determine whether changes in Federal coverage are necessary.

- Exploration of ways to increase the use of civil commitment as a means to bring more drug dependent persons into the treatment system.

- Expanded and improved Federal information collection and research. Priority will be given to describing our current treatment

capacities and needs; evaluating treatment effectiveness for specific populations; and developing methods of treatment for cocaine and crack dependency, cocaine in combination with other substances, and individuals with both psychiatric and drug problems.

III. EDUCATION, COMMUNITY ACTION, AND THE WORKPLACE

Overview

The principal goal of prevention is to see that Americans, especially children, never start taking drugs. Prevention begins at the local level: at homes, in schools, and in the community.

The Federal government should galvanize public opinion to make it clear that illegal use of drugs is wrong and harmful. This includes support for community drug prevention efforts. Activities should be targeted at youth; in addition, individuals, parents, and employers must become involved in drug prevention and education.

Priorities

- Implementation of firm drug prevention programs and policies in schools, colleges, and universities. Such programs and policies will be a condition of eligibility for receipt of Federal funds.
- Development of model alternative school programs for youths with drug problems. Federal assistance to local education agencies will promote such development.
- Federal support for community-wide drug prevention efforts.
- Federal support for development of anti-drug media outreach activities that deal with the dangers of using illegal drugs — particularly crack — and with drug-impaired pregnancies.
- Creation of a national program to mobilize volunteer efforts to prevent the illegal use of drugs.
- Implementation of Executive Order 12564 to ensure a drug-free Federal workforce.

- Drug-free workplace policies in the private sector and State and local government, including clear penalties for drug use, and drug testing where appropriate.

- Establishment of a Demand-Reduction Working Group, chaired by the Office of National Drug Control Policy, to carry out the statutory requirement to "coordinate and oversee the implementation by National Drug Control Program agencies of the policies, objectives, and priorities" defined in the National Drug Control Strategy. This group will consider demand-related drug policy issues that are interdepartmental in nature. It will not deal with operational decisions or have line authority or responsibility.

IV. INTERNATIONAL

Overview

The international drug trade poses a serious threat to the welfare, economy, and national security of the United States. The principal foreign drug threats are cocaine, heroin, and marijuana. Programs are needed to deter and incapacitate international production and the trafficking organizations responsible for bringing these drugs into the United States. Other nations must be motivated to engage their resources and efforts to defeat international narcotics trafficking.

Priorities

- Disruption and dismantlement of drug-trafficking organizations.

- Reduced cocaine supply. Law enforcement, military, and economic assistance will be provided to the three Andean cocaine-producing countries to isolate major coca-growing areas; to block delivery of chemicals used for cocaine processing; to destroy cocaine hydrochloride processing labs; and to dismantle the trafficking organizations. Efforts in transit areas will be improved and Joint Intelligence Collection Centers will be created in the Caribbean Basin.

- Reduced heroin supply through efforts to convince other countries to exert influence on opium growers and reduce heroin processing and distribution.

- Reduced marijuana supply through strengthened foreign law enforcement and eradication, and through efforts to discourage minor producing nations from becoming major producers.

- U.S. assistance and encouragement for European community and multi-lateral efforts aimed at source country and transit country production and distribution, and at European consumption. European community support against international and regional drug organizations will be enlisted.

- Other international objectives:

  - Elevation of drugs as a bilateral foreign policy issue.

  - U.S. ratification of the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, along with other pending Mutual Legal Assistance Treaties. Other nations will be urged to ratify the Convention.

  - Support for the U.S. foreign aid certification process in order to achieve more effective supply- and transit-country compliance with American drug control objectives.

  - Bilateral and multi-lateral efforts against international money-laundering activities.

V. INTERDICTION

Overview

Effective interdiction is critical in the effort to reduce the flow of drugs. Interdicting illegal drug shipments and intercepting other resources is an important method of attacking the drug trade at home and abroad. Interdiction should focus not only on drug seizures, but also on creating serious personal and financial risk for trafficking organizations and their top level personnel.

Priorities

- Development of a comprehensive information-based approach to Federal air, maritime, land, and Port-of-Entry interdiction.

  - Upgraded intelligence support to interdiction, through intensified interdiction-specific investigations and undercover operations.

- Enhanced computer support to interdiction through acceleration of machine readable documentation programs; installation of document machine readers at appropriate Ports of Entry; and development of the International Border Interdiction System (IBIS) and other computerized border information systems.

- Creation of interagency/interdisciplinary teams to analyze and target smuggling modes, methods, and routes.

- Concentration on high-value individuals and shipments.

  - Review of existing methods for deterring air smugglers.

  - Improved operations aimed at money couriers and shipments.

  - Improved container inspection techniques and intelligence.

- Enhanced border systems, operations, and activities.

  - Dramatically reduced document fraud, especially fraudulent use of U.S. birth certificates and other "breeder documents."

  - Expanded use of drug detection dogs, anti-vehicle barriers, and container inspections.

  - Provision of automatic exclusion authority and general arrest authority to Immigration and Naturalization Service officers.

  - Improved detection and monitoring systems and secure operations procedures.

  - Expanded secure communications systems.

VI. RESEARCH

Overview

The quality of information, research, and technological capabilities available to implement drug control policies and programs must be improved. A more up-to-date and flexible data base is needed to refine and target drug control efforts. Technology must be developed and adapted to aid in law enforcement. More medical research is also needed into the causes of and treatment for drug addiction.

Priorities

- Establishment of a Drug Control Research and Development Committee involving directors of research and evaluation, and chief technology advisers to all appropriate drug supply and demand reduction agencies. This committee will:
  - Recommend to the Office of National Drug Control Policy policies and priorities for drug-related research and development;
  - Review, monitor, and coordinate Federal research, data collection, and evaluation activities;
  - Eliminate duplication and gaps in current data collection, and generate accurate and useful information on which to base national drug control policies; and
  - Assist agencies in effectively acquiring and using new technologies to prevent and treat drug use and to detect and suppress the flow of illegal drugs and related commodities.
- Better and more frequent data collection and analysis, including flexible, quick-response data collection instruments.
- Increased basic and clinical research on drug use and addiction.
- Development of new technologies or innovative adaptation of existing technologies for use against illegal drugs.
- Development of a comprehensive information base about "what works" in controlling drug use through support for public and private evaluation of drug enforcement, drug prevention, and drug treatment programs.
- Archived and disseminated information, research, and evaluation results through an appropriate mechanism that combines prevention, treatment, and criminal justice data.

VII. INTELLIGENCE

Overview

The war against drugs cannot be fought without comprehensive collection, analysis, and dissemination of critical information on drug production and trafficking. To target the traffickers' most vulnerable points, more information about the enemy must be obtained.

Priorities

- Increased intelligence efforts to concentrate on the infrastructure of trafficking organizations and their allied enterprises, particularly money laundering.
- Improved drug automation and information systems to allow swifter, better, and more cost-effective drug law enforcement, prosecutions, and interdictions.
- Sharing of intelligence developed in the course of investigations and intelligence operations, and dissemination of finished, analyzed intelligence to appropriate Federal law enforcement and intelligence agencies.
- Establishment of an interagency working group chaired by the Office of National Drug Control Policy to develop plans for an intelligence center to unite U.S. drug-related analytical capabilities, and to improve intelligence capabilities. Results will be presented to the appropriate Cabinet Council.

GOALS AND OBJECTIVES (APPENDIX A)

The Strategy includes comprehensive, research-based, long-range goals for reducing drug use as well as short-term measurable objectives. There are nine goals for reducing drug use in two stages of measurement: during the next two years and over the next ten years. Specific percentage reductions are proposed in the nine categories, including overall drug use, use of specific drugs, use by certain age groups, and overall supply reductions.

FEDERAL IMPLEMENTATION and RESOURCE REQUIREMENTS (APPENDIX B)

Overview

The National Drug Control Strategy recommends the largest dollar increase in the history of the drug war — nearly $2.2 billion, 39 percent above the Fiscal 1989 level. Key funding priorities for Fiscal Year 1990 are to:

- Increase assistance to State and local law enforcement;
- Expand resources for treatment and prevention programs;
- Initiate a major anti-drug campaign in the cocaine source countries;
- Establish order in the nation's public housing projects;
- Build more Federal prisons, expand Federal and State courts and correctional systems, and add more prosecutors;
- Step up efforts against money laundering operations;
- Expand our knowledge base about drugs and how to fight them through more research, data collection, and information sharing; and
- Provide sufficient resources to operate and maintain our border interdiction system.

The following priorities will be added in 1991 and 1992:

- Expand inter-agency drug task force operations;
- Augment drug intelligence capabilities;
- Strengthen the presence of the Border Patrol along the Southwest border;

- Help the police get people who are driving while under the influence of drugs off the highways; and
- Reduce the amount of marijuana cultivated on American soil.

Major changes over FY 1989 are:

Drug Resources, Fiscal Year 1990

Budget Authority (Millions of Dollars)

	FY1989 Enacted	Feb 9 Budget FY1990*	Feb 9 Budget Plus Drug Portion of Crime Bill**	Drug Strategy Sep FY1990**	FY89-FY90 % Increase	FY89-FY90 $ Increase
Corrections	734	894	1,601	1,601	118%	867
International	250	306	306	449	80%	199
State and Local Grants	150	150	156	350	133%	200
Judiciary	209	242	250	250	20%	41
Other Law Enforcement	2,779	3,018	3,058	3,113	12%	334
Prevention/Education	943	1,041	1,041	1,176	25%	233
Treatment	604	735	735	925	53%	321
Total	5,669	6,386	7,147	7,864	39%	2,195

* These columns include resources for the U.S. Court and make other minor adjustments to the figures presented in the "Building a Better America" document issued in February, 1989.

** These columns include the "drug portion" ($0.8 billion) of the President's $1.2 billion crime initiative announced in May, 1989. The Administration supports enactment of the crime initiative (The Comprehensive Crime Control Act of 1989) in its entirety.

The drug portion of prison construction is based on the projected share of drug offenders in Federal prison at the time the construction is completed. This new methodology reflects more accurately the likely impact of drug offenses. For consistency with prior years, the historical prison construction numbers have been adjusted to reflect this new methodology.

Office of National Drug Control Policy
Executive Office of the President
Washington, D.C. 20500

Joe McQ

467-9850

In general, Dr. Kleber

req. $100M for exp of drug treat 91

Cong gave 35M

For FY92, req. 100M

house cut 2/3

Sen. cut 1/2

won't know 'til

Conf. Committee

Treatment Init.

State Tment account plans
been asking for 2yrs.
monitor how fed
funds are being
spent by states.

THE WHITE HOUSE
WASHINGTON

% is not a big #

House voted: cut into services offered now. cut 37 million from block grant → 1/3 of which went to drug treatment

Senate completed:

committee axn

waiting for conference

Joe McHugh

THE WHITE HOUSE
WASHINGTON

House tells us we're treating too many people, so they cut into current services.

~~Sen. has not funded POTUSs program adequately~~

H & S has failed to help → cut $99 (new) Million (new program)

will cut as SHORA but will meet 1/2 way

THE WHITE HOUSE
WASHINGTON

We've stepped up to the plate - we're waiting for Congress.

4

THE WHITE HOUSE
WASHINGTON

Cong Rec. → drugs rkn

2/5/91 - Darman

7/26/91

6/26/91

5/24/91

~~3/21~~ 2/6?

3/13

3/12

THE WHITE HOUSE
WASHINGTON

[redacted]

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The VA/Penn Addiction Research Center

Substance abuse has been perhaps one of the most serious domestic problems to face our nation over the past decade - but the tide is turning. Social pressure has accumulated to the point where drug use is not accepted in any quarter of our society. Criminal justice system forces have placed maximum penalties on persons who sell or distribute drugs. Employers and labor groups have banded together to eliminate drugs from the workplace. Educators have dedicated substantial parts of their curricula (from kindergarten to medical schools) to the facts about drug use and the methods that can be used to avoid drug use. Researchers and clinicians have contributed new medications and behavioral treatments to assist the substance abuser who wants to change. Over the past four years, and with the help of the largest federal expenditure in this area ever made available, the tide has begun to turn. More substance abusers are in treatment now than at any time in the recent past and the evidence shows that with the enduring commitment to that treatment plus the support of families, employers and communities there will be significant gains achieved in their fight against drug use.

Everyone agrees that our nation's drug program must be approached by reducing demand for illegal drugs. One side of demand reduction is to prevent young people from ever starting to use illegal drugs...to get them to understand the dangers so that they will refuse drugs when they are offered. The second way is to develop effective treatments for those already trapped in addiction. With proper treatment, former addicts can return to normal life including jobs, families and recreational activities. But addiction is a very difficult disorder to treat. It involves medical, social and psychological aspects. Recently the Administration has led the drive to fund new treatment programs and to upgrade the quality of existing programs for the treatment of addiction. We have also invested in research to develop new and more effective treatments. The program at the Philadelphia VA Medical Center and the University of Pennsylvania is an example of a program that combines the best in treatment with innovative and rigorous research. That such an outstanding program could be developed within a VA Medical Center is also testimony to the high quality medical care given to our nation's veterans.

The VA/Penn Addiction Research Center was founded in 1971 by a Navy doctor who became impressed with the need to find effective treatments for drug abuse while taking care of active duty servicemen just back from Vietnam. At that time, there were few treatments available for substance abuse and very few scientific studies indicating what was effective. From the beginning, therefore, this program emphasized measuring and evaluating what works and what doesn't work. Treatment and research went hand in hand. Patients were always given the best available treatment, but they were measured before, during and after treatment. As a result of this scientific approach to treating a relatively un-studied disorder, the clinic provided outstanding care to veterans and developed new information about the nature of addiction and its treatment. This work in collaboration with other research clinics has resulted in new treatment techniques and new medications that have benefited patients all over the country. The VA/Penn group has studied a wide range of subjects from basic studies on changes in endorphin levels during addiction to very practical studies showing how to deliver more effective care at lower cost.

While we are all concerned about substance abuse and the problems caused to families, employers and society by drug abuse there is reason to be optimistic based on findings from ongoing treatment research studies supported by federal research funds. The clinical research done here at the VA/Penn Center and elsewhere suggests four significant facts about substance abuse treatments:

1) Substance abuse treatments can work. In fact there are now scientific methods for evaluating the efficacy of substance abuse treatment in terms of the multiple demands that society has a right to expect from those treatments. Scientific studies of several different forms of treatment show that patients who have received treatment for their substance abuse problems have shown reductions of more than 70% in their cocaine, opiate and alcohol use. Patients who have received treatments have been three times more likely to be employed following treatment and only one quarter as likely to commit crimes as as they were before treatment. Patients who have received substance abuse treatment have been less than half as likely to acquire or to spread the AIDS infection as substance abusers who have not received treatments.

2) Substance abuse treatments are inexpensive relative to incarceration or relative to not providing treatment at all. Incarceration for drug related offenders in federal facilities costs between $25,000 to $35,000 per year and more than half of these individuals commit a drug-related crime during the year following release. In contrast, substance abuse treatment costs a fraction of this amount and can result in significant and lasting gains, not

only in the drug and alcohol abuse problems of these individuals but in the important areas of employment, crime, family disruption and use of publicly funded medical and social services. Further, research that has been supported through federal funds indicates that many substance abusers can be treated in outpatient clinics rather than inpatient centers, thus reducing the costs of care by 25 to 60% without reducing efficacy.

3) Substance abuse treatment can be combined with interdiction and supply side efforts to create the optimum conditions necessary to motivate change in substance abusers. Studies done here with federal probationers suggest that standard federal probation, **combined** with twice weekly substance abuse counseling sessions and medications designed to reduce craving for opiates, was more than three times as effective in reducing the re-arrest rates of probationers as standard probation alone.

4) Substance abuse treatments can and should be improved. Given the multiple problems seen among substance abusers applying for treatments it is clear that multiple services are necessary. It is clear that substance abuse rarely occurs in isolation - but instead is usually a significant part of a larger syndrome involving medical, social, family and psychological problems. It therefore follows that medical, employment, family and psychiatric services must be combined with substance abuse counseling - and the individual efforts of the substance abuser - for treatment to achieve its full potential.

SPECIFIC EXAMPLES OF RESEARCH AREAS

Evaluation of Patients

Early on, this group found that not all addicts are alike, even if they are dependent on the same drug. Among heroin addicts, those who have an additional psychiatric disorder such as depression require different treatment from those who suffer from uncomplicated heroin dependence. To respond to the need for measurement, the group developed the Addiction Severity Index (ASI). The ASI measures the severity of addiction problems based on a structured clinical interview that can be administered by any clinician. This instrument has proved valuable for research and for ordinary clinical practice and has been translated into seven languages around the world.

Psychotherapy for Addiction

The VA/Penn group showed that psychotherapy in combination with methadone maintenance is effective in the treatment of heroin addiction. They conducted careful scientific studies involving random assignment to different treatment groups in order to

compare treatments. These studies examined the use of Family Therapy, individual psychotherapy (Supportive-Expressive or Cognitive) and Behavioral Therapy (Cue Extinction). They also compared patients treated in a drug-free therapeutic community with those treated as outpatients by methadone. The results produced guidelines for clinicians showing when psychotherapy is indicated and when it is not. The beneficial effects of methadone treatment were significantly enhanced by the addition of psychotherapy. This series of studies showed very clearly that administering methadone alone, without combining the medication with either counseling or psychotherapy, produced poor results in preventing IV drug use.

AIDS and IV drug use

Almost a third of HIV infected Americans now are IV drug users. In some cities, the infection rate among heroin addicts is 60% to 70%. The VA/Penn group has shown that the infection rate among heroin addicts in treatment remains stable, but in a comparison group that remained un-treated, the rate of infection increased alarmingly over the 18-month follow-up period.

Medications in the treatment of addiction

When used properly, methadone is an effective treatment for opiate dependence. The VA/Penn researchers have conducted studies aimed at using methadone more effectively with appropriate clinic guidelines and psychotherapy or counseling. They have been involved in studies of new opioid maintenance drugs such as LAAM and buprenorphine that may replace methadone in certain situations. They also conducted the first scientific studies demonstrating the effectiveness of anti-depressant medication in heroin addicts. These researchers were among the first to study opiate antagonists in the treatment of addiction. Opiate antagonists block the receptors for all opiate drugs thus preventing the former addict from feeling any drug effect if he begins to relapse and takes a dose of heroin. These studies led to naltrexone being approved by the FDA and it is now used in the treatment of certain subcategories of opiate addicts.

