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National Drug Control Strategy

2000 Annual Report

1st DRAFT for INTERAGENCY COMMENT

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Please forward all comments, edits, and additions by Monday, 2/7/00 to:
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Office of National Drug Control Policy

III. Report on Programs and Initiatives

1. Initiatives to Prevent Drug Use

Preventing or delaying use of psychoactive drugs, alcohol, and tobacco by adolescents is a critical public-health goal. The simplest and most cost-effective way to lower the human and social costs of drug abuse is to avoid it in the first place. More than 255 million Americans do not use illegal drugs. Some sixty-one million Americans who once used illegal drugs have now rejected them; many suffered as a result of drug abuse. Accidents, addiction, criminal involvement, damaged relationships, impaired judgement, and lost educational or employment opportunities are common consequences of substance abuse. Of the fourteen million Americans who currently use illegal drugs, some four million are chronic abusers. Preventing America's sixty-eight million children from using drugs, alcohol, and tobacco is one of the best investments we can make in our country's future. Doing so is preferable to dealing with the consequences of drug abuse through law enforcement or drug treatment.

Prevention is best directed toward impressionable youngsters. Postponing or inhibiting first use of illegal drugs, alcohol, and tobacco is essential. Not only does drug use put young people at risk of negative short-term consequences, but those who do not use illegal drugs, alcohol, or tobacco during adolescence are less likely to develop a chemical-dependency problem later in life. In addition to deterring some initiations completely, drug prevention programs help people who use drugs to reduce the quantities. Successful substance-abuse prevention promotes mental health and leads to reductions in traffic fatalities, violence, unwanted pregnancy, child abuse, sexually transmitted diseases, HIV/AIDS, injuries, cancer, heart disease, and lost productivity.

Evidence from controlled studies, national cross-site evaluations, and SAMHSA/CSAP (Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Prevention) grantee evaluations demonstrates that prevention works. For example, SAMHSA/CSAP's cross-site studies of Community Partnerships, High Risk Youth, and Developmental Predictor Variables have all found positive reductions in substance abuse among program participants. The Residential Student Assistance Program targeting institutionalized adolescents in New York reduced use of marijuana by 58.8 percent, alcohol by 72.2 percent, and tobacco by 26.9 percent. The SMART Leaders program, conducted in community settings in collaboration with Boys & Girls Clubs of America, decreased rates of alcohol, tobacco, marijuana, and illicit drug use among fourteen-to-seventeen-year-old Hispanic, African American, and white adolescents. In other examples, good junior high school interventions affect knowledge and attitudes about drugs, as well as use of cigarettes and marijuana. Positive results persist into the twelfth grade. A Cornell University study of six thousand students in New York state found that the odds of drinking, smoking, and using marijuana were 40 percent lower among students who participated in school-based substance-abuse prevention in grades seven through nine than among counterparts who did not. Similarly, an assessment of Project STAR found that forty-two participating schools in Kansas City, Missouri reported less student use of alcohol, tobacco, and marijuana than control sites. In addition to yielding effective

outcomes for program participants, cost-benefit studies indicate that a single dollar invested in prevention returns four to five dollars in reduced costs to society.[1]

Bridging the gap between research and practice is a major challenge. The federal institutes (NIDA, NIAAA, and NIJ) have taken an active role in synthesizing and disseminating research findings to practitioners who deliver school and community-based prevention and intervention every day. Over 240,000 copies of the NIDA publication *Preventing Drug Use Among Children and Adolescents: A Research-based Guide*[2] have been disseminated nationwide. OJJDP is evaluating the Drug-Free Communities Program, and CSAP is replicating programs that have been effective in early childhood and family-oriented settings.

Studies have shown that drug use rises when people do not perceive a risk in using drugs, when social disapproval of illegal drug use is minimal, when family bonds are weak, when school policies are lax, and when parents or other relatives have a history of alcoholism or drug dependence. Conversely, drug use is low when family, friends, schools, and society disapprove of drugs. Drug-abuse prevention promotes health factors and reduces risk factors.

Early intervention for substance abuse is of critical importance during the infancy to preschool period when brain development is more rapid and extensive, and much more vulnerable to environmental influences. Research provides evidence that stressful experiences during these early years of life negatively affect brain development and place children at risk for developing a variety of cognitive, behavioral and emotional difficulties.[3] Multiple services–including those related to substance abuse–should be available early in a child's life in order to address the child's needs for support in the physical, developmental, cognitive, emotional and social facets of his/her life. Research shows that early intervention programs that target children while their personality and adaptive capacity are still forming, rather than when the personality structure has become less malleable, can be very effective.[4] Prevention services targeting the specific risk factors (e.g., parental substance abuse, inconsistent/harsh parenting, low socioeconomic status) encountered in the child/family are considered highly efficient in early childhood.

The family is vitally important and the long-lasting influence of early parent-child or caregiver-child interactions provide the building blocks for children's social, cognitive, and academic development. A well-functioning family during the early years provides the nurturing environment that is essential for healthy development.[5] Because the stresses of today's economic and social conditions can undermine healthy parent-child relationships, early intervention requires a family-focused approach in order to empower parents in their parenting role, strengthen families, and foster the healthy development of young children.[6]

The Substance Abuse and Mental Health Services Administration (SAMHSA) and its Center for Substance Abuse Prevention (CSAP) have initiated several programs addressing the need to help young children develop positive relationships, emotions, and behaviors, facilitating their readiness to enter and succeed in school and avoid substance abuse. The

Starting Early Starting Smart Program, developed and conducted collaboratively with the Health Resources and Services Administration, the Administration for Children and Families, the U.S. Department of Education, the National Institutes of Health, and The Casey Family Program, is supporting twelve sites, each serving from 100-500 children ages 0-7 and their families. These grant programs are testing the effectiveness of integrating behavioral health services within primary care and/or early childhood service settings. Grantees are providing a variety of services and interventions including pediatric primary care, home visitation, substance abuse intervention and treatment, domestic violence services, and mental health services in expectation that access to and use of behavioral health services will improve and increase, children's development will be enhanced, and family functioning will improve. In CSAP's *Developmental Predictor Variables Program*, grantees are developing knowledge about effective substance abuse prevention interventions by linking them with appropriate developmental stages. In these 10 grants (each serving between 200 and 400 children), children in four age groups (3-5 years old, 6-8 years old, 9-11 years old, and 12-14 years old) and their parents/caregivers are receiving comprehensive interventions in the areas of social competence, self-regulation and control, school bonding and academic achievement, and parental/caregiver involvement. Studies will determine which interventions at which developmental stage work effectively in preventing or redirecting negative behaviors that are predictive of substance abuse.

Nevertheless, a single prevention program is not a vaccination that inoculates children against substance abuse. Multiple exposures to anti-drug material, clear and accurate information, and supportive environments that consistently reinforce prevention messages are necessary. The "no-use" message must be repeated by parents, teachers, clergy, coaches, mentors and other care givers. The effectiveness of prevention is difficult to measure given the lag-time between when a young person participates in a program and when he or she might start using drugs. MTF historical data, for example, demonstrate that marijuana use among adolescents tends to change in inverse proportion to the percentage of youths that disapprove of marijuana or perceive such use to be risky. According to the 1999 MTF, drug-usage rates change two years after attitudes.[7]

The Central Role of Parents

While all parents exert a critical influence on youngsters, mothers and fathers of children, eight to fourteen, years of age, are especially influential. Young people in this age group normally condemn drug use. Such attitudes and attendant behavior are easily reinforced by involved parents. Adults who wait until older ages to guide offspring away from drugs allow peers to make more of a difference in their kids' lives.

SAMHSA/CSAP's High Risk Youth program has found that protective factors and family bonding reduce dramatically between ages ten and fourteen. Based on such evidence, SAMHSA/CSAP has established a new Parenting and Family Strengthening program in states, communities, and organizations. In FY 1999, this 2-year program is funding 96 cooperative

agreements to increase local community capacity to deliver best practices in effective parenting and family programs, to document the decision-making processes for selecting and testing effective interventions in community settings, and to determine the impact of the interventions on target families. Projects are expected to learn about the strategies, programs, and services that are effective in raising awareness that good parenting and health and strong families are major factors in decreasing substance abuse among youth. SAMHSA/CSAP will determine the effectiveness of dissemination materials, technical assistance, and training through feedback from grantees. Grantees will field test the model to determine which programs are most appropriate for the culture and age of a target population. In addition, SAMHSA/CSAP's Parenting IS Prevention uses all accessible media to reach parents -- at home, through their children's school, places of worship, workplaces, and communities.

Children whose parents abuse alcohol or other drugs face heightened risks of developing substance-abuse problems themselves. An estimated eleven million such children under age eighteen live in the United States. Every day, these youngsters receive conflicting and confusing messages about substance abuse. Nevertheless, specially crafted prevention messages can break through the levels of denial inherent in these families. SAMHSA/CSAP's Children of Substance-Abusing Parents is developing community-based interventions for such youngsters. In addition, SAMHSA/CSAP has awarded ninety-three grants to identify, implement and evaluate local adaptations of scientifically defensible family and parenting programs.

People from all walks of life -- including teachers, coaches, youth workers, clergy, scout leaders, and relatives -- can provide youth with important protection from drug abuse. These mentors can help children by modeling, teaching, and reinforcing positive behavior. Data from the CSAP-funded Across Ages program – which involves grandparents or older citizens with elementary school children in community service projects, parenting and family workshops, and tutoring -- suggest that one-on-one mentoring relationships are effective in improving attitudes about substance use if the mentors spend at least four hours per week with young people.

Substance-Abuse Prevention in Early Childhood

Longitudinal studies show that during childhood anti-social behavior is the strongest predictor of chronic delinquency, and that early childhood is a perfect time for intervention.[8] Children who have not developed crucial intellectual, emotional, and social abilities by age three are more likely to have problems that can limit lifelong potential. Early risk factors include parental criminality and substance abuse, low verbal ability, social disorganization and violence in the neighborhood, poor family management practices, inconsistent and/or harsh parenting, low socioeconomic status, and exposure to media violence. Prevention is highly efficient at this early stage when children and caregivers are susceptible to learning.

SAMHSA has initiated *Starting Early-Starting Smart,* a collaborative effort with the Casey Family Program, Department of Education, and Department of Health and Human Services to find new approaches to demonstrate what works, and create community-based partnerships for

children and their families or caregivers. This initiative includes strategies to reach children from birth to seven years who are affected by alcohol, drug abuse, and mental health disorders within families. A population of 8.3 million American children faces a significantly higher risk of early substance abuse, addiction, and a variety of physical and mental health problems. CSAP has developed prevention interventions specifically designed for these children and families as part of an interagency Strengthening Families Initiative.

Since 1992, the Robert Wood Johnson Foundation has supported *Free to Grow: Head Start Partnerships to Promote Substance-Free Communities.* This program provides early childhood education, health, and social services to more than 750,000 low-income children in urban, suburban, and rural communities throughout the United States. This initiative addresses the problem of substance abuse by strengthening families and neighborhoods. *Free to Grow* supports the design and implementation of model substance-abuse prevention projects within local Head Start programs.

National Youth Anti-Drug Media Campaign

The goal of ONDCP's bipartisan five-year National Youth Anti-Drug Media Campaign is to harness the media to educate America's youth to reject illegal drugs. Advertising, television programming, movies, music, the Internet, and print media have a powerful influence on young people's view of drugs and other dangers. The campaign focuses on primary prevention – heading off drug use before it starts – for three reasons:

1. Primary prevention targets the underlying causes of drug use and therefore has the greatest chance of success.
2. Over time, primary prevention will reduce the need for drug treatment, which is in short supply.
3. A media campaign has more potential to affirm the anti-drug attitudes of youth who are not involved with drugs than to persuade regular drug users to give up drugs.

The media campaign is based on medical and behavioral research. The campaign was developed in consultation with scores of experts in behavioral science, medicine, drug prevention, teen marketing, advertising and communications, and representatives from professional, civic, and community-based organizations.

The media can play a critical role in public-health campaigns because of its educational ability to impart information and influence behavior. A carefully planned mass media campaign can reduce substance abuse by countering false perceptions that drug use is normal. In the past, media campaigns have proved successful in changing risky behaviors, such as driving under the influence of alcohol or without seat belts. The media campaign needs to be integrated with anti-drug programs and other outreach initiatives based in homes, schools, places of worship and community-based organizations.

An integrated communications approach was instituted in 1999, at which time the Office of National Drug Control Policy began packaging anti-drug themes for advertising and programming. The topics are divided into four to six-week periods – a process called flighting – during which time a single message "platform" is communicated. Local coalitions and other partners can amplify these messages by adding their own.

Matching contributions from media outlets also multiply the impact of these messages. When advertising is purchased from a media outlet, the outlet must match it dollar-for-dollar with a pro bono public service activity. Most matches involve time and space for public service announcements (PSAs); media outlets match a paid PSA with a second one of equal value in a similar time slot. Magazine inserts, program content, web site development, and community events also qualify for the pro bono match.

The Advertising Council and the American Advertising Federation choose eligible PSAs for both national and local media markets. Themes include underage drug, alcohol and tobacco use, parenting skills, mentoring, and structured activities for young people. In 1999 alone, the campaign shared more than 265,000 radio and television time slots with forty-four national organizations. To cite an analogy, "a rising tide floats all boats." Many related causes are served by the anti-drug media campaign.

"Branding" was also introduced in 1999 to unite parent message platforms; create synergy between advertising and non-advertising programs and maximize campaign awareness and impact. The campaign's parent brand is "The Anti-Drug." It is a promise to provide America's youth and their parents with unequivocally honest and straightforward information -- no hype, just honest, factual information. "The Anti-Drug" branding was launched in September 1999 in new advertising, targeted at parents, for television, radio, print, out of home media and parenting brochures.

In 1999, the following organizations contributed to anti-drug efforts: the national Future Farmers of America (FFA), the YMCA of the USA and Youth Service America, National Association of State Alcohol and Drug Abuse Directors (NASADAD), Community Anti-Drug Coalitions (CADCA), the National Association of Children of Alcoholics, the National Middle School Association, the 21st Century Teachers Network, the National Elementary School Press Association, Cable in the Classroom, *The New York Times, Latina*, the Congress of National Black Churches, Global Mission Church, local churches and synagogues in various cities, Sun Microsystems, Media One, America Online, CSAP, NASA, and more than twenty federal agencies participating in the campaign's Federal Website Initiative.

The campaign developed Internet sites with industry giants like America Online (AOL). Content is being developed for campaign-related web sites. F*reevibe.com* helps youngsters make positive, well-informed, life-style decisions. The Parents' Drug Resource Center -- on AOL at Keyword "Drug Help"-- teaches parents about underage drug use, connects them to drug-help resources, and offers expert advice on child-rearing. Other Internet initiatives

combine online banner ads with educational mini-sites, online sponsorships, promotions and interactive events.

During the past year, the campaign reached 90 percent of America's youth at least four times a week through advertising; and communicated advertising messages in eleven languages to youth and adults of every ethnic group, including African American, Hispanic, Native American, Asian American, and Aleutian. The campaign represents the largest ethnic effort implemented to date by the U.S. government (expenditure in excess of $17 million), as well as strategic use of African American-, Hispanic- and Asian-owned media vehicles to enhance message credibility and impact.

In less than two years, the campaign's messages have become ubiquitous in the lives of America's youth and their parents. From network television advertisements to school-based educational materials, from youth basketball backboards to Internet web sites, and from community festivals to sitcom story lines, the campaign's messages reach Americans wherever they are – work, play, school, worship and home.

Safe and Drug-Free Schools and Communities

The Department of Education's reauthorization proposal for the Safe and Drug-Free Schools and Communities Act (SDFSCA) aims to insure every school in the United States will be free of drugs, violence, and the unauthorized presence of firearms, tobacco, and alcohol. Guided by extensive input from SDFSCA program participants, evaluation studies, and program reviews, the reauthorization proposal requests significant changes that would promote improvements in programs funded under the SDFSCA. Two key changes include the following:

1. Emphasize the importance of research-based programs. States would competitively award subgrants to school districts and other applicants, largely in accordance with the quality of their plans. Consistent with the Principles of Effectiveness, grantees would be required to implement research-based programs to address identified needs and established goals, and to regularly assess progress. The proposal would also increase support for state activities to help applicants create and implement effective, accountable programs.

2. Strengthen program accountability. State and local recipients of SDFSCA funds would be required to adopt outcome-based performance indicators and report regularly on their progress. Continuation of local grants would be conditioned upon achievement of satisfactory progress toward meeting performance targets. School districts would also have to develop a comprehensive "Safe Schools Plan" to ensure that essential program components are in place and that school efforts are coordinated with related community-based activities.

The reauthorization proposal reflects the direction the Department of Education's Safe and Drug-Free Schools Program is taking to ensure that SDFSCA fund recipients -- including

governors, state education agencies, local education agencies, institutions of higher education, and community organizations -- adopt programs and practices that are based on research and evaluation. The proposal calls for a comprehensive approach that requires collaboration among agencies and organizations at the federal, state and local level. One example of such collaboration is the funding provided to more than two thousand community anti-drug coalitions through the 20 percent governors set-aside of SDFSC funds.

Key initiatives of the Safe and Drug-Free Schools Program in 1999 have included the Safe Schools/Healthy Students Initiative and the Middle School Drug Prevention and School Safety Program Coordinators Initiative. The Safe Schools/Healthy Students Initiative, announced by the President in Spring 1999, is a grant program jointly administered by the U.S. Departments of Education, Health and Human Services, and Justice. The Initiative promotes community-wide strategies for school safety and healthy child development across the country. These strategies provide students, schools, and communities enhanced educational, mental health, social service, law enforcement, and, as appropriate, juvenile justice system services that can bolster healthy childhood development and prevent violence and alcohol and other drug abuse. Grants under this Initiative have been awarded to fifty-four local educational agencies in partnership with local law enforcement and public mental health authorities. Awards range from three million dollars per year for urban school districts, two million dollars per year for suburban school districts, and one million dollars per year for rural school districts and tribal schools. A national evaluation of the Safe Schools/Healthy Students Initiative will be conducted to document the effectiveness of collaborative community efforts to promote safe schools and provide opportunities for healthy childhood development.

Under the Middle School Drug Prevention and School Safety Program Coordinators Initiative, ninety-seven school districts received $34.6 million in grants to recruit, train, and hire coordinators in middle schools. The three-year grants were awarded to school districts and a consortia of smaller districts with significant drug, discipline and violence problems in middle schools.

After-School Initiatives

Reducing the precursors of drug use -- aggression, conduct disorders, shyness, and lack of school and family attachment – can be achieved through after-school activities. Mentoring programs increase the involvement of high-risk youth with caring adults. SAMHSA/CSAP is supporting: 1) Project Youth Connect to evaluate the comparative benefits of youth only versus parent AND youth mentors and to determine the conditions under which mentoring flourishes and produces good results; 2) a public education campaign, Your Time --Their Future, to encourage adults to get involved with youth to help young people build skills, self-discipline, and competence to resist alcohol, tobacco, and illicit drugs; and 3) a conference in January 2000 to learn from experts mentoring efforts and to begin development of a mentorship compendium for widespread distribution.

Drug-Free Communities

The nation's drug problem is really a collection of local "epidemics" that cry out for local strategies, carefully crafted interventions, and coordinated action on the part of local schools, churches and other faith-based organizations, human service organizations, law enforcement agencies, business leaders, elected officials, and individual citizens. Local coalitions, comprised of a broad sector of community leadership, are working to devise sound strategies based on local data and knowledge of a growing body of scientifically supported program ideas. Local leaders know that they must sustain their efforts into the foreseeable future if we are to normalize drug use and significantly reduce drug demand at the community level.

The Drug-Free Communities Program, created through the Drug-Free Communities Act of 1997 and implemented by a broad bi-partisan partnership at the federal level provides funds, knowledge, and other resources to help local leaders prevent youthful drug problems, including the underage use of alcohol, tobacco, inhalants, as well as the illicit drugs.

The Drug-Free Communities Program completed its second year of grant-making in 1999 and now supports 215 communities located in forty-five states, Puerto Rico, and the U.S. Virgin Islands. More than three hundred communities submitted applications for grants during 1999, and 124 of those newly funded were selected through a rigorous peer-review process managed by the Office of Juvenile Justice and Delinquency Prevention, one of three federal partners administering the program. OJJDP also administers the independent evaluation being conducted on the Drug-Free Communities Program.

The Drug-Free Communities Program continues to enjoy bi-partisan congressional support that has authorized federal funding over the five-year period from FY1998 through FY2002. Applicant communities must match their grant awards with funding from non-federal sources. Communities may re-apply for federal funds over an additional four years, but after year two become eligible for decreasing levels of federal support. The intent of Congress is to support programs that are able to support themselves in the future through local resources only.

The Center for Substance Abuse Prevention (CSAP) carries out training and technical assistance to grantee communities through a network of private sector collaborators. The regional Centers for the Application of Prevention Technologies (CAPT) offices offer high quality, research-based knowledge and information to the grantees. Several major information clearinghouses and the CSAP-sponsored National Clearinghouse for Alcohol and Drug Information (NCADI) provide free or low-cost material directly to all U.S. communities.[9]

In December 1999, SAMHSA announced the results of an extensive study of community anti-drug partnerships. Statistically significant reductions in drug and alcohol use were found among males in communities with such programs. Furthermore, the study found that adults reporting less illicit drug use also referred to four conditions, correlated with lower rates of substance use. These include 1) living in an anti-drug partnership community, 2) being

involved in substance abuse prevention activities, 3) living in a neighborhood perceived to have minimal illicit drug trading or illicit drug markets, and 4) having a disapproving attitude toward the use of illicit drugs. A core set of desirable strategies that can be used by other communities were identified among model community partnerships identified in this study. These include a comprehensive vision, a wide sharing of this vision, avoidance or resolution of severe conflict in the partnership, nondisruptive partnership staff turnover, a strong core of committed partners, an inclusive and broad-based membership, decentralized management and extensive and diverse prevention activities.

