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

February 3, 1993

MEMORANDUM FOR CAROL RASCO
DOMESTIC POLICY COUNCIL ADVISOR

FROM: RICIA MCMAHON
SPECIAL ASSISTANT TO THE WHITE HOUSE

SUBJECT: Request for Guidance on Drug Policy Issues

I am writing to request policy guidance on several issues that have come to my attention since I began serving as the Administration's liaison at the Office of National Drug Control Policy. I spoke with your assistant, Al Johnston, today about some of these issues and he suggested that I bring these matters to your attention. Attached for your review is a brief description of each of these issues.

One of the issues discussed on the attached is a report on drug testing that may soon be issued by the Department of Health and Human Services (HHS). I intend to speak to Kevin Thorm, an assistant to Secretary Shalala, to express my concerns about the report. I will also send him the attached briefing paper.

Also, on February 9, 1993, I will be addressing HHS's National Prevention Conference. I will be discussing the involvement of the elected political community in drug and alcohol prevention. As the first representative of the Administration to address this group, I would appreciate any guidance you can offer.

If you have any questions about the issues I have raised, I would be pleased to provide you or your staff with additional information or a detailed briefing. I can be reached at 467-9840. Thank you for your assistance.

Attachment

ATTACHMENT

ISSUE PAPER: HHS ON-SITE DRUG TESTING REPORT

ISSUE AND RECOMMENDATION

HHS intends to release a report, "On-Site Drug Testing in the Workplace" that concludes that a system for monitoring on-site drug testing should be developed. We find the report to be incomplete and an insufficient basis for making such a recommendation. We believe that the report should be delayed until the Administration has had an opportunity to examine all the policy considerations.

BACKGROUND AND DISCUSSION

Many private sector businesses implement drug-free workplace programs that include on-site drug testing. On the other hand, some federally regulated industries (e.g. transportation) are not permitted to use on-site drug testing. As a result of this dichotomy, HHS commissioned a report regarding on-site drug testing in the workplace.

In letters of September 15 and January 27, 1992, ONDCP informed HHS that the report is flawed and should not be released in its current form. Despite our concerns, and protests from the Congress and business community, we understand that HHS intends to release this report in two weeks.

If the report's guidelines are implemented, employers may be required to institute costly, elaborate, and complicated procedures that could negate many of the advantages of on-site drug testing. On-site drug tests act as an initial screen that provides immediate results. Usually, only positive test results are sent to a laboratory for confirmation, thus saving employers paperwork and costs.

There is conflicting information emanating from HHS. HHS has told the business community that the study will not be released. However, we understand that PHS plans to publish the report. It is unclear whether the Secretary's office has been informed about the imminent release of this report.

PROS

Publishing the HHS report will stimulate a debate among the public and private sector regarding on-site testing programs. These discussions would be fruitful in the development of standards.

The report is overdue and should have been published two years ago, according to HHS's timetable.

Publishing this report may result in the development of regulations that strengthen current on-site drug testing activities. Employees deserve a testing program that is accurate and contains rigorous and procedural safeguards.

CONS

The Clinton Administration has not yet developed its drug testing policies. Publishing this report without a fully developed position may lock the Administration into a position that it may want to reverse at a later date.

There is no pressing need to publish the report at this time. No member of Congress, the Administration, or the private sector is calling for its release.

Public safety could be jeopardized if this report is released because some companies (e.g., construction) may cease on-site testing. On-site testing can prevent drug using employees at remote construction sites from using dangerous equipment.

On-site testing was exempted from the Clinical Laboratory Improvement Act of 1988 regulation primarily because private businesses opposed such regulation. Publishing this study that calls for regulating on-site testing at this time without new data may open up the President and HHS for criticism from the business community.

Legislation has been recently reintroduced (HR 33) that calls for regulating private sector drug testing. We do not want to release a report that may be interpreted as supporting or opposing this legislation until the Administration position on drug testing has been formulated.

ATTACHMENT

OFFICE OF NATIONAL DRUG CONTROL POLICY

Policy guidance is needed on the following issues:

Whether the Department of Health and Human Services (HHS) should issue its report on on-site drug testing. HHS intends to issue a report soon that concludes that a system for monitoring on-site drug testing should be developed. We find the report to be incomplete and an insufficient basis for making such a recommendation. I suggest that the report be delayed until the Administration has had the opportunity to examine all the policy considerations involved. Such examination should precede a decision on whether on-site drug testing should be regulated. Publishing the report now might lock the Administration into a position that it may want to reverse at a later date. A full discussion of this issue is attached.

How to include drug treatment in the President's National Health Care Reform proposal. President Clinton will propose a national health care reform plan within the first 100 days of his Administration with the goals of providing everyone access to health care and containing costs. Drug treatment could be included in the standard benefit package that will be developed as part of the plan. ONDCP has longstanding relationships with treatment organizations that are developing recommended standard benefit packages for drug treatment. Guidance is needed on how to coordinate their efforts with Federal policy makers.

Whether the Administration should seek to expand drug treatment capacity through Supplemental Security Income (SSI) and Medicaid. Since discretionary funding sources are limited and Congress has not recently provided substantial new funding for drug treatment, other sources of revenue may be needed to fulfill the President's commitment to provide treatment on demand. Two potential resources are Medicaid and SSI. Neither entitlement program is subject to the annual appropriations process. Both can provide funding in support of drug treatment. At issue is whether the Administration should encourage the States to aggressively pursue SSI eligibility for indigent drug addicts and encourage fuller use of existing Medicaid provisions for drug treatment. A more detailed briefing paper on this issue is attached.

Whether to place additional issues before the Commission on Model State Drug Laws. The President's Commission on Model State Drug Laws will hold a public hearing on drug treatment on March 10, 1993 in Philadelphia, Pennsylvania. The main topics to be discussed include: (1) mandating alcohol and drug treatment in health insurance; (2) managed care; (3) overturning the IMD exclusion for drug treatment covered by Medicaid; (4) expanding treatment for pregnant women; and (5) expanding treatment for the criminal justice population. Guidance is needed on whether the Administration would like additional topics covered.

ATTACHMENT

SUPPLEMENTAL SECURITY INCOME AND MEDICAID

Option

Expand drug treatment capacity by urging States to make greater use of existing Supplemental Security Income and Medicaid support for treatment.

Background

Currently, the Department of Health and Human Services estimates that 5.8 million Americans are addicted to illicit drugs and that half, or about 2.8 million, need and can benefit from treatment. In 1992, only about 1.8 million addicts will receive treatment.

For FY 1993, the Congress appropriated less funding for drug treatment than was requested by the Bush Administration. In addition, Congress imposed new mandates on treatment programs receiving funding through the Federal Substance Abuse Block Grant -- the primary source for Federally-funded drug treatment. These mandates (e.g., requirement that TB and AIDS testing and counseling be provided) will make it more expensive to treat each patient. As a result fewer addicts will receive treatment. ONDCP estimates that millions of dollars will be needed to make up the shortfall in FY 1994. Given the current budget situation, it is unlikely that such funding will be appropriated.

Discussion

Since discretionary funding sources are limited and Congress has been reluctant to provide substantial new funding for drug treatment, other sources of revenue may be needed to fulfill President Clinton's commitment to provide treatment on demand. Two potential resources include Medicaid and Supplemental Security Income (SSI). Both are entitlement programs and are not subject to the annual appropriations process. Both can provide funding in support of drug treatment. (SSI cannot be used to pay for treatment *per se*, but it can be used for room and board at residential treatment programs.)

States may fund drug treatment through the Medicaid program, but few States make full use of this option because a funding match is required and regulations governing the use of Medicaid for treatment are complex and restrictive. However, with the shrinking value of each dollar appropriated under the Substance Abuse Block Grant, using Medicaid may become a cost-effective alternative for States to provide drug treatment.

Currently, the Department of Health and Human Services is providing technical assistance to States to facilitate the use of Medicaid for treatment. However, a more aggressive approach could ensure that all States make full use of Medicaid for drug treatment, and that more addicts have the opportunity to access treatment. Such action would greatly expand the nation's treatment capacity without going through the appropriations process.

Another source of funding, SSI, provides benefits to addicts determined to be so severely addicted that they are unable to work. To receive benefits, addicts must undergo appropriate treatment (if available) at an approved facility and demonstrate compliance with the treatment program.

States determine whether addicts are eligible to receive SSI benefits. Those eligible receive monthly payments of about $348. (Actual payments are made to a responsible third party, such as a treatment program or relative.) In addition, addicts receiving SSI benefits are automatically covered by Medicaid, which can be used to pay for drug treatment.

Few States have taken full advantage of the SSI program, and the number of addicts receiving benefits varies considerably from State to State. For example, fewer than 20 addicts receive benefits in the District of Columbia, while over 15,700 receive benefits in California. California and Illinois account for nearly 54 percent of the alcoholics and addicts receiving benefits. Urging more States and treatment programs to use SSI and providing them with technical assistance to do this would provide addicts with an incentive to enter drug treatment and help States gain access to available Medicaid funds for providing additional drug treatment.

Pros

Urging States to make greater use of Supplemental Security Income and Medicaid for funding treatment would:

- Greatly expand the nation's drug treatment capacity for those least able to afford treatment without going through the appropriations process.
- Provide a "guaranteed" source of funding for drug treatment that is not subject to the yearly appropriations process.
- Help ensure that addicts get the treatment that they need so they can potentially lead self-supporting lives.
- Ensure that States and the Federal government jointly support expanding drug treatment.

Cons

Expanding drug treatment capacity by urging States to make greater use of Supplemental Security Income and Medicaid for funding treatment would:

- Increase the amount of money being spent through entitlement programs at a time when many economists are advising President Clinton to cut entitlements.
- Expand the potential for the fraudulent use of Medicaid and SSI funds. (Efforts to monitor program compliance under SSI have been inadequate. Procedures are being developed to improve monitoring.)
- Risk the appearance of placing more burden on the States since Medicaid requires a funding match.

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

January 21, 1993

MEMORANDUM FOR THOMAS McLARTY

FROM: JOHN WALTERS
ACTING DIRECTOR

SUBJECT: National Drug Control Strategy and Budget Issues

The Anti-Drug Abuse Act of 1988, which created the Office of National Drug Control Policy (ONDCP) and defined its mission, contains several statutory requirements that ONDCP and/or the President must meet.

Immediate policy guidance is needed with respect to two of the Act's requirements: the annual submission of a strategy to Congress, and the preparation of a consolidated drug control budget. These requirements are described in more detail below.

Submission of a National Drug Control Strategy to Congress

The Act requires that the President submit to Congress a National Drug Control Strategy by February 1 each year. In consultation with the Congress, the States, private sector groups and citizens, and Federal agency staff, ONDCP has developed a draft Strategy document that describes the existing drug program in such a way as to give the new Administration maximum flexibility to include its initiatives and policy direction.

This draft Strategy does not contain new policy, program, or funding initiatives. Such initiatives are dependent upon policy direction from the Administration and the development of a drug control budget.

It is unlikely, therefore, that we will meet the statutory deadline to submit President Clinton's National Drug Control Strategy by February 1. Accordingly, I would make the following recommendation:

> **Recommend:** We prepare a letter for signature by an appropriate Administration official apprising Congress that the statutory deadline for submitting a National Drug Control Strategy will not be met, but that a Strategy will be submitted once the Administration has conducted a full review of all drug control policies and programs.

Preparation of the FY 1994 Consolidated Drug Control Budget

The Act also requires that ONDCP submit to Congress an annual drug control budget that delineates for each Federal drug control agency the resources required to implement the Strategy. In the past, the release of the consolidated drug budget and Strategy coincided with the release of the President's full Federal budget.

All drug control agencies have submitted their FY 1994 budget requests to OMB and ONDCP for review. By law, ONDCP must certify the adequacy of those budgets to implement the National Drug Control Strategy. Final certification would normally have occurred in November, but it has been delayed pending program and policy direction from the Administration. In light of the requirement to develop a FY 1994 drug control budget, I would recommend the following:

> **Recommend:** We include in the letter to Congress described above the intent to submit a consolidated drug control budget concurrent with the release of the Strategy.

I am attaching proposed letters to the President of the Senate and the Speaker of the House incorporating these recommendations.

The Office stands ready to provide additional information on these matters or any others affecting our mission at your convenience.

Attachments

cc: Christine Varney

The Honorable Albert Gore, Jr.
President of the Senate
U.S. Senate
Washington, D.C. 20510

Dear Mr. President:

Public law 100-690 requires that the President submit to Congress a National Drug Control Strategy by February 1 each year. In addition, the Office of National Drug Control Policy (ONDCP) is required to submit to Congress an annual drug control budget that delineates for each Federal drug control agency the resources required to implement the Strategy.

I am writing to advise you that the Administration will be unable to meet the February 1 deadline this year, pending a complete review of all drug policies, programs, and funding. Once that review has been completed, the Administration will submit its Strategy and budget for drug control purposes.

An identical copy of this letter has been sent to the Speaker of the House. Thank you for your attention to this important matter.

Sincerely,

The Honorable Thomas Foley
Speaker of the House
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

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An identical copy of this letter has been sent to the President of the Senate. Thank you for your attention to this important matter.

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Speaker of the House
U.S. House of Representatives
Washington, D.C. 20515

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An identical copy of this letter has been sent to the President of the Senate. Thank you for your attention to this important matter.

Sincerely,

December 3, 1992

To: Ron Klain
Al From

From: Ed Jurith
George Gilbert

Re: Drug Treatment Expansion

Campaign Position

The campaign position paper on crime and drugs sets forth the following treatment goals:

- Treat more addicts to prevent crime and save resources. Many addicts have not committed violent crimes, but we have to treat them before they do. Their dependency destroys lives, drains the economy, health and social services and supports a violent and dangerous illicit drug market. Drug abuse is costing our country $300 billion a year. Curing addicts saves the taxpayer money and prevents crime.

- Increase the effectiveness and success rate of treatment programs by expanding aftercare. More than half of treated addicts relapse. We have to expand support including skills training and job assistance where appropriate for recovering drug addicts and alcoholics to stop them relapsing.

- Cut dropout rates by making sure addicts are directed to the treatment program which is most appropriate to their circumstances, including outpatient programs, community based programs and residential programs.

- Provide cost effective drug dependency treatment on demand for those who need it. By working in partnership with private clinics, and self help organizations, federal assistance will help communities dramatically increase their ability to offer treatment and support to everyone who needs help.

- Target new treatment at pregnant women who are turned away from many clinics. Less than one in ten pregnant addicts were treated last year; 375,000 drug exposed babies were born.

- Help kids who get hooked on drugs and alcohol through school based clinics and outreach programs.

- Review and evaluate the effectiveness of drug treatment programs and instruct states to set up mechanisms to check that the money is well spent.

Treatment Demand

Estimates of the demand for treatment are imprecise and varied, and data on treatment resources incomplete. Regardless of the exact numbers, however, the overall picture based on available information is of a treatment system that is unable to meet existing needs.

- The National Institute on Drug Abuse (NIDA) has estimated that 6.5 million people in the United States use drugs in a manner that significantly impairs their health and ability to function.

- A 1990 study by the Institute of Medicine (IOM) estimated that 5.5 million people need drug treatment. Of this number, IOM concluded that about 2.5 million drug dependent individuals are clearly in need of treatment, including 1.4 million in the household population and another 1.1 million under criminal justice supervision. Another 3 million are less severe drug abusers who probably need treatment. The IOM study found that in 1987 there were about 260,000 clients in treatment at any one time with annual admissions numbering about 850,000.