In the treatment of alcoholism, recent work by this group has shown that naltrexone may have a role in the prevention of relapse to alcohol dependence. There is evidence that pleasant effects from alcohol may be derived in part from alcohol's effects on the internal system ("Endorphins") on which opiates work. When this system was blocked by naltrexone treatment, the tendency of alcoholics to relapse was decreased and rehabilitation was more effective.

The VA/Penn group is engaged in intensive research to find a medication that helps in the treatment of cocaine dependence. NIDA and the VA have jointly set up a program of research that is being coordinated by the VA/Penn Center to study systematically different classes of medications that might reduce relapse in former cocaine addicts. Thus far, no medication that has been studied is clearly effective.

Behavioral Treatment of Cocaine Dependence

The VA/Penn group was the first to demonstrate in humans that drug abuse produces learning or conditioned responses. This means that a former addict may have a strong involuntary reaction upon seeing, hearing or smelling something that had previously been associated with drug use. These automatic learned reactions consist of physical changes such as heart rate, blood pressure and temperature changes and psychological changes that include craving for the drug to which they had been addicted. Conditioned responses are particularly prominent among cocaine addicts and they may contribute to the strong tendency to relapse. The VA/Penn group developed a series of behavioral treatments that can be integrated with ordinary treatment and that reduce or "un-learn" these responses, thus improving the results of treatment.

Cost-Effectiveness Studies of Treatment

The VA/Penn group has conducted prospective, random assignment comparisons of treatments for alcoholism and other forms of drug dependence that include analysis of economic costs. In the detoxification of alcoholics, outpatient treatment was found to be equal to inpatient treatment in long-term effectiveness and far less costly. In the long-term rehabilitation of alcoholics and cocaine addicts, a day hospital program that involved intensive outpatient care for one month was compared with one month of inpatient rehabilitation where the patient lives at the hospital. The results for both cocaine dependence and alcohol dependence showed that outpatient rehabilitation was equal to inpatient rehabilitation in effectiveness, despite much lower costs for the outpatient care.

Expansion of the Research Center

During the past three years the VA/Penn group has competed successfully for research funds made available by the Administration's War on Drugs. This additional funding has been used to set up a parallel research and treatment program on the University Campus and to begin to do research studies on non-veteran patients. The treatment program for veterans has also been enlarged. Treatment is provided without cost to patients because the costs are borne by research funds. There is a unique efficiency to this

system because new high quality treatment slots have been added to the Philadelphia community and, moreover, the research is contributing new knowledge that will be used to benefit patients across the country.

Training Programs

There is a lack of knowledge about substance abuse among health care workers in general and a lack of trained professionals in the field of substance abuse. The VA/Penn Center has designed an extensive course on the diagnosis and treatment of substance abuse for medical students that is a required course at the University of Pennsylvania Medical School. There is also a formal training program for psychiatry residents and a post-doctoral fellowship program funded jointly by the VA and NIDA that provides specialized training in treatment and research to psychiatrists, family practitioners, internal medicine specialists and graduates of other residency programs. The group also provides training for addiction counselors and other para-professionals in the use of the Addiction Severity Index and in the use of other instruments and techniques developed at the Center.

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HEADLINE: Bush urges 11% hike for drug war

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KEYWORD: US; DRUG; ABUSE; AID; GOVERNMENT; GEORGE BUSH; BUDGET

BODY:

Armed with figures showing national drug use down markedly over the past 18 months, President Bush proposed yesterday an increase in federal spending on the drug war by another 11 percent, saying his commitment to the issue was unswerving.

Bush's national drug control strategy for fiscal 1992, at a cost of $ 11.7 billion, takes a similar approach to that of the past two years, stressing supply reduction through law enforcement at home and abroad with somewhat less emphasis on demand reduction through education and treatment.

Partially in answer to congressional and other critics who favor greater emphasis on stemming drug demand, the new proposal contains an additional $ 100 million for an expansion of drug abuse facilities.

"That means as many as 200,000 more people will receive help to get off and hopefully stay off drugs during fiscal 1992," Bush told reporters yesterday as he presented the proposal.

Sen. Joseph R. Biden Jr., a Delaware Democrat and chairman of the Judiciary Committee, took issue with much of the proposal yesterday, saying "it takes some additional steps in the right direction but falls far short of what must be done to combat the drug epidemic."

The Bush administration has been saying since late last summer that use of virtually all drugs has been down markedly over the past year and a half. For example, occasional use of cocaine is down 29 percent and frequent use of cocaine is down 23 percent, according to a household survey by the National Institute of Drug Abuse. Current overall drug use is listed as down 11 percent.

If true, the numbers are dramatic since they surpass the two-year goals established only 18 months ago by the president's drug control office. Those goals called for a 10 percent drop in overall drug use and a 10 percent drop in occasional cocaine use.

But Biden said the figures are not accurate.

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"Our studies show that the number of weekly cocaine users is continuing to rise - not fall," he said in a statement. "A new drug epidemic is starting to hit rural America. The nation's prisons are releasing millions of untreated addicts back to our streets."

Biden further complained that, based on his statistics, law enforcement needs are going unmet and critical addict groups, such as pregnant women, are being neglected. He further complained that the president still refuses to reduce the supply of military-style assault weapons, which the senator calls the drug dealers' weapon of choice.

In addition, while the administration argues that drug-related violent crime has not risen, Biden, citing FBI figures, said it has.

Bush's plan proposes legislation requiring states to adopt drug testing programs for those arrested for drug-related crimes in order to receive federal criminal justice funds. It also calls for the death penalty for federal drug felons whose offense results in death.

The proposal, which will be submitted to Congress as part of Bush's $ 1.4 trillion 1992 budget, also calls for a $ 125 million increase in military, law enforcement and economic aid to Colombia, Peru and Bolivia.

The post of drug policy chief has been vacant since William J. Bennett resigned in November. Bush nominated former Florida Gov. Bob Martinez to replace him but he has not yet been confirmed by the Senate.

GRAPHIC: PHOTO, AFP PHOTO / President Bush, with Health and Human Services Secretary Louis Sullivan, announces an expanded campaign against illegal drugs.

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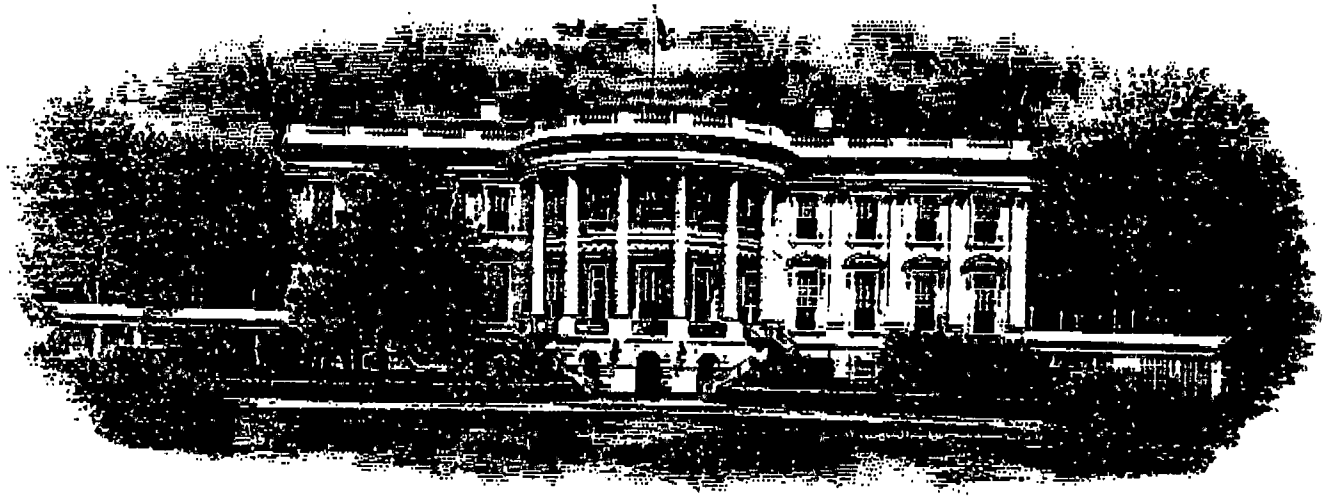
OFFICE OF NATIONAL DRUG CONTROL POLICY
EXECUTIVE OFFICE OF THE PRESIDENT
Washington, D.C. 20500



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TO: Carol Blymyre (sp?)

FAX NUMBER 456-6218

OFFICE NUMBER _____

COMMENTS We generally use statistics from the past month tables to reflect "current" use of drugs. I.E., page 69 - we'd say 14.9 % of adolescents use any illicit drug (1990)

FROM: Dinah Dinwiddie

FAX NUMBER 467-9869

OFFICE NUMBER 467-9880

Table A.5 Trends in Percentage of Persons Aged 12 to 17 Reporting Drug Use in the Lifetime: 1972-1990

Drug (Unweighted N)	1972 (880)	1974 (952)	1976 (986)	1977 (1,272)	1979 (2,165)	1982 (1,581)	1985 (2,246)	1988 (3,095)	1990 (2,177)
Any Illicit Drug Use[1]	--	--	--	--	34.3	27.6[Y]	29.5	24.7	22.7
Marijuana/Hashish	14.0	23.0	22.4	28.0	30.9	26.7	23.6	17.4	14.8
Cocaine	1.5	3.6	3.4	4.0	5.4	6.5	4.9	3.4	2.6
Inhalants	6.4	8.5	8.1	9.0	9.8	--	9.2	8.8	7.8
Hallucinogens	4.8	6.0	5.1	4.6	7.1	5.2	3.3	3.5	3.3
Heroin	0.6	1.0	0.5	1.1	0.5	*	*	0.6	0.7
Nonmedical Use of Any Psychotherapeutics[2,3]	--	--	--	--	7.3	10.3	12.1	7.7	10.2+
Stimulants	4.0	5.0	4.4	5.2	3.4	6.7	5.6	4.2	4.5
Sedatives	3.0	5.0	2.8	3.1	3.2	5.8	4.1	2.3	3.3
Tranquilizers	3.0	3.0	3.3	3.8	4.1	4.9	4.8	2.0	2.7
Analgesics	--	--	--	--	3.2	4.2	5.8	4.1	6.5++
Alcohol[3]	--	54.0	53.6	52.6	70.3	65.2	55.5	50.2	48.2
Cigarettes[4]	--	52.0	45.5	47.3	54.1	49.5	45.2	42.3	40.2

-- Estimate not available.

*Low precision; no estimate reported.

[1]Nonmedical use of marijuana or hashish, cocaine (including crack), inhalants, hallucinogens (including PCP), heroin, or psychotherapeutics at least once.

[2]Nonmedical use of any prescription-type stimulant, sedative, tranquilizer, or analgesic; does not include over-the-counter drugs.

[3]Estimates prior to 1979 for alcohol, and 1982 for psychotherapeutics, may not be comparable to those for later years due to a change in methodology.

[4]For 1979, includes only persons who ever smoked at least five packs.

[Y]The exclusion of inhalants in 1982 is believed to have resulted in underestimates in any illicit use for that year, especially for 12- to 17-year-olds.

+Difference between 1988 and 1990 statistically significant at the .05 level.

++Difference between 1988 and 1990 statistically significant at the .01 level.

+++Difference between 1988 and 1990 statistically significant at the .001 level.

Source: NIDA, National Household Survey on Drug Abuse, 1972-1990.

Table A.6 Trends in Percentage of Persons Aged 12 to 17 Reporting Drug Use in the Past Year: 1972-1990

Drug (Unweighted N)	1972 (880)	1974 (952)	1976 (986)	1977 (1,272)	1979 (2,165)	1982 (1,581)	1985 (2,246)	1988 (3,095)	1990 (2,177)
Any Illicit Drug Use[1]	--	--	--	--	26.0	22.0[Y]	23.7	16.8	15.9
Marijuana/Hashish	--	16.5	16.4	22.3	24.1	20.6	19.7	12.6	11.3
Cocaine	1.5	2.7	2.3	2.6	4.2	4.1	4.0	2.9	2.2
Inhalants	2.9	2.4	2.9	2.2	4.6	--	5.1	3.9	4.0
Hallucinogens	3.6	4.3	2.8	3.1	4.7	3.6	2.7	2.8	2.4
Heroin	*	*	*	0.6	*	*	*	0.4	0.6
Nonmedical Use of Any Psychotherapeutics[2,3]	--	--	--	--	5.6	6.3	6.5	5.4	7.0
Stimulants	--	3.0	2.2	3.7	2.9	5.6	4.3	2.8	3.0
Sedatives	--	2.0	1.2	2.0	2.2	3.7	2.9	1.7	2.2
Tranquilizers	--	2.0	1.8	2.9	2.7	3.3	3.4	1.5	1.5
Analgesics	--	--	--	--	2.2	3.7	3.8	3.0	4.8+
Alcohol[3]	--	51.0	49.3	47.5	53.6	52.4	51.7	44.6	41.0
Cigarettes[4]	--	--	--	--	13.3	24.8	25.8	22.8	22.2

-- Estimate not available.

*Low precision; no estimate reported.

[1]Nonmedical use of marijuana or hashish, cocaine (including crack), inhalants, hallucinogens (including PCP), heroin, or psychotherapeutics at least once.

[2]Nonmedical use of any prescription-type stimulant, sedative, tranquilizer, or analgesic; does not include over-the-counter drugs.

[3]Estimates prior to 1979 for alcohol, and 1982 for psychotherapeutics, may not be comparable to those for later years due to a change in methodology.

[4]For 1979, includes only persons who ever smoked at least five packs.

[Y]The exclusion of inhalants in 1982 is believed to have resulted in underestimates in any illicit use for that year, especially for 12- to 17-year-olds.

+Difference between 1988 and 1990 statistically significant at the .05 level.

++Difference between 1988 and 1990 statistically significant at the .01 level.

+++Difference between 1988 and 1990 statistically significant at the .001 level.

Source: NIDA, National Household Survey on Drug Abuse, 1972-1990.

Table A.7 Trends in Percentage of Persons Aged 12 to 17 Reporting Drug Use in the Past Month: 1972-1990

Drug (Unweighted N)	1972 (880)	1974 (952)	1976 (986)	1977 (1,272)	1979 (2,165)	1982 (1,581)	1985 (2,246)	1988 (3,095)	1990 (2,177)
Any Illicit Drug Use[1]	--	--	--	--	17.6	12.7[Y]	14.9	9.2	8.1
Marijuana/Hashish	7.0	12.0	12.3	16.6	16.7	11.5	12.0	6.4	5.2
Cocaine	0.6	1.0	1.0	0.8	1.4	1.6	1.5	1.1	0.6
Inhalants	1.0	0.7	0.9	0.7	2.0	--	3.4	2.0	2.2
Hallucinogens	1.4	1.3	0.9	1.6	2.2	1.4	1.2	0.8	0.9
Heroin	*	*	*	*	*	*	*	*	*
Nonmedical Use of Any Psychotherapeutics[2,3]	--	--	--	--	2.3	3.8	3.0	2.4	2.7
Stimulants	--	1.0	1.2	1.3	1.2	2.6	1.6	1.2	1.0
Sedatives	--	1.0	*	0.8	1.1	1.3	1.0	0.6	0.9
Tranquilizers	--	1.0	1.1	0.7	0.6	0.9	0.6	0.2	0.5
Analgesics	--	--	--	--	0.6	0.7	1.6	0.9	1.4
Alcohol[3]	--	34.0	32.4	31.2	37.2	30.2	31.0	25.2	24.5
Cigarettes[4]	--	25.0	23.4	22.3	12.1	14.7	15.3	11.8	11.6

-- Estimate not available.

*Low precision; no estimate reported.

[1]Nonmedical use of marijuana or hashish, cocaine (including crack), inhalants, hallucinogens (including PCP), heroin, or psychotherapeutics at least once.

[2]Nonmedical use of any prescription-type stimulant, sedative, tranquilizer, or analgesic; does not include over-the-counter drugs.

[3]Estimates prior to 1979 for alcohol, and 1982 for psychotherapeutics, may not be comparable to those for later years due to a change in methodology.

[4]For 1979, includes only persons who ever smoked at least five packs.

[Y]The exclusion of inhalants in 1982 is believed to have resulted in underestimates in any illicit use for that year, especially for 12- to 17-year-olds.

+Difference between 1989 and 1990 statistically significant at the .05 level.

++Difference between 1988 and 1990 statistically significant at the .01 level.

+++Difference between 1988 and 1990 statistically significant at the .001 level.

Source: NIDA, National Household Survey on Drug Abuse, 1972-1990.

Table A.8 Trends in Percentage of Persons Aged 18 to 25 Reporting Drug Use in the Lifetime: 1972-1990

Drug (Unweighted N)	1972 (772)	1974 (849)	1976 (892)	1977 (1,500)	1979 (2,044)	1982 (1,283)	1985 (1,813)	1988 (1,505)	1990 (2,052)
Any Illicit Drug Use[1]	--	--	--	--	69.9	65.3[Y]	64.3	58.9	55.8
Marijuana/Hashish	47.9	52.7	52.9	59.9	68.2	64.1	60.3	56.4	52.2+
Cocaine	9.1	12.7	13.4	19.1	27.5	28.3	25.2	19.7	19.4
Inhalants	--	9.2	9.0	11.2	16.5	--	12.4	12.5	10.4
Hallucinogens	--	16.6	17.3	19.8	25.1	21.1	11.3	13.8	12.0
Heroin	4.6	4.5	3.9	3.6	3.5	1.2	1.2	0.3	0.6
Nonmedical Use of Any Psychotherapeutics[2,3]	--	--	--	--	29.5	28.4	28.0	17.6	15.6
Stimulants	12.0	17.0	16.6	21.2	18.2	18.0	17.1	11.3	9.0
Sedatives	10.0	15.0	11.9	18.4	17.0	18.7	11.0	5.5	4.0
Tranquilizers	7.0	10.0	9.1	13.4	15.6	15.1	12.0	7.8	5.9
Analgesics	--	--	--	--	11.8	12.1	11.3	9.4	8.1
Alcohol[3]	--	81.6	83.6	84.2	95.3	94.6	92.6	90.3	88.2
Cigarettes[4]	--	68.8	70.1	67.6	82.8	76.9	75.6	74.9	70.5+

-- Estimate not available.

*Low precision; no estimate reported.

[1]Nonmedical use of marijuana or hashish, cocaine (including crack), inhalants, hallucinogens (including PCP), heroin, or psychotherapeutics at least once.

[2]Nonmedical use of any prescription-type stimulant, sedative, tranquilizer, or analgesic; does not include over-the-counter drugs.

[3]Estimates prior to 1979 for alcohol, and 1982 for psychotherapeutics, may not be comparable to those for later years due to a change in methodology.

[4]For 1979, includes only persons who ever smoked at least five packs.