The Drug-Free Communities Program is complemented by a number of private sector organizations and other public agencies, including the National Guard, Mothers Against Drunk Driving (M.A.D.D.), AmeriCorps and National Inhalant Prevention Coalition, that provide useful tools, occasional funding and frequent communications among the communities and other useful resources. The program is ably guided by the Advisory Commission on Drug-Free Communities, an eleven member, presidentially-appointed expert group representing many sectors and organizations across the United States. The Community Anti-Drug Coalitions of America (CADCA) is a coalition membership organization that provides a wide array of technical support, program ideas, and advocacy to community coalitions around the U.S. CADCA (www.cadca.org) actively assists the Drug-Free Community grantees on a regular basis. Join Together, a Boston University based organization, examines and reports on critical issues of interest to communities around the issues of drugs, guns, and violence.

At the national level, future initiatives will involve creating new training capabilities, detailed descriptions of successful local innovations that can be replicated through public/private coalitions, and better dissemination and utilization of scientific knowledge about the application of prevention strategies in the natural environments of neighborhoods and communities.

Civic and Service Alliance

Volunteer-based organizations continue to make major contributions to the national counter-drug effort. Since November 1997, an alliance of civic, fraternal, service, veterans, sports, and women's groups has been helping young people pursue healthy, drug-free lifestyles. Currently, national service organizations representing more than a hundred million volunteers are members of a "Prevention Through Service Alliance."* Through a resolution agreement, member

* Current Alliance member organizations are 100 Black Men of America, Inc., AMBUCS, AMVETS, Benevolent and Protective Order of Elks, Big Brothers Big Sisters, Boys and Girls Clubs of America, Boy Scouts of America, B'nai B'rith Youth Organization, Camp Fire Boys and Girls, Campus Outreach Opportunity League, Civitan International, Fraternal Order of Eagles, General Federation of Women's Clubs, Girls, Inc., Girl Scouts of the USA, Improved Benevolent and Protective Order of Elks of the World, Independent Order of Odd Fellows, Jack and Jill of America, Inc., Junior Chamber International, Knights of Columbus, Lions Clubs International, Moose International, Masonic National Foundation for Children, Mothers Against Drunk Driving, National Beta Club, National Council of Negro Women, National Council of Youth Sports, National Exchange Club, National Family Partnership, National 4-H Council, National FFA Organization, National Panhellenic Conference, National Retired

organizations have pledged to achieve five objectives: increase substance-abuse prevention messages to their members and the youth they serve, establish a communication link to share programs and resources, collaborate on community prevention efforts, promote service opportunities for youth, and publicly recognize young people involved in community service.

Alliance organizations offer mentoring programs, school-based curricula dealing with drug prevention, and educational brochures for youth. Other Alliance-supported activities that promote a drug-free lifestyle include youth groups, sports teams, scholarships, and specific drug-free events. Many Alliance groups have assisted in the ONDCP National Youth Anti-Drug Media Campaign. During this coming year, a significant number of Alliance partner organizations will provide pro-bono contributions to the media campaign through their national publications and web sites.[10]

Workplace Prevention Initiatives

Research on U.S. workers reveals that 73 percent of current illicit drug users were employed in 1998. This number represents 8.3 million full-time and part-time workers.[11] Drug abuse costs American workplaces $14.2 billion dollars in reduced productivity each year.[12]

The federal drug-free workplace initiative was established in 1986. Currently covering 120 agencies and 1.8 million employees, the federal approach includes a clear policy, employee education on the dangers and consequences of illicit drug use, supervisory training, drug testing, and provisions for employee assistance. In developing this program, the federal government drew on the U.S. military's experience, which demonstrated how commitment to a change in institutional values virtually eliminated drug abuse in the workplace. As a result of drug testing federal employees, drug use decreased to less than .005 percent since its inception. In June 1999, President Clinton issued an executive order directing the Federal Employees Health Benefit Program, the nation's largest provider of health insurance, to offer full coverage, by the year 2001, for substance-abuse treatment, equal to any other medical condition by the year 2001.

Implemented in the interest of public safety and expanded under the Omnibus Transportation Employee Testing Act of 1991, the Department of Transportation's (DOT) mandatory drug-free workforce initiative has helped reduce drug abuse in the transportation industry. It also serves as an example for other workplaces in America. DOT's program, covering eight million individuals, encompasses more than just drug testing; it is built around employee education, supervisory training, and rehabilitation for transportation industry workers. The level of positive drug test results among transportation workers has dropped approximately 50 percent since the program's onset. SAMHSA/CSAP works with DOT to assist Canada and Mexico in implementing drug and alcohol testing for Canadian and Mexican drivers on U.S.

Teacher's Association, Optimist International, Pilot International, Quota International, United Native Tribal Youth, Ruritan national, Sertoma International, The Links, Inc., Veteran's of Foreign Wars, YMCA of the USA, Youth Power, Youth to Youth International, YWCA of the USA, and Zeta Phi Beta Sorority, Inc.

highways who are subject to the same drug and alcohol testing regulations that apply to U.S. transportation workers. SAMHSA/CSAP provides consultation services to DOT in its negotiations with the Mexican Government on certifying a government laboratory to conduct drug testing. DOT's testing of workers with safety-sensitive duties -- along with education and referral to treatment -- has proven a winning strategy for preventing and reducing substance abuse on our highways, airways, sea lanes, harbors, pipelines and in transportation workplaces across our nation.

Adoption of anti-drug programs in the private sector, most notably by employers with worksites of more than five hundred employees, has produced a two-thirds reduction in the rate of positive drug test results in the last decade -- from 13.6 percent in 1988 to 4.7 percent in 1999.[13] Within a comprehensive approach, drug testing has proven to be an effective tool not only to identify drug use before serious harm or accidents develop but as a way to cut through the denial of many drug users, which frequently impedes their ability to seek treatment. According to a study by the American Management Association of its membership's (typically larger employers) corporate practices, workplace drug testing increased from 1987 to 1996 by 1200 percent. Likewise, the perceived effectiveness of drug testing increased from 50 percent to 90 percent in 1996. Companies combining testing with other anti-drug initiatives report test positive rates 33 percent to 50 percent lower than companies that conduct drug tests only.[14]

However, 80 percent of private-sector U.S. workers are employed in small or medium-sized organizations which have a significantly lower percentage of drug-free workplace programs. Considerable challenges remain for these businesses to emulate the reduction in work-related accidents, absenteeism, health-care expenses, and worker compensation costs reported by larger employers implementing drug-free programs. To help address this need among smaller employers, Congress passed the Drug-Free Workplace Act of 1998, funding thirty new grants and contracts through the Small Business Administration's new Drug-Free Workplace Demonstration Program. The initiative distributed a total of $4 million to fifteen intermediaries, such as drug-testing firms and employee-assistance programs in twelve states and to fifteen of the SBA's Small Business Development Centers in thirteen states to provide information and specialized technical assistance to help small business owners establish drug-free workplace programs.

Other federal workplace efforts include SAMHSA/CSAP's Workplace Helpline.[15] SAMHSA/CSAP also assists businesses implement drug-free workplace programs through its website (www.health.org/workpl.htm), and by providing supplemental materials, and training programs on request.[16] Additionally, businesses and other employers can access the Department of Labor's (DOL) Working Partners for an Alcohol- and Drug-Free Workplace initiative, which includes specific outreach to small businesses, a web-based Substance Abuse Information Database, and the interactive Drug-Free Workplace Advisor. To date, *Working Partners* has armed two-thousand business associations and labor organizations with information and other resources to implement effective drug-free workplace programs, and has answered more than twenty-one thousand customer inquiries about the Drug-Free Workplace Act of 1988 and similar issues.

Another challenge is helping long-term unemployed substance abusers become productive, employable workers. Many states have experienced remarkable success in decreasing welfare rolls. However, a significant percentage of the remaining unemployed suffer from alcohol or drug abuse, impeding their ability to succeed as wage earners. To help these individuals make a successful transition to meaningful employment, DOL supplies funds through the Workforce Investment Act of 1998 targeted for substance abuse services to the unemployed, and thirty-two million dollars in Welfare-to-Work grants to overcome employment barriers such as substance abuse. The Employment and Training Administration's (ETA) local youth programs prepare young workers at risk of using drugs or experiencing substance-abuse difficulties with drug-abuse counseling and the Job Corps program enforces a zero-tolerance policy that includes drug testing, assessment, and treatment referrals. To date, ETA has awarded fifty million dollars in Welfare-to-Work grants explicitly for those welfare recipients among the hardest to employ with substance-abuse problems. The workplace is an ideal venue for influencing drug-use behavior and shaping community norms for drug-free living.

Athletic Initiative

Each year approximately 2.5 million students play football and basketball in high school and junior high. Millions of children are involved in soccer and softball leagues, among other sports. Studies show that a young person involved in sports is 40 percent less likely to get involved with drugs than an uninvolved peer. Scores of children admire professional athletes, but these stars often convey mixed messages pertaining to drugs -- if not outright pro-drug attitudes.

In 1998, ONDCP began an Athletic Initiative Against Drugs to communicate anti-drug messages and offer young people positive alternatives to getting into trouble with drugs.[17] During 1999, ONDCP provided coaches across the nation with the *Coach's Playbook Against Drugs,* which provides coaches with information to help them prevent drug use among their students and teams.[18] ONDCP/CTAC is sponsoring a comprehensive analysis of the use of banned substances and drugs of abuse among Olympic, professional, collegiate and high school athletes in America to identify more effective substance abuse testing, sanctions and treatment. ONDCP joined a wide-range of athletes and teams -- from the victorious U.S. Women's World Cup soccer team to the New York Rangers and Knicks -- to reach our nation's children.

The use of drugs in sports has become a serious threat -- not just to elite athletes but to high school football, youth soccer, and Little League baseball players across the nation. The 1999 Monitoring the Future Survey found that youth steroid use increased approximately 50 percent over the prior year. To help address this growing threat, ONDCP, the Department of Health and Human Services, and the White House Olympic Task Force have been working together on behalf of young athletes. As part of this effort, ONDCP is assisting the U.S. Olympic Committee in forming an independent, quasi-governmental agency to oversee amateur athletic drug-testing in the United States. Internationally, ONDCP worked with the twenty-six nations assembled at the Sydney, Australia Summit on Drug Use in Sport to develop an international

agreement on combating this threat and with the International Olympic Committee (IOC) to ensure that its new World Anti-Doping Agency can effectively solve the problem.

Faith Initiative

Faith institutions represent stable, strategically placed, accessible influences on social norms, attitudes, and behaviors. Traditionally, they have helped the underserved and marginalized in society, establishing programs for women, youth, and prison communities. Religious communities have established a vast administrative, media, and communication infrastructure. National leaders have the power to shape policy, resources, and activities at the national, state and community levels.

Religion plays a vital role in building social values, informing the actions of individuals and inculcating skills that can help people resist illegal drugs. Many clergy--rabbis, priests, and ministers -- run programs that provide much-needed counseling and drug treatment for members of their community. In 1992, SAMHSA/CSAT established its Faith Initiative and works in collaboration with The Johnson Institute and One Addict, One Church, Inc. In 1999, ONDCP encouraged religious groups to speak out against drugs and develop faith-based initiatives to treat drug use.

ONDCP is actively involved in establishing linkages with faith communities. It plans to identify a national database of congregations and interfaith organizations. Parent groups and civic organizations are natural partners for faith communities whose volunteers devote substantial time to drug prevention and treatment.

In 2000, ONDCP will continue its anti-drug activities so that substance-abuse prevention will remain a prominent part of these groups' agenda. ONDCP provides resource materials (anti-drug brochures, tool kits, and op-ed pieces) to assist faith leaders in incorporating substance-abuse prevention programs into their ministries.

Law-Enforcement Prevention Activities

Many federal agencies form government partnerships to prevent drug use. DEA's Demand-Reduction Program supports youth-oriented drug prevention and educational activities like the Boys Scouts of America's Law Enforcement Explorer Program. The FBI's Community Outreach program disseminates prevention material and sponsors youth programs like Adopt-A-School and Junior Special Agent Classrooms. The Bureau of Justice Assistance (BJA) created Drug Abuse Resistance Education (DARE) – the nation's predominant school-based drug abuse and violence prevention program. BJA helped with the revision of the DARE curriculum, which is being implemented by more than 8,600 law-enforcement agencies, the accreditation of five regional training centers, and the expansion of the program. The Office of Juvenile Justice and Delinquency Prevention (OJJDP) provides a life-skills training program that will provide curriculum materials, training, and technical assistance at seventy demonstration sites. The

National Citizens' Crime Prevention Campaign focuses on educating adults to reduce solutions for reducing juvenile crime and drug use. The Office of Justice Programs supports projects related to juvenile substance abuse, like Combating Underage Drinking Program, and the Juvenile Mentoring program. All Weed and Seed sites are required to have "Safe Havens" -- after-school programs where anti-drug education joins a range of constructive activities.

Countering Attempts to Legalize Drugs

Given the negative impact of drugs on society, the overwhelming majority of Americans reject illegal drug use. Indeed, millions of citizens who once used drugs have turned their backs on such self-destructive behavior. While most people remain steadfast in condemning drugs, small elements at either end of the political spectrum argue that prohibition -- not drug abuse -- creates problems. These groups offer solutions in various guises, but one of the most troublesome is the notion that eliminating the prohibition against dangerous drugs would reduce the harm drugs cause. Such legalization proposals are often presented under the euphemism of "harm reduction."

All drug policies claim to reduce harm. No reasonable person advocates a position consciously designed to be harmful. The real question is: which policies *actually* decrease harm and increase good? The approach advocated by people who say they favor "harm reduction" -- when they are really supporting drug legalization -- would in fact harm Americans.

The theory behind what legalization advocates call "harm reduction" is that illegal drugs cannot be controlled by law enforcement, education, public-health interventions, and other methods. Therefore, proponents say, harm should be reduced by the decriminalization of drugs, heroin maintenance, and other intermediate measures. The real intent of many harm-reduction supporters is the legalization of drugs, which would be a mistake.

Some people argue that they are not calling for the legalization of all drugs but only "soft" drugs. Since many users enter treatment every year to help recover from chronic abuse of marijuana and other "soft" drugs, this idea overlooks the danger posed by such substances. Groups that support decriminalization of drugs, so that drug use would remain against the law but penalties would be minimal, want use of illegal drugs to resemble minor indiscretions like jay-walking. Other defenders emphasize the therapeutic value of specific drugs or economic viability of drug-related products. By making drug use more acceptable, these people argue, society would reduce the harm associated with drug abuse.

The truth is that drug abuse wrecks lives. It is shameful that more money is spent on illegal drugs than on art or higher education, that crack babies are born addicted and in pain, that thousands of adolescents lose their health and future to drugs. Addictive drugs were criminalized because they are harmful; they are not harmful because they were criminalized. If drugs were legalized in the U.S., the cost to the individual and society would grow astronomically.

- The Use of Marijuana as Medicine

Because of its high potential for abuse and lack of accepted medical use, marijuana is a Schedule I drug under the provisions of the Controlled Substance Act, Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970. Federal law prohibits the prescription, distribution, or possession of marijuana and other Schedule I drugs such as heroin and LSD and strictly controls the medical use of Schedule II drugs like cocaine and methamphetamine. Federal law also prohibits the cultivation of *cannabis sativa*, the marijuana plant. Marijuana is similarly controlled internationally through inclusion on Schedule I of the 1961 U.N. Single Convention on Narcotic Drugs. In the past decade, data regarding the negative impact of marijuana on our youth has accumulated. As described in Chapter II, marijuana use by young people correlates with delinquent and antisocial behavior.

The Administration is adamantly opposed to the use of marijuana outside of authorized research.[19] However, legitimate medications containing marijuana components have proven effective in relieving the symptoms of some medical conditions. Dronabinol, a synthetic form of the major psychoactive component in marijuana -- tetrahydrocannabinol (THC) -- has been approved by the Food and Drug Administration (FDA) to control nausea in cancer patients receiving chemotherapy and stimulate appetite in AIDS patients. This pill form of THC has been approved and available for fifteen years and sold under the trade name Marinol.® Dronabinol was rescheduled in 1999 to Schedule III of the Controlled Substances Act, making it more available to patients.

The Administration has opposed marijuana ballot initiatives in jurisdictions throughout the nation. This opposition is based on the fact that such electoral procedures undermine the medical-scientific process for establishing what is a safe and effective medicine; contradict federal law; and are potential vehicles for the legalization of recreational marijuana use. Ballot initiatives to date have generally not limited the use of marijuana to a small number of terminally-ill patients, as most voters envisioned. Rather, they commonly allow marijuana to be obtained without prescription for any medical condition and to be used indefinitely without evaluation by a physician.

The U.S. medical-scientific process has not closed the door on marijuana or any other substance that may offer therapeutic benefit. However, both law and common sense dictate that the process for establishing medicines should be thorough and science-based. By law, laboratory and clinical-trial data must be submitted to medical experts in the DHHS, including the FDA, for evaluation of safety and efficacy. If scientific evidence, including results from well-controlled clinical studies, demonstrates that the benefits of a product outweigh associated risks, then the drug can be approved for medical use. This rigorous process protects public health. Allowing marijuana, or any other substance, to bypass this process is unwise.

In light of the need for research-based evidence, ONDCP asked the Institute of Medicine (IOM) in January 1997, to review the scientific evidence concerning the medical use of

marijuana and its constituent cannabinoids. ONDCP felt that an objective, independent evaluation of research regarding use of marijuana for medical purposes was appropriate given the ongoing debate about the health effects of cannabis. The IOM published *Marijuana and Medicine: Assessing the Science Base* in March 1999.[20] This study is the most comprehensive summary of what is known about marijuana. It emphasizes evidence-based medicine (derived from knowledge and experience informed by rigorous analysis) as opposed to belief-based opinion (derived from judgment or intuition untested by science).

The IOM study concludes that there is little future in smoked marijuana as medication. Although marijuana smoke delivers THC and other cannabinoids to the body, it also contains harmful substances, including most of those found in tobacco smoke. The long-term harms from smoking make it a poor drug delivery system, particularly for pregnant women and patients with chronic diseases. In addition, cannabis contains a variable mixture of biologically active compounds. Even in cases where marijuana can provide symptomatic relief, the crude plant does not meet the modern expectation that medicines be of known quality and composition. Nor can smoked marijuana guarantee precise dosage. If there is any future in cannabinoid medications, it lies with agents of more certain -- not less certain -- composition and in the development of delivery systems that permit controlled doses. Medical marijuana must conform to classical pharmacological practices that support clinical research.

The United Nations' International Narcotics Control Board (INCB), which ensures an adequate world supply of drugs for medical purposes, has stressed that research must not become a pretext for legalizing cannabis. If the drug is determined to have medicinal value, the INCP maintains that its use needs to be subjected to the same stringent controls applied to cocaine and morphine. "Should the medical usefulness of cannabis be established," the 1999 INCB annual report states, "it will be a drug no different from most narcotic drugs and psychotropic substances. Cannabis, prescribed for medical purposes, would also be subject to licensing and other control measures under international drug control treaties." The INCB report concluded that, "Political initiatives and public votes can easily be misused by groups promoting the legalization of all cannabis and/or the prescription of cannabis for recreational use under the guise of medical dispensation."

- "Industrial" Hemp

Under the Controlled Substances Act, the definition of marijuana includes all parts of the Cannabis Sativa plant except for the sterilized seeds, the fiber from stalks, and oil or cake made from the seeds.[21] However, all hemp products which contain any quantity of THC are considered Schedule I controlled substances and cannot be imported into the United States or cultivated domestically without DEA registration and permits for importation.

Hemp products -- fiber for use in the manufacture of cloth, paper, and other products, like seed for birdseed -- were authorized for importation during the last decade. Over the past two years, the Drug Enforcement Administration (DEA) has received information that sterilized cannabis seed, not solely birdseed, has been imported for the manufacturing of food products intended for human consumption. DEA also learned from the Armed Forces and other federal agencies that individuals who tested positive for marijuana use subsequently raised their consumption of these food products as a defense against their positive drug tests. Consequently, the Administration is reviewing the importation of cannabis seeds and oil because of their THC content. NIDA is also studying the effect of ingesting hemp products on urinalyses and other drug tests.

The government is concerned that hemp cultivation may be a stalking horse for the legalization of marijuana. According to the Department of Agriculture, hemp has limited economic viability.[22] Hemp hurds, the woody part of the plant stem, can not compete with materials, like wood that are already in great abundance. Hemp oil is also noncompetitive with better-studied food oils such as soy or canola, or well-established drying oils like linseed or tung. Even if domestically-grown hemp replaced all imported hemp fiber, yarn, and fabric, it could be grown on nine-hundred acres or two average-sized farms in the United States. If hemp has any economic viability, the Department of Agriculture estimates it will be to support a niche market for the fiber -- and then only if high yields and prices can be sustained. Although initial profitability might be observed, the thinness of the current U.S. market might rapidly result in an over-supply of the product.

Child Welfare Initiatives

The safety of children and families is jeopardized by the strong correlation between chemical dependency and child abuse. Several studies recently demonstrated that approximately two-thirds of more than 500,000 children in foster care have parents with substance-abuse problems.[23] Yet, according to the Child Welfare League of America, last year only 10 percent of child welfare agencies were able to locate treatment within a month for clients who needed it.[24] According to SAMHSA, 37 percent of substance-abusing mothers of minors received treatment in the past year.[25] A new federal law regarding adoption and child welfare, the Adoption and Safe Families Act (P.L. 105-89), requires that substance-abuse services for parents be provided promptly if families are to be afforded realistic opportunities for recovery before children in foster care are placed for adoption.

In addition to compromising parental ability to raise children, substance abuse also interferes with the capacity to acquire or maintain employment. An estimated 15 to 20 percent of adults receiving welfare have substance-abuse problems that prevent employment.[20] Nevertheless, our welfare system fails to address adequately the familial consequences of substance abuse. If drug prevention and treatment are not provided for this high-risk population, these families will remain extensively involved in the welfare and criminal-justice systems at great cost to society and with devastating consequences for children. Welfare agencies are typically inexperienced in dealing with substance-abuse issues and may need technical assistance to identify addiction and make appropriate referrals.

