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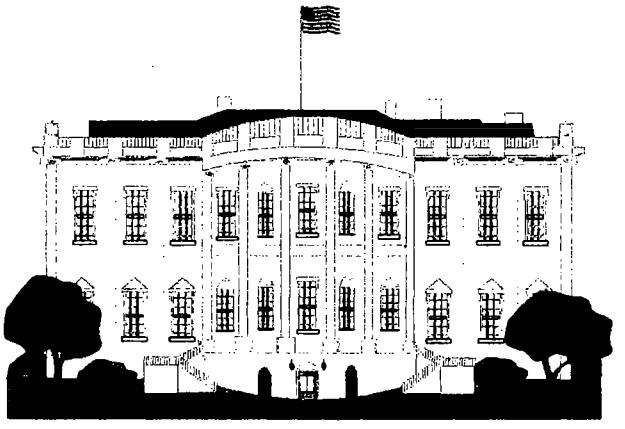

OFFICE OF NATIONAL DRUG CONTROL POLICY

CONFIRMATION BRIEFING BOOK

DR. LEE P. BROWN

MAY, 1993

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A

Divider Title: _____

Federal Drug Control Spending by Function
FY 1991 – FY 1994
($ Millions)

	1991 Actual	1992 Actual	1993 Enacted	1994 President's Budget	FY93 – FY94 Change $	FY93 – FY94 Change %
Criminal Justice System	4,385.6	4,943.1	5,374.8	5,782.6	407.7	8%
Drug Treatment	1,874.2	2,199.8	2,367.7	2,538.1	170.4	7%
Education, Community Action, and the Workplace	1,479.2	1,538.7	1,524.4	1,789.9	265.5	17%
International	633.4	660.4	538.0	490.0	(48.0)	-9%
Interdiction	2,027.9	1,960.2	1,746.2	1,765.2	19.0	1%
Research	450.1	504.5	530.9	548.2	17.2	3%
Intelligence	104.1	98.6	128.7	127.4	(1.3)	-1%
Total	**10,954.5**	**11,905.2**	**12,210.8**	**13,041.4**	**830.6**	**7%**

NATIONAL DRUG CONTROL BUDGET
BY FUNCTION

($ Millions)	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994
INVESTIGATIONS														
U.S. Forest Service	0.0	0.0	0.0	0.1	0.4	0.3	0.3	0.4	0.4	3.0	6.3	6.2	6.3	6.3
Bureau of Indian Affairs	0.7	0.8	0.8	0.8	1.9	1.7	3.6	2.3	7.6	11.8	11.1	18.5	18.8	18.4
Bureau of Land Management	0.0	0.0	0.0	0.0	0.0	0.4	0.5	0.9	0.7	4.9	4.9	4.7	5.4	2.8
National Park Service	0.1	0.2	0.5	0.7	0.8	0.2	1.2	1.2	0.9	5.7	10.9	10.8	8.6	8.6
Drug Enforcement Administration	124.2	140.5	143.7	178.0	211.1	252.9	325.1	327.3	375.2	338.2	433.1	455.4	483.4	494.7
Federal Bureau of Investigation	7.7	11.3	101.5	84.5	103.6	103.2	134.6	172.6	198.4	127.5	152.3	181.3	195.5	194.3
INS	0.1	0.1	0.1	0.1	0.1	5.5	9.8	17.1	28.5	29.3	27.6	31.7	33.7	35.3
U.S. Marshals	3.2	3.7	4.0	5.3	7.4	6.8	8.8	11.2	28.7	39.1	44.2	36.0	41.2	41.3
OCDETF	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	160.5	252.8	308.8	289.0	288.4
Bureau of Alcohol, Tobacco & Firearms	24.6	17.6	27.7	33.7	40.4	27.6	60.1	78.6	87.4	94.2	120.0	133.0	149.0	144.0
U.S. Customs	11.4	13.9	30.4	39.6	44.7	52.2	63.1	75.1	83.6	130.7	57.4	59.1	57.4	52.8
Federal Law Enforcement Training Ctr.	0.9	0.9	1.0	1.5	2.6	4.4	6.5	7.3	17.7	17.2	20.8	16.8	21.9	18.3
Internal Revenue Service	28.3	34.0	41.2	43.5	48.8	53.9	61.6	70.4	84.3	81.0	93.2	102.8	115.5	112.9
U.S. Secret Service	10.2	12.9	18.0	22.3	27.2	28.7	37.1	40.5	46.2	47.3	53.6	42.9	54.2	57.9
	211.3	235.9	369.1	410.1	489.0	537.8	712.2	804.8	959.7	1,090.4	1,288.2	1,408.0	1,479.7	1,475.7

NATIONAL DRUG CONTROL BUDGET
BY FUNCTION

($ Millions)	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994
PROSECUTION														
Judiciary	26.3	30.5	33.0	41.2	52.4	68.0	100.1	133.4	146.3	152.8	179.0	233.8	268.6	330.7
U.S. Attorneys	19.5	20.9	32.7	47.7	54.8	57.3	74.2	80.7	132.0	126.8	161.5	206.7	207.2	207.9
Criminal Division	1.6	1.9	1.8	1.9	2.7	2.7	3.3	9.4	13.3	10.6	18.5	20.2	19.2	20.4
U.S. Marshals	23.1	25.6	27.0	30.6	40.6	45.2	56.7	79.9	95.1	118.0	154.8	179.0	190.5	191.0
OCDETF	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	46.8	68.5	76.2	80.1	79.9
Tax Division	0.0	0.0	0.8	0.8	1.6	2.0	2.0	2.2	2.2	0.9	1.1	1.1	1.2	1.3
	70.6	78.9	95.3	122.2	152.1	175.3	236.3	305.6	388.9	455.9	583.4	716.9	766.8	831.2

NATIONAL DRUG CONTROL BUDGET
BY FUNCTION

($ Millions)	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994
CORRECTIONS														
Judiciary	7.0	8.2	8.8	11.0	14.0	18.2	26.8	35.7	39.2	73.4	80.5	89.6	97.0	119.4
Bureau of Prisons	74.7	97.9	118.1	121.4	182.1	219.5	339.1	465.3	772.1	1,553.8	1,011.0	1,226.8	1,305.4	1,434.9
INS	0.0	0.0	0.0	0.0	0.0	0.0	4.0	34.5	45.0	41.5	38.4	40.0	40.5	42.3
Support of Prisoners	5.9	8.0	13.1	16.4	19.5	21.1	27.9	53.3	77.1	112.0	135.1	164.1	190.6	253.4
Special Forfeiture Fund	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	87.6	114.1	140.0	148.8	215.6	258.8	397.8	588.8	933.4	1,780.7	1,265.1	1,520.5	1,633.4	1,850.0

NATIONAL DRUG CONTROL BUDGET
BY FUNCTION

($ Millions)	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994
REGULATORY AND COMPLIANCE														
U.S. Forest Service	0.1	0.3	0.3	0.4	0.2	0.6	1.0	2.7	2.6	0.0	0.0	0.0	0.0	0.0
Food & Drug Administration	1.4	0.8	0.7	0.7	0.7	1.6	1.6	1.6	6.5	7.2	6.5	6.7	6.8	6.8
Drug Enforcement Administration	17.0	20.3	25.0	21.9	25.0	12.3	15.3	16.9	19.1	19.1	21.7	21.8	21.8	22.3
Bureau of Alcohol, Tobacco & Firearms	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.7	1.6	2.2	3.2	2.9	3.4	3.3
	18.5	21.4	26.0	23.0	25.9	14.5	17.9	21.9	29.8	28.5	31.4	31.4	32.0	32.4
OTHER LAW ENFORCEMENT														
Asset Forfeiture Fund	0.0	0.0	0.0	0.0	0.0	26.0	73.0	85.0	114.3	156.5	154.3	217.7	258.3	243.5
Treasury Forfeiture Fund	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	79.5	86.5
ONDCP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.2	29.0	46.7	55.7	55.5	51.6
Special Forfeiture Fund	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0
	0.0	0.0	0.0	0.0	0.0	26.0	73.0	85.0	115.5	185.5	202.0	273.4	393.4	381.7

NATIONAL DRUG CONTROL BUDGET
BY FUNCTION

($ Millions)	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994
STATE AND LOCAL ASSISTANCE														
U.S. Forest Service	0.4	0.4	0.4	2.0	2.2	2.2	1.9	2.0	2.0	2.0	2.7	2.3	2.4	2.4
Department of Defense	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	27.6	107.4	144.0	189.0	249.6	255.6
Bureau of Indian Affairs	1.0	1.1	1.1	1.2	1.2	2.8	5.4	3.4	0.4	0.4	0.5	0.6	0.7	0.7
Bureau of Land Management	0.0	0.0	0.2	0.2	0.2	0.7	0.6	0.6	0.5	1.5	1.5	1.5	1.5	0.8
Fish and Wildlife Service	0.1	0.1	0.2	0.2	0.4	0.3	0.4	0.4	0.0	0.8	1.0	1.0	1.1	1.0
Asset Forfeiture Fund	0.0	0.0	0.0	0.0	0.0	17.0	47.0	76.0	157.3	176.8	266.8	181.9	226.0	213.0
Treasury Forfeiture Fund	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	106.5	115.9
Bureau of Prisons (NIC)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.1	5.1	5.8	6.2	6.4	7.0
Drug Enforcement Administration	21.6	19.2	23.9	22.6	29.2	12.5	13.2	11.4	13.8	15.6	16.1	16.1	15.4	15.7
Office of Justice Programs	4.5	4.2	6.7	7.2	12.0	12.7	214.6	71.5	126.6	348.4	413.0	425.0	411.2	411.6
OCDETF	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.5	5.0	5.1	0.0	0.0
Exec. Off. for Weed & Seed	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	6.6	6.7
Federal/State Partnerships	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	12.5
ONDCP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	32.9	36.0	36.0	36.0
Nat. Highway Traffic Safety Admin.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.8	5.1	6.7	8.0	6.3	7.5
Community Investment Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	125.0
Customs Forfeiture Fund	0.0	0.0	0.0	0.0	6.0	13.5	24.5	21.2	0.0	29.9	119.4	120.0	0.0	0.0
	27.6	25.0	32.5	33.4	51.2	61.7	307.5	186.5	334.1	696.5	1,015.5	992.7	1,069.5	1,211.5

OVERVIEW

CRIMINAL JUSTICE

GENERAL

This area is by far the largest of the several pieces of the Drug Control Budget. Funding in this area has nearly doubled since FY89. Drug budgets of the past several years have been criticized for putting disproportionate emphasis in this area. Arguments that law enforcement efforts have a deterrent effect and thus constitute in part a form of demand reduction have not been persuasive.

Some of the funding levels in this area are formula driven: that is, the amount scored for drug control in such areas as the Bureau of Prisons and Support of Prisoners is a function of the estimated number of individuals incarcerated for drug-related offenses. That level is projected to grow steadily, as it has for the last several years, and funding in this area will by necessity increase.

Funding levels in other programs in this area are similarly derived; the relative share of various agencies' total effort that is devoted to drug control drives the funding level. This means that in practice it is difficult (if not impossible) to reduce funding for drug control activities in these agencies without also reducing funding for other activities simultaneously. This is especially true in such agencies as the US Marshals Service, the Border Patrol, Customs (inspectors), ATF, etc. Only in DEA (and ONDCP) does adding or subtracting a dollar to the agency total generally add or subtract a dollar of drug effort.

A huge host of controversial and contentious issues surround this area. A good place to start is with the biggest account here -- the Bureau of Prisons. At nearly $1.5 billion, this is the largest single account in drug control.

As noted above, funding in this area has grown significantly, driven by the increase in the proportion of drug-related offenders. This is in turn driven by two critical factors:

1. mandatory minimum sentences and

2. the number of Federal law enforcement agents.

To reduce the BOP account, either or both of these areas could be revisited.

Reducing the number of Federal law enforcement agents would presumably result in fewer investigations, arrests, prosecutions, convictions, and incarcerations. Obviously, however, there are

significant downsides to reducing efforts to enforce drug laws.

For this reason, some have favored revisiting mandatory minimum sentences. However, it is important to note that even if the mandatory sentences were cut in half, the BOP funding level would continue to grow: it's not simply a matter of reducing the number of individuals entering the prison system; unless individuals are also **leaving** prison at a faster rate, the total prison population will rise for some years to come. Reducing mandatory minimum sentences would reduce the prison population eventually -- several years out -- but not immediately.

Another option is to consider alternative penalties for nonviolent first-time offenders, including boot camps, mandatory treatment (though hardly any Federal offenders are incarcerated simply for use), special drug courts, and the like.

Some have argued that what we need is **certainty of punishment rather than severity**. What we **have** is severity but not much certainty.

Having noted this, however, it is probably also accurate to observe that for the most part Federal drug offenders tend to be convicted of trafficking offenses, money laundering, etc., rather than possession of small amounts of drugs. Some of what is perceived in the media as harsh penalties for minor drug offenses probably refers to non-Federal crimes. Still, two Federal judges in New York have recently refused to hear any drug cases because of mandatory minimums. The issue here, though, involves the question of usurping the judges' discretionary authority to pass sentences as much as the actual severity of the mandated sentences.

In a nutshell, then, absent reducing mandatory minimum sentences (or finding alternatives to incarceration) or reducing enforcement (or both), the BOP level will continue both to dominate the law enforcement area and to be a lightning rod for critics of Federal policy.

Paradoxically, there seem to be as many stories about the level of drug-related crime as about the harshness of criminal penalties, thus inviting even more enforcement activity. FBI's UCR reports continued increases in violent crime rates (though the increase slowed between 1990 and 1991), as does the National Crime Victimization Survey. Total arrests were up 1 percent in 1991. Drug-related murders (UCR) appear to have decreased slightly since 1989, and drug-related arrests are down two years in a row. It is interesting to note that the percentage of drug offenders actually sentenced to Federal prison was lower in 1990 and 1991 than in 1989.

Obviously, community policing could be a major initiative to address this problem. An increased law enforcement presence would serve to reduce crime (including drug crime) while avoiding the problems associated with mandatory minimum sentences, prison

overcrowding, and the like.

Other items:

- Up to 1/3 of those in treatment were induced to enter treatment by the criminal justice system.

- Minority groups are overrepresented among those convicted of and incarcerated for drug offenses as well as among those receiving Federally funded drug treatment.

- There has been relatively little success in converting military facilities into boot camps (or facilities for the homeless or for drug treatment, for that matter).

- Federal funding for State and local law enforcement (OJP) grew significantly in 1989-1992 after which it has been slightly reduced (with earmarks added).

- Federal law permits Federal funds to be used to build State prisons; Federal policy has been NOT to do this.

- Treatment in prison: drug education, outpatient treatment, and counseling are available in all Federal penal institutions. Residential treatment is available in 31 institutions, with expansion planned in 1994 and 1995. However, much less is available than is perceived to be needed.

FEDERAL LAW ENFORCEMENT AGENCY MERGERS

For several years possible mergers of Federal law enforcement agencies -- or components within them -- have been considered. None has come to pass.

The most frequently considered merger would combine FBI and DEA. This issue has been raised before; it is extremely contentious. At the end of the process, the status quo was reaffirmed.

A merger of INS (especially Border Patrol) and Customs (especially inspectors) has also been contemplated. This merger would cross Departments (Justice and Treasury). The agencies have different missions and a merger would need to address those. INS has been roundly criticized in the past for mismanagement. In part this derives from the fact that up until the last year INS management has been decentralized, with regional commissioners given a great deal of autonomy. This has made it difficult for there to be centralized authority and control. In fact, except for FBI, all Federal law enforcement agencies repose a great deal of autonomy in agents in the field.

Turf battles and interagency squabbles motivated many of the

efforts to merge agencies; indeed, they motivated in part the creation of ONDCP, which was supposed to reduce if not eliminate these problems.

While there has been much improvement in this area, by no means have turf battles disappeared. The question is whether you give up too much that is good in order to get rid of turf battles and rivalries.

There is also a very real question as to the ability of law enforcement to carry out the responsibilities it has inherited in the drug area.

-- Only ONDCP has been charged in statute with **reducing the supply of drugs**. Other agencies are charged with enforcing various statutes prohibiting sales, manufacture, possession, money laundering, etc.

-- Such a mission -- critically important as it is -- often requires long-term careful planning and execution in order to make successful cases, and agents proceed up the career ladder mainly on that basis.

-- The question remains as to how well adapted law enforcement is to the task of reducing supply (or demand).

Finally, while there have been vocal critics on the Hill about an overemphasis on law enforcement, increased funding for law enforcement has been voted consistently year after year. A number of significant Members, especially of the Senate, strongly support Federal law enforcement, particularly when it is deployed against traffickers smuggling drugs across our borders (especially the Southwest Border area).

CRIME AND JUSTICE DATA 1/

	1988	1989	1990	1991	1992	% Change 1990 - 1991	% Change 1988 - 1991	Yearly % Change
FBI - Unified Crime Reports								
Total Crime Index 2/	13,923,100	14,251,400	14,475,613	14,872,883	NA	2 74	6 82	2 22
Total Crime Rate (rate per 100,000 inhabitants)	5,664.20	5,741.00	5,820.30	5,897.80	NA	1 33	4.12	1 35
Violent Crime Index 3/	1,566,220	1,646,040	1,820,127	1,911,767	NA	5.03	22.06	6 87
Violent Crime Rate (rate per 100,000 inhabitants)	637.20	663.70	731.80	758.10	NA	3.59	18 97	5 96
Total Murder Victims (does not include nonnegligent manslaughter)	18,269	18,954	20,273	21,505	NA	6.08	17 71	6.11
Murders Related to Narcotic Drug Laws	**1,027**	**1,402**	**1,367**	**1,344**	NA	**(1.68)**	**30.87**	**9.38**
Property Crime 4/	12,356,900	12,605,400	12,655,486	12,961,116	NA	2.42	4 89	1 60
Property Crime Rate (rate per 100,000 inhabitants)	5,027.10	5,077.90	5,088.50	5,139.70	NA	1 01	2 24	0.74
BJS - National Crime Victimization Survey								
Number of Victimizations 5/	35,795,840	35,818,410	34,404,000	34,730,000	NA	0 95	(2 98)	(1.00
Violent Crime 6/	5,909,570	5,861,050	6,009,000	6,424,000	NA	6.91	8.71	6 82
Violent Crimes Committed Under the Influence of Drugs or Alcohol	**NA**	**2,109,978**	**2,042,988**	**NA**	NA	**NA**	**NA**	**(3.17**
% of Violent Crimes Committed Under the Influence of Drugs or Alcohol	**NA**	**36.00**	**34.00**	**NA**	NA	**N/A**	**N/A**	**N/A**
Violent Crime Rate (rate per 1,000 persons 12 years of age or older)	29.60	29.10	29.60	31 30	NA	5.74	5.74	1.88
Household Crime 7/	15,829,880	16,127,910	15,419,000	15,774,000	NA	2.30	(0 35)	(0.12
Household Crime Rate (rate per 1,000 households)	169.60	169.90	161 00	162.90	NA	1 18	(3.95)	(1.33
Arrests - FBI Uniform Crime Reports								
Total Arrests	13,812,300	14,340,900	14,195,100	14,211,900	NA	0 12	2 89	0 96
Arrests for Drug Abuse Violations	**1,155,200**	**1,361,700**	**1,089,500**	**1,010,000**	NA	**(7 30)**	**(12.57)**	**(4.37**
Prison Population								
Total	627,600	712,364	774,375	824,509	855,958 6/30/92	6 47	31 37	9 52
State Total 8/	577,672	653,193	706,943	752,901	778,569 6/30/92	6 50	30 33	9 23
Federal Total 8/	49,928	59,171	67,432	71,608	77,389 6/30/92	6 19	43 42	12 77
% of Federal Sentenced Prisoners who are Drug Offenders 9/	**44.80**	**49.90**	**52.30**	**57.00**	**60.00 3/93**	**N/A**	**N/A**	**N/A**
Court Commitments to State Prisons - BJS						**(1988 - 1989)**		
All Offenses	245,310	297,827	NA	NA	NA	21.41	NA	21 41
Drug Offenses	**61,573**	**87,859**	**NA**	**NA**	NA	**42.69**	**NA**	**42.69**
Drugs Offenses as a % of Total	**25.10**	**29.50**	**NA**	**NA**	NA	**N/A**	**N/A**	**N/A**
Federal Criminal Case Processing - BJS								
% of Drug Offenders Sentenced to Prison	**79.20**	**84.20**	**72.00**	**72.30**	NA	**N/A**	**N/A**	**N/A**
Offenders convicted of Drug Violations in U.S. District Courts	**10,599**	**13,306**	**14,092**	**14,738**	NA	**4.58**	**39.05**	**11.61**
Mean Length of Prison Sentences for Drug Offenses (months)	**71.3**	**74.9**	**80.9**	**84.5**	NA	**4.45**	**18.51**	**5.83**
Average Time Served Until First Release for Drug Offenses (months)	**25.2**	**27.7**	**29.7**	**31.3**	NA	**5.39**	**24.21**	**7.49**
Average Time Served Until First Release for All Offenses (months)	18.7	18.7	19.2	21.7	NA	13.02	16.04	5.08
Mean Length of Prison Sentences for All Offenses (months)	55.1	54.5	57.2	61.1	NA	6.82	10.89	3.51

1/ NA: not available, N/A: not applicable.

2/ The crime index is composed of the violent crimes of murder and nonnegligent manslaughter, forcible rape, robbery, and aggravated assault and the property crimes of burglary, larceny-theft, motor vehicle theft, and arson.

3/ Violent crime is composed of murder and nonnegligent manslaughter, forcible rape, robbery, and aggravated assault.

4/ Property crime includes the offenses of burglary, larceny-theft, motor vehicle theft, and arson.

5/ Victimization is composed of personal crimes of rape, robbery, assault, and personal larceny, and household crimes of burglary, household larceny, and motor vehicle theft.

6/ Violent crime is composed of rape, robbery, aggravated assault, and simple assault.

7/ Household crimes include burglary, household larceny, and motor vehicle theft.

8/ Estimated by BJS

9/ Estimated by [illegible]

OPBA 4/23/93

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - MANDATORY MINIMUM PRISON TERMS

Mandatory minimum Federal sentences take into account the type and amount of drugs involved, aggravating circumstances, and the criminal history of the offender. However, the law does allow judges to impose sentences longer than the mandatory minimums, or a lesser sentence if the prosecutor recommends it. The laws also establish minimum periods of supervised release after the full prison sentence has been served.

A growing number of Federal judges are opposing mandatory minimum sentences since they limit their sentencing discretion. Many have argued that mandatory minimums are unduly harsh and unconstitutional. Further, many senior judges, who have some control over their dockets, have refused to handle drug cases because of these problems.

The significant growth in the Federal prison population has been attributed to the increasing number of drug arrests, mandatory minimums, and increased sentence lengths for drug offenders. It has also been argued that the shortage of judicial and correctional resources along with the growth in incarcerated drug offenders are reducing sentence lengths for violent and other offenders.

- For the period 1981 through 1992 the total Federal sentenced prison population has grown 10.8% a year while the number of sentenced drug offenders has grown at a year rate close to 20%. (Source: Bureau of Prisons)

- The percent of the total Federal sentenced population that are drug offenders has increased from 25.6% in 1981 to 59.6% in 1992. (SOURCE: Bureau of Prisons)

- Total Drug Enforcement Administration domestic arrests increased from 13,266 in 1981 to 23,154 in 1991, an annual increase of close to 6%. (SOURCE: Drug Enforcement Administration)

- The average sentence length for drug offenses increased from 50 months in 1981 to 84.5 months in 1991, an increase over the period of approximately 70%. (SOURCE: Bureau of Justice Statistics)

- The average sentence length for violent offenses decreased from 132 months in 1981 to 91.1 month is 1991, a decrease of about 30% over the period. (SOURCE: Bureau of Justice Statistics)

- The average sentence length for property offenses decreased from 29.8 months in 1981 to 21.6 months in 1991, a decrease of approximately 28%. (SOURCE: Bureau of Justice Statistics)

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - THE SENTENCING PROJECT REPORT: DOES THE PUNISHMENT FIT THE CRIME?

In March 1993, The Sentencing Project (a non-profit organization that promotes sentencing reform and conducts research on criminal justice issues) issued a report arguing that the U.S. criminal justice system deals more harshly with minority substance abusers. For drunk drivers, who are predominantly white males, the criminal justice system keeps them functional and in society. Drug possession offenders are disproportionately Black and Hispanic males, and society's response has essentially been incarceration. Some of the main findings of the study:

- Drunk drivers are responsible for an estimated 22,000 deaths annually, along with an estimated $46 billion in injuries and related costs. Alcohol is associated with 94,000 deaths annually (estimated societal costs: $85B).
- Drug use results in a estimated 21,000 deaths annually through overdoses, disease, and indirectly, through the violence associated with the drug trade, along with an estimated cost of $58 billion in drug abuse costs.
- Convicted drunk drivers are predominantly white males.
- Persons convicted of drug possession are disproportionately low-income African-American and Hispanic males.
- Drunk drivers are generally treated as misdemeanants.
- Drug possession arrests are generally charged as felonies, and frequently result in sentences of incarceration.
- Although African-Americans constituted 24 percent of monthly cocaine users in 1990, they represent 48 percent of cocaine possession arrests.
- Blacks and Hispanics totalled 91 percent of all drug possession offenders sentenced to prison in New York and 71 percent in California.
- In New York, African-Americans and Hispanics convicted of drug possession are three times as likely to be sentenced to prison as whites. In California, they are twice as likely.

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OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - SPECIAL DRUG COURTS

- Special courts have been established in a number of locations, to respond to the growing number of drug cases and the impact of those cases on the time required for court processing.

- Many of these courts have achieved some success in reducing processing time, by segregating drug cases and employing specific tracking approaches acceptable to prosecution, defense, and probation departments, as well as judges.

  -- For example, Philadelphia cut median processing time for narcotics cases from 294 days to 158, Milwaukee from 253 to 117, and Chicago from 245 to 69.

- Chicago and Philadelphia courts are viewed as trading more lenient sentences for quicker pleas on the part of drug defendants.

- It is noteworthy that this focus on drug cases did not hinder processing of other cases but resulted in reduced processing time, in all three cities, for nondrug cases as well.

- The Miami/Dade County drug court differs from the others cited, in that its objective is to break the cycle of drug use and recidivism, by getting offenders into drug treatment, rather than to expedite processing.

  -- The judge, the prosecutor, the public defender and the treatment staff function as a team committed to getting drug users into treatment and keeping them in treatment through to completion.

  -- During an extended period of pretrial release, defendants are provided with services that include detoxification, assessment, acupuncture, frequent urinalysis, group and individual counseling, self-help groups, vocational and educational programming and employment referral.

  -- At each appearance, the judge has immediate access to cumulative information on treatment participation, treatment progress and urinalysis results.

  -- Crowding and processing time are not reduced. Indeed, police indicate that they make more drug possession arrests than previously because there is a viable drug program available through the Drug Court.

- Because of the complex nature of its objectives and the time required to apply appropriate measures of progress, a comprehensive outcome evaluation will be required to determine the effectiveness of the Miami/Dade County drug court. Such a study has not yet been done.

- It is clear that transfer of this program to other jurisdictions would require that they put a number of prerequisites in place, prior to start up.

  -- An understanding of drug use and of criminal justice populations, a willingness to depart from the adversary process, and the infrastructure and staff necessary to treat and monitor offenders are essential prerequisites.

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - FUNDING FOR COMMUNITY POLICING

- The total 1994 budget for The Community Policing Program is $50 million. This program is considered to be 25% -- or $12.5 million -- drug related.

- The Community Policing Program focuses on fighting crime by directing resources to the State and local levels for implementing community-policing techniques. State and local governments, as well as qualified community organizations, may apply for grants to create or supplement community-policing programs, which may include hiring new officers or redeploying existing officers. The program will require a 50 percent non-Federal match.

- The long range goal of the program is to reduce violent crime by promoting cooperative efforts between police departments and a community; by placing more officers on the streets; and to prevent crime by employing proactive policing techniques.

- Additionally, the Administration has proposed the Community Investment Program that requests $125 million for community policing efforts.

	FY 94 Total	Drug-Related
Community Policing Program	$50M	$12.5M
Commmunity Investment Program	$1,013M	$125.0M
		$137.5M

BLRS-2
5/18/93

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - ALTERNATIVES TO INCARCERATION

- The Attorney General has said she considers incarceration a last resort, especially regarding drug-dependent offenders, and favors an expansion of community approaches over continued prison building efforts.

- Support for States and localities will proceed on three fronts.

  -- Criminal justice and substance abuse block grants will target the treatment of drug-dependent offenders as a priority for expenditure.

  -- Discretionary and categorical grants will demonstrate effective approaches, document treatment models, and provide support for program infrastructure, such as management information systems.

  -- Technology transfer programs, such as the HHS Treatment Improvement Protocol (TIP) program, and technical assistance programs, such as the DOJ Treatment Alternatives to Street Crime (TASC) assistance and management information system programs, will continue.

ODR-47
5/18/93

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - ASSET FORFEITURE FUNDS

- Proceeds from the Justice Asset Forfeiture Fund have been provided to State/local law enforcement agencies, not just Federal drug enforcement agencies. By law these proceeds must be used to benefit drug enforcement operations. However, Chairman Conyers of the House Committee on Government Operations has drafted a bill which would allow the Fund to be used for demand-related activities. There may be some community policing programs in drug-infested areas that could be eligible to receive funds now.

- The Special Forfeiture Fund (SFF), allocated to ONDCP, provides the mechanism for Congress to appropriate funds for demand programs and community-based programs, and it could be used for that purpose in FY 1994. In Fiscal Year 1993, $15.3 million was transferred to HHS for the Capacity Expansion (Treatment) Program.

- Additionally, Congress created the Treasury Forfeiture Fund in FY 1993. At the end of each fiscal year, up to $10 million can be transferred from this fund to the SFF. This money is only authorized to be appropriated for Department of Education drug grants.

NOTE: There are opposing views on this issue in the Congress. There is also opposition to this proposal from State and local law enforcement and from national law enforcement associations.

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - GANGS AND DRUG-RELATED VIOLENCE

- Revenue-generating criminal activity is the hallmark of gangs in America. Drug trafficking is frequently the cornerstone of their illegal enterprises. Often violence is associated with these gangs and their criminal endeavors.

- Primary responsibility for responding to gang and violence problems rests with state and local jurisdictions. However, the Federal government must support and assist these local efforts.

- There are several areas where state laws and authorities fall short of those available to the Federal law enforcement community. Where overlap does not exist, unique Federal authorities can be exploited to their fullest to assist state and local jurisdictions.

- The following elements of Federal law enforcement can be brought to bear on the problem of gangs and violence. This does not necessarily involve increases in Federal expenditures, but may require a reordering of resources and priorities.

  -- **BLOCK GRANTS -** Every effort should be made to assure that states are using sufficient funds from Federal block grants to expand community policing. By forming partnerships with local communities, police departments across the country have shown that neighborhoods can purge not only gangs, but rampant drug use from their midst. Community policing seeks the involvement of citizens not only to give police information to react to gangs and violence but to implement proactive programs to prevent neighborhoods from being overtaken by violent gangs.

  -- **BUREAU OF ALCOHOL, TOBACCO, AND FIREARMS (ATF) -** While many states have gun laws, for the most part these laws are less effective than Federal laws. Therefore, the unique authorities and expertise of ATF must be used in concert with local authorities. The ATF is the principal agency that addresses guns and violence. Where there are deficiencies in state laws, it will be necessary to bring cases to trial in Federal court.

-- **IMMIGRATION AND NATURALIZATION SERVICE (INS)** - Much of the violence in America is perpetrated by aliens. Approximately 25% of the Federal prison population are illegal aliens or aliens who have violated the terms of their visas. INS estimates that over 100,000 felony offenders in the nation's jails and prisons are aliens. Therefore, we must increase the involvement of the INS in local task forces. Some of the most violent gangs in this country are composed of alien groups, many of which are involved in the drug traffic with ties to their native homeland. Chinese, other Southeast Asians as well as West Africans are responsible for much of the heroin traffic. Cocaine is distributed by Colombians and a growing population of Dominicans. In addition, Colombians are increasingly involved in the heroin traffic. Marijuana and cocaine are trafficked by Haitians, Jamaicans, and other Caribbean ethnic groups.

-- **U.S. POSTAL INSPECTION SERVICE (USPIS)** - Improper use of the U.S. mail is an area where State laws are insufficient. Gangs use the mail to transport their instruments of crime and further their conspiracies. The tools of the USPIS can be better focused to assist state/local jurisdictions combat gangs.

-- **FEDERAL BUREAU OF INVESTIGATION (FBI)** - Working with state and local law enforcement on their Safe Streets Violent Crime Initiative, the FBI currently has 90 separate task forces in 49 Field Divisions. Hundreds of FBI special agents are assigned to this effort to combat gangs, violence and related drug traffic. The intent of the task forces is to eliminate duplication and complement efforts of state and local law enforcement. FBI resources are used to conduct investigations and prosecutions, provide support in criminalistics and intelligence, and apprehend violent fugitives.

-- **U.S. Marshals Service (USMS)** - The USMS is the primary Federal fugitive apprehension agency. They work closely with other Federal as well as state and local agencies to hunt down fugitives and bring them to justice. Violent criminals are a top priority.

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - THE HIDTA PROGRAM

- Section 1005 of the 1988 Anti-Drug Abuse Act created a program to stop the flow of drugs through designated High Intensity Drug Trafficking Areas (HIDTA). The HIDTA program must be assessed for its efficacy, with the goal of determining the cost-effectiveness of continuing the program or expanding the program to other high intensity areas.

- In 1990, the Director of ONDCP, in consultation with the Attorney General, heads of National Drug Control Program agencies, and the Governors of several States, designated New York, Miami, Houston, Los Angeles, and the Southwest Border as High Intensity Drug Trafficking Areas. The designations were based upon the requirements of the statute to consider the extent to which:

  -- the area is a center of illegal drug production, manufacturing, importation, or distribution;

  -- State and local law enforcement agencies have committed resources to respond to the drug trafficking problem in the area, thereby indicating a determination to respond aggressively to the problem;

  -- drug-related activities in the area are having a harmful impact in other areas of the country; and

  -- a significant increase in allocation of Federal resources is necessary to respond adequately to drug-related activities in the area.