[Y]The exclusion of inhalants in 1982 is believed to have resulted in underestimates in any illicit use for that year, especially for 12- to 17-year-olds.

+Difference between 1988 and 1990 statistically significant at the .05 level.

++Difference between 1988 and 1990 statistically significant at the .01 level.

+++Difference between 1988 and 1990 statistically significant at the .001 level.

Source: NIDA, National Household Survey on Drug Abuse, 1972-1990.

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Table A.9 Trends in Percentage of Persons Aged 18 to 25 Reporting Drug Use in the Past Year: 1972-1990

Drug (Unweighted N)	1972 (772)	1974 (849)	1976 (882)	1977 (1,500)	1979 (2,044)	1982 (1,283)	1985 (1,813)	1988 (1,505)	1990 (2,052)
Any Illicit Drug Use[1]	--	--	--	--	49.4	43.4[Y]	42.6	32.0	28.7
Marijuana/Hashish	--	34.2	35.0	38.7	46.9	40.4	36.9	27.9	24.6
Cocaine	--	8.1	7.0	10.2	19.6	18.8	16.3	12.1	7.5++
Inhalants	--	1.2	1.4	1.7	3.8	--	2.1	4.1	3.0
Hallucinogens	--	6.1	6.0	6.4	9.9	6.9	4.0	5.6	3.9
Heroin	--	0.8	0.6	1.2	0.8	*	0.6	0.3	0.5
Nonmedical Use of Any Psychotherapeutics[2,3]	--	--	--	--	16.3	16.1	15.6	11.3	7.0+++
Stimulants	--	8.0	8.8	10.4	10.1	10.8	9.9	6.4	3.4++
Sedatives	--	4.2	5.7	8.2	7.3	8.7	5.0	3.3	2.0
Tranquilizers	--	4.6	6.2	7.8	7.1	5.9	6.4	4.6	2.4++
Analgesics	--	--	--	--	5.2	4.4	6.6	5.5	4.1
Alcohol[3]	--	77.1	77.9	79.8	86.6	87.1	87.2	81.7	80.2
Cigarettes[4]	--	--	--	--	46.7	47.2	44.3	44.7	39.7+

-- Estimate not available.

*Low precision; no estimate reported.

[1]Nonmedical use of marijuana or hashish, cocaine (including crack), inhalants, hallucinogens (including PCP), heroin, or psychotherapeutics at least once.

[2]Nonmedical use of any prescription-type stimulant, sedative, tranquilizer, or analgesic; does not include over-the-counter drugs.

[3]Estimates prior to 1979 for alcohol, and 1982 for psychotherapeutics, may not be comparable to those for later years due to a change in methodology.

[4]For 1979, includes only persons who ever smoked at least five packs.

[Y]The exclusion of inhalants in 1982 is believed to have resulted in underestimates in any illicit use for that year, especially for 12- to 17-year-olds.

+Difference between 1988 and 1990 statistically significant at the .05 level.

++Difference between 1988 and 1990 statistically significant at the .01 level.

+++Difference between 1988 and 1990 statistically significant at the .001 level.

Source: NIDA, National Household Survey on Drug Abuse, 1972-1990.

Table A.10 Trends in Percentage of Persons Aged 18 to 25 Reporting Drug Use in the Past Month: 1972-1990

Drug (Unweighted N)	1972 (772)	1974 (849)	1976 (882)	1977 (1,500)	1979 (2,044)	1982 (1,283)	1985 (1,813)	1988 (1,505)	1990 (2,052)
Any Illicit Drug Use[1]	--	--	--	--	37.1	30.4[Y]	25.7	17.8	14.9
Marijuana/Hashish	27.8	25.2	25.0	27.4	35.4	27.4	21.8	15.5	12.7
Cocaine	--	3.1	2.0	3.7	9.3	6.8	7.6	4.5	2.2+
Inhalants	--	*	0.5	*	1.2	--	0.8	1.7	1.2
Hallucinogens	--	2.5	1.1	2.0	4.4	1.7	1.9	1.9	0.8
Heroin	--	*	*	*	*	*	*	*	*
Nonmedical Use of Any Psychotherapeutics[2,3]	--	--	--	--	6.2	7.0	6.3	3.8	2.6
Stimulants	--	3.7	4.7	2.5	3.5	4.7	3.7	2.4	1.2
Sedatives	--	1.6	2.3	2.8	2.8	2.6	1.6	0.9	0.7
Tranquilizers	--	1.2	2.6	2.4	2.1	1.6	1.6	1.0	0.5
Analgesics	--	--	--	--	1.0	1.0	1.8	1.5	1.2
Alcohol[3]	--	69.3	69.0	70.0	75.9	70.9	71.4	65.3	63.3
Cigarettes[4]	--	49.8	49.4	47.3	42.6	39.5	36.8	35.2	31.5

-- Estimate not available.

*Low precision; no estimate reported.

[1]Nonmedical use of marijuana or hashish, cocaine (including crack), inhalants, hallucinogens (including PCP), heroin, or psychotherapeutics at least once.

[2]Nonmedical use of any prescription-type stimulant, sedative, tranquilizer, or analgesic; does not include over-the-counter drugs.

[3]Estimates prior to 1979 for alcohol, and 1982 for psychotherapeutics, may not be comparable to those for later years due to a change in methodology.

[4]For 1979, includes only persons who ever smoked at least five packs.

[Y]The exclusion of inhalants in 1982 is believed to have resulted in underestimates in any illicit use for that year, especially for 12- to 17-year-olds.

+Difference between 1988 and 1990 statistically significant at the .05 level.

++Difference between 1988 and 1990 statistically significant at the .01 level.

+++Difference between 1988 and 1990 statistically significant at the .001 level.

Source: NIDA, National Household Survey on Drug Abuse, 1972-1990.

Table A.11 Trends in Percentage of Persons Aged 26 and Older Reporting Drug Use in the Lifetime: 1972-1990

Drug (Unweighted N)	1972 (1,613)	1974 (2,221)	1976 (1,708)	1977 (1,822)	1979 (3,015)	1982 (2,760)	1985 (3,979)	1988 (4,214)	1990 (5,030)
Any Illicit Drug Use[1]	--	--	--	--	23.0	24.7[T]	31.5	33.7	35.3
Marijuana/Hashish	7.4	9.9	12.9	15.3	19.6	23.0	27.2	30.7	31.8
Cocaine	1.6	0.9	1.6	2.6	4.3	8.5	9.5	9.9	10.9
Inhalants	--	1.2	1.9	1.8	3.9	--	5.0	3.9	3.8
Hallucinogens	--	1.3	1.6	2.6	4.5	6.4	6.2	6.6	7.4
Heroin	*	0.5	0.5	0.8	1.0	1.1	1.1	1.1	0.9
Nonmedical Use of Any Psychotherapeutics[2,3]	--	--	--	--	9.2	8.8	13.8	11.3	11.5
Stimulants	3.0	3.0	5.6	4.7	5.8	6.2	7.9	6.6	6.9
Sedatives	2.0	2.0	2.4	2.8	3.5	4.8	5.2	3.3	3.7
Tranquilizers	5.0	2.0	2.7	2.6	3.1	3.6	7.2	4.5	4.2
Analgesics	--	--	--	--	2.7	3.2	5.6	4.5	5.1
Alcohol[3]	--	73.2	74.7	77.9	91.5	88.2	89.4	88.6	86.8
Cigarettes[4]	--	65.4	64.5	67.0	83.0	78.7	80.5	79.6	78.0

-- Estimate not available.

*Low precision; no estimate reported.

[1]Nonmedical use of marijuana or hashish, cocaine (including crack), inhalants, hallucinogens (including PCP), heroin, or psychotherapeutics at least once.

[2]Nonmedical use of any prescription-type stimulant, sedative, tranquilizer, or analgesic; does not include over-the-counter drugs.

[3]Estimates prior to 1979 for alcohol, and 1982 for psychotherapeutics, may not be comparable to those for later years due to a change in methodology.

[4]For 1979, includes only persons who ever smoked at least five packs.

[T]The exclusion of inhalants in 1982 is believed to have resulted in underestimates in any illicit use for that year, especially for 12- to 17-year-olds.

+Difference between 1988 and 1990 statistically significant at the .05 level.

++Difference between 1988 and 1990 statistically significant at the .01 level.

+++Difference between 1988 and 1990 statistically significant at the .001 level.

Source: NIDA, National Household Survey on Drug Abuse, 1972-1990.

Table A.12 Trends in Percentage of Persons Aged 26 and Older Reporting Drug Use in the Past Year: 1972-1990

Drug (Unweighted N)	1972 (1,613)	1974 (2,221)	1976 (1,708)	1977 (1,822)	1979 (3,015)	1982 (2,760)	1985 (3,979)	1988 (4,214)	1990 (5,030)
Any Illicit Drug Use[1]	--	--	--	--	10.0	11.8[T]	13.3	10.2	10.1
Marijuana/Hashish	--	3.8	5.4	6.4	9.0	10.6	9.5	6.9	7.3
Cocaine	--	*	0.6	0.9	2.0	3.8	4.2	2.7	2.4
Inhalants	--	*	*	*	1.0	--	0.8	0.4	0.5
Hallucinogens	--	*	*	*	0.5	0.8	1.0	0.6	0.4
Heroin	--	*	*	*	*	*	*	0.2	0.1
Nonmedical Use of Any Psychotherapeutics[2,3]	--	--	--	--	2.3	3.1	5.2	4.7	3.4+
Stimulants	--	*	0.8	0.8	1.3	1.7	2.8	1.7	1.0+
Sedatives	--	*	0.6	*	0.8	1.4	2.0	1.2	0.8
Tranquilizers	--	*	1.2	1.1	0.9	1.1	2.8	1.8	1.0++
Analgesics	--	--	--	--	0.5	1.0	2.9	2.1	1.9
Alcohol[3]	--	62.7	64.2	65.8	72.4	72.0	73.6	68.6	66.6
Cigarettes[4]	--	--	--	--	39.7	38.2	36.0	33.6	31.9

-- Estimate not available.

*Low precision; no estimate reported.

[1]Nonmedical use of marijuana or hashish, cocaine (including crack), inhalants, hallucinogens (including PCP), heroin, or psychotherapeutics at least once.

[2]Nonmedical use of any prescription-type stimulant, sedative, tranquilizer, or analgesic; does not include over-the-counter drugs.

[3]Estimates prior to 1979 for alcohol, and 1982 for psychotherapeutics, may not be comparable to those for later years due to a change in methodology.

[4]For 1979, includes only persons who ever smoked at least five packs.

[T]The exclusion of inhalants in 1982 is believed to have resulted in underestimates in any illicit use for that year, especially for 12- to 17-year-olds.

+Difference between 1988 and 1990 statistically significant at the .05 level.

++Difference between 1988 and 1990 statistically significant at the .01 level.

+++Difference between 1988 and 1990 statistically significant at the .001 level.

Source: NIDA, National Household Survey on Drug Abuse, 1972-1990.

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Table A.13 Trends in Percentage of Persons Aged 26 and Older Reporting Drug Use in the Past Month: 1972-1990

Drug (Unweighted N)	1972 (1,613)	1974 (2,221)	1976 (1,709)	1977 (1,822)	1979 (3,015)	1982 (2,760)	1985 (3,979)	1988 (4,214)	1990 (5,030)
Any Illicit Drug Use[1]	--	--	--	--	6.5	7.5[T]	8.5	4.9	4.6
Marijuana/Hashish	2.5	2.0	3.5	3.3	6.0	6.6	6.1	3.9	3.6
Cocaine	--	*	*	*	0.9	1.2	2.0	0.9	0.6+
Inhalants	--	*	*	*	0.5	--	0.5	0.2	*
Hallucinogens	--	*	*	*	*	*	*	*	0.1
Heroin	--	*	*	*	*	*	*	*	*
Nonmedical Use of Any Psychotherapeutics[2,3]	--	--	--	--	1.1	1.2	2.5	1.2	1.0
Stimulants	--	*	*	0.6	0.5	0.6	0.7	0.5	0.3
Sedatives	--	*	0.5	*	*	*	0.6	0.3	0.1
Tranquilizers	--	*	*	*	*	*	1.0	0.6	0.2+
Analgesics	--	--	--	--	*	*	0.9	0.4	0.6
Alcohol[3]	--	54.5	56.0	54.9	61.3	59.8	60.6	54.8	52.3
Cigarettes[4]	--	39.1	38.4	38.7	36.9	34.6	32.8	29.8	27.7

-- Estimate not available.

*Low precision; no estimate reported.

[1]Nonmedical use of marijuana or hashish, cocaine (including crack), inhalants, hallucinogens (including PCP), heroin, or psychotherapeutics at least once.

[2]Nonmedical use of any prescription-type stimulant, sedative, tranquilizer, or analgesic; does not include over-the-counter drugs.

[3]Estimates prior to 1979 for alcohol, and 1982 for psychotherapeutics, may not be comparable to those for later years due to a change in methodology.

[4]For 1979, includes only persons who ever smoked at least five packs.

[T]The exclusion of inhalants in 1982 is believed to have resulted in underestimates in any illicit use for that year, especially for 12- to 17-year-olds.

+Difference between 1988 and 1990 statistically significant at the .05 level.

++Difference between 1988 and 1990 statistically significant at the .01 level.

+++Difference between 1988 and 1990 statistically significant at the .001 level.

Source: NIDA, National Household Survey on Drug Abuse, 1972-1990.

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Table A.14 Trends in Percentage of Persons Aged 26 to 34 and Persons Aged 35 and Older Reporting Drug Use in the Lifetime: 1988 and 1990

Drug (Unweighted N)	Age Group (Years)/Survey Year					
	26-34 Years		≥35 Years		Total ≥26 Years	
	1988 (1,987)	1990 (2,355)	1988 (2,227)	1990 (2,675)	1988 (4,214)	1990 (5,030)
Any Illicit Drug Use[1]	64.2	62.6	23.0	25.9	33.7	35.3
Marijuana/ Hashish	62.1	60.6	19.6	21.9	30.7	31.8
Cocaine	26.5	25.6	4.0	5.9+	9.9	10.9
Hallucinogens	17.7	15.7	2.7	4.5++	6.6	7.4
Heroin	2.1	1.4	0.8	0.7	1.1	0.9
Nonmedical Use of Any Psychotherapeutics[2]	22.1	19.6	7.5	8.7	11.3	11.5
Stimulants	15.4	13.4	3.6	4.6	6.6	6.9
Sedatives	7.9	7.0	1.7	2.6+	3.3	3.7
Tranquilizers	9.3	8.2	2.9	2.9	4.5	4.2
Analgesics	9.7	8.1	2.6	4.1+	4.5	5.1
Alcohol	93.3	92.0	87.0	85.0	88.6	86.8
Cigarettes	80.8	79.8	79.2	77.4	79.6	78.0

[1]Nonmedical use of marijuana or hashish, cocaine (including crack), inhalants, hallucinogens (including PCP), heroin, or psychotherapeutics at least once.

[2]Nonmedical use of any prescription-type stimulant, sedative, tranquilizer, or analgesic; does not include over-the-counter drugs.

+Difference between 1988 and 1990 statistically significant at the .05 level.

++Difference between 1988 and 1990 statistically significant at the .01 level.

+++Difference between 1988 and 1990 statistically significant at the .001 level.

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

Table A.15 Trends in Percentage of Persons Aged 26 to 34 and Persons Aged 35 and Older Reporting Drug Use in the Past Year: 1988 and 1990

Drug (Unweighted N)	Age Group (Years)/Survey Year					
	26-34 Years		≥35 Years		Total ≥26 Years	
	1988 (1,987)	1990 (2,355)	1988 (2,227)	1990 (2,675)	1988 (4,214)	1990 (5,030)
Any Illicit Drug Use[1]	22.6	21.9	5.8	6.0	10.2	10.1
Marijuana/Hashish	17.6	18.0	3.2	3.6	6.9	7.3
Cocaine	8.0	6.8	0.9	0.9	2.7	2.4
Hallucinogens	1.7	1.0	*	0.2	0.6	0.4
Heroin	0.5	0.2	*	*	0.2	0.1
Nonmedical Use of Any Psychotherapeutics[2]	9.8	5.7+++	2.9	2.6	4.7	3.4+
Stimulants	4.9	2.7++	0.5	0.4	1.7	1.0+
Sedatives	2.0	1.0+	0.9	0.7	1.2	0.8
Tranquilizers	3.7	2.1+	1.2	0.7	1.8	1.0++
Analgesics	4.1	2.8	1.4	1.6	2.1	1.9
Alcohol	80.5	78.8	64.4	62.5	68.6	66.6
Cigarettes	42.8	43.5	30.4	27.9	33.6	31.9

*Low precision; no estimate reported.

[1]Nonmedical use of marijuana or hashish, cocaine (including crack), inhalants, hallucinogens (including PCP), heroin, or psychotherapeutics at least once.

[2]Nonmedical use of any prescription-type stimulant, sedative, tranquilizer, or analgesic; does not include over-the-counter drugs.

+Difference between 1988 and 1990 statistically significant at the .05 level.

++Difference between 1988 and 1990 statistically significant at the .01 level.

+++Difference between 1988 and 1990 statistically significant at the .001 level.

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

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Table A.16 Trends in Percentage of Persons Aged 26 to 34 and Persons Aged 35 and Older Reporting Drug Use in the Past Month: 1988 and 1990

Drug (Unweighted N)	Age Group (Years)/Survey Year					
	26-34 Years		≥35 Years		Total ≥26 Years	
	1988 (1,987)	1990 (2,355)	1988 (2,227)	1990 (2,675)	1988 (4,214)	1990 (5,030)
Any Illicit Drug Use[1]	13.0	9.8+	2.1	2.8	4.9	4.6
Marijuana/Hashish	10.8	8.6	1.4	1.9	3.9	3.6
Cocaine	2.6	1.7	0.3	0.2	0.9	0.6+
Hallucinogens	*	*	*	*	*	0.1
Heroin	*	*	*	*	*	*
Nonmedical Use of Any Psychotherapeutics[2]	2.7	1.6+	0.7	0.8	1.2	1.0
Stimulants	0.9	0.7	0.4	*	0.5	0.3
Sedatives	0.6	*	*	*	0.3	0.1
Tranquilizers	1.2	0.5+	*	*	0.6	0.2+
Analgesics	0.9	0.7	*	0.6	0.4	0.6
Alcohol	64.2	63.3	51.5	48.6	54.8	52.3
Cigarettes	37.1	37.5	27.3	24.3	29.8	27.7

*Low precision; no estimate reported.

[1]Nonmedical use of marijuana or hashish, cocaine (including crack), inhalants, hallucinogens (including PCP), heroin, or psychotherapeutics at least once.