-In a 1989 survey by the National Association of State Alcohol and and Drug Abuse Directors (NASADAD), 41 states and the District of Columbia reported that a total of slightly more that 1.4 million persons per year received alcohol and drug treatment. These states estimated that the total number of additional persons needing substance abuse treatment is nearly 10.6 million. Another NASADAD survey conducted that same year, to which 44 states and the District of Columbia responded, reported a total of 66,766 persons waiting for treatment. Approximately half those on waiting lists had been waiting for 30 days or more, The survey also found an average wait of 22 days for admission to outpatient treatment and 45 days for admission to residential treatment.

- The 1992 National Drug Control Strategy prepared by the Office of National Drug Control Policy (ONDCP) estimates that there are 2.77 million drug users in the nation who need and can benefit from drug treatment (close to IOM's estimate of 2.5 million drug dependent Americans who clearly need treatment). Assuming about 600,000 treatment slots nationally, the strategy estimates an annual capacity to serve 1.7 million Americans, substantially short of the overall need for treatment.

Under all of these analyses, it is clear that fewer drug treatment slots exist in the United States than people needing and seeking treatment. While

treatment spaces may be available in some areas, waiting lists still persist in others. In addition, presently, there is no accurate way to measure the number of people who need treatment but are dissuaded from applying for it due to the paucity of treatment slots. This is a particularly acute problem among pregnant drug abusers. Many drug treatment programs refuse tp admit pregnant women for fear of liability after a poor pregnancy outcome.

Prioritizing Need

A large scale expansion of treatment services should be phased-in in order to properly absorb an infusion of additional Federal funds, and to maximize the effectiveness of new treatment programs funded.

Certain critical populations are obvious targets of priority; pregnant women, at risk youth, correctional inmates and persons under criminal justice supervision (eg. probation and parole) , and individuals at risk for HIV.

Pregnant Women - Approximately 554,400 to 739,200 drug-exposed babies are born each year. This works out to one newborn in ten. Seventy-five percent of these infants were exposed to crack or cocaine. The present cost is staggering. The median cost of daily health care for a drug-exposed infant is $5.500. The aggregate additional costs for drug-exposed children in the first year of life is at least $51 million, with a high estimate of possibly almost $1 billion. Yet, treatment and intervention services aggressively directed at this population can save dollars in the long run. According to the Journal of the American Medical Association (Sept. 18, 1991) every $1 spent on prenatal care for low-income women saves $3.38 in medical care for their infants in their first year of life. JAMA also reported that pregnant women who stop using drugs by the end of the first trimester will in most cases deliver a healthy baby.

At-Risk Youth - Studies indicate that high-school dropouts exhibit higher rates of drug use than high school seniors. According to NIDA, individuals with less that 12 years of education have an incidence of regular drug use 67 percent higher than the general public. This high rate of drug use among high school dropouts often translates into increased criminal activity. According to a study by Dr. Richard Freeman, Harvard University, 18 percent of male high school dropouts ages 18-24 and 30 percent of of male high school dropouts ages 24-35 are either on probation, parole, or in jail. Studies in the District of Columbia and Baltimore show even higher rates of involvement in the criminal justice system by young black males.

Criminal Offenders- According to the Federal Bureau of Prisons (FBP), 51 percent of Federal inmates are serving time for drug offenses. FBP also reports that 47 percent of its prison population had a substance abuse problem

prior to incarceration. By 1995 that figure is expected to rise to 90 percent. However, as of April, 1991, only 347 of the estimated 27,000 Federal inmates with moderate to severe substance abuse problems were in an intensive treatment regimen.

It is also estimated that 70 percent of state prisoners have a history of drug abuse and 50 percent have a problem requiring intensive treatment. Of that 50 percent (325,000) 82,000 are receiving some type of treatment; 15,000 arw on waiting lists; and the remainder are not receiving any programmatic treatment.

While national surveys are not available, studies have demonstrated that effective treatment for addicted offenders can be part of the solution to problems of reducing drug use and criminal behavior. The most effective treatment programs reported to date with addicted offenders have been intensive treatment programs of considerable duration that are designed as modified therapeutic communities. The Stay N' Out program in New York and the Cornerstone program in Oregon have both reported substantial reductions of criminality by treated inmates.

Similarly, Treatment Alternatives to Street Crime (TASC) and other alternatives to incarceration programs have been found to successfully link criminal justice and treatment systems, identify previously untreated drug-involved offenders, and intervene with clients to reduce drug abuse and criminal activity.

Individuals at Risk for HIV - Intravenous drug use is the second leading cause of existing HIV infection and the leading direct and indirect cause of new HIV cases. Thirty-one percent of all AIDS cases are linked to IV drug use. Seventy-one percent of children with AIDS were born to mothers who were either IV drug users or became infected by HIV-positive sex partners.

The cost of treatment for AIDS patients, especially those who contract the disease through IV drug use, is increasingly borne by the public sector. Medicaid currently pays for the care of 40 percent of individuals with AIDS. Twenty-nine percent have neither private insurance nor Medicaid coverage. This coverage gap is attributable to the increasing number of low income individuals contracting AIDS and the reduction in coverage for the disease by third party or private insurance companies.

Treatment Effectiveness

An integral part of any treatment expansion proposal is the need to insure the effectiveness of treatment services and the accountability of Federal dollars expended for substance abuse treatment. The Institute on

Medicine, in its report on Treating Drug Problems (1990), answered the question of whether treatment works as follows:"... the available clinical experience and research data add up to a similarly short and pointed answer: it varies". The report went on to note that drug treatment is not a single entity but a variety of different approaches - methadone maintenance, therapeutic communities, outpatient drug free services, and 28 day chemical dependency treatment - to different populations and with different goals. There are few agreed on standards of success, nor has there been much accountability on the part of treatment providers for their various regimens.

It is imperative that the Department of Health and Human Services (HHS) and its constituent drug abuse services agencies take a lead role in helping the states develop quidelines that can measure treatment outcomes and insure that available funds are being expended on the most successful programs. Drug treatment research must keep up with changing drug abuse trends and be of practical utility to clinicians. Over the course of the last 12 years, HHS failed in both of these roles.

An October 1991 report of the General Accounting Office noted that under the current Alcohol, Drug Abuse and Mental Health Services (ADMS) Block Grant, limited information is available on the results of the Federal investment in drug treatment services. At the time of that report, the then Office of Treatment Improvement (OTI) was implementing a program that would (1) develop Federal drug treatment program guidelines, (2) institute Federal performance reviews of state substance abuse agencies and drug treatment programs, (3) provide technical assistance to states and providers as part of these reviews, and (4) collect more detailed information on how states expend their block grant funds. Unfortunately, compliance by the states with this OTI initiative was discretionary.

In the area of drug treatment research, a September, 1990, GAO Report noted that research knowledge applicable to drug abuse treatment has not significantly advanced in the last decade, There are no recently completed national evaluations of treatment programs, and earlier evaluations may have limited applicability to today's population of drug abusers. Treatment effectiveness depends, in part, on matching client treatment needs to appropriate types of treatment, However, knowledge on patient-treatment matching is limited. Often times a patient ends up in a treatment slot that was available, whether it was the most appropriate one for his/her needs.

GAO found that gaps in drug abuse treatment knowledge exist because the National Institute of Drug Abuse (NIDA) does not have a strategic planning process to assure that the research it funds is targeted at the most critical needs. The report noted that NIDA's support of research on the development of new treatment places greatest emphasis on opiate abuse, although cocaine and crack abusers now far outnumber opiate abusers. GAO

also found that much of NIDA's research was bio-medical in nature, and did not systematically involve treatment practitioners in its decision-making on treatment research priorities.

As part of a treatment expansion effort, HHS and NIDA must implement a strategic planning process that sets forth its long-term treatment research objectives and priorities, current and anticipated trends of drug abuse, and the needs of treatment practitioners.

Quick Response Mechanism

Since 1982, the primary Federal program for providing assistance to states for substance abuse treatment has been the Alcohol, Drug Abuse and Mental Health Services Block Grant. This program was recently split into two separate block grants, one for substance abuse services and one for mental health services, by the 1992 ADAMHA Reorganization Act (P.L. 102-321).

One of the major problems with the block grant has been the lack of accountability by states for use of the Federal funds. This is a problem of the Federal Government's own making. When Congress consolidated existing categorical programs into the block grant in 1981, in response to a Reagan Administration proposal, many state reporting requirements on use of funds, clients in treatment and other information were dropped.

Recognizing the need for improved information on states' use of block grant funds, Congress in 1988 repealed the provision of the block grant statute that prohibited HHS from prescribing the manner in which states must comply with the block grant's requirements or establishing reporting requirements. The October 1991 GAO report to the Select Committee on Narcotics, however, confirmed that information is still not available to determine if states are using Federal treatment funds effectively and to provide services where they are needed most. GAO also found that HHS had failed to exercise the authority provided by Congress in 1988 to establish reporting requirements on use of block grant funds.

GAO's report also supported the initiative begun by the Office For Treatment Improvement (reorganized as the Center for Substance Abuse Treatment by P.L. 102-321) to help states assess their treatment needs and improve delivery of effective treatment services. This initiative, called the statewide systems development plan (SSDP), would provide the type of information needed to respond to changing drug abuse patterns and treatment needs. It would require states to collect uniform information on clients in treatment, treatment resources and treatment utilization. It would also require states to conduct annual needs assessments including incidence and prevalence studies of the general population and subgroups frequently overlooked in general surveys such as pregnant women, criminal justice

populations including youth in the juvenile justice system, and heroin addicts. SSDP would also provide Federal resources and technical assistance to states to help them develop the capability to conduct these data collection and analysis activities. SSDP would enable states to target treatment resources where they are needed most, as required under the block grant, and it would allow the Federal Government to monitor states' performance.

While supportive of the SSDP initiative, GAO expressed reservations about its ultimate success because state participation, at the time, was voluntary. Since then, Congress passed P.L. 102-321 which requires each state to submit an annual statewide needs assessment as a condition of receiving Federal block grant funds. This requirement seems to provide a clear statutory basis for SSDP.

It is not clear, however, that adequate funding has been made available to fully implement SSDP. OTI (now CSAT) has acknowledged that states lack the resources and expertise to carry out SSDP, and states have expressed strong objections to new Federal mandates without the resources to implement them. The block grant includes a 5 percent set-aside for program administration and data collection efforts, but this set-aside is further earmarked for specific purposes unrelated to SSDP. In October 1991, OTI estimated that SSDP would cost about $40 million a year to maintain after a 3-year phase in period.

The Clinton Administration should review the funding for SSDP to assure that it can be effectively implemented. In addition to the 5 percent set-aside in the block grant, other funding sources to consider are a separate authorization and appropriation (legislation along these lines introduced by Mr. Rangel is attached) and the Special Forfeiture Fund under the control of the ONDCP Director.

Finally, while SSDP would provide the basic foundation for a mechanism to respond to changing drug trends and treatment needs, SSDP data should be integrated with existing data systems such as DAWN (drug-related hospital emergency room episodes) and DUF (drug use forecasting, which tracks drug use by criminal arrestees in about 25 cities) to obtain a more complete picture of current drug use patterns. In addition, a systematic review should be undertaken of other Federal data collection efforts by CDC and other health and non-health agencies to see what data on drug use trends are already available or how these other instruments could be modified to collect data that would be useful in identifying and responding to changing drug patterns. In this regard, the existing national household and senior surveys on drug use conducted by HHS are too broad to be of much use in targeting treatment resources where they are needed.

Funding Expanded Treatment Services

Funding and actually getting addicted clients into treatment centers is the nub of treatment expansion. The Institute of Medicine in its 1990 report proposed two treatment capacity expansion options worthy of consideration.

1.) The "Core Strategy" option would address existing waiting lists, remedy deficiencies in program quality and management, and implemement modest program incentives for pregnant women and children. This core strategy would exceed levels of public support by about $1 billion, plus $.5 billion as an additional one-time investment for staff training and facilities construction and renovation. This one-time investment expenditure need not be made in a single year; however, according to IOM it should not be stretched out over more that three years to avoid creating a bottleneck to effective treatment capacity.

2). The "Comprehensive Strategy" would add to the core plan a substantially greater induction of criminal justice clients and a more ambitious plan for treating drug-abusing and drug dependent mothers and children. This comprehensive plan would, in IOM's opinion, provide the optimal level of public treatment resources. This comprehensive plan would entail an annual operating increase of about $2.2 billion, plus a $1 billion one-time investment.

The IOM study also proposed an intermediate strategy option which is a compromise between the core and comprehensive strategies. This proposal would cost about $1.6 billion more in annual operating costs plus a $.8 billion one-time investment.

IOM dollar amounts are defined in terms of increases over estimated 1989 public outlays by state, Federal and local agencies. IOM cautioned that the data supporting the costs and results of proceeding along either recommended option have uncertainties. Improved data collection and analysis will lead to adjustment of these costs figures and the appropriate amount of Federal contribution.

Although these costs will require further refinement, the IOM report yields the best estimate to date on what treatment capacity expansion programs targeted at the highest-risk groups would cost in terms of public expenditures.

Other Funding Options

1. Pregnant Women. As noted above, pregnant substance-abusing women should be a high priority for expanded access to treatment services because of the large numbers of women of child-bearing age drawn into drug

addiction and dependence as a result of the crack epidemic of the 1980's. Many of these heavy drug users are poor, minority women who lack access to basic medical and prenatal care as well as substance abuse treatment services.

Under current law, Medicaid acts as a major barrier to treatment for these women. The Institutions for Mental Diseases (IMD) exclusion under Medicaid bars reimbursement for almost all residential substance abuse services in free-standing programs, which is often the most effective , and cost-effective, treatment for many pregnant substance abusers. Moreover, an individual who is otherwise eligible for Medicaid who enrolls in a residential treatment program loses her Medicaid eligibility for any services. Thus, in the vast majority of cases, the IMD exclusion not only bars coverage for the most appropriate treatment but also removes coverage for prenatal, post-partum and other health care services essential to the treatment process and to improving the overall health and welfare of pregnant, substance abusing women and their infants.

The Clinton Administration should strongly consider supporting legislation to remove the IMD exclusion as it applies to residential treatment for pregnant and post-partum women. Legislation such as H. R. 2489, the Medicaid Family Care Act, would give states the option to allow Medicaid coverage for residential drug treatment during pregnancy and up to one year thereafter for women and their children. Participating programs would be required to provide a comprehensive array of services to help poor, substance abusing women overcome their drug dependence, deliver healthier babies and raise strong, productive families. These services include: counseling; addiction education and treatment; AIDS counseling; access to developmental and educational services for children; daycare; access to prenatal and post-partum medical care for women and pediatric care for their infants; job training and counseling, and other assistance in re-entering society.

This proposal would make available an additional funding stream to expand access to treatment for a population with compelling treatment needs that has been woefully underserved by the existing treatment system The cost of such a proposal, estimated at $550 million over five years, would be more than offset by the potential savings from reduced spending on more expensive medical care, special education and other health and social services for these women and their children as well as the potential increases in productivity and tax revenues from women who successfully complete treatment.

2. Demonstration Programs. A lower cost alternative to begin expand the delivery of treatment services would be the creation of demonstration programs in areas of the country that are the hardest hit by drug abuse and AIDS. Thes demonstration program would seek to integrate effective treatment practices, with other ancillary programs such as job training and

counseling, vocational and other eductional opportunities, non-substances abuse health care, and other appropriate services in order to mainstream abusers back to society as productive citizens.

National Health Insurance

Any proposal for national health insurance should include a substance abuse benefit. Drug and alcohol treatment services should be covered by a benefit that is separate and distinct from a mental health benefit to ensure that services are provided by the appropriate providers in clinically appropriate settings.

The benefit, both in the context of small market reform or more universal coverage, would provide for a comprehensive, continuum of care in which the following services would be available:

- Intervention, including assessment, diagnosis, and referral.

- detoxification.

- rehabilitation services.

- outpatient services.