- The HIDTA Program is a multi-dimensional, multi-agency, focused effort to dismantle the most significant drug trafficking organizations. The HIDTA Program unites Federal, State, and local law enforcement and regulatory agencies and National Guard soldiers in the HIDTAs to produce a true team effort against the most significant organizations smuggling drugs into and laundering their proceeds through the areas of our country with the most severe drug trafficking problems.

The FY 93 HIDTA Program

- By law, ONDCP is required to transfer $86 M of HIDTA funds within 90 days after enactment of the legislation (by January 3, 1993). Transfers of the funds should be completed by the end of December. This year, State and local HIDTA funds will be transferred directly to State and local law enforcement

agencies in the form of cooperative agreements. Major initiatives in the FY 93 program include:

-- Miami - A 230-member, collocated, multi-agency task force focusing on Cali Cartel money laundering and an innovative State and local intelligence and operations center for 57 agencies in South Florida.

-- Houston - A 100-member, collocated, fully integrated task force focusing on Cali Cartel kingpins and a highly productive Texas Department of Public Safety post seizure analysis intelligence center.

-- Los Angeles - A 150-member, collocated, multi-agency, multi-jurisdictional task force investigating several major Colombian and Mexican drug trafficking and money laundering organizations, a Joint Drug Intelligence Group, and several State and local information management systems.

-- New York - Two new, multi-agency, collocated task forces focusing on high level drug money laundering in Manhattan and on heroin trafficking in New Jersey.

-- Southwest Border - Two new collocated money laundering task forces in San Diego and El Paso and State and local information sharing systems in California, New Mexico, and Texas.

Cracking Down

BY JOHN J. DILULIO JR.

Reckoning: Drugs, the Cities, and the American Future
by Elliott Currie
(Hill and Wang, 405 pp., $25)

The Making of a Drug-Free America: Programs That Work
by Mathea Falco
(Times Books, 254 pp., $22.50)

Against Excess: Drug Policy for Results
by Mark A. R. Kleiman
(Basic Books, 474 pp., $26)

Drug Legalization: For and Against
edited by Rod L. Evans and Irwin M. Berent
(Open Court, 355 pp., $32.95, $14.95 paper)

The Clinton administration plans to shrink the Office of National Drug Control Policy, also known as the drug czar's office, from nearly 150 staffers to just twenty-five. But as the ONDCP's body shrinks, its head will swell. The next drug czar, we're told, will be elevated to Cabinet-level status. There's a slight historical irony here. In the 1980s it was congressional Democrats, not Reagan-Bush Republicans, who fought for the creation of the drug czar's office. Reagan vetoed a 1983 crime bill he wanted because it contained a drug czar provision. He accepted the drug czar post only as part of a compromise on the Anti-Drug Abuse Act of 1988. That bill enjoyed strong bipartisan support. The "Clinton-Gore Crime and Drug Plan" issued from Little Rock during the campaign highlighted the bill as one of Senator Gore's great achievements.

But let no one stand on ceremony. If the new administration's decision to slash the ONDCP while elevating its head embodies a decision to pause and think about drug policy, then it's a very wise decision indeed. For the truth is that no one—not unreconstructed drug warriors, not legalization advocates, not mainstream critics of the war on drugs—has a well-formulated idea of what to do next. After twenty-five years of debate, precious little is actually known about drug use and abuse and drug-related crime in America. And virtually nothing is known about what, if anything, government can do (or refrain from doing) to make things better.

During the Nixon administration, the federal government waged its first war on drugs. Since then each drug war has been progressively more ambitious and expensive. The drug war waged by the Reagan and Bush administrations was the most aggressive and costly of them all. Between 1981 and 1989 the number of adult arrests for illegal drug sale or manufacture quadrupled to more than 400,000. Over the same period, the number of arrests for illegal possession more than doubled to nearly 850,000. Federal spending for drug control rose in constant dollars from about $1.5 billion to $6.7 billion. By one estimate, in the 1980s all levels of government spent $100 billion on drug control.

Experts on drug policy generally agree that the war on drugs has failed. There are many different paths to this conclusion, but most analysts proceed from the same basic reading of the data on trends in drug use and abuse. The consensus is roughly as follows: the number of Americans who use illegal drugs is much lower today than it was in the mid-1980s. There has also been a small decrease in the number of drug-abusing Americans—persons whose frequent or reckless use of drugs results in serious problems for themselves or others (child neglect, spouse abuse, job loss, mental or physical debilities). But drug abuse remains a problem in the inner cities.

Echoing the consensus view, Elliott Currie insists that there are now "two drug problems in America":

> One is the problem of the affluent . . . and it has been steadily decreasing for many years, for reasons unrelated to the drug war. The other one is the problem of America's have-nots. That problem has grown malignantly in the face of the drug war. . . . The traditional scourge of the inner-city poor—heroin—has quietly spread. And alongside the problems of cocaine and heroin are other dismaying changes: the proliferation of drugs that were barely on the horizon a generation ago, including PCP, methamphetamine, and inhalants; and the devastating link of drug use with AIDS.

The diagnosis sounds reasonable as far as it goes. But the problem with Currie's analysis is that it treats unknowns as givens. The same goes for the analyses of most other leading drug policy analysts. The fact is that survey data on the extent of drug use and abuse in this country are weak and spotty. Even the best estimates of the number of crack-cocaine addicts, for example, are not much more than guesses. And for some drugs, notably heroin, meaningful post-1980 figures are nowhere to be found.

It is also by no means certain that the drug problem is now concentrated or growing mainly or solely among the inner-city poor. For example, a recent Urban Institute study by Ansley Hamid suggests that crack-cocaine use has dropped to a trickle among the young inner-city poor but increased among older and middle-class urbanites. And the relationship between drug abuse and crime remains a chicken-and-egg question. The best empirical studies hint only that drug abuse acts as a "multiplier" of crime: the onset of criminal activity normally occurs prior to drug abuse. Drug abuse only serves to increase the frequency with which some types of offenders commit some types of crimes. Estimates of how much of a multiplier effect drug abuse has on crime are all over the board, and much depends on how one measures "drug-related" crime.

But even if one accepts the consensus reading of the trends, the less than reliable data make it impossible to know whether the war on drugs has had much, little or nothing to do with the national downturn in drug consumption, and equally difficult to fathom what connection, if any, exists between the war on drugs and the condition of the inner cities. Mark A.R. Kleiman offers this intellectually honest if rather defeatist admission about the state of America's drug-and-crime problem: "Public policy toward drugs involves so many unknown, almost unknowable, facts and so many complicated issues of value that any certainty about which of two alternative policies is the better is likely to be misplaced."

Ideological bents aside, there are really just two kinds of drug policy experts: those who know they're skating on empirically thin ice, and those who don't (or who probably do but won't admit it). In at least three areas, the evidence is murkier, and the obstacles to new policies are steeper, than the latter group of experts would have one suppose: international supply-control initiatives, domestic drug law enforcement measures and demand-reduction programs.

Mathea Falco argues that international supply-control initiatives are futile. There is something to be said for this position. The Nixon administration, for example, made vigorous efforts to block the supply of heroin from Mexico and Turkey. During the late 1970s heroin addiction declined. By 1980 Turkey was no longer a supplier and Mexico's share of the U.S. heroin market had fallen dramatically. But the story has an unhappy ending. South and Southeast Asian countries quickly replaced Mexico and Turkey as suppliers for the American heroin market. By 1982 heroin was once again readily available in the United States. Likewise, when the Reagan administration effectively slammed the door on international marijuana smugglers, domestic producers simply increased their production.

Yet there are at least two problems with the way that Falco writes off international supply-control initiatives, one practical, the other analytical. The practical problem is that the global supply of illegal drugs is exploding. According to a recent Brookings Institution study by Stephen Flynn, during the last few years the worldwide production of opium poppy, coca and cannabis has soared. In 1991 cocaine production in Latin America grew by an estimated eighty-five tons. And Eurasia and many other parts of the world have become major suppliers of illegal drugs. The United States has signed numerous bilateral and multilateral treaties that put it at the center of international supply-control efforts. It is hard to imagine how the United States could walk away from these agreements, many of which it twisted foreign arms to get, or how it could ignore the flourishing illegal drug trade overseas.

The analytical problem is that we do not know how much international supply-control initiatives contribute on the margins to reducing the supply of drugs on U.S. streets. Borrowing loosely from research by Peter Reuter of Rand and others, Falco asserts that even if the United States "were to seize half the cocaine coming from South America—a wildly optimistic prospect—cocaine prices would increase by a little more than 5 percent." Since prices are already so low, "such increases would not affect consumption." She adds that "a relatively small volume of drugs can supply our entire market.... Four Boeing cargo planes or thirteen trailer trucks can supply American cocaine consumption for a year."

These assertions are too cocksure. The studies on which they're based acknowledge methodological and data problems that Falco ignores. But let's assume that she's right. One must still consider the marginal drug-consumption reduction benefits of international supply-control measures. As James Q. Wilson has argued, these benefits may well be quite small, but that is no excuse for not weighing them. In *Drug Legalization: For and Against*, Wilson agrees that the Nixon administration's measures against heroin from Mexico and Turkey were ultimately defeated by alternative sources of supply. But Wilson, who chaired Nixon's National Advisory Council on Drug Abuse Prevention, stresses that the three-year heroin shortage caused by these measures interrupted the easy recruitment of new users. He cites a major study that found that most Vietnam veterans who had used heroin while in Southeast Asia "gave up the habit when back in the United States. The reason: here, heroin was less available and sanctions on its use were more pronounced."

On the effects of anti-drug law enforcement efforts, Falco parrots the drug war critics' party line. "Record numbers of arrests," she asserts, "have not diminished violent crime, addiction and urban blight." Currie goes further. He declares that the failure of the "punitive" drug wars is "devastatingly obvious":

> The failure of American drug policy is depressingly apparent. Twenty years of the "war" on drugs have jammed our jails and prisons, immobilized the criminal justice system in many cities, swollen the ranks of the criminalized and unemployable minority poor and diverted desperately needed resources from the other social needs.

But there is no factual basis for Falco's and Currie's confidence that law enforcement efforts have been all cost, no benefit. Wilson summarizes studies that found a reduction in heroin use among young blacks in Harlem: "Why did heroin lose its appeal for young people? When the young blacks in Harlem were asked why they stopped, more than half answered 'trouble with the law' or 'high cost' (and high cost is, of course, directly the result of law enforcement)."

In fact, it is not unreasonable to argue exactly the opposite of what Currie and Falco do, namely, that the problem with the "get-tough" approach of the last twenty-five years is that it hasn't actually been followed. Despite mandatory sentencing laws, most drug offenders and other felons continue to spend only a fraction of their sentences behind bars. In 1986 the median time served in confinement was fifteen months, the same as it was in 1976. In 1984 most felons served less than half of their time behind bars.

Indeed, while imprisonment rates (the number of prisoners divided by the total U.S. population) have soared, what might be termed "punitivity rates" (the number of prisoners divided by the number of crimes for which people may be sent to prison) most certainly have not. The number of commitments to state prisons for each 1,000 serious crimes was 163 in 1960, 100 in 1970, 134 in 1980 and 131 in 1989. Between 1975 and 1986 the number of days a criminal could expect to stay in prison was about one-fifth what it was in 1960. And in many states, the likelihood of a convicted felon being sentenced to prison has remained under 50 percent for all crimes except homicide.

The risks of going to prison for drug crimes may be especially low. Based on a survey conducted in Washington, D.C., Reuter has calculated that a drug dealer who makes 1,000 transactions in the course of a year faces an imprisonment risk per transaction of only about 1 in 4,500—much lower than the risks associated with other crimes, such as burglary and robbery. A prisoner self-report survey in 1990 found that the average number of unpunished drug offenses committed each year by the typical prisoner ran into the hundreds. Perhaps this helps to explain why more than half of the prisoner-respondents agreed that experienced criminals "never seriously think about going straight."

Thus the arrest and imprisonment binge of the 1980s can just as well be viewed as mild relief from a starvation diet that began in the 1960s and early 1970s. Currie's and Falco's notion that inner-city citizens would be better off with even less criminal justice action against the predatory street punks and drug gangsters in their midst borders on the fanciful. Like Currie and Falco, Kleiman doubts that stepped-up enforcement efforts would make much of a difference. But he is at least open to the evidence that "the benefits to potential victims of confining the average predatory criminal" may exceed the costs. And he acknowledges that "the law enforcement system is most inadequate where

poor people live and least likely to take seriously crimes against them or occurring in their neighborhoods."

When it comes to putting something in place of the war on drugs, Falco opts for a new generation of "demand-reduction" policies. She makes her case by stringing together anecdotes about "programs that work"—prevention programs for elementary and secondary schoolchildren; treatment programs for addicted criminals; education programs sponsored by corporations; and take-back-the-streets programs forged between neighborhood groups and local police. She insists that "a drug-free America is within our grasp" because "we have learned how to reduce demand successfully."

I wish that Falco was right, but she's not. The plural of anecdote is data, but there is no solid evidence that successful drug education, prevention and treatment programs can be duplicated widely. Her inspiring vignettes do nothing to alter this unfortunate reality. So far as anyone can tell, successful programs depend on the lucky accident of caring and competent providers. The talents, energies and ethics of the people who make these programs work do not travel well and cannot be cloned by policy fiat, however well intentioned.

The one exception seems to be prison-based drug treatment programs. Over the last five years, the federal prison system developed a multidimensional (education, counseling, after care) drug treatment program that has benefitted thousands of inmates. With only slight federal assistance, many states have followed suit. More and better prison-based drug treatment programs are surely needed.

By 1990 state prisons had more than 100,000 drug education and counseling slots, and many systems reported a surplus of spaces. But all slots are not created equal. There is tremendous state-by-state variation in how the treatment needs of prisoners are assessed and handled behind bars. Data are shaky, but most research finds that anywhere from 40 to 80 percent of arrestees and prisoners have used or abused drugs at some point in their adult lives. Thus, were all states to follow the federal system's drug classification and treatment protocols, my rough guess is that we'd probably need at least 450,000 slots nationwide for a total prison population of around 900,000.

Inexplicably, Falco seems unaware of the promise in prison programs, misplaying the evidence on all sides. She cites only one narrowly focused General Accounting Office report that concluded that drug treatment in federal prisons is inadequate, and that most prison-based drug treatment programs are ineffective, despite plenty of other research to the contrary. She laments Americans' "ambivalence toward 'treating' criminals even when their crimes are directly related to addiction," adding that "Americans are reluctant to approve any additional spending for the already costly criminal justice system." But every opinion survey shows strong public support for treating addicted criminals, and increased spending on criminal justice remains highly popular.

Currie doesn't share Falco's faith in programs as the answer to the nation's drug-and-crime dilemma. He rejects all "traditional strategies" (law enforcement, treatment, legalization, international interdiction). Finding what he thinks are profound policy lessons buried in outdated urban sociology textbooks, he claims that the only way to save "the American future" is by a complete overhaul of the cities' social and economic structures.

Currie proposes that this overhaul be accomplished by massive public infrastructure spending, tax reform, health and welfare reform and a few other major policy changes that, if enacted, would make the Great Society look like a rider to a National Monuments Service appropriations bill. His hugely expensive recommendations are politically impossible. They are tantamount to a loud paleoliberal whine that will produce nothing.

Kleiman's virtues as a policy analyst are his undoing as a policy adviser. Overly mindful of the ambiguities in the evidence, he dishes out a bunch of drug policy vanillas—"low-arrest strategies," higher taxes on alcohol, nicotine and (maybe) marijuana, and a vaguely worded call for a new legal category of "grudgingly tolerated vices." On cocaine, heroin and other substances that have a "high ratio of problem abuse to total use," he tips his hat to the status quo.

Given the limited state of knowledge, what should the next drug czar, feet elevated firmly on the Cabinet table with twenty-five staffers at hand, do? If he or she wants to gain some real intellectual leverage on the job, I would suggest two things. First, confront openly the $64,000 questions about the efficacy of anti-drug law enforcement. As the drug legalization advocate Ethan Nadelmann has observed, there are a certain number of citizens for whom drug laws represent the principal bulwark between an abstemious relationship with drugs and a self- and other-destructive one. Whatever direction the next drug war takes, it would be immensely useful to know more about the likely magnitude

and composition of this vulnerable population.

The intellectual climate is right for such a probe. Contrary to the impression left by Falco and Currie, today's leading voices for and against drug legalization make no claims about their ability to predict what any given form of legalization might bring. Nadelmann admits that the variables are too numerous and our analytical tools too paltry to know whether legalizing some or all drugs would do more harm or good. Wilson concedes that it's impossible "to know what our society would be like if we changed the law to make access [to illegal drugs] easier." Although he believes strongly (as I do) that legalizing drugs would probably have disastrous social consequences, he admits, "I may be wrong. If I am, then we will needlessly have incurred heavy costs in law enforcement and some forms of criminality."

Whatever the future direction of drug policy in this country, some good might come from debating the legalization option more openly than it has been so far. At a minimum, it might help to clarify the costs and benefits of alternative drug control policies and mop up some popular misconceptions in the bargain. Let me offer just two examples.

Legalization advocates are hardly alone in believing that the war on drugs has placed tens of thousands of petty first-time drug-law violators behind bars. Not so. In 1991 more than 93 percent of all state prisoners were violent offenders, repeat offenders (one or more prior felony convictions) or violent repeat offenders. The vast majority of "drug" criminals behind bars were convicted of sale or manufacture, not simple possession, and had prior criminal records. Many of them would be and should be incarcerated even if the anti-drug laws did not exist.

On the other hand, drug legalization experts are almost certainly right in questioning the general deterrence value of anti-drug law enforcement. By locking up serious drug criminals, society buys protection from the crimes (and not just drug crimes) that these particular offenders would have committed if they were free. That alone may make imprisoning them well worth the price. But drug warriors have greatly underestimated the extent to which drug offenders taken off the streets are immediately replaced by others.

In addition to debate, the new drug czar might use his or her bully pulpit to encourage states and localities to enforce existing anti-drug laws. I'm not talking about "getting tougher." I'm talking about changes in enforcement strategies and correctional practices that would keep serious drug-law violators behind bars for 70 percent to 80 percent of their terms in accordance with the mandatory sentencing laws that are now on the books in many jurisdictions. As it now stands, fewer than half of those convicted of drug trafficking are sentenced to prison. In 1988 the average maximum sentence imposed on drug traffickers was five-and-a-half years. But the estimated time actually served by drug dealers was just twenty months, or less than one-third of the average maximum sentence length. Briefly, this "radical experiment"—the serious enforcement of existing laws—would involve at least three steps.

First, we need to put at least 100,000 more cops on foot patrol in the inner cities. The federal government can and should pay for it. I'm all for community policing, but let's recognize that cops are not community kibitzers with badges. They are trained and authorized to use force in detecting and arresting people who break the law. Second, prosecutors and judges would need to tighten the screws on drug-law violators who are used to copping pleas to lesser charges and spending little or no time locked up. And, third, while we have offenders in hand, let's make participation in well-structured drug treatment programs a condition of any type of furlough and any form of early release or parole. The federal government should mandate these programs, and pay for them, too. Whatever else may be true about the nation's drug and crime problem, there is no practical or moral substitute for ridding poor inner-city neighborhoods of people who assault, rape, rob, burglarize, deal drugs and murder. The law-abiding people who live in these places demand and deserve such protection.

Finally, would-be drug czars take note: only three cents of every government dollar goes for criminal justice agencies. The federal government spends barely a penny of every dollar on justice. With the connivance of former OMB chief Richard Darman, Bush routinely halved the spending requests of the first drug czar, William Bennett. A "drug-free America" is not possible. But it may yet be possible, and highly affordable, to devise ways of better protecting inner-city Americans from drug punks, street gangsters and other criminals.

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Divider Title: _____

Federal Drug Control Spending by Function
FY 1991 – FY 1994
($ Millions)

	1991 Actual	1992 Actual	1993 Enacted	1994 President's Budget	FY93 – FY94 Change $	FY93 – FY94 Change %
Criminal Justice System	4,385.6	4,943.1	5,374.8	5,782.6	407.7	8%
Drug Treatment	1,874.2	2,199.8	2,367.7	2,538.1	170.4	7%
Education, Community Action, and the Workplace	1,479.2	1,538.7	1,524.4	1,789.9	265.5	17%
International	633.4	660.4	538.0	490.0	(48.0)	-9%
Interdiction	2,027.9	1,960.2	1,746.2	1,765.2	19.0	1%
Research	450.1	504.5	530.9	548.2	17.2	3%
Intelligence	104.1	98.6	128.7	127.4	(1.3)	-1%
Total	**10,954.5**	**11,905.2**	**12,210.8**	**13,041.4**	**830.6**	**7%**

NATIONAL DRUG CONTROL BUDGET
BY FUNCTION

($ Millions)	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994
DRUG ABUSE TREATMENT														
Department of Defense	12.4	21.4	23.3	24.1	18.5	19.6	20.9	22.1	12.4	16.6	15.0	17.4	14.8	15.2
Department of Education	6.8	7.3	9.1	11.3	12.7	15.9	20.0	24.9	22.6	61.2	74.1	88.6	87.7	88.8
Administration for Children and Families	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	31.7	31.7	31.8	31.8
ADAMHA	156.1	120.0	130.1	128.5	136.5	130.7	263.3	281.0	463.9	727.9	774.9	829.2	0.0	0.0
SAMSHA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	884.2	962.3
Health Care Financing Administration	70.0	70.0	80.0	90.0	100.0	110.0	120.0	130.0	140.0	170.0	190.5	201.8	231.8	261.2
Health Resources Service Administratio$_r$	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	13.2	16.5	20.9	39.5
Human Development Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.9	0.0	0.0	0.0	0.0
Indian Health Service	1.5	1.6	2.1	2.3	2.4	2.4	21.7	16.2	18.7	30.1	32.4	32.2	41.4	35.9
Judiciary	4.2	4.9	5.3	6.6	8.3	10.8	15.9	21.2	23.3	31.9	34.6	36.5	41.3	50.8
Bureau of Prisons	2.9	2.9	2.8	2.7	3.1	3.3	3.8	4.3	4.1	8.0	10.7	21.5	22.3	24.5
Office of Justice Programs	0.0	0.0	0.0	0.0	0.0	1.2	19.6	8.1	34.4	88.9	83.1	80.0	87.8	87.9
ONDCP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.2	4.0	5.6	5.7	5.5	1.6
Department of Veterans Affairs	259.9	277.5	296.4	316.7	343.9	341.8	341.8	360.7	425.8	492.9	608.4	838.6	898.2	938.7
	513.8	505.6	549.1	582.2	625.3	635.7	827.1	868.5	1,146.3	1,636.4	1,874.2	2,199.8	2,367.7	2,538.1

OVERVIEW

DRUG TREATMENT

The overall effectiveness of drug treatment is well established. Treatment has been found to reduce illicit drug use and criminal behavior, and to improve the social and occupational functioning of drug abusers. Recent evidence indicates that it is also a useful AIDS prevention strategy.

For the majority of those addicted to drugs such as heroin or cocaine, a single episode of treatment will not provide a cure. Drug abusers may pass through cycles of drug dependence, treatment, abstinence, and relapse. However, a commitment to the care of individuals affected with addictive behavior over their lifespan is crucial and effective because each treatment episode extends and maintains abstinence.

It is estimated that 4 million persons will meet the clinical criteria for drug dependency and abuse in FY 1994. The treatment goal for FY 1994 is approximately 2.5 million persons. Of this total, funding will serve 1.4 million persons, creating a shortfall of close to 1.1 million persons (420,000 slots). In order to meet the treatment goal, an additional $2 billion will be required.

OWNERSHIP

Most treatment programs are privately owned (82%). Of these, 78% operate as not-for-profit organizations. State and local governments directly operate 15% of treatment programs. The Federal government, primarily through the Bureau of Prisons, Department of Defense, Indian Health Service, and Department of Veterans Affairs, operates 3% of treatment units. Native American tribal governments own less than 1%.

COST

The current cost of drug abuse treatment is relatively low. However, the cost varies greatly depending on the setting.

- Hospital inpatient care is the most expensive on a daily basis ($300-600 per day), but usually it is of short duration (30 days or less).

- Treatment in nonhospital residential programs is less expensive on a daily basis ($50-100 per day), but it commonly lasts longer (a few months to two years).

- Programs that do not require the individual to live-in are the least expensive, both on a daily basis ($5-15 per day) and over a full course of treatment, which can extend over several years.

The type of treatment setting that individuals enter usually is not based on diagnostic considerations, but rather, whether they have insurance, what their personal preferences are, or what modes of treatment are available in the local community.

FINANCING

Private Insurance. The extent of private insurance coverage for drug treatment improved throughout the 1980s. In 1990, more than 90% of insurance plans had explicit coverage for drug treatment. Even individuals without explicit benefits in their private insurance coverage are likely to find that some services are reimbursable.

Government Financing. Unlike the general health care system, where only 42% percent of the cost of services is reimbursed through government sponsored financing programs (Medicare, Medicaid, workers' compensation, public assistance, etc.), government supplies 75% of the funds for drug treatment. The States traditionally have been the major source of government funds for treatment followed by the Federal Government and then county and local agencies.

- The major funding mechanism that the Federal Government uses is the Substance Abuse Block Grant which is administered by the Department of Health and Human Services. The Block Grant is allocated to States (and Territories) using a formula that takes the characteristics of the State's population into account. Each State then redistributes the funds either directly to treatment providers or to county or local governments which in turn give the funds to providers. The estimated portion of the FY 1993 appropriation for the Substance Abuse Block Grant that will go to drug treatment is $462.3 million.

- The Federal Government also makes "categorical" grants to States and treatment providers to support treatment capacity expansion, innovative treatment approaches, improve the quality of treatment, or to ensure services for underserved or special populations. In FY 1994, the Administration has requested $286.8 million for categorical programs. Examples of initiatives supported include:

  -- capacity expansion ($88.9 million);

  -- programs for drug abusing women and their children ($49.2 million);

  -- programs directed toward certain critical populations ($44.7 million); and

  -- treatment projects directed towards those involved in the criminal justice system ($33.0 million).

Health Care Reform. It is likely that treatment for drug abuse will be included in the President's proposed national health reform package.

TREATMENT CAPACITY

ONDCP estimates that by the end of FY 1994 the Nation will have approximately 608,000 drug treatment slots serving 1.5 million persons (956,000 persons less than those who need and can profit from treatment). However, in many parts of the Nation drug treatment programs continue to be confronted with waiting lists, while in other areas there is a great deal of unused capacity in hospitals and other facilities that can be used for drug treatment.

- o At any point in time 21 percent of the slots are unfilled.

- o Government-owned and private non-profit programs operate over capacity, while the more expensive, for-profit programs are under capacity.

SOLVING THE CAPACITY PROBLEM

The Administration is planning to take steps that can alleviate the waiting list and the unused capacity problem.

- o The Administration is requesting $2.54 billion for drug treatment for FY 94. This includes funds to treat persons with co-morbid substance abuse problems and youths under 21 years of age with alcohol problems. Overall this represents an increase of $170 million, or 7 percent, over the FY 1993 level. The increase includes:

  - -- $23 million that will be used to maintain residential treatment slots for pregnant and postpartum women, supported in FY 1993 by the one-time earmark of set-aside funds from the Substance Abuse Block Grant; and

  - -- $67 million to be used to increase funding for the Treatment Capacity Expansion Program (CEP) to treat an additional 30,000 persons.

Additional approaches have been suggested.

- o HHS could be encouraged to make all awards of categorical grants for drug treatment conditional on the applicant's submission of documentation describing the size of their waiting lists and the extent to which they are operating near or over capacity. The size of waiting lists could be a major criterion in making any drug treatment grant award decision.

- o HHS could require States to maintain a system for measuring the size of waiting lists and to plan for their elimination as a condition of receiving Block Grant funds. HHS has already

taken steps in this direction with regard to the treatment of injecting drug abusers.

IMPROVING THE QUALITY OF DRUG TREATMENT

There is great variation in the general quality of services that treatment providers deliver to their clients. When clients are provided the wrong type of treatment, failure is almost certain.

- To improve the general quality of these services, ONDCP has considered conditioning the receipt of block grant funds on program accreditation. ONDCP is already encouraging States to define treatment outcome standards. In the future, it may be possible to allocate funding based upon individual program performance.

- To ensure that clients are matched with the appropriate type of treatment, HHS continues to encourage centralized intake assessment and referral, and the adoption of standardized Treatment Improvement Protocols.

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - MILITARY FACILITIES FOR DRUG TREATMENT

- The potential offered by these facilities for drug treatment and corrections purposes is not yet realized. To date none is being used as a drug treatment facility, although active planning is underway for the use of two sites in Pennsylvania and drug and alcohol program administrators in some States (e.g., South Carolina) have commenced discussions regarding the use of bases scheduled for closure.

- On the other hand, numerous surplus facilities are being used for the homeless because organizations that serve the homeless can and do avail themselves of the priority provided for the homeless under the McKinney Act. Similar priorities are not established in law for drug treatment.

- Until recently, there has been a limited expression of interest in military facilities on the part of State and local treatment and corrections officials. There were a number of reasons for this: the lack of timely and complete information on available facilities; the lack of desire by locals to have a treatment center in the community; the limited utility of facilities, due to isolated locations and limited or seasonal availability; the need for assistance in meeting Federal application requirements; and concern about the potential cost of needed repairs.

- To remedy some of these problems, ONDCP, the Department of Health and Human Services, and the Commission on Alternative Utilization of Military Facilities are taking action.

  -- The 1992 Report of the Commission on Alternative Utilization of Military Facilities focused both on underutilized facilities and base closures with more timely and extensive information.

  -- Furthermore, personal property programs of the Department of Defense and the General Services Administration were included in the Commission report. Personal property available through base closings has considerable potential for use by drug treatment programs.

  -- Finally, DHHS continues to provide up-to-date information and assistance to the states on all sources of real and personal property.

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OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - TREATMENT ON DEMAND

- The main goal of drug treatment is to get drug users off of drugs and to help them stay off. To successfully achieve this goal, treatment must be available, appropriate and effective. To this end, we should have two major objectives: first to expand treatment capacity, particularly for the populations and areas where there is the greatest need; and second, to improve treatment effectiveness and accountability.

- Providing treatment to those who need it when they want it is good health and social policy. Many believe that treatment success is heavily dependent upon the individual client's motivation and resolve to stop using drugs when he enters treatment. Addicts who willingly seek treatment should not be denied the opportunity to receive it when they are most likely to benefit from it.

- In addition, according to the Institute of Medicine's Treating Drug Problems treatment is cost effective. The report shows that during and after treatment, drug use and criminal behavior declines and employment increases relative to untreated comparison groups. The utility of these results substantially exceeds the costs of the treatment.

- It is estimated that 4 million persons will meet the clinical criteria for drug dependency and abuse in FY 1994. The treatment goal for FY 1994 is approximately 2.5 million persons. Of this amount, funding will serve 1.4 million persons, creating a shortfall of close to 420,000 slots. In order to meet the treatment goal, an additional $2 billion will be required.

- Treatment for substance abuse will be included in the proposed national health insurance package of the First Lady's Task Force. Such coverage will enable all Americans to obtain drug treatment when they need it.

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET -- DRUG TREATMENT IN THE CRIMINAL JUSTICE SYSTEM

- A new working relationship is being forged between the Departments of Justice (DOJ) and Health and Human Services (HHS) to focus more sharply on the need for intervention and treatment services for drug-dependent offenders. ONDCP will work directly with these Departments to foster coordinated action.

- Support for States and localities will proceed on three fronts.

  -- Criminal justice and substance abuse block grants will target the treatment of drug-dependent offenders as a priority for expenditure.

  -- Discretionary and categorical grants will demonstrate effective approaches, document treatment models, and provide support for program infrastructure, such as management information systems.

  -- Technology transfer programs, such as the HHS Treatment Improvement Protocol (TIP) program, and technical assistance programs, such as the DOJ Treatment Alternatives to Street Crime (TASC) assistance and management information system programs, will continue.

  -- ONDCP will track the progress of these efforts through its working groups.

- On the Federal level, the Bureau of Prisons (BOP) and the Administrative Office of the United States Courts (AOUSC) are working cooperatively to provide drug treatment in both institutional and community corrections settings.

  -- In Fiscal Year 1993, drug education is available in all BOP institutions, outpatient treatment and counseling is available in all institutions, and residential treatment is available in 31 institutions, with plans to expand to 36 institutions in Fiscal Year 1994 and 40 institutions in Fiscal Year 1995.

  -- In Fiscal Year 1992: 12,500 inmates participated in drug education; nearly 11,800 in outpatient programs; over 1,100 in residential programs; and 123 in the transitional services program. An estimated 200 offenders will participate in the transitional services program in Fiscal Year 1993, and 500 are projected to participate in Fiscal Year 1994.

- BOP is considering the adoption of mandatory treatment for drug-dependent inmates because only about 8 percent volunteer for the residential treatment program, which could accommodate up to 13 percent.

  -- The abolition of Federal parole removed the most powerful incentive to active participation, the possibility of early release, and BOP treatment must compete for inmate time with the Federal prison industries program, where inmates can earn an appreciable amount of money.

- To bring its programs to capacity, BOP is developing a series of incentives and sanctions, and procedures to ensure their uniform application.

- State circumstances are different. There are clear systemic incentives for offenders to participate and capacity is limited, making mandatory treatment impractical at this time. Most states have parole and with it the promise of early release, most state prison treatment programs offer inmates a safer and more comfortable environment than is available to the general population, and few states have, or soon will have, adequate capacity to treat all those in need.

- The real challenge facing the state systems, and to a lesser extent the Federal system, is to provide adequate post-incarceration supervision, support, and, when necessary, treatment, to foster successful reentry into the community for drug-dependent offenders.

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - NEEDLE EXCHANGE PROGRAMS

- Federal law prohibits the use of ADMS Block Grant funds for needle exchange programs, although the use of research and demonstration funds is permitted.