[2]Nonmedical use of any prescription-type stimulant, sedative, tranquilizer, or analgesic; does not include over-the-counter drugs.

+Difference between 1988 and 1990 statistically significant at the .05 level.

++Difference between 1988 and 1990 statistically significant at the .01 level.

+++Difference between 1988 and 1990 statistically significant at the .001 level.

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

Table A.17 Percentage Reporting Marijuana Use in the Past Month, by Age Group and Demographic Characteristics: 1990

Demographic Characteristic	Age Group (Years)				
	12-17	18-25	26-34	≥35	Total
Total	5.2	12.7	8.6	1.9	5.1
Sex					
Male	6.0	16.5	9.7	2.5	6.4
Female	4.3	9.1	7.5	1.4	3.9
Race/Ethnicity[1]					
White	5.9	13.6	8.3	1.8	5.0
Black	3.4	12.6	13.5	2.7	6.7
Hispanic	4.3	8.2	7.2	1.9	4.7
Population Density					
Large Metropolitan	4.2	14.5	9.1	2.1	5.6
Small Metropolitan	6.2	13.1	8.8	1.9	5.1
Nonmetropolitan	5.4	8.4	7.3	*	4.0
Region					
Northeast	5.9	15.4	10.2	1.9	5.5
North Central	5.3	12.4	9.7	2.2	5.7
South	5.1	10.2	8.0	0.9	4.0
West	4.4	15.0	7.0	3.2	5.7

*Low precision; no estimate reported.

[1]The category "Other" for Race/Ethnicity is not included.

Source: NIDA, National Household Survey on Drug Abuse, 1990.

Drugs are going down
Rate of decrease has slowed in the past few years.

From about Dec. 88 to about June 90.

estimated 11%

→ Dinah Dinwiddie
Policy Analyst, ONDCP

called
Tues. 11am

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1ST STORY of Level 1 printed in FULL format.

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May 17, 1991, Friday, NORTH SPORTS FINAL EDITION

SECTION: PERSPECTIVE; Pg. 26; ZONE: C; Voice of the people (letter)

LENGTH: 561 words

HEADLINE: Denying the facts in war on drugs

BYLINE: Herbert D. Kleber, deputy director for Demand Reduction Office of National Drug Control Policy

DATELINE: WASHINGTON

BODY:

A wide range of scientific surveys and reports released over the past year indicate that the drug problem - once widely believed to be intractable - is no longer spinning out of control. Casual drug use has been dropping since 1985, and even heavy drug use began to turn down in 1989. In virtually every age, income and ethnic group, illegal drug use is down.

Good news to celebrate? Not a chance.

Disbelief and claims of "evidence" to the contrary abound. For example, the mayor of New York City called the president's announcement of further declines in drug use "nonsense," despite the fact that cocaine emergencies there have declined over 30 percent. Some members of Congress have cited anecdotes and statistically-dubious estimates to counter the evidence from scientific surveys.

This reluctance to acknowledge the facts can be ascribed to a number of motives. The first, as always, is politics. President Bush devoted his first nationally televised presidential speech to the National Drug Control Strategy. He has since sent annual budgets up to Congress that call for large increases in anti-drug funding. And now, statistics show things actually getting better - too much for some Democratic politicians to bear. The solution? Deny the facts.

But not all the motives are ulterior ones. In especially hard-hit pockets of the country, the problem just doesn't seem to be getting any better. In others, the situation has moved only from critical to serious. While the drop in both heavy and casual use has been substantial, the number of Americans using drugs remains intolerably high.

Further, there is an inevitable lag between declines in drug use and declines in casualties, such as addicts and drug-impaired newborns. Such a lag can be as long as three to four years, and explains why although casual use began to drop around 1985, heavy use did not decline until late 1989. Because of the large number of users that entered the drug pipeline in the '80s, we will be mopping up after this epidemic for some time.

We also are beginning to witness an increasing disconnect between drug use and violence, a separation that will probably widen over the coming decade as declines in drug use continue. Drug-related violence may indeed increase in

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the short-term from fierce competition among dealers for fewer users.

We are far from being out of the woods. Because government and community efforts are essential to achieving further significant declines, the president is seeking still increased funding for next year, and a stronger national commitment.

Ironically, political and popular support for this necessary funding and commitment may wane if objective measures of progress continue to be so cavalierly dismissed. Too often, bad news is devoured by the press without question, while good news is immediately held suspect or relegated to obscure and brief stories. Our scientific surveys and reports - the source of front-page bad news not long ago - have been using the same methods consistently for 10 or 15 years. Now that they primarily report good news, however, they are automatically subjected to skepticism and ridicule.

The American people have worked hard to bring solutions to bear on the drug problem, and they are not being given the opportunity to find encouragement in the news that their efforts are beginning to pay off.

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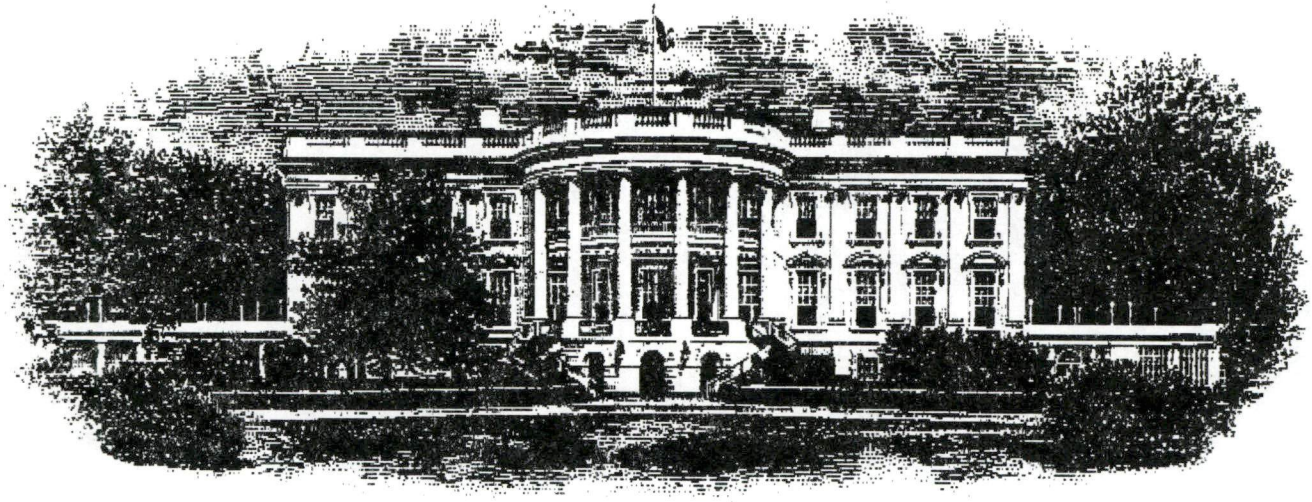
Washington, D.C. 20500



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COMMENTS Per our conversation

FROM: Joe McHugh

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401-9215

IMPACT OF CONGRESSIONAL APPROPRIATIONS ACTION ON THE FY 1992 DRUG BUDGET

Key: Last acted on by...
Su – Subcommittee
C – Committee
S – Full Senate

Budget Authority ($ Millions)	President's Budget	House Passed	Senate Mark	Status	Congress vs President: House Percent	House Dollars	Senate Dollars	Senate Percent
Department of Justice								
Drug Enforcement Administration	748.0	706.3	740.7		-5.6%	(41.7)	(7.3)	-1.0%
8/ Federal Bureau of Investigation	224.5	215.0	222.0		-4.2%	(9.5)	(2.5)	-1.1%
Org. Crime Drug Enforcement Task Force	402.0	363.4	380.3		-9.6%	(38.6)	(21.8)	-5.4%
8/ Criminal Division	18.0	16.8	17.5		-6.8%	(1.2)	(0.5)	-2.9%
8/ Tax Division	1.4	1.3	1.2		-10.0%	(0.1)	(0.2)	-16.9%
U.S. Attorneys	200.8	185.7	185.6		-7.5%	(15.1)	(15.1)	-7.5%
U.S. Marshals	233.4	210.2	209.9		-9.9%	(23.2)	(23.5)	-10.1%
1,8/ Prisons	1,350.3	1,291.6	1,301.9		-4.3%	(58.7)	(48.4)	-3.6%
Support of Prisoners	159.7	152.7	156.9		-4.4%	(7.0)	(2.8)	-1.8%
14/ Immigration and Naturalization Service	161.4	151.6	155.2		-6.1%	(9.8)	(6.2)	-3.8%
OJP: Formula Grants to States	405.3	398.0	395.1		-1.8%	(7.3)	(10.2)	-2.5%
8/ OJP: Other	116.7	141.1	145.6		21.0%	24.4	29.2	25.0%
Forfeiture Fund	382.5	382.5	382.5		0.0%	0.0	0.0	0.0%
Interpol	1.9	1.9	0.9		0.0%	0.0	(1.0)	-52.6%
Total, Justice	4,405.8	4,218.1	4,295.6	S	-4.3%	(187.7)	(110.2)	-2.5%
Department of the Treasury								
2/ Customs Service	683.7	647.3	719.4		-2.5%	(16.4)	55.7	8.4%
FinCEN	18.1	18.1	18.1		0.0%	0.0	0.0	0.0%
10/ Internal Revenue Service	86.7	86.0	114.7		-0.8%	(0.7)	28.0	32.3%
3,8/ Alcohol, Tobacco, and Firearms	129.2	139.8	134.0		8.1%	10.4	4.8	3.7%
11/ U.S. Secret Service	38.6	38.6	43.6		0.0%	0.0	5.0	12.9%
Federal Law Enforcement Training Center	15.2	15.2	19.3		0.0%	0.0	4.1	27.3%
Total, Treasury	951.5	944.7	1,049.1	S	-0.7%	(6.7)	97.6	10.3%
Department of Transportation								
Coast Guard	704.1	661.9			-6.0%	(42.2)		
Federal Aviation Administration	36.0	36.0			-0.1%	(0.0)		
National Highway Traffic Safety Admin.	7.8	7.7			-0.8%	(0.1)		
Total, Transportation	747.9	705.6			-5.7%	(42.3)		
Department of State								
Bureau of International Narcotics Matters	171.5	150.0			-12.5%	(21.5)		
9/ Emer. in the Dip. and Consular Service	0.5	0.3			-40.0%	(0.2)		
Agency for International Development	294.1	294.0			-0.0%	(0.1)		
U.S. Information Agency	4.5	4.0	4.5		-11.1%	(0.5)	0.0	0.0%
4/ Military Assistance	141.1	122.0			-13.5%	(19.1)		
Total, Department of State	611.7	570.3	4.5		-6.8%	(41.4)	0.0	0.0
Department of Agriculture								
Agricultural Research Service	6.5	6.5	6.5		0.0%	0.0	0.0	0.0%
8/ U.S. Forest Service	8.5	9.7	9.3		13.5%	1.2	0.8	8.8%
Total, Agriculture	15.0	16.2	15.8	S	7.7%	1.2	0.8	5.0%
Department of the Interior								
8/ Bureau of Land Management	11.9	9.2	9.4		-22.9%	(2.7)	(2.5)	-21.2%
National Park Service	12.9	11.1	11.0		-14.3%	(1.8)	(1.9)	-15.0%
Bureau of Indian Affairs	20.3	24.5	20.3		20.9%	4.2	0.0	0.2%
Fish & Wildlife Service	1.0	1.0	1.0		-0.1%	(0.0)	(0.0)	-0.1%
Office of Territorial and International Affairs	1.7	1.4	1.4		-17.6%	(0.3)	(0.3)	-17.8%
Total, Interior	47.9	47.2	43.1	C	-1.3%	(0.6)	(4.7)	-9.9%
Department of Health and Human Services								
ADAMHA								
NIDA	457.9	443.6	433.2		-3.1%	(14.3)	(24.7)	-5.4%
13/ OSAP	281.6	268.5	294.5		-4.6%	(13.1)	13.0	4.6%
ADAMHA Block Grants	512.3	496.9	565.1		-3.0%	(15.4)	52.7	10.3%
12/ Capacity Expansion Program	99.0	31.0	0.0		-68.7%	(68.0)	(99.0)	-100.0%
Other ADAMHA	127.0	122.4	93.6		-3.6%	(4.6)	(33.4)	-26.3%
Subtotal, ADAMHA	1,477.8	1,362.4	1,386.4		-7.8%	(115.4)	(91.4)	-6.2%
5,8/ Health Care Financing Administration	201.5	201.5	201.5		0.0%	0.0	0.0	0.0%
5/ Centers for Disease Control	29.3	29.3	29.3		0.0%	0.0	(0.0)	-0.1%
5/ Indian Health Service	44.3	44.3	44.3		0.0%	0.0	(0.0)	-0.1%
5/ Food and Drug Administration	7.6	7.6	7.6		0.0%	0.0	0.0	0.0%
5,6,8/ Admin. for Children & Families	75.5	67.8	75.5		-10.2%	(7.7)	0.0	0.1%
Total, Health and Human Services	1,836.0	1,713.0	1,744.6	C	-6.7%	(123.1)	(182.8)	-10.0%

IMPACT OF CONGRESSIONAL APPROPRIATIONS ACTION ON THE FY 1992 DRUG BUDGET

Key: Last acted on by...
Su – Subcommittee
C – Committee
S – Full Senate

Budget Authority ($ Millions)	President's Budget	House Passed	Senate Mark	Status	Congress vs. President: House Percent	House Dollars	Senate Dollars	Senate Percent
Department of Defense								
Interdiction and Other Activities	1,158.6	1,156.0			-0.2%	(2.6)		
Int'l (505(a) & Excess Defense Articles)	0.0	0.0			0.0%	0.0		
Total, Defense	1,158.6	1,156.0			-0.2%	(2.6)		
Department of Housing and Urban Development								
Total, H.U.D.	165.0	165.0	165.0	S	0.0%	0.0	0.0	0.0%
Department of Education								
DFSC State Grants	497.7	497.7	517.7		-0.0%	(0.0)	20.0	4.0%
Emergency Grants	49.5	25.0	30.3		-49.5%	(24.5)	(19.2)	-38.8%
8/ Other, Education	170.0	174.7	178.4		2.8%	4.7	8.4	4.9%
Total, Education	717.2	697.4	726.4	C	-2.8%	(19.8)	9.2	1.3%
Department of Labor								
5,8/ Total, Labor	79.2	85.0	80.2	C	7.3%	5.8	1.0	1.3%
Department of Veterans Affairs								
8/ Total, Veterans Affairs	546.0	546.0	546.0	S	0.0%	0.0	0.0	0.0%
ACTION								
Total, ACTION	11.1	10.0	10.9	C	-9.9%	(1.1)	(0.2)	-1.9%
U.S. Courts								
Total, U.S. Courts	424.4	411.0	410.2	S	-3.2%	(13.4)	(14.2)	-3.3%
Office of National Drug Control Policy								
Operations	20.2	20.1	29.1		-0.5%	(0.1)	8.9	44.2%
HIDTA	50.0	50.0	85.0		0.0%	0.0	35.0	70.0%
7/ Special Forfeiture Fund	0.0	0.0	0.0		0.0%	0.0	0.0	0.0%
Total, ONDCP	70.2	70.1	114.1	S	-0.1%	(0.1)	43.9	62.6%
8/ TOTAL FUNDING LEVELS	11,787.3	11,355.8	N/A		-3.7%	(431.5)		
SUMMARY, ALL ACTION TO DATE			9,205.6				(152.9)	-1.7%

1/ The House transferred $10 million from the Special Forfeiture Fund (of which $6.9 million is scored as drug-related) whereas the President's budget requested a $46 million transfer fom the Special Forfeiture Fund (of which $31.7 million was scored as drug-related).
2/ The House cut $53 million in appropriations from the President's proposed budget for the U.S. Customs Service, but partially restored these cuts with a $21 million transfer from the Special Forfeiture Fund.
3/ BATF received the full amount requested in the President's budget plus $15 million from the ONDCP Special Forfeiture Fund in House appropriations. Of the $15 million transferred, $11.3 million was scored as drug-related.
4/ Based on a House authorization ceiling of $116 million for FMF and full funding of IMET.
5/ Reflects ONDCP estimate of funding levels.
6/ The Administration for Families and Children is a new program which replaces the Human Development Services and the Family Support Administration.
7/ Funds appropriated to the Special Forfeiture Fund appear in the receiving agencies' balances. The following amounts were appropriated to the Special Forfeiture Fund: $77 M in the President's budget; 677 million in the House; and $67 million in the Senate.
8/ Reflects a revised estimate for the President's budget.
9/ This figure reflects ONDCP's estimation of narcotics awards based on the overall reduction in the Emergencies account.
10/ IRS received the full amount requested in the President's budget plus $28 million from the ONDCP Special Forfeiture Fund in Senate appropriations. The entire transfer of $28 million was scored as drug-related.
11/ U.S. Secret Service received the full amount requested in the President's budget plus $5 million from the ONDCP Special Forfeiture Fund in Senate appropriations. The entire transfer of $5 million was scored as drug-related.
12/ ADAMHA's Capacity Expansion Program received $31 million in transfers from the ONDCP Special Forfeiture Fund in House appropriations. The entire transfer of $31 million was scored as drug-related.
13/ OSAP received a $10 million transfer from ONDCP's Special Forfeiture Fund in the Senate. The entire transfer was scored as drug-related.
14/ A $7.3 million cut by House appropriations in INS funding was partially offset by a $10 million transfer from ONDCP's Special Forfeiture Fund. $1.5 million of the $10 million transfer was scored as drug-related.

- President Bush has made it clear that the number one goal of our anti-drug efforts is to reduce the number of people using drugs and prevent others from trying drugs for the first time.

- The President has made fighting drugs a top domestic priority. No other domestic initiative has received as high a priority as the Federal drug budget. Since the President entered office in 1989, total spending for all anti-drug efforts rose from approximately $6 billion to nearly $11.7 billion if Congress enacts the President's budget. In the important areas of treatment and prevention, drug spending rose from $1.6 billion to $3.2 billion.

- The government has also gotten smarter about what works in treatment and prevention. This has helped us to target the money not only into areas where there are high addiction rates but in pairing up addicts with programs that effectively address their particular problems.

- Drug prevention policy has focused on programs which develop partnerships between communities, businesses, churches, schools and Federal, State and local governments. This focus on partnerships ensures that anti-drug messages are heard in the classroom, the workplace, neighborhoods, television, radio, newspapers, doctors' offices, athletic events, clubs, and many other places. The anti-drug message is reinforced every day across our nation under President Bush's National Drug Control Strategy.