To address these issues, SAMHSA/CSAP's Parenting Adolescents and Welfare Reform Program focuses on the parenting adolescent, who often must rely on welfare, to prevent or reduce alcohol, tobacco, and drug use; improve academic performance; reduce subsequent pregnancies; and foster improvement in parenting, life skills, and general well-being through preventative interventions. This program will generate information about the effects of welfare reform on parenting teens and identify effective procedures for dealing with such a population. This program funded ten grants to begin investigating the interface between the social support system and its most vulnerable clients. Results expected in 2002 should be informative, despite the program's limited scope and duration.

Youth Tobacco Initiative

The Youth Tobacco Initiative is a multifaceted HHS campaign coordinated by the Centers for Disease Control and Prevention (CDC). Its purpose is to reduce availability and access to tobacco and the appeal tobacco products have for youth. The initiative includes funding for tobacco prevention and cessation programs, research, legislative projects, regulation, and enforcement. It is supported by the FDA, NIH (National Institutes of Health), and SAMHSA. The FDA, under the Food, Drug and Cosmetics Act, regulates and enforces federal age and identification requirements regarding the sale of tobacco products. The FDA also conducts an extensive advertising campaign to deter retailers from selling tobacco products to minors. The NIH -- through the National Cancer Institute, NIDA, and others -- supports biomedical and clinical research on tobacco. SAMHSA, through its Substance Abuse Prevention and Treatment (SAPT) Block Grant, administers the SYNAR Amendment, which requires state legislative and enforcement efforts to reduce the sale of tobacco products to minors. Since the enactment of SYNAR in 1994, states have increased their retailer compliance rates from approximately 30 percent to 74 percent in 1998.

States are at the forefront of efforts to prevent tobacco use by youth. Arizona, California, Florida, and Massachusetts are conducting paid anti-tobacco media campaigns restricting minors' access to tobacco, limiting smoking in public places, and supporting school-based prevention. CDC provides funding for state health departments and national organizations to conduct tobacco-use prevention and reduction programs, including media and educational

campaigns, training, and surveys. The CDC's Office on Smoking and Health has developed a four-point prevention and control strategy to support state campaigns. CDC's Media Campaign Resource Center provides the states with television and radio advertisements as well as printed material. The federal government is responsible for the diffusion of science-based models and strategies in support of state and community efforts. Accordingly, the CDC funds evaluations of specific programs and disseminates information to the public. The CDC's *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction*, for example, includes recommendations on tobacco-use policies, tobacco prevention education, teacher training, family involvement, tobacco-use cessation programs, and evaluation.

Youth Alcohol Use Prevention

Alcohol is clearly the drug of choice among American youth. Although the legal drinking age in all states is twenty-one, data from the 1998 NHSDA indicate that about 10.4 million current drinkers (meaning they used alcohol at least once during the previous thirty days) were age twelve to twenty years old. NIAAA is sponsoring a number of initiatives to address youth use of alcohol, including: Alcohol Screening Day, NIAAA National Advisory Council's Subcommittee on College Drinking, and the Kettering Foundation National Issue Forums on alcohol. The Surgeon General also supports an initiative on underage drinking. SAMHSA/CSAP, in collaboration with NIAAA, is conducting a five-year research grant to determine the short- and long-term exposure of youngsters to alcohol advertising, alcohol expectancies, and other mediating variables -- including actual consumption of alcohol by youth. This research will identify, test, and/or develop interventions that are effective in reducing alcohol-related problems among college students. SAMHSA/CSAP is studying drinking on colleges and universities; drinking and driving; children of parents in treatment; Native Americans; media literacy; practitioner education; Fetal Alcohol Syndrome prevention; environmental strategies to provide teens and their parents with information, materials, and skills to communicate about drinking among underage youth; prevention practices; and alcohol policy at the federal, state and local level. The National Youth Anti-Drug Media Campaign's pro-bono match requirement has generated more than twelve million dollars in public service advertising time and space for organizations like Mothers Against Drunk Driving and NCADD.

Comprehensive Prevention Systems

It has been well established that prevention works best when a comprehensive approach is used -- including youth, family, school, and community activities. Results from SAMHSA/CSAP's Community partnership and coalition programs reflect the positive effects of such an approach.

SAMHSA/CSAP's State Incentive Grant (SIG) is designed to coordinate all substance-abuse prevention funding within a state and implement prevention programs in selected communities. This competitive grant serves as an incentive for states to synchronize state-wide prevention with private and community-based organizations. Eighty-five percent of SIG funds must be devoted to actual prevention programming, and 50 percent or more of the activities must involve science-based programs. Twenty-one grants have already been awarded to states and the District of Columbia, with some governors reporting having leveraged as much as $10 for every $1 invested. For example,

- In Vermont, funds from United Way agencies, Safe and Drug-Free Schools, and other grants from state and local agencies and private businesses have been merged to support local prevention activities.

- The SIG program in Oregon calls upon the state to work with every county to develop a comprehensive plan incorporating substance-abuse prevention in schools, the juvenile justice system, and teen pregnancy concerns. The state is also working for the first time with nine tribal governments to implement substance-abuse prevention.

- In Kansas the SIG prompted the governor to issue an executive order establishing a Governor's Substance-Abuse Prevention Council. This cabinet level group has already conducted a county-level resource assessment and developed a science-based prevention publication that integrates guidelines and strategies across multiple federal and state funding sources.

To address the technical assistance and training needs of SIG states and community subrecipients, as well as non-SIG states, and to facilitate the selection and adoption of science-based prevention models at the local level that meet community needs, SAMHSA/CSAP's Centers for the Application of Prevention Technologies will be expanded.

2. Treating Addicted Individuals

Despite our best efforts, some people invariably will use drugs. A proportion will become addicted. Since this group causes untold damage to themselves, their families, and their communities, the addicted population must be targeted as a vital part of the *Strategy*. In a given year, addicts consume most of the heroin and cocaine in America. By reducing the number of addicts, we can greatly decrease the negative social and human consequences of drug abuse. Drugs have severe negative consequences for abusers' mental and physical health. Drug abuse and addiction also have tremendous implications for the health of the public since drug use is now a major vector for the transmission of infectious diseases, particularly HIV/AIDS, hepatitis, and tuberculosis -- and for the infliction of violence. Because addiction is such a complex and pervasive health issue, overall strategies must encompass a public-health approach, including extensive education and prevention efforts, treatment, and research.

Research on Addiction[27]

Scientific research and clinical experience have increased our understanding of addiction, which is characterized by compulsive drug-seeking and use -- even in the face of negative consequences. Virtually all drugs of abuse have common effects, either directly or indirectly, on a single pathway deep within the brain: the mesolimbic reward system. Activation of this system appears to be what motivates substance abusers to keep taking drugs. All addictive substances affect this circuit. Not only does acute drug use modify brain function in important ways, but prolonged drug use causes pervasive changes in brain function that persist long after the individual stops taking a drug. Significant effects of chronic use have been identified for many drugs at all levels: molecular, cellular, structural, and functional.

The addicted brain is distinctly different from the non-addicted brain, as manifested by changes in metabolic activity, receptor availability, gene expression, and responsiveness to environmental cues. Some of these long-lasting changes are unique to specific drugs whereas others are common to many drugs. We can actually see these changes through use of recently developed technologies, like positron emission tomography. Understanding that addiction is, at its core, a consequence of fundamental changes in brain function means that a major goal of treatment must be to reverse or compensate for brain changes through medication or behavior modification.

Addiction is not just a brain disease. The social context in which the disease develops and expresses itself is critically important. The case of thousands of returning Vietnam veterans who were addicted to heroin illustrates this point. In contrast to addicts on the streets of America, the veterans were relatively easy to treat. American soldiers in Vietnam who became addicted did so in a totally different setting from the one to which they returned. At home in the United States, veterans were exposed to very few of the conditioned environmental cues that had been associated with drug use in Vietnam. Conditioned cues can be a major factor in causing recurrent drug cravings and relapse even after successful treatment.

Addiction is rarely an acute illness. For most people, it is a chronic, relapsing disorder with a significant volitional dimension. Total abstinence for the rest of one's life is relatively rare following a single experience in treatment. Relapses are not unusual. Thus, addiction must be approached like other chronic illnesses – such as diabetes, hypertension -- rather than acute conditions, such as a bacterial infection or broken bone. This approach has serious implications for how we evaluate treatment. Viewing addiction as a chronic, relapsing disorder means that a good treatment outcome may be a sizeable decrease in drug use and long periods of abstinence.

Status of Drug Treatment

Significant progress has been made in understanding and treating addiction. Major longitudinal studies shown that drug use and criminal activity decline upon entry into treatment and remain below pre-treatment levels for up to six years. Progress is being made in developing a strategy for treatment, an infrastructure to foster accountability, and superior practices.

The Center for Substance Abuse Treatment (CSAT) is responding to *the National Drug Control Strategy's* performance measures of effectiveness with a plan that addresses the treatment gap, the stigma associated with treatment, improving treatment systems, and connecting services and research. The plan resulting from expert analysis and public testimony will be available in the summer of 2000.

The Office of National Drug Control Policy (ONDCP) is piloting an information system with treatment programs around the country that will be expanded by the Department of Health and Human Services (HHS) into the National Treatment Outcome Monitoring System (NTOMS). Under NTOMS, treatment performance will be measured and compared. In addition, an agreement has been negotiated with the states to establish a common set of outcome measures to be applied to programs receiving federal funding. ONDCP is working with HHS to reform methadone treatment, replacing process-oriented regulations with clinically-based accreditation. These changes will improve treatment accountability.

Treatment services are being fostered through manuals created by the National Institute on Drug Abuse (NIDA), Treatment Improvement Protocols and addiction curricula by CSAT, clinical guidelines by the Veteran's Administration (VA), and a comprehensive curriculum for treatment by the Federal Bureau of Prisons (BOP). State and local treatment programs with promising results are applying these resources. CSAT's Addiction Technology Transfer Center's (ATTC) Curriculum Committee, in collaboration with the National Association of Drug and Alcohol Counselors (NAADAC), the International Certification Reciprocity Consortium/Alcohol & Other Drug Abuse (ICRC), International Coalition of Addiction Studies Educators (INCASE), and the American Academy of Health Care Providers in the Addictive Disorders, produced CSAT Technical Assistance Publication No.21, Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice, describing the educational outcomes essential to the competent practice of addiction counselors. This CSAT

publication has been widely distributed to the field and is now serving as the basis of the NAADAC and the ICRC practice guidelines. CSAT has also joined with the Certification Board for Addiction Professionals of Florida and a number of national stakeholder organizations to develop core competencies for substance-abuse counselors. Ultimately, these efforts will lead to a body of certified professionals equipped with manuals reflecting the most advanced approaches to treatment.

Progress on so many fronts not withstanding, a significant treatment gap -- defined as the difference between individuals requiring treatment and those receiving it -- remains. Many more people are in need of treatment than are receiving it. According to recent estimates drawn from the *National Household Survey on Drug Abuse* (NHSDA), approximately five million drug users needed immediate treatment in 1998, and 2.1 million received it. The NIAAA report, *Improving the Delivery of Alcohol Treatment and Prevention Services,* estimates that there are fourteen million alcohol abusers whereas the *1998 National Household Survey on Drug Abuse* found approximately ten million dependent on alcohol.

Certain parts of the country have little treatment capacity of any sort. Likewise, some populations -- adolescents, women with small children, as well as racial and ethnic minorities -- are woefully under-served. Some modalities – namely methadone -- fall quite short of needed capacity. Furthermore, while treatment should be available to those who seek it, society also has a strong interest in treating populations that need treatment but will not seek it. Drug-dependent criminal offenders and addicts engaging in high-risk behavior are important candidates for treatment, whether they seek it or not. Ultimately, calculations of the treatment gap should include both actual demand and populations that society has a special interest in treating due to the high social cost associated with their drug use.

Starting in 2000, a new methodology -- based on clinical criteria -- will be employed in the NHSDA. This new approach will provide improved national estimates by August 2001. More precise numbers will be helpful in determining the magnitude of the treatment gap and targeting resources to the areas where the gap is greatest.

Inadequate funding for substance-abuse treatment is a major problem. Over the last decade, spending on substance-abuse prevention and treatment increased more slowly than overall health spending, to an estimated annual level of $12.6 billion. Of this amount, public spending is estimated at $7.6 billion. The public sector includes Medicaid, Medicare, federal agencies like the Veterans Administration, the Substance Abuse Prevention and Treatment (SAPT) Block Grant, and other state and local government expenditures. Private spending is estimated at 4.7 billion and includes individual out-of-pocket payment, insurance, and other non-public sources.

One of the main reasons for the higher outlay in public spending is the frequently limited coverage by private insurers. The lack of coverage and recent changes in payment structures affects attitudes, resources, treatment plans, and the quality of treatment. Private and public insurers are not working collaboratively; thus, more public resources are utilized and

government funds, which were intended to be a safety net, have become a primary option for many individuals.

In addition to resource limitations, other factors block drug treatment, including restrictive policies and regulations, incomplete knowledge of best practices, resistance to treatment on the part of certain populations in need, and limited information on treatment at the state and local level. To address these problems, the *National Drug Control Strategy* lays out specific actions in five areas:

1. Increase SAPT Block Grant funding to close the treatment gap.

2. Target funding under SAMHSA's Targeted Capacity Expansion program that requires best practices and outcome measures in addressing existing and emerging treatment needs; expanding treatment service to vulnerable and underserved populations, including minorities, injection drug users, substance abusers at risk of HIV/AIDS, women and their children, adolescents, methamphetamine users; expanding outreach programs to those at risk of HIV/AIDS; and expanding community options for criminal justice sanctions with criminal and juvenile justice clients.

3. Regulatory change to make proven modalities more accessible: reform regulation of methadone/LAAM treatment programs, maintain and improve program quality; train treatment programs and physicians on the proper administration of opiate agonists and emerging pharmacotherapies; conduct demonstrations of physician administration of opiate agonists; and provide for comprehensive evaluation of the impact of regulatory reform on treatment access, quality, and cost.

4. Continue to examine possible changes in policy to remove current barriers such as providing parity in insurance coverage. For example, the President recently announced that the Federal Employees Health Benefits Plan (FEHB) would provide parity for both substance abuse and mental health services.

5. Review restrictive policies or practices such as the Medicaid IMD exclusion, which limits access to residential substance abuse treatment services.

6. Prioritize research, evaluation, and dissemination, including: state-by-state estimates of drug treatment need, demand, and treatment services resources; dissemination of best treatment practices; guidance on ways to increase retention in treatment and reduce relapse; and foster progress from external coercion to internal motivation.

Expanding Treatment for Adolescents

More community-based drug treatment for troubled teens is needed, particularly within the juvenile correctional system. Adolescents with alcohol and drug problems are not adequately served in most existing drug-treatment programs designed for adults. IOM's 1990 report, *Treating Drug Problems*, estimated that about four hundred thousand people under eighteen years of age were annually in need of treatment. Adolescents rarely seek help for problems related to alcohol and other drug use. Referrals by juvenile courts are too often the first intervention. By this time, substance abuse has contributed to delinquent behavior, violence, and high-risk activities like unprotected sex and driving while intoxicated. There is also a paucity of research-based information about the juvenile treatment. SAMHSA/CSAT, in collaboration with NIAAA, is supporting a five-year research grant, titled *Treatment for Adolescent Alcohol Abuse and Alcoholism,* which will contribute to the development of good treatment for adolescents. SAMHSA/CSAT is addressing these problems by evaluating interventions for teens and providing communities with grants for adolescent treatment through its Targeted Capacity Expansion program.

Services for Women

Although women use illegal drugs at lower rates than men, they experience the use and consequences of drugs and alcohol differently and require gender-appropriate prevention and treatment. Women who use illegal drugs, alcohol, or tobacco during pregnancy create health risks for themselves and the unborn children. Exposure to alcohol in-utero is associated with Fetal Alcohol Syndrome, Fetal Alcohol Effects, infant mortality and morbidity, attention deficit disorder, and other health problems. Women face unique barriers to treatment, such as the stigma associated with being a substance-abusing mother, fear of losing custody of children or housing, and lack of child-care. Substance abuse by older women, including alcohol and misuse of prescription and over-the-counter drugs, is a problem that merits more attention as our population ages.

Women in recovery from drug abuse are likely to have a history of violence and trauma. Consequently, they may be suffering from post-traumatic stress disorder. SAMHSA is addressing this issue in a two-phased study on Women, Co-Occurring Disorders, and Violence. This research seeks to discover ways to improve women's outcomes following substance abuse. In addition, the study promotes improved coordination of services through an integrated delivery system for services.

Providing Services for Vulnerable Populations

As a result of managed care and changes in the welfare and health-care system, much-needed services may be less available to vulnerable populations, including racial and ethnic

minorities like African-Americans, Native Americans, Alaskans, Hispanics, Asian American/Pacific Islanders; children of substance-abusing parents; the disabled; the poor; and people with co-occurring mental disorders. Our overall challenge is to help chronic drug users overcome dependency and lead healthy, productive lives.

Substance Abuse and Co-Occurring Mental Disorders

According to the National Comorbidity Survey, more than 40 percent of persons with addictive disorders also have co-occurring mental disorders. Data suggests that mental disorders precede substance abuse more than 80 percent of the time, generally by five to ten years.[28] We must take advantage of this window of opportunity to predict drug-abuse and prevent it. In addition, treatment providers must recognize co-occurring mental disorders and addiction in order to prevent relapse and improve the likelihood of recovery.

Roughly ten million people in the United States have co-occurring substance abuse and mental disorders. These individuals experience more severe symptoms and greater functional impairment than persons with a single disorder, have multiple health and social problems, and require more care. In addition, dual disorders are often associated with unemployment, homelessness, contact with law enforcement, and other medical problems, like HIV/AIDS.

According to the Department of Veterans Affairs, about a third of adult homeless people once served their country in the armed services. On any given day, as many as 250,000 veterans (male and female) are living on the streets or in shelters, and perhaps twice as many experience homelessness at some point during the course of a year. About 45 percent of homeless veterans suffer from mental illness and 70 percent have alcohol or other drug abuse problems. Considerable overlap exists between these two categories.

Treatment of co-occurring substance abuse and mental-health disorders have historically been provided by multiple service delivery systems, which at times have been at odds with one another, organizationally, philosophically, and financially -- often to the detriment of the people in need.

A new paradigm is necessary for providing services to a spectrum of co-occurring disorders. Early intervention, integrated treatment, cross-training of staff, licensing of medical personnel (psychiatrists, psychologists, etc.), consistent qualifications for other mental-health and addiction personnel, and sufficient funding are among the areas where innovative solutions are badly needed. Long-term studies of co-occurring disorders can help identify the best courses of treatment.

Parity for Substance-Abuse Treatment

From a scientific standpoint, management of addiction is similar to treating other chronic relapsing disorders. Were insurance parity in place, substance-abuse treatment would be subject

to the same benefits and limitations as other comparable disorders. Unfortunately, most employer-provided insurance policies currently require greater burdens on the patient in terms of cost-sharing, co-payment, and deductibles while offering less coverage for the number of visits or days of coverage and annual lifetime dollar expenditures for treatment. Many health insurance companies impose lower lifetime limits on amounts that can be expended for drug and alcohol treatment than for other illnesses. Parity for substance-abuse treatment would correct this unfair practices and expand the amount of available treatment.

Parity is affordable. According to the SAMHSA report *The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits*, the average premium increase due to full parity would be 0.2 percent -- just a dollar per month for most families.[29] Furthermore, other medical expenses incurred by treated patients are less than for untreated clients. Therefore, substance-abuse prevention and intervention would save employers money in both the short and long term. Documentation and validation of best practices for health-service providers are currently underway and will provide added cost offset, cost benefit, and cost utility incentive for both private- and public-sector employers.

Ending the disparity between drug abuse and other diseases through legislation would reduce the treatment gap. Such action could be particularly useful for adolescents who are covered by parents' insurance plans. Parity legislation will lessen demands on publicly funded treatment programs by people with private insurance. Parity and the ensuing privatization of treatment would encourage more effective interventions. Indeed, the lack of private insurance for drug-abuse treatment discourages the development of new therapies.[30] Legislation supporting parity will move drug treatment further into the mainstream of health care and reduce the stigma associated with addiction.

The federal government has taken an historic step with regard to drug abuse and is serving as a model for other employers. In June 1999, the President announced that the Federal Employee Health Benefit Program would offer parity for mental-health and substance-abuse coverage by 2001. This unprecedented initiative will provide access to treatment for nine million people including federal employees, retirees, and their families. This action underscores the federal government's commitment to quality coverage for mental illness, substance abuse, and physical illness.

Medications for Drug Addiction

Pharmacotherapies are essential for reducing the number of addicted Americans. Methadone therapy, for example, is one of the longest-established, most thoroughly evaluated forms of drug treatment. NIDA's Drug Abuse Treatment Outcome study found that methadone treatment reduced participants' heroin use by 70 percent and criminal activity by 57 percent while increasing full-time employment by 24 percent. A 1998 review by the General Accounting Office put the situation this way: "Research provides strong evidence to support methadone maintenance as the most effective treatment for heroin addiction." Methadone

therapy helps keep more than 100,000 addicts off heroin, off welfare, and on the tax rolls as law-abiding, productive citizens. "A Notice of Proposed Rule Making" -- published in the Federal Register on July 22, 1999 -- proposed a new system for federal oversight of opioid treatment programs. This new system will transfer regulatory oversight from FDA to SAMHSA, provide greater flexibility to practitioners, and require program accreditation as a means of implementing *best practice* guidelines.

Buprenorphine is another medication under consideration for the treatment of opiate addiction. Buprenorphine and the combination drug Buprenorphine/Naloxone were developed under a cooperative research and development agreement between NIDA and a private industry. Buprenorphine shares some, but not all, of the properties of an opiate. Unlike methadone, which is an agonist, Buprenorphine is a "partial" agonist. In other words, it possesses both agonist and antagonist properties and therefore poses less potential for abuse or overdose. Another benefit of Buprenorphine is that the withdrawal syndrome that occurs upon discontinuation is mild to moderate and often can be managed without the administration of narcotics. ONDCP is working with HHS, NIDA, FDA, DEA, and Congress to expedite use of this medication in clinics as well as office-based treatment settings.