- therapeutic community.

- case management.

- pharmacotherapeutic intervention.

- family outpatient services.

- halfway house care.

- three-quarter-way house care.

INTRODUCTION OF THE STATEWIDE SUBSTANCE ABUSE ASSESSMENT AMENDMENTS ACT

HON. CHARLES B. RANGEL
OF NEW YORK
IN THE HOUSE OF REPRESENTATIVES

Friday, November 1, 1991

Mr. RANGEL. Mr. Speaker, today, I am introducing the Statewide Substance Abuse Assessment Amendments Act, a bill to improve the management and accountability of publicly funded substance abuse treatment programs supported under the Federal Alcohol, Drug Abuse and Mental Health Services [ADMS] block grant.

The ADMS block grant is the primary vehicle for Federal funding to States for substance abuse treatment. From 1986 to 1991, Federal spending on substance abuse programs under the block grant increased fourfold, from approximately $240 million to nearly $960 million. As Federal spending for substance abuse treatment has grown rapidly in recent years, so have concerns about accountability.

At my request, the General Accounting Office [GAO] conducted a review of the ADMS block grant. Specifically, I wanted to know if Congress has the information it needs to determine whether the investment Congress is making in substance abuse treatment is being used for effective programs and services.

The GAO recently completed its study of the block grant. On October 17, 1991, at a hearing of the Select Committee on Narcotics Abuse and Control, which I chair, GAO presented its findings and recommendations.

Unfortunately, the results of GAO's study are not encouraging. Despite increases in Federal spending for drug treatment, GAO concluded that little information is available on the nature of State drug abuse treatment activities or on the quality and appropriateness of services. What information does exist is often not comparable from State to State because the data collected are not uniform. GAO also found that the Department of Health and Human Services [HHS] provides minimal oversight of State activities because of a departmental policy of deference to a State's interpretation of block grants requirements unless HHS finds that the State's interpretation is clearly erroneous. HHS adheres to this policy even though Congress, in 1988, repealed the provision of the block grant statute that had prohibited HHS from either prescribing the manner in which states should comply with the block's grant's requirements or establishing reporting requirements.

GAO also found that the Office of Treatment Improvement [OTA], which administers the block grants, is taking important steps to help States access their needs and improve the delivery of treatment services that are effective in reducing drug abuse. OTI's program is designed to provide for uniform data collection, technical assistance including the establishment of treatment program guidelines or performance standards called treatment improvement protocols, and monitoring of state activities. GAO concluded, however, that OTI's efforts to improve treatment services and increase State accountability for ASMS funds will be difficult to achieve because State participation is voluntary. Consistance with HHS policy to grant State wide discretion in meeting block grant requirements, implementation of OTI's program will be left to the States. GAO recommended that HHS exercise the authority granted by Congress to establish reported requirements for the States that will provide the information needed to determine if block grant funds are being used for effective programs and services.

In addition to GAO, the Select Committee heard testimony from Dr. Beny Primm, the head of OTI, and Arthur Webb, director of the State of New York Division of Substance Abuse Services. Neither witness took issue with GAO's report, which was supportive of OTI's statewide systems development plan [SSDP], OTI's program to improve the accountability and effectiveness of treatment programs. OTI acknowledged that States currently lack the capabilities and resources to conduct needs assessments and that without current data on the incidence and prevalence of drug abuse and treatment availability, States cannot target ADMS fund to areas of greatest need as required by the block grant. While supporting OTI's SSDP initiative and GAO's call for enhanced State reporting requirements to realize the full potential of OTI's program, Arthur Webb made clear that current economic conditions make it impossible for States to implement new Federal mandates without the dollars to carry them out.

The bill I am introducing today addresses the concerns raised in the GAO's report and the testimony at our hearing. It establishes as a requirement of the block grant that States conduct annual, statewide assessments of the extent of substance abuse and the capacity and utilization of treatment services in the State. Each State would be required to use the data collected in the assessments to target block grant funds to the areas of greatest need for substance abuse treatment within the State. The requirement for the assessments would be phased in over a 3-year period, and by fiscal year 1995, the conduct of annual statewide assessment would be a condition for a State's receipt of its block grant payments. The types of assessments required would include: Incidence and prevalence studies of substance abuse among the general population of a State; incidence and prevalence studies of specified subpopulations which are intended to provide a clearer picture of substance abuse among groups frequently overlooked in general surveys such as pregnant women, criminal justice populations including youth in the juvenile justice system, and heroin addicts; and treatment capacity and utilization studies.

To assure that States have adequate resources to conduct these mandated needs assessments, the bill requires the Secretary of Health and Human Services to provide grants or contracts to States each year for these data collection activities. Funds for these grants and contracts would be reserved from amounts already set aside under the block grant for various services research, technical assistance and data collection efforts. The bill reserves $13 million for these statewide assessments for fiscal year 1992, $26 million for 1993, $39 million for 1994 and not less than $39 million for each subsequent fiscal year. These amounts are consistent with estimates by OTI of what these assessments will cost under its SSDP proj

In addition, the bill requires the secretary to provide technical assistance to the States to help States develop the expertise they need to conduct these needs assessments and utilize the data effectively. The costs of providing this technical assistance would be met out of funds reserved by the bill for the conduct of statewide assessments.

The bill also requires the Secretary to develop uniform criteria for these new statewide assessments. These criteria must be developed after consultation with the States and appropriate national organizations. This requirement is intended to ensure the collection of comparable data to permit analyses of substance abuse needs and services at the sub-State, State and national levels. It is also intended to ensure that implementation of the statewide needs assessment requirement is a collaborative effort. States are expected to comply with reasonable requests for data. At the same time, OTI is expected to work cooperatively with the States and other Federal agencies involved in substance abuse data collection to assure a coordinated effort that meets State and local requirements as well as Federal needs for accurate, timely data without imposing undue burdens on the States.

The administration has called for States to prepare statewide treatment plans as a way of establishing greater accountability for State's use of substance abuse funds under the block grant. The needs assessments my bill would require provide the basic foundation a State must have before it can build an effective treatment plan. These assessments would establish the data collection and reporting requirements GAO says are needed so that State and Federal administrators and the Congress will have the information to determine if block grant funds are being used effectively to reduce substance abuse.

The GAO did not propose legislation to Congress because it concluded that Congress had already granted HHS sufficient authority to establish the reporting requirements GAO recommends. To date, however, HHS has failed to exercise the authority Congress has provided. My bill will require HHS to establish the data collection and reporting requirements GAO recommends to assure that block grant funds are targeted to areas of greatest need, as required by law, and are used for effective programs and services. These reporting requirements are also needed to successfully implement OTI's SSDP initiative for improving the accountability of block grant funds. In addition, my bill assures the availability of funds for this effort from funds now set aside in the block grant for data collection, services research and technical assistance. Much of these funds are currently being allocated for projects that are not directly related to management of the block grant and that could be funded under other authorities. It is time to make sure that these funds are used first to provide the information that we as policymakers need in order to know that our investment in substance abuse treatment is being used effectively.

I urge my colleagues to support this measure. The text of the bill follows:

H.R. 3698

To amend the Public Health Service Act to provide for assessments in each State of the incidence and prevalence of substance abuse and of the extent to which the avail-

ability, from public and nonprofit private providers, or treatment for such abuse is insufficient to meet the need for such treatment, and for other purposes.

H.R. 3660

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled.

SECTION 1. SHORT TITLE.

This Act may be cited as the "Statewide Substance Abuse Assessment Amendments Act".

SEC. 2. ESTABLISHMENT, IN PROGRAM OF BLOCK GRANTS REGARDING SUBSTANCE ABUSE, OF REQUIREMENT FOR STATEWIDE ASSESSMENT OF EXTENT OF SUBSTANCE ABUSE AND CAPACITY FOR TREATMENT.

(a) ALLOCATION OF APPROPRIATION.—Section 1911 of the Public Health Service Act (42 U.S.C. 300x) is amended—

(1) in subsection (b), by striking "For the purpose" and all that follows through "1923," and inserting the following: "For the purpose of carrying out section 509D, section 1916B, and sections 1921 through 1923,"; and

(2) by adding at the end the following new subsection:

"(c) For the purpose of carrying out section 1916B, the Secretary shall obligate, from the amounts reserved under subsection (b) for the fiscal year involved, $13,000,000 for fiscal year 1992, $26,000,000 for fiscal year 1993, $39,000,000 for fiscal year 1994, and not less than $39,000,000 for each subsequent fiscal year."

(b) STATEWIDE ASSESSMENT.—Subpart 1 of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x et seq.) is amended by inserting after section 1916A the following new section:

STATEWIDE ASSESSMENT OF EXTENT OF SUBSTANCE ABUSE AND CAPACITY FOR TREATMENT

"SEC. 1916B. (a) For fiscal year 1995 and subsequent fiscal years, the Secretary may not make payments under section 1914 to a State for a fiscal year unless the State agrees to complete, by the end of the fiscal year, whichever of the following assessments the Secretary determines is appropriate for the State for the fiscal year:

"(1) An assessment of the incidence and prevalence in the State of substance abuse among the general population.

"(2) An assessment of the incidence and prevalence in the State of such abuse among subpopulations specified by the Secretary.

"(3) An assessment of the extent to which the number of individuals in the State seeking treatment for such abuse from public and nonprofit private entities in the State exceeds the number of individuals to whom the entities have the capacity to provide treatment.

"(b)(1) For fiscal year 1992 and subsequent fiscal years, the Secretary shall, from amounts available pursuant to section 1911(c), provide grants or contracts to States for the conduct of assessments described in subsection (a). Subject to the extent of the amounts so available, the Secretary shall in making the grants ensure that—

"(A) for fiscal year 1992, assessments described in such subsection are conducted by ⅓ of the States;

"(B) for fiscal year 1993, such assessments are conducted by ⅔ of the States, including each State for which the assessments were conducted for fiscal year 1992; and

"(C) for fiscal year 1994, such assessments are conducted by each State.

"(2) Paragraph (1) may not be construed as requiring that the Secretary, in making grants under such paragraph for any fiscal year, provide for the conduct by any State of more than one of the assessments described in subsection (a).

"(c) The Secretary shall provide to the States technical assistance regarding the conduct of assessments under this section.

"(d)(1) The uniform criteria developed by the Secretary under section 509D(d) shall include uniform criteria for conducting the assessments described in subsection (a). The Secretary shall ensure that each assessment conducted pursuant to this section is conducted in accordance with the uniform criteria that are developed for the assessments, subject to paragraph (2).

"(2) Upon the request of a State, the Secretary may provide a waiver to the State of all or part of the requirement established in paragraph (1), subject to the Secretary ensuring that the data collected pursuant to the waiver will have sufficient utility for purposes of the program carried out under this section.".

SEC. 3. USE OF ASSESSMENTS BY STATES IN ALLOCATING BLOCK GRANT AMONG COMMUNITIES.

Section 1916(c)(19) of the Public Health Service Act (42 U.S.C. 300x-4(c)(19)) is amended by striking "will be targeted" in the matter preceding subparagraph (A) and all that follows through the semicolon at the end of such subparagraph and inserting the following: "will be targeted to communities in the State with the greatest need for treatment for substance abuse, as determined by the State after consideration of—

"(A)(i) data collected in the assessments conducted by the State under section 1916B; or

"(ii) with respect to any assessment under such section that has not been conducted by the State, such data as the State may possess on the categories of information with respect to which the assessment is to be conducted;".

SEC. 4. RULE OF CONSTRUCTION REGARDING DELEGATION OF AUTHORITY TO STATES.

With respect to States receiving payments under subpart 1 of part B of title XIX of the Public Health Services Act—

(1) such subpart may not be construed as authorizing the Secretary of Health and Human Services to delegate to the States the primary responsibility for interpreting the governing provisions of the subpart, including delegating authority with the result that different States are permitted to reach different interpretations of any provision of the subpart; and

(2) the Secretary may not give any legal effect to section 50(e) of part 96 of title 45, Code of Federal Regulations (45 CFR 96.50(e)).

October 16, 1992

To: Vernon Jordan
Kirk O'Donnell

From: Edward H. Jurith

Re: Presidential Transition/Drug Policy

Introduction

Consider the following statement:

"Drugs are reshaping the landscape, the city, the community. The neighborhood is no longer the place it once was; it is a more hostile place, a more dangerous place, a less predictable place, an uglier place to live.

Despite the combined best efforts of Federal, state and local governments, they have not been able to bring the drug problem under control. The marketing, selling and use of drugs threatens American values and the great traditions of a society that respects the rule of law.

The nation will control the flood of drugs only when we control the insatiable demand for illegal drugs. That means that a priority must be placed on the education of the public in general and children and youth in particular of the danger of drugs to their health and to their lives".

This quote is not from the drug position paper issued by Governor Clinton and Senator Gore. Nor, is it from a report of the House Select Committee on Narcotics commenting on the current status of the nation's war on drugs. It is from the 1988 report of the American Agenda, a Report to President-elect Bush by former Presidents Gerald Ford and Jimmy Carter. Unfortunately President Bush and his administration did not heed the advice of his predecessors and insure that the drug issue remained at the top of his national agenda. By the end of 1992, the record of the Bush Administration on controlling drug abuse disintegrated into a muddle of claims of success that are overshadowed by reports of rising drug trafficking and abuse, and drug related crime.

The drug issue is one that the Clinton Administration will have to confront shortly after it takes office.

On February 1, 1993, the President will be required to submit to the Congress his National Drug Control Strategy as required by 21 USC 1504. On March 1, 1993, the State Department will be required to issue the International Narcotics Control Strategy Report (INCSR) along with a list of Presidential certifications of drug producing and trafficking nations that are cooperating with the United States on drug control. If the President fails to certify such cooperation, the offending country is subject to the loss of United States bilateral assistance, U.S. opposition to multilateral development assistance, and favorable tariff treatment of products and other trade sanctions. 22 USC 2291; 19 USC 2491.

Both the strategy document and the INCSR will set the tone for how the Clinton Administration will address the drug control issue. While a new Administration may get some slack in submitting the strategy document to the Congress, the drug issue is one on which the political opposition in Congress will closely be watching Mr. Clinton's performance because it is considered to be a social "wedge" issue. This being the case, an affirmative drug policy should be part of the new administration's initiatives in the first 100 days of this Presidency. The Clinton's Administration's first strategy must meet the statutory goals of:

1) long range goals for reducing drugs abuse

2) short-term objectives that can be achieved in two years

3) balance of resources between supply and demand reduction programs, and

4) coordination with State and local drug control activities.

and relate to the overall budget modifications and programs that Governor Clinton submits in the early days of the Administration.

Addressing the Issue

After Election Day thought must be given to the tone and direction of February strategy document, and the filing of key drug policy positions in the new Administration.

Key Drug Policy Positions in the Executive Branch include:

Agency	*Position*
Office of National Drug Control Policy	Director
	Chief of Staff
	Deputy Director for Supply
	Deputy Director for Demand
	Associate Director for State and Local Affairs
ONDCP (cond't)	General Counsel
Department of State	Assistant Secretary for International Narcotics Matters
	Deputy Assistant Secretary for International Narcotics Matters (Political)
	Deputy Assistant Secretary for International Narcotics Matters (Career)
Department of Treasury	Assistant Secretary for Enforcement
	Deputy Assistant Secretary for Enforcement
	Commissioner of Customs
Department of Defense	Coordinator for Drug Enforcement Policy and Support
Department of Justice	Attorney General

	Deputy Attorney General
	Assistant Attorney General for the Criminal Division
	Director Office of Policy Development
	Director of Liaison Services
	Drug Enforcement Administrator
Department of Health and Human Services	Secretary of Health and Human Services
	Administrator, Substance Abuse and Mental Health Services
	Director, Center for Substance Abuse Treatment
	Director, Center for Substance Abuse Prevention
Department of Eduction	Office of Elementary and Secondary Education Drug Abuse Oversight Staff
Department of Transportation	Commandant of the Coast Guard

Funding and New Initiatives

In fiscal year 1993, the Federal drug budget is approximately $14 billion. The drug budget is allocated approximately between 70% for supply side activities, and 30% for demand side programs. The present allocation needs to be reexamined with greater emphasis on treatment and prevention, however it should not be subject to radical change immediately.