- As we mark the second anniversary of the first National Drug Control Strategy, it is clear that as a nation we have made remarkable progress. The same surveys that once showed the drug problem spinning out of control now show the problem getting better. The American people deserve a lot of credit for their individual and collective efforts. The significant declines in drug use and increasing intolerance to drug use among Americans of all ages is helping to create a safer, more productive America.

- The indicators are showing remarkable progress in meeting the goal that President Bush committed to in his inaugural address. How remarkable? From 1985 to 1990, the number of Americans using illicit drug drugs decreased 44% -- from 23 million to 12.9 million. Some of these people quit drugs on their own and others found help in one of the 300,000 new treatment slots created in the last two years. President Bush has properly noted that the progress in reducing drug use is the result of these partnerships.

- Americans need and deserve to hear that their individual, neighborhood, and community efforts are working. This good news will reinvigorate our national commitment to see this

problem through to an end. But we must caution them also that much more needs to be done. We cannot walk away from this effort now that we have come so close to realizing our goals. In fact, as we bite deeper into the addict population, progress will most likely become more difficult.

TALKING POINTS
LAW ENFORCEMENT AS DRUG PREVENTION

o Under President Bush's leadership, law enforcement in general, and drug-related enforcement in particular, has been a top domestic priority. The President has demonstrated an unwavering commitment to fight drugs and crime.

o As a Nation, we have devoted more law enforcement effort to fighting drugs than any other single area of crime.

o Since he took office in 1989, President Bush has overseen a 58% increase in our anti-drug law enforcement budget. For the coming year, the President has requested over $8 billion for these programs.

o Recognizing the primary role of state and local drug control efforts, the President's FY 1992 budget requests over $2.9 billion for state and local drug control funding, an increase of more than $100 million over the 1991 level. As one of the three federal block grants to the states (treatment, education, and law enforcement), state and local law enforcement funding has increased by over 250% since 1989 and will total over $400 million in FY 1992 if Congress adopts the President's current budget request. State and local governments already receive over 1 out of every 4 dollars in the Federal drug control budget.

o And what are the results of this unprecedented focus on law enforcement and resources? Law enforcement is working as a vital component in the President's National Drug Control Strategy. More criminals are being arrested and punished for drug related crime. And drug crime and drug use in the nation are beginning to decline.

o In order for criminal justice efforts to be truly effective, it is critical that, once arrested, criminals face swift and certain prosecution and - if convicted - punishment. Sanctions such as mandatory minimum sentences and strong user accountability measures, serve to disrupt drug trafficking and abuse in two ways: by preventing offenders from committing future crimes and by deterring others from involvement in the drug trade.

o Despite numerous attempts in recent years, the Congress has failed to make a sincere effort toward securing a more effective and efficient criminal justice system. The President calls on the Congress once again to enact his crime bill, which transforms the present "criminal rights" system into a fair and equitable criminal justice system for victims and law-abiding citizens as well as offenders.

o While violent crime has remained relatively steady since 1975, the FBI Uniform Crime Report shows that total drug arrests by state and local officials were down by 20% from 1989 to 1990. Additionally, reported drug-related arrests for people under 18 were down by 22% from 1989 to 1990.

o Despite these significant improvements, the job is far from done. These recent statistics show that crime, unrelated to drugs, rose 2% from 1989 to 1990 and that violent crime increased by 11% during the same period. We must sustain that pressure that has carried us this far -- we must continually strive to reduce the demand for drugs, as well as the supply.

o Law enforcement is in a position of strength. In addition to the deterrent value, sanctions create incentives for persons in need to seek treatment. In fact, law enforcement is responsible for placing nearly 30% of all addicts into treatment. A strong police presence also provides safe schools in which students can learn safely and more effectively. And, working with the community, law enforcement encourages all to become participants in what is essentially a grass-roots effort.

o As critics are quick to note, law enforcement and interdiction consume expensive time and resources. However, in order to maintain a position of strength and assist in treatment, education, and community initiatives, law enforcement must have the resources to make good on its obligation to society. Moreover, the cost of deterrence and punishment is far outweighed by the cost in terms of dollars and lives wrought by drugs and drug related crime.

o We are on the road to victory against drugs. With the resolve of this President and the American people, this scourge will surely end.

(Hinchliffe/Blymire)
September 4, 1991 11 a.m.
DRUGS Draft One

PRESIDENTIAL REMARKS: DRUG TREATMENT CENTER VISIT
Philadelphia, Pennsylvania
September 12, 1991

In September 1989 we introduced this nation's first National Drug Control Strategy. An ambitious document that reflected America's anguish in trying to cope with this 20th century plague, the strategy spoke of despair -- but it also spoke of hope. It enunciated clear goals and, most importantly, it called upon the collective spirit of determination that is the greatest strength of this -- the greatest nation on earth.

We look back now on two years of intense work. We still stand weary in the midst of a battlefield, but we can survey with pride the distance we have come -- and the victories we have begun. **It is clear that we, as a nation, have made remarkable progress in the war against drugs**. The American people deserve a lot of credit for their efforts -- individually and together. They have brought about significant declines in drug use -- and increasing intolerance of every kind of drug. **We are well on our way to making this a safer, more productive America**.

We wage this war on many fronts -- beginning with immediate, vital attacks against drug flow through interdiction efforts and tough changes in the criminal justice system. But we still have much to do. You need look no further than the doors of this center to see the mounting casualties and hostages of this struggle. We must never waver in our determination to develop and provide effective treatment for those trapped in the hell of addiction.

But there's really nothing I can tell you about treating the victims of drugs. You're the ones who can tell **me**. You're the ones who, day in and day out, live this war for human life and dignity. You're the ones who win the fights -- one soul at a time. Yours are the hands that give sustenance -- the words that give strength -- the presence that gives hope. You're our front-line army of rebirth, doing daily battle against an enemy more evil than any this nation has faced on a battlefield.

I am here today to thank you, to pay tribute to you, and to tell you that your government and your country will never forget what you are doing. **The primary goal of our anti-drug efforts is to reduce the number of people using drugs**. The consequences of compulsive drug use erode the safety, the morality, and the entire fabric of our nation. Think of the enormous costs associated with the desperate hard-core drug users -- the violent crime; the broken families; the accidents, disease and death; the energy siphoned from our economy, and the terrible inheritance of the 300,000 drug-addicted babies born each year.

Drug treatment **is** the linchpin in our drug control strategy -- because it loosens the vise-like grip that drugs hold on individuals, on their families, on their neighborhoods, and on our entire society. You show us that drug treatment can work. Your statistics prove that patients who receive treatment reduce drug use by more than 70% -- that they're 3 times more likely to be employed -- and only 1/4 as likely to commit crimes.

That's the message of hope your center tells. I know it's

tough work -- demanding rigorous responsibility and sacrifices from you and from your patients. But it's important work. You literally affect our country's future. You combine the best in treatment with innovative research -- as a matter of fact, I came here today because you have created precisely the kind of treatment center we talk about in our Drug Control Strategy.

You were trailblazers. Until barely 25 years ago, only two places in this country were publicly funded for drug treatment and research -- and they were prison hospitals. Into that climate lacking in scientific studies and societal concern, came the VA/Penn Addiction Research Center. From the beginning you have led in developing new information about the nature and treatment of addiction -- and millions of patients across this country have benefitted as a result. More will continue to benefit, since for the last three years we've been able to give you additional research funds provided by our budget for the war against drugs.

Those funds are only a part of this Administration's absolutely unwavering commitment to a full-scale battle. We will fund new treatment programs and upgrade existing ones. The good news is that more substance abusers are in treatment now than ever before. But fierce challenges still remain.

When we issued our Drug Control Strategy, our number one drug treatment priority was to increase federal funds -- in order to expand the number of treatment slots and the range of treatment methods available. I'm proud that, based on the proposed FY'92 budget I've sent to Congress, in the three years

of this Adminsitration, federal funding for drug treatment has increased by $855 million dollars -- that's 85%. This means the number of persons treated has risen from 1.5 to 2.25 million. If state, local and other sources had continued to increase their support at the same rate as the federal government has, nearly 3/4 million more patients could have received treatment.

In those same three years, our total annual spending against drugs has nearly doubled -- from $6 to $11.7 billion. The federal drug budget is our #1 domestic initiative. This year, despite pressure to hold the line, we have increased drug-related expenditures 11% -- one of the largest increases in the entire federal government. This will add $171m billion to treatment plans alone. If states kick in their share, this means that up to 200,000 more addicts will have a chance to reclaim their lives this year.

But we have a problem. It's called Congress. To begin with, it's missed the urgent need for accountability in drug treatment programs -- time after time it hasn't approved legislation that would demand state accountability for drug treatment programs **before federal money could be released**.

The biggest problem with Congress, however, is the budget. For instance, in FY'90 Congress axed $1/4 billion from my request for anti-drug funds. Then look at what it did for FY'91. We wanted $100m for an ADMS block grant for drug treatment programs. Well, not only did Congress approve only $76m -- but that was for **all** programs combined including drugs, alcohol and mental health. That meant only $20m -- 1/5 of our request -- could go to drug

treatment. 200,000 fewer addicts could be treated that year.

But even budget problems aside, we still have a long way to go as a country. **America must realize that success at staying off drugs depends on the environment from which the addict came and to which he will return**. That's why effective local law enforcement, strong families, caring neighborhoods, good schools and active churches are critical. Treatment cannot succeed in a vacuum. It certainly cannot succeed in a weak society.

Of course we need more and better treatment programs. But as a nation, we have to go even deeper and attack the root causes of drug use. That's the most important battle of all.

People think the problem in our world is crack, or suicide, or babies having babies. But those are the symptoms. **The disease is moral emptiness. That's what we must annihilate**.

We cannot continue producing generations born numbly into despair, finding meaning in a needle or a vial. We must act now against this plague which is a winter in our souls.

If, as President, I had the power to give just one thing to this country -- it would be the return of an inner moral compass, nurtured by the family and valued by society. This compass would guide all people to value life -- every life -- knowing that each life lost to drugs or despair devalues us all.

We need to ask ourselves why modern society -- which has the tools to be the most enlightened society of human history -- has instead become one devoted to personal gratification. Why do we give our children everything -- everything except conscience.

God bless you in the work you do here as guardians of the Phoenix -- that mythological bird that rose to glory from the dust of its own ashes. You offer us inspiration, hope, and a glimpse of how to restore the American dream. Thank you.

# # # # #

To Carol

Date 9/8 Time 11:43

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M Janice Crouse

of Dr Sullivan's

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Area Code Number Extension

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WANTS TO SEE YOU		URGENT	
RETURNED YOUR CALL			

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Understanding Drug Treatment

An Office of National Drug Control Policy White Paper

June 1990

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June 1990

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Understanding Drug Treatment

Introduction

Drug use is the heart of our Nation's drug problem: drugs are all too plentiful in America, and the number of people using them is all too high. For many, drug use has become a compulsive habit — an addiction. They will not respond to education and prevention efforts. Their lives are centered around acquiring illegal drugs, using them, and then seeking more.

Getting these people off drugs is among the most pressing tasks confronting national policy. People dependent on drugs consume a disproportionate amount of the illegal drugs in this country. They are not only a danger to themselves but also to virtually everyone with whom they come in contact. They lie to friends. They deceive those who try to help them. They steal — even from family members and neighbors — to support their habit.

Indeed, the life of drug addiction is often intimately connected with other criminal behavior. And like the career criminal, the drug addict — even when not involved in predatory crime — risks his own life and has little regard for the lives and property of others. That is why our response to the problem of heavy drug use has been not only through the health care system, but also through the criminal justice system. Although much public debate has framed these two responses as diametrically opposed, they are not. The common tendency to think of drug treatment as a soft, nurturing, and easy route away from drugs could not be further from the truth. To the drug addict, genuine drug treatment that works can be demanding, difficult, and physically and emotionally exhausting. The ethos of personal accountability and adherence to rules that pervades the criminal justice system is fre-

quently a part of effective drug treatment. Good treatment programs insist on a code of conduct, individual responsibility, personal sacrifice, and sanctions for misbehavior. There is now an impressive amount of evidence to suggest that when drug treatment contains these elements, we get results: addicts change their self-destructive pattern of behavior and stop or dramatically reduce drug use. That's why drug treatment and criminal justice must be understood as allies in our fight against drug use.

The United States has had long experience with the criminal justice system, and most Americans are familiar with its basic elements. Our experience with drug treatment, however, has been relatively brief. In the mid-1930s, two Public Health Service Hospitals, one in Lexington, Kentucky, one in Fort Worth, Texas, were opened to treat drug addicts and to conduct research on the problem of addiction. Until the mid-1960s, these prison-hospitals were practically the only publicly funded facilities devoted to drug treatment and drug-related research. Today treatment, research, or both go on at over 5000 institutions, and some form of drug treatment is available in virtually every locality. Despite this rapid growth and a substantial increase in research, the level of public knowledge about drug treatment remains inadequate. It would be only a slight exaggeration to say that public opinion on drug treatment — and this includes the opinions of many government officials — is divided between two extremes: nay-saying cynicism ("it never works") and wild-eyed optimism ("treatment is the only solution"). Far too often, our public and political debates about the role of drug treatment are filled with superstitions, prejudices, wishful thinking, and anecdotal evidence masquerading as scientific fact. Policy decisions made on this type of foundation hardly serve the cause of fighting America's drug problem. It is time we got serious about understanding what drug treatment is and what role it must play in our national efforts against drugs.

The Federal government, along with most State governments, has embarked upon an unprecedented public investment in drug treatment programs and research. Our hopes for this investment are optimistic: we want drug addicts to get effective treatment. We want to provide them the help they need to stop using drugs. And, in the process, we want to learn more about what works in drug treatment. Knowing what works (and allocating resources accordingly), rather than simply increasing funding levels, is the real key to increasing the overall success rate of the drug treatment system. In fact, if we've learned anything so far, it is that money alone — applied without thought — doesn't produce more effective treatment. Data from studies of private treatment programs reveal that those charging $12,000 a month are usually no more successful at stopping drug addiction than those charging half that amount. The point is that we must know more about *how* treatment

gets people to stop using drugs, in addition to a realistic assessment of what kind of success we can expect, so that increased public spending on treatment produces results rather than becoming a series of shots in the dark, of which only a lucky few land on target. Even worse, money spent on ineffectual treatment only diminishes public confidence in treating drug addiction and erodes public and political support for it.

We needn't proceed so blindly. The President's National Drug Control Strategy described in detail the goals and funding levels of Federal drug treatment programs and initiatives. This White Paper has a narrower, more limited purpose. In the pages that follow, it describes what is currently known about what works — and what doesn't work — in drug treatment. The paper will also explain who needs drug treatment, what kind of treatment they should be getting, and what happens to them after they've made the decision to stay in treatment. While it is written in plain English intended for the general public, it is also intended for the policy maker and government official. The goal of the White Paper is, in short, to contribute to our public discussion of drug treatment so that the decisions we make about funding and administration are based on a deeper understanding of the subject. Drug treatment will play a large role in our national drug reduction efforts in the months and years ahead; if we want to develop an effective treatment system, we need to understand what results we should expect from it and how to achieve them.

The information presented here provides the basic outline of what is a complex and often highly technical field. But it is information that should and must guide our plans to build a better drug treatment system. More urgently, it is information that can be used now to get those addicted to drugs into the type of treatment that will help them stop drug use and become more responsible citizens.

William J. Bennett
Director, Office of National Drug Control Policy

Drug Addiction

Who Needs Drug Treatment?

Treatment is for those drug users who cannot or will not stop their use of drugs without the help of a formal program which may include therapy, counseling, or medication. The majority of drug users, however, don't need drug treatment. What is crucial is that they stop using drugs. And most people who aren't yet addicted are often able to make the decision to stop drug use, and have the strength to stick with their decision. People who use drugs no more than once a month, for example, don't really need treatment in order to stop doing drugs. But they do need the social climate of intolerance toward drugs and criminal penalties that deter them from becoming habitual drug users. Those who use cocaine or heroin at least once a week are more likely to require treatment, but many of them can still quit of their own volition; they grow weary of a life whose main satisfaction increasingly comes only from the depressing or stimulating effect of drugs. Others need the persuasion that comes from the threat of social, legal, or employer sanctions: an arrest, an angry spouse, the loss of family or a job, or deteriorating health. These are the kinds of motivations that provide the bulk of casual and many regular drug users with a compelling reason to quit on their own. Formal drug treatment, on the other hand, is designed for those who have become physically or psychologically dependent upon drugs. Without the benefit of a drug treatment program, or the assistance of self-help groups like Narcotics Anonymous, most of these compulsive drug users find it very difficult to live more than a few days without drugs, no matter what harm they know they are bringing to themselves, their family and friends, or even their unborn child.

The Road From Casual Use to Addiction

Contrary to a widely-held belief, most people who use drugs — even heroin and cocaine — do not become addicted the first time they use them. Newspaper accounts describing the latest drug as "instantly addictive" are simply mistaken. The fact is that some people are able to use drugs frequently without acquiring either psychological or physical dependence. (Nonetheless, they may be the cause of a whole host of societal problems, including car accidents, domestic violence, and drug dealing.)

Even so, heroin and cocaine are highly addictive substances, as a wide array of animal and epidemiological studies have shown. Although precise data are still unavailable, studies of American soldiers in Vietnam, and results from the National Household Survey, indicate as many as one-fourth to one-third of those who use heroin or cocaine more than

a few times eventually become addicted. These probabilities are about as bad as they could be: high enough to ensure that any level of drug use in the population will always create addicts; but low enough to delude younger thrill-seekers into thinking that they can use drugs and beat the odds.

Numerous studies have been conducted over the past twenty-five years in hopes of identifying biological factors or personality traits common to drug addicts, but currently there is no precise way to identify in advance those who will be able to control their use and those who will not. In particular, individuals who experiment with drugs make poor assessments of their own vulnerability. And once they start using drugs regularly, their opinions about their own powers of resistance become even more suspect. No one is a good judge in his own case, and drug users are the worst judges of their own addiction. Most addicts maintain the delusion that they have a firm grip on their habit, even as they lose control of their drug use, and, indeed, of their lives. They are often the last ones to recognize their need for help.