NIDA will continue funding a high-priority program to discover new medications for treating drug abuse. These research projects could result in new pharmacotherapies. Specific projects include development of an anti-cocaine agent, a controlled-release dosage of oral methadone, medications to treat withdrawal symptoms in babies born to opiate-dependent mothers, and medicines for methamphetamine addiction. Under ONDCP/CTAC sponsorship, Columbia University College of Physicians and Surgeons has been synthesizing highly active protein compounds of catalytic antibodies, which will act as a peripheral blocker and reduce serum cocaine concentrations in the blood. SAMHSA will develop treatment standards for new medications, as required by the Narcotic Addict Treatment Act (NATA).

Behavioral Treatment Initiative

Behavioral therapies remain the only effective treatment for many drug problems, including cocaine addiction, where viable medications do not yet exist. Furthermore, behavioral intervention is needed even when pharmacological treatment is being used. An explosion of knowledge in the behavioral sciences is ready to be translated into new therapies. NIDA is encouraging research in this area to determine why particular interventions are effective, to develop interventions that could reduce AIDS-risk behavior, and to disseminate new interventions to practitioners in the field. More specifically, this initiative will focus on adolescent drug use.

National Drug Abuse Treatment Clinical Trials Network

Over the past decade, NIDA-supported scientists have improved pharmacological and behavioral treatment for drug addiction. However, most of the newer methods are not widely

used in practice because they have been studied in relatively short-term, small-scale contexts conducted in academic settings on stringently selected populations. To reverse this trend and improve treatment nationally, NIDA is establishing a National Drug Abuse Treatment Clinical Trials Network (CTN) to conduct large, rigorous, statistically powerful, multi-site studies in community settings using diverse patients. Science-based therapies that are ready for testing in the CTN include new cognitive behavioral therapies, operant therapies, family therapies, brief motivational enhancement therapy, and manualized approaches to individual and group drug counseling. Among the medications to be studied are: naltrexone, LAAM, buprenorphine for heroin addiction, and a few other substances currently being developed by NIDA for use against cocaine addiction.

Practice Research Collaboratives Program (PRC)

This SAMHSA/CSAT-supported initiative will improve the quality of substance-abuse services by increasing interaction and knowledge exchange among community-based stakeholders, including drug-abuse treatment providers, researchers, and policy makers. Nine grantees have been funded to create the necessary infrastructure for bridging the gap between research and practice in various parts of the country. During an implementation phase, PRCs will develop a provider-based knowledge agenda, create a provider-based research infrastructure, and implement studies on the application of evidenced-based practices in community settings.

Treatment Research and Evaluation

NIDA supports over 85 percent of the world's research on drugs of abuse. Recent studies of pharmacotherapies and behavioral therapies for abuse of cocaine/crack, marijuana, opiates and stimulants (including methamphetamine) will improve the likelihood of successfully treating substance abuse. In addition, a comprehensive epidemiological system needs to be developed to measure the success of new therapies. NIDA will conduct clinical and epidemiological research to improve the understanding of drug abuse and addiction among children and adolescents. These findings will be widely disseminated to assist in finding more effective approaches to prevention. ONDCP/CTAC is sponsoring the development of the Drug Evaluation Network System (DENS), a system to evaluate and monitor substance abuse treatment programs by tracking, in real time, patients entering treatment, their characteristics and discharge status. This information is online and made available to treatment providers, researchers and managers. To ensure that basic research is put to good use, SAMHSA supports applied research. For example, SAMHSA is funding evaluations of sixteen-week methamphetamine interventions in non-residential (outpatient) psychosocial settings in California, Hawaii, and Montana. The objective is to determine whether promising results from stimulant treatment attained by the MATRIX Center in Los Angeles can be replicated.

Improving Federal Drug-Related Data Systems

This initiative will develop a comprehensive data system to inform drug policy. It will support ninety-four targets that constitute the *Strategy's* PME system. The ONDCP-coordinated Advisory Committee on Drug Control Research, Data, and Evaluation is reviewing existing data systems to identify "data gaps" and determine what modifications can be made to enhance the system. SAMHSA, for example, is increasing the sample size and scope of NHSDA to provide state-by-state data and greater information about drug use among twelve to seventeen-year-olds. More frequent estimates of the social costs of drug abuse will be made. The U.S. interdiction coordinator will complete a "cocaine flows" estimate model.

This initiative will improve the policy relevance of federal drug-related data systems by bringing them into alignment with the PME system. The Drug Control Research, Data, and Evaluation Advisory Committee's Subcommittee on Data, Research and Interagency Coordination has been reviewing data systems to identify "data gaps" and determine what enhancements can be made. Some of the efforts that the Subcommittee has supported include:

- National Institute on Justice expansion and revision of the Drug Use Forecasting program into the Arrestee Drug Abuse Monitoring (ADAM) system. Plans call for the expansion of ADAM to seventy-five sites with probability-based samples representative of their respective metropolitan areas. The new ADAM instrument will include questions that will enable estimation of the prevalence of drug abuse among arrestee populations, comparable with those generated for the general household population. The first ten new ADAM sites were funded by ONDCP in 1998.

- SAMHSA expansion of the sample for the National Household Survey on Drug Abuse -- nearly a tripling in size -- will permit, for the first time, estimation of drug-use prevalence at the state level. The first wave of new data will be available in August 2001.

- SAMHSA/CSAT is expected in FY 2001 to fund the implementation of the National Treatment Outcome Monitoring System (NTOMS). NTOMS will combine the work of two existing data systems currently funded by ONDCP -- the Drug Evaluation Network System, which provides real-time data on treatment admissions, and the Random Access Monitoring of Narcotics Addicts system, which estimates the size and characteristics of hardcore drug-using populations. NTOMS will provide essential data for the PME system on treatment, waiting time, and hardcore users.

ONDCP is currently leading an interagency effort to develop drug-flow models – from a source country through availability in the United States -- for cocaine, heroin, marijuana, and methamphetamine. Results from this project are providing critical measures for the PME system, enabling assessment of the nation's supply-reduction programs. The results from initial efforts are presented in the accompanying update on the Performance Measures of Effectiveness system.

Research into the Mechanisms of Addiction

Advanced brain imaging technology is being made available -- under ONDCP/CTAC funding to research scientists working on grants from the National Institute on Drug Abuse -- to identify the underlying causes of substance abuse. Over the last two years, CTAC has sponsored the development of advanced brain imaging at several leading research facilities throughout the country:

- Functional Magnetic Resonance Imaging to map brain reward circuitry, blood volume and flow associated with drug metabolism, and interactions with potential therapeutic medicines (Massachusetts General Hospital and Emory University)

- Positron Emission Tomography (PET) for ultra high resolution of neurobiological substrates of addiction via use of radioisotope tracers (University of Pennsylvania)

- Magnetic Resonance Spectroscopy to image the drug's metabolic and chemical processes (Harvard University/McLean Hospital).

Reducing Infectious Disease among Injecting Drug Users

Although the number of new AIDS cases has declined dramatically during the past two years because of the introduction of combination therapies, HIV infection rates have remained relatively constant. CDC estimates that 650,000 to 900,000 Americans are now living with HIV, and at least forty-thousand new infections occur each year. HIV rates among African Americans and Hispanics are much higher than among whites. Studies of HIV prevalence among patients in drug-treatment centers and women of child-bearing age demonstrate that the heterosexual spread of HIV in women closely parallels HIV among injection drug users (IDUs). The highest prevalence rate in both groups has been observed along the East Coast and in the South. Hepatitis B and C are also spreading among IDUs. IDUs represent a major public-health challenge. Addicted IDUs frequently have multiple health, mental health, and complex social issues that must be overcome in order to address their addiction, criminal recidivism, and disease transmission problems.

NIDA has created a center on AIDS and other Medical Consequences of Drug Abuse to coordinate a comprehensive, multi-disciplinary research program that will improve the knowledge base about drug abuse and its relationship to other diseases through biomedical and behavioral research. This work will incorporate a range of scientific investigation from basic molecular and behavioral research to epidemiology, prevention, and treatment. Information from each of these areas is essential for understanding the links between drug abuse and AIDS, TB, and hepatitis and for developing strategies for stemming infectious diseases spread through injection drug users. NIDA is conducting public-health campaigns to increase awareness of infectious diseases.

SAMHSA will continue its support of early intervention services for HIV through the SAPT block grants. Under the Congressional Black Caucus Initiative aimed at reducing the disproportionate impact of HIV/AIDS on racial and ethnic minorities, SAMHSA has awarded 108 new grant totaling over $39 million. The grants from SAMHSA's Targeted Capacity Expansion and Outreach Programs will improve substance-abuse treatment and prevention services in minority communities highly affected by the twin epidemics of substance abuse and HIV/AIDS.

Training for Substance-Abuse Professionals

Many health-care professionals lack the training to identify the symptoms of substance abuse. Most medical students, for example, receive little education in this area. If physicians and other primary-care managers were more attuned to drug-related problems, abuse could be identified and treated earlier. Many competent community-based treatment personnel lack professional certification. Consequently, SAMHSA/CSAT has worked collaboratively with the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) and the International Certification Reciprocity Consortium/Alcohol and Other Drugs (ICRC) to improve the states' credentialing systems that respect the experiences of individual treatment providers while they earn professional credentials. CSAT's publication *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* -- developed in consultation with CSAT's National Curriculum Committee of the Addiction Technology Transfer Centers, NAADAC, ICRC, International Coalition of Addiction Studies Educators (INCASE), and the American Academy of Health Care Providers in the Addictive Disorders -- provides a developmental framework for the acquisition of knowledge and skills required for professional counselor certification.[31]

3. Breaking the Cycle of Drugs and Crime

Drug-dependent individuals are responsible for a disproportionate percentage of our nation's violent and income-generating crimes like robbery, burglary, or theft. According to ADAM data, between one-half and three-quarters of all arrestees tested in twenty-three of the thirty-five cities around the country had drugs in their system at the time of arrest. About half of those charged with violent or income-generating crimes test positive for more than one drug. In 1997, a third of state prisoners and about one in five federal inmates said they had committed the offenses that led to incarceration while under the influence of drugs. Nineteen percent of state inmates and 16 percent of federal inmates said they committed their current offense to obtain money for drugs (up from 17 percent and 10 percent, respectively, in 1991).[32]

The nation's incarcerated population is now more than 1.8 million. According to the 1997 data (the latest year available), more than 60 percent of inmates in federal prison are sentenced for drug offenses, up from 53 percent in 1990. Time served for these offenses more than doubled between 1986 and 1997, rising from 20.4 months to 42.5 months. In the same period, overall time served nearly doubled, mostly due to increased penalties for drug, weapon, and immigration offenses. Increases for violent crime (9 percent) and property crime (1 percent) were modest by comparison. State prisons are also experiencing significant growth in the population of drug offenders: 21 percent of state prisoners in 1997 were incarcerated for drug law violations. Between 1990 and 1997, the number of drug offenders in state prison grew by 77,000.

Given the link between drugs and crime, reducing the number of drug-dependent criminals would decrease the amount of drugs consumed, the size of illegal drug markets, the number of dealers, and the amount of drug-related crime and violence. The corrections and treatment professions must join in common purpose to break the tragic cycle of drugs and crime by reducing drug consumption and recidivism among individuals in the criminal justice system. We should accelerate the expansion of programs that offer alternatives to imprisonment for non-violent drug offenders. Treatment must be made more available for drug-dependent inmates and those on probation or parole. Finally, adequate transitional programs should support inmates following release. The end result will be fewer addicts and drug users, less demand for drugs, less drug trafficking, less drug-related crime and violence, safer communities, and fewer people behind bars. The criminal justice system has already made much progress in providing treatment for offenders in correctional settings and in the community, but these programs can be expanded.

Substance Abuse Treatment for Incarcerated Offenders

Both state and federal agencies have established substance-abuse treatment programs in correctional institutions. Incarcerating offenders without treating underlying substance abuse simply defers the time when addicts return to our communities to start harming themselves and

the larger society. Between 60 and 75 percent of untreated parolees with histories of cocaine and/or heroin use reportedly resume use of those drugs within three months of release. As a crime-control measure alone, drug treatment for criminally active addicts is strikingly cost-effective. It offers the potential of reducing crime by two-thirds for about half the cost of incarceration alone.

According to the Federal Bureau of Prisons (BOP), the number of federal inmates receiving residential substance-abuse treatment increased from 1,236 in 1991 to 10,816 in 1999.[33] BOP provides drug treatment for inmates prior to release. The number of federal institutions offering residential treatment has grown from thirty-two to forty-four since 1994. In 1998 nearly 34,000 inmates participated in all types of BOP treatment services. A joint BOP/NIDA study is examining the effects and has provided an interim report addressing the first six months after release from custody. This period is significant because recidivism is generally highest within the first year after prison. The study found that the treated population was 73 percent less likely to be re-arrested and 44 percent less likely to use drugs than a comparison group that received no treatment.[34]

The Corrections Program Office of the U.S. Department of Justice has funded 118 state projects for substance-abuse treatment through Residential Substance Abuse Treatment (RSAT) for State Prisoners grants. One example of these projects is Delaware's in-prison program, which has provided institutional and transitional drug treatment since the late 1980s. The population that participated in both institutional and transitional treatment programs was 69 percent arrest-free and 35 percent drug-free, three years after release from custody, compared to 29 percent and 5 percent, respectively, for the non-treated group.[35]

The Drug-Free Prison Zone Demonstration Project

This initiative is being conducted jointly by ONDCP, the National Institute of Corrections, and BOP to reduce the availability of drugs in prisons. The program combines policy, testing, technology, treatment, and training -- including a program of regular inmate drug testing, the use of advanced technologies (e.g., ion spectrometry) for detection of drugs entering facilities, and the training of correctional officers and other institutional staff.

Detection technology contributed to a recent evaluation of Pennsylvania's comprehensive drug interdiction program. The results showed that drug use went down 64 percent, drug finds decreased by 41 percent, assaults on staff were reduced by 57 percent, assaults on other inmates dropped 70 percent, and the number of weapons seized declined by 65 percent. Similarly, at the Federal Correctional Institution in Tucson and the Metropolitan Detention Center in Los Angeles, detection technology produced a reduction in the rate of serious drug-related inmate misconduct (introduction, use, or possession of drugs) by 86 percent and 58 percent, respectively.

Twenty-eight BOP facilities are gathering information on visitor screening, inmate drug-testing, and five types of inmate misconduct. Eight states (Alabama, Arizona, California, Florida, Kansas, Maryland, New Jersey, and New York) began participating in January 1999 and are employing a variety of education, training, interdiction, and treatment measures. The initiative is being independently evaluated, and interim findings from BOP are expected by mid-2000 and from the states by the end of 2000.

Operating Standards for Prison-Based Therapeutic Communities (TCs)

The field-testing of operating standards was conducted by Therapeutic Communities of America (TCA) with ONDCP support. The resulting document was made available in December 1999. This groundbreaking contribution brings a new level of discipline to practitioner discussions of drug treatment. A comprehensive set of operating standards for prison-based TCs – over 120 across eleven program domains – has now been validated in operational prison settings. In its present form, the standards provide a blueprint for state and local leaders, and they will eventually be put into a format appropriate for use by national accrediting organizations. In the interim, continuing leadership by TCA and other professional organizations will be needed to provide guidance for the application of emerging standards and manuals.

Substance-Abuse Treatment Provided with Community Supervision

While there is a unique opportunity to offer substance-abuse treatment for the incarcerated, providing this treatment with community resources is more cost-effective. In 1996, states and localities spent over $27 billion in corrections, of which $21 billion was used for prison operations alone. The average annual cost per inmate was $20,142, ranging from a low of $8,000 to a high of $37,800. For the federal system, the annual cost per inmate was $23,500. By comparison, probation and parole costs in 1997 ranged from $1,110 per year for regular supervision to $3,470 for intensive supervision, and $3,630 for electronic supervision. Cost variation is explained primarily by caseload. The average caseload for regular probation was 175, and sixty-nine for regular parole. Average caseloads for intensive supervision probation and parole were thirty-four and twenty-nine, respectively; electronic supervision was twenty and eighteen.

Using the Federal Bureau of Prisons as a representative program, the annual cost of residential and transitional treatment and services was estimated at $3,000 per inmate. Generally accepted estimates of annual treatment costs per person in the community are: regular outpatient, $1,800; intensive outpatient, $2,500; short-term residential, $4,400; and long-term residential, $6,800. Thus, combining the most expensive community supervision with the most expensive treatment yields an estimated average cost of $10,430 per person per year compared to $20,142 for incarceration alone, and $23,142 for incarceration combined with treatment and transitional services. Drug Education for Youth (DEFY) is an intensive prevention program to

decrease youth interaction with the criminal justice system. Drug courts, TASC, BTC, and Zero-Tolerance have all helped make community supervision and treatment more effective.

DEFY

The DOJ-DEFY Program is an example of youth outreach intended to utilize role models (military personnel, police officers, etc.) to promote positive life choices, including drug resistance, in nine-to-twelve year-olds. The two-phased curriculum covers an intensive summer leadership camp coupled with a school-year mentoring program. Phase I is a five to eight-day summer leadership camp consisting of anti-drug and anti-gang education, self-esteem development, peer leadership, and physical education. Phase II consists of mentoring, workshops, and special events. The DOJ will sponsor the DEFY program's summer leadership camp and mentoring programs for civilian children and during the 2000-2001 school year in designated Weed and Seed sites.

Drug Courts

Drug courts provide a means of diverting drug offenders out of jails and prisons and referring them to community treatment. Drug courts seek to reduce drug use and associated criminal behavior by retaining drug-involved offenders in treatment. Defendants who complete the program either have their charges dismissed (in a diversion or pre-sentence model) or probation sentences reduced (in a post-sentence model). Title V of the Violent Crime Control and Law Enforcement Act of 1994 (P.L. 103-322) authorizes the Attorney General to make grants to state and local governments to establish drug courts. In October 1999, 416 drug courts were operating nationwide, including eighty-one juvenile, eleven tribal, ten family, and seven combined drug courts. Two hundred and seventy-nine were in planning stages, up from a dozen in 1994.[36]

Drug courts have been an important step forward in diverting non-violent offenders with drug problems into treatment and other community resources, leaving the criminal justice system to deal with violent and acts. One hundred and seventy-five thousand people have entered drug courts since their inception, and 122,000 graduated or remained active participants. A review of thirty evaluations involving twenty-four drug courts found that these facilities keep felony offenders in treatment or other structured services at roughly double the retention rate of community drug programs. Drug courts provide closer supervision than other treatment programs and substantially reduce drug use and criminal behavior among participants.[37]

Treatment Accountability for Safer Communities (TASC)

Created in the early 1970s and originally named Treatment Alternatives to Street Crime, TASC has demonstrated that the coercive power of the criminal justice system can be used to get individuals into treatment and manage their behavior without undue risk to communities. Through TASC, some drug offenders are diverted out of the criminal justice system into

community-based supervision. Others receive treatment as part of probation, and still others are placed into transitional services as they leave an institutional program. TASC monitors client progress and compliance – including expectations for abstinence, employment, and improved personal and social functioning – and reports results to the referring criminal-justice agency.[38]

Breaking the Cycle (BTC)

BTC encompasses the integrated application of testing, assessment, referral, supervision, treatment and rehabilitation, routine progress reports to maintain judicial oversight, graduated sanctions for noncompliance, relapse-prevention and skill-building, and structured transition back into the mainstream community. Since its inception in Birmingham, Alabama in June 1997, 8,385 assessments have been conducted with felony offenders to ascertain treatment needs; 2,395 offenders are currently active within the BTC Program. Over 72,447 drug tests were performed on offenders. Over 6,652 treatment referrals were made at the point of assessment. A bond has been implemented requiring felony offenders to report to TASC within forty-eight hours for assessment and urinalysis. The period of time that elapsed between a BTC offender's entry into the system and his/her TASC assessment dropped from twenty-four days in December 1997 to four days in August 1999. Disposition alternatives, including deferred and expedited dockets, have been established. These sentencing options were designed to utilize BTC compliance information to qualify defendants for early dispositions. By diverting these cases prior to the grand jury, circuit court docket space is available for jail cases. This "rocket docket" has allowed Birmingham to postpone construction of a new jail pending full review of needs.

According to results of the 1998 Arrestee Drug Abuse Monitoring Program, 67.1 percent of male offenders tested positive for drug use at the time of arrest. By contrast, only 23 percent of BTC offenders tested positive during routine random urinalysis after intervention had occurred. Retention rates exceeded 70 percent, and the rearrest rate remained in the single digits. A Policy and Advisory Oversight Committee composed of criminal justice representatives proactively identified systemic barriers and made substantial steps to develop solutions, including the development of a management information system to automate the assessment, offender tracking, and drug testing conducted by TASC.

Birmingham's success led to the expansion of the demonstration to three additional sites, for adult offenders in Jacksonville, Florida and Tacoma, Washington and for juvenile offenders in Eugene, Oregon. These sites are now beginning implementation.

Zero Tolerance Drug Supervision Initiative

This Presidential initiative proposes comprehensive drug supervision to reduce drug use and recidivism among offenders. The federal government will help states and localities implement tough new systems to drug test, treat, and sanction prisoners, parolees and probationers. This initiative will ensure that states fully implement the comprehensive plans to drug-test prisoners

and parolees as required by law. Results must be submitted to the Justice Department. This initiative also supports efforts by states like Maryland and Connecticut to begin drug-testing probationers on a regular basis.

Initiatives Currently Underway

Over the past two years, ONDCP has joined with the Departments of Justice and Health and Human Services to lay the foundation for systemic collaboration between justice and public health. Working together, these federal agencies have documented the state-of-the-science at the March 1998 consensus meeting of scholars, clinicians, and other practitioners and then proceeded on two fronts:

- Applying the science: expanding breaking the cycle demonstration to additional sites, demonstrating interdiction and intervention policies and technology through the drug-free prison zone demonstration, and validating operating standards for prison-based TCs.

- Crafting a policy – in concert with federal, state, and local agencies, as well as national organizations – to realize a separation of powers and contribute to public safety and health.

This science-based policy calls for the criminal and juvenile justice systems to operate in concert with other service systems, as a series of opportunities for intervention with drug and alcohol disordered offenders, with interventions to be carried out in a systematic manner, and at the earliest possible opportunity:

- To prevent entry into the criminal/juvenile justice system for individuals who can be safely diverted to community social-service systems;

- To limit entry into the criminal/juvenile justice system for adult and juvenile nonviolent offenders through community justice interventions in concert with other social-service systems; and

- To intervene with people who must be incarcerated or securely confined, through appropriate treatment and supervision, **both during and after** the period of confinement.

