The original documents are located in Box 12, folder "Drug Abuse - Domestic Council Task Force Report (1)" of the John Marsh Files at the Gerald R. Ford Presidential Library.

OCT 1 1975

THE WHITE HOUSE

WASHINGTON

September 30, 1975

MEMORANDUM FOR: PHIL BUCHEN
ROBERT T. HARTMANN
JACK MARSH
BILL SEIDMAN
MAX FRIEDERSDORF
JIM LYNN
BRENT SCOWCROFT

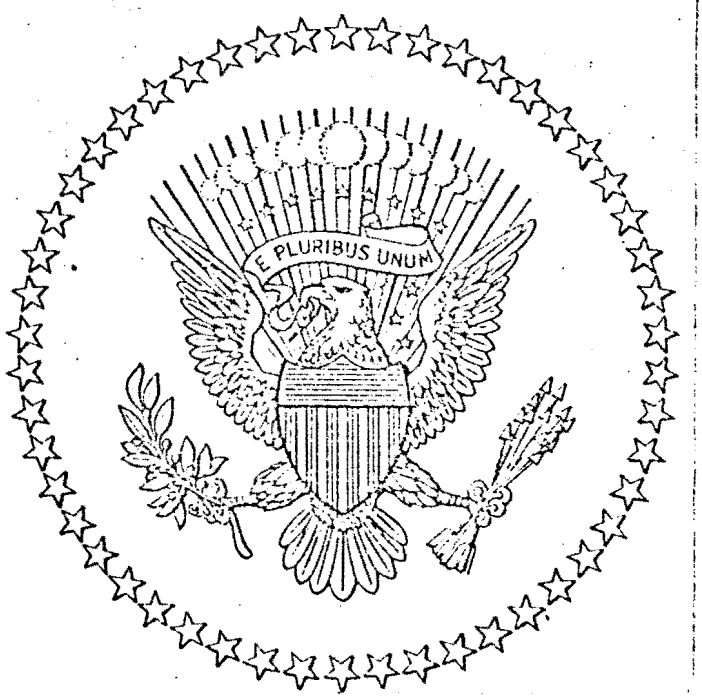
FROM: JIM CANNON

SUBJECT: Domestic Council Drug Abuse Report

Attached is a copy of the final draft of the Report of the Domestic Council Drug Abuse Task Force for your review and information.

Attachment

WHITE PAPER
ON
DRUG ABUSE



September 1975

A REPORT TO THE PRESIDENT
FROM
THE DOMESTIC COUNCIL DRUG ABUSE
TASK FORCE

WHITE PAPER
ON
DRUG ABUSE

SEPTEMBER 1975

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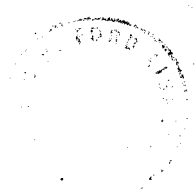

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THE VICE PRESIDENT

WASHINGTON

Dear Mr. President:

I am pleased to submit for your consideration the White Paper on Drug Abuse prepared at your request by the Domestic Council Drug Abuse Task Force. The White Paper documents the principal findings of the Task Force, assesses the current extent of drug abuse in America and presents a number of recommendations for improving the Federal government's overall program to reduce drug abuse.

Drug abuse is one of the most serious and most tragic problems this country faces. Its cost to the nation is staggering: counting narcotics-related crime, health care, drug program costs and addicts' lost productivity, estimates range upwards of $17 billion a year. In addition to these measurable costs, the nation bears an incalculable burden in terms of ruined lives, broken homes and divided communities.

The Task Force believes that the optimism about "winning the war on drugs" expressed so eloquently and confidently only a few years ago was premature. It urgently recommends that the federal government reaffirm its commitment to combatting drug abuse and that public officials and citizens alike accept the fact that a national commitment to this effort will be required if we are to ultimately succeed.

The Task Force submits this White Paper in the knowledge that it does not provide all of the answers to solving the drug abuse problem. The issues are complex and changing and the Federal effort represents only part of the nation's total response. However, I believe that the recommendations contained in the White Paper provide a solid base upon which a re-invigorated national effort can be built.

The Members of the Task Force, the contributors to the White Paper and I appreciate the opportunity to have participated in this vital undertaking.

Respectfully submitted,

Nelson A. Rockefeller

The President
The White House
Washington, D. C.

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PREFACE

Commencing in 1969, the Federal Government launched a major commitment toward eliminating the drug abuse problem in America. Sufficient progress had been made by late 1973 that Administration spokesmen, including President Nixon, began to make cautious statements about "turning the corner on drug abuse." These statements were always accompanied by warnings that the data were not yet conclusive and that there was still a long way to go even if the corner had been turned. But, somehow, the qualifying statements were overlooked and the notion that we had "turned the corner on drug abuse" became accepted as fact by many in government and by most of the public and the press.

We now know that the very real progress which led to this confidence was, in the main, temporary and regional. In fact, at that very time, the underlying trends had already begun to turn up after having declined steadily for almost two years.

By the summer of 1974, Federal drug abuse program administrators began to realize that conditions were worsening and that the gains of prior years were being eroded. The deteriorating situation was confirmed over the next several months and, by early 1975, the Congress, the press and the public at large were becoming aware of the new and worrisome situation the Nation faced.

Deeply concerned over evidence indicating an increase in the availability and use of illicit drugs, President Ford, in April, called for a thorough appraisal of the nature and extent of drug abuse in America today. The President directed the Domestic Council, under the leadership of the Vice President, to undertake a priority review of the overall Federal effort in the prevention and treatment of drug abuse, to give him a frank assessment of our effectiveness, and to make recommendations concerning ways to make the Federal drug abuse program more effective in the future.

The specific objectives of the review were to:

- assess the effectiveness of current drug programs and policies; and
- determine if the Federal drug strategy, priorities and organizational structures are appropriate to meet current needs.

In addition, the review was to examine the need for, and structure of, a drug management and coordination mechanism in the Executive Office of the President.

To accomplish this mission, a task force, consisting of high-level representatives of twelve Federal departments and agencies having responsibilities in the drug abuse area, was created and charged with responsibility for preparing a comprehensive white paper on drug abuse which would be responsive to the President's concerns. As its first order of business, the task force established

working groups to perform the analysis and to prepare initial drafts for its consideration. During the course of the review, more than 80 individuals from more than 20 different government organizations participated in work group activities. More than 30 other individuals, representing almost as many community organizations involved in the drug abuse area, also contributed valuable perspective and ideas.

The white paper does not attempt to evaluate each Federal drug agency or program in terms of its past performance or to compile a scorecard showing which agencies or programs produced the most impressive numbers of arrests, or seizures, or reformed addicts. It was the view of the task force that this type of statistical approach to evaluation is responsible, in large measure, for much of the dysfunction of our current efforts. Nor did the task force attempt to perform a management audit. Rather, the white paper seeks to review and assess the agencies and the programs in an operational context to see if they are rational (Do they make sense?), properly targeted (Are our objectives and priorities appropriate?), and reasonably structured to achieve their intended purposes (Can we expect them to accomplish what we created them to accomplish?).

The task force recognizes that, while this kind of analysis may not highlight where we have stumbled in the past, it will tell us where we should be headed in

the future. The task force views the making of recommendations for improving the Federal drug program as its most important assignment.

Finally, the task force made every effort to reach unanimity on each recommendation, but this was not always possible given the widely disparate institutional and individual perspectives of its members. Accordingly, to provide the most useful document possible, the task force decided to work by consensus, identifying conflicts or differences of opinion where necessary. To ensure that all views were properly represented, however, members of the task force who did not share the majority view on any issue were invited to submit memoranda outlining points of disagreement. These memoranda are appended to, and made a part of, the white paper.

1. OVERVIEW

A STRATEGY FOR CONTAINING DRUG ABUSE

The "drug problem" is not a recent phenomenon; the use of narcotics in the United States began prior to the Civil War. The fact that the earliest narcotics laws were passed over 60 years ago indicates that drugs have been a matter of national concern since the turn of the century.

Early efforts to deal with the problem focused on limiting the supply of drugs, first through taxation, then by prohibition and strict legal controls. The ever-increasing severity of Federal anti-narcotic laws reached a peak in the late-1950's with the passage of laws calling for life imprisonment and even death in certain cases.

The assumption behind this increasingly tough approach to the drug problem was that reducing the supply of illicit drugs would encourage drug-dependent individuals to detoxify and would keep drugs out of the hands of new users. Some did detoxify, but many did not, and the behavior and condition of those who did not detoxify continued to deteriorate. By the end of the 1950's there was general agreement that Federal policy was ineffective.

The belief that strict supply reduction by itself wasn't enough, coupled with the spread of drug use to new population groups, led to increasing experimentation with treatment for drug abusers during the 1960's. Finally, with the passage of the Drug Abuse Office and Treatment Act of 1972, Federal policy clearly called for a balanced response to the problem of drug abuse by adding a vigorous prevention and treatment component to the existing law enforcement efforts.