This simple fact is that law enforcement/supply side activities cost more; the worldwide production and trafficking of heroin and cocaine is at an all time high and it would be foolish in the extreme to lessen our interdiction deterrence; Congress in the last few budget cycles has generally level-funded or in many cases reduced funding for law enforcement and drug interdiction

activities, and law enforcement initiatives announced by Governor Clinton during the campaign will need to be funded. These include putting 100,000 new police officers on the street, law enforcement scholarships, and the Safe Schools Initiative.

Similarly, we need to do a much better job in getting value out of our treatment dollars. The campaign advocated increased spending on treatment initiatives, including prison-based programs, expanded aftercare, and treatment for pregnant women. Additional funds are critically needed in this area but the Administration must insist on much better accountability of treatment dollars that are expended.

A unique opportunity exists. This year the Congress reorganized the Alcohol, Drug Abuse and Mental Health Administration into the Substance Abuse and Mental Health Services Administration.(SAMHSA) The new structure should be used to enhance Federal leadership in the area of treatment accountability The reorganization act gave SAMHSA new authority to assist State and local treatment and to insure treatment effectiveness. The leadership of this new agency must be committed to treatment effectiveness, be willing to challenge the leadership of the treatment community and practitioners to take up the effectiveness mantle, and be a strong national advocate for treatment programs.

Similarly, the same type of aggressiveness must be given to drug abuse education and prevention initiatives, particularly those directed at high-risk youth. One great failure of the Bush Administration has been its reliance on drug education programs that are directed at middle-class youth, at the expense of community-based prevention efforts aimed at high-risk children, youth, and ex-offenders.

Lastly, the urban agenda is closely tied to a successful war on drugs. During the campaign Governor Clinton announced his support of 75-125 comprehensive enterprise zones which combine capital incentives and new community development block grants to help revive economically disadvantaged communities. The plan also calls for permanently expanding the Low Income Housing Tax Credit and the Targeted Jobs Tax Credit to create affordable housing and create jobs around the country. These initiatives were passed at the end of the last session of Congress, but as the campaign entered its last week were the subject of a veto threat by President.Bush These are important programs that demonstrate the commitment of the

Governor to urban issues, and assisting communities hardest hit by crime and violence.

Leadership and Coordination

The appointments made to the Office of National Drug Control Policy are of critical importance. Established by the Anti-Drug Abuse Act of 1988 to provide central direction and budget to the National Drug Control Strategy, the drug office in the Bush Administration became a sideshow to the drug policy making being done in the other Cabinet Departments. It is perceived by both Democrats and Republicans on Capitol Hill as not particularly effective. Moreover, it became seen as an extension of the White House Political Office, further reducing its effectiveness. During the Bush Administration , More than 40 percent - the highest of any Federal agency - of the 109 employees in ONDCP were political appointees.

Appointment to the ONDCP staff must be based on thorough knowledge of the drug problem and merit. Most importantly, the individual named as Director of ONDCP must be a nationally known leader in the drug field, with the power and authority to lead a comprehensive effort against drug abuse. Thought should be given to establishing a Cabinet-level council on drug abuse chaired by the Director of ONDCP to in sure high level visibility to the drug issue and a central role for ONDCP.

Among key issues ONDCP must address **right away** include:

- Drafting the 1993 National Drug Control Strategy

- Launch an immediate review of the drug interdiction program, with a view toward centralizing authority for the nation's drug interdiction effort, to reduce duplication of effort, spur technological innovations, and end interagency rivalries.

- Take in active role in the structuring and setting priorities for the new Substance Abuse and Mental Health Services Administration (SAMHSA), with a view toward increasing the effectiveness of drug treatment, expanding the availability of aftercare programs, treatment services for pregnant women and insuring treatment accountability.

- Insure proper coordination with the Administration's AIDS prevention and research program.

- In concert with the Department of Justice develop an effective working partnership with State and local law enforcement, initiative the Administration's plans for prison alternatives, and for expanding prison-based drug treatment programs.

- Foster the implementation of the Administration's enterprise zone program and urban community development initiative.

Drugs and Foreign Policy

In addition to issuing the International Narcotics Control Strategy and Presidential Certifications of cooperation in March, international drug control efforts must become a foreign policy priority.

Presently, the production and trafficking of cocaine and heroin is spiraling out of control. New emphasis must be given to improving policies to eliminate narcotic crops and provide market alternatives. To do this will require an emphasis on narcotics control in geopolitical, trade, and international development policies. The President and Secretary of State must make clear to the foreign policy establishment that effective drug control is integral to American national security. Moreover, for too long U.S. international drug policy has been bogged down in a series of bilateral efforts with the drug producing and trafficking nations that know neither victory or defeat. What is required is a "internationalization" of the drug effort through the UN and other international and regional organizations that fosters the political will that marshals the resources and commitment to fight the global drug cartels, control money laundering, regulate precursor chemicals, halt the flow of illicit arms, and create trade and commercial incentives for alternative crops and economic development.

Further, a new and ominous development is the increasing worldwide influence of organized crime groups in drug trafficking, money laundering, and other terrorist activities. International organized crime has evolved into a sophisticated transnational commercial industry. Colombian cocaine cartels have forged extensive links with Italian organized crime groups. The collapse of

communism has lead to the rise of criminal groups throughout Eastern Europe and the republics of the former Soviet Union. In Central Asia thousands of acres have been given over to the cultivation of opium poppies and cannabis.

U.S. drug control and international criminal justice efforts need to be strategically coordinated with the activities of the United Nations, the European Community, the OAS and other international organizations to effectively suppress transnational criminal organizations. Intelligence and research must be coordinated and supported to identify emerging patterns of criminal activity, the shifting patterns of drug trafficking and money laundering, and the infiltration of legitimate avenues of commerce, finance transportation, and communications.

Executive Summary
Transition Paper on the Office of National Drug Control Policy

- President-elect Clinton has stated that he will appoint a national drug expert at the Cabinet level with the power and authority to lead a comprehensive crusade against drugs. This is imperative. For the Director of ONDCP to be a member of the Cabinet means access to the President, the ability to challenge other senior Administration officials on their implementation of drug policy, and is a clear signal that drug policy is a top Administration priority. Further, by nature of the office, the ONDCP Director resolves high level fights. Symbolic inclusion in the Cabinet is not enough -- backing of the President is essential. To enhnace the statute of the ONDCP Director consideration should be given to creating a Cabinet-level council on drug abuse chaired by the ONDCP Director, Alternatively, because of the estimated $300 billion loss drug abuse costs the U.S. economy, consideration should also be given to putting the ONDCP Director on the new Economic Security Council.

- Immediately after Inauguration Day it is recommended that a communication be sent by the President to the Speaker and Majority Leader of the Senate which recognizes the statutory requirement of February 1, sets forth some general policy guidance, but requests leave to September 1, 1993, to formally issue the Administration's first strategy document. This would be the same length of time used by the Bush Administration to prepare its first strategy.

- The Director needs to reach agreement with the agencies receiving HIDTA funds on (1) the performance milestones and measurable goals the HIDTA-funded initiatives would be expected to meet, (2) the output measures that would be appropriate for evaluating progress and success in achieving those goals and milestones, and (3) the way this information is to be reported.

- It is recommended that the strategy use a set of reasonably measurable goals that more closely reflect the Administration's strategy and priorities. These would include finite objectives such as the creation of a specific number of new treatment slots per year, putting a specific number of new police on the streets each year, targeting comprehensive drug abuse education at specific age groups, and expanding the number of prison-based drug treatment slots each year, among others.

- It is recommended that the Associate Director position be enhanced. A formal liaison structure between ONDCP and the various Federal administrative regions should be developed to maintain constant contact between state and local agencies and community groups in the development and implementation of the strategy.

Federal agencies in these various administrative regions who have drug control responsibilities should also be involved in this process.

- Thus the "Federal drug budget" is an estimate at best and is somewhat artificial, based to some extent on accounting methods rather than on distinct programmatic initiatives. We suspect some of the growth in drug expenditures in recent years is due to the accounting procedures used rather than specific funding increases for new or expanded drug programs.

- The new Administration should be wary of arbitrary funding allocations as the only measure of a balanced drug strategy. The bottom line is that much more needs to be done to reduce both the demand for and supply of illicit drugs.

- As a first step, the Clinton Administration should consider supporting enactment of the enterprise zones/social investment legislation vetoed as part of the tax package. This would free $500 million already appropriated for targeted spending in areas most affected by drugs and crime.

- More important than any specific powers granted to the director is the person selected to fill that position and that person's relationship to the President and the cabinet. Ultimately, the process of developing the drug strategy and the budget to support it is a negotiation. The ONDCP director should be a person of national stature who is included as a fully participating member of the President's cabinet and is viewed as a co-equal with the cabinet heads whose drug policies and programs the director is responsible for coordinating. The director must also be a person who has the ear of the President and his full support and confidence. For his director to be effective, the President must make clear to his cabinet and the public that drugs are a top priority of his Administration, that his drug director is his chief drug policy adviser and that he expects his team to cooperate to develop an aggressive, comprehensive anti-drug strategy.

- Congress has already directed cuts in ONDCP's staff, the Clinton Administration may want to consider whether additional personnel cuts may be made without depriving ONDCP of the professional staff it needs to oversee Federal agency drug programs and budgets and develop the annual strategy and consolidated drug budget.

- Some consideration should be given to revising the way in which requests for appropriations from the Special Forfeiture Fund are submitted to Congress so that they are reflected in the budgets of the agencies whose programs will benefit and so that they will be adequately reviewed by the appropriate subcommittees of jurisdiction.

- ONDCP needs to undertake an immediate review of the drug interdiction and intelligence gathering operations with a view toward centralizing operational authority for these important tasks. A strong central authority would increase the effectiveness of resources and manpower, spur the development and use of new technologies, and decrease overlapping jurisdiction and interagency rivalries that have hindered coordination in the past.

December 17, 1992

To: Ronald Klain:

From: Edward H. Jurith

Re: Office of National Drug Control Policy (ONDCP)

Introduction

The Office of National Drug Control Policy (ONDCP) was established by the Congress in the National Narcotics Leadership Act, 21 U.S.C. 1501 et seq., enacted as part of the Anti-Drug Abuse Act of 1988. ONDCP was created to bring coherence to drug abuse policy making in the Executive Branch, provide a central point of accountability for drug policy, and improve coordination between the many Executive Branch departments and agencies in the development and implementation of national drug control policies.

This paper will outline for the Transition Team four key aspects of ONDCP; structure and management, budget (the Federal drug budegt and ONDCP's budget), personnel, and policy priorities.

Structure and Management

Current Structure

With little guidance from Congress in the legislation or its history, the current management structure of ONDCP was devised by the first director of the office, former Education Secretary William J. Bennett. In addition to the four statutory positions -- Director, Deputy Director for Supply Reduction, Deputy Director for Demand Reduction, and Associate Director for State and Local Affairs, -- Bennett put in place an "Executive System" that reflected his experience at the Education Department. These executive positions included a Chief of Staff, General Counsel, Director of Budget and Planning, Director of Congressional Affairs, and Director of Public Affairs. In the 1990 Crime Bill the Congress added a fifth statutory position to ONDCP, the Director of Counter-Drug Technology.

No Clout on Top/Confusion Below

If the goal of ONDCP was to develop a coherent drug abuse policy making structure, the Bennett management system was probably doomed at the outset by two separate decisions that combined to seriously hinder the effectiveness of ONDCP. The first was the decision of President Bush to exclude the Director of Drug Abuse Policy from the cabinet. The second was Bennett's over-reliance on his executive staff to manage and carry out the major functions of the agency.

After selecting his top appointees after the 1988 election, President-elect Bush announced that ONDCP Director Bennett would not be a member of the Cabinet or of the Domestic Policy Council. This was a severe blow to the ability of ONDCP to effectively develop drug abuse policy, and to function as an equal with Cabinet Secretaries that have operational control over the executive agencies that actually carry out drug abuse policy. This decision by Mr. Bush was singularly devastating. For example, in the aftermath of the Los Angeles riots, ONDCP Director Martinez was not involved in any of the Cabinet-level meetings that were held to develop a Federal response to the problems in America's cities.

President-elect Clinton has stated that he will appoint a national drug expert at the Cabinet level with the power and authority to lead a comprehensive crusade against drugs. This is imperative. For the Director of ONDCP to be a member of the Cabinet means access to the President, the ability to challenge other senior Administration officials on their implementation of drug policy, and is a clear signal that drug policy is a top Administration priority. Further, by nature of the office, the ONDCP Director resolves high level fights. Symbolic inclusion in the Cabinet is not enough -- backing of the President is essential. To enhnace the statute of the ONDCP Director consideration should be given to creating a Cabinet-level council on drug abuse chaired by the ONDCP Director, Alternatively, because of the estimated $300 billion loss drug abuse costs the U.S. economy, consideration should also be given to putting the ONDCP Director on the new Economic Security Council.

The current management of ONDCP has placed most of the authority for the development and implementation of the strategy in the control of the Director, the Chief of Staff, and the Director of Budget and Planning. The current budget director at ONDCP, although he had no prior experience in drug policy, amassed an inordinate amount of influence compared to his position. The three substantive statutory officials were cut out of the policy planning process. For most of the duration of ONDCP these officials operated on the periphery of the office and became advocates for the narrow interests of Executive Branch agencies within their policy areas. Only the designation of former Chief of Staff John Walters to be the Deputy Director for Supply Program brought some influence to that position. This, however, was more reflective of his prior position in the agency than his own drug policy expertise.

Policy Development

Policy development at ONDCP must be set by the Director along with substantive input from the Deputy Directors for Supply and Demand and the Associate Director for State and Local Affairs. The

power and influence of the Executive Staff must be downgraded. The function of the Executive Staff should be to assist the orderly implementation of the National Drug Control Strategy as devised by the ONDCP Directorate in concert with the relevant Executive Branch agencies.

One of the major statutory requirements of ONDCP is the development of the annual National Drug Control Strategy. This document is mandated by 21 U.S.C. 1504 and sets forth the tone and direction of the Administration's anti-drug strategy. By law the document must :

- include comprehensive, research-based, long range goals for reducing drug abuse in the United States;

- include short-term measurable objectives which the Director determines may be realistically achieved in a 2-year period;

- describe the balance between resources devoted to supply and demand; and

- review State and local drug control activities to ensure that the United States pursues well-coordinated and effective drug control at all levels of government.

The first strategy document issued by the Administration is most important. It will be a seminal piece, and set the parameters of the Administration's drug policy for the balance of the term. Pursuant to the statute, the Clinton Administration will be required to submit a strategy document on February 1, 1993. Obviously it would not be reasonable to expect a comprehensive document that reflects the priorities of the Clinton Administration within 13 days of the Inauguration. **Immediately after Inauguration Day it is recommended that a communication be sent by the President to the Speaker and Majority Leader of the Senate which recognizes the statutory requirement of February 1, sets forth some general policy guidance, but requests leave to September 1, 1993, to formally issue the Administration's first strategy document. This would be the same length of time used by the Bush Administration to prepare its first strategy.**

Heretofore, the Bush Administration strategies were prepared by ONDCP's Executive Staff with little input from the line agencies charged with the day-to-day implementation of drug policy (DEA, FBI, State Department Bureau of International Narcotics Matter (INM), the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), and the National Institute on Drug Abuse). The two statutory deputies for supply and demand, and the associate director for state and local affairs need to be tasked with the responsibility to work with the line

agencies in the development of relevant sections of the strategy document. Placing the ONDCP Director in the Cabinet would assist in the strategy formulation process. His three deputies would have a clear mandate to delve into the agencies, identify problem areas and interagency conflicts, and develop innovative policy recommendations. The objective of this senior level tasking would not be to achieve a consensus document that all of the agencies can live with, but to create a dynamic strategy that identifes shortcomings of the current approaches to drug control and provides Administration policy makers with realistic alternatives.