NIJ: INSERT INFORMATION ON THE EXPANSION OF THE ADAM PROJECT

Future Focus and Initiatives

In December 1999, a National Assembly of nine-hundred state and local officials, national organizations, and federal officials gathered in Washington, D.C. to address drugs, alcohol abuse, and the criminal offender. The assembly represented an unprecedented collection of health and justice officials from all branches and levels of government. It focused on what needs to happen for different service systems to enhance public safety and health. It worked toward consensus on policy to guide actions. Finally, it established clear expectations within government – operating as teams, developing action plans to implement sound policy, providing access to best practices, and providing one-stop technical assistance and training. Work is underway to establish a schedule for follow-through with each state.

In developing future strategies for expanding substance-abuse treatment within the criminal justice system, participants in the National Assembly expressed concern over: 1) the needs of juveniles; 2) the importance of keeping treatment providers in contact with all other agencies -- i.e. welfare, healthcare, and legal -- involved in monitoring the offender; and 3) the way in which treatment effectively deals with dually diagnosed offenders.

Juvenile Justice

The juvenile justice system presents an opportunity to break the cycle of substance-abuse and crime. The juvenile justice system was specifically developed to respond differently than the adult justice system to youth who commit crimes. Since its inception, the primary goal of this institution has been rehabilitation rather than punishment of youth in the context of the family. We are developing policy, passing laws, and implementing programs that enhance this approach. By nature, youth tend to be risk-takers and experimenters, who may engage in illegal behaviors at times. From a developmental perspective, adolescence is a transitional phase defined by physical growth coupled with some aggressive behavior, conflicts with parents, problems with other authority figures, and attraction to peers rather than families. Community, schools, and family all play prominent roles in juvenile development, and must be incorporated into any solution. The "strength-based approach" looks at the positive attributes of youth and builds on these factors, rather than focusing exclusively on what the youth has done wrong.

System Integration

Another challenge for the justice system is to reach beyond the immediate defendant and address family crises, domestic violence, juvenile delinquency, abuse and neglect, and a host of related problems. The justice system must incorporate means of intervening in a child's first problems with adults -- often in his or her own home during the early years of life. Community involvement in legal issues, particularly when they intersect with families and children, is essential for breaking the cycle of substance abuse, crime, and violence. An example of this concept in action is New Jersey's Unified Family Courts, which encompass a network of six

thousand volunteers, who bring together diverse segments of the court and community to collaborate on effective approaches to families in crisis.

4. Enforcing the Nation's Laws

The correlation between drugs and crime is high. Drug users commit crimes at several times the rate of people who do not use drugs. According to the Department of Justice, as many as 83 percent of inmates are past drug users. More than 51 percent reported substance abuse while committing the offense that led to their conviction. The heavy toll drug abuse exacts on the United States is reflected in related criminal and medical costs totaling over $67 billion. Almost 70 percent of this figure is attributable to the cost of crime.

Law-enforcement professionals show supreme dedication and face risks daily to defend citizens against criminal activity. Since 1988, nearly seven hundred officers throughout the country have been killed in the line-of-duty, and over 600,000 were assaulted. We owe a debt of gratitude to the men and women who put their lives on the line in defense of our safety.

The United States is based on the rule of law that ensures the security of all people. Reducing drugs and crime are among the nation's most pressing social problems. Trafficking and use of illicit drugs are inextricably linked to crime and place a tremendous burden on the economic and social conditions of our communities. Drugs divert precious resources that support the quality of life all Americans strive to achieve. Illegal drugs create widespread problems that produce fear, violence, and corruption. Residents are afraid to go out of their homes, legitimate businesses flee urban neighborhoods, and quality of life suffers. The data in Chapter II documents the nexus between drugs and crime. Strong law-enforcement policies contribute a great deal to reducing drug abuse and its consequences by:

Reducing demand. By enforcing the laws against drug use, police strengthen social disapproval of drugs and discourage use of drugs. Moreover, arrest -- and the resulting threat of imprisonment -- offers a powerful incentive for many addicts to take treatment seriously.

Disrupting supply. The movement of drugs from sources of supply to our nation's streets requires sophisticated organizations. When law enforcement detects and dismantles a drug ring, less heroin, cocaine, methamphetamine, or marijuana finds its way to our streets. Seizures reduce availability.

To use the power of law enforcement effectively, the *Strategy* promotes coordination, intelligence sharing, advanced technology, equitable sentencing policies, and a focus on criminal targets that cause the nation the most damage.

Law Enforcement Coordination

In unity there is strength. The more local, state, and federal law-enforcement operations reinforce one another, the more they share information and resources, the more they "deconflict" operations, establish priorities, and focus energies across the spectrum of criminal activities, the more successful the outcome of separate activities. The illegal drug trade is not a local but a national problem that is, in fact, international in scope. Drug trafficking gangs do not confine their activities to limited geographic boundaries. Accordingly, various federal, state, and local agencies have joined forces on national and regional levels to achieve better results. The El Paso Intelligence Center and the National Drug Intelligence Center (in Johnstown, Pennsylvania) produce strategic assessments of the drug threat and direct support to state and local law enforcement.

An example of outstanding collaborative effort among law-enforcement agencies was the partnership between the United States Marshals Service (USMS), United States Customs Service, and Internal Revenue Service in 1999. That year, the USMS arrested more than twenty-five thousand federal and fourteen thousand state and local fugitives. Over 85 percent of such arrests have a drug component. USMS leads fifty-four federal state and local Fugitive Apprehension Teams.

DOJ's Special Operations Division (SOD) is a national, multi-agency law-enforcement coordinating entity composed of agents, analysts, and prosecutors from the DEA, FBI, Customs, and DOJ's Criminal Division. SOD coordinates regional and national investigations against major drug-trafficking organizations threatening the United States – particularly transnational organizations. SOD works closely with OCDETF, HIDTA, and U.S. Attorneys' offices across the country. *Operation Rio Blanco* is an example of a successful SOD operation. It resulted in the arrest of fifty-five individuals and the seizure of three thousand kilograms of cocaine as well as fifteen million dollars in U.S. currency.

Assisting State and Local Agencies

The Department of Justice has adopted a two-pronged approach to help state and local communities. First, DOJ provides funding and technical assistance to law enforcement agencies at all levels. Second, DOJ funds initiatives by promoting testing and treatment for offenders, thus helping communities offer employment opportunities and prevent drug abuse.

The U.S. Attorney, as chief federal law-enforcement officer in each judicial district and the Department of Justice as a whole, works with state and local law-enforcement agencies to develop priorities, implement strategies, and provide leadership. DoJ assists communities and neighborhoods through the Edward Byrne Memorial State and Local Law Enforcement Assistance Program. Grants support multi-jurisdictional task forces, demand-reduction education involving police officers, and other activities directly related to preventing drug-related crime and violence. The Local law Enforcement Block Grant Program contributes

funds for hiring police, improving school safety, purchasing equipment, and setting up multi-jurisdictional task forces. Major national coordination programs include:

- High Intensity Drug Trafficking Area (HIDTA)

HIDTAs are regions with critical drug-trafficking problems that harm other areas of the United States. The ONDCP director -- in consultation with the Attorney General, Secretary of Treasury, heads of drug-control agencies, and appropriate governors -- designates these locations. There are currently thirty-one HIDTAs. In addition to coordinating drug-control efforts, HIDTAs assess regional drug threats, develop strategies to address the threats, integrate initiatives, and provide federal resources to implement initiatives. HIDTAs strengthen America's drug-control efforts by forging partnerships among local, state, and federal law-enforcement agencies; they facilitate cooperative investigations, intelligence sharing, and joint operations against drug-trafficking organizations. The Department of Defense gives priority support to HIDTAs in the form of National Guard assistance, intelligence analysts, and technical training. In 1999, the director of ONDCP designated selected counties in the following areas as HIDTAs: Central Valley California, Hawaii, New England, Ohio, and Oregon.

The HIDTA program advances the *National Drug Control Strategy* by providing a coordination "umbrella" for local, state, and federal agencies to combine anti-drug efforts through an outcome-focused approach. The resulting synergy eliminates unnecessary duplication of effort, maximizes resources, and improves information sharing within and between regions. Intelligence is coordinated at HIDTA Investigative Support Centers, which offer technical, analytical, and strategic support to participating agencies with access to agency databases and supplemental personnel. Currently, 949 local, 172 state and thirty-five federal law-enforcement agencies and eighty-six other organizations participate in 462 HIDTA-funded initiatives.

Regional HIDTA strategies concentrate on the formation of co-located, multi-agency drug task forces. Fundamental program standards and multi-jurisdictional efforts promote coordination among law-enforcement agencies. Strategies are developed based on the specific drug-trafficking threat in a region. Each regional HIDTA office is required to review its strategy and initiatives annually to improve effectiveness and respond to changes in the threat.

- Community-Oriented Policing

Community-Oriented Policing is an innovative crime-fighting strategy which recognizes that neighborhood problems can be solved best when police and community work together. This collaboration between civilians and officers has successfully decreased drug-related crime. The Office of Community Oriented Policing Services (COPS) advances policing of

anti-drug actions at the street level. It has funded the addition of over 100,000 community police officers to the beat. The COPS Office supports four drug-related grant programs: (1) a Methamphetamine Initiative that combats production, distribution, and use (2) the COPS Technology Program which deploys the Southwest Border States Anti-Drug Information System; (3) School-Based Partnerships that encourage law-enforcement agencies to work with schools and community-based organizations against crime; and (4) the Distressed Neighborhood Pilot Project which funds a pilot project in eighteen cities that face particularly high crime rates. Building on the successful COPS initiative, the President has proposed a new twenty-first Century Policing Initiative to help communities hire, redeploy, and retain thirty-thousand to fifty-thousand additional community policing officers; acquire the latest crime-fighting technologies; and engage the entire community in anti-crime measures.

- Organized Crime Drug Enforcement Task Forces (OCDETF)

The most effective way to attack sophisticated drug-trafficking organizations and attendant criminal activity -- like money laundering, corruption, violence, organized crime, and tax evasion -- is through a coordinated, inter-agency, task-forces. Accordingly, the Department of Justice calls upon the OCDETF program, with its nine federal law-enforcement agencies, to employ a wide range of expertise in disrupting and dismantling drug-trafficking organizations. The collaboration between law enforcement and U.S. Attorneys, as well as state and local district attorneys and attorneys general, plays an integral part in OCDETF's fight against drug traffickers. OCDETF had the single most productive year in its history in fiscal year 1998, initiating 1,356 investigations with 2,447 indictments returned (more than double the number during the previous two years combined with a 41.6 percent increase in indictments).

The HIDTA and OCDETF programs are mutually reinforcing. In September 1999, OCDETF and HIDTA -- in concert with the DEA, FBI, and USCS -- concluded a two-year international investigation, dubbed *Operation Impunity*, which culminated in the arrest of ninety-three individuals linked to the Amado Carillo Fuentes drug-trafficking cartel headquartered in Juarez, Mexico. This organization moved hundreds of tons of Colombian cocaine from Mexico to the United States. This investigation was especially significant because it targeted the syndicate's importation, transportation, and distribution network -- substantially hindering its ability to move cocaine and other drugs into and around the United States. During Operation Impunity, over twenty-six million dollars in U.S. currency and assets were seized as well as 12,434 kilos of cocaine and 4,800 pounds of marijuana. The most critical aspect of the investigation was the arrest of three drug-trafficking kingpins -- individuals who were on the payroll of major drug lords directing their operations within U.S. cities.

- Weed and Seed.

This flagship neighborhood-based program is a multi-disciplinary approach to combating crime. Present in 176 sites across the nation under the leadership of U.S. Attorneys, this program brings together federal, state, and local crime-fighting agencies, social service providers, representatives from the public and private sector, prosecutors, business owners, and neighborhood residents. Weed and Seed sites implement programs to reduce drug-trafficking in particular geographic areas, e.g. campaigns to investigate and prosecute individuals involved in methamphetamine manufacture and sales (Salt Lake City, Utah), cocaine distribution (Las Vegas, Nevada and Galveston, Texas), and trafficking in crack and powder cocaine, marijuana, and heroin (Tampa, Florida). In Seattle, violent crime in the Weed and Seed area dropped 54 percent between 1991 and 1996 while crime city-wide decreased only 38 percent. In Hartford, Connecticut the number of violent crimes in the Weed and Seed target area decreased 46 percent in 1996 compared to 1994 -- the year before Weed and Seed was started. During the same period, city-wide crime declined only 22 percent. In Las Vegas, serious crime in the target area dropped 8 percent between 1993 and 1996 while city-wide crime decreased 3 percent.

- Money Laundering

Illicit drug trafficking produces billions of dollars in income both domestically internationally. The success of drug-traffickers, and organized crime in general, is based largely upon the ability to launder money. Through money laundering, the criminal transforms the proceeds derived from criminal activity into funds with a seemingly legal source. This process has devastating social consequences. Criminals manipulate financial systems in the United States and abroad to further a wide range of illicit activities. Left unchecked, money laundering can erode the integrity of financial institutions. The Department of Treasury, Department of Justice, Postal Inspection Service, Internal Revenue Service, federal regulators, and state and local law enforcement work in an integrated manner to target specific sectors of the financial system.[39]

In light of the threat posed by money laundering, Congress passed the Money Laundering and Financial Crimes Act of 1998, which calls for the development of a five-year anti-money laundering strategy. In September 1999, the Departments of Treasury and Justice responded by releasing the first National Money Laundering Strategy (NMLS). The NMLS calls for: (1) designating high-risk money laundering zones where coordinated law enforcement efforts can be concentrated; (2) rules for focusing attention on suspicious activities across the range of financial institutions; (3) implementing the Money Laundering Act of 1999 to bolster domestic and international enforcement; (4) reviewing measures to restrict the use of accounts in the United States by offshore institutions that pose a money-laundering risk; and (5) intensifying pressure on nations that lack adequate controls to counter money laundering. This strategy

entails an enhanced level of cooperation among government agencies and between the private and public sectors.

To assist further in the fight against money laundering, banks are required to report financial activity they suspect involves funds derived from criminal activity.[40] This information is placed in a secure database co-owned by the primary bank and credit union regulators and administered by the Department of the Treasury. High priority has been given to the problems raised by criminal abuse of a group of financial service providers known collectively as "money services businesses" (MSBs).[41] In August 1999, a ruling that announced the registration of MSBs was finalized. Over the next year, the Department of the Treasury will be extending mandatory suspicious reporting to other financial service provider sectors vulnerable to money laundering, including money service businesses, like money transmitters, "casas de cambio," and sellers of money orders and travelers' checks. Thereafter, suspicious reporting will be extended to casinos, brokers, and dealers.

Operation Casablanca is an example of a multi-departmental money-laundering investigation that exposed links between Colombian and Mexican drug-trafficking organizations and fourteen Mexican and Venezuelan financial institutions laundering the proceeds.

Enhancing Asset Forfeiture

The Department of Justice uses asset forfeitures to attack the economic infrastructure of drug-trafficking organizations and money-laundering enterprises. DOJ strategically integrates this tool into its overall enforcement plan to strike traffickers at the source of their power. Asset forfeiture is part of the department's Southwest Border Initiative. In FY 1998, *Operation Magnolia* trafficker Luis H. Cano consented to a twenty-eight million dollar forfeiture judgment. *Operation Kids* in Puerto Rico resulted in the forfeiture of 4.1 million dollars in drug-related assets. The Equitable Sharing Program encourages federal, state, and local law-enforcement cooperation by dividing the proceeds of a forfeiture among state and local law - enforcement agencies that participated in an investigation which resulted in a forfeiture. During FY 1998, DOJ worked with nearly three-thousand agencies that participated in this program.

Preventing Chemical Diversion

Precursor and essential chemicals are crucial for manufacturing most illicit drugs sold in the United States. Two DOJ initiatives target chemical distributors involved in diverting chemicals to the illicit marketplace. *Operation Backtrack* targets "rogue" chemical companies that sell methamphetamine precursor chemicals without adhering to federal regulations and international protocols. Since its inception in February 1997, this initiative has resulted in 146 arrests, the seizure of 9.6 million dollars in assets, and the confiscation of chemicals that could have been used to produce 9,400 pounds of methamphetamine. The California Precursor Committee, directed by the U.S. Attorney's office in San Diego, coordinates chemical investigations in that state. During FY 1998, the committee investigated 115 chemical distributors and prosecuted thirty-three. In FY 1998, regulatory controls by the DEA prevented the diversion of 49.95 tons of ephedrine and fourteen tons of pseudoephedrine.

Intelligence/Information Sharing

Intelligence gleaned from the collection, evaluation, analysis, and synthesis of information must be shared in order to reduce cultivation, production, trafficking, and distribution of drugs. Cooperation in sharing and deconflicting strategic and operational intelligence is critical for combating the international and domestic drug problem. Tactical intelligence is time-sensitive and crucial to the execution of arrests and seizures. Agencies must be able to share relevant information across jurisdictional boundaries without risk of compromise to intelligence and the operations that derive from it. Under the Border Coordination Initiative (BCI), personnel from the U.S. Customs Service, the Immigration and Naturalization Service, and the Border Patrol have been co-located into Intelligence Collection Analysis Teams along the Southwest border to gather and disseminate tactical intelligence. DoJ's Regional Information Sharing System consists of a network of centers that jointly process intelligence on drug trafficking, violent crime, gang activity, and organized crime. In FY 1999, this network contributed to the arrest of 4,160 individuals and the seizure of drugs valued at 104 million dollars. The HIDTA program establishes Information Support Centers in designated areas specifically to create a communication infrastructure that can facilitate information-sharing between federal, state, and local law-enforcement agencies.

ONDCP's Counterdrug Technology Assessment Center

Technology can play a dramatic role in combating drug-related crime. Law-enforcement agencies increase their effectiveness by integrating technology and coordinating operations. ONDCP's Counterdrug Technology Assessment Center (CTAC) was established by the Counter-Narcotics Technology Act of 1990 (P.L. 101-510). CTAC is the federal government's drug-control research and development organization. It coordinates the activities of twenty federal agencies. CTAC identifies short, medium, and long-term scientific and technological needs of federal, state, and local drug-enforcement agencies -- including surveillance; tracking;

electronic support measures; communications; data fusion; and chemical, biological, and radiological detection.

CTAC research supports law enforcement in such areas as drug detection, communications, and surveillance. CTAC conducts an array of operational tests and activities to evaluate off-the-shelf and emerging technology prototypes for use in the field. In 1998, Congress authorized a technology transfer program (TTP) for CTAC to provide these technologies to state and local law-enforcement.[42] Over the past two years, CTAC's technology transfer program has provided 1,083 systems to 769 agencies across the country. Since nighttime counterdrug operations are especially dangerous for officers and undercover narcotics agents, many of the technologies requested by law enforcement have dealt with improved officer safety through more reliable communications and night-vision systems.

The companion volume to this annual report –*Counterdrug Research and Development Blueprint Update* – reviews CTAC's research agenda in support of efforts to reduce the availability and abuse of drugs. It also assesses the effectiveness of federal technology programs aimed at improving drug-detection capabilities used in interdiction and at ports-of-entry.

Targeting Gangs and Violence

The Department of Justice -- through the FBI, DEA, USMS, United States Attorneys' office, and Criminal Division along with state and local law-enforcement counterparts -- is focusing on identifying, disrupting, and dismantling criminal gangs. Available tools include the application of federal racketeering statutes, federal and state narcotics and weapons laws, and collaborative multi-agency task forces. DOJ's Anti-Violent Crime Initiative, which targets gangs and violent crime, has reduced drug trafficking substantially. Gangs are involved in the national distribution of drugs and frequently use automatic weapons. Thirty years ago, only twenty cities reported gang activity. Today, more than seven hundred U.S. cities are plagued by gangs.

The DEA and FBI lead federal efforts to break up trafficking organizations. The FBI's National Gang Strategy is the framework for combating such violence in America. In 1998, for example, the FBI -- in conjunction with the New York Police Department and the Office of the Inspector General of the Department of Housing and Urban Development -- targeted the Almighty Latin King and Queen Nation. This organization was involved in violent criminal activity, including murder, robbery, and drug and weapons trafficking. The FBI established 166 Safe Street task forces to address violent crime, much of which is drug-related. In early 1995, DEA launched the Mobile Enforcement Team (MET)* program to assist state and local police in combating the problem of drug-related crime. METs have been established in all but one of

* The MET program helps local authorities attack violent drug organizations by: 1) identifying major drug-traffickers that commit homicide and other violent crimes; 2) collecting, analyzing, and sharing intelligence with state and local counterparts; 3) conducting investigations against violent drug offenders and gangs; 4) arresting drug traffickers and assisting in the arrest of violent offenders; 5) seizing the assets of violent drug-offenders; 6) supporting state and local prosecutors.

DEA's field offices and are deployed in diverse communities throughout the country. The Department of Justice is using the National Gang Tracking Network, a comprehensive computer database that keeps tabs on gang members operating across state lines.

The Bureau of Alcohol, Tobacco, and Firearms (ATF) targets armed drug traffickers through the Achilles Program, which oversees task forces in jurisdictions where drug-related violence is severe. The ATF also conducts Gang Resistance Education and Training (G.R.E.A.T.) in schools. Since 1992, more than two million children have received G.R.E.A.T. instruction. HIDTAs and OCDETFs also coordinate multi-agency attacks on criminal drug organizations.

Equitable Sentencing Policies

The Administration supports the revision of the 1986 federal law which mandates a minimum five-year prison sentence for anyone possessing either five hundred grams of powder cocaine or a mere five grams of crack cocaine. This law, which punishes crack cocaine involvement one hundred times more severely than powder cocaine crimes, is problematic for two reasons. First, since crack is more prevalent in black, inner-city neighborhoods, the law has fostered a perception of racial injustice in our criminal justice system. In fact, 90 percent of those convicted on crack cocaine charges are African American. Second, harsher penalties for crack possession compared to powder have resulted in long incarceration for low-level crack dealers instead of increased apprehension of middle and large-scale cocaine traffickers.