- Scientific information on the efficacy of needle exchange programs has been mixed. However, NIDA-funded evaluations of needle exchange programs in New Haven and Seattle are underway, and should provide additional information. Many cities are experimenting with such programs and reliable data might be generated by some of these experiments.

- Earlier ONDCP analysis found that needle exchange programs often attracted a low-risk population and always experienced a very high rate of attrition. This resulted in a progressively smaller and safer program population. The combined impact of low-risk entrants and high attrition virtually guaranteed that program statistics would become progressively more positive.

- On the other hand, significant results have been achieved through outreach to high-risk populations, with services that do not include needle distribution. NIDA programs have been successful in encouraging drug users to both enter treatment and reduce their risk of contracting the HIV virus by providing information on AIDS and by distributing, and providing training in the use of, bleach and condoms.

- In short, available data demonstrate that outreach programs are superior in all respects to needle exchange programs. They reach high-risk populations, get many to enter treatment and/or change high-risk drug use behaviors, and get some to change high-risk sexual behaviors.

- ONDCP, in conjunction with HHS, will examine data on the effectiveness of needle exchange programs to determine whether existing Federal policy should be changed.

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The New York Times

SATURDAY, AUGUST 17, 1991

Giving Away Needles Won't Stop AIDS

By Mitchell S. Rosenthal

Allowing drug users to exchange dirty needles for new ones seems like an enlightened idea — simple, sensible and compassionate. AIDS is rampant among addicts who inject heroin or cocaine, and they transmit the HIV virus to one another by sharing needles and syringes.

But despite all the happy headlines and editorials, there is no evidence that this approach actually works and will reduce transmission of the virus.

Let's look at the widely reported "success" of a model needle-exchange program in New Haven. A preliminary report predicted a 33 percent reduction in new infections among addicts in the program. But this result was projected, not achieved. Using a mathematical model, the report forecast, after seven months, what the program would accomplish in a year.

Mathematical models cannot produce valid results unless all the information they include is accurate. The New Haven model makes several questionable assumptions, and the key issue — how needle-sharing behavior has changed — is not addressed directly.

Instead, the returned needles are tracked and tested. When a participant in the program returns someone else's needles, the conclusion is that those needles were shared. But when an addict returns the same needles he or she was issued, it is assumed that the needles were *not* used by anyone else.

Even if it were possible to discover by this means which needles were shared, it would not reveal how many intravenous drug users were sharing them. By testing, it is possible to discover how many needles are contaminated with the HIV virus, but not how many intravenous drug users have been exposed. Casting further doubt on the New Haven projection is the apparent failure to consider how

So why are we undercutting the war on drugs?

the high dropout rate — 60 percent — might skew the findings.

But premature optimism has put opponents of needle exchange on the defensive, and revealing the study's flaws isn't likely to reduce the pressure for more such programs. Even if it doesn't work, supporters demand, what's the harm in trying? It isn't enough to argue that needle exchange puts government in the bizarre position of abetting illegal and life-threatening behavior that we have been trying desperately to control.

But we can point out that clean needles, even if they could prevent sharing, wouldn't reduce a spread of the AIDS virus from addicts to people who don't use drugs. In the U.S. today, AIDS is being spread most rapidly by heterosexual contact, primarily through transmission of the virus from intravenous drug users to their sexual partners. Clean needles won't alter irresponsible sexual behavior.

Indeed, clean needles aren't going to alter any of the irresponsible and antisocial ways in which drug abusers threaten society. Only treatment can do this. And although clean-needle programs may provide a route to treatment for some drug users, the overwhelming effect would be to impede their movement into treatment.

To be effective, treatment must make demands of drug abusers that few are willing to accept. The great majority will only enter treatment under pressure — and pressure on addicts directly reflects public attitudes about drugs.

By accommodating drug use, through needle exchange, we foster ambivalence, making it harder for communities to discourage drug use and demand that abusers accept treatment.

When we consider this cost and the absence of any proven benefits, we might question whether needle exchange is really such a terrific idea.

Dr. Mitchell S. Rosenthal, president of Phoenix House, a drug rehabilitation agency, is chairman of the New York State Advisory Council on Substance Abuse.

Leadership on Needle Exchange Can Help Stop AIDS in the Cities

The Honorable John Daniels

National AIDS statistics have staggered all of us by their high numbers and catastrophic long- and short-range implications.

In New Haven, where we have a high incidence of IV drug users, and a higher than national average of diagnosed cases of newborn, pediatric and female AIDS or HIV, I concluded that action had to be taken, and as mayor I had to take it.

New Haven Mayor John Daniels delivered these remarks at the Sixth International Conference on Drug Policy Reform on Nov. 12, 1992.

So, yes, I am a convert to the needle exchange method. After talking with many addicts who were in despair of receiving treatment and in fear of getting AIDS, and while faced with the cold, hard fact that well over 60 percent of all AIDS cases in New Haven were connected to drug use, I became an activist and advocate on behalf of needle exchange as a preventative control method.

Today, my belief in the needle exchange program and the New Haven Health Department AIDS Division's work on behalf of the program has been more than vindicated.

The drop in the level of infection among needles due to the needle exchange program is dramatic. By itself, it represents a very convincing argument in favor of needle exchange. We have produced the first real evidence that the incidence of new infections has been reduced by 33 percent and that the needle exchange directly reduces the spread of HIV and AIDS. We also discovered that the program saves lives and significantly reduces health care costs, which would have accrued for AIDS treatment. Over the two-year period of our study, statistics revealed that by preventing 20 persons from being infected, between $1 million and $2 million dollars would be saved on the dispensing of AIDS treatment.

Additionally, crime in New Haven actually dropped 20 percent over the same period. New Haven needle exchange program statistics have been touted on network television, public television, radio, and in the print media. They appear to prove critics of needle exchanges wrong.

Still, the controversy continues. Our national policy, vociferously defended by drug czar Bob Martinez, continues to maintain that needle programs promote drug use.

The constant lines in and out of our evaluation van seem to belie that position. The evaluation van travels to New Haven neighborhoods four times a week. In exchange for used needles, code-named addicts receive their survival kits: bottles of bleach and water, clean needles and condoms. They do this out of fear; they do not want to get AIDS.

Soon, we will have a new van and will be able to better serve those in need, and in turn, help our city. The van is to have an added dimension — thanks to the Yale School of Medicine. Two medical professionals will soon join the outreach workers to provide health care on wheels once a week. They will consult, treat and refer people to treatment facilities and agencies.

The van and the salaries of the outreach workers will be funded by the Robert Wood Johnson Foundation, which also funds New Haven's "Fighting Back," our drug and alcohol abuse prevention agency.

I wish to give credit where credit is well deserved. We are indebted to, and fortunate to be working with, Yale University on this and numerous other urban issues and projects. Because of the university's generosity, faculty representing the Yale School of Organization and Management, the Yale School of Internal Medicine, and the Department of Operations have worked with the New Haven AIDS Division to insure the success of our effort.

Professor Edward Kaplan, the point person in this important venture, came up with the mathematical model to track and evaluate our needle exchange program. Dr. Kaplan and Elaine O'Keefe co-authored a study entitled, "Let the Needles Do the Talking: Evaluating the New Haven Needle Exchange." It serves as the nation's definitive, positive work on needle exchange as a preventative measure.

It takes a lot of money, energy and effort to mount a significant campaign against the spread of HIV and AIDS. You are all too familiar with what the costs are in terms of human life if you have no program or if the one you begin becomes hobbled with so many rules and regulations that the persons you aim to serve become ineligible.

A needle exchange program must be preceded by passage of legislation that will decriminalize the possession of needles, among many other things. The findings of our study motivated the Connecticut legislature to continue our study for another year, and to consider expanding the use of needle exchange to include Bridgeport and Hartford.

In California, however, Governor Pete Wilson recently vetoed a bill that would have paved the way for needle exchange programs in his state. Perhaps his decision reflected Bush administration policies; perhaps it was politically motivated.

Being an advocate for needle exchange does not always make one popular at the polls. But in retrospect, I would definitely take the advocacy stand for needle exchange again, given the chance.

With the addition of our new evaluation van and our continued partnership with Yale University and Dr. Kaplan, I hope I will be able, at the next Drug Policy Foundation conference, to reveal even more astounding results.

Dr. Margaret Hamburg, the New York City health commissioner, in commenting on New Haven's needle exchange program in a recent *Time* magazine article, said, "It all came together in the New Haven experiment."

It did for me, too. And for all those who did the evaluating, the outreach work ... but most of all, it came together for those in treatment, who now have the chance to begin a new life.

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - MEDICAL MARIJUANA

- There is some evidence that therapeutic doses of tetrahydrocannabinol (THC), a psychoactive ingredient of marijuana, can reduce eye pressure of glaucoma patients, relieve nausea and spark appetites in cancer/chemotherapy patients, and reduce muscle spasms of M.S. patients.

- Until recently, smokable marijuana was made available, by the National Institute on Drug Abuse (NIDA), to individual patients under the supervision of licensed physicians, registered with DEA, conducting research protocols, approved by the Food and Drug Administration (FDA). This program is referred to, under the Investigational New Drug (IND) program, as the "compassionate" or "single-patient" IND.

- Approved active applications totaled 46, as of June 23, 1991, and only 16 approved applicants were receiving marijuana. All were patients not helped by other medications and many were terminally ill. Most approved applicants were suffering from glaucoma or from nausea associated with cancer chemotherapy, although a few were afflicted with HIV-wasting syndrome.

- On June 23, 1991, the FDA stopped action on single-patient INDs, refused to provide marijuana to the 30 approved applicants who had not yet received it, and commenced a medical review of the program.

- On March 6, 1992, the Public Health Service (PHS), parent agency of FDA, formally terminated the provision of marijuana plant material, based on the results of medical review. According to PHS,

  -- Termination of the program was justified to avoid sending the wrong message regarding marijuana use and because single-patient INDs do not yield significant research information.

  -- There are effective medications available for virtually all of the symptoms associated with the conditions suffered by marijuana IND applicants.

  -- Smoked marijuana has not been proven safe and effective for nausea associated with cancer therapy, HIV-wasting syndrome, spasticity associated with multiple sclerosis, or glaucoma.

- Although they can no longer receive smokable marijuana,

patients not helped by other medications may be prescribed synthetic THC pills (trade name Marinol, Schedule II), under the IND provisions.

- The Administration will review the 1992 PHS decision and consider reinstating the marijuana IND program for certain illnesses.

  -- Research does not indicate that proven effective medications are available for HIV-wasting syndrome or for muscular disorders. In fact, PHS is now conducting an interactive study of Marinol and Megace for HIV-wasting syndrome, with clinical trials underway.

  -- It is appropriate to provide relief for those suffering from wasting syndrome and spasticity, pending the availability of alternative medications. And reinstating the program (especially for the 2 conditions cited above) would be consistent with available medical research.

  -- A balanced approach is necessary to recognize the medical utility of certain drugs with abuse potential. It should be noted that Cocaine is on Schedule II of the Controlled Substances Act, while Marijuana plant material remains on Schedule I, as a drug of high abuse potential and no proven medical use.

  -- Controlled medical provision of Marijuana might spur neglected research on the effectiveness of alternative methods of administration of THC. Although there is a growing body of research on the negative health and behavioral consequences of chronic marijuana use, little rigorous research on the therapeutic effects of marijuana has been conducted recently. PHS has expressed an interest in conducting such research and will be encouraged to do so.

Sometimes Marijuana Is the Best Medicine

Counterpoint

By Doug Bandow

Advances in medical research and technology have allowed doctors to increasingly extend the lives of many terminally ill patients and ultimately save others. Unfortunately, there is often little that doctors can do to preserve the quality of their patients' lives. What has proved to be of value to some of the very ill, however, is marijuana. Before she died in early 1991, Barbara Jenks, desperately sick not only from AIDS but also from heavy doses of AZT to combat AIDS, explained that "I've got to smoke marijuana. I've got to, or I'll die."

But the Bush administration terminated the program under which Ms. Jenks, her husband, Kenneth, a hemophiliac who contracted AIDS from a blood transfusion, and roughly a dozen other patients acquired marijuana legally through the federal government. Although the Public Health Service is continuing to supply current recipients, no new patients are being accepted. Explained Bill Grigg, a Public Health Service spokesman, the government was afraid that marijuana might sicken the dying, proving to "be harmful to people with compromised immune systems."

The agency's decision was bizarre. In June 1991, Public Health Service head James Mason, a political appointee, announced that he was going to review the government's policy of providing marijuana to people suffering from AIDS, cancer, glaucoma and other illnesses. After concluding that "existing evidence does not support recommending smoked marijuana as a treatment of choice," explained Mr. Grigg, Dr. Mason canceled the program.

The agency's decision, which should be reversed by President Clinton, left out in the cold the 28 patients whose applications had already been approved by the Food and Drug Administration. The Public Health Service said not to worry: It would provide Marinol, a synthetic form of marijuana's active component. However, many users report that Marinol is inferior to marijuana—being less effective, having more side-effects, and failing to stimulate the appetite, a particularly important benefit for AIDS sufferers. The Public Health Service is "giving me a death sentence," complained Tim Braun, a 44-year-old AIDS patient whose application had been approved by the FDA. Mr. Braun, who died in May, said that when he found marijuana unavailable, his weight dropped by one-third in a single month.

While the Public Health Service provided a pile of "fact sheets" to back up its decision, it did not dispute marijuana's benefits for many patients. Instead, the agency complained that, for instance, marijuana's effectiveness varies by patient in controlling cancer-chemotherapy-induced nausea and vomiting and that the drug causes side-effects in glaucoma patients. As for pain control, the Public Health Service even admitted that "there may well be some patients for whom marijuana is a moderately effective pain reliever when no other treatment is of benefit, but this has not been rigorously studied." One wonders: Why didn't the government conduct such research before cutting off desperate patients?

In short, it appears that the Public Health Service made a political rather than a medical judgment, one predetermined before the review even started. For Dr. Mason had previously complained, "If it's perceived that the Public Health Service is going around giving marijuana to folks there would be a perception that this stuff can't be so bad."

But there is an obvious difference between someone smoking a joint to get high and using marijuana under the guidance of a doctor to relieve suffering from a serious illness. The public obviously sees the distinction: In 1991 San Francisco's electorate and Massachusetts' Legislature approved measures allowing doctors to prescribe marijuana for those who are seriously ill. While the latter two laws have little effect, since only the federal government now provides the drug legally, more significant is legislation passed in 1992 by Maine's Legislature. The measure, ultimately vetoed by the governor, would have exempted from prosecution those cultivating marijuana for medical use—effectively legalizing the drug for this purpose.

The agency's decision, which should be reversed by President Clinton, left out in the cold the 28 patients whose applications had already been approved by the Food and Drug Administration.

Even Herbert Kleber of the Bush administration's drug policy office called the Public Health Service's marijuana program a "compassionate" option for the sick. Moreover, the medical profession sees an important treatment role for marijuana. More than 70% of cancer specialists in a recent Harvard University survey stated that they would prescribe marijuana if it were available legally; nearly half said that they have advised patients to break the law, if necessary, to obtain the drug. And break it many do. Joe Hutchins, who suffers from a rare skin disease, is facing prison in Massachusetts after having exhausted his appeal of a 1984 marijuana conviction. The Jenkses, too, were prosecuted for growing their own marijuana before they were admitted into the now discontinued federal program.

The point is not that marijuana should be the preferred treatment for every patient. Rather, a physician and his or her patient should be able to choose marijuana if it is the best medicine in that case.

The best solution would be for the Drug Enforcement Administration to stop classifying marijuana as a Schedule I drug; which makes it unavailable even for medical use. In 1989 a DEA administrative law judge declared the DEA's stance to be "unreasonable, arbitrary and capricious," but, despite several challenges in federal court, the agency has so far refused to reconsider its position.

Unfortunately, a Clinton spokesman says that the president, perhaps afraid to address the issue because of criticism over his student marijuana use, supports current law. He could nevertheless direct the Public Health Service to provide marijuana when prescribed by a doctor for a seriously ill patient. In fact, Mr. Clinton's nominee for surgeon general, Joycelyn Elders, says that the drug "should be available" in such cases.

By allowing the medical use of marijuana, the government would simultaneously help those with a fighting chance to survive and ease the pain of those who are dying. What better opportunity could there be for the new president to demonstrate his commitment to change than to stop treating AIDS and cancer patients as the enemy?

Mr. Bandow is a Cato Institute fellow and a former special assistant to President Reagan.

WASHINGTON POST

DEC 2 3 1992

Choice for Surgeon General Favors Medicinal Marijuana Use

Associated Press AP

LITTLE ROCK, Ark., Dec. 19—President-elect Clinton's choice for U.S. surgeon general said today she will advocate the medicinal use of marijuana, and will support distributing condoms from high school-based health clinics around the country.

If physicians feel marijuana "would be beneficial for use by the patient . . . it should be available," said Joycelyn Elders, director of the Arkansas Health Department.

Elders said marijuana could be useful in treating glaucoma, and to relieve nausea and improve appetite in patients with cancer or AIDS.

Federal law bans the use of marijuana as medicine. Clinton spokeswoman Max Parker said the president-elect "supports the current law and has no plans to review it at this time."

Clinton aides say the president-elect offered Elders the surgeon general's job last week, but Elders says she might not take it until this coming summer.

Elders, 59, a pediatrician, has raised the ire of conservative groups in Arkansas by promoting distribution of contraceptives at school-based health clinics to combat AIDS and teenage pregnancy. She said she would continue supporting the idea when she comes to Washington.

The current surgeon general, Antonia C. Novello, says she wanted to stay on to complete some programs she had planned and "that's fine with me," Elders said after talking to Novello.

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OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - MEDICATIONS DEVELOPMENT

- The Administration proposed $47 million for medications development in Fiscal Year 1994, an $2 million increase over Fiscal Year 1993.

- The Medications Development Program, which is administered by NIDA, is coordinated with the private sector and the Food and Drug Administration to develop new and improved medications for treating drug addictions.

- Important progress has been made with heroin dependence treatment medications. NIDA has nearly completed all registrational studies for the approval of LAAM (levo-alpha-acetylmethadol hydrochloride), an longer-acting alternative to methadone. LAAM is dosed every other day and may prove more acceptable to some addicts.

- NIDA is working closely with FDA and DEA to expedite the review and approval of LAAM and the associated Federal regulations necessary to make it available at treatment centers. As a result, LAAM will probably be approved in late spring.

- NIDA is also completing a registrational trial of buprenorphine, a unique opiate treatment agent.

- Finally, NIDA has developed a new 30 day dosage form of the narcotic antagonist naltrexone, which is currently under study.

  -- Agents which work in heroin treatment dependence will also work for the treatment of other forms of opiate addiction (i.e., prescription drugs which are opiate based).

- A number of potential cocaine medications have also been identified by researchers to offer promise in treating cocaine and crack addicts. Desipramine, flupenthixol, amantadine, buprenorphine, and other potential agents are among those compounds for which more rigorous (double-blind, placebo controlled) clinical trials are being pursued to determine if they will ultimately be useful.

- Through interagency agreements, NIDA has made use of the Department of Veterans Affairs' (VA) hospitals and Cooperative Studies Programs to run clinical trials. NIDA has had access

to a large pool of addicts (substance abuse is often the number one psychiatric disorder in many VA facilities) and the VA has provided inpatient and outpatient facilities at cost effective rates. VA facilities have had the opportunity to participate in cutting edge research, to upgrade facilities,

and to integrate clinical research and training opportunities into their treatment mission.

- o While new medications are being developed, psychosocial therapies remain the primary method of treatment for most addictions. Pharmacological treatments will help stabilize patients and allow them to derive the full benefit from their treatment regimens, and will reduce the compulsive drug seeking behaviors and injection drug use which spreads AIDS, hepatitis, and tuberculosis. However, psychosocial therapies will still be necessary to allow addicts, many of whom live highly disordered lives, to successfully re-integrate into society.

  -- The primary psychosocial therapies are behavioral, supportive, and psychodynamic, and critical research continues to improve them as well.

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - COCAINE BLOCKER

- Researchers [not directly funded by the government] have recently developed a potentially effective way to treat cocaine addiction by using catalytic antibodies to destroy the drug immediately after it reaches the blood stream but before it reaches the brain. The research team is led by Dr. Donald W. Landry from the College of Physicians and Surgeons at Columbia University.

- The novel approach could lead to a new strategy to curb cocaine use, including crack. Currently, the research is at the test-tube stage, but the investigators have been able to bind the catalytic antibodies to the cocaine molecule and split it into two inactive ingredients. Although human experiments are several years away, the antibody would serve as a kind of vaccination against relapse for cocaine and crack addicts who seek treatment.

- Researchers hope that the fully-developed antibody would be given intravenously, perhaps every two weeks, to addicts who are in treatment, providing protection against relapse to cocaine use, until other treatments and psychotherapy have had the chance to become effective.

ODR-50
5/17/93

Scientists Find Enzyme That May Ease Cocaine's Addictive Effects

By WARREN E. LEARY
Special to The New York Times

WASHINGTON, March 25 — Scientists say they have developed an artificial enzyme that reduces the addictive effect of cocaine in test tube studies, a development some experts say could eventually lead to a new weapon to treat cocaine abuse.

New York researchers said initial tests indicated that the enzyme they developed seeks out and binds to the cocaine molecule and then breaks it into two inert byproducts.

The enzyme, part of a family of new compounds called catalytic monoclonal antibodies, not only blunts cocaine's effects but also survives the reaction to attack additional cocaine molecules as it encounters them, they said.

Years of animal studies and clinical tests with humans will be necessary to see if the enzyme is as effective in those addicted to cocaine as it is in laboratory studies, said the researchers from the College of Physicians and Surgeons at Columbia University. But if the treatment works, they said, it would be a major tool to fight addiction.

A Long Search

"Because the agent inactivates cocaine and crack, the free-base form of cocaine, it holds the promise of preventing a complete relapse for addicts in treatment who succumb to renewed drug use," said Dr. Donald W. Landry, the lead researcher in the team that developed the new enzyme.

The findings are being reported in Friday's issue of the journal Science.

Scientists have been searching for years for a substance that could either block cocaine's euphoric effects or diminish a person's craving for the drug. The quest took on new importance last fall when the National Institute for Drug Abuse issued a request for research proposals on chemicals that could be used to battle cocaine addiction.

"If this new technique proves workable, it would be a breakthrough in treatment," Dr. Herbert Kleber, a professor of psychiatry and a drug treatment expert at Columbia University, said in an interview. "We currently have no overall effective medication to treat cocaine abuse, and we need something that helps keep patients drug free for months while they undergo counseling and behavioral therapy."

Not a 'Magic Bullet'

About 20 medications to combat cocaine have been studied in human trials, and the few that have proved effective only seem to work in small groups of patients, said Dr. Kleber, a former deputy director of the White House National Drug Control Policy Office. "What's encouraging about the new development is that it shows promise at being effective in a wide range of patients," he said.

Mark A. R. Kleiman, who teaches drug policy at Harvard University, said that "in the face of not having very effective treatment for cocaine, anything is progress."

A drug that blocks the effects of cocaine while having few adverse side effects that discourage using it could be very useful, Mr. Kleiman said in an interview. But no one should expect any treatment to be a "magic bullet" that solves the drug problem, he said.

The Columbia researchers said their artificial enzyme should destroy most cocaine in the bloodstream before it reaches the brain. This should affect not only how intoxicated a user gets when using the drug, but also the addictive potential of the drug, Dr. Landry said in an interview.

To develop their catalytic antibody against cocaine, Dr. Landry said, his team used techniques pioneered by Dr. Richard Lerner of the Scripps Research Institute in San Diego, Dr. Peter G. Schultz of the University of California at Berkeley and Dr. Stephen Benkovic of Pennsylvania State University.

Dr. Lerner, the institute's president, said in an interview that he has been working on similar applications of catalytic antibodies but that Dr. Landry's work leapfrogged his own.

"I've seen the study, and it's really a marvelous, very exciting piece of work that moves catalytic antibodies into treating human problems for the first time," Dr. Lerner said. "It isn't going to be that hard to move this into a form that can be used in people."

Clinton Presidential Records
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Divider Title: _____

Federal Drug Control Spending by Function
FY 1991 – FY 1994
($ Millions)

	1991 Actual	1992 Actual	1993 Enacted	1994 President's Budget	FY93 – FY94 Change $	FY93 – FY94 Change %
Criminal Justice System	4,385.6	4,943.1	5,374.8	5,782.6	407.7	8%
Drug Treatment	1,874.2	2,199.8	2,367.7	2,538.1	170.4	7%
→ Education, Community Action, and the Workplace	1,479.2	1,538.7	1,524.4	1,789.9	265.5	17%
International	633.4	660.4	538.0	490.0	(48.0)	–9%
Interdiction	2,027.9	1,960.2	1,746.2	1,765.2	19.0	1%
Research	450.1	504.5	530.9	548.2	17.2	3%
Intelligence	104.1	98.6	128.7	127.4	(1.3)	–1%
Total	**10,954.5**	**11,905.2**	**12,210.8**	**13,041.4**	**830.6**	**7%**

NATIONAL DRUG CONTROL BUDGET
BY FUNCTION

($ Millions)	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994
DRUG ABUSE PREVENTION														
Action	2.5	6.8	6.9	6.8	6.9	6.9	7.8	5.9	10.1	10.5	12.5	10.0	9.9	10.1
Agency for International Development	0.0	0.0	0.0	0.0	1.2	1.9	5.2	4.5	3.1	5.4	7.1	7.8	5.0	3.5
Department of Defense	21.2	36.2	46.4	49.8	63.0	63.4	77.8	83.8	69.7	66.8	71.5	73.6	72.0	73.7
Department of Education	2.9	2.9	2.9	2.9	3.0	2.9	203.0	229.8	354.5	541.7	609.1	626.1	612.7	620.0
Administration for Children and Families	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	74.6	79.4	83.8	83.8
ADAMHA	16.1	30.0	32.5	32.1	34.1	32.6	98.4	85.2	150.7	329.7	420.1	441.6	0.0	0.0
SAMHSA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	418.9	455.9
Centers for Disease Control	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	20.0	25.2	29.3	28.6	31.2	36.6
Family Support Administration	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.0	2.0	0.0	0.0	0.0	0.0
Human Development Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	43.9	57.1	0.0	0.0	0.0	0.0
Indian Health Service	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.7	2.9	3.0	3.5	3.0
Dept. of Housing & Humand Develop.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	8.2	98.3	150.0	165.0	175.0	265.0
Bureau of Indian Affairs	0.0	0.0	0.0	0.0	0.0	0.0	3.5	0.8	2.6	2.2	3.1	3.6	4.4	4.3
Bureau of Land Management	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.3	0.3	0.4	0.4	0.2
National Park Service	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.4	0.4	0.3	0.6	0.6
OTIA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.4	0.7	0.6	0.6
Drug Enforcement Administration	0.0	0.0	0.0	0.1	0.1	0.4	0.9	1.9	2.2	2.2	2.2	2.1	1.5	1.5
Office of Justice Programs	0.0	0.0	0.0	0.0	0.0	3.3	3.7	7.4	13.0	34.2	21.6	21.3	20.3	20.3
Department of Labor	43.4	25.9	35.8	36.0	37.3	33.1	41.1	37.5	38.6	46.0	60.9	61.5	70.5	72.7
ONDCP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.2	4.0	5.6	5.7	5.5	1.6
Small Business Administration	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.0	0.0
Federal Aviation Administration	0.4	0.2	0.4	0.5	0.4	0.5	0.9	5.5	4.3	9.1	7.3	7.3	8.1	7.5
Department of Veteran Affairs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.5	0.5
Community Investment Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	128.375
White House Conference	0.0	0.0	0.0	0.0	0.0	0.0	2.0	2.5	0.0	0.0	0.0	0.0	0.0	0.0
	86.4	101.9	124.9	128.1	146.0	145.0	444.3	464.7	725.4	1,238.0	1,479.2	1,538.7	1,524.4	1,789.9

OVERVIEW

EDUCATION, COMMUNITY ACTION, AND THE WORKPLACE

One of the most important goals of the Nation's anti-drug effort is to prevent Americans, especially young people, from ever using drugs. The Federal government administers several programs to assist States, local governments, and nonprofit organizations in developing drug prevention and education programs. Many of these programs target diverse populations such as young people determined to be at high-risk of using drugs, pregnant women, elementary and secondary school students, and employed individuals.

Most Federal prevention programs are administered by the Departments of Health and Human Services (HHS), Education (ED), and Housing and Urban Development (HUD). HHS oversees implementation of the Substance Abuse Block Grant, 20 percent of which must be spent by the States on primary prevention and early intervention, as well as numerous discretionary grant programs including the High Risk Youth and Community Partnership Programs. ED administers the Drug-Free Schools and Communities Block Grant, which provides funding for drug education to virtually every school district in the Nation. HUD oversees the Drug Elimination Program, which provides grants to public housing authorities for anti-drug activities.

DRUG-FREE SCHOOLS AND COMMUNITIES PROGRAM

The Drug-Free Schools and Communities Program will be considered for reauthorization in 1994. ED has recommended that the program be continued, but expanded to include anti-violence programs. In addition, ED has recommended that the formula used to distribute funds be modified to better reach those areas most devastated by drugs and that a new national evaluation reporting system be established to assess the effectiveness of the program.

HIGHER EDUCATION

Department of Education regulations require institutions of higher education to certify that they have anti-drug policies and drug prevention programs. All have certified. However, studies show that drug use on college campuses, especially alcohol use among underage students, is still a significant problem, and that college and university anti-drug programs are usually "harm reduction" programs rather than "prevention programs."

Beginning in 1992, colleges and universities were required to report to parents, students and prospective students on crimes related to substance abuse--an approach which will focus greater attention to the problem.

COMMUNITY-BASED PREVENTION

- Community Partnerships. Since Fiscal Year 1989, the Federal government has awarded about 250 grants to establish community-based anti-drug partnerships. These partnerships bring all segments of the community, including businesses, schools, churches, police, and health officials, together to reduce local drug use. The Administration has requested $117 million for partnerships for Fiscal Year 1994 -- a $12 million increase over the previous year.

- Community Policing. The Federal government is committed to providing funding for community policing. The Administration has requested $137.5 million in Fiscal Year 1994 to support this approach. These funds will be awarded primarily through the Administration's newly proposed Community Investment Program.

- Public Housing. The Administration is also committed to ensuring that public housing developments are drug-free. To assist in this effort, the Administration has requested $267 million for grants to public housing authorities for Fiscal Year 1994 -- a $90 increase over the previous year.

ALCOHOL

ONDCP's authorizing statute restricts its purview to illegal substances and prohibits ONDCP from addressing alcohol abuse by adults. Because alcohol is an illegal substance for those under 21, ONDCP may address the problem of alcohol use by young people.

Most communities believe that alcohol use by teens presents a greater threat than illegal drugs. The Federal government assists State and local government efforts to reduce alcohol use through a variety of drug prevention programs, including the Drug-Free Schools and Communities and High Risk Youth Programs. Such programs provide young people with education about the harmful effects of alcohol use.

Other Federal alcohol prevention programs are aimed at pregnant mothers to provide them with information on the toxic effects of alcohol on the unborn.

DRUG-FREE WORKPLACE

Drug use is a major concern for American business because nearly 70% of current users of illegal drugs are employed. Drug use in the workplace adversely affects employee health and safety, productivity, and health care costs. However, the workplace can also be used to reach and treat users.

- The best comprehensive drug-free workplace programs include a written policy against drug use, employee education, employee

assistance programs, supervisory training, and drug testing where appropriate.

- Evidence indicates that drug testing can deter drug use. Testing programs have led to marked decreases in drug use in the military and in large corporations. Currently, the Federal Government is undertaking research to determine which drug testing rates (i.e., 50% vs 100%) of employees should be employed to deter drug use.

- Statistics show that most small businesses, where over 50% of the workforce is employed, do not have a formal policy on drug use. Drug policy experts believe that drug users have been gravitating towards small businesses to avoid testing programs conducted by large companies.

- The Federal Drug-Free Workplace Program was established in 1986 by Executive Order 12564. In 1991, ONDCP was designated as the lead agency in administering the program. All Federal agencies have an approved plan for implementing their drug programs, but some agencies have not fully implemented their plans (e.g., Department of State).

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - PRIVATE SECTOR ROLE IN PREVENTION

- The private sector has done an excellent job in supporting drug prevention programs both at the local level and through national programs. Private sector organizations contribute substantial funds as well as volunteer efforts to help implement drug prevention programs. This support reflects local commitment to solving drug problems within communities.

- The community anti-drug partnerships funded by the Department of Health and Human Service's Center for Substance Abuse Prevention (CSAP) require that many segments of communities be involved in anti-drug efforts, including businesses, schools, police, parents, churches, treatment programs, social and health care services. Thus far about 250 partnerships have been funded and are leading local efforts across the Nation to reduce drug use.

- A major private sector supporter of community partnerships is the Robert Wood Johnson (RWJ) Foundation which has provided over $45 million to fund 14 "Fighting Back" community partnership grants. These grantees are bringing communities together to take back their streets, their schools, and their families from the blight of substance abuse.

- Organizations such as the Elks, Moose, Rotarians, Boys and Girls Clubs of America, Boy Scouts, and many other service clubs manage drug prevention programs. These organizations participate in community-wide efforts as well as carry out their individual program goals.

- The Partnership for a Drug-Free America, another private sector organization, has been instrumental in arranging for $1 million per day of free anti-drug messages in the media.

- The American Bar Association is providing pro bono services to assist local community coalitions on how to develop and enforce local laws regarding drug paraphernalia sales and related issues.

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - LEGALIZATION OF DRUGS

Occasionally, social and political leaders suggest that the best way to decrease drug use is by legalizing drugs. By this, most mean the decriminalization of the possession of less harmful (or "soft") drugs for personal use, as opposed to making legal the purchase and sale of all controlled substances, of whatever type or addictive nature, to whatever age. Proponents of the legalization/decriminalization viewpoint frequently make a number of points to support their position:

- Drug production, trafficking and use continue to increase. As a philosophy and practical matter, drug prohibition and enforcement do not work to diminish the supply of drugs. The result is more Americans are using drugs today than before.