Working with Other Executive Branch Departments

How ONDCP coordinates its role with other Executive Departments and other agencies is key to whether it will successfully perform its mission in the Clinton Administration. Three department are critical in this regard; Justice, Health and Human Services, and State.

- Justice - For a variety of reasons there exists a great deal of tension between ONDCP and the Department of Justice. Prior to the establishment of ONDCP, in the Reagan Administration the Attorney General was the Chairman of the National Drug Control Policy Board, the primary drug control policy body in the Executive Branch. It also should be recognized that a majority of the Department of Justice's case load is drug-related, creating potential rivalries with ONDCP on drug policy issues. Moreover, ONDCP has tasked Justice with management of the High Intensity Drug Trafficking (HIDTA) program, one of the few operational assignments given ONDCP when created by Congress in 1988.

Managing conflicts with Justice agencies involve significant issues. For example, DEA attempted to implement a plan which would have placed DEA in operational control of drug interdiction efforts in the Caribbean through the placement of helicopters in strategic places like Jamaica and others. The Customs Service and the Coast Guard objected to this plan, arguing correctly, that this would be duplicative of their ongoing operations, and was within the purview of Customs' and Coast Guard's interdiction responsibilities. While ONDCP came in and resolved the issue in favor of the Customs Service, they should have been involved in the initial stages of this proposal.

Section 1005 of the Anti-Drug Abuse Act of 1988 (P.L. 100-690) permits the classification of "any specified area of the United States as a high intensity drug trafficking area" (HIDTA). In January 1990, ONDCP designated the Southwest border, New York, Los Angeles, Miami, and Houston as HIDTA's. As stated in the strategy, "the purpose of the high intensity drug trafficking area designation is to identify areas experiencing the most serious drug trafficking

problems... and to determine the most pressing need for Federal intervention." The legislative intent of the HIDTA program was to designate certain areas of the United States as areas of high intensity drug trafficking and to direct Federal resources to better equip these areas to respond aggressively to this problem.

The following are areas of concern:

- On the issue of collaboration, all five HIDTA's now have local steering committees, and for the most part State and local representatives report that they are satisfied with the roles they played in planning and in making operational decisions on the fiscal programs. ONDCP still needs to emphasize that state and local HIDTA steering committees must include state and local representatives when they are discussing and establishing steering committee ground rules. The ground rules need not to be formal, and they may vary from HIDTA to HIDTA, but they should have the support of all the members of the steering committee; this has not been the case in New York.

- On the issue of assessing HIDTA's effectiveness, ONDCP has taken some steps to put a framework in place to measure HIDTA effectiveness, but it is still not in a position to reach judgements about the progress HIDTA's are making. What is lacking in too many cases is a clear articulation up front when programs are proposed of what results are expected, without which no yardstick for program assessment really exists. **The Director needs to reach agreement with the agencies receiving HIDTA funds on (1) the performance milestones and measurable goals the HIDTA-funded initiatives would be expected to meet, (2) the output measures that would be appropriate for evaluating progress and success in achieving those goals and milestones, and (3) the way this information is to be reported.**

- On the issue of timeliness of HIDTA disbursements of funds to State and local agencies, the majority of State and local steering committee representatives polled by the U.S. General Accounting Office in the first quarter of 1992 reported that problems that they had in the past resulting from delays of Federal funds have, by and large, now been resolved.

- On the issue of direct funding to state and local representatives in the HIDTA program, ONDCP did request funding at a level of $36 million for the state and local portion for fiscal year 1993. This is the first time the ONDCP had made such a request. (In previous years the Bush Administration denied funding the state and local portion of the program. Subsequently, the Congress funded this portion of the program.)

However, OMB saw fit to eliminate this portion of the 1993 HIDTA funding. The Congress again provided this funding as it has in past years. Direct funding to the state and local representatives is a critical component of the program.

- In the Miami HIDTA, in addition to the U.S. Attorney coordinating the overall HIDTA program, there is a State and local coordinator who oversees the State and local issues in the Miami HIDTA. This appears to be quite successful in Miami and should be an option for the other areas.

In April 1991, ONDCP released an evaluation of the HIDTA program. Section 1005 of the Anti-Drug Abuse Act of 1988 requires that the Director of National Drug Control Policy report to the Congress concerning the effectiveness of and need for the designation of areas under this section as HIDTA's along with any comments or recommendations for legislation.

The report provides the history, strategy, implementation, and funding plans for the program. In their evaluation ONDCP stated that "barely six months have passed since the first HIDTA funds were allocated to the agencies, and it is too soon for a detailed evaluation." The statute required a report concerning the effectiveness of and need for designations of areas under this subsection. The report fails to accomplish this in the manner that Congress intended. There is no detailed evaluation of the program despite the fact that at the time of the report it was the second fiscal year of funding.

The report recommended that consideration should be given to modifying the administrative funding mechanism established for this program and that Congress might consider phasing out the separate appropriation.

- Health and Human Services -

HHS is the lead executive agency for providing effective drug treatment and prevention services. Cooperation between ONDCP and HHS is essential because HHS conducts the major data surveys for drug policy making. Unfortunately, under the Bush Administration, treatment simply was not a policy priority. As a result, efforts by ONDCP, particularly by the former Deputy Director for Demand Reduction, Dr. Herbert Kleber, to expand and improve treatment services made little headway.

For example, a major priority of HHS was the reorganization of the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA)

into the Substance Abuse and Mental Health Services Administration (SAMHSA). The substance abuse research institutes of the former ADAMHA were moved to NIH, and the services delivery functions were to be streamlined in the new SAMHSA. The merits of the reorganization aside, HHS officials were so anxious to get the reorganization approved by Congress that Department officials in dealing with Congressional staff accepted questionable proposals to drop the ban on the use of Federal funds to support needle exchange programs, as well as to mandate the establishment of "minimum methadone maintenance" programs (e.g. dispensing methadone without the supporting services). Neither of these proposals make sense in an effective drug policy, but ONDCP only became involved in the consideration of these issues after release of the Conference Report. HHS did not coordinate its policy with ONDCP. Notwithstanding the objections of ONDCP, HHS was prepared to accept both provisions. Congress reinstated the ban on Federal support for needle exchange programs, yet the methadone proposal was enacted over the complaints of ONDCP and concerned methadone program providers.

State/International Narcotics Control Issues

In the 1988 drug bill, the State Department was given the lead in coordinating all U.S. government international narcotics control efforts. State has allocated this responsibility to the Bureau of International Narcotics Matters. ONDCP has the authority to establish priorities and coordinate all aspects of the government's drug programs. There is some inherent conflict in these two mandates.

During the first year of ONDCP's existence, much time and attention was given to developing the "Andean Strategy", the cocaine reduction strategy for the source countries. The primary players in the development of the strategy were the Chief of Staff at ONDCP and staff of the National Security Council. The lack of INM involvement in this process was never fully explained.

INM fought Congress for a couple of years in the Congressional attempt to get coverage of all countries (not just "major" drug source and transshipment nations) included in the International Narcotics Control Strategy Report (INCSR). This would be particularly helpful as a number of European countries, for example, are becoming increasingly big drug consumers and big suppliers of the chemicals needed to produce illicit drugs. Working with these nations is crucial to successful international drug control. Yet, this is an area largely ignored by the INCSR. A compromise was reached this fall and INM will be required to report on all countries which receive INM assistance. Again, if this were a higher priority, there would be a greater effort to educate the Congress and the public by including more information in the INCSR.

The due date of the INCSR and the accompanying Presidential Certifications has been moved from March 1 to April 1. The new Administration will be immediately faced with the task of assessing our international drug control programs and the activities of drug producing and transit nations.

There still tends to be problems in terms of inter-agency coordination and cooperation in international narcotics matters. This was highlighted during the summer of 1992 when DEA unveiled its plan to borrow DoD helicopters for interdiction missions in the Caribbean, as noted above. Supposedly the inter-agency community had signed off on this plan. However, Customs and Coast Guard who have traditionally had responsibility in Caribbean interdiction balked; the plan was reviewed and the interdiction capacity in the area was enhanced with DoD support, but the operational control went to Customs rather than DEA.

The tragic incident in Peru in late April 1992 when Peruvian Air Force Aircraft fired at a DoD C-130 drug reconnaissance plane, killing one U.S. airman and injuring four more, again demonstrated problems in the coordination of our efforts. This was largely the result of poor or mis-communication both within our system and between the U.S. and Peruvian authorities. Although there have been actions taken to improve communication, it appears that no single person or office coordinates the various agencies' drug flights in a region or in the world. SouthCom coordinates DoD missions, but not CIA, INM or DEA missions. Each country Ambassador should know about all agency flights in that country, but many flights are regional and cross borders. No one at ONDCP, State, DoD or in the intelligence community has a handle on this.

The drug issue is not a high enough priority within the State Department. The appointment of a career foreign service officer and former Ambassador to head INM did elevate the prestige of the Bureau within the Department, and some token gestures have been made -- a cable went out to our Embassies around the world saying that drugs have to be a priority (we have never heard of any follow-up on these instructions). It seems, however, that the drug issue has been completely removed from any priority list of the Secretary or Undersecretary. Anything drug-related is referred to the Bureau.

In most source and transit countries, the drug issue is tied up with a variety of internal problems, frequently including poverty and other economic issues, but also including political turmoil, insurgencies, and weak democratic institutions. In some cases our drug policy has gradually evolved to include these other issues. However, in most cases, the drug issues either stands alone or is overcome by other policy considerations. In order to be effective, our

bilateral drug programs must be designed to work with other programs that address these related problems. We must not allow the other problems (such as human rights violations in Burma which resulted in the suspension of our entire drug program in Burma, the producer of over half the world's heroin) to preclude any efforts to address the drug production problem.

There are a number of countries where production and traffic is escalating with little or no attempt at enforcement. Mostly, this is happening where we have no programs in place and where overall relations are strained: Burma (program suspended in 1988); Afghanistan (no program); Syria (no program); and Peru (Andean Strategy assistance took several years to negotiate and shortly after it was to go forward, President Fujimori abandoned democracy, resulting in the U.S. suspension of non-humanitarian aid).

The total drug related military assistance program for FY 1992 was almost $83 million, of which $75.4 million was for the Andes. The request for the Andes had been $141 million for FY 1992; the Congress cut that request nearly in half. No narcotics related military assistance was provided for any Asian or African nations. The military assistance to the Andean countries has been controversial both within the region and in the U.S., mostly because of the history of military dictatorships and serious human rights violations by the militaries within the region. Now, several years into the program, we should evaluate whether this military assistance has really been effective or detrimental.

Better end use monitoring and evaluation of programs is needed. For example, expensive boats were purchased for riverine operations in Bolivia; reports are that the boats rarely are used, are not maintained, and when used for "interdiction" have not yielded any seizures or arrests.

The international drug war must be waged by the multinational community. Bi-lateral programs often breed or enhance resentment against "Yankee Imperialism". Also we simply do not have the resources to do this by ourselves. Peru, which produces between 60 and 70 percent of the world's coca gets most of its foreign aid from Japan. Japan, not the U.S., got Fujimori to agree to elections in November. By ourselves we do not have the money to have the necessary clout, but we can take a leadership role within the world community. Whether enhanced multi-lateral efforts go through the U.N. or some other institution, perhaps a new organization, should be under serious consideration. For FY 1992 our contribution to international organizations for drug control was only about $2.8 million. It is planned to increase to $4 million in 1993, still less than 1 percent of our international drug budget.

In the last several years, we have made small, but significant steps in getting the international community interested in working together on narcotics issues. Many Members of Congress have been at the forefront of pushing for global cooperation in the drug area. Some accomplishments have been made:

The U.N. has held a special session on narcotics. The United Kingdom hosted a major international conference on cocaine. The Group of Seven has established a donor group to coordinate drug efforts. The United Nations has consolidated its previously fragmented drug missions into one organization. The finger-pointing between producing countries in South America and their primary consumer (the U.S.) has evolved into a cooperative effort to address this shared problem in a comprehensive manner.

There is evidence of increasing cooperation between ethnic organized crime groups around the world: Colombian cartels, Italian Mafia and Camorra, Chinese Triads, Japanese Yakusa, Dominican and other smaller ethnic gangs are now forming alliances to traffic drugs, guns, and to conduct other criminal enterprises. With the fall of the Soviet Union, East European organized crime groups have gained considerable power and threaten that region. They are also increasingly involved in drug production and traffic. International law enforcement cooperation is essential to control this burgeoning international criminal activity.

Other Issues

Setting Goals -

As noted above, one of the statutory mandates of the National Drug Control Strategy is the setting of goals and objectives for reducing drug abuse in the United States. Currently ONDCP relies on a series of data sets to demonstrate the status and progress in the national anti-drug effort. These data sets include two self-report surveys; the National Household Survey, and the High School Senior Survey. ONDCP also relies heavily on the data contained in the Drug Abuse Warning Network (DAWN) of drug-related hospital room emergency mentions and medical examiners' episodes.

Reliance on these data has been widely criticized. In testimony before the House Select Committee on Narcotics Abuse and Control last June, Dr. Mark Kleiman of Harvard's Kennedy School of Government discussed the limitations of existing data sets and the over-reliance that has been placed on quarter-to quarter and year-to-year changes in the data sets. Dr. Kleiman suggested that by evaluating all existing data sources, reanalyzing existing data, and adding targeted studies, our ability to detect trends in drug abuse, such as the onset of new heroin use, would be greatly enhanced. He suggested this type of

monitoring effort which would integrate data from national surveys and targeted studies, data from the criminal justice system, and data on supply and purity should be an ONDCP priority.

The Household and Senior surveys are repeatedly pointed to by ONDCP policy makers as evidence of success of the current drug policy. However, self-report surveys have serious limitations. Published studies have documented the unreliability of self-report data, particularly among populations at high risk for substance abuse.

Notwithstanding the limitations of these data sets, ONDCP continues to rely heavily on this data. This forced official pronouncements of drug policy by 1992 into a muddle where declines in casual drug use were being overwhelmed by increases in serious hard-core addiction. The use of the data served only a political end to show some level of casual drug use was declining, while policy planning to attack the more serious problem of hard-core addiction went unattended.

While ONDCP needs to improve its data collection and analysis systems, these data sets should no longer be the sole basis for defining policy goals. **Instead it is recommended that the strategy use a set of reasonably measurable goals that more closely reflect the Administration's strategy and priorities. These would include finite objectives such as the creation of a specific number of new treatment slots per year, putting a specific number of new police on the streets each year, targeting comprehensive drug abuse education at specific age groups, and expanding the number of prison-based drug treatment slots each year, among others.** These kinds of objectives would make the Administration's drug strategy more meaningful and measurable, and if developed in concert with the Cabinet agencies -- and not at odds with it -- has a much better chance of achieving its goals.

State and Local Liaison - When the Congress created ONDCP in 1988, it specifically created the position of Associate Director of State and Local Affairs to ensure that national drug control functions are properly coordinated with state and local governments and community-based groups. This is a very important position. Successful implementation of proposals to expand drug treatment, have more police presence in our communities, and expose more kids to quality drug education and prevention programs requires the input and involvement of state and local government and community-based groups. Success of the Administration's drug demand reduction strategy will to a large extent be dependent on a putting in place a grassroots policy that has community acceptance. The acceptance will come from giving state agencies and community groups a stake in the strategy development process. The Associate Director is the link brings those entities into the process.