At first, every addict has a "honeymoon" with drugs. For most, it begins with experimentation at an early age with alcohol and cigarettes, which often evolves into regular marijuana use and then into the heavy use of drugs like cocaine and heroin. During this period he can use drugs while still controlling his level of use. With most drugs, this

Selected Characteristics of Drug Treatment Patients

Patient Characteristics	*Type of Treatment* Outpatient (Methadone) %	Outpatient (Non-methadone) %	Therapeutic Community %
Previous treatment for drug abuse	75	34	53
Referral through the criminal justice system	3	31	31
Public assistance as the source of income	24	14	11
Private health insurance coverage	17	28	14

Source: *Drug Abuse Treatment*, University of North Carolina Press, 1989

"honeymoon" can sometimes last several years before deteriorating into an uncontrollable psychological or physical appetite. Frequent and increased use of drugs can literally change brain chemistry, rendering a user *physically* addicted. Stimulants like crack as well as opiates like heroin cause addicts to experience various withdrawal symptoms upon cessation of drug use.

The most difficult aspect of addiction to treat, however, is psychological addiction. Drug use produces an altered state of mind that addicts come to depend upon *psychologically*. Drug users report taking drugs to enjoy a momentary thrill, to temporarily allay despair, to find a shortcut to success, or just because it feels good. Drug addicts, on the other hand, frequently report that they eventually take drugs because sobriety itself is uncomfortable or even unbearable. Making a bad situation worse, many addicts like to offset the negative side effects of one drug by the use of another, and they often end up becoming addicted to more than one drug. In major cities, a large portion of the arrestees test positive for more than one drug, and the mixing of heroin and cocaine — "speedballing" — is widely reported.

The Addictive Use of Drugs

The person addicted to crack, the solid, smokable form of cocaine, will smoke a "rock" (currently sold in large cities for $3 to $15) and within 8 to 15 seconds feel an intense high that will last 15 or 20 minutes. Once the high subsides, a craving develops for more of the drug and for its powerful but brief high. It is not unusual for crack addicts to go on binges — smoking crack every 20 minutes — for up to three days, sometimes longer. Because of the effects of stimulants on the human body (including rapid heartbeat, increased blood pressure, hyperactivity, insomnia, and fatigue), crack addicts will reach a point when they physically can't take anymore. At this point they will "crash" and sleep for long periods, sometimes for days. When they wake up, they often return to the feverish search for and consumption of crack. Several days after sustained crack use ends, addicts suffer from depression because of what researchers believe to be cocaine's effect on the brain, which can render addicts almost incapable of deriving pleasure from anything except more cocaine. Because cocaine is psychologically and physically addictive, addicts can crave the drug intensely *months* after their last crack high. Cocaine is a stimulant and people who become addicted to it will often turn to depressants like alcohol, marijuana, or heroin in order to "soften" the crash from cocaine or to enjoy a more mellow high after the physically demanding and exhausting cocaine high.

Opiate addicts — those addicted to heroin, morphine, or opium — behave somewhat differently. The typical heroin addict, for instance, will inject heroin into his veins every four to six hours if possible. And if the purity of the heroin available on the streets is high, heroin users will be able to get the same potent and long-lasting high from smoking the drug as they can from injecting it. In Los Angeles or New York, a heroin habit can cost between $75 and $100 per day (and perhaps twice that in a smaller city). The sleepy high lasts three or four hours. Unless the addict takes more heroin within a few hours after the effects of the previous "shot" have worn off, the very uncomfortable side effects of heroin withdrawal will begin and can last for days. The symptoms of withdrawal from heroin include fever, insomnia, nausea, muscle twitches (which gave rise to the expression "kicking the habit"), diarrhea, aching joints, cramps, chills, and goose flesh (which gave rise to the expression "going cold turkey"). Since all heroin addicts have at one time or another experienced some degree of withdrawal (or at least recognize its oncoming effects), not having a ready supply of drugs makes them anxious for more of the drug in order to *avoid* the physical discomfort of withdrawal. The caricature of the half-crazed "dope fiend" who will do anything for a fix is not wholly inaccurate: heroin addicts can be satisfied only by more drugs.

Patient Behavior in the Year Preceding Admission to Treatment

Patient Behavior	*Type of Treatment* Outpatient (Methadone) %	Outpatient (Non-methadone) %	Therapeutic Community %
Predatory criminal activity	33	37	60
Illegal activity as primary source of income	23	12	34
Fully employed (40 weeks or more)	24	24	15
Heavy alcohol use	25	36	42
Suicidal thoughts or attempts	29	48	44
Multiple drug-related problems (3 or more)	41	50	63

Source: *Drug Abuse Treatment*, University of North Carolina Press, 1989

Is Drug Addiction a Disease?

Some scientists, health professionals and social psychologists insist that drug addiction be understood as a disease, though not for the same reasons. Advocates of the "disease model" have theorized that some people have a genetic or hereditary susceptibility to drug dependency — they cannot help getting hooked if they use drugs. Others liken drug addiction to a disease because they see it as a manifestation of underlying psychological problems like depression, childhood trauma, or feelings of despair.

Addiction researchers have provided still further — and different — arguments to support the idea that drug addiction be considered a disease. They have found evidence to suggest that habitual drug use can actually alter brain chemistry, which may make future controlled use extremely difficult if not impossible. At that point, it is argued, the heavy drug user has developed the disease of drug addiction, a disease that requires total abstinence and treatment.

But none of these views is without controversy. Critics assert that whether or not these hypotheses are borne out by further research, drug consumption and addiction must be distinguished from illnesses like Multiple Sclerosis or Alzheimer's Disease. Those diseases, they argue, are not dependent upon the actions and decisions of the individual. By contrast, illegal drug use almost always involves choices (though it is plausible that blameworthiness for some choices may vary with particular circumstances).

As long as disagreements over psychological and biological causes of drug dependency and the debate over individual motivation for drug use persist, no single account is likely to prove entirely satisfactory. Yet the controversy continues to ensnare and confound public health officials, insurance companies, and policy makers. Nevertheless, none of the arguments precludes the need for drug treatment as a major and necessary element in any adequate solution for the problems of addiction. No matter how the issues sort out, the challenge faced by the drug treatment field — and society as a whole — remains essentially the same: many drug addicts will not curb their drug consumption even when offered reasoned arguments and passionate pleas from friends and loved ones, or when threatened with arrest, imprisonment, or even death. However their problems started, the task of drug treatment is to stop consumption and reverse addiction by laying the groundwork for self-control. And for hard core drug users, drug treatment is often the only avenue available to break what has already become a deeply ingrained pattern of self-destructive behavior.

Getting Addicts Into Treatment

How Addicts Enter Treatment

The notion that all drug addicts will eventually come to their senses and decide on their own to seek treatment, is as false as it is widespread. Yet it is in part the basis for the popular cry of "treatment on demand" — a policy prescription aimed at supplying treatment space to whomever asks for it, whenever they ask for it. Such proposals are undoubtedly well-intentioned, but they neither address the real needs of the treatment system, nor accord with the realities of drug addiction and treatment. Research conducted in 1988 by Douglas Anglin and Yih-Ing Hser found that as many as 90 percent of the people undergoing treatment did not seek it on their own — let alone "demand" it — but were compelled to do so by family, legal, or employment pressure, or some combination of the three.

The reasons for avoiding treatment are fairly clear. It is no secret among addicts that quitting drugs is extremely difficult. Treatment programs are often demanding and difficult experiences for which people who have been engaged in a relentless pursuit of the euphoria of drugs can scarcely be expected to volunteer. Drug treatment is directed at denying drug addicts their single greatest source of pleasure and comfort. And every addict knows that. One of the chief reasons people do drugs is because it makes them feel very good. Despite all the other destructive and terrible things drugs do to mind, body, and soul, drugs produce temporary states of euphoria, excitement, intoxication, overconfidence, delirium, and a host of other altered states. During the initial period of heavy drug use, few addicts feel they have a problem with drugs, and those that do repeatedly promise themselves to get help — tomorrow.

But the larger problem with the call for treatment on demand is that it ignores the more immediate and fundamental problems that confront the treatment system. While it is certainly true that there are addicts who do seek treatment voluntarily, many of these volunteers repeatedly enter and impulsively drop out of treatment. Their goal, unlike the goals of their treatment providers, is to return to "controlled use" or to "stay clean" for a few days to reduce their tolerance so the same high can be achieved from lower and cheaper doses. Others who seek treatment on their own do so only after they have "bottomed-out": they have reached a point where their addiction has so consumed them and devastated their lives that they can no longer function; they cannot care for their children, show up for work, or even associate with people who don't use drugs.

For addicts like these, simply providing additional treatment slots does nothing by itself to ensure that treatment generally is made more

effective and provided in a more rational way. Even where treatment slots are plentiful, the treatment system must still improve its ability to assess the medical and psychological background of all potential treatment patients, direct them to the most appropriate kind of treatment, provide properly trained staff, and then ensure that addicts, once in the system, complete a treatment program.

A policy designed primarily to provide treatment "on demand" would create a costly, unbalanced system that brings no guarantee of higher treatment success rates. Moreover, the call for such a system obscures the far more pressing and practical needs of drug treatment. Addressing those needs requires us to come to grips with the fact that while the need for treatment is high, the actual demand for it is relatively low. The overwhelming majority of addicts must be "jolted" into drug treatment and induced to stay there by some external force: the criminal justice system, employers who have discovered drug use, spouses who threaten to leave, or the death of a fellow addict.

Treatment and the Criminal Justice System

Frequently, the jolt that gets addicts to enter treatment is trouble with the law. In fact, according to the 1989 Treatment Outcome Prospective Study (TOPS) done at the Research Triangle Institute — one of the most comprehensive evaluations of drug treatment ever conducted — as many as one out of two people who enter public drug treatment programs are under either direct or indirect legal pressure to do so. It is becoming increasingly common for arrestees in pre-trial detention to be professionally evaluated to determine if they are, in fact, addicted. If it is determined that an arrestee is drug dependent, the criminal justice system can steer offenders toward drug treatment in a number of circumstances: as a condition for deferred prosecution; in lieu of incarceration; as part of a reduced prison sentence; or as terms for probation or parole.

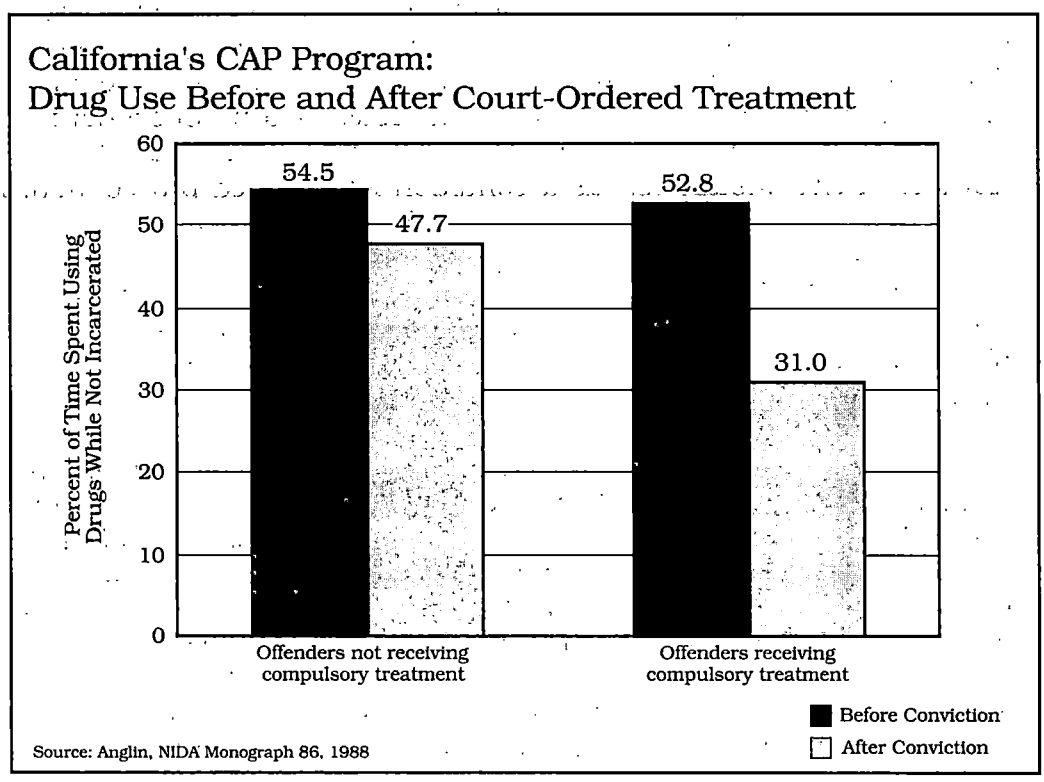
In all cases, the addict diverted into treatment is expected to be — but not always held — accountable for entering and remaining in a treatment program by either a probation officer or other authority who, by means of supervision — and in the best cases, urinalysis — keeps the court informed of the addict's compliance.

Research has determined that those who enter treatment under some form of coercion are likely to do at least as well as — sometimes better than — those who enter voluntarily. Douglas Anglin and the late William McGlothlin of the University of California at Los Angeles examined data from California's Civil Addict Program (CAP), which referred drug dependent criminal offenders to compulsory drug treatment under court order. The program began in the early 1960s, but the data it generated continues to be of value today because of its long-term evaluation of those who went through the program and the careful supervi-

sion they received after they completed it. Anglin and McGlothlin studied two groups of drug dependent offenders: those who were convicted and completed treatment under CAP, and a similar group of offenders who were convicted, sentenced to undergo treatment, but were released before they received treatment. They found that for seven years following release from incarceration, CAP participants had lower rates of drug use, fewer self-reported crimes, fewer rearrests, and higher rates of employment than those offenders who had not participated in CAP. (See graph below)

Similar results emerged from a 1988 TOPS study that examined the effectiveness of coerced treatment. The study also found that those under legal pressure to undergo treatment tended to do as well as or better than those who sought treatment on their own. They do better, in part, because legal pressure keeps an addict in treatment for a longer period of time, and virtually all studies agree that the longer an addict receives treatment, the better are his chances for long-term success.

This research provides vivid illustrations of how the criminal justice system can constructively contribute to better drug treatment. The person who voluntarily enters treatment is always free to drop out of the program when the going gets tough. That is a temptation that every recovering addict must overcome. For those referred to treatment by the courts, whose only other option is imprisonment or further legal sanc-



tions, the incentive to complete treatment is even more powerful. Yet similar incentives exist for anyone whose marriage, family, job, or finances depend on successfully completing a treatment program. That's why those who have a lot to lose are on the whole better candidates for treatment success.

No matter how the addict gets there, drug treatment can be a gruelling experience. Getting treatment under the supervision of the criminal justice system often means that an addict will have to complete very difficult treatment regimens, be held accountable for frequent urinalysis as a condition of return to the community, and closely supervised throughout the process. New York's "Stay 'N Out," like many other prison treatment programs, found that a number of convicted criminals with a history of drug use willingly return to the general prison population after a few weeks in the more demanding treatment unit.

Treatment for Pregnant Women and Infants

In the past three decades, the majority of illicit drug users have been men. The arrival of crack in 1985 has somewhat altered that pattern. The rate of cocaine use is still twice as high for men than for women, but there are now unprecedented numbers of female addicts, many of them pregnant or of childbearing age. Unfortunately, pregnant addicts are often among the most reluctant to seek treatment, and many treatment programs are neither equipped nor prepared to accept them.

The large number of press stories on pregnant women using drugs is not merely sensationalism. Pregnant women and their infants represent an especially difficult problem for which there is no ready answer. The long-term consequences of the problem may become more evident as the first wave of "crack babies" enter our Nation's kindergartens. No single phenomenon has demonstrated the destructive power of drugs as vividly as the anguish of newborns who have been exposed to crack and other drugs before birth.

Yet babies exposed to drugs suffer widely different consequences after birth. Research by a number of pediatricians suggests that babies born exposed to cocaine are more likely to be delivered prematurely, have smaller head circumference, low birth weight, and severe birth defects. Some newborns are born addicted, and because of cocaine withdrawal symptoms cannot be touched or held for days following delivery. Other babies have been exposed to cocaine *in utero*, but are not born addicted or obviously afflicted. They may, however, later suffer from hyperactivity, poor attention span, and other learning disabilities. Surprisingly, many drug-exposed babies escape physical and mental harm. Douglas Besharov of the American Enterprise Institute estimates that there are 30,000-50,000 "crack babies" born each year in the

United States, while the Inspector General of the Department of Health and Human Services estimates that as many as 100,000 babies are exposed to cocaine before birth.

Both addicted pregnant women and drug-affected infants can benefit from some form of treatment. Infants usually require special care immediately after birth. Addicted pregnant women need treatment that will bring their drug use to an end and allow them to properly care for their children; many treatment centers are already engaged in ambitious outreach efforts to identify and contact drug using pregnant women. In too many cases today, however, treatment centers are not equipped to respond to the special problems presented by pregnancy, addiction, and women with young children. Yet at the same time, what is true for all addicts is true of pregnant women with serious drug problems: many of them will not seek treatment on their own, even when it is available. When they do receive treatment, it is often a result of going through the criminal justice system first.

What Constitutes Drug Treatment?

Treatment: One Size Does Not Fit All

Many approaches have been developed to help addicts permanently kick their habit, but not all these approaches work equally well for each type of addict. Unfortunately, the type of treatment a patient currently receives is frequently determined by the first door on which he happens to knock. If a heroin addict knocks on the door of a therapeutic community program, that's what kind of treatment he will receive. If he knocks on the door of a methadone maintenance program and meets FDA requirements, he'll receive methadone.

Most addicts, though, stand a much better chance of success in treatment when aspects such as personality, background, mental condition, and duration, extent and type of drug use are evaluated during a pre-admission screening process that places an addict in a treatment program that is most likely to meet his needs and produce the best outcomes. If someone isn't getting the right kind of treatment initially, then the chances for success are diminished until he is redirected or transferred to a more appropriate program. And patients who have a serious mental illness on top of their addiction — what psychiatrists call "dual diagnosis" — may not be able to recover from drugs regardless of what sort of treatment they receive without proper attention to their psychological condition.

Described below are the principal methods of treatment most commonly found in the United States. They are intended to be general

descriptions of each method, rather than rigid parameters. In practice, of course, each form of treatment will vary with the circumstances and type of patient a particular clinic will encounter. And as treatment has expanded, varieties of treatment practice have emerged that borrow elements from two or more different traditional methods. For the sake of clarity and simplicity, however, the division of treatment that follows roughly depicts the lion's share of drug treatment as it is practiced today.

Detoxification

Detoxification is often the first stage of the treatment process. Its aim is to stabilize the heavy drug user until his body is relatively free of illicit drugs. Detoxification is sometimes essential if the patient is to end immediate drug use and cope with the discomfort of withdrawal from drugs such as heroin, and the craving and depression of withdrawal from drugs such as cocaine. Withdrawal from barbiturates can in some instances be life-threatening. "Detox" is not, however, in and of itself a form of treatment. Detoxification helps people *get off* drugs; treatment helps them *stay off*. Although it is not uncommon in our treatment system today for an addict's experience in treatment to begin and end at this stage, experts agree that detox does little good unless it constitutes a transition to, or preparation for, a long-term drug treatment program.