- The costs to society of prohibition are greater than those that might obtain if citizens were permitted to acquire drugs for personal use.

- Only drug traffickers profit by prohibition and enforcement regimes. A corollary to this "economic profit" argument is that if drug sales were legalized, tax revenues would increase.

- In the end, drug use, particularly the use of "soft" drugs, is crime which, like alcohol, victimizes the user only.

The following facts are relevant to these points, and to the issue generally:

- As a result of Federal and other country enforcement efforts, the supply of cocaine to the U.S., which rose to dramatic levels in the late 1980's, has stabilized. The Federal marijuana eradiction program has achieved substantial reductions in the domestic production and availability of marijuana, with concomitant dramatic price increases for this drug.

- Such efforts, combined with the growing abstinence of Americans towards substance use generally, have resulted in significant decreases in overall drug use, and major decreases in the use of drugs by our youth, not the converse.

- Reputable experts acknowledge that increases in drug availability -- whether through a relaxation of enforcement or through the legalization or decriminalization of use -- will

increase drug demand. The American experience with the prohibition of alcohol between 1917 and 1935 is clear that alcohol use dropped dramatically in those years, and rose just as dramatically once the Prohibition Act was repealed.

The probable increases in consumption resulting from a decision to decriminalize use cannot be estimated without specific knowledge of the type of regulatory regime that would be involved. But it is to be noted that the number of persons who use illicit drugs is estimated to be less than 12 million on a current (once per month or more) basis, while those who use legalized but regulated substances is more than 110 million in the case of alcohol, and 50 million in the case of cigarettes.

- Current costs to society of drug supply and demand include, in addition to violent crime and crimes to property, drug-associated sickness and premature death, the enormous costs of treating addiction (and the fact that in some number of cases, treatment will not be successful), loss of productivity, drug-related accidents, and social disorders, including the breakdown of communities and families. Clearly these are not the only or inevitable consequence of drug use by individuals; but experience shows that when large numbers of persons are involved, such effects will result.

- It is not clear that crime, and profits to drug traffickers, would be reduced significantly by a decision to decriminalize use. Several types of drugs, including crack and PCP, can induce violent behavior. And if a profit-creating black market is to be fully undercut, drugs would have to be available on demand at low cost to individuals of all ages.

- No responsible person would now agree that the only victim of drug use is the user. Children suffer from their parents' use; families suffer the health and economic costs; communities suffer from the consumption of health-damaging substances by their members; and the nation suffers the health, social and economic costs of use.

- In short, the consequences of a decision to decriminalize would have a major, negative impact on this country. The costs of prohibition should not be minimized but, overall, these cannot be compared to those likely to result from the significantly increased availability of drugs that would result from the decriminalization of use.

It can be added that while some other countries do not impose criminal sanctions on drug users, no other country permits the legal purchase and sale of scheduled drugs.

Against the Legalization of Drugs

James Q. Wilson

In 1972, the President appointed me chairman of the National Advisory Council for Drug Abuse Prevention. Created by Congress, the Council was charged with providing guidance on how best to coordinate the national war on drugs. (Yes, we called it a war then, too.) In those days, the drug we were chiefly concerned with was heroin. When I took office, heroin use had been increasing dramatically. Everybody was worried that this increase would continue. Such phrases as "heroin epidemic" were commonplace.

That same year, the eminent economist Milton Friedman published an essay in *Newsweek* in which he called for legalizing heroin. His argument was on two grounds: as a matter of ethics, the government has no right to tell people not to use heroin (or to drink or to commit suicide); as a matter of economics, the prohibition of drug use imposes costs on society that far exceed the benefits. Others, such as the psychoanalyst Thomas Szasz, made the same argument.

We did not take Friedman's advice. (Government commissions rarely do.) I do not recall that we even discussed legalizing heroin, though we did discuss (but did not take action on) legalizing a drug, cocaine, that many people then argued was benign. Our marching orders were to figure out how to win the war on heroin, not to run up the white flag of surrender.

That was 1972. Today, we have the same number of heroin addicts that we had then—half a million, give or take a few thousand. Having that many heroin addicts is no trivial matter; these people deserve our attention. But not having had an increase in that number for over fifteen years is also something that deserves our attention. What happened to the "heroin epidemic" that many people once thought would overwhelm us?

The facts are clear: a more or less stable pool of heroin addicts has been getting older, with relatively few new recruits. In 1976 the average age of heroin users who appeared in hospital emergency rooms was about twenty-seven; ten years later it was thirty-two. More than two-thirds of all heroin users appearing in emergency rooms are now over the age of thirty. Back in the early 1970's, when heroin got onto the national political agenda, the typical heroin addict was much younger, often a teenager. Household surveys show the same thing—the rate of opiate use (which includes heroin) has been flat for the better part of two decades. More fine-grained studies of inner-city neighborhoods confirm this. John Boyle and Ann Brunswick found that the percentage of young blacks in Harlem who used heroin fell from 8 percent in 1970-71 to about 3 percent in 1975-76.

Why did heroin lose its appeal for young people? When the young blacks in Harlem were asked why they stopped, more than half mentioned "trouble with the law" or "high cost" (and high cost is, of course, directly the result of law enforcement). Two-thirds said that heroin hurt their health; nearly all said they had had a bad experience with it. We need not rely, however, simply on what they said. In New York City in 1973-75, the street price of heroin rose dramatically and its purity sharply declined, probably as a result of the heroin shortage caused by the success of the Turkish government in reducing the supply of opium base and of the French government in closing down heroin-processing laboratories located in and around Marseilles. These were short-lived gains for, just as Friedman predicted, alternative sources of supply—mostly in Mexico—quickly emerged. But the three-year heroin shortage interrupted the easy recruitment of new users.

Health and related problems were no doubt part of the reason for the reduced flow of recruits. Over the preceding years, Harlem youth had watched as more and more heroin users died of overdoses, were poisoned by adulterated doses, or acquired hepatitis from dirty needles. The word got around: heroin can kill you. By 1974 new hepatitis cases and drug-overdose deaths had dropped to a fraction of what they had been in 1970.

Alas, treatment did not seem to explain much of the cessation in drug use. Treatment programs can and do help heroin addicts, but treatment did not explain the drop in the number of *new* users

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(who by definition had never been in treatment) nor even much of the reduction in the number of experienced users.

No one knows how much of the decline to attribute to personal observation as opposed to high prices or reduced supply. But other evidence suggests strongly that price and supply played a large role. In 1972 the National Advisory Council was especially worried by the prospect that U.S. servicemen returning to this country from Vietnam would bring their heroin habits with them. Fortunately, a brilliant study by Lee Robins of Washington University in St. Louis put that fear to rest. She measured drug use of Vietnam veterans shortly after they had returned home. Though many had used heroin regularly while in Southeast Asia, most gave up the habit when back in the United States. The reason: here, heroin was less available and sanctions on its use were more pronounced. Of course, if a veteran had been willing to pay enough—which might have meant traveling to another city and would certainly have meant making an illegal contact with a disreputable dealer in a threatening neighborhood in order to acquire a (possibly) dangerous dose—he could have sustained his drug habit. Most veterans were unwilling to pay this price, and so their drug use declined or disappeared.

Reliving the Past

Suppose we had taken Friedman's advice in 1972. What would have happened? We cannot be entirely certain, but at a minimum we would have placed the young heroin addicts (and, above all, the prospective addicts) in a very different position from the one in which they actually found themselves. Heroin would have been legal. Its price would have been reduced by 95 percent (minus whatever we chose to recover in taxes.) Now that it could be sold by the same people who make aspirin, its quality would have been assured—no poisons, no adulterants. Sterile hypodermic needles would have been readily available at the neighborhood drugstore, probably at the same counter where the heroin was sold. No need to travel to big cities or unfamiliar neighborhoods—heroin could have been purchased anywhere, perhaps by mail order.

There would no longer have been any financial or medical reason to avoid heroin use. Anybody could have afforded it. We might have tried to prevent children from buying it, but as we have learned from our efforts to prevent minors from buying alcohol and tobacco, young people have a way of penetrating markets theoretically reserved for adults. Returning Vietnam veterans would have discovered that Omaha and Raleigh had been converted into the pharmaceutical equivalent of Saigon.

Under these circumstances, can we doubt for a moment that heroin use would have grown e: ponentially? Or that a vastly larger supply of ne users would have been recruited? Professor Frie man is a Nobel Prize-winning economist whos understanding of market forces is profound. Wh: did he think would happen to consumption unde his legalized regime? Here are his words: "Lega: izing drugs might increase the number of addict: but it is not clear that it would. Forbidden frui is attractive, particularly to the young."

Really? I suppose that we should expect n increase in Porsche sales if we cut the price b 95 percent, no increase in whiskey sales if we cu the price by a comparable amount—becaus young people only want fast cars and strong liquor when they are "forbidden." Perhaps Friedman's uncharacteristic lapse from the obvious implications of price theory can be explained by a misunderstanding of how drug users are recruited. In his 1972 essay he said that "drug addicts are deliberately made by pushers, who give likely prospects their first few doses free." If drugs were legal it would not pay anybody to produce addicts, because everybody would buy from the cheapest source. But as every drug expert knows, pushers do not produce addicts. Friends or acquaintances do. In fact, pushers are usually reluctant to deal with non-users because a non-user could be an undercover cop. Drug use spreads in the same way any fad or fashion spreads: somebody who is already a user urges his friends to try, or simply shows already-eager friends how to do it.

But we need not rely on speculation, however plausible, that lowered prices and more abundant supplies would have increased heroin usage. Great Britain once followed such a policy and with almost exactly those results. Until the mid-1960's, British physicians were allowed to prescribe heroin to certain classes of addicts. (Possessing these drugs without a doctor's prescription remained a criminal offense.) For many years this policy worked well enough because the addict patients were typically middle-class people who had become dependent on opiate painkillers while undergoing hospital treatment. There was no drug culture. The British system worked for many years, not because it prevented drug abuse, but because there was no problem of drug abuse that would test the system.

All that changed in the 1960's. A few unscrupulous doctors began passing out heroin in wholesale amounts. One doctor prescribed almost 600,000 heroin tablets—that is, over thirteen pounds—in just one year. A youthful drug culture emerged with a demand for drugs far different from that of the older addicts. As a result, the British government required doctors to refer users to government-run clinics to receive their heroin.

But the shift to clinics did not curtail the growth in heroin use. Throughout the 1960's the number

of addicts increased—the late John Kaplan of Stanford estimated by fivefold—in part as a result of the diversion of heroin from clinic patients to new users on the streets. An addict would bargain with the clinic doctor over how big a dose he would receive. The patient wanted as much as he could get, the doctor wanted to give as little as was needed. The patient had an advantage in this conflict because the doctor could not be certain how much was really needed. Many patients would use some of their "maintenance" dose and sell the remaining part to friends, thereby recruiting new addicts. As the clinics learned of this, they began to shift their treatment away from heroin and toward methadone, an addictive drug that, when taken orally, does not produce a "high" but will block the withdrawal pains associated with heroin abstinence.

Whether what happened in England in the 1960's was a mini-epidemic or an epidemic depends on whether one looks at numbers or at rates of change. Compared to the United States, the numbers were small. In 1960 there were 68 heroin addicts known to the British government; by 1968 there were 2,000 in treatment and many more who refused treatment. (They would refuse in part because they did not want to get methadone at a clinic if they could get heroin on the street.) Richard Hartnoll estimates that the actual number of addicts in England is five times the number officially registered. At a minimum, the number of British addicts increased by thirtyfold in ten years; the actual increase may have been much larger.

In the early 1980's the numbers began to rise again, and this time nobody doubted that a real epidemic was at hand. The increase was estimated to be 40 percent a year. By 1982 there were thought to be 20,000 heroin users in London alone. Geoffrey Pearson reports that many cities—Glasgow, Liverpool, Manchester, and Sheffield among them—were now experiencing a drug problem that once had been largely confined to London. The problem, again, was supply. The country was being flooded with cheap, high-quality heroin, first from Iran and then from Southeast Asia.

The United States began the 1960's with a much larger number of heroin addicts and probably a bigger at-risk population than was the case in Great Britain. Even though it would be foolhardy to suppose that the British system, if installed here, would have worked the same way or with the same results, it would be equally foolhardy to suppose that a combination of heroin available from leaky clinics and from street dealers who faced only minimal law-enforcement risks would not have produced a much greater increase in heroin use than we actually experienced. My guess is that if we had allowed either doctors or clinics to prescribe heroin, we would have had far worse results than were produced in Britain, if for no other reason than the vastly larger number of addicts with which we began. We would have had to find some way to police thousands (not scores) of physicians and hundreds (not dozens) of clinics. If the British civil service found it difficult to keep heroin in the hands of addicts and out of the hands of recruits when it was dealing with a few hundred people, how well would the American civil service have accomplished the same tasks when dealing with tens of thousands of people?

Back to the Future

Now cocaine, especially in its potent form, crack, is the focus of attention. Now as in 1972 the government is trying to reduce its use. Now as then some people are advocating legalization. Is there any more reason to yield to those arguments today than there was almost two decades ago?*

I think not. If we had yielded in 1972 we almost certainly would have had today a permanent population of several million, not several hundred thousand, heroin addicts. If we yield now we will have a far more serious problem with cocaine.

Crack is worse than heroin by almost any measure. Heroin produces a pleasant drowsiness and, if hygienically administered, has only the physical side effects of constipation and sexual impotence. Regular heroin use incapacitates many users, especially poor ones, for any productive work or social responsibility. They will sit nodding on a street corner, helpless but at least harmless. By contrast, regular cocaine use leaves the user neither helpless nor harmless. When smoked (as with crack) or injected, cocaine produces instant, intense, and short-lived euphoria. The experience generates a powerful desire to repeat it. If the drug is readily available, repeat use will occur. Those people who progress to "bingeing" on cocaine become devoted to the drug and its effects to the exclusion of almost all other considerations—job, family, children, sleep, food, even sex. Dr. Frank Gawin at Yale and Dr. Everett Ellinwood at Duke report that a substantial percentage of all high-dose, binge users become uninhibited, impulsive, hypersexual, compulsive, irritable, and hyperactive. Their moods vacillate dramatically, leading at times to violence and homicide.

Women are much more likely to use crack than heroin, and if they are pregnant, the effects on their babies are tragic. Douglas Besharov, who has been following the effects of drugs on infants for

* I do not here take up the question of marijuana. For a variety of reasons—its widespread use and its lesser tendency to addict—it presents a different problem from cocaine or heroin. For a penetrating analysis, see Mark Kleiman, *Marijuana: Costs of Abuse, Costs of Control* (Greenwood Press, 217 pp., $37.95).

twenty years, writes that nothing he learned about heroin prepared him for the devastation of cocaine. Cocaine harms the fetus and can lead to physical deformities or neurological damage. Some crack babies have for all practical purposes suffered a disabling stroke while still in the womb. The long-term consequences of this brain damage are lowered cognitive ability and the onset of mood disorders. Besharov estimates that about 30,000 to 50,000 such babies are born every year, about 7,000 in New York City alone. There may be ways to treat such infants, but from everything we now know the treatment will be long, difficult, and expensive. Worse, the mothers who are most likely to produce crack babies are precisely the ones who, because of poverty or temperament, are least able and willing to obtain such treatment. In fact, anecdotal evidence suggests that crack mothers are likely to abuse their infants.

The notion that abusing drugs such as cocaine is a "victimless crime" is not only absurd but dangerous. Even ignoring the fetal drug syndrome, crack-dependent people are, like heroin addicts, individuals who regularly victimize their children by neglect, their spouses by improvidence, their employers by lethargy, and their coworkers by carelessness. Society is not and could never be a collection of autonomous individuals. We all have a stake in ensuring that each of us displays a minimal level of dignity, responsibility, and empathy. We cannot, of course, coerce people into goodness, but we can and should insist that some standards must be met if society itself—on which the very existence of the human personality depends—is to persist. Drawing the line that defines those standards is difficult and contentious, but if crack and heroin use do not fall below it, what does?

The advocates of legalization will respond by suggesting that my picture is overdrawn. Ethan Nadelmann of Princeton argues that the risk of legalization is less than most people suppose. Over 20 million Americans between the ages of eighteen and twenty-five have tried cocaine (according to a government survey), but only a quarter million use it daily. From this Nadelmann concludes that at most 3 percent of all young people who try cocaine develop a problem with it. The implication is clear: make the drug legal and we only have to worry about 3 percent of our youth.

The implication rests on a logical fallacy and a factual error. The fallacy is this: the percentage of occasional cocaine users who become binge users *when the drug is illegal* (and thus expensive and hard to find) tells us nothing about the percentage who will become dependent when the drug is legal (and thus cheap and abundant). Drs. Gawin and Ellinwood report, in common with several other researchers, that controlled or occasional use of cocaine changes to compulsive and frequent use "when access to the drug increases" or when the user switches from snorting to smoking. More cocaine more potently administered alters, perhaps sharply, the proportion of "controlled" users who become heavy users.

The factual error is this: the federal survey Nadelmann quotes was done in 1985, *before* crack had become common. Thus the probability of becoming dependent on cocaine was derived from the responses of users who snorted the drug. The speed and potency of cocaine's action increases dramatically when it is smoked. We do not yet know how greatly the advent of crack increases the risk of dependency, but all the clinical evidence suggests that the increase is likely to be large.

It is possible that some people will not become heavy users even when the drug is readily available in its most potent form. So far there are no scientific grounds for predicting who will and who will not become dependent. Neither socioeconomic background nor personality traits differentiate between casual and intensive users. Thus, the only way to settle the question of who is correct about the effect of easy availability on drug use, Nadelmann or Gawin and Ellinwood, is to try it and see. But that social experiment is so risky as to be no experiment at all, for if cocaine is legalized and if the rate of its abusive use increases dramatically, there is no way to put the genie back in the bottle, and it is not a kindly genie.

Have We Lost?

MANY people who agree that there are risks in legalizing cocaine or heroin still favor it because, they think, we have lost the war on drugs. "Nothing we have done has worked" and the current federal policy is just "more of the same." Whatever the costs of greater drug use, surely they would be less than the costs of our present, failed efforts.

That is exactly what I was told in 1972—and heroin is not quite as bad a drug as cocaine. We did not surrender and we did not lose. We did not win, either. What the nation accomplished then was what most efforts to save people from themselves accomplish: the problem was contained and the number of victims minimized, all at a considerable cost in law enforcement and increased crime. Was the cost worth it? I think so, but others may disagree. What are the lives of would-be addicts worth? I recall some people saying to me then, "Let them kill themselves." I was appalled. Happily, such views did not prevail.

Have we lost today? Not at all. High-rate cocaine use is not commonplace. The National Institute of Drug Abuse (NIDA) reports that less than 5 percent of high-school seniors used cocaine within the last thirty days. Of course this survey

misses young people who have dropped out of school and miscounts those who lie on the questionnaire, but even if we inflate the NIDA estimate by some plausible percentage, it is still not much above 5 percent. Medical examiners reported in 1987 that about 1,500 died from cocaine use; hospital emergency rooms reported about 30,000 admissions related to cocaine abuse.

These are not small numbers, but neither are they evidence of a nationwide plague that threatens to engulf us all. Moreover, cities vary greatly in the proportion of people who are involved with cocaine. To get city-level data we need to turn to drug tests carried out on arrested persons, who obviously are more likely to be drug users than the average citizen. The National Institute of Justice, through its Drug Use Forecasting (DUF) project, collects urinalysis data on arrestees in 22 cities. As we have already seen, opiate (chiefly heroin) use has been flat or declining in most of these cities over the last decade. Cocaine use has gone up sharply, but with great variation among cities. New York, Philadelphia, and Washington, D.C., all report that two-thirds or more of their arrestees tested positive for cocaine, but in Portland, San Antonio, and Indianapolis the percentage was one-third or less.

In some neighborhoods, of course, matters have reached crisis proportions. Gangs control the streets, shootings terrorize residents, and drug-dealing occurs in plain view. The police seem barely able to contain matters. But in these neighborhoods—unlike at Palo Alto cocktail parties—the people are not calling for legalization, they are calling for help. And often not much help has come. Many cities are willing to do almost anything about the drug problem except spend more money on it. The federal government cannot change that; only local voters and politicians can. It is not clear that they will.

It took about ten years to contain heroin. We have had experience with crack for only about three or four years. Each year we spend perhaps $11 billion on law enforcement (and some of that goes to deal with marijuana) and perhaps $2 billion on treatment. Large sums, but not sums that should lead anyone to say, "We just can't afford this any more."

The illegality of drugs increases crime, partly because some users turn to crime to pay for their habits, partly because some users are stimulated by certain drugs (such as crack or PCP) to act more violently or ruthlessly than they otherwise would, and partly because criminal organizations seeking to control drug supplies use force to manage their markets. These also are serious costs, but no one knows how much they would be reduced if drugs were legalized. Addicts would no longer steal to pay black-market prices for drugs, a real gain. But some, perhaps a great deal, of that gain would be offset by the great increase in the number of addicts. These people, nodding on heroin or living in the delusion-ridden high of cocaine, would hardly be ideal employees. Many would steal simply to support themselves, since snatch-and-grab, opportunistic crime can be manged even by people unable to hold a regular job or plan an elaborate crime. Those British addicts who get their supplies from government clinics are not models of law-abiding decency. Most are in crime, and though their per-capita rate of criminality may be lower thanks to the cheapness of their drugs, the total volume of crime they produce may be quite large. Of course, society could decide to support all unemployable addicts on welfare, but that would mean that gains from lowered rates of crime would have to be offset by large increases in welfare budgets.

Proponents of legalization claim that the costs of having more addicts around would be largely if not entirely offset by having more money available with which to treat and care for them. The money would come from taxes levied on the sale of heroin and cocaine.

To obtain this fiscal dividend, however, legalization's supporters must first solve an economic dilemma. If they want to raise a lot of money to pay for welfare and treatment, the tax rate on the drugs will have to be quite high. Even if they themselves do not want a high rate, the politicians' love of "sin taxes" would probably guarantee that it would be high anyway. But the higher the tax, the higher the price of the drug, and the higher the price the greater the likelihood that addicts will turn to crime to find the money for it and that criminal organizations will be formed to sell tax-free drugs at below-market rates. If we managed to keep taxes (and thus prices) low, we would get that much less money to pay for welfare and treatment and more people could afford to become addicts. There may be an optimal tax rate for drugs that maximizes revenue while minimizing crime, bootlegging, and the recruitment of new addicts, but our experience with alcohol does not suggest that we know how to find it.

The Benefits of Illegality

THE advocates of legalization find nothing to be said in favor of the current system except, possibly, that it keeps the number of addicts smaller than it would otherwise be. In fact, the benefits are more substantial than that.

First, treatment. All the talk about providing "treatment on demand" implies that there is a demand for treatment. That is not quite right. There are some drug-dependent people who genuinely want treatment and will remain in it if offered; they should receive it. But there are far more who want only short-term help after a bad crash; once stabilized and bathed, they are back

on the street again, hustling. And even many of the addicts who enroll in a program honestly wanting help drop out after a short while when they discover that help takes time and commitment. Drug-dependent people have very short time horizons and a weak capacity for commitment. These two groups—those looking for a quick fix and those unable to stick with a long-term fix—are not easily helped. Even if we increase the number of treatment slots—as we should—we would have to do something to make treatment more effective.

One thing that can often make it more effective is compulsion. Douglas Anglin of UCLA, in common with many other researchers, has found that the longer one stays in a treatment program, the better the chances of a reduction in drug dependency. But he, again like most other researchers, has found that drop-out rates are high. He has also found, however, that patients who enter treatment under legal compulsion stay in the program longer than those not subject to such pressure. His research on the California civil-commitment program, for example, found that heroin users involved with its required drug-testing program had over the long term a lower rate of heroin use than similar addicts who were free of such constraints. If for many addicts compulsion is a useful component of treatment, it is not clear how compulsion could be achieved in a society in which purchasing, possessing, and using the drug were legal. It could be managed, I suppose, but I would not want to have to answer the challenge from the American Civil Liberties Union that it is wrong to compel a person to undergo treatment for consuming a legal commodity.

Next, education. We are now investing substantially in drug-education programs in the schools. Though we do not yet know for certain what will work, there are some promising leads. But I wonder how credible such programs would be if they were aimed at dissuading children from doing something perfectly legal. We could, of course, treat drug education like smoking education: inhaling crack and inhaling tobacco are both legal, but you should not do it because it is bad for you. That tobacco is bad for you is easily shown; the Surgeon General has seen to that. But what do we say about crack? It is pleasurable, but devoting yourself to so much pleasure is not a good idea (though perfectly legal)? Unlike tobacco, cocaine will not give you cancer or emphysema, but it will lead you to neglect your duties to family, job, and neighborhood? Everybody is doing cocaine, but you should not?

Again, it might be possible under a legalized regime to have effective drug-prevention programs, but their effectiveness would depend heavily, I think, on first having decided that cocaine use, like tobacco use, is purely a matter of practical consequences; no fundamental moral significance attaches to either. But if we believe—as I do—that dependency on certain mind-altering drugs is a moral issue and that their illegality rests in part on their immorality, then legalizing them undercuts, if it does not eliminate altogether, the moral message.

That message is at the root of the distinction we now make between nicotine and cocaine. Both are highly addictive; both have harmful physical effects. But we treat the two drugs differently, not simply because nicotine is so widely used as to be beyond the reach of effective prohibition, but because its use does not destroy the user's essential humanity. Tobacco shortens one's life, cocaine debases it. Nicotine alters one's habits, cocaine alters one's soul. The heavy use of crack, unlike the heavy use of tobacco, corrodes those natural sentiments of sympathy and duty that constitute our human nature and make possible our social life. To say, as does Nadelmann, that distinguishing morally between tobacco and cocaine is "little more than a transient prejudice" is close to saying that morality itself is but a prejudice.

The Alcohol Problem

Now we have arrived where many arguments about legalizing drugs begin: is there any reason to treat heroin and cocaine differently from the way we treat alcohol?

There is no easy answer to that question because, as with so many human problems, one cannot decide simply on the basis either of moral principles or of individual consequences; one has to temper any policy by a common-sense judgment of what is possible. Alcohol, like heroin, cocaine, PCP, and marijuana, is a drug—that is, a mood-altering substance—and consumed to excess it certainly has harmful consequences: auto accidents, barroom fights, bedroom shootings. It is also, for some people, addictive. We cannot confidently compare the addictive powers of these drugs, but the best evidence suggests that crack and heroin are much more addictive than alcohol.

Many people, Nadelmann included, argue that since the health and financial costs of alcohol abuse are so much higher than those of cocaine or heroin abuse, it is hypocritical folly to devote our efforts to preventing cocaine or drug use. But as Mark Kleiman of Harvard has pointed out, this comparison is quite misleading. What Nadelmann is doing is showing that a *legalized* drug (alcohol) produces greater social harm than *illegal* ones (cocaine and heroin). But of course. Suppose that in the 1920's we had made heroin and cocaine legal and alcohol illegal. Can anyone doubt that Nadelmann would now be writing that it is folly to continue our ban on alcohol because cocaine and heroin are so much more harmful?

And let there be no doubt about it—widespread heroin and cocaine use are associated with all manner of ills. Thomas Bewley found that the mortality rate of British heroin addicts in 1968 was 28 times as high as the death rate of the same age group of non-addicts, even though in England at the time an addict could obtain free or low-cost heroin and clean needles from British clinics. Perform the following mental experiment: suppose we legalized heroin and cocaine in this country. In what proportion of auto fatalities would the state police report that the driver was nodding off on heroin or recklessly driving on a coke high? In what proportion of spouse-assault and child-abuse cases would the local police report that crack was involved? In what proportion of industrial accidents would safety investigators report that the forklift or drill-press operator was in a drug-induced stupor or frenzy? We do not know exactly what the proportion would be, but anyone who asserts that it would not be much higher than it is now would have to believe that these drugs have little appeal except when they are illegal. And that is nonsense.

An advocate of legalization might concede that social harm—perhaps harm equivalent to that already produced by alcohol—would follow from making cocaine and heroin generally available. But at least, he might add, we would have the problem "out in the open" where it could be treated as a matter of "public health." That is well and good, *if* we knew how to treat—that is, cure—heroin and cocaine abuse. But we do not know how to do it for all the people who would need such help. We are having only limited success in coping with chronic alcoholics. Addictive behavior is immensely difficult to change, and the best methods for changing it—living in drug-free therapeutic communities, becoming faithful members of Alcoholics Anonymous or Narcotics Anonymous—require great personal commitment, a quality that is, alas, in short supply among the very persons—young people, disadvantaged people—who are often most at risk for addiction.

Suppose that today we had, not 15 million alcohol abusers, but half a million. Suppose that we already knew what we have learned from our long experience with the widespread use of alcohol. Would we make whiskey legal? I do not know, but I suspect there would be a lively debate. The Surgeon General would remind us of the risks alcohol poses to pregnant women. The National Highway Traffic Safety Administration would point to the likelihood of more highway fatalities caused by drunk drivers. The Food and Drug Administration might find that there is a nontrivial increase in cancer associated with alcohol consumption. At the same time the police would report great difficulty in keeping illegal whiskey out of our cities, officers being corrupted by bootleggers, and alcohol addicts often resorting to crime to feed their habit. Libertarians, for their part, would argue that every citizen has a right to drink anything he wishes and that drinking is, in any event, a "victimless crime."

However the debate might turn out, the central fact would be that the problem was still, at that point, a small one. The government cannot legislate away the addictive tendencies in all of us, nor can it remove completely even the most dangerous addictive substances. But it can cope with harms when the harms are still manageable.

Science and Addiction

One advantage of containing a problem while it is still containable is that it buys time for science to learn more about it and perhaps to discover a cure. Almost unnoticed in the current debate over legalizing drugs is that basic science has made rapid strides in identifying the underlying neurological processes involved in some forms of addiction. Stimulants such as cocaine and amphetamines alter the way certain brain cells communicate with one another. That alteration is complex and not entirely understood, but in simplified form it involves modifying the way in which a neurotransmitter called dopamine sends signals from one cell to another.

When dopamine crosses the synapse between two cells, it is in effect carrying a message from the first cell to activate the second one. In certain parts of the brain that message is experienced as pleasure. After the message is delivered, the dopamine returns to the first cell. Cocaine apparently blocks this return, or "reuptake," so that the excited cell and others nearby continue to send pleasure messages. When the exaggerated high produced by cocaine-influenced dopamine finally ends, the brain cells may (in ways that are still a matter of dispute) suffer from an extreme lack of dopamine, thereby making the individual unable to experience any pleasure at all. This would explain why cocaine users often feel so depressed after enjoying the drug. Stimulants may also affect the way in which other neurotransmitters, such as serotonin and noradrenaline, operate.

Whatever the exact mechanism may be, once it is identified it becomes possible to use drugs to block either the effect of cocaine or its tendency to produce dependency. There have already been experiments using desipramine, imipramine, bromocriptine, carbamazepine, and other chemicals. There are some promising results.

Tragically, we spend very little on such research, and the agencies funding it have not in the past occupied very influential or visible posts in the federal bureaucracy. If there is one aspect of the "war on drugs" metaphor that I dislike, it is its tendency to focus attention almost exclusively on the troops in the trenches, whether engaged in enforcement or treatment, and away from the

research-and-development efforts back on the home front where the war may ultimately be decided.

I believe that the prospects of scientists in controlling addiction will be strongly influenced by the size and character of the problem they face. If the problem is a few hundred thousand chronic, high-dose users of an illegal product, the chances of making a difference at a reasonable cost will be much greater than if the problem is a few million chronic users of legal substances. Once a drug is legal, not only will its use increase but many of those who then use it will prefer the drug to the treatment: they will want the pleasure, whatever the cost to themselves or their families, and they will resist—probably successfully—any effort to wean them away from experiencing the high that comes from inhaling a legal substance.

If I Am Wrong . . .

No one can know what our society would be like if we changed the law to make access to cocaine, heroin, and PCP easier. I believe, for reasons given, that the result would be a sharp increase in use, a more widespread degradation of the human personality, and a greater rate of accidents and violence.

I may be wrong. If I am, then we will needlessly have incurred heavy costs in law enforcement and some forms of criminality. But if I am right, and the legalizers prevail anyway, then we will have consigned millions of people, hundreds of thousands of infants, and hundreds of neighborhoods to a life of oblivion and disease. To the lives and families destroyed by alcohol we will have added countless more destroyed by cocaine, heroin, PCP, and whatever else a basement scientist can invent.

Human character is formed by society; indeed, human character is inconceivable without society, and good character is less likely in a bad society. Will we, in the name of an abstract doctrine of radical individualism, and with the false comfort of suspect predictions, decide to take the chance that somehow individual decency can survive amid a more general level of degradation?

I think not. The American people are too wise for that, whatever the academic essayists and cocktail-party pundits may say. But if Americans today are less wise than I suppose, then Americans at some future time will look back on us now and wonder, what kind of people were they that they could have done such a thing?

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - DFSCA REAUTHORIZATION

- The DFSCA, which provides funding to States to implement drug education programs in schools, will be up for reauthorization in 1994. Earlier this year, the Department of Education (ED) held public hearings on the reauthorization and convened an in-house working group to prepare recommendations. ONDCP participated in the development of the recommendations which included expanding the scope of the DFSCA to include anti-drug violence programs, consolidating several of the DFSCA's discretionary grant programs, and initiating a new evaluation reporting system.

- Additionally, ONDCP proposed that the formula of the DFSCA's block grant be modified to better reach those areas most devastated by drugs.

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TIMES
Los Angeles-Long Beach Met Area

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LUCE PRESS CLIPPINGS

Workplace Drug Testing on the Rise

■ Hiring: Employees screened at 85% of major companies, compared to 75% a year ago and 22% in 1987, according to poll.

From Reuters

NEW YORK—Drug testing in the workplace has grown at a frantic pace, with 85% of major companies testing workers and job applicants, compared to 75% a year ago, a survey released Thursday showed.