It is recommended that the Associate Director position be enhanced. A formal liaison structure between ONDCP and the various Federal administrative regions should be developed to maintain constant contact between state and local agencies and community groups in the development and implementation of the strategy. Federal agencies in these various administrative regions who have drug control responsibilities should also be involved in this process.

Congressional Affairs - The Office of Congressional Affairs is important to the functioning of ONDCP. It will take on increased importance in 1993, as ONDCP will have to be reauthorized by the Congress. Generally, the Office of Congressional Affairs received good marks from those that dealt with it. However, it needs to coordinate its mission more closely with the legislative affairs offices of the other drug control agencies. This would avoid duplication of efforts, ease interagency conflicts, and ensure that the Administration's drug control strategy has a consistent message on Capitol Hill.

Department of Defense/Intelligence and Interdiction- DoD has taken on a larger role in drug interdiction and intelligence gathering. The 1989 DoD Authorization Bill gave DoD the lead role in drug detection and monitoring. How this role is coordinated with the traditional intelligence and interdiction functions of Customs, Coast Guard and DEA is still outstanding

Drug intelligence collection and sharing is an area that needs dramatic improvement. It has become apparent that there is no overall guidance and coordination in the collection and dissemination of drug intelligence among the Coast Guard, DEA, the FBI, Customs, Defense Intelligence Agency (DIA) and the rest of the intelligence and drug interdiction communities. An April, 1992, GAO report entitled "Inadequate Guidance Results in Duplicate Intelligence Production Efforts" stated, "No one individual or organization has the authority to direct what specific intelligence will be collected, analyzed, and reported, and by whom, to support efforts to disrupt drug organizations and detect and monitor drug trafficking".

Further, a number of agencies have responsibility for drug interdiction and drug intelligence gathering, analysis, and action with resulting overlapping jurisdictions and interagency rivalries. No effective drug intelligence or interdiction strategy exists for controlling air and sea smuggling, trafficking in cargo containers, or at border crossings.

ONDCP needs to undertake an immediate review of the drug interdiction and intelligence gathering operations with a view toward centralizing operational authority for these important tasks. A strong central authority would increase the effectiveness of resources and manpower, spur the development and use of new technologies, and

decrease overlapping jurisdiction and interagency rivalries that have hindered coordination in the past.

Reauthorization of ONDCP

Pursuant to 21 USC 1506, ONDCP is scheduled to terminate on November 18, 1993. It is clearly in the interests of President-elect Clinton to maintain ONDCP in the Executive Office of the President to permit continued high-level direction to the nation's anti-drug efforts. Keeping the current status of ONDCP is politically important to the President-elect. It fulfills a campaign promise to elevate ONDCP to Cabinet-status, it ensures that the Director is a person of high stature and is seen as the senior adviser to the President on drug policy, and most importantly, strong support for reauthorization within the Cabinet is a demonstration of President Clinton's commitment to the anti-drug effort.

The Administration may want to address some of ONDCP's structure and authority in the reauthorization process. There are a number of vehicles that are available for that task. They are:

- a general reorganization plan submitted by the Administration.

- administrative changes proposed and implemented by the White House.

- the normal reauthorization process for ONDCP.

What must be kept in mind is that ONDCP was created by Congress and placed in the Executive Office of the President to ensure that priority is given to the drug problem by the President and the Cabinet. Over the last twelve years the Congress has taken the lead on the formulation of federal drug abuse policy. A perceived downgrading of ONDCP by the new Administration would not be well-received on Capitol Hill.

Federal Drug Budget

What Is It?

The Federal Government will spend approximately $12 billion on all anti-drug programs for 1993, according to a preliminary ONDCP analysis prepared after completion of the appropriations process. This amount is about $750 million less than requested by the President, a 6 percent decrease owing to spending constraints imposed by the budget agreement. A brief analysis of the 1993 request (attachment 1)

and ONDCP's preliminary estimate of final 1993 drug budget authority (attachment 2) are included.

For FY 1993, Congress did appropriate an additional $500 million for social investments in areas designated as enterprise zones. This amount, which could be used for drug abuse treatment and prevention and a variety of other programs to help restore communities most seriously affected by drugs and crime, is contingent upon passage of an authorization measure. The authorization for enterprise zones and the related social investment package was included in H.R. 11, the tax bill vetoed by President Bush for unrelated tax reasons.

The "Federal drug budget" is something of a misnomer. There is no single line or account in the Federal budget for all Federal anti-drug programs. Rather, the Federal budget is the sum of what individual agencies spend on drug-related programs and activities. For some agencies whose entire efforts are dedicated to narcotics control efforts, like the Drug Enforcement Administration, the Bureau of International Narcotics Matters at State, and the National Institute on Drug Abuse, their entire budgets are included in the Federal drug budget. For multimission agencies, however, such as Customs, Coast Guard or the Bureau of Prisons, the amount of each agency's budget allocated to drugs is an estimate of how much of each of the agency's accounts for operating expenses, salaries, administration, procurement, construction, etc., goes to support anti-drug activities. For example, the Bureau of Prisons estimates that approximately 64 percent of its salaries and expenses account is drug-related, based on the current number of inmates convicted of drug-related crimes. Similarly, BOP estimates that roughly 70 percent of its building and facilities account, which supports new prison construction, modernization and repair costs, is drug-related based on the projected drug offender inmate population at the time current-year initiatives are scheduled to become operational (on average, three years after appropriations).

Different programs are counted differently, too, in arriving at the overall Federal drug budget. For example, the entire amount appropriated for the Drug Free Schools and Communities Act in the Department of Education (about $600 million for 1993) is allocated to drug prevention spending even though schools also use these funds for anti-alcohol and anti-smoking activities, as permitted under the law. The Federal drug budget, however, includes an estimate for only the drug portion of the Substance Abuse Block Grant which funds state alcohol and drug treatment and prevention services.

Thus the "Federal drug budget" is an estimate at best and is somewhat artificial, based to some extent on accounting methods rather than on distinct programmatic initiatives. We suspect some of

the growth in drug expenditures in recent years is due to the accounting procedures used rather than specific funding increases for new or expanded drug programs.

Demand vs. Supply

A perennial issue of debate is how much of Federal drug expenditures should be allocated to demand reduction activities versus supply reduction activities. At present, supply reduction efforts (law enforcement, interdiction, international narcotics control) receive about 70 percent of the overall Federal drug budget, while demand reduction activities (treatment, prevention, education, rehabilitation) receive about 30 percent. This ratio has remained fairly constant throughout the Bush years, reflecting both the Administration's requests and Congressional action on those requests.

Some have suggested that a balanced drug strategy requires a 50/50 split in spending between supply reduction and demand reduction. To accomplish this goal in a budget neutral manner, they advocate shifting funds from supply reduction efforts, which they argue are ineffective, to demand reduction efforts. Most experts agree that more needs to be done on the demand side; but, in part, for the reasons outlined above it may not be as easy to reallocate resources from the supply side to the demand side as some suggest. Shifting a Coast Guard cutter from drug patrols in the southeast to fisheries enforcement or some other primary mission in the northeast will not produce "savings" that can be applied to drug treatment and prevention. Likewise, searching for drugs or drug cash are just a few of the factors performed by Customs inspectors. Reducing Customs drug inspections does not produce a cost savings that can be shifted to demand reduction unless the decision is made to actually cut the number of Customs inspectors, a choice that Congress has consistently rejected.

Shifting funds from supply reduction to demand reduction has policy and political pitfalls as well. Budget constrains in recent years have made it impossible to fund requested increases for a variety of supply and demand reduction programs, and some programs have even experienced funding cuts from previous years, the DEA for example. Proposing deeper cuts in drug enforcement to fund increases in treatment and prevention will face stiff opposition on the Hill from Members who oversee drug enforcement agency budgets. Arguing the merits of such a shift is also problematic because at this point there is no clearcut evidence to show that treatment/demand reduction is more effective than law enforcement/supply reduction in reducing drug abuse. In addition, the treatment system at this time is not capable of using a massive infusion of cash effectively without major steps to improve facilities, upgrade staff and enhance accountability.

The new Administration should be wary of arbitrary funding allocations as the only measure of a balanced drug strategy. The bottom line is that much more needs to be done to reduce both the demand for and supply of illicit drugs. Available data and information point clearly to the fact that existing treatment capacity is insufficient in many areas to meet current treatment needs, and supplies of illicit drugs are readily available, potent and cheap. Our prevention efforts seem to be least effective in reaching those at high risk in our society for substance abuse problems. The Administration and the Congress must find the political will and the resources to enhance our efforts on both the demand and supply sides and to target our resources to those programs that are most effective and the areas most in need. **As a first step, the Clinton Administration should consider supporting enactment of the enterprise zones/social investment legislation vetoed as part of the tax package. This would free $500 million already appropriated for targeted spending in areas most affected by drugs and crime.**

ONDCP Role

Under existing law (21 U.S.C. 1502 (c)), the ONDCP director is responsible for developing an annual, consolidated national drug control program budget to implement the President's drug strategy. Federal officials responsible for drug control programs are required to submit their budget proposals to ONDCP at the same time they submit their requests to their agency superiors, and before submission to OMB. The ONDCP director is required to review each request, certify in writing as to the adequacy of each request to implement the President' s drug strategy for the year, and notify the requesting official of the certification. In the past, ONDCP has used the threat of "decertification" as a lever to force agencies to increase drug spending requests ONDCP felt were inadequate (see 4/6/92 Washington Times clip, enclosed, attachment 3) In addition, no agency may submit a request to Congress to reprogram anti-drug funds in excess of $5 million without the approval of the ONDCP director.

In effect, ONDCP is intended to operate like a "mini-OMB" for drug programs and budgets. This invariably creates tension and controversy between and among ONDCP, OMB and the agencies with line responsibilities for anti-drug programs. While the authority to certify drug budget requests and approve reprogramming requests are strong tools, ONDCP officials have complained privately that all too often they get rolled in budget disputes with cabinet heads and OMB.

A draft bill to reauthorize ONDCP, prepared by ONDCP staff but never formally submitted to Congress, proposed to strengthen the director's authority to shape the drug budget. In addition to the existing tools, this proposal would allow the ONDPC director to modify

agency drug requests proposed for submission to OMB. The director also would be given the authority to restrict agency obligation of drug-related resources through the issuance of "Funds Control Notices" to curb spending on projects not consistent with the President's drug strategy and ensure that high priority projects are undertaken. Federal officials who violate Funds Control Notices would be subject to administrative discipline and criminal penalties. The director also would be authorized to transfer drug control funds between accounts, up to 5 percent at a time, and temporarily reassign agency anti-drug personnel without the concurrence of the agency head, as currently required.

A copy of this draft bill is enclosed for consideration (attachment 4). The Clinton Administration should view it with some caution. Some of these proposals delegate broad authority over budget and spending decisions to the director and likely would be viewed with skepticism on the Hill. From the stand point of the executive, the power to issue written Fund Control Notices provides yet another point for Congress and other interested parties to insert themselves in internal executive branch decision-making. The certification process already allows such intrusions, as the attached Washington Times article illustrates.

More important than any specific powers granted to the director is the person selected to fill that position and that person's relationship to the President and the cabinet. Ultimately, the process of developing the drug strategy and the budget to support it is a negotiation. The ONDCP director should be a person of national stature who is included as a fully participating member of the President's cabinet and is viewed as a co-equal with the cabinet heads whose drug policies and programs the director is responsible for coordinating. The director must also be a person who has the ear of the President and his full support and confidence. For his director to be effective, the President must make clear to his cabinet and the public that drugs are a top priority of his Administration, that his drug director is his chief drug policy adviser and that he expects his team to cooperate to develop an aggressive, comprehensive anti-drug strategy.

ONDCP's Budget

Salaries and Expenses

For 1993, Congress appropriated $103,348,000 for ONDCP. Of this amount, $86 million is earmarked for the High Intensity Drug Trafficking Areas (HIDTA) program discussed elsewhere in this paper. The remainder, $17,348,000, supports ONDCP's direct operations and staff. This is about $1.0 million less than requested, not counting amounts expected to be contributed to the Gift Fund for use by the

Director for drug-related activities, primarily for operating expenses of the President's Drug Advisory Council (established by Ex. Or. No. 12696, 11/13/89, and Ex. Or. No. 12756 of 3/18/91). Congress approved 112 FTE's for ONDCP instead of the 130 FTE's (127 positions) requested because ONDCP did not meet its budgeted FTE levels in the two previous fiscal years. In 1992, ONDCP had a paid staff of 110 on board; these staff were supplemented by 40 non-reimbursable detailees from other Federal drug control agencies.

A major concern about ONDCP has been the use of the agency as a dumping ground for political appontees. More than 40 percent of the agency's 110 paid employees in 1992 were filled by political appointees, substantially above the level at most other executive branch agencies. The 1993 appropriation for ONDCP includes language requiring ONDCP, by September 30, 1993, to reduce by no less than 20 percent the number of Schedule C and non-career Senior Executive Service positions on board as of September 30, 1992. In addition none of the positions eliminated may be converted to career positions.

The Clinton Administration may want to consider whether additional personnel cuts may be made without depriving ONDCP of the professional staff it needs to oversee Federal agency drug programs and budgets and develop the annual strategy and consolidated drug budget.

Special Forfeiture Fund

The Anti-Drug Abuse Act of 1988 (21 U.S.C. 1509) established a Special Forfeiture Fund in the U.S. Treasury for use by the ONDCP director to supplement amounts that would otherwise be available for priority programs under the drug strategy. Amounts in the Fund are derived from transfers from the Justice Department's Assets Forteiture Fund and may not exceed $150 million. Transfers to the fund are authorized through fiscal year 1993. Amounts in the fund are available to the director as specified in appropriations acts. The President, in consultation with the director, must submit a detailed request for use of amounts in the fund as part of his annual budget.

For 1993, Congress appropriated $75.7 million to support a broad range of demand and supply reduction efforts by ADAMHA (now SAMHSA), DEA Border Patrol, Customs and other Federal agencies. In the past, the Special Forfeiture Fund has proven to be a cumbersome mechanism because it falls under the jurisdiction of the Treasury Appropriations Subcommittees but has been used to supplement funding for programs not under the jurisdiction of those subcommittees. Since all the amounts appropriated for the fund are scored against the Treasury Subcommittees' budget allocations, there has been a strong incentive to resist requests for programs outside the

subcommittees' jurisdiction because any funding provided for such programs reduces the amounts available to the Treasury Subcommittees for programs within their jurisdiction. The process also prevents full review by the appropriate Appropriations Subcommittees of budget requests made through the Special Forfeiture Fund for programs outside the Treasury Subcommittees' purview. **Some consideration should be given to revising the way in which requests for appropriations from the Special Forfeiture Fund are submitted to Congress so that they are reflected in the budgets of the agencies whose programs will benefit and so that they will be adequately reviewed by the appropriate subcommittees of jurisdiction.**

Personnel

Currently, over 40 percent of ONDCP's 109 employees are political employees with little or no drug policy experience. Appointment to ONDCP by President-elect Clinton should be based on professional knowledge of the drug problem and merit.

Director of National Drug Control Policy

The Director is the chief drug policy adviser to the President and the Executive Branch. The Director is the chief spokesman for the Administration on drug policy, directs the operation of ONDCP, is responsible for the preparation of the National Drug Control Strategy, develops in conjunction with other executive agencies a consolidated national drug control program budget, manages expenditures from the Special Forfeiture Fund, coordinates the High Intensity Drug Trafficking Area program, and generally guides the drug abuse policy of the United States.