No treatment program can effectively work on changing the attitude and behavior of patients who are still in a drug haze, suffering through a painful withdrawal, or having memory trouble for two weeks after they have stopped using the drug (as is sometimes the case with cocaine addicts). Patients go through the detoxification process by remaining completely drug-free or with the help of medications that ease withdrawal. Methadone, for instance, can be given in decreasing doses to those still on heroin in order to enable addicts to avoid the symptoms of heroin withdrawal.

Only a few addicts require detoxification inside a hospital (where costs can run as high as $500 a day); some need to be in residential treatment centers (which charge between $60 and $120 per day); but the large majority of addicts can be detoxified on a far less expensive outpatient basis. Wherever it takes place, there can be complications and challenges when working with addicts who are still on drugs. But with supportive staff, careful supervision, and a number of medications, detoxifying patients is generally a routine task. The hard part comes after: getting addicts to *stay* off drugs.

Therapeutic Communities and Residential Treatment

Therapeutic Communities (TCs) are designed to get patients to face the fact that they are addicted to drugs, and then to foster change in their personalities so they can live without drugs. One of the first such

programs, Synanon, was founded in 1958 in California. By the late 1970s, Synanon had developed a controversial reputation and was no longer regarded as a drug treatment program. Yet parts of the original concept of Synanon were both sound and successful. The Synanon model, albeit much improved upon and modified, remains the foundation of hundreds of TCs across the country, including some programs in prisons.

TCs are staffed by both former addicts and professionals who impose personal and community responsibility by means of a rigid hierarchy among staff and patients. Each member of the TC is given a job and expected to carry his own weight. The house rules must be strictly observed. The TC staff rewards good behavior with privileges and promotions to positions of more responsibility, and punishes bad behavior through "learning experiences" — the suspension of privileges or the assignment of some menial chore. Because addicts ascend in the hierarchy by demonstrating their ability to handle increasing responsibility within the community, those near the top are thought to be ready to graduate to a life free of drugs outside the therapeutic community.

Much of what is accomplished in this form of treatment is done through "encounter groups," in which addicts confront each other about their behavior and their shortcomings. These encounter group sessions tend to be confrontational and intense and are generally effective in stripping away the self-deceit, rationalization, and defensiveness common to addicts. Addicts are then able to begin redressing their weaknesses and rebuild their self-confidence and motivation.

In the later stages of treatment, and when not engaged in encounter groups or other behavior-changing exercises, members of TCs spend time working first in the treatment facility, and later in the community. The length of stay in a TC ranges from 6 to 24 months, and the cost can range from $1,200 to as high as $2,500 per month. The time commitment, combined with a confrontational and demanding regimen, makes for a very high attrition rate among patients. As many as 4 out of 5 patients who begin treatment in a TC drop out or are expelled for violence or drug use before completion of the program. And while TCs may be suited for young and old, rich and poor, alike, and for those with heroin, cocaine, amphetamine, or marijuana problems, the program is not appropriate for patients with more serious mental or other illnesses. But therapeutic communities seem especially good for those with a history of criminal behavior or social pathology — people unaccustomed to rules and responsibilities. Overall, TCs have a good record of success, with as many as 4 out of 5 patients who complete the program drug-free several years out of treatment. Research indicates that those who spend more than three months in a TC — even without completing the program — reduce drug use and criminal behavior.

A wide range of hybrid residential programs have evolved from the TC model and are growing in popularity. While borrowing heavily from the TC model, these residential programs are usually less intense and confrontational. They often incorporate more traditional forms of therapy, professional counseling, drug education, and self-help activities into the treatment regimen. Such residential programs seem to be as effective and generally cost about the same per month as a TC, although the stays are often shorter, ranging from 6 to 12 months.

Minnesota Model and Inpatient Hospital Programs

The "twelve-step" or Minnesota Model approach was developed in the 1950s at Willmar State Hospital in Minnesota for the treatment of alcoholism. These programs, however, have recently been used for the treatment of drug addiction, especially since the onset of the cocaine epidemic. They are residential programs in hospitals or in free-standing facilities, and last usually three to four weeks long. The core of the counseling and program activities are derived from the self-help therapy of the Alcoholics Anonymous "twelve steps to recovery." The twelve steps prescribe for addicts what some have termed a spiritual or moral awakening. The steps include the admission of addiction, acknowledgement of one's impotence to stop it without the help of a higher power, and the need to confront the harm one has done. Although scientific outcome data from these programs are scarce, they appear to have helped thousands of individuals.

Other types of inpatient programs in hospitals come closest to what many people imagine when they think of someone getting "psychiatric help." Psychiatric treatment in hospital settings lasts anywhere from 4 to 12 weeks, although longer stays of up to six months for troubled adolescents are common. The programs are usually run by psychiatrists, psychologists, and health professionals who employ a variety of basic clinical approaches, including traditional group, individual, and family therapy. Programs often include training in relaxation, exercise, and what psychiatrists call "coping skills." Special psychiatric attention is given to those addicts who have a serious mental illness on top of their drug problem. Attendance at Alcoholics Anonymous or Narcotics Anonymous is often compulsory, although in psychiatric programs this tends to be an auxiliary rather than a central aspect of treatment.

Anecdotal evidence suggests that many people have benefited from both the Minnesota model and psychiatric inpatient programs, but it is, with few exceptions, extremely expensive: a four-week stay can cost anywhere from $6,000 for a non-hospital, not-for-profit "Minnesota Model" program to $30,000 for psychiatric hospital care. For reasons of cost, these programs remain almost exclusively private, and are not part of the publicly funded treatment system.

Methadone Maintenance

Methadone is a legally controlled synthetic medication. It was developed in Germany during World War II as a substitute analgesic, or pain killer, when morphine was in short supply. Its use as an on-going (maintenance) treatment for narcotic addicts was pioneered by Vincent Dole and Marie Nyswander at Rockefeller University in 1964. When taken orally in carefully regulated amounts, methadone produces little if any high, yet it relieves withdrawal symptoms and craving for heroin for about twenty-four hours. It also prevents addicts from feeling the effects of heroin should they happen to take the drug while on methadone. Patients drink a small cup of methadone diluted in orange juice every day, and are able to work, attend school, and take part in family and community responsibilities. The annual cost of a methadone maintenance program can range from $3,000 to as much as $4,500.

Methadone is addictive, but gradual withdrawal from it is much less painful than the discomfort of heroin withdrawal. The greatest benefit of methadone maintenance is that it switches the heroin addict from use of an illegal, dangerous, injectable, short-acting drug that produces a sense of euphoria to the supervised use of a relatively safe, orally administered, long-acting controlled drug that has a minimal euphoric effect. It thus provides a new opportunity for addicts to be well enough to receive drug counseling and therapy, and vocational and other types of training, all of which can play an important role in improving an addict's ability to live in the community free of illicit drug use. It can also be life-saving in this era of AIDS, as a number of studies have shown, by providing heroin addicts with an alternative to intravenous drug use, which exposes them to the risk of HIV infection.

Methadone maintenance is the most researched and evaluated of all the various treatment methods, and there is considerable evidence that methadone can help addicts become better, more productive citizens. In a properly run methadone program, patients markedly decrease their use of illegal drugs, although a minority continue with drug use, especially cocaine. The arrest rates of methadone patients are significantly lower than they were prior to getting the patients on the program. And the employment and school records improve over pre-program performance. Methadone is appropriate mainly for people who have been on heroin or other opiates for two years or more, and it is apt to be more effective with older, motivated addicts who do not have major psychological problems.

There is some quite understandable philosophical objection to methadone maintenance. Critics argue that it merely substitutes one addicting drug for another, and rarely helps the addict become free of the influence of drugs. In support of this view, they cite the example of thousands of Vietnam veterans who were addicted to heroin while in Vietnam, but upon returning home were able to kick the habit without

resorting to therapy or medication. This history makes a compelling argument about the effect of drug availability on the level of drug addiction: when drugs are plentiful, as they were in Southeast Asia, addiction rates can be high. But this case does not provide an argument against the beneficial aspects of methadone. Many heroin addicts benefit greatly from methadone maintenance programs, often after several attempts to quit heroin by other means. And many do emerge from this type of treatment completely drug-free one, two, or more years after. While still on methadone, drug addicts may not be "cured" of their dependence on drugs, but they can control the destructive, anti-social habits that addiction brings in its wake.

The main problems with methadone involve the difficulty many patients have in getting off the drug, and the inadequate way in which some programs administer it. In these programs, patients receiving daily methadone get little or no counseling or therapy and virtually no attention to their continued drug use, without which no meaningful changes in the addict's habits and way of life can take place. In these respects, methadone programs need to be improved. But methadone itself — because it is a powerful and addicting substance — should not be considered as a treatment method of first resort for heroin addicts with a short history of drug use. These addicts need to be encouraged to enter a methadone program only after trying other intensive methods first.

Non-Methadone Outpatient Treatment

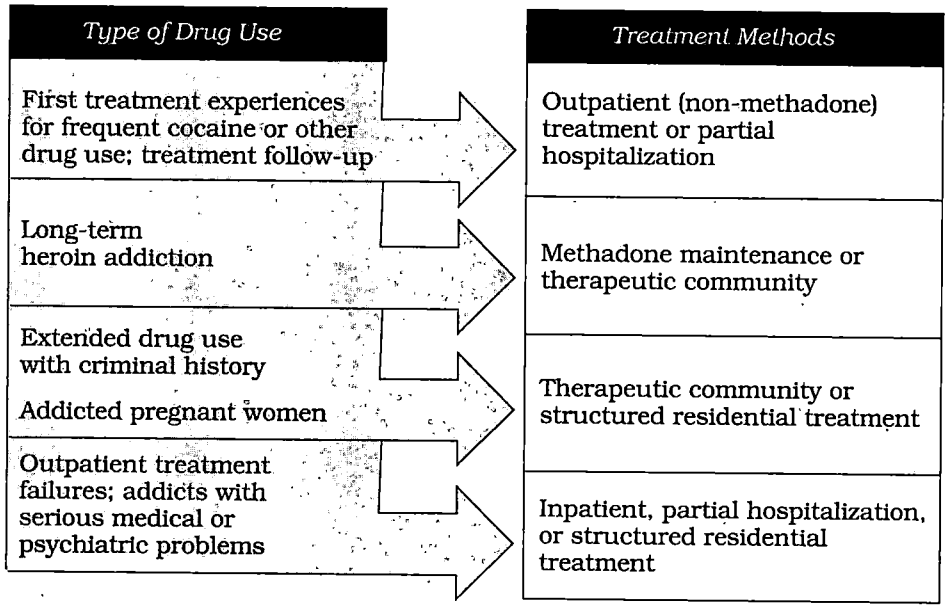
Outpatient treatment programs vary greatly in approach and intensity. Some programs use medications such as naltrexone that blocks the effect of heroin, or various drugs that reduce craving for cocaine as a part of treatment. Others are entirely "drug-free." Their common denominator is that they do not use methadone. Operating out of hospital clinics or free-standing facilities, outpatient treatment serves a number of different types of patients with different drug histories: the addicts who have never sought treatment before; those who have successfully completed another type of treatment and seek continued support and counseling; recovering addicts who have relapsed following treatment; and addicts who require treatment after being released from prison or an inpatient hospital stay. While methadone maintenance or therapeutic communities can serve the heroin or cocaine addict, outpatient treatment can be the main therapy for marijuana, psychedelic, or multi-drug users as well.

For all of these people, outpatient programs offer a mixture of individual counseling, group counseling, family therapy, and specific relapse prevention training. Individual and group therapy is used in many programs in an effort to resolve psychological problems that may underlie a patient's drug dependence. For those who need "habilitation"

instead of rehabilitation, some programs offer education and vocational training as well. Although programs cannot supervise an addict 24 hours a day, good outpatient programs monitor their patients through frequent visits (which decrease as patients improve), drug tests, and phone conversations when the patients do not come in for counseling or training. The cost for outpatient treatment can range anywhere from $200 to $600 per month, and can be effective, not only as follow-up for those who have already been through another type of treatment program, but also for those in treatment for the first time. Because of the added incentive to remain drug-free and enrolled in the program, legal pressure often contributes to treatment success. Outpatient programs generally encourage patients to become involved with self-help groups such as Narcotics Anonymous, both for the insight and the communal support they offer, as well as for the drug-free network of friends they provide.

Despite its success, there remains a great deal of skepticism about the effectiveness of outpatient treatment. Programs have been criticized for "leaving addicts on the street," or for not being intensive enough to overcome the power of addiction. While it is true that addicts in outpatient treatment do have access to drugs and the free time to associate with those who continue to sell and use drugs, many outpatient programs have had a good record of success. Keeping in contact

Matching Drug Use to Treatment Methods



Source: ONDCP, 1990

with addicts by phone on the days they don't come in seems to be an important factor. And the medications being researched today that may alleviate craving or block the effects of drugs will make outpatient treatment increasingly applicable and effective for more patients in the future.

A hybrid of both inpatient and outpatient programs is the partial hospital program, which operates on a day or evening schedule. It provides more intensive intervention in the daily life of an addict than outpatient programs, but at a much lower cost than inpatient programs.

Common Ingredients of Treatment

Although the various approaches to drug treatment differ in many ways, there are a few basic elements that are part of most, if not all, good programs. The most fundamental of these is that in treatment addicts begin to eat and sleep properly, often for the first time since their addiction began. Eating and sleeping on a regular schedule are the minimum requirements for a normal, healthy life. But to someone coming off a serious drug habit, they constitute a radical change in behavior. The life of an addict is chaotic. The normal human needs that most people take for granted are foreign to the daily behavior of an addict. So the first step of treatment is often to see to it that addicts get basic nourishment, medical attention, and rest, thus bringing a degree of order into their lives.

Another common element in treatment is holding those who receive treatment accountable. Accountability means clear expectations for behavior, rewards for meeting them, and certain consequences if they do not. Treatment is often the first time addicts realize that to be a functioning adult, they must answer to others and to themselves for their actions. Programs hold patients accountable for showing up and being on time to counseling meetings and therapy sessions. Therapeutic Communities and residential programs hold residents accountable for a daily set of chores. Most importantly, effective treatment programs hold patients accountable through the use of frequent drug tests to determine if they are, in fact, staying off drugs. If drug use is discovered, programs often impose appropriate sanctions and higher degrees of supervision. Even in treatment, most addicts remain ambivalent about their drug use: they want to stop because of the problems their drug use has created, and yet they still wish to return to the "honeymoon" period when they could control their use and simply enjoy the pleasurable effects of drugs. Drug testing within a treatment program therefore becomes a powerful deterrent when temptation occurs. One way or another, accountability measures in treatment encourage addicts to make responsible, adult decisions — including decisions about their use of drugs.

Either implicitly or explicitly, most treatment programs inculcate the concepts of trust, respect, right and wrong — ideas that are essential for human civility but alien to the world of drug addiction. Programs that bring a group of recovering addicts together create an atmosphere of support and friendship. They use peer pressure to promote the habits of honesty and responsibility. In a number of programs, this same objective is pursued through what could be described as a spiritual or moral awakening that often includes a strong faith in God or some higher power. Whether through the twelve steps of Narcotics Anonymous, the tenets of a therapeutic community, or the teachings of religiously oriented programs, the effort to get addicts to abstain from drugs involves fostering their faith in something above and beyond themselves, and certainly beyond the self-absorbed euphoria of drugs.

Finally, effective treatment programs are managed and staffed by competent people who have the capacity to be both tough and compassionate. Whatever the method, treatment relies heavily upon the leadership, skill, personality, and charisma of the men and women who work with addicts every day.

Magic Bullets

In building a bridge from the initial cessation of drug use to successful drug treatment, a number of methods have emerged, each claiming to be the "cure" for drug addiction. Some look for new medications to come along and painlessly solve the problems of addiction. Others look to techniques like acupuncture, supplements of amino acids, even the use of psychedelic drugs as the elixir that will provide patients instant relief from drug addiction. The truth is that new medications, and in some cases acupuncture, can be helpful in relieving some of the painful symptoms addicts face when they stop their drug use. No medication, however, including methadone, can cure drug addiction. Acupuncture needles, pharmacological agents, or "miracle cures" cannot provide the structure, the discipline, the soul-searching, or the reasons to remain drug-free that each addict must find himself. False, untested claims to the contrary mislead the public and serve only to discredit the legitimate, albeit less sensational, methods of treatment.

Completing Treatment

Addicts never emerge from a treatment program completely "cured." In fact, it is only after they leave the relatively protective environment of a treatment program that they face the greatest challenges to their ability to stay off drugs. Unfortunately, former addicts tend to yearn for the days when they could control their use of drugs, and most believe that they can go back to that "honeymoon" period, despite numerous warnings from counselors and former addicts. The experience of many

recovering addicts shows that they can't. For psychological, social, and perhaps even biological reasons, attempts at moderate drug use after the completion of treatment often rapidly lead addicts back to their former patterns of compulsive drug use. As a result, most patients go through what treatment professionals call a "relapse" — a return to using the drug to which they are addicted. For some, relapse is merely a temporary falter — a "slip" rather than a "fall" — and it serves as a hard lesson that they cannot go back to controlled use. But for the others, relapse leads back to ongoing, compulsive drug use. They need more treatment. And if renewed drug use leads to other criminal activity, they need criminal sanctions.

Specific relapse prevention training, regular contact with outpatient treatment, and involvement in self-help and support groups like Narcotics Anonymous, become very important in both preventing and surviving relapse. Addicts with strong support from family, friends, and counselors are better able to resist the temptation to go back to drug use. And drug testing as a regular part of a follow-up outpatient program provides recovering addicts with the added incentive — and excuse — to resist their craving for drugs.

Does Treatment Work?