The Domestic Council Task Force on Drug Abuse strongly endorses the concept of a Federal program which balances the effort to control and, ultimately, reduce the supply of drugs with an effort to control and, ultimately, reduce the demand for drugs.* We believe that this concept should continue to be the cornerstone of the Federal strategy.

In addition to confirming the validity of this fundamental strategy, the past several years have taught us several lessons which are the basic themes upon which our specific recommendations are based.**

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* The demand reduction program is intended to: (1) dissuade the non-user from experimenting with drugs; (2) deter the occasional user or experimenter from progressing to the abuse of drugs; (3) make treatment available for abusers of drugs who seek it; and (4) help the former abuser regain his place as a productive member of society.

** These themes are in large part consistent with the basic findings of the National Commission on Marihuana and Drug Abuse, as well as those expressed in three issues of the Federal Strategy for Drug Abuse and Drug Traffic Prevention prepared by the Strategy Council on Drug Abuse. Thus, this white paper represents a gradual evolution of a consistent policy, rather than any abrupt departure.

This chapter discusses ~~three~~ these basic themes, after first outlining the rationale for a balanced strategy.

NEED FOR A BALANCED PROGRAM

The fundamental objective of supply reduction efforts is to make drugs difficult to obtain, expensive, and risky to possess, sell or consume. The basic assumption is that if taking drugs is hazardous, inconvenient and expensive, fewer people will experiment with drugs, fewer who do experiment will advance to chronic, intensive use of drugs, and more of those who currently use drugs will abandon their use.

This assumption is well supported by historical evidence. Both in cases of individual drug use and in outbreaks of drug epidemics, the easy availability of the drugs themselves has been found to be a major factor. For example:

- Following the passage of the Harrison Act in 1914, which made opiates illegal for the first time, the number of opiate users in the United States was halved.

- An analysis of a Chicago heroin epidemic which began shortly after World War II, reached its peak in 1949, and declined in the early 1950's determined that: "The decline of this epidemic . . . (was) . . . most clearly associated with decreased quality and increased cost of heroin."*

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* Hughes, Patrick H., et al. "The Natural History of a Heroin Epidemic," American Journal of Public Health, July, 1972.

- Immediately after World War II, an epidemic of amphetamine use swept Japan when this drug became readily available. A similar epidemic of amphetamine use occurred in Sweden in the early to mid-1960's. The Japanese experience is of particular interest because it developed in a country noted for low rates of alcoholism and ~~or~~ other forms of excessive drug use.

- When relatively pure heroin at low cost became available to U.S. servicemen serving in Southeast Asia in 1970-71, use was widespread. When these same servicemen returned to the United States, where heroin is much more costly and much more hazardous to obtain, use dropped dramatically.

- During the period 1972-73, a shortage of heroin on the East Coast coincided with significant reductions in both the incidence and prevalence of heroin use on the East Coast.

Furthermore, most studies indicate that experimental users rarely search intensively to find drugs. In over 90 percent of the cases, they "happen on" drugs, or are introduced to drug use by a friend. This finding implies that if new users had to go beyond their normal contacts to find drugs, many would probably not use them.

In addition, several studies have shown that some people who began and enjoyed drug use, but eventually abandoned it, did so because drugs became expensive, inconvenient or dangerous to procure. A study of neophyte heroin users who abandoned use in Los Angeles indicated that 55 percent did so because they lost their "connection." * Most did not make a concerted effort to establish a new "connection." The definitive survey of heroin users

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* Schasre, Robert, "Cessation Patterns Among Neophyte Users," International Journal of Addiction, Vol. I, No. 2, 1966.

civil liberties -- which we are not -- or spend enormous sums on supply reduction efforts, some drugs would continue to flow into illicit markets. Further, supply reduction is not very effective in discouraging the casual illicit use of legitimate drugs, since it is practically impossible to develop a system of controls that will prevent legitimate drugs from occasionally being available to illicit users.

Listing the costs and limitations of the supply reduction strategy is not meant to imply that supply reduction efforts are not justified; on the contrary, the task force believes that the effort to control availability through supply reduction should remain a central element of our strategy. But we must be mindful of the consequences of supply reduction efforts, so that we concentrate on ways of securing the benefits of supply reduction while ameliorating, to the extent possible, its adverse effects.

Balancing supply reduction efforts with complementary demand reduction efforts is one way to reduce the adverse costs of supply reduction, as well as being itself another avenue for reducing drug abuse. For example, the availability of treatment gives the drug user who finds drugs becoming scarce and expensive an alternative.

The problems created for users by high prices, impure drugs, uncertain doses, arrests, and victimization by other drug users can be reduced by making a range of treatment easily available to users.

In fact, supply reduction and demand reduction are not only complementary in that one compensates for the limitations of the other, they are also interdependent, in that increases in the resources devoted to one activity will be most effective only if increased resources are simultaneously devoted to the other.

For example, reduced drug availability increases pressure on drug users to seek treatment. If law enforcement is intensified in a city, additional treatment capacity will be required to care for the increased number of addicts forced to seek treatment. A good illustration of this occurred during the East Coast heroin shortage of 1973, when the number of people seeking treatment grew by 42 percent.

Secondly, demand reduction efforts complement the limited but valuable prevention effects of supply reduction efforts. Programs to provide employment, counselling, and recreation may succeed in preventing experimentation with drugs among inner-city youth despite the difficulty of substantially decreasing the availability of drugs in those areas.

For many years, social and legal policy dichotomized drug use as either a "criminal" or "social" problem. The fact is that it is both at once, and that activities aimed at reducing supply (including law enforcement) and those aimed at reducing demand (prevention, treatment, and rehabilitation) are mutually supportive. Thus, a balanced program of supply and demand reduction should be the cornerstone of the Federal strategy to reduce drug abuse in America.

SUPPORTING THEMES

In addition to confirming the validity of the basic strategy of balancing mutually supportive supply reduction and demand reduction activities, the experiences of the past six years, in which the drug program has been a major priority of the Federal Government, have taught us important lessons. These lessons become general themes which underlie findings, conclusions, and recommendations contained in the chapters which follow. Together with the supply/demand balance, these themes form the basis for a comprehensive Federal strategy to combat drug abuse. They are:

1. We must be realistic about what can be achieved and what the appropriate Federal role is in the war against drugs. We should stop raising unrealistic expectations of total elimination of drug abuse from our society. At the same time, we should in no way signal tacit acceptance of drug abuse or a lessened commitment to continue aggressive efforts aimed at eliminating it entirely. The sobering fact is that some members of any society will seek escape from the stresses of life through drug use. Prevention, education, treatment, and rehabilitation will curtail their number, but will not eliminate drug use entirely. As long as there is demand, criminal drug traffickers will make some supply available, provided that the potential profits outweigh the risks of detection and punishment. Vigorous supply reduction efforts will reduce, but not eliminate, supply. And reduction in the supply of one drug may only cause abuse-prone individuals to turn to another substance.

   All of this indicates that, regrettably, we probably will always have a drug problem of some proportion. Therefore we must be prepared to continue our efforts and our commitment indefinitely, in order to contain the problem at a minimal level, and in order to minimize the adverse social costs of drug abuse.

   We must develop better measures of program progress than the "addict counts" or gross seizure and arrest statistics which have been used in the past, and we must educate the public to shift its focus to the more relevant trend, availability, and quality arrest data which are available.

   Further, we must be realistic about what the Federal Government can and cannot accomplish in this area. It can play a major role in limiting supplies of drugs, in maintaining a widespread treatment capacity, and in providing technical assistance, research, demonstration, and evaluation. It can take the lead in enlisting the cooperation of other nations of the world in suppressing the production of illicit drugs. It can provide leadership in our domestic effort to reduce the levels of drug abuse, particularly if our national leaders clearly articulate their commitment to this effort.

We must recognize, however, that the Federal Government cannot single-handedly eliminate drug abuse or its effects on our society. Only through the combined efforts of the Federal, State and local governments, private individuals and businesses, and a variety of local organizations, working together, can we hope to ultimately succeed in this vital undertaking.

2. Not all drug use is equally destructive, and we should give priority in our treatment and enforcement efforts to those drugs which pose the greater risk, as well as to compulsive users of drugs of any kind. At any given level of consumption, different drugs pose different threats to the behavior and condition of users. Further, at high levels of consumption -- particularly with intravenous injection -- the effects are vastly increased. Public policy should be most concerned with those drugs which have the highest social cost.

   This does not suggest devoting all resources to the highest priority drugs, and none to lower priority drugs. All drugs are dangerous in varying degrees and should receive attention. But where resource constraints force a choice, those drugs with the potential for causing the highest social cost should be given priority.