The Director should be a nationally-known leader on drug policy issues, possess a thorough understanding of the drug problem from both supply and demand perspectives, and have the personal and professional stature to serve as the chief adviser to the President on drug policy and to influence other members of the Cabinet on the formulation and implementation of the National Drug Control Strategy.

Deputy Director for Supply Reduction

The Deputy Director for Supply Reduction is the chief policy maker in ONDCP for international narcotics control, drug interdiction and domestic law enforcement efforts. The Deputy Director is the liaison of ONDCP to the Department of Justice (Attorney General, Deputy Attorney General, DEA, FBI, INS, US Attorneys, Criminal Division), Department of the Treasury (Customs Services, FINCEN, Bureau of Alcohol, Tobacco and Firearms), the Department of State (Bureau of International Narcotics Matters), the Department of

Transportation (Coast Guard) , Department of Defense, and other Federal agencies with law enforcement responsibilities. The Deputy Director for Supply should be well known and respected by law enforcement, knowledgeable of criminal justice issues, understand the complex issues attaching to international narcotics control, and have a firm historical understanding of drug policy over the last decade.

Deputy Director for Demand Reduction

The Deputy Director for Demand Reduction is the chief policy maker in ONDCP for drug abuse treatment, prevention, and education programs. The Deputy Director is the liaison of ONDCP to the Department of Health and Human Services (Substance Abuse and Mental Health Services Administration, the Center for Substance Abuse Prevention, NIH, and the National Institute on Abuse), the Department of Education, and other Federal agencies with drug demand reduction responsibilities. The Deputy Director for Demand Reduction should be well-known and respected by drug abuse treatment professionals and state drug abuse agency heads. This is particularly important as the Clinton Administration expands treatment availability, effectiveness, and accountability. The Deputy Director must appreciate that a wide range of social services beyond traditional drug treatment including job training, vocational and remedial education, health care and other supportive services must be part of effective treatment regimens. A major task of the Deputy Director should be the development of models of successful treatment and prevention programs that can be replicated in local communities.

Associate Director For State and Local Affairs

The Associate Director for State and Local Affairs is the chief liaison of ONDCP to state and local law enforcement and demand reduction agencies, as well as community-based anti-drug programs. The Associate Director serves the vital role of explaining the National Drug Control Strategy to state and local agencies, and assists them in developing state and local programs that reflect national programs and priorities. The Associate Director should have a good understanding of local law enforcement needs, and effective community-based prevention programs. While serving as a sounding board for local input into the strategy, the Associate Director's primary responsibility should be the implementation of the strategy at the local level.

Chief of Staff

The Chief of Staff of ONDCP should be a seasoned government professional capable of running the organization. Familiarity with drug issues is important, as is good political sense, an understanding of how the Congress works, and the ability to coordinate the work of ONDCP with representatives of other Executive Departments and agencies.

Director of Congressional Affairs

The Director of Congressional Affairs should be experienced on Capitol Hill, with a knowledge and understanding of the key House and Senate Committees with oversight and legislative jurisdiction of drug abuse issues. This will be a key position in 1993, as ONDCP is scheduled for reauthorization by November, 1993. The Director of Congressional Affairs will play a pivotal role in that process.

Director of Budget, Planning and Administration

The Director of Budget, Planning and Administration as noted above amassed significant power and influence in the current structure of ONDCP. While this is an important post, the focus of this position should be developing the National Drug Control Program Budget in concert with executive branch drug control agencies. The individual holding this position needs to be familiar with the Federal budget process and have an understanding of existing Federal drug programs.

Short-Term Goals and Objectives

After taking office the new team in place at ONDCP must turn its direction to the following areas that will require the immediate attention of the office:

1. As noted earlier, immediately after Inauguration Day a communication should be sent by the President to the Speaker of the House and the Majority Leader of the Senate which recognizes the statutory requirement of February 1 for the submission of the National Drug Control Strategy, but requests leave to September 1, 1993, to formally issue the Administration's first strategy document.

2. On April 1, 1993, the State Department will be required to issue the International Narcotics Control Strategy Report (INCSR) along with a list of Presidential certifications of drug producing and trafficking nations that are cooperating with the United States on drug control. If the President fails to certify such cooperation, the offending country is subject to the loss of United States bilateral assistance, loss of favorable tariff treatment of products and other trade sanctions, and U.S. opposition to multilateral development assistance . 22 USC 2291; 19 USC 2491. While the State Department's Bureau of International Narcotics Matters has the lead responsibility for the preparation of this report and the certifications, ONDCP must be involved in this process to insure consistency with the Administration's drug control program.

3. ONDCP needs to take an active role in the structuring of and setting priorities for the new Substance Abuse and Mental Health Services Administration (SAMHSA) in the Department of Health and Human Services. This new agency should be used to enhance Federal leadership in the areas of treatment expansion, effectiveness, and accountability. ONDCP needs to take the lead, along with SAMHSA to, ensures that treatment services are directed at high-risk populations; pregnant women and their children, those at risk for HIV infection, inmates in correctional institutions, and at-risk youth.

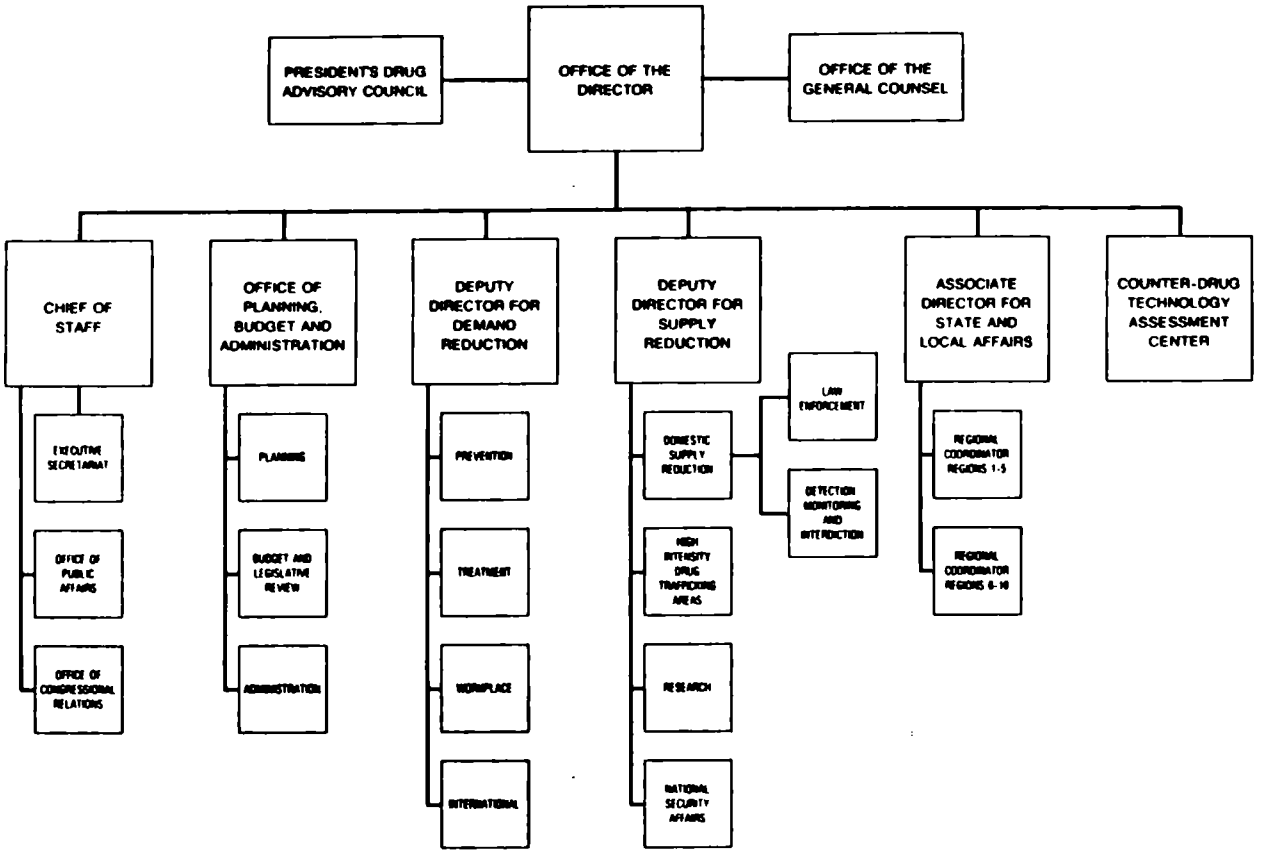
4. ONDCP must take an active role in shaping the Administration's economic agenda, particularly as it relates to assistance to urban communities. Drug abuse and drug-related crime exact a high price from the value of urban life. After the Los Angeles riots, ONDCP was not consulted by the White House for its input on urban policy. Thereafter, the Congress has enacted legislation to create comprehensive enterprise zones that combine tax incentives for business to invest in urban communities along with enhanced social services. While the President vetoed the authorization for this program, $500 million is available in this fiscal year for the expansion of existing social services in inner city communities. ONDCP should take the lead in ensuring that these funds stay earmarked for the purposes they were intended, and that inner city redevelopment remains part of the Administration's economic agenda.

5. ONDCP needs to undertake an immediate review of drug interdiction and intelligence operations with a view toward centralizing operational authority for these tasks. A strong central authority would increase the effectiveness of available manpower and resources, spur the development and use of new technologies, and decrease overlapping jurisdictions and interagency rivalries that have hindered coordination in the past.

6. ONDCP must work closely with the Department of Justice in the implementation of President-elect Clinton's plan to put 100,000 additional police on the street, develop an effective working partnership between Federal law enforcement agencies and State and local law enforcement, and to expand prison-based drug abuse treatment programs.

7. ONDCP needs to be supportive of President Clinton's desire to establish national service programs. Drug abuse demand reduction efforts should not be overlooked in this effort. Working through agencies such as the Department of Education's regional training centers, a comprehensive program shouldbe developed to train individuals and groups in effective community-based drug abuse prevention efforts.

OFFICE OF NATIONAL DRUG CONTROL POLICY



Attachment 1

DRUG BUDGET FACTS: FY 1993

- **President's Total Anti-Drug Request for 1993: $12.7 Billion.**

- **President's Increase Over 1992 Anti-Drug Funding: $776 million or 6.5%** (approximately 3.1% over inflation estimated at 3.4% by the President's Budget).

- **The President's total budget request for 1993 proposes to increase budget authority (appropriations) by 3.1% and spending (outlays) by 3.9% .**

- **Federal anti-drug funding has increased 770% since 1981 and $6.1 Billion (93%) since the beginning of the current administration.**

- **President's 1993 Request for Supply Reduction vs. Demand Reduction**

  -- 68% for supply reduction
  -- 32% for demand reduction
  -- Nearly the same allocation as Congress appropriated for FY 1992

- **Amounts Requested for 1993** (compared to 1992 funding levels):

  -- **Supply Reduction: $8.6 Billion (+$443 Million/+5.4%)**

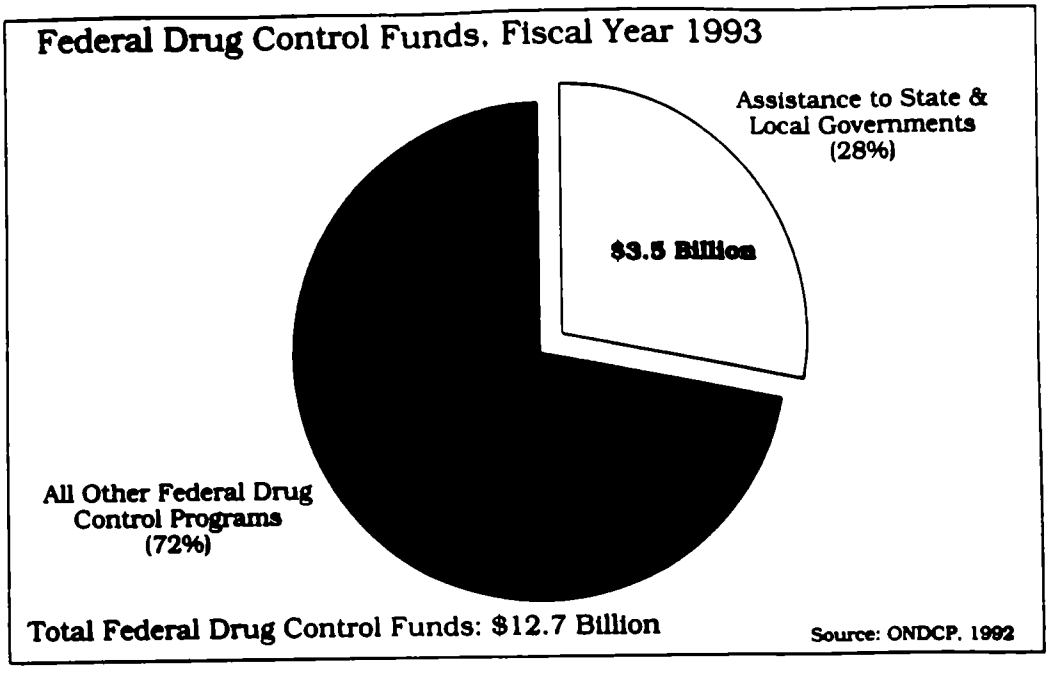
  Supply Reduction includes:
  Criminal Justice: $5.4 Billion (+$453 Million/+9%)
  Interdiction: $2.2 Billion (No Change)
  International: $768 Million (No Change)
  Research: $131 Million (-$32 Million/-24%)
  Intelligence: $129 Million (+14 Million/+12%)

  -- **Demand Reduction (including research): $4.1 Billion (+$333 Million/+8.8%)**

  Demand Reduction includes:
  Treatment (including research): $2.3 Billion (+256 Million/+12.3%)
  Prevention (including research): $1.8 Billion (+77 Million/+4.5%)
  [Research (included in above amounts): $380 Million (+18 Million/+5%)]

- **Weed and Seed.** $500 million, an increase of $491 million, included for a much expanded initiative that combines law enforcement efforts to "weed" out drug dealers and violent criminals from communities and to "seed" these communities with public and private social services, community assistance and economic development programs, community-based policing and the tax incentives of enterprise zones. Of the total requested, $280 million is new funding. The remaining $220 million is earmarked from current programs. Up to $400 million will go to neighborhoods designated as Urban Enterprise Zones by the HUD Secretary. Approximately one-quarter of the $500 million is included in the President's anti-drug budget.

- **Allocation of Federal Resources to State and Local Government**



- **Balance of Resources Between Supply/Demand**

The Strategy asserts that a supply/demand distinction that looks only at the budget's bottom line to assess whether efforts are appropriately balanced overlooks three important factors:

1) Many supply reduction activities also impact demand, e.g., arresting users deters others from using drugs.

2) Supply reduction is inherently more expensive and involves costly capital outlays for patrol cars, aircraft, prisons, etc. Demand reduction relies less on capital expenditures and more on community involvement and individual commitment.

3) Many supply reduction activities are intrinsically governmental functions (e.g., international and border control efforts), whereas demand reduction efforts can and should be shared by schools, churches and communities.