"Every year a greater share of companies without a testing program begin to test; every year a greater share of companies with programs expand them," said Eric Greenberg, director of the American Management Assn. survey.

In 1987, when the survey was initiated, 22% of companies tested for drugs. Since then testing has soared nearly 300%, reaching a record level each year. Big companies account for the bulk of testers.

The management group attributed the rise to new federal regulations for transportation and defense workers, new corporate policies and attempts to reduce liability insurance costs.

Although the survey polled 630 companies, the management group said that it can infer that more than a third of all Americans applying for jobs this year will be asked to take a drug test, most likely by giving a urine sample.

As companies have thrown a wider net in testing workers and job applicants, the amount of people testing positive has dropped rapidly.

Only 2.5% of all workers tested and 4.3% of job applicants gave a positive signal for drug use. In 1988, 8.1% of employees and 11.2% of applicants tested positive.

"The decline in test-positive rates reflects a wider testing pool, not lesser drug use," Greenberg said.

While the group [illegible] was no evidence yet to support the contention that drug testing prevents drug use, they did find that education had a positive effect.

DRUG: More Companies Are Testing Workers

Among companies polled in the January, 1993, survey, those that had education programs for employees and managers had a 26% lower rate of positive drug tests.

"Drug education and counseling can increase any program's effectiveness and should be the cornerstone of any company's efforts, regardless of whether it conducts drug testing or not," said Bill Current, executive director of the American Council for Drug Education.

Because of the cost—an average of $43 for each test—most companies test employees randomly. Three-quarters of all companies test job applicants, and 67% of these test each and every prospective employee.

Despite the proclivity of companies to test for drugs, only 73% retest for verification.

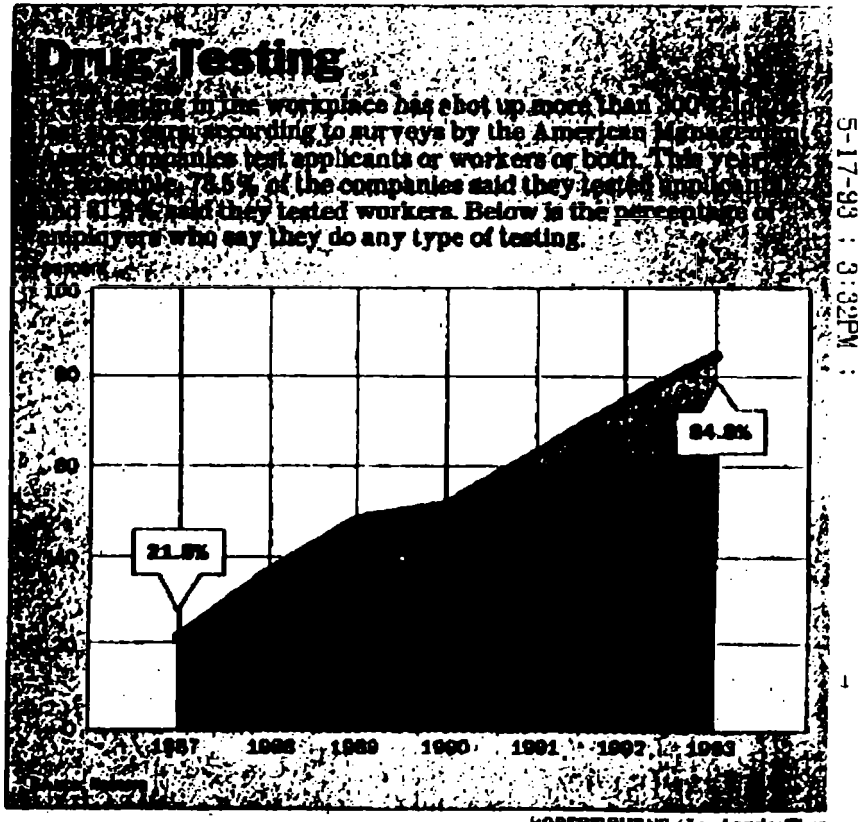
A worker who eats a poppy seed bagel for breakfast may test positive for heroin use. The common, over-the-counter pain reliever ibuprofen may appear as marijuana.

But [illegible]rly a quarter of all companies do not follow guidelines in verification, and 6% don't bother to validate the results at all.

Applicants who test positive face virtually no hope of being hired by a company.

If an employee tests positive, 54% of all companies will suggest counseling, while 25% will fire the worker outright. The remainder would demote, reassign or deny promotion to the worker.

Overall, companies believe that drug testing is effective and worth the cost. Eighty-four percent of the companies that undertake drug testing believe that it is an effective way to deal with drug abuse. Only 12% disagreed.



ROBERT BURNS / Los Angeles Times

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Divider Title: _____

Federal Drug Control Spending by Function
FY 1991 – FY 1994
($ Millions)

	1991 Actual	1992 Actual	1993 Enacted	1994 President's Budget	FY93 – FY94 Change $	FY93 – FY94 Change %
Criminal Justice System	4,385.6	4,943.1	5,374.8	5,782.6	407.7	8%
Drug Treatment	1,874.2	2,199.8	2,367.7	2,538.1	170.4	7%
Education, Community Action, and the Workplace	1,479.2	1,538.7	1,524.4	1,789.9	265.5	17%
→ International	633.4	660.4	538.0	490.0	(48.0)	-9%
Interdiction	2,027.9	1,960.2	1,746.2	1,765.2	19.0	1%
Research	450.1	504.5	530.9	548.2	17.2	3%
Intelligence	104.1	98.6	128.7	127.4	(1.3)	-1%
Total	**10,954.5**	**11,905.2**	**12,210.8**	**13,041.4**	**830.6**	**7%**

NATIONAL DRUG CONTROL BUDGET
BY FUNCTION

($ Millions)	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994
INTERNATIONAL														
Agency for International Development	0.0	15.7	9.2	10.6	6.7	23.5	7.1	9.9	13.3	54.5	189.6	250.2	134.8	96.4
DoD (506(A)(2) & Excess Def. Articles)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	65.0	53.3	0.0	0.0	0.0	0.0
Assets Forfeiture Fund	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	12.4	14.0	13.2
Drug Enforcement Administration	31.0	34.3	36.9	42.8	51.0	67.7	91.1	97.4	97.6	141.3	172.4	161.4	166.6	170.5
Federal Bureau of Investigation	0.0	0.0	0.0	0.0	0.0	0.0	1.3	1.1	1.1	1.5	1.8	2.2	1.8	1.8
International Narcotics Matters	34.7	36.7	36.7	41.2	50.2	55.1	118.4	98.8	101.0	129.5	150.0	144.8	147.8	147.8
Interpol	0.1	0.1	0.1	0.1	0.1	0.2	0.6	0.8	0.7	1.1	1.3	1.9	1.9	1.9
U.S. Marshals	0.0	0.0	0.0	0.1	0.2	0.2	0.3	0 5	0.6	0.9	3 5	2.6	2.8	2.8
Treasury Forfeiture Fund	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.6	6.1
Bureau of Politico/Military Affairs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	21.6	114.5	107 6	75.3	52.3	38.7
Emer. in the Dip. & Consular Service	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.0	0.0	0.0	0.3	0 3
U.S. Information Agency	1.0	1.0	1.0	1.0	1.0	1.0	2 0	1.0	2.8	3.4	7.3	9.7	10.1	10.6
	66.8	87.8	83.9	95.8	109.2	147.7	220.9	209.3	304.0	500.1	633.4	660.4	538.0	490.0

OVERVIEW

INTERNATIONAL DRUG CONTROL PROGRAMS

Efforts to reduce the use of illegal drugs in America include programs and initiatives in source countries where drugs are produced and from which they are exported to the United States by major trafficking organizations.

Central to this endeavor is the destruction of trafficking infrastructures through the investigation, prosecution, punishment, and, where appropriate, extradition of drug traffickers and money launderers; the seizure of drugs and assets; and the destruction of processing and shipping facilities.

Currently, the principal objectives of the United States in this area are to strengthen the political commitment of the governments of drug producer and transit countries by helping them strengthen their laws, legal institutions, and programs, and increasing the effectiveness of their own law enforcement and security activities to enable them to take action against drug trafficking organizations.

COCAINE

A major component of the international effort is the support of the principal cocaine producing countries -- Colombia, Peru, and Bolivia -- in their efforts against drug trafficking organizations.

- The first goal is to strengthen the political commitment and institutional capability of these governments to confront the cocaine trade.

- The second goal is to work with these countries to increase the effectiveness of their law enforcement and military activities against the cocaine industry, including planning law enforcement, paramilitary, and military operations against trafficking organizations and coordinating them with other countries.

- The third goal is to work with these countries to inflict significant damage on the trafficking organizations by disrupting or dismantling the operations and elements of greatest value to them.

- The fourth goal is to strengthen and diversify the legitimate economies of the Andean nations to enable them to overcome the destabilizing economic (and political) effects of eliminating cocaine.

Assistance is conditioned on drug-control performance and the existence of sound economic policies of the host countries. In

some instances, assistance is further conditioned on a country's meeting specific human rights criteria.

In addition, the U.S. attempts to limit or deny Andean trafficking organizations access to potential source countries (Brazil, Ecuador, and Venezuela) for the production, transportation, or financing of illicit drugs by encouraging these governments to take aggressive action against Andean traffickers infringing on their territory.

The National Security Council review and coordination process is considering a number of actions which could improve the effectiveness of both U.S. and host nation efforts to reduce the flow of drugs in and from the Andean region. In addition, discussions are ongoing concerning the nature of our continuing presence in Peru.

- Andean Strategy Funding:

  FY92: $410.3 million
  FY93: $267.3 million
  FY94: $214.9 million (requested)

HEROIN

Heroin use indicators and data on price, purity, and seizures give cause for concern. Nearly 60 percent of the heroin available for consumption in the U.S. is imported from Southeast Asia; consequently, intelligence efforts are attempting to improve identification and understanding of Asian trafficking organizations.

Efforts are being made to increase cooperation with foreign governments in the Pacific Rim (Japan, Hong Kong, Malaysia, and Thailand), including the updating of extradition treaties and the negotiation of Mutual Legal Assistance Treaties to facilitate the exchange of evidence and information.

- **Annually, the U.S. must certify the adequacy of the efforts of foreign countries to take action against drug trafficking. All countries have been certified except Burma, Iran, and Syria.**

INTERNATIONAL DEMAND REDUCTION

Illicit drug use is increasing in virtually all regions of the world. The U.S. seeks to motivate other countries to act vigorously to curtail domestic drug supply and demand, and to work cooperatively with other nations to end international trafficking.

The U.S. provides general information, research findings, and

technical expertise to other countries our U.S. demand reduction efforts and helps train foreign educators, health professionals, and other specialists.

The U.S. also sponsors a broad range of exchange and information programs.

The U.S. engages developed countries in support of international demand reduction objectives through consultative mechanisms, bilateral activities, and multilateral organizations.

- Some fear that NAFTA will increase drug trafficking through Mexico, but cooperation with Mexico is excellent on a variety of counternarcotics issues.

- San Antonio Summit: progress to implement programs in law enforcement, demand reduction, and economic development has been slowed by President Fujimori's "auto-coup" and by elections in other countries in the region.

OPBA
5/17/93

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - PABLO ESCOBAR

- The capture of Pablo Escobar would probably not have a direct impact on drug trafficking to the United States, since Escobar no longer controls the bulk of cocaine shipments to the U.S.

  -- Pablo Escobar is the head of the so-called Medellin cartel, which at one time dominated the Colombian drug trade.

  -- Recent events -- including Escobar's negotiated surrender in 1991, his bloody purge of disloyal lieutenants last summer while he was in prison, and the government manhunt following his escape in July -- have apparently left his organization in tatters. Former Escobar associates have formed new alliances with other Medellin and Cali groups and are gaining control over what remains of the Medellin drug scene.

  -- As a result, the Medellin cartel's share of the world drug trade has decreased. The Cali cartel probably now dominates the world cocaine market.

- Nevertheless, the U.S. has a vested interest in seeing that Escobar is recaptured as soon as possible.

  -- The Colombia government's reputation is at stake, both at home and abroad. (Impact on election.)

  -- The massive manhunt for Escobar is being carried out largely by military and police forces which would otherwise be dedicated to counternarcotics efforts. As a result, cocaine seizures in Colombia have dropped significantly since last summer.

  -- Escobar's recapture will allow the Colombian government to better concentrate it's efforts against the Cali cartel.

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - INTERNATIONAL DEMAND REDUCTION

International Epidemiology

- For the past two years, ONDCP has sought to develop a broad-based initiative to motivate countries of strategic importance (the Andean group; Mexico and Caribbean transit countries; and the Europeans) to initiate or intensify surveys that can determine the level, nature, direction and consequences of drug use, and that can then motivate these countries to act more vigorously against drug supply and demand on their own. The U.S. now supports epidemiology in Colombia, Peru, Ecuador and Bolivia; assists the Organization of American States to develop a surveillance program in Central America; participates in border programs with Mexico; and is developing a Caribbean surveillance network linked to NIDA through the State of Florida.

U.S.-Spanish Demand Reduction Bilateral Agreement

- In November, 1991, the U.S. and Spain entered a bilateral agreement which created a joint Demand Reduction Commission to discuss demand reduction issues of interest to both. The Commission met in Washington in May 1992, when the Spanish sought full briefings on U.S. demand reduction policies and programs. Spain may seek a reciprocal meeting in Madrid in 1993.

Demand Reduction Actions that follow the San Antonio Summit

- The March, 1992, San Antonio Summit (involving the U.S., Colombia, Peru, Bolivia, Ecuador, Venezuela and Mexico) concluded with a Declaration that, among other actions, urges the participant countries to intensify national efforts in the areas of public awareness, prevention, treatment, scientific research and training. The Bolivian Government is to chair a meeting early in 1993 to discuss ways to further support the terms of the Declaration.

U.S.-Mexican Demand Reduction Working Group

- At the first meeting of the Working Group in October, 1991, the U.S. and Mexico agreed to discuss drug prevention and treatment specific to Hispanic populations in the U.S.; hold a joint technical seminar on prevention education;

and to exchange data base information on drug use. Mexico may ask for a reciprocal meeting in Mexico City during the coming year.

Commission on Narcotic Drugs (CND), Vienna, April 1993

- The coming session of this annual meeting of the United Nations' principal drug control agency will discuss demand reduction as a global issue. The French have agreed to draft a resolution on the subject and circulate it to the U.S. and others, prior to submitting it for consideration at the CND. The Vienna CND meeting is one of four or five international fora involving demand reduction where ONDCP representation is requested or desired.

International Private Sector Initiatives

- Several initiatives are planned to promote the increased involvement of U.S. and foreign private sectors in curbing drug demand abroad. The most important involves a U.S.-generated initiative to convene a major international conference on drugs and the private sector, scheduled to take place under U.N. auspices in mid-September, 1993, likely in Europe. ONDCP has been involved in the planning of this conference, and may be asked to attend.

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RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

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b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

U.S. ANDEAN STRATEGY NARCOTICS-RELATED ASSISTANCE

Authorized Program by Fiscal Year – Budget Authority
($ in Millions)

COUNTRY	FY 1990 Actual	FY 1991 Actual	FY 1992 Actual	FY 1993 Estimate	FY 1994 Request
COLOMBIA:					
Military Assistance					
FMF	$69.734	$34.500	$28.200	$15.600	$18.000
IMET	$1.500	$2.593	$2.296	$2.200	$2.000
Economic Assistance					
ESF	$2.328	$50.000	$54.879	$20.000	$15.000
DA	$1.540	$0.000	$0.000	$0.000	$0.000
Law Enforcement					
INM	$20.000	$20.000	$23.383	$25.000	$25.000
FMF	$1.996	$12.500	$18.800	$10.400	$12.000
DEA Support	$4.900	$6.200	$6.500	$6.500	$6.500
SUBTOTAL	$101.998	$125.793	$134.058	$79.700	$78.500
PERU:					
Military Assistance					
FMF	$0.000	$6.813	$0.000	$0.000	$0.000
IMET	$0.458	$0.524	$0.113	$0.740	$0.500
Economic Assistance					
ESF	$3.286	$60.014	$94.950	$40.000	$22.500
DA	$0.468	$0.000	$0.000	$0.000	$0.000
Law Enforcement					
INM 1/	$19.000	$19.000	$12.500	$17.500	$17.000
FMF	$1.000	$5.600	$0.000	$0.000	$0.000
DEA Support	$3.600	$4.700	$4.100	$4.100	$4.100
SUBTOTAL	$27.812	$96.651	$111.663	$62.340	$44.100
BOLIVIA:					
Military Assistance					
FMF	$38.228	$30.000	$20.000	$14.400	$12.000
IMET	$0.552	$0.899	$0.900	$0.900	$0.900
Economic Assistance					
ESF	$33.413	$76.500	$99.879	$70.000	$40.000
DA	$8.601	$11.437	$1.954	$8.471	$8.471
Law Enforcement					
INM	$15.700	$15.700	$15.700	$17.000	$17.000
FMF	$1.000	$5.000	$5.000	$3.600	$3.000
DEA Support	$8.400	$10.100	$10.900	$10.900	$10.900
SUBTOTAL	$105.894	$149.636	$154.333	$125.271	$92.271
Andean Narcotics Information System (ESF):	$0.000	$0.500	$0.000	$0.000	$0.000
TOTAL ASSISTANCE:					
Military Assistance					
FMF	$107.962	$71.313	$48.200	$30.000	$30.000
IMET	$2.510	$4.016	$3.309	$3.840	$3.400
Economic Assistance					
ESF	$39.027	$187.014	$249.708	$130.000	$77.500
DA	$10.609	$11.437	$1.954	$8.471	$8.471
Law Enforcement					
INM	$54.700	$54.700	$51.583	$59.500	$59.000
FMF	$3.996	$23.100	$23.800	$14.000	$15.000
DEA Support	$16.900	$21.000	$21.500	$21.500	$21.500
SUBTOTAL	$235.704	$372.580	$400.054	$267.311	$214.871
DOD SECTION 506(a)(2)	$27.800	--	$7.000	--	--
EDA	--	$3.099	$3.251	--	--
SUBTOTAL	$27.800	$3.099	$10.251	--	--
GRAND TOTAL	$263.504	$375.679	$410.305	$267.311	$214.871

1/ FY 1990 law enforcement assistance for Peru includes $9.0 million in support from the INM Interregional Airwing.

The FY 1993 and 1994 FMF split between military assistance and law enforcement is an estimate only.
AID is developing an estimate for FY 1994. For now, the figures for AID's DA are placeholders.
DEA is developing an estimate for FY 1994. For now, the figures for DEA Support are placeholders.

Source: Budget and Legislative Review Staff

29-Apr-93

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Divider Title: _____

Federal Drug Control Spending by Function
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($ Millions)

	1991 Actual	1992 Actual	1993 Enacted	1994 President's Budget	FY93 – FY94 Change $	FY93 – FY94 Change %
Criminal Justice System	4,385.6	4,943.1	5,374.8	5,782.6	407.7	8%
Drug Treatment	1,874.2	2,199.8	2,367.7	2,538.1	170.4	7%
Education, Community Action, and the Workplace	1,479.2	1,538.7	1,524.4	1,789.9	265.5	17%
International	633.4	660.4	538.0	490.0	(48.0)	-9%
Interdiction	2,027.9	1,960.2	1,746.2	1,765.2	19.0	1%
Research	450.1	504.5	530.9	548.2	17.2	3%
Intelligence	104.1	98.6	128.7	127.4	(1.3)	-1%
Total	**10,954.5**	**11,905.2**	**12,210.8**	**13,041.4**	**830.6**	**7%**

NATIONAL DRUG CONTROL BUDGET
BY FUNCTION

($ Millions)	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994
INTERDICTION														
Department of Defense	0.0	4.9	9.7	14.6	54.8	105.7	405.3	94.7	329.1	543.4	751.0	854.4	743.8	761.7
Bureau of Land Management	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2	2.3	2.8	1.4
OTIA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5	1.0	1.3	0.8	0.8	0.8
Immigration and Naturalization Service	0.2	0.2	0.3	0.4	0.4	0.7	17.2	17.5	52.0	48.6	62.6	67.7	70.1	73.3
U.S. Coast Guard	227.5	328.9	359.9	508.2	506.6	397.8	553.0	509.8	628.9	661.2	714.6	431.2	417.7	458.0
Federal Aviation Administration	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.8	3.2	9.3	16.5	15.1	12.8	11.8
U.S. Customs	122.0	124.0	103.6	183.7	245.3	239.7	367.1	317.5	427.0	488.3	481.8	588.8	498.2	458.2
Payments to Puerto Rico	0.0	0.0	0.0	0.0	0.0	0.0	7.8	7.8	0.0	0.0	0.0	0.0	0.0	0.0
	349.7	458.0	473.5	706.9	807.3	744.0	1,350.5	948.1	1,440.7	1,751.9	2,027.9	1,960.2	1,746.2	1,765.2

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. paper	Interdiction (3 pages)	05/18/1993	P1/b(1)

COLLECTION:
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Domestic Policy Council
Jose Cerda
OA/Box Number: 5320

FOLDER TITLE:
Office of National Drug Control Policy Confirmation Briefing Book: Dr. Lee Brown - May 1993 [binder]

2016-0931-S
rc2344

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
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OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - THE SOUTHWEST BORDER

- As a result of successful air and maritime interdiction efforts in the Southeastern United States and the Bahamas, drug smugglers shifted their focus towards Mexico as a primary transfer point for smuggling drugs into the United States. This shift created an especially intense drug trafficking area along the Southwest Border.

- Drugs smuggled into Mexico are marshalled at clandestine sites near the border. Private and commercial vehicles and freight containers are used to smuggle drugs into the United States because they are all but lost in the tremendous volume of legitimate trade and commerce between the two countries. Private aircraft are also used because they can launch from sites close to the border, make airdrops over U.S. territory, and return to safe havens across the border.

- To interdict drugs shipped across the Mexican border, the U.S. Government stresses law enforcement efforts in this area, uses sophisticated technology to monitor relevant traffic, and cooperates closely with the Mexican government in coordinating mutual efforts.

  -- DOD Joint Task Force Six. This regional task force command and control headquarters oversees and coordinates DOD support to Federal, State, and local law enforcement organizations in the area.

  -- Operation Alliance. Alliance, a law enforcement coalition of Federal, State, and local law enforcement agencies, provides coordinated interdiction efforts along the Southwest Border.

  -- High Intensity Drug Trafficking Area (HIDTA). The Southwest Border was designated as a HIDTA in 1990. As such, ongoing Federal, State, and local law enforcement initiatives to dismantle drug trafficking organizations have received supplemental funding.

  -- Aerostats. These unmanned blimps contain radar and are used to detect, monitor, identify, and assist in tracking drug aircraft. Seven of the 16 planned aerostats are planned to be employed along the Southwest Border -- two in Arizona, one in New Mexico, and four in Texas.

OSR-20
5/18/93

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET -- FEDERAL DRUG SEIZURES

DRUG	FY 1989	FY 1990	FY 1991	FY 1992
Cocaine	99.2 MT	107.3 MT	109.5 MT	137.8 MT
Heroin	1,095.2 KGS	815.0 KGS	1,374.4 KGS	1,120.5 KGS
Cannabis	1,122,095 LBS	500,411 LBS	677,259 LBS	780,987 LBS
Marijuana	1,070,514 LBS	483,349 LBS	499,049 LBS	776,939 LBS
Hashish	51,581 LBS	17,062 LBS	178,210 LBS	4,047 LBS

- The Federal-Wide Drug Seizure System (FDSS) contains information about unduplicated Federal drug seizures made within the jurisdiction of the United States by the DEA, FBI, Customs, Coast Guard.
- The FDSS data base contains seizures by other Federal agencies to the extent that the custody of the drug evidence was transferred to one of the agencies identified above .
- FDSS reports on total Federal seizures. Information about individual agency seizures are not available from this system.

OPBA-5
4/12/93

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F

Divider Title: _____

Federal Drug Control Spending by Function
FY 1991 – FY 1994
($ Millions)

	1991 Actual	1992 Actual	1993 Enacted	1994 President's Budget	FY93 – FY94 Change $	FY93 – FY94 Change %
Criminal Justice System	4,385.6	4,943.1	5,374.8	5,782.6	407.7	8%
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NATIONAL DRUG CONTROL BUDGET
BY FUNCTION

($ Millions)	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994
RESEARCH AND DEVELOPMENT														
Agricultural Research Service	1.4	1.4	1.4	1.4	1.4	1.3	1.4	1.3	1.3	1.5	6.4	6.5	6.5	6.5
U.S. Forest Service	0.0	0.0	0.0	0.1	0.2	0.0	0.0	0.0	0.1	0.1	0.5	0.5	0.5	0.5
Department of Defense	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	11.6	61.0	91.6	60.5	62.0
Drug Enforcement Administration	1.4	1.8	3.9	2.9	2.2	1.5	4.3	3.2	2.7	2.9	3.0	0.0	0.0	0.0
Federal Bureau of Investigation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.6	3.8	3.7	3.7
INS	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	1.0	0.5	0.4	0.5
Office of Justice Programs	0.0	0.2	2.2	0.3	0.9	2.7	4.7	9.6	11.6	14.7	17.9	16.7	22.0	22.0
OCDETF	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.4	0.4	0.4
ONDCP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	8.5	1.5	0.9	0.9
Special Forfeiture Fund	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	20.0	15.0	28.0
FinCEN	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.2	1.0	3.7	3.2
Coast Guard	0.3	0.3	0.2	0.4	1.5	3.6	4.1	4.1	4.0	4.0	4.0	5.2	2.4	2.6
FAA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.7	0.9	0.8
Nat. Highway Traffic Safety Admin.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2	0.5	0.5	1.4	1.7
U.S. Customs	1.8	1.6	1.5	1.2	1.5	1.3	1.1	3.7	4.8	4.7	3.4	3.7	3.8	3.5
Pres. Com. Organized Crime	0.0	0.0	0.2	1.6	2.2	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
ADAMHA - - Prevention	30.1	24.1	26.4	32.0	35.8	40.8	65.9	73.4	81.0	127.7	150.6	157.5	0.0	0.0
NIDA - - Prevention	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	164.3	165.5
SBA - - Prevention	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2
ADAMHA - - Treatment	41.5	33.2	35.3	39.1	45.4	44.6	74.1	74.4	122.7	158.1	185.7	191.8	0.0	0.0
NIDA - - Treatment	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	239.9	241.6
Veterans Affairs - - Treatment	0.0	2.0	2.5	2.7	2.7	2.3	2.0	2.1	2.2	2.1	2.2	2.7	4.4	4.6
	76.5	64.7	73.6	81.7	93.8	99.0	157.6	171.8	230.6	327.7	450.1	504.5	530.9	548.2

OVERVIEW

RESEARCH

For FY94, the President has requested $548 million in drug-related research, an increase of 3% over FY93 and $318 million (+138%) over the FY89 level. About 80% of this funding is in demand reduction; about 75% of the total is in NIDA alone. Of the $407 million in NIDA, 60% is in treatment research; the remainder is in prevention research.

Federal funds support:

- Expanded drug treatment research focused on addiction, HIV/AIDS and drug use, medications development, treatment for pregnant addicts, and basic issues related to neurobiological and behavioral studies on drug use.

- Expanded and broadened national data colleciton on drugs and drug use, including larger and more frequent household surveys; surveys targeted on hard-to-reach populations; broader high school surveys; enlarged information collection on drug treatment; and market-oriented drug consumption research.

- Development of regional and State drug-related data.

- Increased technological and scientific research related to drug enforcement and interdiction.

Other items:

- Much of the NIDA research funding has been ear-marked by the Hill or tied up in long-term commitments; very little is available for new discretionary projects.

- Supply side agencies place a relatively low priority on R&D. In tight budget times, this is one of the first areas cut.

- ONDCP has a $1.5 million research contract through OPBA that enables the agency to do small quick analyses of data sets and conduct small-scale field survey work that provides real-time information to the ONDCP Director on current developments in drug use patterns and price/purity. Other data sets lag 6-12 months.

- Congress created the Counter-Drug Technology Assessment Center in ONDCP, mandating that it have 5 staff members. Its function is to fund projects that bring sophisticated technology into the hands of law enforcement agencies. Funding for CTAC is approximately $15 million in FY93 appropriations.

OPBA
5/17/93

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - CTAC R&D PROGRAM

- Public Law 101-509 provided appropriations to establish within ONDCP the Counter-drug Technology Assessment Center (CTAC), whose purpose is to serve as the central counterdrug research and development center for the Federal Government.

- CTAC is headed by the Chief Scientist of Counter-drug Technology, who is appointed by the Director of ONDCP. Acting on behalf of the Director, the Chief Scientist oversees CTAC's five Congressionally mandated responsibilities:

  -- To identify and define the short-, medium, and long-term scientific and technological needs of Federal, State, and local law enforcement agencies involved in the anti-drug program. Research emphasis will be on advanced surveillance, tracking and radar imaging measures, electronic support measures, communications, and ADP systems and applications;

  -- To assign priorities to the identified research needs by considering the technological and fiscal feasibility;

  -- To oversee and coordinate counterdrug technology initiatives of other Federal civilian and military departments;

  -- To submit reprogramming and transfer requests of funds appropriated for counterdrug enforcement research and development; and

  -- To conduct research and development activities for substance abuse addiction and rehabilitation research, as directed in Public Law 102-141.

- All CTAC R&D funds have been appropriated as no-year funds. The Special Forfeiture Fund has been the primary source of funding for the CTAC R&D funds.

- Status of CTAC R&D Funds (in $ millions):

	FY 92	FY 93	Total
Appropriation	$21.0	$15.0	$36.0
Obligations to date	$ 7.8	$ 5.1	$12.9
Available Funds	$13.2	$ 9.9	$23.1

- CTAC makes a determination as to which projects and technologies should be funded. Funds are then obligated and transferred to other Federal agencies for award to vendors and contractors.

- BAA Process -- CTAC published a Broad Agency Announcement (BAA) in the Commerce Business Daily to solicit white papers from a broad spectrum of potential vendors and contractors for various counterdrug technologies and projects. CTAC, through several interagency evaluation panels, reviews and ranks these white papers, and will recommend award based on their merit.

  -- The BAA closed March 31, 1993. Over 600 white papers were received.

  -- All evaluations by the interagency review panels should be completed by the end of May.

  -- No awards have been made under the BAA process to date. Awards are expected to be made during June to September 1993.

- The FY 1994 budget request for the Special Forfeiture Fund includes potential funding for CTAC R&D projects. These projects, along with other high-priority drug control projects consistent with the National Drug Control Strategy, will be funded at the discretion of the Director, ONDCP.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003. paper	re: CTAC Background [partial] (1 page)	00/00/0000	b(7)(E)

COLLECTION:
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Domestic Policy Council
Jose Cerda
OA/Box Number: 5320

FOLDER TITLE:
Office of National Drug Control Policy Confirmation Briefing Book: Dr. Lee Brown - May 1993 [binder]

2016-0931-S
rc2344

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CTAC BACKGROUND

CTAC was established in 1990 legislation and a Chief Scientist has been on board since November 1991. In this short period of time, CTAC has built a solid, ambitious national counterdrug R&D effort.

- It has initiated a widely accepted national counterdrug R&D program --fully supported by the federal law enforcement agencies -- and a Counterdrug Enforcement Research and Development Blueprint to the President and Congress that outlines -- for the first time -- a national counterdrug R&D strategy, including program and budgetary priorities.

- CTAC has established a technology testbed program. The testbeds will be fully instrumented, largely centralized locations from which scientists, engineers and law enforcement personnel can test and evaluate specific prototype technologies. In effect, the testbeds will serve as "laboratories in the field," where objective data can be collected from field trials of promising new technologies.

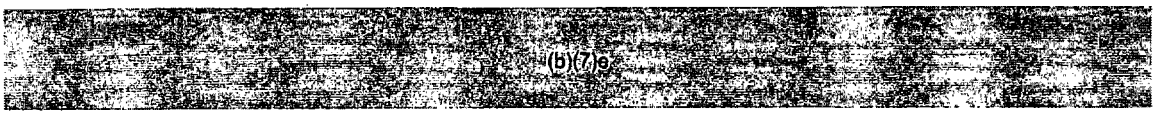
  Its first Tactical Technology Testbed in Miami, Florida will be activated during June 93 and, initially, will evaluate covertly emplaced geolocation position satellite receiver technologies. The participants in these tests include the FBI, DEA, Customs, Secret Service, and various state and local organizations.

- Full scale development of the radiochemistry laboratory at the Addiction Research Center (ARC) should be completed in fourth quarter Fiscal Year 1993. CTAC's current plans include providing Fiscal Year 1993 funding to continue supporting the PET research being conducted at ARC by developing accelerator technology for improved resolution and lower-cost PET facilities.

- CTAC has undertaken a number of initiatives to establish formal and informal lines of communication with scientific and technical experts in academia, the national laboratories, the HBCUs, private industry and other federal agencies that can assist in the identification and development of promising new counterdrug technologies.

- CTAC has put together a project with the Columbia Medical School to develop an artificial enzyme to reduce serum cocaine concentrations. SCIENCE Magazine had a recent article on the work. CTAC sponsored a Cargo and Contraband Inspection (CCI) Technology International Symposium in conjunction attended by 450 people from 18 countries and will sponsor a Wide Area Surveillance and Tactical Technologies in Chicago, this November.

- CTAC initiated 18 projects representing the LEAs priority technology needs. Several of these have already been put into the hands of the LEAs and in a few instances, for example, drug detection test kits, have been given to state and local people. Other examples of research successes include:



0003

NARCOTICS DETECTION TECHNOLOGY ASSESSMENT. This project supports field tests to determine detection limits for illicit drug signature and signal processing Several field tests have taken place starting with the first one last summer in Miami. It has been expanded into a full scale program which will use Argonne National Laboratory as a test series integrator for all future tests.

§ 1502a. Counter-Drug Technology Assessment Center

(a) Establishment. There is established within the Office of National Drug Control Policy, the Counter-Drug Technology Assessment Center (hereinafter in this section referred to as the "Center"). The Center shall operate under the authority of the Director of National Drug Control Policy and shall serve as the central counter-drug enforcement research and development organization of the United States Government.