3. Supply reduction is broader than law enforcement and we should utilize a variety of supply reduction tools. Federal supply reduction efforts should be targeted at all aspects of illicit production (or diversion from licit production) and distribution of drugs. The activities involved range from crop substitution and economic development to interdiction of illicit shipments and the removal of important traffickers from the supply system through long prison terms. More effective regulation and monitoring of the legitimate production and distribution of drugs such as amphetamintes and barbiturates, which are also abused or used illicitly, is one supply reduction tool which should receive greater attention than it does now.

   Undertaking a comprehensive supply reduction program requires the cooperation of many foreign nations and the active participation of numerous Federal, State and local agencies. Full utilization of all resources should be encouraged, and closer cooperation fostered to ensure that all are contributing optimally to the overall supply reduction effort.

4. Federal law enforcement efforts should focus on the development of major conspiracy cases against the leaders of high-level trafficking networks, and should move away from "street-level" activities. The most effective way to control and reduce supply is to immobilize large trafficking networks through the prosecution and conviction of their leaders. Since the leaders of trafficking organizations normally insulate themselves from overt illegal acts by delegating these acts to subordinates, conspiracy cases often are the only effective means for the law to reach them.

   To optimize the development of conspiracy cases, (1) higher priority should be placed on developing and analyzing operational intelligence, (2) the percentage of Federal agent time spent on "street-level" activities should decline, and (3) cooperation with border interdiction forces and with State and local police forces must be improved. This last item, improving cooperation with border interdiction and local police forces, is also important to insure that other vital law enforcement efforts continue to be adequately performed.

5. The current treatment focus of demand reduction efforts should be supplemented with increased attention to prevention and vocational rehabilitation. The bulk of Federal resources and attention have gone for treatment since the drug program was elevated to a high priority. In light of the acute need which existed at that time, this focus was clearly necessary.

   Yet, treatment is a response to a problem which has already developed. Given the difficulties of successful treatment, it is obvious that effective programs which prevent the problem before it develops are highly desirable. Similarly, vocational rehabilitation during and after treatment which enhances the probability that a former abuser will not return to drug use should be given priority. The task force believes both these areas should be important parts of the overall demand reduction program.

6. Neither successful prevention or successful rehabilitation is drug specific; both should be closely integrated with other social programs. The successful prevention models which exist have not been drug specific. That is, they have dealt with the broad range of adolescent problem behavior -- drug use, alcoholism, truancy, and juvenile delinquency. Further, the more successful programs have been tailored to the specific problems and resources of a local community. Thus, prevention should be centered in broad range, community-based programs. The Federal role should be catalytic in nature, providing technical assistance, training, and limited seed money.

   Rehabilitation is a critical step in returning a drug user to a productive life. Individuals need help in developing or recovering skills which enable them to support themselves. Some need basic schooling, vocational counselling, and skills training; some need a form of supported work; and still others simply need a job. All of these services are provided by existing community manpower services; we must be sure that they are available to former drug users and stabilized patients in treatment.

In addition to these six programmatic themes, there are three themes related to effective management of the drug program at the Federal level which are woven into the task force's recommendations.

1. Cabinet management should be strengthened, and direct White House involvement should be restricted. A central theme of this Administration is that program management is properly a function of the Cabinet departments, and White House involvement should be restricted to participating in major policy decisions, maintaining oversight to ensure that the President's policies and directives are being effectively implemented, and assisting in interagency coordination.

   This theme meets the current needs of the drug program. During the past several years, a great deal of direct White House involvement was required to get the major drug agencies launched and to ensure that the Federal

Government's commitment to the drug program was implemented. Now that these agencies have been in existence for several years, they are capable of assuming greater responsibility for program management and coordination.

2. We must more effectively mobilize and utilize all the resources available in the Federal Government, State and local governments, and the private community. While the task force endorses the "lead agency" concept, we believe that opportunities exist to more fully utilize the resources of the U.S. Customs Service and the FBI within an integrated Federal law enforcement program, and to utilize vocational rehabilitation services available in the Department of Labor as part of a comprehensive demand reduction program. Further, the Federal Government should take the lead in mobilizing the enormous potential resources available in State and local law enforcement agencies, and in State, local, and private prevention, treatment, and rehabilitation services. Only through full utilization of all available resources, and close cooperation among all involved agencies, can we hope to reduce the extent of drug abuse in America.

3. There is a significant need to improve the efficiency and effectiveness with which the drug program is managed. During the period of rapid growth in the drug program, there was little time for addressing management issues; rather, the focus was to launch a large drug program as rapidly as possible. Now that the program (and new agencies) have matured, it is time to consolidate the gains that have been made and to strengthen program management.

Improvement is necessary in three areas:

- Effectiveness of management within agencies.
- Coordination between and among agencies.
- Evaluation and follow-up of program and research results to determine their impact in reducing drug abuse in the United States.

4. Significant progress can be made without requiring the commitment of substantial additional resources. This is really the net result of implementing the preceding strategies and themes. In summary, a great deal of progress can be made in both supply and demand reduction efforts through better utilization and targeting of existing resources.

# # # # # #

Before discussing specific recommendations for improving supply and demand reduction efforts, Chapter 2 examines the nature and extent of the drug problem in an effort to establish an understanding of the task which faces the Nation. Chapters 3 and 4 discuss the task force's evaluation of supply and demand reduction efforts, respectively, and present specific recommendations for improvement. Chapter 5 pulls the program together by discussing overall program management. The major conclusions and recommendations are summarized in Chapter 6.

2 - ASSESSMENT OF THE CURRENT SITUATION

The cost of drug abuse to the nation is staggering. Counting narcotic-related crime, addicts' lost productivity, and treatment and prevention programs as major items, estimates range from a conservative $10 billion upwards to $17 billion a year, and there is no calculating the social toll in terms of lives ruined and homes broken. This chapter attempts to put this problem in perspective by discussing the current situation in detail. Then it draws on this assessment to make recommendations concerning Federal priorities.

The terms "drug abuse" and "drug problem" mean different things to different people. For the purposes of this assessment, "drug abuse" is defined as non-medical use of any drug in such a way that it adversely affects some aspect of the user's life; i.e., by inducing or contributing to criminal behavior, by leading to poor health, economic dependence, or incompetence in discharging family responsibilities, or by creating some other undesirable condition. Using this definition, the "drug problem" is the total effect on society of these adverse effects of non-medical use of drugs, not only the physical effects of drugs on the individuals using them.

Because we are unable to accurately measure the adverse effects of drug use, we frequently use the number of users as an indicator of the magnitude of the drug problem. In using estimates of the total number of users as a measure of the problem, we must keep several factors in mind:

1. The magnitude of the drug abuse problem is related to the particular drug being used. At any given level of consumption, different drugs pose radically different threats to the behavior and condition of users.

2. The magnitude of the drug abuse problem is related to the frequency and quantity of consumption (or "use pattern"). At high levels of consumption -- particularly with intravenous administration -- the user's behavior and physical condition may deteriorate rapidly. For this user, a reduction in drug consumption is likely to significantly alter behavior and therefore impact on the drug problem.