Attachment 2

NATIONAL DRUG CONTROL BUDGET SUMMARY
FY 1992 – FY 1993
Budget Authority ($ Millions)

Column→	FY 1992	FY 1993			
	-1- Revised Enacted	-2- Pres. Request	-3- Estimated Enacted	-4- Pres. – Enacted	-5- % Change
Action	12.3	13.4	13.0	(0.4)	-3%
Agency for International Development	279.0	260.9	149.9	(111.1)	-43%
Department of Agriculture					
Agricultural Research Service	6.7	6.7	6.5	(0.2)	-4%
U.S. Forest Service	9.4	9.3	9.6	0.3	4%
Total, Agriculture	16.1	16.1	16.1	0.1	0%
Department of Defense*	1,274.6	1,223.4	1,140.7	(122.7)	-10%
Department of Education	715.6	751.0	699.5	(51.5)	-7%
Dept. of Health and Human Services					
Administration for Children and Families	111.0	121.5	120.0	(1.5)	-1%
Substance Abuse and Mental Health Administration & NIDA**	1,609.9	1,793.9	1,709.3	(75.6)	-4%
Centers for Disease Control	28.8	31.5	32.0	0.5	2%
Food and Drug Administration	6.7	7.0	7.0	0.0	1%
Health Care Financing Administration	201.5	231.5	232.0	0.5	0%
Indian Health Service	35.2	37.0	37.0	(0.0)	-0%
Total, HHS	1,993.1	2,222.3	2,137.3	(76.0)	-3%
Dept. of Housing and Urban Dev.	165.0	165.0	175.0	10.0	6%
Department of the Interior					
Bureau of Indian Affairs	22.7	19.4	23.8	4.3	22%
Bureau of Land Management	8.9	10.3	11.5	1.2	12%
Fish & Wildlife Service	1.0	1.1	1.1	0.0	0%
National Park Service	11.1	10.8	9.1	(1.7)	-15%
Office of Territorial and International Affairs	1.5	1.1	1.4	0.3	28%
Total, Interior	45.2	42.7	46.8	4.1	10%

* DoD--Enacted level compared to re-priced FY 1993 funding level of $1.283 billion.
**SAMHSA--Enacted level compared to re-priced FY 1993 funding level of $1,784.8 million.

NATIONAL DRUG CONTROL BUDGET SUMMARY
FY 1992 -- FY 1993
Budget Authority ($ Millions)

Column→	FY 1992 -1- Revised Enacted	FY 1993 -2- Pres. Request	FY 1993 -3- Estimated Enacted	-4- Pres. - Enacted	-5- % Change
Department of Transportation					
U.S. Coast Guard	679.7	679.1	661.3	(17.8)	-3%
Federal Aviation Administration	26.1	35.6	26.1	(9.5)	-26%
National Highway Traffic Safety Administration	8.2	9.4	7.1	(2.4)	-26%
Total, Transportation	714.0	724.1	694.5	(29.6)	-4%
Department of the Treasury					
Bureau of Alcohol, Tobacco, and Firearms	131.7	141.3	148.2	6.9	5%
U.S. Customs Service	789.1	752.9	745.0	(7.9)	-1%
Federal Law Enforcement Training Center	16.3	18.8	21.9	3.1	16%
Financial Crimes Enforcement Network	14.4	18.2	16.9	(1.3)	-7%
Internal Revenue Service	102.8	111.1	111.0	(0.1)	-0%
U.S. Secret Service	44.7	62.9	55.2	(7.7)	-12%
Total, Treasury	1,099.1	1,105.2	1,098.2	(7.0)	-1%
U.S. Information Agency	8.0	8.4	8.0	(0.4)	-4%
Department of Veterans Affairs	544.2	590.6	590.6	0.0	0%
Total Fed. Program (not incl. W&S)	12,008.5	12,714.3	11,979.3	(754.0)	-6%
Weed and Seed*	0.0	14.4	6.6	2.2	54%
Total Fed. Program (incl. W&S)	12,008.5	12,728.7	11,985.9	(751.8)	-6%

* Weed & Seed: the President's FY 1993 request was re-priced to $4.4m. The repriced request was used in making comparisons to Congressional action.

Attachment 3

The Washington Times

Drug policy office puts heat on Cabinet agencies

THE ASSOCIATED PRESS

The Office of National Drug Control Policy has waged intense, behind-the-scenes battles to force six Cabinet agencies to seek $115.3 million in additional funds for the war on drugs, according to documents.

The drug policy office threatened late last year to expose agencies seeking what it believes is too little money after less drastic measures failed to persuade six departments to increase their anti-drug budget proposals for fiscal 1993.

After the warning, the six increased their total budget requests by $115.3 million, most of that for drug demand reduction programs, according to the documents sent to the Senate Judiciary and House Government Operations committees by the office of drug czar Bob Martinez.

The Bush administration has asked Congress for $12.7 billion to pay for federal anti-drug efforts in fiscal 1993.

Thus far, the office has not used its ultimate weapon: sending letters signed by Mr. Martinez to a department head declaring the department's drug-war funding inadequate.

Bob Martinez

Instead, it has fired warning shots.

"We've threatened by sending over drafts of unsigned letters that would decertify agencies, and that got an answer," Bruce Carnes, the drug policy office's director of planning, budget and administration, told a Senate panel last week. "There we've got definite big-time power."

Because the congressional committees requested the drafts as well as Martinez's signed letters certifying every department's final budget request as adequate, the threats to expose the reluctant drug warriors to Congress became, unintentionally, reality.

The documents show the secretaries of Education, Health and Human Services, the Treasury, Housing and Urban Development, Veterans Affairs and Labor received draft letters.

After receiving the letter, the Education Department boosted its proposal for Drug-Free Schools and Communities grants by $62.5 million.

Other increases were:

- Treasury, $14.9 million for IRS money-laundering investigations.
- VA, $11.4 million for veterans' drug treatment.
- Labor, $10 million for its Employment and Training Administration program.
- HUD, $8.25 million for public housing drug elimination grants.
- HHS, $8.2 million for the Administration for Children and Families and the federal Centers for Disease Control.

4/6/92

A BILL

To enhance the authorities and responsibilities of the Office of National Drug Control Policy, and for other purposes.

Be it enacted by the Senate and the House of Representatives of the United States of America in Congress assembled,

SEC. 1. SHORT TITLE

This Act may be cited as "The 1992 Amendments to the National Narcotics Leadership Act".

SEC. 2. NATIONAL DRUG CONTROL PROGRAM BUDGET AMENDMENTS

21 U.S.C. 1502(c) is amended by redesignating paragraphs (5), (6), and (7), as (6), (7), and (8), respectively, and by inserting after paragraph (4) the following:

"(5) The Director may modify budgets prepared for submission to the Office of Management and Budget (OMB) to reflect the President's funding priorities for the National Drug Control Strategy. Agencies and OMB shall be notified of the Director's funding determinations."

SEC. 3. CONTROL OF DRUG-RELATED RESOURCES

21 U.S.C. 1502 is amended by redesignating paragraphs (d) and (e) as (f) and (g), respectively, and by inserting after paragraph (c), the following:

"(d)(1) To ensure compliance with the Drug Control Program of the President, the Director may issue a Funds Control Notice to the head of a National Drug Control Program agency which restricts the obligation of drug-related resources appropriated to such agency. The notice may direct that specific drug-related resources be obligated by --"

"(A) months, fiscal year quarters, or other time periods;"

"(B) activities, functions, projects, or object classes; or"

"(C) a combination of the ways referred to in clauses (A) and (B) of this paragraph."

"(2) An officer or employee of a National Drug Control Program agency may not make or authorize an expenditure or obligation contrary to a Funds Control Notice issued by the Director under paragraph (1)."

"(3) If an officer or employee of a National Drug Control Program agency violates paragraph (2) of this section, the head of the agency shall report immediately to the Director all relevant facts and a statement of actions taken."

"(4) An officer or employee of a National Drug Control Program agency violating paragraph (2) shall be subject to appropriate administrative discipline including, when circumstances warrant, suspension from duty without pay or removal from office."

"(5) An officer or employee of a National Drug Control Program agency knowingly and willfully violating paragraph (2) shall be fined not more than $5,000, imprisoned for not more than 2 years, or both."

SEC. 4. POWERS OF THE DIRECTOR OF ONDCP

21 U.S.C. 1502(d) is amended --

(a) by striking in paragraph (2), ", with the concurrence of the Secretary of a department or head of an agency,";

(b) by inserting after paragraph (7) the following:

"(8) notwithstanding the provisions of any other law, transfer up to 5 percent of funds appropriated to a National Drug Control Program agency account. Congress shall be notified of all such transfers. Proposed transfers may be executed following 15 days of review by the Congress."

SEC. 5. TERMINATION OF OFFICE OF NATIONAL DRUG CONTROL POLICY

21 U.S.C. 1506 is amended by striking, "the date which is 5 years after the date of enactment of this subtitle", and inserting, "September 30, 1997".

SEC. 6. AUTHORIZATION OF APPROPRIATIONS

21 U.S.C. 1508 is amended by striking "4" and inserting "8".

SECTION-BY-SECTION ANALYSIS

The 1992 Amendments to the National Narcotics Leadership Act

Section 2. National Drug Control Program Budget Amendments

This section authorizes the Director of ONDCP to modify agency budget submissions to the Office of Management and Budget (OMB). The Director's changes would be for the purpose of making agency budgets consistent with the President's National Drug Control Strategy.

Section 3. Control of Drug-Related Resources

This section authorizes the Director of ONDCP to issue a new kind of document know as a "Funds Control Notice." These notices could restrict the way in which agencies obligate drug-related resources. This authority would allow ONDCP to limit spending on projects not consistent with the National Drug Control Strategy, while ensuring that high-priority initiatives are undertaken.

In addition, an officer or employee of a National Drug Control Program agency who violates a Funds Control Notice would be subject to the same administrative and criminal penalties as provided under Title 31, United States Code, for violating apportionment restrictions.

Section 4. Powers of the Director

Currently, statute allows the Director of ONDCP to temporarily reassign personnel of a National Drug Control Program agency, with the concurrence of the relevant agency head. This section eliminates the requirement that agency heads concur in these actions.

Also, this section allows the Director of ONDCP to transfer drug control funds between agencies. A single transfer would be limited to no more than 5 percent of funds appropriated to a particular National Drug Control Program agency account.

Sections 5 & 6. Reauthorization

These sections extend ONDCP's activities through the end of Fiscal Year 1997.

TO: **RON KLAIN**

Fr: **Chris P.**

Re: **Office of National Drug Control Policy**

Per your request, the memo outlines some of the powers and authorities necessary for the drug office to complete its mission. As we have discussed, all these changes are properly made by executive order -- particularly as personnel decisions are being implemented.

Based on our conversation, I have pared down our proposal to three key elements necessary to permit the drug director to ensure that drug agency budget and policy decisions are consistent with the President's drug policy. We also propose an additional change necessary to confirm the stature of the office.

Key Authorities for Office of National Drug Control Policy

A. Budget Authority

Current authority requires that the drug director certify drug agency budgets as consistent with national drug strategy -- such once-a-year, "yes-no" authority has proven too blunt a tool for effective leadership.

Thus, new -- intermediate -- authority is necessary:

** Quarterly review of budgets (authority similar to current OMB authority) to monitor use of funds during year; and

** Permitting the drug director (similar to the authority of the DCI) to give specific direction to agencies about how much to request for drug budget (not simply to give a "yes/no" answer).

B. DRUG POLICY DECISIONS:

Current authority requires drug agencies to notify the drug director whenever the agency undertakes a change in drug control policy. The director must certify in writing that the change is consistent with the National Strategy. Unfortunately, drug agencies

have notified the drug director of policy changes only after the fact, or otherwise ignored the certification requirement.

Thus, to clarify the authority of the drug director to ensure that drug agencies implement the National Strategy, the proposed change would prohibit change in drug control policy unless drug director certifies change is consistent with strategy. Where exigent circumstances prevent advance approval, the policy change is rescinded with 180 days unless certified by drug director.

C. URBAN AID BILL:

As you know, Congress is likely to pass legislation (that was vetoed in last year's tax bill) authorizing the $500 million appropriated last year for Enterprise Zones. In this legislation, the drug director is a member of the Interagency Council that will oversee the urban enterprise zone program. As you know, the Council will not select the sites (selection is the duty of the Agriculture and HUD Secretaries).

Naming the drug director as the chair of the council would send a clear signal of the role and importance of the drug director.

Other Authorities:

There are a few other minor changes we would propose for the drug directors office, covering such routine matters as information requests, data collection, and Special Asset Forfeiture fund. We should discuss these when you have the chance.

To: Bruce Reed

Fr: CH Rasco

Subj: Response needed 1/24/93

McLarty's office has forwarded this to me. Please prepare a memo to McLarty, route through me!

Thanks!

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

Jose -
FYI
BR
No action necess.

January 21, 1993

MEMORANDUM FOR THOMAS McLARTY

FROM: JOHN WALTERS
ACTING DIRECTOR

SUBJECT: National Drug Control Strategy and Budget Issues

The Anti-Drug Abuse Act of 1988, which created the Office of National Drug Control Policy (ONDCP) and defined its mission, contains several statutory requirements that ONDCP and/or the President must meet.

Immediate policy guidance is needed with respect to two of the Act's requirements: the annual submission of a strategy to Congress, and the preparation of a consolidated drug control budget. These requirements are described in more detail below.

Submission of a National Drug Control Strategy to Congress

The Act requires that the President submit to Congress a National Drug Control Strategy by February 1 each year. In consultation with the Congress, the States, private sector groups and citizens, and Federal agency staff, ONDCP has developed a draft Strategy document that describes the existing drug program in such a way as to give the new Administration maximum flexibility to include its initiatives and policy direction.

This draft Strategy does not contain new policy, program, or funding initiatives. Such initiatives are dependent upon policy direction from the Administration and the development of a drug control budget.

It is unlikely, therefore, that we will meet the statutory deadline to submit President Clinton's National Drug Control Strategy by February 1. Accordingly, I would make the following recommendation:

> **Recommend**: We prepare a letter for signature by an appropriate Administration official apprising Congress that the statutory deadline for submitting a National Drug Control Strategy will not be met, but that a Strategy will be submitted once the Administration has conducted a full review of all drug control policies and programs.

Preparation of the FY 1994 Consolidated Drug Control Budget

The Act also requires that ONDCP submit to Congress an annual drug control budget that delineates for each Federal drug control agency the resources required to implement the Strategy. In the past, the release of the consolidated drug budget and Strategy coincided with the release of the President's full Federal budget.

All drug control agencies have submitted their FY 1994 budget requests to OMB and ONDCP for review. By law, ONDCP must certify the adequacy of those budgets to implement the National Drug Control Strategy. Final certification would normally have occurred in November, but it has been delayed pending program and policy direction from the Administration. In light of the requirement to develop a FY 1994 drug control budget, I would recommend the following:

> **Recommend**: We include in the letter to Congress described above the intent to submit a consolidated drug control budget concurrent with the release of the Strategy.

I am attaching proposed letters to the President of the Senate and the Speaker of the House incorporating these recommendations.

The Office stands ready to provide additional information on these matters or any others affecting our mission at your convenience.

Attachments

cc: Christine Varney

The Honorable Albert Gore, Jr.
President of the Senate
U.S. Senate
Washington, D.C. 20510

Dear Mr. President:

Public law 100-690 requires that the President submit to Congress a National Drug Control Strategy by February 1 each year. In addition, the Office of National Drug Control Policy (ONDCP) is required to submit to Congress an annual drug control budget that delineates for each Federal drug control agency the resources required to implement the Strategy.

I am writing to advise you that the Administration will be unable to meet the February 1 deadline this year, pending a complete review of all drug policies, programs, and funding. Once that review has been completed, the Administration will submit its Strategy and budget for drug control purposes.

An identical copy of this letter has been sent to the Speaker of the House. Thank you for your attention to this important matter.

Sincerely,

The Honorable Thomas Foley
Speaker of the House
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

Public law 100-690 requires that the President submit to Congress a National Drug Control Strategy by February 1 each year. In addition, the Office of National Drug Control Policy (ONDCP) is required to submit to Congress an annual drug control budget that delineates for each Federal drug control agency the resources required to implement the Strategy.

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