The Administration recommends that federal sentencing treat crack as ten times worse than powder, not one hundred times worse. Specifically, the amount of powder cocaine required to trigger a five-year mandatory sentence would be reduced from five hundred to two hundred and fifty grams while the amount of crack cocaine required to trigger the same sentence would increase slightly from five grams to twenty-five grams. This difference would reflect -- without gross exaggeration -- the greater addictive potential of crack (which is smoked) compared to powder (when snorted), the greater violence associated with the trafficking of crack cocaine, and the importance of targeting mid and higher-level traffickers as opposed to smaller-scale dealers. The Administration also recommends that mandatory minimums be abolished for simple possession of crack. Among all controlled substances, crack is the only one with a federal mandatory minimum sentence for a first offense of simple possession.

Community support is critical to the success of law enforcement. When people lose confidence in the fairness and logic of the law -- as has been the case with the 1986 statute, law-enforcement suffers. By revising the inequitable sentencing structure for powder versus crack cocaine, the Administration intends is to restore overall respect for the law and foster a more effective division of responsibility between federal, state, and local law-enforcement authorities.

State Drug Laws

State laws are an important vehicle for translating the concepts in the *National Drug Control Strategy* into action. The *Strategy's* policies are embodied within a tangible legislative framework with which state policymakers shape policies and laws. Laws are a mechanism for trying to change behavior by using penalties to discourage certain activities and incentives to rewards.

With this goal in mind, Congress in 1998 mandated the creation of a bipartisan, presidentially appointed commission to develop model state drug laws. The resulting President's Commission on Model State Drug Laws drafted forty-four model drug and alcohol laws and policies covering enforcement, treatment, education, prevention, intervention, employment, housing, and community issues.

Since 1996, the Commission's non-profit successor -- the National Alliance for Model State Drug Laws -- has been conducting state model law workshops. These workshops brought together hundreds of diverse participants on the state level who recommended more than a hundred pieces of drug and alcohol legislation, programming, funding, and coordination initiatives. With these recommendations, state and local leaders have adopted new statutes, formed more effective multi-disciplinary partnerships, and streamlined legislative and programmatic applications.

5. Shielding U.S. Borders from the Drug Threat

Borders delineate the sovereign territories of nation-states. Guarding our country's 9,600 miles of land and sea borders is one of the federal government's most fundamental responsibilities and challenges – especially in light of the historically open, lengthy borders with our northern and southern neighbors. The federal government maintains three hundred ports-of-entry, including airports where officials inspect inbound and outbound individuals, cargo, and conveyances. All are vulnerable to the drug threat. By curtailing the flow of drugs across our borders, we reduce drug availability throughout the United States and decrease the negative consequences of drug abuse and trafficking in our communities.

In FY 1999, more than seventy-five million passengers and crew members arrived in the United States aboard commercial and private aircraft over nine million arrived by marine vessels, and 395 million through land border crossings. They arrived on 200,000 ships, 900,000 aircraft, and 135 million trucks, trains, buses, and automobiles. Cargo arrived in sixteen million containers. This enormous volume of movement makes interdiction of illegal drugs difficult.

Even harder is the task of interdicting drug trafficking in cargo shipments because of the ease with which traffickers can switch modes and routes. Containerized cargo has revolutionized routes, cargo tracking, port development, and shipping companies. A recent study by the Office of Naval Intelligence indicated that over 60 percent of the world's cargo travels by container. Moreover, the use of intermodal containers by vessels carrying as many as six thousand containers – which have the ability to offload cargo onto rail or trucks at various ports of entry and then transport it into the heart of the United States – further complicates the interdiction challenge. Drug-trafficking organizations take advantage of these dynamics by hiding drug shipments in cargo or secret compartments. False seals have also been used on containers so that shipments can move through initial ports of entry unimpeded. To counteract this threat, the federal government is constantly seeking new technologies which, together with capable forces and timely intelligence, facilitates a well-coordinated interdiction plan responsive to changing drug-trafficking trends.

Organizing against the Drug Threat

The U.S. Customs Service has primary responsibility for ensuring that all cargo and passengers moving through ports of entry comply with federal law. Customs is the lead agency for preventing drug trafficking through airports, seaports, and land ports of entry. Customs is also responsible for stemming the flow of illegal drugs into the United States through the air. It accomplishes this task by apprehending drug smuggling aircraft trying to enter the country. The Customs' Aviation Interdiction program conducts twenty-four-hour surveillance along the entire southern tier of the United States, Puerto Rico, and the Caribbean using a wide variety of civilian and military ground-based radar, tethered aerostats, reconnaissance aircraft, and other sensors. In fiscal year 1999, Customs seized 1,341,303 pounds of marijuana, cocaine, and heroin – a 20 percent increase over seizures in FY 1998.

The U.S. Border Patrol is the primary federal drug interdiction agency along our land borders with Canada and Mexico. The Border Patrol specifically focuses on drug smuggling between land ports of entry. In FY 1998, the Border Patrol seized 395,316 kilograms of marijuana, 10,285 kilograms of cocaine, and fourteen kilograms of heroin. In addition, the Border Patrol made 6,402 arrests of suspected traffickers in areas other than ports-of-entry.

The Coast Guard is the lead federal agency for maritime drug interdiction. It shares responsibility for air interdiction with the U.S. Customs Service. Our Armed Forces provide invaluable support to federal, state, and local law-enforcement agencies involved in drug-control operations, particularly in the Southwest border region.

All these agencies and their personnel deserve credit for ceaseless efforts to defeat drug smugglers. The task of a strategy is to coordinate activities so individual attempts contribute to the overall objective of reducing drug availability in the United States.

Trafficking across the Southwest Border

In 1999, 295 million people, eight-eight million cars, four million trucks, and 461,000 rail cars entered the United States from Mexico. More than half of the cocaine on our streets and large quantities of heroin, marijuana, and methamphetamine come across the Southwest border. Illegal drugs are hidden in all modes of conveyance – car, truck, train, and pedestrians. Drugs cross the desert in armed pack trains as well as on the backs of human "mules." They are tossed over border fences and then whisked away on foot or by vehicle. Operators of ships find gaps in U.S./Mexican interdiction coverage and position drugs close to the border for eventual transfer to the United States. Small boats in the Gulf of Mexico and eastern Pacific seek to outflank our interdiction efforts and deliver drugs directly to the United States. Whenever possible, traffickers try to exploit incidences of corruption in U.S. border agencies to facilitate drug smuggling. It is a tribute to the vast majority of American officials dedicated to the anti-drug effort that integrity, courage, and respect for human rights overwhelmingly characterizes their service. Rapidly growing commerce between the United States and Mexico complicates efforts to keep drugs out of cross-border traffic. Since the Southwest border is currently the most porous part of the nation's periphery. We must mount a determined effort to stop the flow of drugs there. At the same time, we cannot concentrate resources along the Southwest border at the expense of other vulnerable regions because traffickers follow the path of least resistance and funnel drugs to less defended areas.

Five principal departments are concerned with drug-control issues along the Southwest border: Treasury (drug interdiction, anti-money laundering and anti-firearms trafficking), Justice [DOJ] (drug and immigration enforcement, prosecutions), Transportation (drug interdiction), State (counterdrug cooperation with Mexico), and Defense [DoD] (counterdrug support). During the past decade, the federal presence along the Southwest border expanded. Customs' budget for Southwest border programs increased 72 percent since FY 1993. The number of assigned

DEA special agents increased 37 percent since FY 1990. The number of assigned INS agents has almost doubled since FY 1990. DoD's drug-control budget for the Southwest border increased 53 percent, since FY 1990. The number of U.S. attorneys handling cases there went up by 80 percent since FY 1990. The Southwest Border Initiative enabled federal agencies to coordination of intelligence and operational assignments at Customs, DOJ's Special Operations Division, HIDTA, and state and local law-enforcement agencies.

The United States Coast Guard plays a critical role in protecting the maritime flanks of the Southwest Border. *Operations Border Shield* and *Gulf Shield* protect the coastal borders of Southern California and along the Gulf of Mexico from maritime drug smuggling with USCG air and surface patrol assets. The Coast Guard operations are coordinated multi-agency efforts that focus on interdiction to disrupt of drug trafficking activities.

All Borders

We must stop drugs everywhere they enter our country – through the Gulf Coast, Puerto Rico, the U.S. Virgin Islands, Florida, the northeastern and northwestern United States, or the Great Lakes. The vulnerability of Alaska, Hawaii, and the U.S. territories must also be recognized. Florida's location, geography, and dynamic growth will continue to make that state particularly attractive to traffickers for the foreseeable future. Florida's six hundred miles of coastline render it a major target for shore and airdrop deliveries in the 1980s. The state is located astride the drug-trafficking routes of the Caribbean and Gulf of Mexico. The busy Miami and Orlando airports and Florida's seaports -- gateways to drug-source countries in South America -- are used as distribution hubs by international drug rings. To varying degrees, Florida's predicament is shared by other border areas and entry points. As we focus on specific parts of our borders, we must anticipate activities elsewhere. In the end, we need to shield all U.S. borders from the flow of illegal drugs.

DOJ's Southern Frontier Initiative focuses law enforcement efforts on drug trafficking organizations operating along the Southwest border and the Caribbean. *Operation Trinity* resulted in 1,260 arrests, including eight hundred members of the five largest drug syndicates in Mexico and Colombia. DOJ's Caribbean Initiative substantially enhanced its counterdrug capabilities in this region, with more law-enforcement agents in the area, greater communications, and improved interception. In fiscal year 1999, USCG *Operation Frontier Shield* seized 18 vessels in its efforts to disrupt drug smuggling efforts into Puerto Rico and the U.S. Virgin Islands – a three fold increase from 1998.

Organizing for Success

The problems law-enforcement officials face in connection with illegal drugs are significant but not insurmountable. Twenty-three separate federal agencies and scores of state and local governments are involved in drug-control efforts along our borders, air, and seaports. The Departments of Justice and Treasury and their respective drug-law agencies are working closely

with The Interdiction Coordinator (TIC) in a review of coordination among federal agencies responsible for anti-drug operations. This review is focusing initially focusing on the Southwest border.[43]

A review of the counterdrug intelligence architecture concluded that clear, consistent inter-community and interagency coordination is essential. To this end, the General Counterdrug Intelligence Plan (GCIP) strengthens the El Paso Intelligence Center.

All cross-border movements are subject to inspection. We cannot, however, paralyze commerce and travel to search for contraband. Non-intrusive inspection technologies cued by intelligence to high-risk cargo are being deployed to keep drugs out of legal commerce. Access roads, fences, lights, and surveillance devices can prevent the movement of drugs between ports of entry while serving the legal, economic, and immigration concerns of the United States, Canada, and Mexico. We must continue to insure the presence of trained, well-equipped inspectors, agents, investigators, and prosecutors. Last year, for example, the Border Patrol hired a thousand additional agents.

Border Coordination Initiative (BCI)

To improve coordination along the land borders of the United States, the Departments of Justice and Treasury – along with other agencies with border responsibilities – established the Border Coordination Initiative (BCI). Organized as a five-year program and initially emphasizing the Southwest border, BCI envisions the creation of integrated border management to improve the effectiveness of this joint effort. It emphasizes increased cooperation to support the interdiction of drugs, illegal aliens, and other contraband while maintaining the flow of legal immigration and commerce. BCI plans call for:

Port Management. A Customs and INS Port Management Model that will streamline enforcement, traffic management, and community partnership plans at each of the SWB's twenty-four POEs.

Investigations. A unified strategy for SWB seizures that capitalizes on investigative operations and the dissemination of intelligence to enhance inspections. The Department of Justice's Narcotic and Dangerous Drug Section prosecutes major drug-trafficking cases along the Southwest border. For example, there is an ongoing Organized Crime Drug Enforcement Task Force (OCDETF) case in the Southern District of California against sixteen individuals charged with smuggling a metric ton of marijuana into the United States

Intelligence. Joint intelligence Collection Analysis Teams (ICATs) – comprised of personnel from Customs, Immigration and naturalization, and the Border Patrol are collecting and disseminating tactical intelligence in regard to drug interdiction, illegal aliens, money laundering, and document fraud.

Technology. A joint plan to capitalize on future technological advances while making better use of existing capabilities.

Communications. Inter-operable, secure, mutually supportive, wireless communications through coordinated fielding, user training, compatible systems, and shared frequencies.

Aviation and Marine. Joint air interdiction operations and the identification of opportunities to share air and marine support facilities.

Port and Border Security Initiative

This initiative seeks to reduce drug availability by preventing the entry of illegal substances into the United States. The initiative covers all U.S. ports-of-entry and borders but focuses on the Southwest border. Over the next five years, this initiative will result in appropriate investments in Immigration and Naturalization Service (INS) inspectors and Border Patrol agents, Customs' agents, analytic, and inspection staff, improved communication and coordination between Customs and INS, employment of advanced technologies and information management systems, and greater U.S.-Mexico cooperation.

Working with the Private Sector to Keep Drugs Out of America

Agreements with the private sector can deter drug smuggling via legitimate commercial shipments and conveyances. As the primary drug-interdiction agency at ports of entry, the U.S. Customs Service is implementing programs like the air, sea, and land Carrier Initiative Programs (CIP), the Business Anti-Smuggling Coalition (BASC), and the Americas Counter-Smuggling Initiative (ACSI) to keep illegal drugs out of licit commerce. These initiatives have resulted in the seizure of 212,000 pounds of drugs since 1995.

Harnessing Technology

Technology is an essential component in the effort to prevent drug smuggling across our borders and via passenger and commercial transportation systems. Automated targeting systems can analyze databases to assess the likelihood that a particular individual, vehicle, or container is carrying drugs. Customs is deploying first-generation X-ray systems to detect drugs in luggage, cars, and shipments from pallet-sized items up to large marine containers transported in trucks, railroad cars, and ships. Customs is also employing high-energy neutron interrogation systems to measure the density of tires, fuel tanks, panels, and cargo. These systems are being deployed along the southern tier of the United States, from Florida to California. Technology can also prevent trafficking in unoccupied spaces. The Immigration and Naturalization Service's Integrated Surveillance Information System/Remote Video Surveillance (ISIS/RVS) project, for example, is improving the Border Patrol's effectiveness between ports of entries along the Southwest border.

The Department of Defense and U.S. Customs Service are working with CTAC to develop and test advanced non-intrusive inspection (NII) technologies to inspect vehicles and containers for drugs at ports of entry. Systems have been deployed at Otay Mesa, CA, Calexico, CA, Pharr, TX, El Paso, TX, Nogales, TX, Laredo, TX, Brownsville, TX, Santa Teresa, NM, and Nogales, NM. In addition, devices have been installed at Port Everglades, Newark and Houston seaports, and a mobile truck x-ray is in operation in South Florida.

The U.S. Customs Service is deploying advanced technology for seizing drugs at ports of entry. Intelligence-based information systems provide Customs inspectors with *a priori* information on suspicious shipments. A superior of drug-detecting canines, derived from a cooperative effort with Australian customs, has been placed at key ports-of-entry. Non-intrusive inspection systems, employing x-ray and neutron technologies, are assisting inspectors in finding drugs hidden in cargo without opening the containers and conveyances. New systems are also being developed to overcome the disadvantages of x-ray and large-scale neutron systems – including the need for particle accelerators, mechanical scanning, and tight pulsing – while reducing costs.

Review of Counterdrug Intelligence Architecture

An extensive interagency review of counterdrug intelligence was commissioned in 1997 by the Attorney General, the Director of Central Intelligence (DCI), the Secretary of the Treasury, and the Director of National Drug Control Policy, supported by the Secretaries of Defense, Transportation, and State. The Review, conducted by a White House Task Force (WHTF), was mandated in the Treasury and General Government Appropriations Act of 1998 and the 1998 Intelligence Authorization Act. According to the WHTF report, counterdrug investigative information and intelligence sharing has improved over the past several years. Despite laudable achievements, boundaries between various law-enforcement and intelligence components produce gaps in coverage as well as incomplete or inaccurate analysis, unnecessary duplication, single-agency perceptions of critical drug threats or issues, and occasional mistrust or confusion in the counterdrug community.

The Administration's General Counterdrug Intelligence Plan (GCIP) establishes a framework to support field operators; improves Federal, state, and local counterdrug relationships; and respond to policymakers as they formulate counterdrug policy. For the first time, the GCIP has created a permanent coordination mechanism to resolve drug intelligence issues and aid national agencies in satisfying performance measures of effectiveness. The GCIP facilitates the appropriate and timely exchange of information between the intelligence and drug law enforcement communities.

6. Reducing the Supply of Illegal Drugs

Supply reduction is an essential component of a well-balanced strategic approach to drug control. When illegal drugs are readily available, the likelihood increases that they will be abused. Supply reduction has both domestic and international dimensions. Within the United States, supply reduction includes regulation (through the Controlled Substances Act), enforcement of anti-drug laws, eradication of marijuana cultivation, control of precursor chemicals, inspection of commerce and persons entering the country, screening for drugs in prisons, and the creation of drug-free school zones. Internationally, supply reduction includes building consensus; bilateral, regional, and global accords; coordinated investigations; interdiction; control of precursors; anti-money-laundering initiatives; drug-crop substitution and eradication; alternative development; strengthening public institutions; and foreign assistance.

Interdiction Operations

Despite our best efforts, we will never seize all drugs that arrive at borders or air and seaports. Drug traffickers are adaptable, reacting to interdiction successes by shifting routes and modes of transportation. International drug organizations have access to sophisticated technology to support their crimes. The United States must surpass traffickers' flexibility, quickly deploying resources to changing high-threat areas.

The U.S. government designs coordinated interdiction that anticipates shifting drug-traffick patterns. These integrated operations are led by the two Joint Inter-Agency Task Forces (JIATF-East based in Key West, FL and JIATF-West in Alameda, CA) that coordinate transit zone activities; the Customs' Domestic Air Interdiction Coordination Center (in Riverside, CA) that monitors air approaches to the United States; and the El Paso, Texas-based Joint Task Force Six and Operation Alliance that coordinate activities along the Southwest border. The current U.S. Interdiction Coordinator, which is responsible for efficiently deploying and integrating the U.S. assets committed to international interdiction effort, is the Commandant of the U.S. Coast Guard.

Several key changes were made in 1999 to the regional counterdrug support architecture of the United States. In May of 1999, JIATF-East added to its set of responsibilities the Source Zone-focused counterdrug support missions previously executed by JIATF-South. The merger of JIATF-East and JIATF-South offers a considerable opportunity for maximizing the efficient operation of these counterdrug missions in the years to come.

JIATF-East counterdrug air detection and monitoring missions are carried out from a number of bases in the continental United States and the Caribbean. Assets previously based out of Howard AFB, Panama are now operating from several Forward Operating Locations (FOLs) in the Caribbean and South America. The U.S. government has obtained a long-term agreement with Ecuador to operate from an FOL in their territory. A second FOL, based in the Netherlands Antilles and Aruba, is operating under a temporary agreement. In the upcoming

year, the United States hopes to sign a long-term FOL agreement with the Kingdom of the Netherlands, ensuring continued detection and monitoring coverage in the region. There is also a tentative plan to for a third FOL in Central America. The United States anticipates an increase in the total number of counterdrug detection and monitoring flight hours that previously originated from Howard AFB.[44]

Transit Zone Operations

Drugs coming to the United States from South America pass through a six million square-mile transit zone roughly the size of the continental United States. This zone includes the Caribbean, Gulf of Mexico, and eastern Pacific Ocean. The interagency mission is to reduce the supply of drugs from source countries by denying smugglers the use of air and maritime routes. In patrolling this vast area, U.S. federal agencies closely coordinate their operations with the interdiction forces of a number of nations.

The Coast Guard is key to reducing the flow of drugs through the transit zone. Through a strategic plan designed to meet the interdiction performance goals of the *National Drug Control Strategy*, the Coast Guard works to deny the use of maritime routes by concentrating assets and operations in high-threat areas. These forces locate, intercept, stop, and board suspect vessels for end-game success. Once a credible law enforcement presence is established and smuggling activity is deterred, interdiction forces will are re-deployed to other high threat areas, leaving behind an enhanced presence to deter and interdict subsequent smuggling. A primary force provider for the JIATF force structure, the Coast Guard also deploys Law Enforcement Detachments (LEDETs) aboard ships of the U.S. Navy and international partners in the Caribbean and Eastern Pacific. In 1999, LEDETs were responsible for nearly one-third of Coast Guard cocaine seizures.

"Go-fast" boats* accounted for approximately 70 percent of known maritime smuggling events during fiscal year 1999. The Coast Guard has responded to the threat by acquiring new equipment, developing new capabilities, and changing use of force policies. Initial deployments of specially configured helicopters and pursuit boats that utilized warning shots and disabling fire to effect Go-fast interdictions were highly successful, resulting in the seizure of 3,014 pounds of cocaine and 3,875 pounds of marijuana. Additionally, multi-national operations have allowed the Coast Guard to assist Caribbean nations to maintain regional interdiction efforts through the training of host-nation law enforcement personnel.

The decline in the cocaine trafficking in Jamaica, the Bahamas, and Cuba followed the execution of several joint interdiction operations in the area. There were, however, increases in overall drug trafficking in Haiti, the Dominican Republic, and Puerto Rico as well as smuggling through fishing vessels in the Eastern Pacific. In fiscal year 1999, seventy-eight metric tons of cocaine were seized in the Transit Zone. Coast Guard interdiction efforts in 1999 seized

* A "Go-fast" boat is the term used to describe the small, very fast, and difficult to detect vessels favored by drug traffickers.

111,689 pounds of cocaine and 61,506 pounds of marijuana. Cocaine seizures surpassed the previous record of 103, 617 pounds set in FY 1997. The retail value of these drugs was estimated at $3.7 billion.

The Department of Defense (DoD) helps reduce the flow of illegal drugs into the United States through command and control, high-tech communications, intelligence sharing, detection, and monitoring. As the interagency lead for detection and monitoring, DoD quickly disseminates information gathered by detection platforms through the JIATF structure to the appropriate interdiction agency.