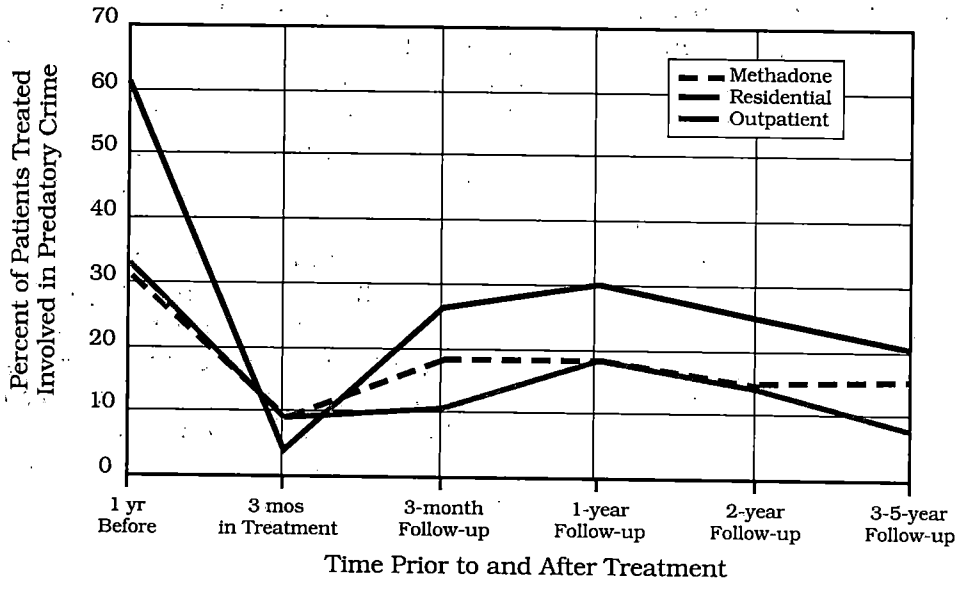
Defining Success

It would seem obvious that if, upon completion of a program, a patient no longer uses drugs, then treatment could be declared successful. But as has just been described, success often comes only after a relapse into drug use and further treatment, which complicates attempts to measure the efficacy of any single treatment program. And although it is interesting to examine whether formerly criminal addicts are engaged in criminal activity after treatment (they often aren't), or whether formerly unemployed addicts are gainfully employed (they often are), these questions are important but not central to the determination of treatment success. Drug treatment may be deemed successful when, three to five years after treatment, a former addict is no longer using drugs.

Yet, the ultimate goal of treatment should not obscure the fact that partial success can be found when former heavy drug users reduce their consumption of illegal drugs, decrease their involvement in criminal activity, and generally impose a smaller burden on society. They may still use drugs on occasion, but the damage they inflict on society has been minimized, and that can only be viewed as a benefit.

Prevalence of Predatory Crime Before and After Treatment

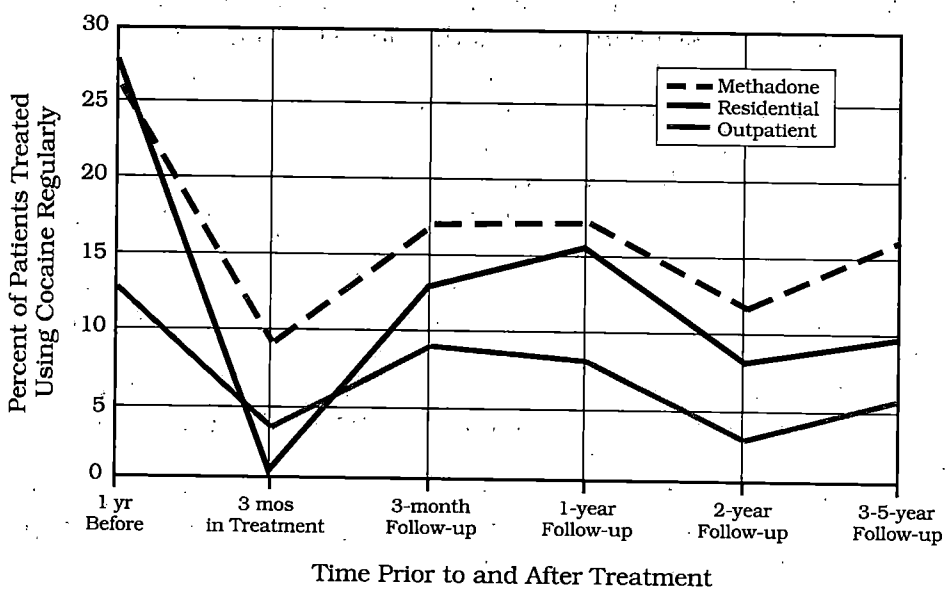
(Clients treated three months or longer)



Source: *Drug Abuse Treatment*, University of North Carolina Press, 1989

Prevalence of Regular Cocaine Use Before and After Treatment

(Clients treated three months or longer)



Source: *Drug Abuse Treatment*, University of North Carolina Press, 1989

For Whom Does Treatment Work?

The TOPS study (which examined publicly funded treatment) and a number of independent studies of private treatment done in the 1980s, when taken together, suggest that, all things being equal, about half of the people who go through treatment are drug-free or have dramatically reduced their use of drugs three to five years afterwards. But all things are not equal. Some treatment programs are better managed than others. Some addicts have strong friendships and family ties while others do not. Some have the education and background that allow them to reintegrate themselves into society more easily.

Those addicts who have something to lose if they don't get off drugs — a job, a family, a house — do much better than those who have nothing to lose. Some of the people who fail might seek treatment again, and eventually succeed in kicking their drug habit. And the uncomfortable truth every program can attest to is that some — maybe as many as one out of four drug addicts, many of them career criminals — will not choose to live without drugs despite numerous rounds of even the best treatment available. These failures are too often cited as "evidence" that treatment can't work. Rather, they are grim reminders that for some people, drugs have so penetrated their lives that no form of treatment can protect them from themselves or protect others from them.

Making Treatment Work Better

Treatment, especially of cocaine and crack addiction, is still a relatively new science. There is much more that we can and must learn in order to do a better job of treating addicts. Research is currently underway which should yield important developments that will improve treatment success. For instance, we do not currently have reliable data to tell us how many addicts there are who need treatment, or who is in what sort of treatment and what kind of success they are having. Increased efforts to gather such data are underway, although it will be a few years until we have answers to these questions.

A great deal of research is being done to develop medications to aid in the treatment of cocaine and crack addiction. There is good reason to believe that by the end of the decade medications will be available that can reduce an addict's craving for cocaine. Other medications may be able to prevent addicts from deriving any effect from cocaine. And still others may help in the treatment of those who have become addicted to both heroin and cocaine. Pharmacological agents like these will enable more addicts to undergo treatment successfully.

Researchers such as Alan Marlatt at the University of Washington and Charles O'Brien at the University of Pennsylvania are conducting studies to develop ways to teach addicts how better to avoid relapse after leaving treatment. The premise of this research is that if addicts

can catch the warning signs and rationalizations attendant to relapse, they also can learn to buttress themselves against the temptation to use drugs.

All of these research efforts and others like them are crucial to the future success of treatment. Nevertheless, there are a number of ways we already know are certain to make treatment work better. One is family involvement. When family members become involved in the treatment, the chances for success are significantly greater. Another is making sure appropriate treatment programs have the resources or the ability to tie in with existing community agencies to provide recovering addicts with vocational and educational services necessary to compete for jobs in today's job market. And the single best way to make treatment more successful is to get people to stay in appropriate treatment longer. Every treatment program better serves its patients when it establishes both formal and informal rewards and sanctions that induce them to complete the program.

Treatment Availability

The Federal Role in Treatment

The national drug treatment system is divided into two sectors, one public and one private. Private treatment is available at hospitals and free-standing facilities to those able to pay the costs or who possess adequate insurance coverage. The public treatment system, funded by Federal, State, and local tax dollars, is intended for those who cannot afford private treatment. Most of the Federal money for drug treatment is allocated by the Department of Health and Human Services in the form of block grants to the States. In 1987, Federal funds made up about 23 percent of the Nation's treatment funding. Other money came from State and local governments (33 percent), third party insurers (27 percent), and private individuals and charities (17 percent). Since then, Federal expenditures have increased rapidly. All told, the Nation spends well over $2 billion annually to treat drug addiction.

The Federal government also supports drug treatment at hospitals operated by the Department of Veteran Affairs and a variety of treatment demonstration projects. In addition, the Federal government supports basic research on how to decrease drug addiction, investigations into the physiological characteristics of addiction, and the development of medications that could be instrumental in treating addiction.

Waiting Lists

There is a great deal of concern over the apparent dearth of available treatment in cities across the country and the long waiting lists reported by many treatment facilities. It is certainly true that there are many programs — good programs — for which people are waiting for the next available space. Recent substantial increases in Federal funding for treatment should go a long way in helping these programs to expand their services accordingly.

Actual lists of addicts, however, who have sought treatment from one program or another are not the best measure of the extent of the need for treatment. There may be waiting lists for a program in one city, but not in others. In large cities, for example, the existence of a waiting list for a methadone program may only be a function of the demands a particular program makes on an addict: unstructured methadone programs that merely dispense the medication and make few demands on an addict will often be oversubscribed, while more rigorous programs that require counseling, therapy, and frequent drug tests may have vacancies.

In other cases, addicts put their name on one waiting list, unaware that there may be other openings in a program nearby, because no central registry exists. Further, because of a lack of communication among treatment programs, an addict can put his name on a number of waiting lists, and it is likely to remain there indefinitely, even after the addict enters a program for treatment.

The bottom line is that all drug treatment waiting lists tend to be soft. Anyone can put their name on a waiting list. The real test of drug treatment is to help someone undergo treatment on the terms set by the program rather than on terms set by the addict. The fact that an addict asks to be placed on a treatment waiting list one day is no guarantee that he will want to make the sacrifices necessary for treatment when space does come available days or weeks later.

Paying for Treatment

When trying to estimate the numbers of addicts and the need for treatment, it is important to keep in mind that, according to the National Institute on Drug Abuse, the largest proportion of drug addicts are white males between the ages of 18 and 40. Many of them have the means or the health insurance to pay for treatment, and at many publicly funded treatment facilities, a sliding fee scale is established for patients who are able to pay for some or all of their treatment. At private treatment centers, meanwhile, where these addicts usually seek treatment, it is not uncommon to have vacancy rates of 45 percent. For those with adequate insurance or sufficient income, availability is not an issue.

The facilities that receive public support, however, were financially strained during the late 1970s and the 1980s, and unprepared for the recent onslaught of patients produced by the crack epidemic. In order to help more addicts, proposed Federal spending on treatment has been increased 68% in the past two years, and some States are following suit.

Staffing Problems

The single greatest impediment to the improvement and expansion of treatment is the lack of trained, quality staff. Although it is useful in policy discussions to talk of the treatment system and effective treatment methods, the truth is that the success of any individual treatment program depends upon the training and competence of its staff. Many current programs lack trained professionals, and too often counselors and other staff also have limited or inadequate training. In some cities, salaries are often too low to attract or retain the few who have proper training. In fact, advertisements have appeared in the "help wanted" section of large city newspapers that read, "Drug treatment counselors needed; no experience necessary; $14,000 per year starting salary." New or expanded treatment programs will clearly require many more trained men and women. Training programs are being expanded, and former addicts with years of experience but little formal training can accomplish much in TCs and similar programs. Nevertheless, it will take some time before there are sufficient numbers of trained or experienced staff necessary to achieve a significant increase in treatment quality and availability.

Finding Sites

Another impediment to significant expansion is the fact that increased treatment availability requires sites for new facilities, and new sites have been very difficult to find. All too often community resistance prevents the location of new programs in neighborhoods where they are needed most. For instance, the State of Missouri has been unable to spend more than $4 million it had budgeted for the St. Louis area because communities have denied zoning for treatment centers. And the same difficulty has been encountered in New York, California, and many other States.

Community resistance to siting drug treatment facilities cannot be easily dismissed. Although support for a larger and more effective drug treatment system is widespread, many city residents share the common and not unexpected fear that the arrival of a drug treatment center will have an adverse effect on their neighborhood, increasing crime, attracting drug addicts from other areas, and lowering property values.

Research by the National Institute on Drug Abuse, however, suggests that these fears are largely unwarranted. The data confirmed what has been the experience of many well-managed treatment centers

long in operation; namely, that the establishment of a treatment facility creates no discernable rise in crime and no drop in property values in the surrounding area. Nevertheless, finding suitable sites for treatment facilities remains a major obstacle. One State recently proposed legislation that allows the State government to override local zoning legislation that prohibits treatment facilities. While this solution certainly would solve some legal and bureaucratic problems, it does little to allay the sincerely felt anxiety of local residents. And as long as that anxiety exists, the NIMBY — "not in my backyard" — problem will persist.

Part of the solution may lie in better public relations. If further research confirms that drug treatment centers pose no risk to the safety and property value of a neighborhood, then that message needs to be bolstered and communicated more effectively. Other solutions might involve tax incentives or community funding schemes that make the establishment of a local treatment center an economically more attractive proposition to communities. Leadership must come both from local leaders such as politicians, business executives, and members of the clergy, as well as from the community of treatment professionals who will need to assure neighborhoods that their facilities will be properly managed and accountable.

Treatment in Prison

The places in our society with the highest concentration of drug addicts are our prisons. An estimated 50 percent of Federal prison inmates, and nearly 80 percent of State prison inmates, have had experience with drug use, and many are drug addicts. Most convicts who were once heavily involved with drugs finish their prison terms without having any drug treatment, and many return to a life of drugs and crime upon release.

Of course, prisons are designed to incapacitate criminal offenders and provide just punishment. But prisons can also provide a useful setting for drug treatment: drugs are harder to come by inside a prison; drug testing and accountability are usually not new to correctional facilities; and inmates preparing for release are sometimes eager to find a way out of the type of behavior that put them in prison in the first place.

A number of States are now working to make drug treatment available in their prisons, and the Federal Bureau of Prisons (BOP) has begun an ambitious drug treatment program based at a number of Federal correctional facilities. The BOP program will include professional evaluation and long-term follow up to determine the effect of the program on recidivism and future drug use. In the months and years ahead, they will furnish us with a wealth of information on how effective treatment in prisons can be.

What Doesn't Work

Needle Exchange

Although it is not touted as treatment, the high rate of HIV transmission among intravenous drug users has prompted some to call for the free distribution of hypodermic needles. The rationale most frequently given is that these addicts won't share needles if clean ones are provided for them, and informal studies done in Holland are often cited as evidence. Yet more comprehensive, controlled studies done in England in the 1980s have shown that the distribution of free needles has not lived up to its original intent. Enrollment in programs is low and those most likely to be sharing needles are also less likely to enroll in the first place. What's more, drop-out rates are very high, and there is no reliable evidence that addicts who receive the needles are not continuing to share them.

No matter what addicts promise when they aren't on drugs, they may still share needles when they shoot up heroin or cocaine. In many cases it is simply part of the ritual of taking drugs that accompanies an illicit and socially condemned activity. More often, drug-induced stupefaction overwhelms rational thinking. Many addicts know that they can get AIDS from dirty needles. Yet hazards to their health — even deadly ones — do not weigh heavily on their minds, especially when they are strung out. We have to remind ourselves that drug addicts are primarily concerned with the instant gratification of drugs; their time horizons are extremely limited. Knowledge that one might acquire a disease fatal within 5 or 10 years is usually not compelling to individuals who might die at anytime from a drug overdose or from the criminal violence associated with the life of a street addict. Today the best way to help drug addicts escape the AIDS virus is to either make drugs unavailable to them or get them into treatment.

Needle exchange programs may also confound a community's anti-drug efforts by implicitly condoning the intravenous use of illegal drugs. For this reason, many inner-city neighborhood leaders vigorously oppose needle exchange programs. Also, the distribution of needles may make recovery more difficult for recovering addicts to stay off drugs by inducing a craving when they see the needles. Studies done by Dr. Charles O'Brien at the University of Pennsylvania have demonstrated that those things that remind addicts of past drug use can induce a conditioned or "Pavlovian" response in former addicts. Drug paraphernalia induces the strongest conditioned response, so that the mere sight of needles being handed out on a street corner or laying on the ground in parks may quickly rekindle a burning desire for drugs.

Treatment and Legalization

The spiralling increases in drug use and its related harms in the last decade have stirred a number of people to advocate making the use and possession of drugs legal. In most instances, such proposals are borne out of the frustration that has come with facing a drug epidemic. But as a policy it must be rejected out of hand. The one, certain result of a policy of drug legalization is that currently illegal drugs would become more widely available, cheaper, and safe to obtain. The number of cocaine and heroin addicts would surely rise. Further, nothing could be more damaging to our efforts at drug treatment. As virtually all treatment experts — and former addicts — will attest, the hardest challenge faced by an addict completing treatment is to resist drugs when he once again has the opportunity to use them. If drugs are made legally available and tolerated by society, recovering heroin and cocaine addicts stand a much lower chance of successfully staying off drugs. When recovering addicts do manage to keep off drugs, it is in great measure due to their ability to live a life in which their contact with drugs and drug users is severely limited. Staying away from drugs is often a factor of their perceived availability and the degree to which a community is intolerant of drug use. Moreover, former addicts need the moral suasion not just of counselors and family, but of the community as well. Legalization sends a mixed signal that can be both confusing and debilitating to the one-time addict.

The most important point that is lost on the supporters of legalization is that many people — studies suggest at least 50 percent — are in treatment because of legal pressures. And the criminal justice system can direct them to treatment and make them accountable for staying in treatment and making it work.

Understanding Drug Treatment

Drug treatment is a great source of hope in our battle against drug use because it is focused on relieving the most stubborn part of the problem: compulsive, destructive, and dangerous drug use. Those who habitually consume heavy amounts of illegal drugs are most often associated with a wide variety of anti-social behavior that imposes enormous costs on American society. Violent crime, loss of employment, broken families, drug-impaired accidents, drug-addicted babies, the transmission of the AIDS virus, premature death — all of these ills can be caused by the problem of drug addiction.

We now know on the basis of more than two decades of research that drug treatment can work. It can help turn many drug addicted people into productive, law-abiding citizens. But no one, certainly no

treatment professionals, can be satisfied with our current rates of success. The difference between effective drug treatment and treatment that is little more than a temporary hiatus from chronic drug use can often be found in providing the right kind of treatment for each addict, and then giving him every incentive to see it through to its completion. The challenge now facing the field of drug treatment is to improve the quality of treatment, identify which sorts of treatment work best with different types of addicts, increase the rates of recovery from addiction, and learn more about what works and why. A well-planned drug treatment system that insists on accountability, coordination, and results helps build the public support for treatment that is essential to its success in the long run.

The intention of the President's National Drug Control Strategy is to make the treatment of drug addiction a crucial part of a broad strategy that includes law enforcement, prevention and education, border interdiction, and international cooperation. That requires making drug treatment — as with each other element of the Strategy — a more powerful and effective tool in reducing drug use. Understanding drug treatment helps us build a better treatment system and, most importantly, helps those who are addicted to drugs by providing them with a way out of the debilitating life of habitual drug use.

For further information about treatment for
drug addiction contact the

National Clearinghouse for Alcohol and Drug Information (NCADI)
P.O. Box 2345
Rockville, Maryland 20852
1-800-729-6686

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