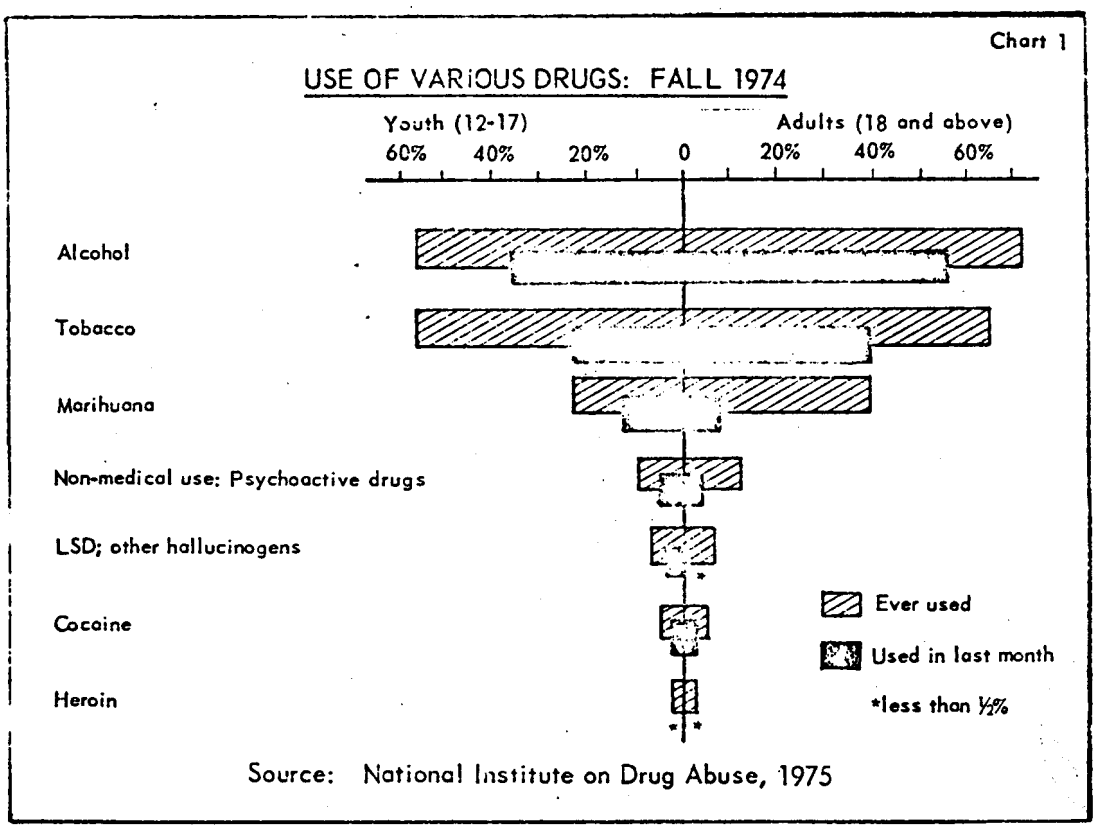
   On the other hand, at low levels of use, drugs are probably not particularly important in a user's daily life, so reducing his already low consumption is unlikely to have much impact on behavior or health. Thus, the largest portion of the drug abuse problem (and the portion where efforts at reduction should be focused) is created by chronic, intensive users of drugs.

3. These factors are interrelated. The likelihood of advancing to chronic, intensive levels of consumption differs from drug to drug and from individual to individual. Users of dependence-producing drugs such as heroin are more likely to advance to high levels of use than are users of non-dependence-producing drugs such as marihuana.

Thus, in using estimates of numbers of drug users as an indicator of the drug abuse problem, it is important to distinguish among drugs being used, to recognize the variation of use patterns, and to predict how use patterns will change over time. These factors, much more than

the absolute number of users, determine the magnitude of the drug abuse problem.

Chart 1 shows the results of the most recent national statistical sample of drug use taken in the Fall of 1974. It shows that a majority of both adults and youth have used alcohol and tobacco,* and that exposure to marihuana and non-medical use of so-called "dangerous drugs"** is widespread. The dark bands show recent use and, because the adverse effects of drug use are associated with frequent, habitual use, are a better measure of the drug problem.



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* See note concerning alcohol and nicotine on opposite page.

** The term "dangerous drugs" is commonly used to refer to the non-medical use of prescription or over-the-counter tranquilizers, barbiturates, and amphetamines and other stimulants.

NOTE CONCERNING ALCOHOL AND NICOTINE

Although alcohol and nicotine are the two most widely used drugs in the United States today, and are clearly psychoactive or mood-altering substances, their use and its consequences are not a central theme in this study. The task force excluded them from extensive consideration because public and social policy regarding these drugs is significantly different than that regarding the other drugs being discussed. Alcohol and nicotine are legally obtainable and socially acceptable drugs; with a few exceptions, the drugs considered in this report are not.

Clearly, alcohol and nicotine are bonafide substances of abuse whose use often create significant adverse social costs and consequences. As such, they should be dealt with along with other substances of abuse. The task force recognizes this interrelationship and encourages efforts to integrate all elements of substance abuse into broader health care programs, as is now being done in the Veterans Administration.

However, it must be remembered that the development of discrete drug abuse health care delivery system was necessary because existing systems did not respond to the need of the hard-core narcotic addict and other chronic drug abusers. In part, this was due to a reluctance -- not evident in the areas of alcohol treatment or nicotine-related problems -- of existing treatment units to treat what was ~~considered to~~ considered to be a less desirable population of drug abusers.

Consequently, unlike alcohol, which has a greater historical basis of support and integration within community health care delivery systems, and which receives the vast majority of its financial support from non-Federal sources, other drugs of abuse required Federal intervention to provide needed treatment and prevention services. The Federal Government has taken a direct lead in the development and support of drug abuse prevention and treatment services which should ultimately be effectively and fully integrated into other community health systems. The task force supports those activities which are designed to better integrate the various programs developed to respond to the problems of substance abuse.

In this chapter, each of the principal illicit drugs is discussed in turn, with a summary of historical trends in use, availability, and supply, followed by a description of the current situation. Finally, the concluding section of this chapter examines the overall social cost of each drug, and recommends a priority for Federal efforts.

A - PRINCIPAL DRUGS OF ABUSE

While it is convenient for the purposes of discussion to consider each of the drugs of abuse separately, in practice, these drugs are often used in combination. Even some heroin addicts do not use heroin exclusively. This multiple drug use occurs for a variety of reasons: beginning users often experiment with a variety of drugs singly and together in quest of novel experiences; experienced drug users sometimes use combinations of drugs for the more intense combined effect; and sometimes one drug is substituted for another which is unavailable.

These complicated patterns of drug use make it difficult to estimate the true scope of the drug problem. For example, estimates of the number of current abusers of different drugs are not necessarily additive, since a single individual may be counted in several groups.

Multiple drug abuse is not discussed in detail here because little reliable information is available about

the combined effect of various drugs; however, research is in progress, as the matter is one of increasing Federal concern.

HEROIN

Heroin. The name itself evokes fear is most of us, and many consider heroin to be the drug problem. Most of the Federal effort in the drug abuse field has been directed at it. The concern is well founded; heroin is a very serious drug of abuse. But despite the attention it has received (and perhaps because of it) heroin remains one of the most misunderstood drugs and continues to be surrounded by many myths. Hopefully, this chapter will help dispel some of the myths and place the problem in its proper perspective.

Historical Trends

In 1965, an epidemic of heroin use began in the United States. New use (or incidence) increased by a factor of 10 in less than seven years.* Both hepatitis data -- important as an indicator because of the high rate of hepatitis among heroin users -- and incidence data obtained from clients in treatment deomonstrate this

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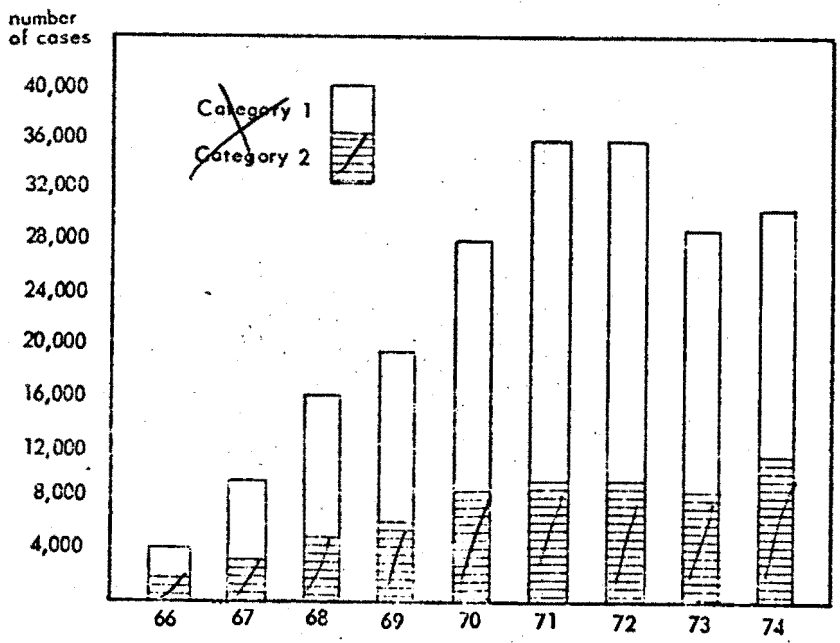
* Incidence refers to the number of new users during a stated period of time; Prevalence refers to the total number of users at a particular point in time.

phenomenon (see Charts 2 and 3).