Stopping drugs in the transit zone involves more than intercepting drug shipments at sea or in the air. It also entails denying traffickers safe haven in countries within the transit zone and preventing the corruption of institutions or financial systems to launder profits. Consequently, international cooperation and assistance is an essential aspect of a comprehensive transit-zone strategy. The United States will continue helping Caribbean and Central American nations to implement a broad drug-control agenda that includes modernizing laws, strengthening law-enforcement and judicial institutions, developing anti-corruption measures, opposing money laundering, and backing cooperative interdiction.

Breaking Cocaine Sources of Supply

Table 3-_: Amount of Coca Leaf Cultivated and Eradicated, Calendar Years 1987-98 (hectares)

YEAR	BOLIVIA	COLOMBIA	PERU	BOLIVIA	COLOMBIA	PERU
	cultivated	cultivated	cultivated	Eradicated	eradicated	eradicated
1987	41,400	22,960	109,155	1,040	460	355
1988	50,400	34,230	115,530	1,475	230	5,130
1989	55,400	43,400	121,685	2,500	640	1,285
1990	58,400	41,000	121,300	8,100	900	
1991	53,386	38,472	120,800	5,486	972	
1992	50,649	38,059	129,100	5,149	959	
1993	49,600	40,493	108,800	2,400	793	
1994	49,200	49,610	108,600	1,100	4,910	
1995	54,093	59,650	115,300	5,493	8,750	
1996	55,612	72,800	95,659	7,512	5,600	1,259
1997	52,800	98,500	72,262	7,000	19,000	3,462
1998	49,600	115,450	58,825	11,621	13,650	7,825

Coca, the raw material for cocaine, is grown primarily in the Andean Region of South America. Dramatic successes in Bolivia and Peru have been tempered by the continued expansion of coca cultivation in Southern Colombia. Despite a doubling of the coca crop in Colombia between 1995-1998, successes in the rest of the Andes has reduced global cultivation by 11 percent.[45]

The Government of Bolivia achieved a 53 percent reduction in coca cultivation since 1995. An extremely effective eradication program in the principal growing regions surpassed last year's results. In addition, a successful chemical interdiction program forced the remaining Bolivian coca traffickers to rely on inferior substitutes and a less efficient production process, which has reduced the purity of Bolivian cocaine. These actions, combined with an extensive alternative development program, decreases potential cocaine production in Bolivia from 240 metric tons in 1995 to less than 70 metric tons in 1999.[46] The current Banzar administration continues to make progress towards eliminating all illegal coca from Bolivia by 2002.

However, challenges remain. Coca prices are still high and disruption of the cocaine industry is incomplete. Although coca growers have committed only sporadic acts of violence and been unable to create a mass movement to resist eradication efforts, the potential for violence in the Chapare and Yungas growing regions remains a serious concern.

The government of Peru also made enormous strides toward eliminating illegal coca cultivation. Since 1995, Peru achieved a 66 percent reduction in areas under coca cultivation and a corresponding 61 percent drop in cocaine production.[47] This reduction is due to a combination of eradication, law enforcement, and alternative development. In previous years, the Peruvian Air Force directed a successful drug interdiction effort, which prevented drug crops from reaching secondary markets and disrupted the coca industry in Peru. However, in 1999 air interdiction became less effective because drug traffickers changed their flight routes and increased their operational security. The result of these new trafficker tactics has been an increase in drug flights in and out of Peru, higher coca prices, and the threat of rejuvenating coca fields in the central growing regions.

The Fujimori government adjusted its own tactics and increased the number of law-enforcement to its ground eradication program by 350 personnel in 1999. In Bolivia, eradicators are using a new tool to pull coca plants out by the roots, which eliminates coca field rehabilitation efforts. Law-enforcement efforts have constricted the flow of precursor chemical into the growing region and alternative development efforts have provided licit economic opportunities for former coca growers. Despite higher prices, Peru achieved a 24 percent reduction in coca cultivation last year.[48]

80 percent of the cocaine that enters the United States originates in or passes through Colombia. Colombia also produces up to six metric tons of heroin annually. Coca cultivation of has nearly tripled in Colombia since 1992.[49] Colombian traffickers and coca farmers have also adopted new cultivation and processing techniques, increasing the amount of drugs processed from each acre of crop. Colombia now cultivates more than half of the coca leaf grown in the world. If unchecked, the rapid expansion of coca crops and cocaine production in Colombia threatens to significantly increase the global supply of cocaine over the next several years.

Colombia's efforts to attack the drug trade are hampered by guerrillas and paramilitary

groups that control the major drug-producing regions. Lack of government presence makes eradication and interdiction operations difficult and dangerous in most of Colombia's coca-growing regions. The lack of security in southern Colombia prevents alternative development programs from succeeding.

In addition to the armed groups that control the vast countryside, organized drug mafias control the international distribution. The vast amount of money in the hands of these outlaw groups generates violence, corruption, and threatens Colombia's democratic institutions. The drug threat, violence, and insecurity have compounded the problems associated with Colombia's first economic recession in almost 60 years.

The Government of Colombia has responded to the problem by increasing law-enforcement and eradication efforts in areas accessible to security and police forces. U.S.-supported Colombian efforts have achieved double-digit reductions in cultivation in the Guaviare growing region in each of the last two years. Despite the gains in Guaviare, coca cultivation continues to explode in the Putumayo and Caqueta regions, which are beyond the government's reach. The Colombian National Police have also seriously disrupted lab production operations in some areas, while leaving the lab production infrastructure untouched in regions beyond government control.

In 1998, the Colombian government formed a counter-drug joint task force with elements from all the military services and the National Police. In December 1999, the first of several new counterdrug battalions became operational. Supported by US-provided air mobility and a joint military-police intelligence center, these battalions will provide Colombian security forces with a framework for eventually moving into the less accessible drug producing regions in southern and eastern Colombia.

President Andres Pastrana devised a comprehensive, integrated strategy, "Plan Colombia," to address Colombia's drug and interrelated social and economic troubles. The Colombian Government estimates that Plan Colombia, a comprehensive, three-year plan, will cost seven billion dollars. The Government of Colombia will fund more than half of the cost and wants the United States and the international community to support the additional three and a half billion dollars.

To assist the Government of President Pastrana, the Clinton Administration has proposed $1.6 Billion in additional aid to Colombia over the next two years. The budget proposes to increase assistance programs through an emergency supplemental of $954 million in FY2000 and $318 million in FY2001. Funds will be used for Colombian counterdrug efforts and for other programs to help President Pastrana strengthen democracy and promote prosperity. The proposal would enhance alternative development, strengthen the justice system and other democratic institutions, and provide counterdrug equipment, training, and technical assistance to Colombian police and military forces. The Administration is also encouraging U.S. allies and international institutions to assist Colombia in implementing *Plan Colombia*. The budget proposal would also provide additional funding to shore up significant gains against drug production in Peru and Bolivia and

prevent the traffickers from simply moving their operations to avoid law enforcement.

Breaking Heroin Sources of Supply

For most of the past twenty years, heroin has followed cocaine as second illegal drug coming from South America. Efforts to reduce domestic heroin availability face significant problems. Unlike cocaine where the supply is concentrated in the Andean region of South America, heroin available in the United States is produced in four distinct geographical areas: South America, Mexico, and Southeast Asia, and Southwest Asia. Worldwide heroin production was estimated at 313 metric tons in 1998 with between twelve to eighteen metrics tons destined for the United States.50

In the past decade, Latin America emerged as the primary supplier of U.S. heroin. Although production in Latin America stabilized at a production level of twelve tons of pure heroin, which accounts for less than 5 percent of worldwide production, Mexican and Colombian heroin comprises 17 and 65 percent respectively of the heroin seized today in the United States. Both countries have been aggressive in their heroin-control programs. Mexican eradication has destroyed between 60 and 70 percent of the crop each year for the past several years. In 1998, the government of Mexico eradicated 9,500 hectares of poppies and interdicted 1.35 metric tons of the remaining opium. In Colombia, 8,000 hectares of poppies were eradicated in the last two years. Aerial spraying has been used to combat the heroin threat. Spray operations have stabilized Colombia's illicit poppy crop at about 6,000 hectares.

Total opium production from Southeast and Southwest Asia continued to decline over the last three years, with a net drop of 11 percent in 1999 -- primarily due to a drought in Southeast Asia. A dramatic increase in opium production in Afghanistan kept this decline from being even greater. Afghanistan production increased 21 percent in the past year. The government of Pakistan, after years of work and with the assistance of funding from U.S. crop-control programs, has essentially eradicated poppy cultivation in areas were alternative development have been established. Thailand's crop substitution program remains the world's most effective and has contributed to a 91 percent drop in net production since 1985. Eradication programs through the UNDCP resulted in decreases in Southeast Asia, particularly in Laos and to a lesser extent in Burma, but the main contributing factor was adverse weather, which caused a 35 percent reduction in potential opium production.

In the coming decade, additional progress is achievable if governments can cordon off growing areas, increase their commitment, and implement counternarcotics programs. U.S.-backed crop-control programs reduced illicit opium cultivation in countries like Guatemala, Mexico, Pakistan, Thailand, and Turkey. However, progress is unlikely in Afghanistan where the ruling Taliban does not appear committed to narcotics control. The United States will continue supporting UN drug-control programs in Burma and other countries, pressing the Burmese government to take effective anti-drug action. In Colombia, the U.S. will provide additional support to the CNP opium poppy eradication campaign. Twelve twin-engine

helicopters (6 Bell 212s and 6 UH-60s) have been given to the CNP to facilitate high-altitude operations. We will help strengthen law-enforcement in heroin source countries by supporting training programs, information sharing, extradition of fugitives, and anti-money laundering measures. Finally, the United States will work through diplomatic and public channels to increase the level of international cooperation and support the ambitious UNDCP initiative to eradicate illicit opium poppy cultivation in ten years.

Table 3-TBD: Amount of Opium Poppy Cultivated and Eradicated, Calendar Years 1990-98 (hectares)

		1990	1991	1992	1993	1994	1995	1996	1997	1998
Afganistan	Cultivated	12,370	17,190	19,470	21,080	29,180	38,740	37,950	39,150	41,720
Pakistan	Cultivated	8,405	8,645	9,147	7,136	7,733	6,950	4,267	4,754	5,224
Burma	Cultivated	161,012	154,915	166,404	166,945	149,945	154,070	163,100	155,150	130,300
Laos	Cultivated	30,580	29,625	25,610	26,040	18,520	19,650	25,250	28,150	26,100
Thailand	Cultivated	3,435	3,000	2,050	2,880	2,110	1,750	2,170	1,650	1,350
Colombia	Cultivated		2,316	32,858	29,821	23,906	10,300	12,328	13,572	
Guatemala	Cultivated	1,930	1,721	1,200	864	200	125	12	10	15
Mexico	Cultivated	10,100	10,130	10,170	11,780	12,415	13,500	13,000	12,000	15,000
Pakistan	Eradicated	185	440	977	856	463	0	867	654	2,194
Burma	Eradicated		1,012	1,215	604	3,345	0	0	0	0
Thailand	Eradicated	720	1,200	1,580	0	0	580	880	1,050	715
Colombia	Eradicated		1,156	12,858	9,821	3,906	3,760	6,028	6,972	
Guatemala	Eradicated	1,085	576	470	426	150	86	12	3	12
Mexico	Eradicated	4,650	6,545	6,860	7,820	6,620	8,450	7,900	8,000	9,500

Domestic heroin demand-reduction programs are all the more essential due to difficulties in attacking heroin sources of supply. U.S. law-enforcement agencies use strategic information about domestic heroin distribution rings to break up international crime rings. The ad-hoc task force established in Plano, Texas is an excellent example of this approach. It consists of representatives from numerous area sheriffs' offices and police departments as well as the Texas Department of Public Safety, the U.S. Attorneys' Offices, the U.S. Immigration and Naturalization Service, the FBI, and DEA.

Countering the Spread of Methamphetamine

Since the mid-1980s, the world has faced a wave of synthetic stimulant abuse. Approximately nine times the quantity of such drugs were seized in 1993 compared to 1978, the equivalent to an average annual increase of 16 percent.[51] The principal synthetic drugs produced clandestinely are amphetamine-type stimulants. Domestic manufacture and importation of methamphetamine pose a continuing public-health threat. In the past, outlaw motorcycle gangs largely supplied methamphetamine. More recently, Mexican-based trafficking groups dominated wholesale trafficking in the United States. These organized crime groups have developed large-scale laboratories -- both in Mexico and the United States -- capable of

producing enormous quantities of methamphetamine. The manufacturing process involves toxic and flammable chemicals. Abandoned labs require expensive, dangerous clean up.

The 1996 National Methamphetamine Strategy (updated in May of 1997) remains the basis for the federal response to this problem. It was buttressed by the Comprehensive Methamphetamine Control Act of 1996, which increased penalties for production and trafficking while expanding control over precursor chemicals like ephedrine, pseudoephedrine, and phenylpropanolamine. It also created a Methamphetamine Interagency Task Force, co-chaired by the Attorney General and the Director of ONDP.52 The Methamphetamine Trafficking Penalty Enhancement Act of 1998 was signed into law as part of the omnibus spending agreement for FY 1999, further stiffening sanctions against this dangerous drug. Federal, state, and local investigators are targeting companies that supply precursor chemicals to methamphetamine producers. The DEA also supports law-enforcement agencies by conducting training in Kansas City and San Diego. Many retailers are adopting tighter controls for over-the-counter drugs containing ingredients that can be made into methamphetamine. Useful actions include educating employees, limiting shelf space for these products, and capping sales.

Internationally, the United States is promoting controls over precursor chemicals. Cooperation with Mexico, which is home to powerful methamphetamine trafficking organizations, is crucial. A bilateral chemical-control-working group oversees investigation of cases that interest both countries and exchanges of information on legal and regulatory matters. Mexico recently came into compliance with the 1988 U.N. Convention against Traffic in Narcotic Drugs and Psychotropic Substances.

Table X: Number of Drug Labs Destroyed in Calendar Years 1990-98

		1990	1991	1992	1993	1994	1995	1996	1997	1998
Bolivia	coca base	1446	1461	1393	1300	1891	2226	2033	1022	1205
Bolivia	cocaine HCl	33	34	17	10	32	18	7	1	1
Brazil	cocaine HCl	3	3	0	5	0	0	0	0	0
Colombia	cocaine & base	269	239	224	401	560	396	861	213	311
Colombia	morphine & heroin		5	7	10	9	11	9	9	10
Ecuador	cocaine HCl	1	4	0	0	0	0	1	0	2
Peru	coca base	151	89	88	38	21	21	14	18	
Mexico	n/a	13	9	4	5	9	19	19	8	7
Thailand	heroin labs	2	5	0	2	0	1	2	0	0
Thailand	meth labs							1	0	15
Pakistan	n/a		18	11	13	18	15	10	4	0

Reducing Domestic Marijuana Cultivation

Marijuana is the most readily available illegal drug in the United States. While no comprehensive survey of domestic cannabis cultivation has been conducted, the DEA estimates

that much of the marijuana consumed in the United States is grown domestically, both outdoors and indoors, by commercial and private operators. The DEA-coordinated Domestic Cannabis Eradication and Suppression Program provides support to state and local law-enforcement agencies. In FY 1998, this program contributed to the seizure of more than 2.5 million marijuana plants. The Department of the Interior has deep concern about marijuana cultivation on public and tribal lands. Suppression of marijuana cultivation (and clandestine drug laboratories) on approximately 525 million acres for which the Interior Department has stewardship is a priority for its four bureaus with major law-enforcement responsibilities.

Recognizing that successful domestic cannabis eradication must be supported by information about the acreage of illegal drug cultivation, Congress directed the Secretary of Agriculture to submit to the ONDCP director annual assessment of illegal drug cultivation in the United States.[53] Congress also appropriated funds for USDA to research and develop environmentally sound biological control techniques to eliminate illicit drug crops -- including cannabis, coca, and opium poppy -- in both the United States and foreign countries.

The detection of cannabis from aerial platforms remains a problem due to difficulty in developing spectral signatures unique to cannabis. This problem is primarily due to the high degree of genetic heterogeneity of illicit cannabis, as well as the general practice of concealing small plots within agricultural plantings, e.g. corn, or on public lands. Because the plots of land are often small, satellite imagery is not a viable option. Despite these difficulties, the Agricultural Research Service, in cooperation with NASA and the Naval Systems Weapons Laboratory, made progress in developing hand-held sensors for deployment in helicopters.

Mycoherbicides

Mycoherbicides utilize natively occurring microbial enemies of the coca, opium poppy, and marijuana plant that cause the crop to wilt. ONDCP stated in its March 1, 1999 report to Congress that mycoherbicides could become a critical tool in controlling coca and poppy production abroad and marijuana production within the United States. ONDCP transferred $4.5 million in fiscal year 1999 to the United States Department of Agriculture's (USDA) Agriculture Research Service to support studies dealing with biocontrol alternatives to herbicidal eradication. These funds, along with nearly $23 million Congress provided through the State Department's Bureau of International Narcotics Control and Law Enforcement for use on bio-control of narcotics crops in fiscal year 1999, represent a significant investment in the future of illicit crop eradication technologies. The grant also provided for the detection and estimation of illicit narcotics crops and the development of economic alternatives to illicit drug cultivation in foreign countries. In the coming year, the United States and the United Nations are working together to begin small-scale field testing of mycoherbicides.

7. International Drug-Control Cooperation

The transnational nature of the drug threat prevents any country from successfully combating it unilaterally. Our efforts to reduce drug availability, abuse, and adverse consequences within the United States are supported by extensive international activities. Only the federal government can undertake international supply reduction. This specific function is reflected in this *Strategy*, the accompanying *Classified Annex*, and the programs and budgets that implement it. International programs confront illegal drug cultivation, production, trafficking, abuse, diversion of precursor chemicals, and the corrosive effects of the illegal drug trade -- including corruption, violence, environmental degradation, damage to democratic institutions, and economic distortion.

A series of bilateral, multilateral, sub-regional, regional, and global accords create a bullwork for anti-drug measures. The international community's mature understanding of the scope of this problem is helping dissolve the myth that the U.S. market is the engine driving the global drug trade. In fact, the United States comprises just 2 percent of the world's consumers. Even with the relatively high price Americans are willing to pay for illegal drugs, U.S. citizens still account for only 10 to 15 percent of more than four hundred billion dollars spent globally on drugs every year.[54]

As demonstrated by the 1998 UNGA Special Session, the 1998 Summit of the Americas, and the inauguration of the Multilateral Evaluation Mechanism (MEM) by the OAS, international organizations are key elements in the attempt to control illegal drugs. Working through these organizations promotes the best practices and encourages parallel efforts.

Drug Control Efforts through International Organizations

Recent U.S. activities through the UN Drug Control Program resulted in an expansion of South East Asia programs that target Burma, the second largest opium producer in the world; eradication in Afghanistan; and training officials in Asia and Latin America. In addition, UNDCP established regional Caribbean efforts to teach judicial personnel how on how to handle narcotics-related cases, assisted Southern African nations in developing anti-drug legislation, and established demand-reduction centers in Central Europe.

The contributions of the U.S. to Colombia's Advisory Program led to increased commitment from other donors, particularly Japan, Korea, and Australia. These contributions resulted in the development of host nation-funded drug treatment in South Asia, China, and the Philippines as well as prevention programs throughout the region.

The legislatively mandated certification process is an important instrument in our international narcotics-control policy. Under this law, the President is required to identify illicit drug-producing and transit countries on an annual basis and then "certify" whether these nations cooperated fully with the United States or took adequate steps on their own to implement the

1988 UN Drug Convention. The President must impose certain economic sanctions on countries that do not meet these requirements unless he certifies that vital interests of the United States preclude such sanctions. The sanctions include cutting off foreign assistance (other than humanitarian and counternarcotics aid) and voting against requests for loans from multilateral lending institutions. The certification process helped underscore the importance the United States attaches to international narcotics control and encouraged some countries to take steps they might otherwise have avoided in pursuit of sound drug-control policy. At the same time, this unilateral certification process is contentious in many countries.

Promoting International Demand Reduction

The problem of increasing drug abuse is shared by many nations. In the United Kingdom (UK), for example, 48 percent of sixteen to twenty four year-olds questioned in 1996 said they had used illegal drugs in their lifetime, and 18 percent were past-month users. In Mexico, the 5.3 percent of the population had ever used drugs in 1998, compared to 3.9 percent in 1995 – a 36 percent increase. Drug use rates have also increased in Argentina, Chile, Colombia, and Peru in recent years.

Recognizing that no government can reduce drug use and its consequences by itself, the United States encourages and supports private-sector prevention initiatives. Examples include the *Consejo Publicitario Argentino,* the *Parceria Contra Drogas* in Brazil, and the *Alianza para una Venezuela sin Drogas.* The 120,000 U.S. tax-payer dollars that helped establish these national organizations contributed to the generation of more than $120 million in anti-drug media messages in these three countries. Media campaigns were launched last year in Peru and Uruguay. The United States Information Agency supports public diplomacy campaigns that publicize the threat drug abuse and trafficking poses to societies in source and transit nations.

Supporting Democracy and Human Rights

Democracies make peaceful neighbors and reliable trade partners. They are good for security and provide an environment for cooperation on drug issues. Democracies have a greater propensity to respect human rights, are less tolerant of corruption, and are more likely to build legal systems which set fair ground rules for everybody -- including foreign investors. If any area in the world can boast of a sweeping trend toward greater respect for democratic practices in the past quarter-century, it is Latin America and the Caribbean. Civil society is still very weak in some countries. Greater honesty and ethics in government, improved administration of justice, effective and humane law enforcement, and greater respect for free expression are all needed.

The Administration continues to be very sensitive about Human Rights. Under the Leahy Amendment to the FY 1999 Foreign Operations Appropriation Bill, the administration can only provide training and assistance to those security units, which do not have in their ranks, violators of human rights. If the Secretary of State has credible evidence to believe that a unit

committed gross violations of human rights, no funds made available by this Act may be provided, unless the Secretary determines and reports to the Committees on Appropriations that the foreign government responsible for the security unit is taking steps to bring the responsible members to justice.

Regional Drug Control in the Western Hemisphere and the Multilateral Evaluation Mechanism

The Organization of American States' Inter-American Drug Abuse Control Commission (OAS/CICAD) has become an essential link in our international drug-control regime. U.S. contributions to OAS/CICAD have had a direct impact on the development of model workshops to target money laundering and asset forfeiture, regional mechanisms for tracking pre-cursor chemicals, anti-drug laws, and judicial or legal training. Other areas of emphasis have been assisting our regional partners in the development of demand-reduction strategies and bolstering drug-abuse prevention.