(b) Director. There shall be at the head of the Center the Chief Scientist of Counter-Drug Technology (hereinafter in this section referred to as the "Chief Scientist"). The Chief Scientist shall be appointed by the Director of National Drug Control Policy from among individuals qualified and distinguished in the area of science, engineering, or technology.

(c) Additional responsibilities of the Director.

(1) The Director, acting through the Chief Scientist, shall—

(A) identify and define the short, medium, and long-term scientific and technological needs of Federal, State, and local drug enforcement agencies, including—

(i) advanced surveillance, tracking, and radar imaging;

(ii) electronic support measures;

(iii) communications;

(iv) data fusion, advanced computer systems and artificial intelligence; and

(v) chemical, biological, radiological (including neutron, electron, and graviton) and other means of detection;

. .

(B) make a priority ranking of such needs according to fiscal and technological feasibility, as part of a National Counter-Drug Enforcement Research and Development Strategy;

(C) oversee and coordinate counter-drug technology initiatives with related activities of other Federal civilian and military departments; and

(D) under the general authority of the Director of National Drug Control Policy, submit requests to Congress for the reprogramming or transfer of funds appropriated for counter-drug enforcement research and development.

(2) The authority granted to the Director under this section shall not extend to the award of contracts, management of individual projects, or other operational activities.

(d) Counter-drug budget submission. Beginning with the budget submitted to Congress for fiscal year 1992 pursuant to section 1105 of title 31, United States Code, the President shall submit a separate and detailed request relating to those Federal departments and agencies having responsibility for counter-drug enforcement research and development programs.

(e) Personnel. Subject to subsections (d) and (e) of section 1003 [21 USCS § 1502(d), (e)], the Chief Scientist shall select and appoint a staff of not more than 10 employees with specialized experience in scientific, engineering, and technical affairs.

§ 1503. Coordination with executive branch departments and agencies

(a) Access to information.

(1) Upon request of the Director, and subject to laws governing disclosure of information, the head of each National Drug Control Program agency shall provide to the Director such information as may be required for drug control.

(2) (A) The authorities conferred on the Office of National Drug Control Policy and its Director by this Act shall be exercised in a manner consistent with provisions of the National Security Act of 1947. The Director of Central Intelligence shall prescribe such regulations as may be necessary to protect information provided pursuant to this Act regarding intelligence sources and methods.

(B) The Director of Central Intelligence shall, to the fullest extent possible in accordance with subparagraph (A), render full assistance and support to the Office of National Drug Control Policy and its Director.

(b) Certification of policy changes by Director.

(1) The head of a National Drug Control Program agency shall, unless exigent circumstances require otherwise, notify the Director in writing regarding any proposed change in policies relating to the activities of such department or agency under the National Drug Control Program prior to implementation of such change. The Director shall promptly review such proposed change and certify to the department or agency head in writing whether such change is consistent with the National Drug Control Strategy.

(2) If prior notice of a proposed change under paragraph (1) is not possible, the department or agency head shall notify the Director as soon as practicable. The Director shall review such change and certify to the department or agency head in writing whether such change is consistent with the National Drug Control Program.

(c) General Services Administration. The Administrator of General Services shall provide to the Director on a reimbursable basis such administrative support services as the Director may request.

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - ONDCP RESEARCH AGENDA

- The ONDCP research agenda focuses on the analysis of topical areas for which we have little or no information, evaluation of existing public policies and programs, and forecasting of drug use trends. The ultimate objective is to inform the scope and direction of the National Drug Control Strategy.

- ONDCP uses several national data sets to monitor the scope of the drug problem and the success of strategies designed to reduce the problem. A portion of the research agenda is devoted to finding ways to improve existing data or undertaking sophisticated analyses to develop the information we need, based on the data that exists. For example, we sponsor projects designed to estimate the number of hard-core drug users, who are an increasing but elusive pool of users, largely responsible for perpetuating illicit drug markets. We also sponsor ongoing analyses of a wide variety of supply and demand information to determine if the Nation is experiencing outbreaks of drug epidemics. In this regard, our research agenda has helped us to determine that, despite consistent rumors of a new heroin epidemic, there is no evidence that the country is experiencing any drug epidemic.

- The Anti-Drug Abuse Act of 1988 permits the Office of National Drug Control Policy to evaluate the effectiveness of drug control programs. The objectives of such evaluations are to determine whether drug programs are operating effectively, and to determine whether such programs are achieving the ultimate goal of reducing drug use, as called for in the National Drug Control Strategy. The Office of Planning, Budget and Administration has performed macro evaluations of the anti-drug effort to determine the effectiveness of the National Drug Control Strategy and to identify changes in overall program direction. In addition, OPBA's evaluations have been geared toward getting the drug control agencies to focus on the priorities and objectives of the National Strategy rather than on their own agency program management interests. With the doubling of the Federal drug control budget since the enactment of the Anti-Drug Abuse Act of 1988, there is a need for more extensive program evaluation to identify what has worked and what needs to be changed. OPBA and the ONDCP program offices are working to prioritize programs for evaluation. OPBA will be involved in the development of the agenda and with providing technical assistance to each office within ONDCP conducting the evaluations.

- Part of the research agenda is devoted to statistical and econometric modelling for the purpose of anticipating changes in drug availability and drug use given varying parameters. These models are designed to describe and forecast the illicit drug flow for cocaine and heroin from source countries to the street corner, and the relationship of drug distribution and consumption to various control programs. In addition, we continue to support modelling efforts designed to project the user population and its characteristics given changes in drug availability, and so forth.

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Divider Title: _____

Federal Drug Control Spending by Function
FY 1991 – FY 1994
($ Millions)

	1991 Actual	1992 Actual	1993 Enacted	1994 President's Budget	FY93 – FY94 Change $	FY93 – FY94 Change %
Criminal Justice System	4,385.6	4,943.1	5,374.8	5,782.6	407.7	8%
Drug Treatment	1,874.2	2,199.8	2,367.7	2,538.1	170.4	7%
Education, Community Action, and the Workplace	1,479.2	1,538.7	1,524.4	1,789.9	265.5	17%
International	633.4	660.4	538.0	490.0	(48.0)	-9%
Interdiction	2,027.9	1,960.2	1,746.2	1,765.2	19.0	1%
Research	450.1	504.5	530.9	548.2	17.2	3%
Intelligence	104.1	98.6	128.7	127.4	(1.3)	-1%
Total	**10,954.5**	**11,905.2**	**12,210.8**	**13,041.4**	**830.6**	**7%**

NATIONAL DRUG CONTROL BUDGET
BY FUNCTION

($ Millions)	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994
INTELLIGENCE														
U.S. Forest Service	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.2	0.4	0.4	0.4
Drug Enforcement Administration	20.9	23.0	21.5	23.6	25.4	25.0	36.2	34.4	32.3	39.0	43.9	53.2	67.4	69.0
Federal Bureau of Investigation	0.6	0.6	5.3	4.5	5.5	5.4	7.1	9.1	10.4	9.6	23.6	17.4	17.8	17.7
INS	0.0	0.0	0.0	0.0	0.0	0.3	0.2	0.9	0.8	0.8	1.0	1.3	1.4	1.5
OCDETF	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.1	7.8	0.0	15.7	15.7
Special Forfeiture Fund	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.0	0.0	0.0	0.0
U.S. Customs	1.6	2.0	2.4	2.8	4.5	4.9	3.7	8.3	9.8	11.4	12.1	13.1	12.7	11.7
FinCEN	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	10.6	13.1	13.2	11.4
	23.1	25.6	29.2	30.9	35.4	35.6	47.2	52.8	53.4	64.9	104.1	98.6	128.7	127.4

OVERVIEW

INTELLIGENCE

For FY94, the President has requested $127 million for counter-drug intelligence programs, a decrease of about one percent from the FY93 appropriation. The bulk of these funds ($69 million) are for the Drug Enforcement Administration (DEA). Other major recipients of drug-related intelligence funds are the Federal Bureau of Investigation (FBI, $18 million), the Justice Department's Organized Crime Drug Enforcement Task Forces (OCDETF, $16 million), the U.S. Customs Service ($12 million), and the Treasury Department's Financial Crimes Enforcement Network (FinCEN, $11 million). A number of national security agencies -- Defense, DIA, and CIA -- also collect drug intelligence. Their budgets are classified, however, and therefore are not included in the totals.

The central and most urgent issue in counter-drug intelligence is to facilitate the timely sharing of intelligence collected by the various Federal intelligence-gathering entities. A number of the national intelligence programs (e.g, Defense, DIA, CIA, etc.) are prohibited by law from collecting intelligence on U.S. citizens. Domestic law enforcement agencies, on the other hand, collect intelligence on U.S. citizens and residents, and to a lesser extent on foreign nationals (although DEA collects the most intelligence, it is least sophisticated in its analysis. The DEA's data remains unautomated, residing in boxes of hard copies).

Melding these products has been a significant challenge, particularly because the nature of the intelligence collected differs. Law enforcement agencies tend to collect tactical or operational intelligence, intended to help build cases against drug suspects. The national intelligence programs produce strategic intelligence, which permits them to undertake the detailed analytic mapping of drug organizations. What is needed is to bring the methodology of the national intelligence organizations to bear on the intelligence products of the law enforcement agencies.

Coordination of Domestic Drug Intelligence

- Since the mid-1970's, numerous domestic law enforcement and Defense Department intelligence centers and functions have been established, and coordinating these entities -- and avoiding duplication -- has been a major issue. For example, the El Paso Intelligence Center (EPIC), the DoD Joint Task Forces, the U.S. Customs Command, Control, Communications and Intelligence (C3I) facilities, and the various field intelligence elements in the various DEA, Customs, and FBI field offices. Though established to meet agency-specific intelligence support needs, there is an unacceptable level of duplication and overlap between several of the centers. Recent GAO and departmental IG reports have specifically cited

duplication of analysis and production as well as a lack of coordination among DoD intelligence components.

- In 1990, the Federal Bureau of Investigation (FBI) began establishing Regional Drug Intelligence Squads (RDIS) in major metropolitan areas across the country. In October, 1991, the Deputy Attorney General directed the FBI and the Drug Enforcement Administration (DEA) to jointly develop RDISs in each of the 13 OCDETF core cities. Though the FBI has established "interagency" (Federal, state and local law enforcement agencies) RDISs in Houston and Los Angeles, DEA and FBI have not been able to work out a mutually agreeable plan and division of labor including how and by whom the overall RDIS program is managed. The FY93 OCDETF budget includes $15 million for RDIS staffing and both agencies have requested funding in their FY94 budget requests. The 1993 HIDTA program includes approximately $2 million for three RDISs. To date, the establishment of the RDIS program has remained primarily within the Department of Justice and has not included discussions with headquarters elements of the other major Federal law enforcement agencies.

National Drug Intelligence Center

- The 1990 National Drug Control Strategy called for the establishment of the National Drug Intelligence Center (NDIC) to "...consolidate and coordinate all relevant intelligence gathered by law enforcement agencies and analyze it to produce a more complete picture of drug trafficking organizations". Development of the NDIC has been problematic partially because of conflicting legislative guidance and funding prohibitions. Funding ($50 million) for the NDIC currently is contained in Department of Defense appropriations for FY91/92 (available until expended). It is principally the creation of Rep. John Murtha (D-PA), who chairs the Defense Department's House appropriations committee and stipulated that NDIC be located in his District, in Johnstown, PA. The FBI has been given primary responsibility for establishing the NDIC. When fully operational (estimated to be July, 1993) NDIC will have about 150 analysts, agents and support personnel. Most will be in Johnstown but about thirty (including the Director) will be located in Tysons Corner, VA.

Coordination of Drug Intelligence Programs - Overseas

- In 1989, the Director of Central Intelligence established the Counternarcotics Center (CNC) to serve as the principal coordinator for the drug intelligence activities of the National Foreign Intelligence Community. The CNC, which is housed at CIA headquarters, has three divisions; the CIA Assessments Group, the Community Coordination Group, and the S&T Group. Since its inception, the CNC has made significant

strides in improving the coordination among the NFIC members and between the NFIC and the law enforcement community.

- Despite the significant progress, several significant problem areas/issues continue to exist. For example: the flow of foreign and law enforcement intelligence information between the two communities must be improved without jeopardizing the equities of either; overseas intelligence roles and missions of intelligence and law enforcement agencies must be clarified; and the duplication of intelligence analysis and production must be reduced while ensuring adequate coverage and support.

- A recent report by the House Permanent Select Committee on Intelligence recommended that ONDCP be given the authority to approve (not simply certify) the intelligence budget submissions of all drug intelligence agencies so it can ensure compliance with national drug control policies and priorities.

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - MULTIPLE DRUG-RELATED INTELLIGENCE ENTITIES

- Duplication of effort in drug intelligence activities is largely a result of the fact that most of the agencies engaged in the counternarcotics effort have their own intelligence organizations. With the exception of DEA, each of those intelligence organizations treats the collection and processing of drug intelligence as just one part of a much larger intelligence mission (which, for example, might include military intelligence, technology transfer, non-proliferation, economic intelligence, etc.)

- No one agency or entity in the U.S. government has the authority to establish priorities, assign tasks and allocate resources for the collection, processing and dissemination of counternarcotics intelligence.

  -- The Director of Central Intelligence has the authority to manage those agencies of the National Foreign Intelligence (CIA, DIA, NSA, State/INR) which do counternarcotics intelligence.

  -- The Secretary of Defense has authority over those defense counterdrug intelligence activities which are not part of the NFIP. This includes the tactical intelligence activities of the major commands involved in DoD counterdrug operations.

  -- The Law Enforcement Drug Intelligence Council was formed to coordinate the counternarcotics intelligence activities of law enforcement agencies. But, apart from one kickoff meeting, the group has not met.

- A recent report by the House Permanent Select Committee on Intelligence recommended that ONDCP should be given the authority to approve (not simply certify) the intelligence budget submissions of all drug intelligence agencies so it can ensure compliance with national drug control policies and priorities.

  -- The ONDCP is the only organization with a charter that includes policy oversight over all the players in drug intelligence.

- The Director of Central Intelligence should be given the explicit authority to coordinate and manage all drug-related foreign intelligence activities, including those of the

Department of Defense and the law enforcement agencies, in accord with the National Drug Control Strategy and ONDCP guidance.

- The Law Enforcement Drug Intelligence Council, chaired by the Attorney General, should be energized and begin coordinating the domestic drug intelligence activities of the Federal law enforcement agencies.

MAJOR FEDERAL DRUG INTELLIGENCE AGENCIES AND CENTERS

FOREIGN INTELLIGENCE

Central Intelligence Agency/DCI's Counternarcotics Center

State Department/Bureau of Intelligence and Research

Department of Defense

- Defense Intelligence Agency/Joint Counterdrug Intelligence Center
- National Security Agency
- US Atlantic Command: Joint Task Force Four
- US Pacific Command:
  - -- Joint Task Force Five
  - -- Joint Intel Center, Pacific/Joint Drug Intel Team
- US Forces Command: Joint Task Force Six
- US Southern Command: Joint Intel Center
- North American Air Defense Command
- 12th Air Force
- Naval Maritime Intelligence Center

LAW ENFORCEMENT

El Paso Intelligence Center

National Drug Intelligence Center

OFFICE OF NATIONAL DRUG CONTROL POLICY

Drug Enforcement Agency/ Office of Intelligence

U.S. Customs Service/ Office of Intelligence

- o C3I East (with Coast Guard)
- o C3I West

U.S. Coast Guard

- o Office of Intelligence
- o District 7/ Maritime Intel Center

Federal Bureau of Investigation

- o Drug Intelligence Unit
- o Joint Drug Intelligence Groups (several)

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

March 16, 1993

NOTE TO JENNIFER O'CONNOR
ANDRE OLIVER

The House Permanent Select Committee on Intelligence, chaired by Rep. Dan Glickman (D-Kansas), recently sent me a copy of a **TOP SECRET** report issued by the Committee called "Intelligence Support to Counternarcotics."

The Committee has advised me that the recommendations to this report are unclassified, so I am attaching them for your information and consideration. You will note that the first recommendation applies very specifically to ONDCP. On its face, this recommendation appears to be in accord with existing legislation, but in fact would entail significant modifications. I would be happy to discuss these with you at your convenience, if you're interested. I would also be pleased to discuss the rest of the recommendations too.

Bruce Carnes
Acting Director

Attachment

cc: Ricia McMahon

RECOMMENDATIONS

1. The Office of National Drug Control Policy should be given clear authority to review, make changes and approve the anti-narcotics budgets of all participating agencies and departments before they are submitted to Congress. ONDCP should ensure that budgets are consistent with national policy.

2. The Counternarcotics Center should be the intelligence community's lead agency for the provision of intelligence support to law enforcement agencies and it should be responsible for coordinating and directing the counternarcotics activities of all intelligence agencies. The CNC's authority over all elements of the intelligence community should be clearly stated by the President and the Director of Central Intelligence.

3. Airborne reconnaissance and detection and monitoring missions should be coordinated with and conducted in support of law enforcement agencies. There needs to be one single focal point for coordinating all such missions, irrespective of the agency or department responsible for their implementation.

4. The budget for detection and monitoring should be substantially reduced. Such support should be provided only for missions cued by intelligence or for which there exists law enforcement resources which can apprehend suspected traffickers.

5. The Community Management Staff (CMS) should undertake a study of all the various roles and missions of all the intelligence centers currently providing and projected to provide support to counternarcotics. This study should examine the utility of finished intelligence to the law enforcement community and policymakers, identify duplicative analytic efforts, assess the capability of the centers to provide timely tactical intelligence and consult with law enforcement agencies on ways to appropriately improve intelligence support.

6. The Director of Central Intelligence should ensure that intelligence center analytic efforts are not duplicative, assign specific responsibilities to those centers over which the NFIP has authority, and ensure that those responsibilities are carried out. The Secretary of Defense should do the same for those activities under the Department's cognizance.

7. Except for operations support purposes, intelligence analysts located within the defense department's Joint Task Forces should be transferred to the Unified Command's Joint Intelligence Centers.

8. *The administration should reconsider the establishment of a National Drug Intelligence Center. The DEA's El Paso Intelligence Center (EPIC) could serve as the premier law enforcement intelligence center.*

9. *The Linear Approach to attacking cocaine and the 'Linkage Strategy' for heroin have proven to be effective ways to focus intelligence resources on counternarcotics. These efforts should continue to be fully coordinated with the law enforcement community.*

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DRUG USE TRENDS

	1979 (1,000s)	1982 (1,000s)	1985 (1,000s)	1988 (1,000s)	1990 (1,000s)	1991 (1,000s)	1992 (1,000s)	%Change 1988–91	%Change 1985–91	%Change 1988–92	%Change 1985–92
Current Overall Drug Use	24,289	22,263	22,980	14,479	12,948	12,813					
%change over previous survey		**–8%**	**3%**	**–37%**	**–11%**	**–1%**		**–12%**	**–44%**		
Current Cocaine Use	4,330	4,170	5,750	2,923	1,601	1,892					
		–4%	**38%**	**–49%**	**–45%**	**18%**		**–35%**	**–67%**		
Current Adol. Drug Use	4,061	2,560	3,260	1,866	1,622	1,362					
		–37%	**27%**	**–43%**	**–13%**	**–16%**		**–27%**	**–58%**		
Occasional Cocaine Use	NA	9,666	8,568	5,803	4,143	4,348					
			–11%	**–32%**	**–29%**	**5%**		**–25%**	**–49%**		
Frequent Cocaine Use	NA	690	647	862	662	625					
			–6%	**33%**	**–23%**	**–6%**		**–27%**	**–3%**		
Current Adol. Cocaine Use	330	380	390	225	115	83					
		15%	**3%**	**–42%**	**–49%**	**–28%**		**–63%**	**–79%**		
Drug–Related Mentions (Q2)	NA	NA	NA	166,565	159,624	173,354					
					–4%	**9%**		**4%**	**NA**		

National Household Survey on Drug Abuse

Cocaine Readily Available				1,541	1,432	1,286					
					–7%	**–10%**		**–17%**			
Marijuana Readily Available				2,381	2,218	2,101					
					–7%	**–5%**		**–12%**			
Number Not Disapproving:											
Marijuana (occasional use)	1,255	916	728	512	520						
		–27%	**–21%**	**–30%**	**2%**			**–29%**	**–43%**		
Cocaine (1–2 times)	701	554	305	223	161						
		–21%	**–45%**	**–27%**	**–28%**			**–47%**	**–71%**		
Cocaine (regular use)	255	166	106	87	68						
		–35%	**–36%**	**–18%**	**–22%**			**–36%**	**–59%**		
High School Senior Drug Use:											
Current Overall Drug Use	32.5%	29.7%	21.3%	17.2%	16.4%	14.4%					
		–9%	**–28%**	**–19%**	**–5%**	**–12%**		**–23%**	**–45%**		
Current Cocaine Use	5.0%	6.7%	3.4%	1.9%	1.4%	1.3%					
		34%	**–49%**	**–44%**	**–26%**	**–7%**		**–59%**	**–79%**		

High School Senior Survey

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - CHANGING USER PROFILES

- Since the enactment of the Anti-Drug Abuse Act of 1988, between 1988 and 1991, drug use declined in the U.S. According to the primary Federal demand indicators, overall drug use decreased by 12 percent, current cocaine use decreased by 35 percent, current adolescent drug use decreased by 27 percent, and current adolescent cocaine use decreased by 63 percent. Despite the apparent success in reducing the number of drug users, continued analyses have reinforced our belief that we are fighting a two-front war: one against the casual user, and one against the hard-core user.

- Estimates of casual or recreational users (that is, persons who use on less than a weekly basis) are usually obtained through nationwide household or school-based surveys. Casual users tend to live stable lives and are more likely to be part of mainstream America. That is, they are likely to be employed and have at least a high school education. And, although minorities are disproportionately represented, casual users are more likely to be white. These users can be reached by prevention messages and treatment programs, and as a result, there has been an actual decline in their numbers. Between 1988 and 1991, almost two million of these users stopped using drugs. The gains are particularly noticeable among adolescents.

- But the number of hard-core users, about whom less is known, seems to be increasing. The nature of hard-core drug use makes it difficult to survey users through standard data collection methodologies. As a result, inferences must be made about the size and characteristics of the population. Based on analysis of data sets that capture some of these users, they appear to be generally under- or unemployed, are likely to come into contact with the criminal justice system, and are likely to move a lot, rarely living in their own home or with relatives. They are increasingly minority and over the age of 35. Hard-core users are typically older, long-term drug users. Econometric modelling, which uses various information about the availability of drugs and user characteristics to offset short-comings in the existing data sets, estimates that the hard-core cocaine group has grown about 5 percent since 1988, from about 2.0 million in 1988 to 2.1 million in 1991.

- Although the estimated number of all drug users has declined, the need for targeted prevention, treatment, and information-gathering to reach at-risk and hard-core

populations is clear. The hard-core user group is harder to reach and affect with prevention messages and treatment programs that have proven successful among casual users. In addition, the differences in the characteristics of casual users and hard-core users point to the need for programs designed specifically to address the needs of hard-core users. A fundamental objective is to better understand the demographic and consumption characteristics of this group. Although their numbers are thought to be small in comparison to the casual group, we believe they are largely responsible for perpetuating the illicit drug markets.

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - DRUG USE TRENDS

There is currently no single measurement or data set that accurately describes the drug epidemic in all its complexity. To measure the problem, we use a wide range of existing indicators, most of which were developed for purposes unique to the sponsoring agency. From these indicators we get some answers, but there are gaps in our knowledge that affect our ability to make policy decisions. Broad, regular, and objective measurement is required to understand the scope of the drug crisis -- and to guide the development of intelligent and effective policy and measure that policy's impact.

The primary drug use data sets[1] indicate that while drug use has continued down throughout the 80s and into the 90s, the rate of decrease has begun to slow in the last two years across most survey populations (estimates below are subject to sampling and nonsampling error).

1991 NATIONAL HOUSEHOLD SURVEY ON DRUG ABUSE [2]

The National Institute on Drug Abuse's National Household Survey on Drug Abuse, conducted and published annually, tracks drug use among persons in households and noninstitutionalized facilities (such as dorms) for several broad categories.

Current Drug Use

Any illicit drug. Use decreased from 6.4 percent in 1990 to 6.3 percent in 1991.

Marijuana. Use decreased from 5.1 percent to 4.8 percent.

LSD and Other Hallucinogens. Use remained stable at .3 percent

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[1]The primary Federal drug indicators include the National Household Survey on Drug Abuse, the Drug Abuse Warning Network, the Drug Use Forecasting Program, the High School Senior Survey, treatment data, price and purity indicators, crime statistics, the International Narcotics Strategy Report, and the National Narcotics Intelligence Consumers Committee Report.

[2]Although many changes in the 1991 Household Survey were not statistically significant at standard levels, for policy purposes there was sufficient chance that a real change in drug use did occur, giving policy makers evidence of progress, or (depending upon the direction of the trend), lack of progress.

in 1990 and 1991.

Cocaine.

- Use increased from 0.8 percent to 0.9 percent. After a large decline between 1988 and 1990, the number of current cocaine users increased from 1.6 million in 1990 to 1.9 million in 1991. However, the number of current cocaine users remains 35 percent **below** the 2.9 million current cocaine users in 1988. Hard-core drug use is particularly hard to fight because persons will relapse, especially those using highly addictive drugs such as cocaine.

- Although systematic information is not available, prices have declined in many U.S. cities, reflecting a surplus of cocaine on the streets. The relationship between price and use is complex. High prices are more likely to dissuade occasional users from using cocaine; however, very heavy users will try to get drugs regardless of price.

- The bulk of cocaine users have stopped their use of cocaine in the last few years. We are now facing a population of cocaine users who are more addicted, older, and harder to treat successfully. We expect that ONDCP's greater emphasis on treatment within the criminal justice system will begin to effect this population.

Current Drug Use by Age

For adolescents (12-17):

- An Illicit Drug. The percentage using any illicit drug, marijuana, or cocaine decreased from about 8 percent in 1990 to about 7 percent in 1991.

- Alcohol. The percentage decreased significantly, from 24.5 percent in 1990 to 20.3 percent in 1991.

For those 35-and-older:

- Any illicit drug. The percentage increased from 2.8 percent in 1990 to 3.1 percent in 1991.

- Cocaine. The percentage increased significantly from 0.2 percent to 0.5 percent. The largest portion of the increase in the number of persons reporting past month use of cocaine is found among those 35-and-older. The same is true for those reporting frequent use of cocaine and occasional use of cocaine. We believe the increases among the age group is the combined result of an aging group of long-term, hard-core drug users, and former addicts relapsing into cocaine use.

Current Drug Use by Socioeconomic Status

Among the college educated, there were 1.41 million current users of any illicit drug in 1991.

Overall, current use of cocaine by college educated persons increased 22.1 percent from 1990 to 1991.

Use of any illicit drug increased among the unemployed, but decreased among the employed. The decrease in the number of employed drug users and a similar increase in the number of drug users who are unemployed suggests that work place prevention programs are working, and in tough economic times, drug users may be the ones laid off.

- There were 6 million full-time employed current users of any illicit drug in 1991.
- Current use of illicit drugs those employed full-time decreased 8.4 percent from 1990 to 1991.
- Current use of cocaine among those employed full-time decreased 11.1 percent from 1990.

1992 HIGH SCHOOL SENIOR SURVEY

All measures of drug use by high school seniors in 1992 were at their lowest levels since the Senior Survey began in 1975.

Current Drug Use

- Any illicit drug. Use declined from 16.4 percent to 14.4 percent between 1991 and 1992.
- Cocaine. Use declined significantly from 1.4 percent to 1.3 percent.
- Use of marijuana, inhalants, and tobacco each also registered slight declines from 1990 to 1991.
- Heroin. Use increased slightly from 0.2 percent to .03 percent.
- LSD. Use increased slightly form 1.9 percent to 2.0 percent.
- Use of alcohol declined significantly from 57 percent to 54 percent.

Annual Drug Use (1991)

- Any illicit drug. Use declined significantly from 32.5 percent in 1990 to 29.4 percent in 1991.

- Cocaine. Use declined significantly from 5.3 percent to 3.5 percent.

- Marijuana. Use declined significantly from 27 percent to 24 percent.

- Alcohol. Use declined significantly from 80.6 percent to 77.7 percent.

- Heroin. Use declined slightly (but not significantly) from 0.5 percent to 0.4 percent.

- LSD. Use also declined (but not significantly) from 5.4 percent to 5.2 percent.

DRUG ABUSE WARNING NETWORK (DAWN)

Emergency Room Mentions (from 3Q 1991 to 3Q 1992).

- Total emergency room mentions increased about 3.9 percent.

- Cocaine mentions increased about 8 percent, primarily in central cities of large metropolitan areas. The level of cocaine mentions rose above peak 1988 levels. We believe these increases are the result of an aging group of drug users who, as a result of their drug use, are suffering chronic medical problems. In addition, the relapse of former cocaine addicts would also account for some of the increase.

- Heroin mentions increased 29 percent, primarily within central cities of large metropolitan areas, reaching an all-time high of 13,327.

- There was no change in LSD mentions for this time period.

- The President is very concerned about the increases in drug-related emergencies. In third quarter 1992, the latest information available, cocaine mentions increased to 30,924, reaching peak levels set in 1989. Heroin mentions reached an all time high of 13,387.

- We've expected some increases in cocaine- and heroin-related emergencies because of the high purity and availability of those drugs in the street. The bulk of these emergencies continues to occur predominantly among older, long-term drug users suffering the consequences of substance abuse. Additionally, they are increasingly concentrated in large, urban areas.

- Nonetheless, these statistics represent real human tragedies, and they underscore the urgent need to expand our efforts to provide effective drug treatment, and to educate

young people about the dangers of drug abuse. That is why the President is seeking over $400 million in additional funds in these areas for FY 1994.

DRUG USE FORECASTING PROGRAM (DUF)

From 1988 to 1990, only 4 of the 18 cities in the DUF system experienced decreasing rates of drug use among arrestees: Birmingham, Ft. Lauderdale, Houston, and San Diego. From 1988 to 1990, the percent of arrestees testing positive for any illicit drug ranged from about 50 percent to about 80 percent. Chicago, New York, Philadelphia, and San Diego consistently produced the highest rates (73 to 83 percent). Indianapolis and Kansas City produced the lowest rates, ranging from 45 to 60 percent.

Drug Use by Age. In 1990, males aged 31-35 consistently had the highest rates of positive tests for any illicit drug, and cocaine, The next highest age group was 26-30 year olds.

HEROIN

The availability of increasingly pure and cheap heroin on the Nation's streets is cause for concern, but the evidence does not support the notion that we are facing a significant heroin epidemic. However, heroin use is increasing, and we remain vigilant:

- **There is no evidence of a heroin epidemic:** Because of society's intolerance of drug use in general and heroin in particular, and because the highly addictive nature of heroin is widely known, we are not seeing a substantial pool of new, younger heroin users who would fuel heroin consumption to epidemic levels.

- **But Heroin Use is Increasing:** Increased heroin availability, higher purity, lower prices, and the availability of a snortable form of heroin are contributing factors to what appears to be increased heroin use among established heroin and cocaine users. The high purity of heroin means that it can be inhaled instead of injected. That fact, coupled with an increasing tolerance for the drug, makes the current group of heroin users capable of increasing the dosage, the frequency of the dosage, or both.

- **New Heroin Users are Experienced Drug Users:** Although some experimental use of heroin by those with little or no prior drug experience is expected, the bulk of new users continue to be current cocaine users who are moving to heroin to mitigate the effects of cocaine.

HEAVY DRUG USE

No single survey of drug use measures the number of heavy drug users. Consequently, this estimate must be calculated using numerous sources.

- Last year, we estimated that there were 2.1 million heavy users of cocaine (people who use cocaine once or more a week). This estimate is our best guess of the heavy cocaine user population for 1991.

- The 1991 estimate was based on two methods that each generated separate estimates. Our estimate of 2.1 million users equals the average of the estimates generated by these two methods.

It is important to keep in mind that these are estimates subject to the possibility of large sampling errors. Furthermore, we know that hard-core drug users are likely missed in surveys employing standard data collection methodology (such as household interviewing, telephone interviewing, and questionnaire mailout, to name a few) because of their transient and illegal lifestyles. Estimates of hard-core drug users are subject to variation.

IMPROVEMENTS TO THE PRIMARY DRUG INDICATORS

National surveys of drug use and consequence often require large samples of the population in order to collect enough observations to make any one statistic reliable. Such samples are expensive and take time to design, implement, and analyze. Often, costs prohibit the collection of particular pieces of information. Further, these surveys, by nature, tend to miss hard-to-reach subsections of the population, such as homeless and transients, who are not easily found through standard data collection methodologies.

ONDCP Initiatives

ONDCP has pressed for refinement and improvements to the primary drug indicators, development of policy-relevant drug use indicators, and use of innovative techniques for measuring drug use in the United States. The Data Committee, established in 1990, addressed data collection and evaluation under ONDCP auspices. The committee:

- Inventoried existing drug-related data collection and evaluation efforts in the drug area and published a comprehensive list for use by all Federal agencies;

- Identified gaps and flaws in existing data sets and evaluation efforts; and

- Developed a series of special projects and initiatives to fill the gaps and correct the flaws.

In addition, ONDCP has developed a strategy that provides a framework in which Federal agencies can prioritize and standardize the drug-related data collection, processing, analysis and dissemination. The strategy has three primary objectives:

- Identify requirements and priorities for the most immediate data needs for policy purposes so that each agency may establish priorities for existing or planned data collection activities;

- Define data requirements for assessing efficacy of drug-related policies and programs;

- Identify improvements to the policy-relevance of extant drug-related data.

ONDCP Consultation Findings

As part of the ongoing consultation effort mandated by ADAA-88, ONDCP regularly seeks input about changes in both drug use and drug availability patterns from a range of experts in the drug arena. These experts include treatment providers, police officers, and street ethnographers. Through this, ONDCP seeks to obtain the most current information for use in policy and budget decisions, to inform the strategic process, and to assist in the measurment of the impact of the Administration's policies.