Chart 2

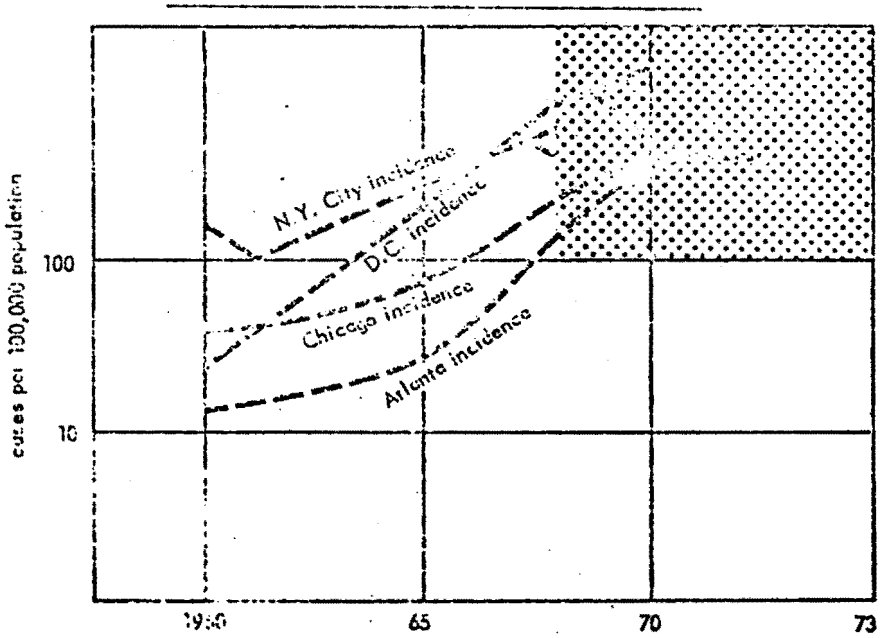
NARCOTIC RELATED HEPATITIS CASES



Source: Center for Disease Control, 1975

Chart 3

ESTIMATED INCIDENCES OF HEROIN USE



Source: National Institute on Drug Abuse, 1974

This widespread epidemic was composed of several smaller ones linked by a diffusion process which was surprisingly fast. The epidemic began among minority populations living in metropolitan areas on both coasts (e.g., New York City, Washington, D.C., Los Angeles, San Francisco). It spread quickly to other populations living in those same metropolitan areas, and then to other large metropolitan areas (e.g., Detroit, Boston, Miami, Phoenix). By about 1970, heroin use had begun to appear in smaller cities in the United States. Chart 4 shows the incidence of narcotic-related hepatitis among blacks and whites, and among men and women.

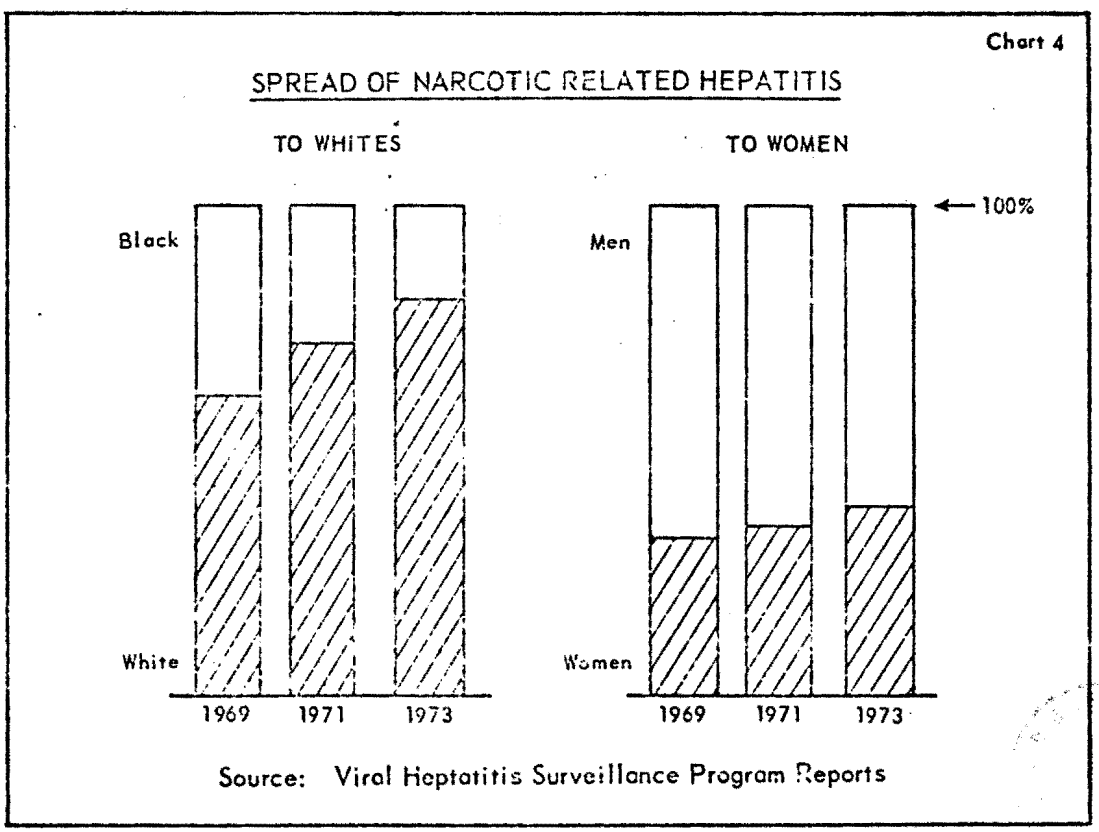


Chart 5 shows the spread of heroin use to new metropolitan areas derived from DAWN emergency room visits.*

Chart 5

"AGE" OF HEROIN PROBLEM IN MAJOR CITIES

	% first Heroin use 1970-74
Los Angeles	27%
New York	33
Detroit	53
Boston	59
Minneapolis	60
Miami	75
Phoenix	75

Source: Derived from DAWN data

This sudden upsurge in heroin use sparked an intensified effort by the Federal Government to reduce the supply of heroin and to seek new methods of treating heroin addicts. In 1972, as a result of this effort, the upswing in incidence and prevalence of heroin use was interrupted, and there was a subsequent decline throughout 1973.

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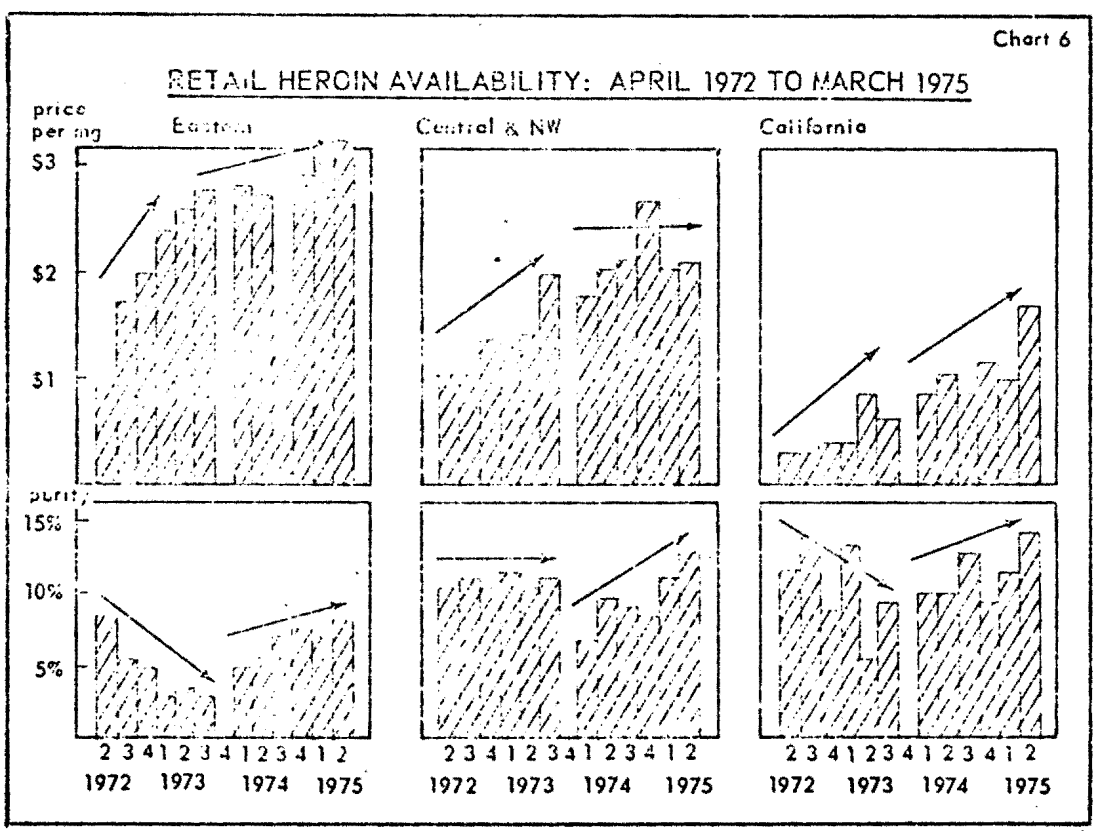
* Drug Abuse Warning Network, (DAWN) a data acquisition system which routinely collects information from emergency rooms, medical examiners' offices, and crisis centers indicating trends in drug abuse.

There are at least two interdependent factors which contributed to this decline in the magnitude of the heroin problem.