After eighteen months of discussion and negotiation, a Multilateral Evaluation Mechanism (MEM) was inaugurated in 1999 during the twenty-sixth regular session of CICAD in Montevideo, Uruguay (October 1999). The MEM is a multilateral system of counter-drug performance measurement. Its creation was mandated by thirty-four democratically elected presidents who attended 1998 Summit of the Americas in Santiago, Chile. The establishment of the MEM will have no direct impact on the United States' annual drug certification process, which is required by law. However, the MEM should facilitate more effective counterdrug efforts by all nations in the hemisphere.

Although individual nations in the hemisphere have made progress in developing comprehensive counterdrug strategies, many have yet to develop an adequate system to collect and report basic statistics on drug use, production, seizures, arrests, money laundering, chemical diversion, and drug trafficking. In addition, the data many nations collect is based on different methodologies. This problem prevents accurate regional comparisons, discourages information sharing, and inhibits the development of a hemispheric picture of the drug problem as it changes over time. MEM was designed to fix these difficulties.

The initial steps in implementing the MEM have already begun. Nations have been sent a detailed questionnaire with sixty-two performance indicators, which require detailed answers pertaining to prevention, treatment, law enforcement, and interdiction. The questionnaires will be turned over for review to a Government Experts Group (GEG). Recommendations will be written by the GEG and published by CICAD on the Internet. Results of the first round of evaluations will be reported to the hemisphere's presidents at the Summit of the Americas in 2001 in Quebec City, Canada.

Bilateral Cooperation with Mexico

Most of the cocaine and much of the marijuana, heroin, and methamphetamine

consumed in the U.S. comes through Mexico. Mexican drug networks control a substantial portion of the illicit drugs distributed in the United States. Conversely, cash and firearms derived from illegal drug trafficking move South from the U.S. into Mexico.

Senior levels of the Mexican government are willing to confront the national security threat posed by drug trafficking, drug-related corruption, and violence. Corruption and fragile counter-drug institutions have hurt Mexico. Mexico must remain committed to disrupting drug-trafficking organizations and reducing the amount of illegal substances that enter Mexico and the United States.

In the last four years, Mexico prosecuted a number of high-ranking public officials for corruption. It established a Confidence Control Center to address corruption. Mexico enacted anti-crime laws that strengthen law enforcement and provide the basis for effective prosecution. Cooperation between the two nations improved in terms of counterdrug information sharing, investigations, extradition, and military coordination. Twenty-five metric tons of cocaine were seized as the result of maritime coordination between the U.S. Coast Guard and the Mexican Navy during the first nine months of 1999. In January 2000, the U.S. and Mexico will conduct the first opium yield survey in almost fifteen years.

In 1998, the United States and Mexico developed a comprehensive bi-national anti-drug strategy. The strategy builds on the *Bi-national Drug Threat Assessment and the U.S.-Mexico Alliance against Drugs* signed by Presidents Clinton and Zedillo in 1997. The agreement demonstrates the shared commitment to address drug problems while upholding the principles of sovereignty, mutual respect, territorial integrity, and nonintervention. The U.S./Mexico Performance Measures of Effectiveness, developed in February 1999, are designed to assess if Mexico and the U.S. have taken effective action to implement the bi-national strategy. A second bi-national demand-reduction conference was held in Tijuana, Mexico in June of 1999, and a third conference will take place in Tucson, Arizona in April of 2000.

Over the long term, the United States and Mexico need to preserve institutions of cooperation like the U.S.-Mexico High Level Contact Group (HLCG) for Drug Control and the Senior Law Enforcement Plenary. Mexico must strengthen its law-enforcement and anti-corruption efforts in order to reduce the flow of drugs.

Targeting International Drug Trafficking Organizations

Over the last decade, Latin American drug-trafficking organizations fundamentally changed the way they do business. A diverse group of smaller, specialized Colombian drug rings have emerged following the collapse of the Medellin and the Cali cartels. The smaller suppliers in South America and the transportation groups in the Caribbean and Mexico filled the void left by the demise of the large cartels and expanded their roles in the international cocaine industry.

The increase in smaller suppliers, producers, and trafficking groups made targeting drug

trafficking organizations much more difficult. The sheer power, influence, and sophistication of these groups put them in a category by themselves. Whereas traditional Mafia families bribed officers and judges, today's international drug organizations corrupt entire institutions of government.

These traffickers model their operations after international terrorists. They maintain tight control of their workers through highly compartmentalized cell structures that separate production, shipment, distribution, money laundering, communications, security, and recruitment. Traffickers have at their disposal the most technologically advanced airplanes, boats, vehicles, radar, communications equipment, and weapons. They have also established vast counterintelligence capabilities and transportation networks.

Although presented with a problem of growing complexity, international law enforcement had a number of important successes in 1999. Operation Impunity was a two-year project completed in September 1999, which resulted in the arrest of ninety-three individuals linked to the Amado Carrillo-Fuentes drug-trafficking organization headquartered in Juarez, Mexico. Operation Impunity dismantled an entire trafficking organization through the identification and arrest of three drug-trafficking leaders who had been operating inside the United States. The arrests of these individuals and ninety of their subordinates helped disable all facets of their organization -- the group's headquarters in Mexico, the heads of U.S. cells, drug and money transportation systems, and local distribution groups. As a result of Operation Impunity, 12,434 kilos of cocaine and 4,800 pounds of marijuana were seized along with nineteen million dollars in U.S. currency and another seven million dollars in assets.

Operation Millennium, a one-year investigation, concluded in October of 1999 with the arrest of thirty-one individuals, including Fabio Ochoa-Vasquez and Alejandro Bernal-Madrigal -- former members of the original Medellin cartel. Operation Millennium targeted major suppliers responsible for shipping vast quantities of cocaine from Colombia through Mexico and into the United States. By his own admission, Alejandro Bernal-Madrigal, had been smuggling thirty tons of cocaine, or five hundred million dosage units, into the United States every month. Working with the government of Colombia, both Ocha and Bernal were eventually extradited to the United States to stand trial on drug-trafficking charges.

International Anti Money Laundering Efforts

A multi-agency training program is helping banks and law-enforcement agencies in emerging democracies detect and deter money laundering. Treasury's Financial Crimes Enforcement Network (FinCEN) continues to provide training in the area of anti-money laundering measures as well as technical support to other governments; it also assists in resolving controversial issues concerning anti-money laundering laws or regulations.

The United States supports global efforts to disrupt the flow of illicit capital, track criminal sources of funds, forfeit ill-gained assets, and prosecute offenders. Twenty-nine nations belong

to the Financial Action Task Force (FATF): Argentina, Brazil, and Mexico participate as observers. Formed by the G-7 Economic Summit in 1989, the FATF is dedicated to promoting anti-money laundering controls around the world. As a result, all members of the FATF have now criminalized money laundering and are working toward implementing a full range of international anti-money-laundering standards.

Working with the FATF and other governments, the U.S. promotes the establishment of FATF-style regional bodies. A major achievement of the FATF in 1999 the second mutual evaluation of each member's anti-money laundering measures. This past year, progress was made in creating an internationally accepted methodology to measure the financial dimensions of the illicit drug industry. In 1999, a unique partnership was forged among the G-7 FATF, the United Nations Drug Control Program, European Drugs Monitoring Center, and several other European agencies to produce the first reliable estimate of illicit drug proceeds in the FATF nations.

In addition, the United States has been working with FATF to develop Financial Intelligence Units (FIUs), which receive, analyze, and (where appropriate) refer for prosecution suspicious transactions reported by financial institutions. The operation of financial intelligence units (FIUs), modeled after FinCEN, may prove to be one of the most effective means for combating money laundering around the globe. This development provides a centralized mechanism for tracking criminal proceeds, collecting investigative data, and contributing to international cooperation by combating money laundering. There are now forty-eight FIUs in operation with more in the planning stages. The United States has been assisting interested countries with technical support associated with FIU operation. Currently, FinCEN is working with governments to share information through a secure Intranet. Accomplishing this goal will be important to U.S. efforts to identify, investigate, and prosecute transnational financial crimes.

The United States government is also attacking the financial networks of drug trafficking organizations by seizing illegally gained assets. In December of 1999, the President signed into law the Foreign Narcotic Kingpin Designation Act, which establishes a global program targeting the activities of narcotics traffickers. The new act provides a statutory framework for the President to institute sanctions against foreign drug kingpins in order to deny illegal businesses access to the U.S. financial system and benefits from U.S. trade. Once locked out of American trade, criminal organizations have difficulty participating in open commerce.

Actions directed against drug assets are most effective when undertaken with international support. The United States must continue encouraging other nations to join in coordinated efforts against drug organizations. As kingpin designations are made under the new law, we will continue working with host governments to pursue additional measures against drug criminals.

Controlling Precursor Chemicals

The twenty-two chemicals most commonly used in the production of cocaine also have

extensive industrial applications. We can disrupt illegal drug production if these chemicals are difficult to obtain. For this reason, an important element in the U.S. drug-control policy is to insure that all countries have an effective, flexible system that regulates the flow of precursor chemicals without jeopardizing legitimate commerce. The Multilateral Chemical Reporting Initiative -- formulated by the U.S. and accepted internationally -- completed its second year in 1999. This program encourages governments to exchange chemical-control information on a voluntary basis in order to identify suspicious orders. Over the past decade, key international bodies like the Commission on Narcotic Drugs and the U.N. General Assembly's Special Session (UNGASS) have addressed the issue of chemical diversion in conjunction with U.S. efforts. These organizations raised specific concerns about potassium permanganate (a chemical essential in making cocaine) and acetic anhydride (a heroin precursor).[55]

To facilitate the flow of information about precursor chemicals, the United States -- through its relationship with the Inter-American Drug Control Abuse Commission (CICAD) -- continues to assess the status of precursor chemicals and assist countries in strengthening controls. Many countries still lack the capacity to determine whether the import or export of precursor chemicals is related to legitimate needs or illicit drugs. The problem is complicated by the fact that many chemical shipments are directed through third countries in an attempt to disguise their purpose and destination. More can be done to prevent diversions, and the international community -- through the United Nations -- has become increasingly involved in concerted global action to limit the availability of precursor chemicals.

In countries where strict chemical controls were put in place, illicit drug production has been seriously affected. For example, few of the chemicals needed to process coca leaf into cocaine HCl are manufactured in Bolivia. Most are smuggled in from neighboring countries with advanced chemical industries. DEA estimates that licensed importers are diverting only small amounts. However, increased interdiction of chemicals, particularly in the Chapare, raised the price of many smuggled chemicals in 1998. Bolivian lab operators are now using inferior substitutes (cement instead of lime, sodium bicarbonate for ammonia), recycled solvents (ether), and a streamlined production process that virtually eliminates oxidation in producing cocaine base. Some laboratory operators are not using sulfuric acid during the maceration stage; consequently, less cocaine alkaloid is extracted from the leaf, producing less HCl. The lower quality of Bolivian cocaine has affected its marketability.

Operation Purple In 1999, Operation Purple was conducted with the cooperation of seven major countries that produce potassium permanganate, exporting/transshipment countries, and cocaine-producing countries of the Andean region. This operation tracked shipments of potassium permanganate that were greater than a hundred kilograms. During seven months of operation, these investigative efforts had a major impact on the traffickers' ability to obtain chemicals necessary to process cocaine. Some were 187 shipments of the chemical were tracked worldwide, involving more than six million kilograms. There were twenty-four shipments seized or halted during transit – accounting for 1.7 million kilograms of potassium permanganate – which, if used for processing cocaine, could have created up to 17 million kilograms of the drug.

Reducing Corruption

Like an opportunistic disease attacking a weakened immune system, the drug trade draws strength from the economic, social, and moral decay that corruption fosters. Drug syndicates exacerbate corruption through wealth. Enormous resources give the large drug organizations a nearly open-ended capacity to corrupt. We have seen instances in the recent past where senior officials charged with destroying drug syndicates were in fact in the syndicates' employ. By focusing world attention on the need to eliminate corruption, we can prevent this fate from befalling elected governments.

Stemming corruption and protecting the integrity of a nation's judicial system were central to Vice President Gore's global forum on fighting this problem, held in February 1999. Corruption was also discussed at the Western Hemisphere Drug Policy summit held in November 1999. Both forums emphasized the need for justice, security, and financial regulatory officials as well as accountability in the private sector and the press. Nations suffering from corruption must take the tough measures required to develop democratic institutions that inspire investor confidence and public support.

Endnotes

[1] Citation required.

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[3] Carnegie Corporation of New York, *Starting Points: Meeting the Needs of our Youngest Children.* New York, NY, 1994.

[4] Meisels, S.J., Dichtelmiller, M., Liaw, F., "A Multidimensional Analysis of Early Childhood Programs," in Handbook of Infant Mental Health, Zeanah, C. Ed, The Guilford Press, 1993.

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[7] The NIDA pamphlet *Preventing Drug Use Among Children and Adolescents a Research-Based Guide*, (Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse, March 1997, reprinted November 1997. (http://www.health.org/pubs/prev/PREVOPEN.html), January 29, 1999) provides a comprehensive overview of prevention, including principles and examples of research-based programs.

[8] Yoshikawa, H. 1995. *Long Tem Effects of Early Childhood Programs on Social Outcomes and Delinquency* Future of Children 5 (3): 51-75.

[9] On-line resources include: www.whitehousedrugpolicy.org/; www.samhsa.gov/csap/; www.ojjdp.ncjrs.org/; www.health.org/.

[10] Information about the "Prevention Through Service" Alliance can be obtained at (http://www.ptsa.net/), January 29, 1999.

[11] Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *Results from the 1998 National Household Survey on Drug Abuse* (Rockville, MD: U.S. Department of Health and Human Services, 1999), 14.

[12] Harwood, H., Fountain, D., Livermore, G., et .al. *The Economic Cost of Alcohol and Drug Abuse in the United States.* Rockville, MD., National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism, 1998.

[13] ODR PLEASE PROVIDE A SOURCE

[14] *Workplace Drug Testing and Drug Abuse Policies*, American Management Association. 1996. 1601 Broadway, New York, NY.

[15] 1-800-WORKPLACE, staffed since 1989 by experts providing personalized assistance to employers, labor unions, and community-based organizations regarding the "how to" of worksite substance abuse prevention and intervention strategies. In 1999, Helpline received more than 4,500 calls from small businesses. In follow-up calls, more than 50 percent of those contacted reported taking action as a result of information received via Helpline.

[16] To date, SAMHSA/CSAP has distributed more than 100,000 copies of *Making You Workplace Drug Free: A Kit for Employers* through the above website, including a Spanish language version through a cooperative venture with Mexico. Information about SAMHSA workplace initiatives can be obtained at the website given above, or by e-mail (helpline@samhsa.gov)

[17] Information about the ONDCP Athletic Initiative can be obtained at http://www.ondcpsports.org/), January 29, 1999.

[18] The *Coach's Playbook Against Drugs* can be viewed at http://www.ondcpsports.org/coachesplaybook/index.html), January 29, 1999.

[19] As "medical use" may be defined in different ways, it is important to underscore that "medical use" is not the equivalent of "recreational use."

[20] *Marijuana and Medicine: Assessing the Science Base*, Institute of Medicine, Janet E. Joy, Stanley J. Watson, Jr., and John A. Benson, Jr., Editors, National Academy Press, Washington, D.C., 1998.

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[22] "The Status and Potential of Industrial Hemp in the United States" An Internal Document prepared for ONDCP by the USDA Economic Research Service, March 1, 1999.

[23] The National Center on Addiction and Substance Abuse at Columbia University. *No Safe Haven: Children of Substance Abusing Parents*, (New York, NY: The National Center of Addiction and Substance Abuse, 1999). U.S. General Accounting Office. *Foster Care Agencies Face Challenges Securing Stable Homes for Children of Substance Abusers*, (Washington, DC: U.S. General Accounting Office, 1998). Child Welfare League of America. *Alcohol and Other Drug Survey of State Child Welfare Agencies*, (Washington, D.C.: Child Welfare League of America, 1998).

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[25] Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. *Substance Use Among Women in the United States*, (Washington, D.C.: 1997).

[26] The Legal Action Center. *Making Welfare Reform Work: Tools for Confronting Alcohol and Drug Problems Among Welfare Recipients*, (New York, NY: Legal Action Center, 1997).

27. The following discussion of addiction is based primarily on articles and speeches by Alan I. Leshner, Ph.D. Dr. Leshner is Director of the National Institute on Drug Abuse. A fuller discussion of addiction by Dr. Leshner can be found in Department of Justice, Office of Justice Programs, *National Institute of Justice Journal*, "Addiction Is a Brain Disease - and It Matters," October 1998.

28. Kessler, R., Nelson, C., McGonagle, K. "The Epidemiology of Co-Occurring Addictive and Mental Disorders: Implications for Prevention and Service Utilization," *American Journal of Orthopsychiatry*, 1996; 66, pp. 17-31.

[29] Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. *The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits*, (Washington, D.C.: 1998), available online at (http://www.mentalhealth.org), January 29, 1999.

[30] See for example *The Development of Medications for the Treatment of Opiate and Cocaine Addictions*, Institute of Medicine, 1995 and *Market Barriers to the Development of Pharmacotherapies for the Treatment of Cocaine Abuse and Addiction*, Department of Health and Human Services, September 1997.

31. CSAT Technical Assistance Publication (TAP) No. 21, *Addiction Counseling Competencies: The Knowledge, Skill, and Attitudes of Professional Practice*, is available online through the National Addiction Technology Transfer Centers' Coordinating Center (http://www.nattc.org), January 29, 1999.

[32] Christopher Mumola, *Substance Abuse and Treatment, State and Federal Prisoners, 1997* (Washington, DC: Bureau of Justice Statistics, 1999).

[33]. *Substance Abuse and Treatment, State and Federal Prisoners, 1997*, p. 10.

[34]. Department of Justice, Bureau of Prisons. *TRIAD Drug Treatment Evaluation, Six-Month Report, Executive Summary*, p.1. (http://www.bop.gov/triad/html), January 29, 1999.

[35] Need complete citation from ODR – info provided: Martin, Butzin, Saum, and Inciardi, 1999, *The Prison Journal*

[36] More information about Drug Courts can be obtained at (http://www.drugcourt.org/), January 29, 1999.

[37] Belenko S. "Research on Drug Courts: a Critical Review," *National Drug Court Institute Review*, 1 (1), 1998.

[38] More information about TASC can be obtained at (http://www.ncjrs.org/txtfiles/tasc.txt), January 29, 1999.

[39] The Internal Revenue Service's Criminal Investigative Division estimates that 25 percent of its investigations are drug-related.

[40] The Annunzio-Wylie Anti-money Laundering Act (P.L. 102-550) authorized the reporting of suspicious transactions. The second, the Money Laundering Suppression Act of 1994 (P.L. 103-325) expanded the policies of Annunzio-Wylie, to include the designation of Treasury as the single collection point for the suspicious transaction reports. The Money Laundering Suppression Act of 1994 also expanded Annuzio-Wylie to require registration with the Treasury of money transmitters, check cashiers, and currency exchange houses.

[41] MSBs include businesses and their authorized agents who provide the distinct but often-complementary services of money transmission, check cashing, currency exchange, and the issuance, sale and redemption of money orders and traveler's checks.

[42] The Web site www.epgctac.com provides up-to-date information about the Counterdrug technology Transfer Program.

[43] Section 629 (1) of Public Law 105-277 (Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999) directs: "...the Director of the Office of National Drug Control Policy, The Secretary of Treasury, and the Attorney General shall conduct a joint review of Federal efforts and submit to the appropriate congressional committees, including the Committees on Appropriations, a plan to improve coordination among the Federal agencies with responsibility to protect the borders against drug trafficking. The review shall also include consideration of Federal agencies' coordination with State and local law enforcement agencies."

44 Congressional testimony of GEN Charles E. Wilhelm, Commander-in-Chief, United States Southern Command, June 22, 1999.

45 DCI Crime and Narcotics Center, Major Coca & Opium Producer Nations, 1994-1998, p.5

46 DCI Crime and Narcotics Center, Crop Assessment Briefing, Bolivia, January 2000.

47 DCI Crime and Narcotics Center, Crop Assessment Briefing, Peru, January 2000.

[48] Ibid

49 DCI Crime and Narcotics Center, Revised Crop Assessment Briefing for Colombia, January 2000.

50 Worldwide heroin production estimates are from the U.S. Department of State, 1998 International Narcotics Control Report. The Crime and Narcotics Center (Central Intelligence Agency)'s estimate indicates 18 metric tons of heroin are being delivered to the United States.

[51] United Nations, United Nations International Drug Control Programme. *World Drug Report,* 1998, p. 19. (http://www.un.org/ga/20special/wdr/wdr.htm), January 29, 1999.

52 The Methamphetamine Interagency Task Force brought together federal and non-federal experts who reviewed current practices regarding methamphetamine. The Task Force published a report that describes the methamphetamine problem and makes recommendations in the areas of law enforcement, prevention and education, and treatment. The report also establishes research priorities to advance the understanding of the nature and effects of the methamphetamine problem and to measure the effectiveness of prevention, enforcement, and treatment interventions. A final section discusses promising strategies that the federal government should undertake to assist communities in combating methamphetamine. The Task Force Co-Chairs announced in January that demonstration programs will be developed in several cities, using the local U.S. Attorney's office to facilitate local prevention, treatment and law enforcement strategies to combat the spread of methamphetamine.

53.Section 705(a)(2)(B)(3) of the ONDCP Reauthorization Act of 1998.

[54] ***World Drug Report,*** p. 124. The report notes that "many estimates have been made of the total revenue accruing to the illicit drug industry - most range from US$300bn to US$500bn. However, a growing body of evidence suggests that the true figure lies somewhere around the US$400bn level. A US$400bn turnover would be equivalent to approximately 8 per cent of total international trade. In 1994 this figure would have been larger than the international trade in iron and steel and motor vehicles and about the same size as the total international trade in textiles."

[55] Drug Enforcement Administration, *The Diversion of Drugs and Chemicals*, 14.