Overall, data from the most recent round of consultation indicates a continued high availability of both heroin and cocaine. As with past consultive rounds, there is some evidence of new initiation to heroin use, but these initiates are largely current users of other drugs who are adding heroin to their polydrug list -- not new drug users. Also, for the first time in recent years there appears to be an increase in the availability of marijuana.

While there do not appear to be any major changes in drug use patterns, there are some developments worth noting:

- There appears to be a steady resurgence in the availability and use of hallucinogens, including LSD and MDMA.

- There are indications of increased availability and use of a combination of crack and snortable or smokable heroin.

- There is an increasing appearance of amphetamines in the drug market in some areas.

- A combination of crack with marijuana and/or tobacco seems to be increasingly popular.

In terms of drug sale or marketing, there seems to be some evidence that more non-drug users -- in some areas these are

gangs -- are entering drug distribution at the street level. There is also a mixing of distribution of heroin and cocaine that has not been evident in the past.

The prices of heroin and marijuana have remained steady or dropped in most areas, while the quality remains high. Cocaine's price and purity appears to be more variable across the country, and cocaine in the powdered form (Hcl) seems to be less available in many places. Despite this, the popularity and ascendancy of cocaine in the drug arena is almost unchallenged.

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - THE AVAILABILITY OF DRUGS IN THE U.S. MARKET

- The Anti-Drug Abuse Act of 1988 required that the Office of National Drug Control Policy develop goals for reducing drug use in the United States. The Strategy incorporates numerous goals aimed directly at the most urgent drug use problems, for example, reducing adolescent use of cocaine. It also incorporates goals to reduce the availability of drugs, which in turn affects the overall Strategy goal of reducing drug use.

- Supply reduction programs seek to limit the availability of drugs to make it more difficult for users to obtain drugs by increasing both the time it takes them to find drugs and the price (including penalties) they must pay for the drugs. In theory, as it becomes increasingly difficult to find and expensive to use drugs, fewer users would be likely to begin or continue using drugs. And hard-core users would likely be more disposed to enter treatment if it is more difficult to maintain their drug use.

- The inability to sustain reductions in drug availability frustrates prevention and treatment programs that seek to reduce drug use. While the long-term key to winning the drug war is to eliminate the demand for drugs, short-term success may be impaired if supplies remain plentiful, cheap, and of high quality. Some progress was achieved in reducing the availability of drugs during the late 1980s. Since then, however, supply reduction efforts have been unable to reduce consistently the availability of both cocaine and heroin in the U.S. drug market.

- With respect to cocaine, availability appears to be fluctuating from year to year. It declined from 1988 to 1990, but then increased in 1991 (although it remained below the 1988 and 1989 levels). Although final estimates are not yet available, it appears that seizures have increased modestly and that the amount of cocaine entering the U.S. in 1992 is not much different from the level seen in 1991.

- The increased availability of cocaine that occurred in 1991 correlates with an increase in cocaine use. According to the Household Survey, in 1991 there were 1.9 million current (monthly) users, up from 1.6 million users in the previous year. ONDCP also estimates that the number of heavy cocaine users increased from 1.9 million to 2.1 million between 1990 and 1991. The evidence suggests that the increase in supply in 1991 led to lower cocaine prices (relative to 1990), which induced existing consumers to purchase more cocaine.

- With respect to heroin, there is no reliable estimate of the amount available in the U.S. market. However, seizures increased from 424 kilograms in the first half of 1991 to 508 kilograms in the first half of 1992, which suggests that the amount entering the U.S. could be on the rise. Other indicators of increased availability are changes in price and purity of heroin. Recent evidence shows the trend in heroin price is down and that purities are up -- together these facts suggest that availability is up.

- The primary indicators by which we monitor drug use trends have not revealed any significant increases in heroin use. There were some increases in the number of emergency room cases involving heroin, but these were mostly confined to aging, long term drug users suffering the consequences of years of drug use. Other data show relatively stable rates of heroin use. For example, the National Household Survey on Drug Abuse shows that less than one percent of the general population used heroin in 1991, representing no change from rates reported in survey years 1988 and 1990.

- Emphasis on eradicating marijuana within the United States led to significant price increases, and these were in turn accompanied by continuous reductions in use as measured by the Household Survey and other instruments. The latest seizure data appear to indicate an increase in importation of marijuana, which may be in response to several years of increased success in domestic eradication efforts. In recent years more than 70 percent of the marijuana available to the domestic market has come from outside the U.S. Eradication efforts in Latin America, particularly in Mexico, also have increased significantly, however. Current marijuana use has declined steadily, from 12.7 percent of the population in 1979 to 4.8 percent in 1991.

- With respect to other drugs, such as methamphetamines, LSD, and various narcotics, the cadre of users and the market structure are such that estimates of availability are impossible to make. Statistics show no change in the small number of people reporting use of these drugs since 1988.

- These developments raise many questions, perhaps chief among them whether supply reduction programs as they are currently being implemented have achieved demonstrable, cost-effective reductions in drug use, and whether such programs could be made more effective if done differently. For example, the emphasis could be shifted toward disrupting the importation of drugs into this country, rather than making arrests and seizing drugs. And local law enforcement personnel could concentrate on maintaining a very public and visible presence in drug trafficking areas, disrupting drug transactions and intimidating buyers and sellers alike.

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - WHAT AMERICA'S USERS SPEND ON ILLEGAL DRUGS

As part of an ongoing project to determine how much Americans spend on illegal drugs, this report focuses on the amount and retail sales value of cocaine, heroin, marijuana, and other illegal drugs Americans consumed from 1988 through 1991. We used two approaches to make these estimates. First, we estimated the amount of illicit drugs Americans consume. From this perspective, we estimate that:

- 1991, Americans spent about $49 billion on these drugs: $30 billion on cocaine, $9 billion on heroin, $8 billion on marijuana, and $2 billion on other illegal drugs and legal drugs used illicitly (Table A).[1]

- Between 1988 and 1991, the expenditures on cocaine and heroin appear to have been stable.[2]

- Between 1988 and 1991, consumption of marijuana fell markedly (although dollar expenditures on marijuana fell less because the price increased throughout this period).

- Between 1988 and 1991, expenditures on other illicit drugs, and on legal drugs used illicitly, both fell.

A second approach to estimating the retail sales value of illicit drugs consumed in the United States is to estimate the amounts supplied to the domestic market. From this perspective, we estimate that:

- About 274 to 442 metric tons of cocaine were available for domestic consumption in 1991 (Table B) (for reasons discussed in the report, it is not practical to develop estimates for heroin, marijuana, and other drugs).[3] There has been about a 1 percent decrease in the amount of cocaine available for consumption in the United States between 1988

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[1] Money is not the only form of payment for illicit drugs. Dealers often keep drugs for personal use, users help dealers in exchange for drugs, and users perform sex for drugs (especially crack cocaine). When such "income in kind" is valued at current retail prices, an additional $2 billion to $3 billion must be added to the total for cocaine and about $3 billion to the total for heroin.

[2] A temporary rise in the price of cocaine in 1990 probably caused a reduction in consumption. Total expenditures remained about the same, however, as the higher price partly offset the decline in use.

[3] About 331,140 metric tons of coca leaf crop were cultivated in South America during 1991, yielding about 930 metric tons of cocaine hydrochloride. To arrive at the total available for domestic consumption, we subtracted from this amount losses in shipment, shipments to other consumer countries, and Federal seizures.

and 1991.

- The street value of the 274 to 442 metric tons of cocaine is $42 to $68 billion (Table B).[4] Between 1988 and 1991, Americans spent $38 billion to $68 billion annually on cocaine.

Note that the $38 billion to $68 billion range on cocaine expenditures from the supply model is larger than the consumption-based estimates of $27 billion to $30 billion (Table A). There are two reasons for this. First, the supply model does not take into account most losses and consumption within the producer countries or State and local seizures in this country. Second, the United States may transship more drugs to Europe than our model assumes. Had we been able to account for these factors, the $38 billion to $68 billion supply-based estimate (Table B) would have been lower. Still, the estimates based on drug consumption are remarkably close to those based on drug supply.

Although these estimates are imprecise, they are sufficiently reliable to conclude that the trade in illicit substances was roughly $45 billion to $51 billion between 1988 and 1991, according to consumption-based estimates (Table A).[5] The costs to society from drug consumption, however, exceed this amount. Drug use fosters crime; causes catastrophic health problems, such as hepatitis, endocarditis, and AIDS; and disrupts personal, familial, and legitimate economic relationships. The public bears much of the burden of these indirect costs because it finances the criminal justice response to drug-related crime, a public treatment system, and anti-drug prevention programs.

The importance of these estimates is that they facilitate the development of a systematic methodology for integrating the various indicators (e.g., crops in foreign countries, drugs seized at the borders, arrests made in American cities) that can help policymakers to better understand the dynamics of the drug trade and to better fashion appropriate policy responses.

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[4] Prevailing retail prices are used to convert drug supply to a dollar equivalent value when sold to final users.

[5] By comparison, Americans spent $26 billion on alcohol and $23 billion on tobacco in 1989. State and local governments spent $26 billion on law enforcement and $170 billion on public education.

OFFICE OF NATIONAL DRUG CONTROL POLICY

TABLE A

Total U.S. Expenditures on Illicit Drugs, 1988-1991

($ in billions)

	1988	1989	1990	1991
Cocaine	$26.5	$30.0	$26.9	$29.7
Heroin	$9.7	$9.4	$8.2	$8.9
Marijuana	$9.5	$8.5	$7.5	$7.7
Other Drugs	$3.2	$2.8	$2.3	$2.4
Total	$48.9	$50.7	$44.9	$48.6

Note: Columns may not add due to rounding.
Source: See Tables 1 through 13

OFFICE OF NATIONAL DRUG CONTROL POLICY

TABLE B

Trends in Cocaine Supply, 1989-1991
(in metric tons unless otherwise noted)

	1989	1990	1991
Coca Leaf Crop[1]	295,072	305,893	331,140
Maximum Potential Cocaine HCl Produced[2]	826	858	930
Seized in Foreign Countries[3]	70	152	199
Shipped to the United States	377-544	361-525	382-550
Seized by Federal Authorities[4]	99	107	108
Available for Consumption in the United States	278-445	254-418	274-442
Retail Value in the United States (in billions of dollars)	$38-$60	$45-$74	$42-$68

[1] *International Narcotics Control Strategy Report (INCSR), 1992,* 28. There is an error in the coca leaf estimate for 1989 in Bolivia; refer to Bolivia Statistical Table (p. 97) for the correct number.

[2] This is the amount of cocaine HCl (or pure cocaine) that could have been produced had there been no seizures, consumption, or losses at any stage of production.

[3] *INCSR, 1992;* United Nations, International Narcotics Control Board (INCB), *Narcotic Drugs, Statistics for 1990;* and the Royal Canadian Mounted Police, *National Drug Intelligence Estimate 1990.*

[4] Drug Enforcement Administration, Federal-Wide Drug Seizure System, 1989-1991.

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - DRUG USE IN OTHER COUNTRIES

- Only a few other countries conduct surveys that provide data on current drug use. Most are in Europe, although a few Latin American countries -- Mexico, for example -- have good prevalence surveys in place. Estimates of drug use that most countries provide to the U.N. are unreliable.

- Despite this, it is possible to infer some drug use levels on a regional basis. We know that the use of cocaine in Latin America is low, but growing in many cities throughout the region, particularly among the wealthy urban classes. Relative to the U.S., European consumption of cocaine is also low, but there are increasingly frequent reports of cocaine use across the continent, especially in Spain (a major thoroughfare for trafficking into Europe), Germany and the U.K. Overall European consumption of cocaine may be in the neighborhood of 15% of that of the U.S. Negligible amounts of cocaine are used in Asia and Africa.

- Heroin use varies widely. Reports from Europe indicate that prevalence ranges from an estimated 350,000 in Italy to some 70,000 in the U.K. (where only 20,000 addicts are registered). Eastern European rates are high, particularly in Poland and Romania, and areas of the former Soviet Union such as Central Asia, where illicit opium is extensively grown. Very high levels of opium and heroin use are estimated for India (up to 6 million persons), and Iran and Pakistan may each have a million opiate consumers. Overall, opiate use in South and East Asia may involve as many as 10 million persons.

- As far as can be determined from country estimates available to the U.S., the number of illicit drug users appears to be rising globally. This is evidently the case for cocaine outside the United States, and heroin outside of Western Europe.

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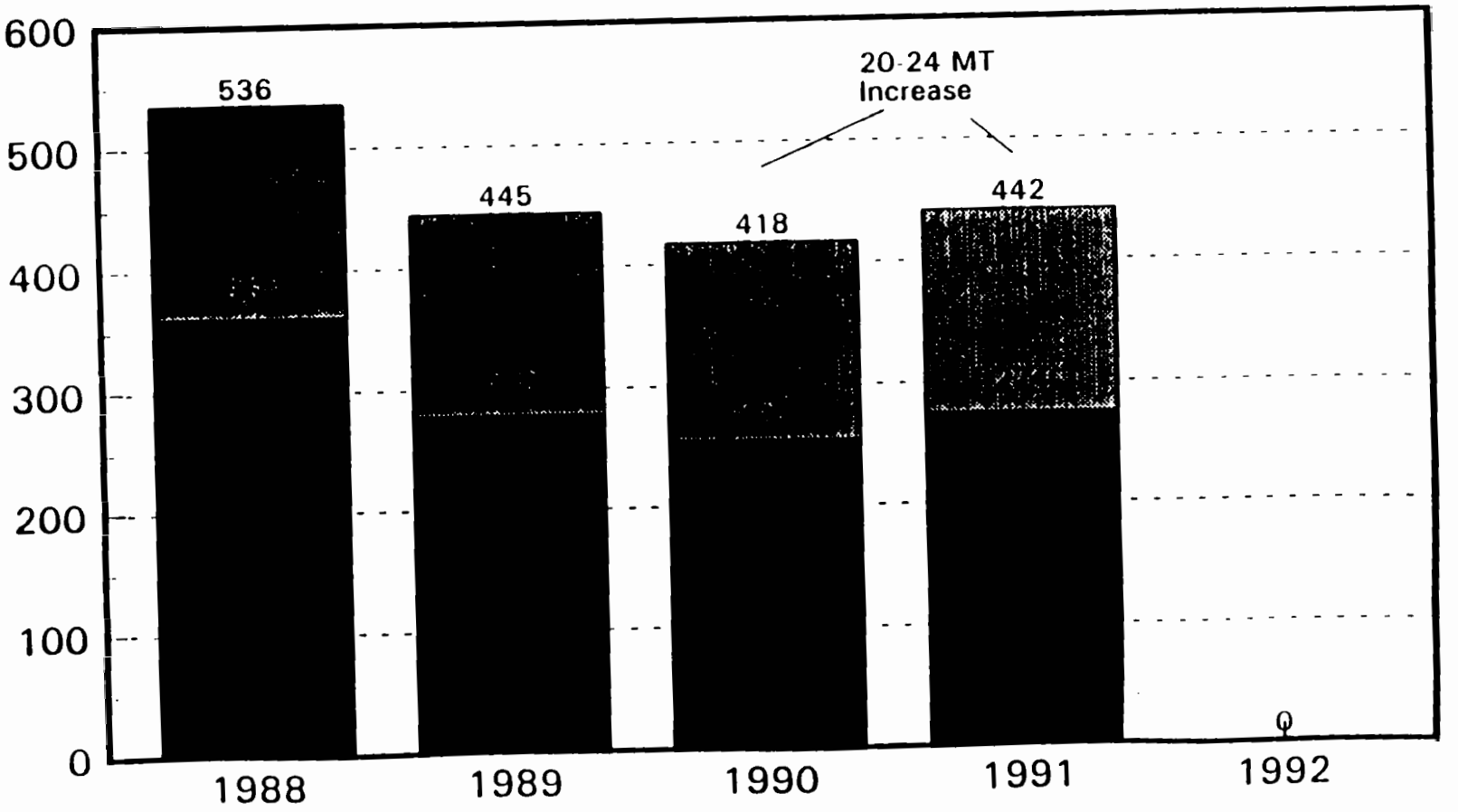
ONDCP COCAINE AVAILABILITY ESTIMATES

(Metric Tons)



Note: 1992 estimate is being developed.

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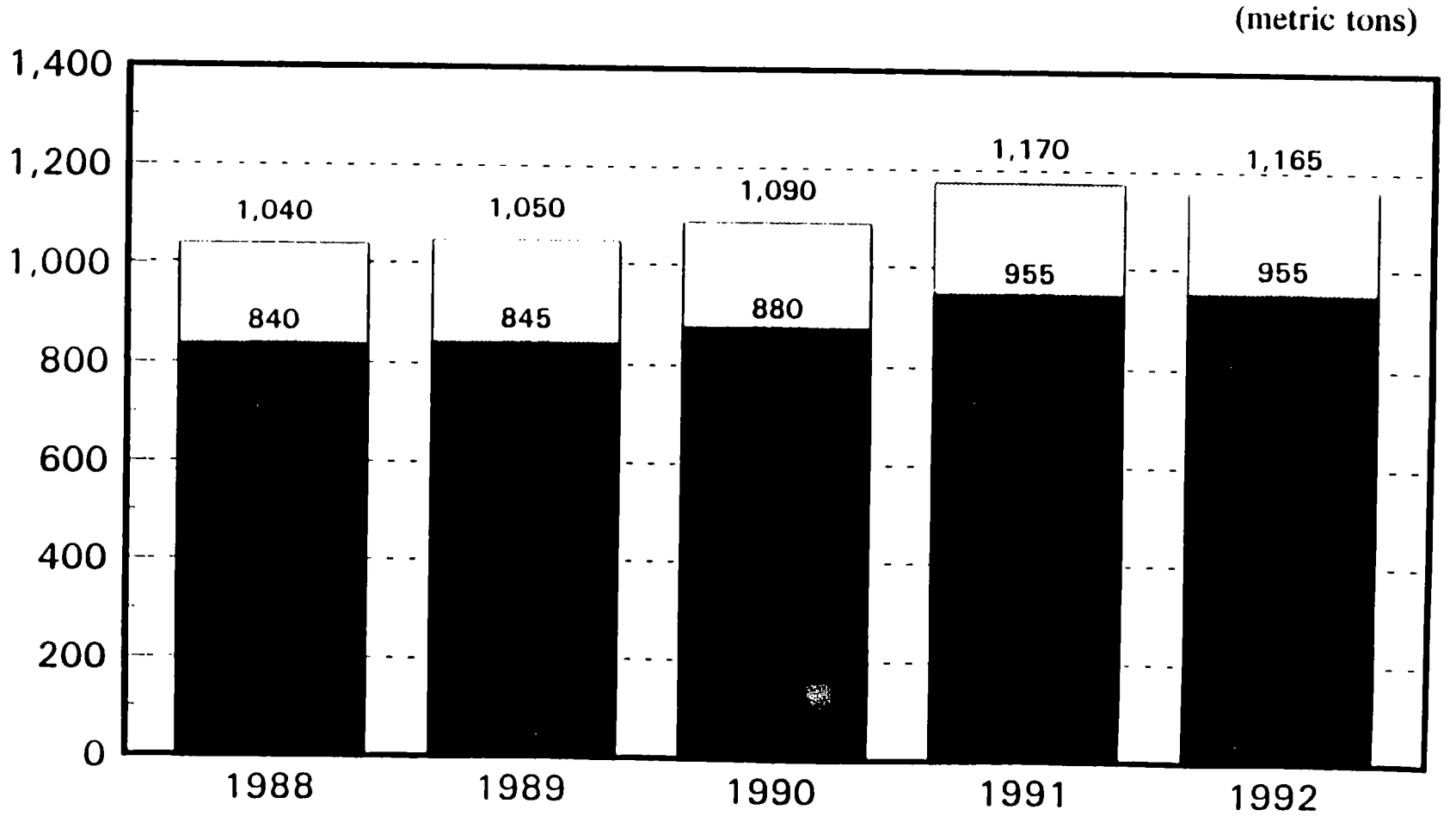
TOTAL POTENTIAL HCL PRODUCTION, 1988-1992



Source: INCSR, 1990-1993

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Cocaine Price and Purity

Cocaine Summary Data
1987 – 1992 (Q2)

Quantity	Metropolitan Area	1987		1988		1989		1990		1991		1992 (Q2)	
		Low	High	Low	High	Low	High	Low	High	Low	High	Low	High
Kilogram	National Range	$12,000	$40,000	$11,000	$34,000	$11,000	$35,000	$11,000	$40,000	$11,000	$40,000	$11,000	$42,000
	Miami	$12,000	$15,000	$13,000	$20,000	$16,000	$22,000	$16,000	$25,000	$14,000	$25,000	$13,500	$25,000
	New York	$15,000	$30,000	$16,000	$23,000	$17,000	$25,000	$20,000	$38,500	$14,000	$29,000	$12,500	$35,000
	Chicago	$20,000	$40,000	$17,000	$24,000	$19,000	$25,000	$18,000	$35,000	$18,000	$30,000	$18,000	$37,000
	Los Angeles	$10,000	$18,000	$11,000	$16,000	$14,000	$20,000	$14,000	$32,000	$12,000	$28,000	$11,000	$20,000
Ounce	National Range	$800	$2,100	$500	$2,000	$450	$2,500	$500	$2,500	$400	$2,500	$600	$2,200
	Miami	$800	$1,200	$800	$1,200	$800	$1,200	$600	$1,200	$800	$1,000	$800	$1,000
	New York	$800	$1,600	$600	$1,000	$600	$1,000	$750	$1,450	$800	$1,600	$800	$1,600
	Chicago	$1,100	$1,800	$750	$1,400	$850	$1,100	$850	$1,400	$800	$1,200	$800	$1,400
	Los Angeles	$600	$1,000	$500	$800	$500	$800	$600	$1,200	$700	$1,200	$700	$1,200
Gram	National Range	$80	$120	$50	$120	$35	$125	$35	$175	$35	$175	$30	$150
	Miami	$50	$60	$55	$85	$50	$80	$35	$80	$60	$95	$60	$95
	New York	$80	$100	$50	$90	$50	$80	$50	$80	$50	$90	$50	$90
	Chicago	$80	$120	$75	$100	$70	$100	$60	$100	$100	$140	$100	$150
	Los Angeles	$80	$120	$50	$100	$60	$125	$80	$125	$80	$125	$60	$125

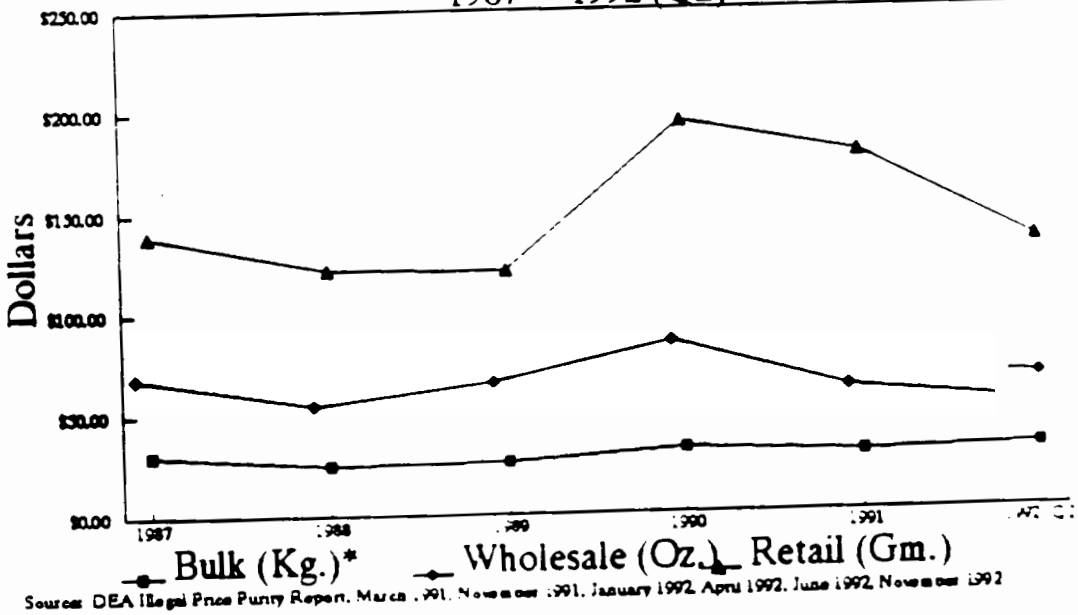
Cocaine Purity Data
1987 – 1992 (Q2)
National Range

Quantity	1987	1988	1989	1990	1991	1992 Q2
Kilogram	87%	90%	5[illegible]%	80%	86%	44%
Ounce	78%	50%	[illegible]%	58%	[illegible]%	[illegible]%
Gram	72%	70%	56%	54%	60%	5[illegible]%

Cocaine Price and Purity

Calendar Year	Bulk (Kilogram)			Wholesale (Ounce)			Retail (Gram)		
	Price	Purity	$/Pure Gm	Price	Purity	$/Pure Gm	Price	Purity	$/Pure Gm
1987	$26,000	87%	$29.89	$1,450	8[illegible]%	$[illegible]	$100	[illegible]%	$128.99
1988	$22,500	90%	$25.00	$1,250	80%	$[illegible]	$80	70%	$121.43
1989	$23,000	87%	$26.44	$1,475	[illegible]%	$[illegible]	$80	[illegible]%	$121.21
1990	$25,500	80%	$31.88	$1,500	[illegible]%	$[illegible]	$105	[illegible]%	$196.44
1991	$25,500	86%	$29.65	$1,450	[illegible]%	$[illegible]	$105	[illegible]%	$177.97
1992 (Q2)	$28,500	44%	$31.53	$1,400	[illegible]%	$[illegible]	$80	[illegible]%	$134.33

Cocaine Price Per Pure Gram
1987 – 1992 (Q2)



Source: DEA Illegal Price Purity Report, March 1991, November 1991, January 1992, April 1992, June 1992, November 1992

Heroin Price and Purity

Heroin Summary Data
1987–1992 (Q2)
National Range

Quantity			1987		1988		1989		1990		1991		1992 Q2	
			Low	High	Low	High	Low	High	Low	High	Low	High	Low	High
Kilogram		Mexico (MEX)	$100,000	$200,000	$100,000	$200,000	$70,000	$130,000	$65,000	$180,000	$50,000	$200,000	$50,000	$140,000
		Southeast Asia (SEA)	$100,000	$220,000	$100,000	$210,000	$60,000	$204,000	$70,000	$260,000	$90,000	$260,000	$90,000	$240,000
		Southwest Asia (SWA)	$100,000	$220,000	$70,000	$200,000	$45,000	$160,000	$70,000	$200,000	$80,000	$220,000	$80,000	$200,000
Ounce			$3,200	$10,000	$2,200	$12,000	$1,500	$10,000	$1,000	$13,000	$900	$14,000	$1,500	$12,000
Gram	Powder		$115	$125	$90	$200	$80	$450	$50	$450	$40	$450	$100	$600
	Black Tar		$150	$600	$200	$500	$150	$400	$100	$460	$110	$500	$100	$500

Heroin Purity Data 3
1987–1992 (Q2)
National Range

Quantity	1987		1988		1989		1990		1991		1992 Q2	
	Purchase	Seizures	Purchase	Seizures	Purchase	Seizures	Purchase	Seizures	Purchase	Seizures	Purchase	Seizures
Kilogram	63%	66%	53%	76%	68%	79%	75%	85%	77%	77%	77%	77%
Ounce	38%	41%	43%	50%	50%	63%	34%	59%	43%	59%	59%	59%
Gram	8%	33%	17%	41%	26%	49%	22%	44%	32%	45%	33%	33%

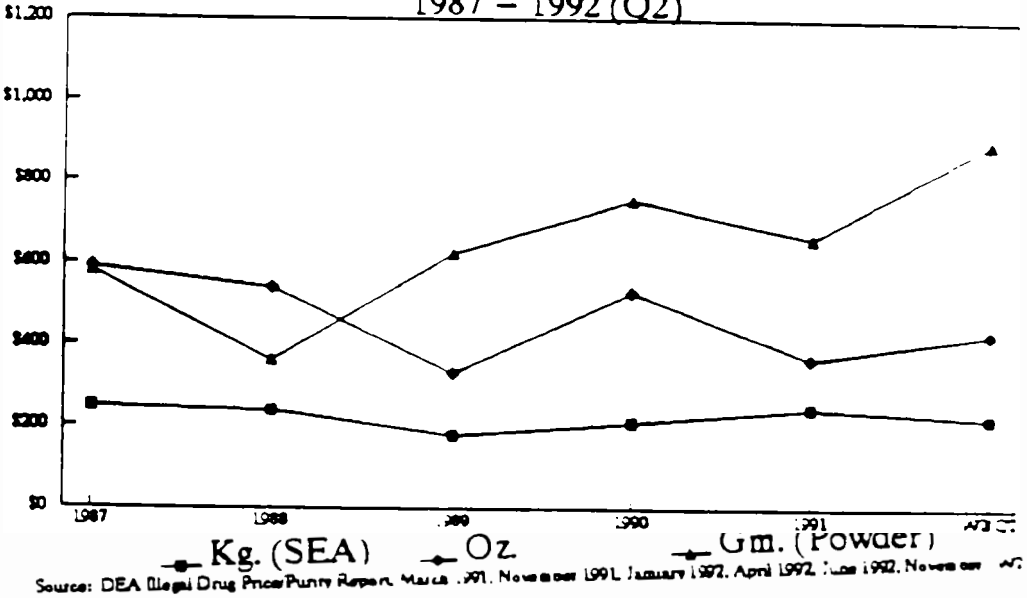
1 Grams of purported SEA heroin in Hawaii have sold for as much as $800 each.
2 Grams of black tar heroin in Hawaii have sold for as much as $600 each.
3 Purity data are based on STRIDE printouts of average purities for the 1–10 gram, 1–10 ounce, and 1–10 kilogram ranges. The left column represents the average purity of heroin purchases; the right column represents the average purity of heroin seizures.

Heroin Price and Purity

Calendar Year	Bulk* (Kilogram)			Wholesale (Ounce)			Retail** (Gram)		
	Price	Purity	$/Pure Gm	Price	Purity	$/Pure Gm	Price	Purity	$/Pure Gm
1987	$160,000	64%	$248.45	$6,600	39%	$588.90	$120	21%	$581.11
1988	$155,000	65%	$239.75	$7,100	47%	$537.46	$145	40%	$362.50
1989	$132,000	73%	$180.82	$5,750	61%	$331.80	$265	43%	$623.53
1990	$165,000	78%	$211.54	$7,000	47%	$529.89	$250	33%	$757.58
1991	$175,000	72%	$244.76	$7,450	72%	$366.77	$245	37%	$662.16
1992(Q2)	$165,000	75%	$220.00	$6,750	56%	$428.11	$350	39%	$897.44

Notes: *Bulk prices and purities are for kilogram samples of Southeast Asian heroin, the most prevalent variety in the United States.
**Retail prices are for heroin powder.

Heroin Price per Pure Gram
1987 – 1992 (Q2)



Source: DEA Illegal Drug Price/Purity Report, March 1991, November 1991, January 1992, April 1992, June 1992, November

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OVERVIEW OF THE BUSH ADMINISTRATION DRUG STRATEGY

The Anti-Drug Abuse Act of 1988 created ONDCP and set forth its mission: to advise the President on a national drug control strategy and consolidated drug control budget with the overall goal of significantly reducing the production, availability, and use of illegal drugs, both at home and abroad. To achieve this goal, ONDCP was charged with producing the National Drug Control Strategy, which unified anti-drug efforts in a comprehensive plan of action that established drug policies, objectives, and priorities. The following fundamental principles provided the underpinning of the Bush Administration's National Drug Control Strategy:

I. BASIC PRINCIPLES:

The essence of the drug problem is drug use, and demand reduction is the ultimate goal. The success of anti-drug efforts cannot be measured by such criteria as the number of people treated for addiction, treatment results, the number of arrests, conviction rates, or drug interdiction and seizure levels. These are useful indicators, but only address symptoms of the problem. Instead, the levels of drug use remain the paramount indicator against which drug policy success is judged.

"User Accountability" is critical. Drug use can be deterred through a range of meaningful criminal, civil, and social sanctions that persuade drug users to enter treatment, and convince non-users to avoid the use of drugs.

To be effective, the Strategy must be comprehensive and fully integrate supply and demand reduction policies and programs. Supply and demand programs should not be discrete phenomena that are employed in isolation from one another. No single tactic -- pursued alone or to the detriment of others -- can work to contain or reduce drug use. Instead, pressure must be applied along all fronts of the drug war simultaneously, recognizing that prevention is the only answer in the long run, but that in the short run it is necessary to provide drug treatment and to continue interdiction, international, and law enforcement efforts.

The Strategy must be national in scope. The Strategy outlines a partnership between the private sector, and individuals throughout the Nation. There are some things that only the Federal government can do (e.g., international efforts to block drug production and transportation, interdiction, and border security). States and localities, on the other hand, provide publicly funded drug prevention and treatment and bear primary responsibility for arresting, prosecuting, and punishing most of the Nation's drug offenders.

II. ELEMENTS OF THE STRATEGY

DEMAND REDUCTION

A major goal of the National Drug Control Strategy is to prevent Americans from ever using drugs. For those who have begun to use drugs, the goal is to get them to stop. This has led to support of broad-based prevention efforts directed at the mainstream population, as well as special programs targeting hard-to-reach and high-risk groups.

DRUG TREATMENT:

- Drug treatment works, and the Strategy seeks to improve its availability, quality, and effectiveness.

- For FY 1993, increased Federal funds will result in the availability of an additional 7,700 drug treatment slots nationwide. The bulk of these would be Federally-funded slots in existing local treatment settings.

- In 1993, the Nation's total treatment capacity would grow by more than 28,000 slots (633,319 to 661,368). This will allow for the treatment of at least 1.9 million persons with drug problems.

- Current Federal treatment initiatives:

  -- Continuing efforts, working through the Congress, to fund treatment in States and communities with a high need for treatment.

  -- A drug treatment/job training initiative.