- The availability of a nationwide system of drug abuse treatment and rehabilitation services provided addicts with an alternative to street life and an opportunity to return to a more productive role in society.

- Law enforcement officials at all levels of government put unprecedented pressure on the distribution system. It became much more difficult, if not impossible, for an individual to secure drugs, and those which were available were of low purity. Central to the reduction in the supply of heroin was a combination of the Turkish opium ban, aggressive enforcement by the police of several European countries (particularly France) and several significant international conspiracy cases made by Federal enforcement agencies. These combined efforts produced a shortage of heroin on the East Coast, which was reflected in higher street prices and lower purity (see Chart 6).



The effects of these efforts were clear. In the cities on the East Coast where an estimated half of the users lived, heroin use declined significantly.

In Washington, D.C., for example, both incidence and prevalence declined significantly.* The decline in the number of new users was shown through dramatically reduced numbers of clients with a recent onset of heroin use coming into treatment. The decline in the total number of users was reflected in declining heroin overdose deaths and diminishing rates of detection of heroin among arrestees.

During the period of the East Coast heroin shortage, Mexico emerged as a major source country. Mexico's share of the U.S. illicit heroin market (measured by heroin removals from the U.S. market resulting either from seizures or undercover purchases) increased from about one-third to about three-fourths between 1972 and 1974. At the same time, the share supplied by the French-Turkish connection fell from slightly more than half to less than 10 percent as shown in the following table:

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* While it is sometimes misleading to use single cities as indicators of general trends in drug use, the experience of Washington, D.C., during this period of shortage illustrates developments in other East Coast cities, where a similar, but less dramatic, pattern existed.

APPROXIMATE SHARE OF U.S. HEROIN MARKET

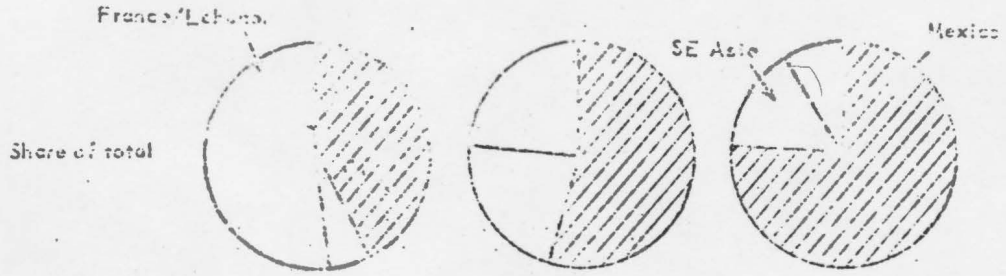
		1972	1973	1974
France/Lebanon	certain 43% / probable 10%	43% / 10% 53%	18%	9%
Southeast Asia		7%	17%	12%
Mexico		38%	63%	77%
Unknown		2%	2%	1%

(Estimates based on the Drug Enforcement Administration's Heroin Signature Program)

Mexico assumed this major importance not solely because traffickers operating in Mexico expanded their supply capabilities, but because other sources had disappeared and the total market had declined. In effect, Mexico became a large component of a reduced national market. By 1974, Mexico's supply capabilities had increased to a point where it was offsetting some of the reduced supply from France and Turkey. Thus, the task force estimates that the total supply available in 1974 was higher than in 1973, but still lower than in 1972.

Chart 7

SOURCES OF HEROIN



Source: DEA Signature Program

Current Situation

While data for 1975 are not as clear as the historical data, we can discuss several important features of the current situation.

1. There are several hundred thousand daily chronic users of heroin not currently in treatment.* These chronic users represent only a small percentage of those who have ever used heroin.

2. Incidence and prevalence of heroin use remain high on the West Coast and Southwest Border, areas which were not affected by the East Coast heroin shortage.

3. The East Coast heroin shortage appears to have leveled off and heroin is becoming more available. After increasing threefold over the period from June 1972 to March 1974, the price of heroin on the East Coast has remained steady. The rise in purity throughout 1974 combined with steady prices indicates increasing availability.

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* The task force debated including a more precise estimate, but concluded that any number used would be imprecise, highly influenced by the estimating methodology, and subject to misinterpretation if compared to other estimates based on different methodologies. The simple fact is that it is neither possible nor particularly relevant to make a specific estimate of the number of addicts: not possible because of the imprecision of available estimating methodologies and the difficulty of defining precisely who is an addict; and not relevant because other data -- trends in availability as measured by price and purity, patients in and waiting for treatment, drug related deaths, hepatitis cases, etc. -- are better measures of whether things are getting better or worse. All of these measures indicate that significant improvement was made all through late 1972 and 1973, and that conditions have been gradually worsening since early 1974. While they have not yet returned to the levels of 1972, the trend is definitely upward.

4. A number of cities which showed a decline in heroin use in 1972-1973 are now reporting an increase in prevalence based on rising numbers of heroin-related emergency room visits and heroin-related overdose deaths. These cities are also experiencing rising heroin purity. All these factors indicate a deteriorating situation.

5. A number of serious threats to supply reduction efforts exist which could, if left unchecked, increase the street availability of heroin. Illicit supplies from Mexico continue to pose a serious problem despite the commendable efforts of the Mexican Government. Illicit production in Southeast Asia remains the highest in the world, and the fact that new trafficking routes have been established to Northern European cities is worrisome. While it appears that Turkey is effectively controlling its current poppy crop, if such control diminishes the amount of heroin reaching the United States could increase.

6. The demand for treatment continues to grow and is geographically dispersed. Whether this growth in treatment demand is the result of an increasing pool of users, of users recycling back into treatment or the result of more effective outreach efforts by treatment agencies is not altogether clear. It is likely, however, that an increasing pool of users is responsible for at least some of the growth in demand for treatment.

These signs, taken together, are ominous. They indicate not only that the work of 1972-1974 is uncompleted, but that some of the significant gains that were achieved during this period have been lost and that new losses may accumulate unless our efforts in supply and demand reduction are intensified.

BARBITURATES, TRANQUILIZERS AND AMPHETAMINES

The various "dangerous drugs" present a special problem, for, unlike heroin, cocaine, and marihuana -- which are totally illegal -- these categories of drugs are frequently prescribed by doctors for valid medical purposes. The existence of this legal market vastly complicates control problems and, as a consequence, procurement in the illicit market has tended to be easy and inexpensive.

Historical Trends

At present, we are unable to track trends in the use and sources of these "dangerous drugs" as well as we can for heroin. However, it is clear that their use has increased rapidly in the United States during the last decade. Two different trends have led to this growth:

1. These drugs are being prescribed more frequently and used more often in the general population. Currently, about 25 percent of adult Americans have used one or more stimulants, sedatives or tranquilizers during the last year. Most of this use is under medical direction and controlled by prescription. But uncontrolled non-medical use of these drugs has grown sharply during this period of increasing usage. Currently, active non-medical use of these drugs is estimated to be 5 percent among the adult population, or 7 to 8 million Americans.

2. Non-medical use of prescription drugs has become widespread among youth (especially students), a trend which roughly duplicates the recent history of wholly illegal drugs. Not only are common substances such as amphetamines and barbiturates widely abused, but there has been a continuing stream of "fad" drugs. Since 1972, this unsupervised use by young people has apparently leveled off.

Both trends are apparent in a series of surveys of different portions of the population as shown in Chart 8.

Chart 8

TRENDS IN THE USE OF DANGEROUS DRUGS

BARBITURATES – SEDATIVES EVER USED	1968	1969	1970	1971	1972	1973	1974
National Sample of Adults	—	—	—	—	4%	—	4%
National Sample of Youths	—	—	—	—	3%	—	5%
Regional Sample of High School Graduates	—	—	16%	18%	15%	15%	14%
National Sample of High School Graduates	—	6%	9%	—	—	—	19%

BARBITURATES – SEDATIVES WITHIN LAST YEAR	1968	1969	1970	1971	1972	1973	1974
National Sample of Adults	—	—	—	—	—	—	1%
National Sample of Youths	—	—	—	—	—	—	3%
Regional Sample of High School Graduates	—	—	5%	6%	5%	5%	4%
National Sample of High School Graduates	—	3%	4%	—	—	—	6%

AMPHETAMINES – STIMULANTS EVER USED	1968	1969	1970	1971	1972	1973	1974
National Sample of Adults	—	—	—	—	5%	—	6%
National Sample of Youths	—	—	—	—	4%	—	5%
Regional Sample of High School Graduates	16%	20%	20%	23%	24%	20%	19%
National Sample of High School Graduates	—	9%	15%	—	—	—	32%

AMPHETAMINES – STIMULANTS WITHIN LAST YEAR	1968	1969	1970	1971	1972	1973	1974
National Sample of Adults	—	—	—	—	—	—	2%
National Sample of Youths	—	—	—	—	—	—	3%
Regional Sample of High School Graduates	6%	8%	7%	9%	10%	8%	7%
National Sample of High School Graduates	—	9%	13%	—	—	—	21%

These drugs are much more readily available in the illicit market than are wholly illicit drugs such as cocaine and heroin. This ready availability is reflected in the relatively low cost of a day-long "binge" with tranquilizers and amphetamines: less than $10, compared with $50 - $100 per day for heroin or cocaine. The individual and social cost of dangerous drug abuse is, however, as high as that of almost any other abused substance.

There are three important sources of "dangerous drugs": (1) diversion from legitimate domestic production and distribution; (2) illicit domestic production; and (3) illicit foreign production and smuggling.

It is possible to estimate the share of the illicit market from each source by looking for tell-tale "signatures" on seizures and undercover purchases made by law enforcement officials. (Signatures can be as complicated as a trace chemical due to faulty processing or as simple as a letter stamped on each tablet.) While these signatures are somewhat less developed than are the signatures for heroin, the estimating procedure provides the best available indicator of the relative market share of the various sources of "dangerous drugs."

Barbiturates are primarily a diversion problem, methamphetamines are primarily a problem of illicit production, and amphetamines are obtained from both sources.* The share of the illicit market for methamphetamines diverted from legitimate sources has decreased dramatically, and the share for amphetamines has decreased somewhat, both declines reflecting significant quota tightening by the Drug Enforcement Administration (DEA) under the Controlled Substances Act. At the same time, the share from legitimate sources for barbiturates has remained roughly constant.

Current Situation

Based on the survey data summarized in Chart 8, we can make the following general statements about the use of these drugs:

First, chronic, intensive, medically unsupervised use of amphetamines and barbiturates probably ranks with heroin use as a major social problem. Even if we restrict our attention to users "in trouble" -- meaning those who regularly use a number of these drugs for non-medical purposes -- a large group is involved.

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* Chart 13 in Chapter 3 illustrates relative market shares.

Chart 9 illustrates how this estimate of users "in trouble" is derived. Assuming a substantial overlap among drugs, this chart shows that there are still more than one-half million regular, medically unsupervised users of different "dangerous drugs."

Chart 9

REGULAR USE OF DANGEROUS DRUGS

% of Population aged 14 or over

	Ever Used	Regular Use	Regular Non-Medical Use	Regular Non-Medical Multiple Drugs	Number of Users in trouble
Sedatives	5.7%	2.3%	0.3%	0.2%	270,000 300,000
Stimulants	3.1	1.8	0.7%	0.3	400,000 490,000
Tranquilizers	9.1	4.9	1.6%	0.3	400,000 490,000

Second, the problem could easily get worse. Serious individual and social consequences from drug use occur primarily among chronic, intensive users. Until recently, only a small fraction of all users of these drugs fell into this category.

However, the probability of moving to a chronic, intensive use pattern is related to the age at which one began using drugs, as well as the number of different drugs used and the length of time since first use. We know that a large number of people: (1) began using drugs in the early 1970's in their mid-teens; and (2) have used many different drugs. If many in this group follow the traditional pattern of falling into chronic use around age 20, the number of "in trouble" users of dangerous drugs will increase substantially.

COCAINE

Cocaine, though available for many years, is the new "in" drug, and the various implements and rituals associated with the use of cocaine have recently become subject to extensive commercial exploitation.

Historical Trends

Except for use in several highly publicized "in-groups" (e.g., musicians), cocaine use in this country was apparently insignificant as late as the early 1960's. Since then, however, use has increased rapidly, a trend which has received a great deal of attention in the press.

The increasing popularity of cocaine is reflected in law enforcement data. Since 1970, there has been a steady upward trend in the amount of cocaine seized en route to the United States from South America. DEA seizures and undercover purchases of cocaine have increased steadily in the last five years, both in the United States and internationally. Cocaine arrests by State and Federal agents have also risen sharply.

Virtually all of the cocaine entering the United States comes from South America and principally from Columbia, where the refining process is completed.*

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* The finished cocaine is smuggled from Columbia into the United States by a variety of routes; direct, through Mexico, through the Caribbean, and even through Europe or Canada.

Current Situation

Chart 1 showed that 4 percent of youths and 3 percent of adults have used cocaine at least once, and that 1 percent of each group used it in the month prior to the survey.

Rates of cocaine use vary greatly among specific groups within the general population. In a national survey conducted in 1972, 1.2 percent of junior high school students, 2.6 percent of senior high school students, and 10.4 percent of college students reported experience with cocaine. Almost half of those youths reported that their first use occurred recently -- that is, during the previous twelve months. Additional studies indicate that as many as 16 percent of male high school graduates followed in a national sample had used cocaine at some time during the five years following graduation. There are other subpopulations in which use of cocaine is also high.

The data indicate that cocaine is used for the most part on an occasional basis (several times a month or less); usually in the company of others; and is likely to be taken in combination with alcohol, marihuana, or some other drug. Cocaine is not physically addictive.

About one percent of patients admitted to Federally funded treatment facilities reported cocaine as their

primary drug of abuse; an additional 12 to 13 percent reported that they used cocaine in association with other drugs, mainly heroin. Thus, the data obtained from treatment programs and surveys generally reflect the fact that cocaine, as currently used, usually does not result in serious social consequences such as crime, hospital emergency room admissions, or death.* The implications of this conclusion are discussed later in this chapter.

In summary, although the rate of increase of first use of cocaine is alarming, significantly less is known about cocaine use in the United States than about the other drugs described in this assessment.

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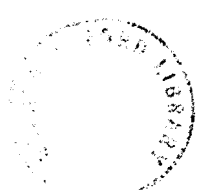
* The phrase "as currently used" is important. The effects of cocaine if used intensively -- particularly if injected -- are not well known, but recent laboratory studies with primates, as well as reports of the effects of chronic cocaine injection during the early 1900's suggest that violent and erratic behavior may result. For this reason, the apparently low current social cost must be viewed with caution; the social cost could be considerably higher if chronic use began to develop.



MARIHUANA*

Marihuana is the most widely used illicit drug, with an estimated 20 percent of Americans above the age of 11 -- 25 to 30 million people -- having used it at least once. In short, marihuana has joined alcohol and tobacco as one of the most widely used drugs in the United States.

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* A great deal of controversy exists about marihuana policy. On the one hand, recent research indicates that marihuana is far from harmless, and that chronic use can produce adverse psychological and physiological effects. Therefore, its use should be strongly discouraged as a matter of national policy.

However, in light of the widespread recreational use -- and the relatively low social cost associated with this type of use -- the Federal Government has been deemphasizing simple possession and use of marihuana in its law enforcement efforts for several years. For example, very few persons are arrested by Federal agents for simple possession and use; those who are charged with this offense normally are also being charged with some other, more serious offense as well. However, vigorous law enforcement aimed at major traffickers has been and should continue to be undertaken at the Federal level.

The task force endorses this moderate view and expects the lower priority that has been established for marihuana will also be reflected in our demand reduction efforts by the elimination of many non-compulsive marihuana users now in our treatment system.

Historical Trends

National attention first focused on marihuana following reports of widespread use during the mid-1930's. Discussion culminated in legislation which imposed Federal criminal sanctions against both the distribution and use of marihuana. Although proscribed by Federal law, the use of marihuana continued during the ensuing years, but at relatively low levels. Marihuana use was most common among urban minority groups and Mexican-American workers in the Southwest during this period.

A significant increase in the use of marihuana began to occur during the mid-1960's when its use became associated with artistic and anti-establishment life-styles; use then rapidly spread across geographic, demographic, and social boundaries.

The sources of supply have traditionally been Mexico, the Caribbean and South America. They remain so today.*

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* In addition, there is an unknown but presumed small amount of domestic growth.

Current Situation

Rates of marihuana use have been rising steadily over recent years as shown in Chart 10.

Chart 10

TRENDS IN THE USE OF MARIHUANA

EVER USED

	1968	1969	1970	1971	1972	1973	1974
National Sample of Adults	—	—	—	15%	16%	—	19%
National Sample of Youths	—	—	—	14%	14%	—	23%
Regional Sample of High School Graduates	32%	40%	43%	50%	51%	55%	—
National Sample of High School Graduates	—	20%	35%	—	—	—	62%

CURRENTLY USED

	1968	1969	1970	1971	1972	1973	1974
National Sample of Adults	—	—	—	5%	8%	—	7%
National Sample of Youths	—	—	—	6%	7%	—	12%
Regional Sample of High School Graduates	18%	25%	25%	33%	35%	36%	38%
National Sample High School Graduates	—	6%	9%	—	—	—	21%

Current estimates suggest that up to 20 percent of the general population over the age of 11 has used marihuana at least once, and that use is encountered in nearly all population groups. Over 40 percent of those who have ever used marihuana are current users, and at least half of the current users use it at least once a week.