  -- Technical assistance to States to better use Medicaid.

  -- Greater efforts to integrate into treatment appropriate AIDS services.

- Other treatment improvement efforts:

  -- Grants to target efforts in selected cities and for special populations (e.g., adolescents, women, ethnic groups, and criminal justice populations).

  -- Training efforts and demonstrations to show the efficacy of central intake and referral.

-- Better coordination of treatment, rehabilitative, and social services, along with better outreach.

- Treatment works best when clients are appropriately matched to programs and services. The Strategy addresses through a strong commitment to support the development of Treatment Improvement Protocols, which provide treatment programs with standard procedures for screening and treating specific populations and specific drug problems. The Strategy also supports the establishment of central intake and referral services and of improved access for clients to adjunct services (i.e., general health, social, educational, and vocational services).

- The NIDA Medications Development Division (MDD), created to focus public and private efforts at developing pharmacotherapies, has moved aggressively to capitalize on recent important discoveries, and has elicited vital assistance from other Federal agencies and the private sector.

  -- Pharmacological treatment approaches can be used to augment the basic psychological therapies, but, however effective medications may be, psychological approaches are the primary tool in treating addictions.

  -- The primary psychological approaches are behavioral, supportive and psychodynamic therapies. Critical research will continue to improve these.

DRUG EDUCATION AND PREVENTION:

- Drug education and prevention programs can be effective in reducing the likelihood that young people will start using drugs.

- For those who do start, such programs also slow the progression to more frequent use and to the use of more dangerous substances.

- The most effective school-based prevention programs are comprehensive: they start early, provide children with skills to resist offers to use drugs and with techniques for managing stress without resorting to drug use, provide firm drug policies and appropriate assistance for young people who violate those policies, and involve parents in prevention activities.

- The policies of effective programs demonstrate to young people that drug use is wrong, that it is harmful, and against the law.

- The best school drug prevention activities are but one component of a comprehensive community effort.

- All of our major epidemiological systems have reported significant declines in drug use and drug consequences over the last two years.

  -- The National Household Survey on Drug Abuse estimated that current (past month) use of illicit drugs by those ages 12 and over declined by 13 percent, from 14.5 million in 1988 to approximately 12.6 million in 1991.

  -- Occasional (less than once a month) cocaine use fell by 22 percent between 1988 and 1991.

  -- Among adolescents, current drug use fell 27 percent and current cocaine use fell 63 percent between 1988 and 1991.

COMMUNITY PARTNERSHIPS: The 1989 National Drug Control Strategy announced a Presidential initiative to assist in combating drug use at the local level. Since that time, hundreds of community partnerships have been established with Federal funds.

PREVENTION INFORMATION: The National Clearinghouse on Alcohol and Drug Information receives 16,000 requests for information each month, and annually provides materials that reach over 18,000,000 Americans.

EDUCATION INITIATIVES: As a condition of receiving Federal funding, Local Educational Agencies (LEAs), State Educational Agencies, and Institutions of Higher Education are required to submit certifications that they have comprehensive drug prevention programs in place.

PUBLIC HOUSING: The 1990 National Drug Control Strategy announced an initiative to assist public housing agencies and residents in eliminating the threat of drugs from public housing. By the end of this year, over 1,300 grants will have been awarded to public housing agencies.

HIGH RISK POPULATIONS: There have been more than 280 Federal grants awarded to programs that target youth at high risk for using drugs. In addition, a national network of research studies targeting substance using pregnant women and their infants has been created.

Another major program has awarded 130 grants to develop comprehensive prevention and treatment systems for substance using pregnant and postpartum women and their infants.

In response to the crisis of drug-affected infants abandoned in hospitals around the country, 24 demonstration grants to prevent abandonment, to train hospital staff, and to expedite adoption of abandoned babies have been awarded.

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Divider Title: _____

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

Executive Office of the President
Office of National Drug Control Policy

I. MISSION STATEMENT

GENERAL

The Office of National Drug Control Policy (ONDCP) provides the President's primary Executive Branch support for drug policy and program oversight. The law provides for four Presidentially-appointed positions: a Director, a Deputy Director for Supply Reduction, a Deputy Director for Demand Reduction, and an Associate Director for State and Local Affairs. The law also provides for the position of Chief Scientist for counter-drug enforcement research and development. The Director is charged by law with formulating, evaluating, coordinating, and overseeing both international and domestic anti-drug abuse functions by all Executive Branch agencies, and ensuring that such functions sustain and complement State and local anti-drug abuse efforts.

Mandated ONDCP activities include:

- Developing an annual National Drug Control Strategy;
- Developing a consolidated National Drug Control Budget for presentation to the President and the Congress (including budget certifications and quarterly reprogramming reports);
- Coordinating and overseeing Federal anti-drug policies and programs involving approximately 50 Federal agencies and 12 cabinet Departments and the programs they administer;
- Encouraging private sector and State and local initiatives for drug prevention and control;
- Recommending to the President changes in the organization, management, and budgets of Federal departments and agencies engaged in the anti-drug effort;
- Representing the Administration's drug policies and proposals to Congress;
- Participating in National Security Council deliberations which concern drugs;
- Producing legislatively mandated studies and reports for submission to the President and the Congress;

- o Establishing and overseeing numerous legislatively-mandated national campaigns and commissions;

- o Certifying the budgets of programs, bureaus, agencies, and Departments;

- o Certifying drug policy changes by programs, bureaus, agencies, and Departments;

- o Reviewing and approving reprogrammings submitted by bureaus, agencies, and Departments;

- o Designating areas as high intensity drug trafficking areas and making grants to State and local law enforcement entities in these areas; and

- o Establishing a counter-drug technology assessment center to serve as the central counter-drug enforcement research and development center for the Federal Government.

NATIONAL DRUG CONTROL STRATEGY

As mandated by law, each annual National Drug Control Strategy must be submitted by February 1 of each year and include:

- o Comprehensive, research-based, long-range goals for reducing drug use in the United States;

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

- o A complete list of goals, objectives, and priorities for supply and demand reduction and a description of the balance of resources devoted to supply and demand reduction efforts;

- o Private sector initiatives and cooperative efforts between the Federal Government and State and local governments for drug control;

- o Three-year projections for program and budget priorities and achievable projections for reducing drug availability and usage, and a complete assessment of budget proposals for each Federal anti-drug program;

- o A plan for improving the compatibility of automated information and communication systems to provide Federal agencies with timely and accurate information for the National Drug Control Program; and

- o Designation (in consultation with the Attorney General, heads of Federal Drug Control program agencies, and Governors) of high intensity drug trafficking areas within the U.S.

Preparation of the Strategy involves consultation with members of Congress, representatives of Federal Departments and agencies, State and local officials throughout the Nation, and private citizens throughout the Nation with expertise in supply and demand reduction. In accordance with law, a report detailing persons consulted is submitted to the Congress with each National Drug Control Strategy.

In addition, ONDCP has established several senior-level management committees (for example, ONDCP chairs a Supply Reduction Working Group and a Demand Reduction Working Group) to oversee and coordinate the efforts of Federal agencies in implementing the National Drug Control Strategy. Other working groups have been formed to coordinate these and other essential Strategy programs and objectives.

NATIONAL DRUG CONTROL BUDGET

ONDCP annually submits to the President and the Congress a consolidated National Drug Control budget that includes:

- o Three-year projections on program and budget priorities; and

- o An assessment of how the budget proposal is intended to implement the strategy and whether the funding levels contained in the budget proposal are sufficient to implement such a strategy.

The law requires that the Director develop for each fiscal year a consolidated National Drug Control Program Budget proposal to implement the National Drug Control Strategy. In developing this budget proposal, each National Drug Control program head, agency head, and Department head with responsibilities under the National Drug Control Strategy must transmit the drug control budget request of the program, agency, or Department for review by the Director of ONDCP at the same time as the request is submitted to their superiors (and before submission to the Office of Management and Budget).

The Director of ONDCP reviews each drug control budget request, certifies in writing as to the adequacy of such request to implement the objectives of the National Drug Control Strategy for the budget year. The Director is also required to maintain records regarding certifications. Program managers and agency/Department heads are apprised of the results of the certification review.

Reprogramming or transfer requests by a drug-control agency of drug control resources greater than $5,000,000 must be approved by the Director, ONDCP, prior to submission to Congress. The Director reports to Congress on a quarterly basis regarding the need for any reprogramming or transfer of appropriated funds for National Drug Control Program activities. Correspondingly, ONDCP must maintain familiarity with the budget issues of each of the 50 Federal drug control agencies as they execute their respective budgets.

TITLE 21. FOOD AND DRUGS
CHAPTER 20. COORDINATION OF NATIONAL DRUG POLICY
NATIONAL DRUG CONTROL PROGRAM

§ 1501. Establishment of office

(a) Establishment of office. There is established in the Executive Office of the President the "Office of National Drug Control Policy".

(b) Director and deputy directors.

(1) There shall be at the head of the Office of National Drug Control Policy a Director of National Drug Control Policy.

(2) There shall be in the Office of National Drug Control Policy a Deputy Director for Demand Reduction and a Deputy Director for Supply Reduction.

(3) The Deputy Director for Demand Reduction and the Deputy Director for Supply Reduction shall assist the Director in carrying out the responsibilities of the Director under this Act.

(c) Bureau of State and Local Affairs.

(1) There is established in the Office of National Drug Control Policy a Bureau of State and Local Affairs.

(2) There shall be at the head of such bureau an Associate Director for National Drug Control Policy.

(d) Access by Congress. The location of the Office of National Drug Control Policy in the Executive Office of the President shall not be construed as affecting access by the Congress or committees of either House to—

(1) information, documents, and studies in the possession of, or conducted by or at the direction of the Director; or

(2) personnel of the Office of National Drug Control Policy.

§ 1502. Appointment and duties of Director, Deputy, Directors, and Associate Director

(a) Appointment.

(1) The Director, the Deputy Director for Demand Reduction, the Deputy Director for Supply Reduction, and the Associate Director for National Drug Control Policy shall each be appointed by the President, by and with the advice and consent of the Senate.

(2) The Director, the Deputy Director for Demand Reduction, the Deputy Director for Supply Reduction, and the Associate Director for National Drug Control Policy shall each serve at the pleasure of the President. No person

shall serve as Director, a Deputy Director, or Associate Director while serving in any other position in the Federal Government.

(b) Responsibilities. The Director shall—

(1) establish policies, objectives, and priorities for the National Drug Control Program;

(2) annually promulgate the National Drug Control Strategy in accordance with section 1005 [21 USCS § 1504];

(3) coordinate and oversee the implementation by National Drug Control Program agencies of the policies, objectives, an priorities established under paragraph (1) and the fulfillment of the responsibilities of such agencies under the National Drug Control Strategy;

(4) make such recommendations to the President as the Director determines are appropriate regarding—

(A) changes in the organization, management, and budgets of Federal departments and agencies engaged in drug enforcement; and

(B) the allocation of personnel to and within such departments and agencies; to implement the policies, priorities, and objectives established under paragraph (1) and the National Drug Control Strategy;

(5) consult with and assist State and local governments with respect to their relations with the National Drug Control Program agencies;

(6) appear before duly constituted committees and subcommittees of the House of Representatives and of the Senate to represent the drug policies of the executive branch; and

(7) notify any National Drug Control Program agency if its policies are not in compliance with the responsibilities of such agency under the National Drug Control Strategy and transmit a copy of each such notification to the President.

(c) National Drug Control Program budget.

(1) The Director shall develop for each fiscal year, with the advice of the program managers of departments and agencies with responsibilities under the National Drug Control Program, a consolidated National Drug Control Program budget proposal to implement the National Drug Control Strategy, and shall transmit such budget proposal to the President and to the Congress.

(2) Each Federal Government program manager, agency head, and department head with responsibilities under the National Drug Control Strategy shall transmit the drug control budget request of the program, agency, or department to the Director at the same time as such request is submitted to their superiors (and before submission to the Office of Management and Budget) in the preparation of

the budget of the President submitted to the Congress under section 1105(a) of title 31, United States Code.

(3) The Director shall—

(A) review each drug control budget request transmitted to the Director under paragraph (2);

(B) certify in writing as to the adequacy of such request to implement the objectives of the National Drug Control Strategy for the year for which the request is submitted; and

(C) notify the program manager, agency head, or department head, as applicable, regarding the Director's certification under subparagraph (B).

(4) The Director shall maintain records regarding certifications under paragraph (3)(B).

(5) (A) No National Drug Control Program agency shall submit to the Congress a reprogramming or transfer request with respect to any amount of appropriated funds greater than $ 5,000,000 which is included in the National Drug Control Program budget unless such request has been approved by the Director.

(B) The head of any National Drug Control Program agency may appeal to the President any disapproval by the Director of a reprogramming or transfer request.

(6) The Director shall report to the Congress on a quarterly basis regarding the need for any reprogramming or transfer of appropriated funds for National Drug Control Program activities.

(7) The head of each National Drug Control Program agency shall ensure timely development and submission to the Director of drug control budget requests transmitted pursuant to subsection (c)(2), in such format as may be designated by the Director with the concurrence of the Director of the Office of Management and Budget.

(d) Powers of Director. In carrying out the responsibilities established under subsection (b), the Director may—

(1) select, appoint, employ, and fix compensation of such officers and employees as may be necessary to carry out the functions of the Office of National Drug Control Policy under this title;

(2) direct, with the concurrence of the Secretary of a department or head of an agency, the temporary reassignment within the Federal Government of personnel employed by such department or agency, in order to implement United States drug control policy;

(3) use for administrative purposes, on a reimbursable basis, the available services, equipment, personnel, and facilities of Federal, State, and local agencies;

(4) procure the services of experts and consultants in accordance with section 3109 of title 5, United States Code, relating to appointments in the Federal Service, at rates of compensation for individuals not to exceed the daily equivalent of the rate of pay payable for GS-18 of the General Schedule under section 5332 of title 5, United States Code;

(5) accept and use donations of property from Federal, State, and local government agencies;

(6) use the mails in the same manner as any other department or agency of the executive branch; and

(7) monitor implementation of the National Drug Control Program, including—

(A) conducting program and performance audits and evaluations; and

(B) requesting assistance from the Inspector General of the relevant agency in such audits and evaluations.

(e) Personnel detailed to the Office.

(1) Notwithstanding any provision of chapter 43 of title 5, United States Code [5 USCS §§ 4301 et seq.], the Director shall perform the evaluation of the performance of any employee detailed to the Office of National Drug Control Policy for purposes of the applicable performance appraisal system established under such chapter for any rating period, or part thereof, that such employee is detailed to such office.

(2) (A) Notwithstanding any other provision of law, the Director may provide periodic bonus payments to any employee detailed to the Office of National Drug Control Policy.

(B) An amount paid under this paragraph to an employee for any period shall not be greater than 20 percent of the basic pay paid or payable to such employee for such period.

(C) Any payment under this paragraph to an employee shall be in addition to the basic pay of such employee.

(D) The aggregate amount paid during any fiscal year to an employee detailed to the Office of National Drug Control Policy as basic pay, awards, bonuses, and other compensation shall not exceed the annual rate payable at the end of such fiscal year for positions at level III of the Executive Schedule.

§ 1502a. Counter-Drug Technology Assessment Center

(a) Establishment. There is established within the Office of National Drug Control Policy, the Counter-Drug Technology Assessment Center (hereinafter in this section referred to as the "Center"). The Center shall operate under the authority of the Director of National Drug Control Policy and shall serve as the central counter-drug enforcement research and development organization of the United States Government.

(b) Director. There shall be at the head of the Center the Chief Scientist of Counter-Drug Technology (hereinafter in this section referred to as the "Chief Scientist"). The Chief Scientist shall be appointed by the Director of National Drug Control Policy from among individuals qualified and distinguished in the area of science, engineering, or technology.

(c) Additional responsibilities of the Director.

(1) The Director, acting through the Chief Scientist, shall—

(A) identify and define the short, medium, and long-term scientific and technological needs of Federal, State, and local drug enforcement agencies, including—

(i) advanced surveillance, tracking, and radar imaging;

(ii) electronic support measures;

(iii) communications;

(iv) data fusion, advanced computer systems and artificial intelligence; and

(v) chemical, biological, radiological (including neutron, electron, and graviton) and other means of detection;

(B) make a priority ranking of such needs according to fiscal and technological feasibility, as part of a National Counter-Drug Enforcement Research and Development Strategy;

(C) oversee and coordinate counter-drug technology initiatives with related activities of other Federal civilian and military departments; and

(D) under the general authority of the Director of National Drug Control Policy, submit requests to Congress for the reprogramming or transfer of funds appropriated for counter-drug enforcement research and development.

(2) The authority granted to the Director under this section shall not extend to the award of contracts, management of individual projects, or other operational activities.

(d) Counter-drug budget submission. Beginning with the budget submitted to Congress for fiscal year 1992 pursuant to section 1105 of title 31, United States Code, the President shall submit a separate and detailed request relating to those Federal departments and agencies having responsibility for counter-drug enforcement research and development programs.

(e) Personnel. Subject to subsections (d) and (e) of section 1003 [21 USCS § 1502(d), (e)], the Chief Scientist shall select and appoint a staff of not more than 10 employees with specialized experience in scientific, engineering, and technical affairs.

§ 1503. Coordination with executive branch departments and agencies

(a) Access to information.

(1) Upon request of the Director, and subject to laws governing disclosure of information, the head of each National Drug Control Program agency shall provide to the Director such information as may be required for drug control.

(2) (A) The authorities conferred on the Office of National Drug Control Policy and its Director by this Act shall be exercised in a manner consistent with provisions of the National Security Act of 1947. The Director of Central Intelligence shall prescribe such regulations as may be necessary to protect information provided pursuant to this Act regarding intelligence sources and methods.

(B) The Director of Central Intelligence shall, to the fullest extent possible in accordance with subparagraph (A), render full assistance and support to the Office of National Drug Control Policy and its Director.

(b) Certification of policy changes by Director.

(1) The head of a National Drug Control Program agency shall, unless exigent circumstances require otherwise, notify the Director in writing regarding any proposed change in policies relating to the activities of such department or agency under the National Drug Control Program prior to implementation of such change. The Director shall promptly review such proposed change and certify to the department or agency head in writing whether such change is consistent with the National Drug Control Strategy.

(2) If prior notice of a proposed change under paragraph (1) is not possible, the department or agency head shall notify the Director as soon as practicable. The Director shall review such change and certify to the department or agency head in writing whether such change is consistent with the National Drug Control Program.

(c) General Services Administration. The Administrator of General Services shall provide to the Director on a reimbursable basis such administrative support services as the Director may request.

§ 1504. Development and submission of National Drug Control Strategy

(a) Development and submission of the National Drug Control Strategy.

(1) Not later than 180 days after the first Director is confirmed by the Senate, and not later than February 1 of each year thereafter, the President shall submit to the Congress a National Drug Control Strategy. Any part of such strategy that involves information properly classified under criteria established by an Executive order shall be presented to the Congress separately.

(2) The National Drug Control Strategy submitted under paragraph (1) shall--

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

(B) include short-term measurable objectives which the Director determines may be realistically achieved in the 2-year period beginning on the date of the submission of the strategy;

(C) describe the balance between resources devoted to supply reduction and demand reduction; and

(D) 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.

(3) (A) In developing the National Drug Control Strategy, the Director shall consult with--

(i) the heads of the National Drug Control Program agencies;

(ii) the Congress;

(iii) State and local officials;

(iv) private citizens with experience and expertise in demand reduction; and

(v) private citizens with experience and expertise in supply reduction.

(B) At the time the President submits the National Drug Control Strategy to the Congress, the Director shall transmit a report to the Congress indicating the persons consulted under this paragraph.

(4) Beginning with the second submission of a National Drug Control Strategy, the Director shall include with each such strategy a complete evaluation of the effectiveness of drug control during the preceding year.

(b) Goals, objectives, and priorities. Each National Drug Control Strategy shall include--

(1) a complete list of goals, objectives, and priorities for supply reduction and for demand reduction;

(2) private sector initiatives and cooperative efforts between the Federal Government and State and local governments for drug control;

(3) 3-year projections for program and budget priorities and achievable projections for reductions of drug availability and usage;

(4) a complete assessment of how the budget proposal transmitted under section 1003(c) [21 USCS § 1502(c)]is intended to implement the strategy and whether the funding levels contained in such proposal are sufficient to implement such strategy;

(5) designation of areas of the United States as high intensity drug trafficking areas in accordance with subsection (c); and

(6) a plan for improving the compatibility of automated information and communication systems to provide Federal agencies with timely and accurate information for purposes of this subtitle.

(c) High intensity drug trafficking areas.

(1) The Director upon consultation with the Attorney General, heads of National Drug Control Program agencies, and the Governors of the several States, may designate any specified area of the United States as a high intensity drug trafficking area. After making such a designation and in order to provide Federal assistance to the area so designated, the Director may--

(A) direct the temporary reassignment of Federal personnel to such area, subject to the approval of the Secretary of the department or head of the agency which employs such personnel;

(B) take any other action authorized under section 1003 [21 USCS § 1502]to provide increased Federal assistance to such areas; and

(C) coordinate actions under this paragraph with State and local officials.

(2) When considering the designation of an area under this subsection as a high intensity drug trafficking area, the Director shall consider, along with other criteria the Director may deem appropriate--

(A) the extent to which the area is a center of illegal drug production, manufacturing, importation, or distribution;

(B) the extent to which State and local law enforcement agencies have committed resources to respond to the drug trafficking problem in the area, thereby indicating a determination to respond aggressively to the problem;

(C) the extent to which drug-related activities in the area are having a harmful impact in other areas of the country; and

(D) the extent to which a significant increase in allocation of Federal resources is necessary to respond adequately to drug-related activities in the area.

(3) Before March 1, 1991, the Director shall submit a report to th House of Representatives and to the Senate concerning the effectiveness of and need for the designation of areas under this subsection as high intensity drug trafficking areas, along with any comments or recommendations for legislation.

(d) Lead agencies.

(1) The President shall designate lead agencies with areas of principal responsibility for carrying out the National Drug Control Strategy.

(2) The Director shall require that any National Drug Control Program agency that conducts a major supply reduction activity which is in the area of principal responsibility of a lead agency designated under paragraph (1) shall—

(A) notify such lead agency in writing of the activity; and

(B) provide such notification prior to conducting such activity, unless exigent circumstances require otherwise.

(3) If a lead agency objects to the conduct of an activity described under paragraph (2), the lead agency and the agency planning to conduct such activitiy shall notify the Director in writing regarding such objection.

§ 1505. Executive reorganization study

(a) Report to the Congress and the President. Not later than January 15, 1990, the Director shall submit a report to the President and to the Congress regarding the necessity to group, coordinate, and consolidate agencies and functions of the Federal Government involved in supply reduction and demand reduction in order to—

(1) promote better execution of the laws;

(2) provide more effective management of the executive branch:

(3) reduce expenditures and promote economy to the fullest extent consistent with the efficient operation of the executive branch; and

(4) reduce the number of agencies by consolidating under a single head agencies having similar functions, and by abolishing agencies and functions which are unnecessary for the efficient conduct of the executive branch.

(b) Recommendations. The report submitted under subsection (a) shall include any appropriate recommendations for legislation.

§ 1506. Termination of Office of National Drug Control Policy

This subtitle and the amendments made by this subtitle, other than section 1007, are repealed on the date which is 5 years after the date of the enactment of this subtitle [enacted Nov. 18, 1989].

§ 1507. Definitions

As used in this subtitle—

(1) the term "drug" has the same meaning as the term "controlled substance" has in section 102(6) of the Controlled Substances Act (21 U.S.C. 802(6));

(2) the term "drug control" means any activity conducted by a National Drug Control Program agency involving supply reduction or demand reduction;

(3) the term "supply reduction" means any enforcement activity of a program conducted by a National Drug Control Program agency that is intended to reduce the supply or use of drugs in the United States and abroad, including—

(A) international drug control;

(B) foreign and domestic drug enforcement intelligence;

(C) interdiction; and

(D) domestic drug law enforcement, including law enforcement directed at drug users;

(4) the term "demand reduction" means any activity conducted by a National Drug Control Program agency, other than an enforcement activity, that is intended to reduce the demand for drugs, including—

(A) drug abuse education;

(B) prevention;

(C) treatment;

(D) research; and

(E) rehabilitation;

(5) the term "National Drug Control Program" means programs, policies, and activities undertaken by National Drug Control Program agencies pursuant to the responsibilities of such agencies under the National Drug Control Strategy;

(6) the term "National Drug Control Program agency" means any department or agency and all dedicated units thereof, with responsibilities under the National Drug Control Strategy, as designated—

(A) jointly by the Director and the head of the department or agency; or

(B) by the President;

(7) the term "Director" means the Director of National Drug Control Policy; and

(8) the term "National Drug Control Strategy" means a strategy developed and submitted to the Congress under section 1005 [21 USCS § 1504].

§ 1508. Authorization of appropriations

For the purposes of carrying out this subtitle, there are authorized to be appropriated $ 3,500,000 for fiscal year 1989 and such sums as may be necessary for each of the 4 succeeding fiscal years, to remain available until expended.

§ 1509. Establishment of special forfeiture fund

(a) In general. There is established in the Treasury of the United States the Special Forfeiture Fund (hereafter referred to in this section as the "Fund") which shall be available to the Director of the National Drug Control Policy without fiscal year limitation in such amounts as may be specified in appropirations acts.

(b) Deposits. Deposits in the Fund shall be made by transfer from the Department of Justice Assets Forfeiture Fund in the manner provided in section 524(c)(9) of title 28, United States Code.

(c) Investment of fund. Amounts in the Fund which are not currently needed for the purposes of this section shall be kept on deposit or invested in obligations of, or guaranteed by, the United States and all earnings on such investments shall be deposited in the Fund.

(d) President's budget. The President shall, in consultation with the Director for National Drug Control Policy, include, as part of the budget submitted to the Congress under section 1105(a) of title 31, United States Code, a separate and detailed request for the use of the amounts in the Fund. This request shall reflect the priorities of the National Drug Control strategy.

(e) Funds provided supplemental. Funds disbursed under this subsection shall not be used to supplant existing funds, but shall be used to supplement the amount of funds that would be otherwise available.

(f) Annual report. No later than 4 months after the end of each fiscal year, the President shall submit to both Houses of Congress a detailed report on the amounts deposited in the Fund and a description of expenditures made under this subsection.

NATIONAL DRUG CONTROL AGENCIES

Action

Agency for International Development

Department of Agriculture

- Agricultural Research Service
- U.S. Forest Service

Department of Defense

Department of Education

Department of Health & Human Services

- Administration for Children and Families
- Centers for Disease Control
- Food and Drug Administration
- Health Care Financing Administration
- Indian Health Service
- Substance Abuse and Mental Health Services Administration
- National Institute on Drug Abuse

Department of Housing & Urban Development

Department of the Interior

- Bureau of Indian Affairs
- Bureau of Land Management
- Fish and Wildlife Service
- National Park Service
- Office of Territorial & International Affairs

The Judiciary

Department of Justice

- Assets Forfeiture Fund
- U.S. Attorneys
- Bureau of Prisons
- Criminal Division
- Drug Enforcement Administration
- Executive Office for Weed and Seed
- Federal Bureau of Investigation
- Immigration and Naturalization Service
- INTERPOL - U.S. National Central Bureau

- U.S. Marshals Service
- Office of Justice Programs
- Organized Crime Drug Enforcement Task Forces
- Support of U.S. Prisoners
- Tax Division

Department of Labor

Office of National Drug Control Policy
- Operations
- High Intensity Drug Trafficking Areas
- Special Forfeiture Fund

Small Business Administration

Department of State
- Bureau of International Narcotics Matters
- Bureau of Politico/Military Affairs
- Emergencies in the Diplomatic & Consular Service

Department of Transportation
- U.S. Coast Guard
- Federal Aviation Administration
- National Highway Traffic Safety Administration

Department of the Treasury
- Bureau of Alcohol, Tobacco and Firearms
- U.S. Customs Service
- Federal Law Enforcement Training Center
- Financial Crimes Enforcement Network (FinCEN)
- Internal Revenue Service
- Treasury Forfeiture Fund
- U.S. Secret Service

U.S. Information Agency

Department of Veterans Affairs

LEAD AGENCIES

Section 1005 of the Anti-Drug Abuse Act of 1988 requires the President to designate lead agencies with areas of responsibility for carrying out the National Drug Control Strategy. The Office of National Drug Control Policy (ONDCP) coordinates all national drug policy and thereby is, in essence, the "lead" agency for national policy in this area. This paper lists those agencies that have been officially designated as lead agencies by the President, by statute, or by the National Drug Control Strategy. ONDCP is the lead agency for conducting evaluations to improve the implementation and direction of the National Drug Control Strategy and to ensure the availability of accurate measures of the absolute and relative effectiveness of drug programs funded by the Strategy [**Anti-Drug Abuse Act of 1988 and Department of Transportation and Related Agencies Appropriations Act of 1990**]

SUPPLY REDUCTION

INTERDICTION

Detection and Monitoring of Air, Sea, and Surface Traffic. The Department of Defense (DoD) is the lead agency for detecting and monitoring of such traffic within 25 miles of and outside the geographical boundaries of the U.S. border. [**FY 1989 and FY 1993 DOD Authorization Act**]

Land Interdiction. The Customs Service is the lead agency at ports of entry [**Strategy II**] and the Border patrol is the primary agency for drug interdiction between the ports. [**Strategy IV**]

Maritime Interdiction. The Coast Guard is the lead agency for maritime interdiction on the high seas and in U.S. territorial seas, supported by the Customs Service (which has identical jurisdiction in the territorial seas) [**Strategy II**] and DoD (which conducts random patrols on the high seas).

Air Interdiction. The Customs Service and the Coast Guard are joint lead agencies for air interdiction, assisted by other agencies depending on the location and assets needed. [**Strategy II**]

SCIENCE AND TECHNOLOGY

ONDCP is the lead agency for coordinating U.S. Government counterdrug law enforcement technology development. ONDCP recommends priorities on scientific and technological needs of Federal, State, and local drug enforcement agencies and for apportioning research resources. [**P.L. 101-510**]

INTERNATIONAL

The Treasury Department is the lead agency for money laundering control programs abroad. [**International Narcotics Control Act of 1988**]

INTELLIGENCE

The Central Intelligence Agency is the lead agency for overseeing drug-related intelligence gathering activities of the national foreign intelligence community. [**Strategy II**]

DEA is the lead agency for foreign drug law enforcement intelligence. [**Strategy II**]

DEMAND REDUCTION

PREVENTION

ONDCP oversees Federal agency implementation of Executive Order 12564, which requires the establishment of drug-free workplace programs, including drug testing. ONDCP is the lead agency for the drug testing programs for Federal employees [**Presidential memo, dated March 5, 1991**]

ONDCP STANDING COORDINATION GROUPS

SUPPLY REDUCTION WORKING GROUP

The Supply Reduction Working Group is chaired by the Deputy Director for Supply Reduction, and is comprised of senior level representatives of the Federal supply reduction agencies. The purpose of the working group is to coordinate and oversee the implementation by National Drug Control Program Agencies of the supply-related policies, objectives, and priorities.

Member agencies of the Supply Reduction Working Group are:

Drug Enforcement Administration
United States Secret Service
Bureau of Prisons
Internal Revenue Service
Department of Agriculture
National Security Council
Office of Management and Budget
Bureau of Alcohol, Tobacco, and Firearms
United States Customs Service
Department of the Treasury
Federal Aviation Administration
United States Coast Guard
Department of Defense/Joint Chiefs of Staff
Department of Interior
Department of Transportation
Department of State
United States Marshals Service
Immigration and Naturalization Service
Federal Bureau of Investigation
Financial Crime Enforcement Network

Subcommittees:

Border Interdiction Committee
Southwest Border Committee
Drug-related Financial Crimes Policy Group
Public Lands Drug Control Committee
Metropolitan HIDTA Committee
Automated Data Processing Working Group
Communication Interoperability Working Group

DEMAND REDUCTION WORKING GROUP

The Demand Reduction Working Group coordinates and oversees implementation of the President's National Drug Control Strategy by Federal drug control agencies. The Working Group is chaired by the Deputy Director for Demand Reduction, and addresses demand reduction policies, objectives, and outreach activities in the areas of treatment, education and prevention, workplace and

international demand reduction. Agencies are generally represented by senior policy-level officials.

Member agencies of the Demand Reduction Working Group are:

Action
Agency for International Development
Department of Defense
Department of Education
Department of Energy
Department of Health and Human Services
Department of Housing and Urban Development
Department of Interior
Department of Justice
Department of Labor
Department of State
Department of Transportation
Office of Management and Budget
Office of Personnel Management
Small Business Administration
United States Information Agency
Department of Veterans Affairs

Subcommittees:

Treatment Subcommittee
Education/Prevention Subcommittee
Workplace Subcommittee
International Demand Reduction Subcommittee
Executive Committee, Interagency Coordinating Group (assists ONDCP in fulfilling its lead role in overseeing implementation of the Executive order mandating Federal agencies to have drug-free workplace programs)

OFFICE OF NATIONAL DRUG CONTROL POLICY

FACT SHEET - COMMUNITY INVESTMENT PROGRAM

- Public Law 102-368 (Dire Emergency Supplemental Appropriations Act of 1992) created the Community Investment Program (CIP) to implement initiatives to improve the quality of life and expand economic opportunity. In 1993, $500 million was appropriated for the program, subject to enactment of subsequent authorizing legislation.

- The CIP is composed of an "Enterprise Community Block Grant Demonstration Program" and a "National Public/Private Partnership Program".

- The 1994 budget submission process proposes an additional $513.5 million in assistance for distressed communities under the Community Investment Program. Of the total funds available for the CIP in 1994, up to $500 million will be used to provide grants to local units of government to hire new police officers through a Police on the Street Program. Also, up to $50 million will be used for an economic strategy initiative administered by the Secretary of Housing and Urban Development to enable distressed communities to develop and implement coordinated economic strategies that address both short and long-term community needs. Additional authorizing language is required.

- Approximately 25% of the Community Investment Program resources available in FY 1994 are drug-related.

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