Rates of use may be considerably higher or considerably lower, depending on the segment of the population under study. The highest rates of use

have been reported among so-called "hippies" and high school dropouts. There appears to be a slight preponderance of males among marihuana users, although this distribution varies considerably from study to study. Other findings which occur consistently include the following:

- urban residents use at higher rates than rural residents;
- use is greater among those with higher levels of education and income;
- use is more frequent in the northeastern and western United States than in other regions.

A recent development which is cause for great concern is the increasing availability of the much more potent marihuana derivations -- hashish, and other preparations of high THC (tetrahydrocannabinol) content. Unlike common forms of marihuana, these potent drugs are known to have serious physical and social effects on the user.

DAWN provides some interesting data on various drug crises attributed to marihuana. During the nine months between July 1973 and March 1974, marihuana comprised only one percent of all emergency room drug mentions, but 51 percent of all crisis center drug mentions. This distribution of mentions by facility type reflects the kind of acute psychological problems likely to occur in association with the use of marihuana, with panic reactions or "bad trips" predominating over the more life-threatening

reactions which would lead to appearance in an emergency room.

From a treatment point of view, data show that approximately 17 percent of patients admitted to Federally funded drug treatment programs from January to April 1975, reported marihuana as their primary drug of abuse.* There is considerable controversy regarding the interpretation of these data for a number of reasons. The frequency of use reported by these "primary marihuana abusers" is less than once a week for nearly 45 percent of the patients. It seems clear that these people do not have a serious drug problem and should not be in treatment. Most likely, they were referred to treatment by the criminal justice system, by schools, or by parents who were concerned about the marihuana use. But when treatment facilities are full, this is a poor utilization of resources and these occasional marihuana users should not be occupying treatment slots. (Chapter 4 will develop this concept further.)

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* This includes NIDA, VA, and DOD. When NIDA is viewed alone, the marihuana figure is 21 percent.

OTHER DRUGS

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

Hallucinogens*

Except for the use of peyote in the religious ceremonies of some American Indian tribes, the use of hallucinogens is a recent development in the United States.

Limited, non-medical use of LSD began in California in the 1950's, but was greatly accelerated in the early 1960's as publicity associated with its use grew. In the early 1960's this drug was diverted from legitimate research sources, but by 1964 illegal manufacture of LSD was established. Today, virtually all LSD in the United States is produced illicitly and, because only very small amounts are needed to produce an effect, it is easily concealed.

Hallucinogen use is very different from most other drugs. Addiction, or even extended regular use is very unusual. These drugs are rarely used more than twice a week. Since a major reason people use these drugs is to experience unusual mental effects, most users stop taking these drugs entirely after the "trips" lose their novelty.

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* LSD, (Lysergic Acid Diethylamide Tartrate), mescaline, psilocybin, peyote, etc.

Surveys of hallucinogen use show that most who use do so less than once a month, and that weekly use is very rare. None of the surveys support conclusively the widespread belief that these drugs are not as popular as they once were, but there has been a definite decline in the number of hallucinogen-related medical problems.

Hallucinogens can cause a number of side effects, including panic reactions and long psychotic or depressive episodes. Most reactions are unpredictable and the negative side effects can occur after several "safe trips." The possibility of medical side effects such as chromosomal or genetic change has neither been thoroughly documented nor entirely eliminated.

Solvents and Inhalants

These are chemicals that are used for a variety of medical, industrial, and household purposes, and can also be inhaled to produce intoxication. The ingredients of these products are often unknown to the purchaser, abuser or doctor treating an adverse reaction.

Very little is known about the pharmacology of solvents. Partial tolerance may develop, and the effects of these substances are intensified when used with other depressants, especially alcohol.

Data on solvent use are sparse. The few available surveys indicate that about 7 percent of junior and senior high school students may have inhaled solvents once or twice and that about one percent of these experimenters continue to inhale periodically.

Volatile substance abuse occurs almost exclusively among the young, perhaps because solvents are often the most readily available intoxicants to children. Accordingly, maturing out of the inhalant habit is the general rule. Even heavy users will persist for only a few years, and then abandon solvent sniffing by their teens. (Many of these individuals, however, then begin the excessive use of alcohol, barbiturates or other substances.)

The fact that solvent inhalation lasts for such a short time for most users leads to the conclusion that it is primarily a reflection of the immaturity of those young people who become involved with it. Nonetheless, abuse must be monitored and action taken as appropriate. One simple action might be to use unpleasant additives in the manufacturing process. Further, the task force believes that the intervention efforts using peer groups discussed in Chapter 4 will help some young people resist the pressure to experiment with these substances if and when the inhaling of solvents becomes temporarily popular among their friends.

B - DRUG PRIORITIES

One of the major themes of the Federal strategy discussed in Chapter 1 was the importance of differentiating in terms of the particular drug of abuse, and the frequency and quantity of use. Implicit in that decision to differentiate is the assumption that public policy should be most concerned with those drugs which have the highest costs to both society and the user, and with those individuals who have chronic, highly intensive patterns of drug use.

In order to determine the social cost of a particular drug, we should consider the following factors:

- The likelihood that a user will become a compulsive user, either physically or psychologically dependent on the drug: closely linked to this concept is the ability of the drug to produce tolerance, requiring successively higher intake to achieve the same result.

- Severity of adverse consequences of use, both to the individual and to society: in terms of criminal behavior, health consequences, economic dependence and the like. (This is discussed in greater detail below.)

- Size of the core problem: the number of compulsive users who are currently suffering (or causing others to suffer) adverse consequences.

ADVERSE CONSEQUENCES
TO THE INDIVIDUAL

The adverse consequences of drug use are of two types: consequences which are the direct result of drug use, and indirect consequences which are associated with drug use. Direct consequences include:

- Illness or death: Illness or death can occur from overdose, a severe toxic or allergic reaction to a drug, or from rapid withdrawal. In New York City, drug-related deaths are a major cause of death for males aged 15 to 25. Death due to drug abuse is often the result of ignorance -- ignorance of possible contaminents in drugs, ignorance of the danger of using combinations of drugs, ignorance of the strength of the drug purchased and of techniques to determine non-lethal doses. If drug use affects reproductive organs, or when certain drugs are taken during pregnancy, a second generation may suffer casualties.

- Acute behavioral effects: The paranoia produced by intravenous injection of amphetamines can cause violent behavior and consequent criminal acts such as rape and homicide. Acute paranoia and extreme anxiety from the effects of hallucinogenics and depression (in the withdrawal state) from stimulants such as amphetamines, are other examples of behavior effects.

- Chronic behavioral impairment: Adverse behavioral effects may also be chronic as with the inertia, apathy and depression associated with long-term heroin use. Also, impairment can be measured in things such as loss of productivity, health costs, welfare assistance, and criminal costs.

- Intellectual Impairment: Some evidence of intellectual impairment has been reported by clinicians on the West Coast. Specifically, mental status evaluations of chronic users of hallucinogens who stopped after two or more years revealed a clinical impression not unlike that of mild chronic brain disease.

Indirect consequences include:

- Injury or death associated with impaired judgment: Potent, mind-altering drugs such as LSD can affect judgment, which may for example, result in accidental death by succumbing to bizarre hallucinations, such as believing one can fly. Even a "mild" drug such as marihuana may distort preception and thus increase the risk of death in automobile accidents of either a driver or pedestrian.

- Injury or death associated with conditions of use: Poor nutrition and neglected hygiene stemming from the total focus of energy on obtaining drugs can cause damage to vital organs. Transmission of viral hepatitis from shared needles is another medical problem of drug abusers. Young people in the drug culture are particularly susceptible to pneumonia. Infections associated with injections using unsterile needles may be fatal.

- Developmental difficulties: The potential for personality impairment due to drug use is an important consequence , but one difficult to assess. There are crisis periods in the course of every individual's development, but adolescence is a particularly vulnerable period because the individual seems inundated with crises. These crises provide an opportunity for growth, formation of new ideas, and the emergence of a healthier and more mature personality. The use of drugs as a means to deal with these crises may diminish, delay, or prevent this maturation process.

. Barriers to social acceptance: The public image of the drug user is extremely negative; thus, the user is often stigmatized, making it extremely difficult for a current or former drug user to find acceptance in society. Moreover, arrest and conviction for violation of drug laws results in the creation of a criminal record which may follow a user for the rest of his life.

ADVERSE CONSEQUENCES TO SOCIETY

Obviously the above adverse effects to individual drug users are society's loss, too. But there are also more directly measurable costs to society. A recent study estimated that the total measurable cost of drug abuse -- direct program costs, health care costs, property losses attributable to drug-related theft, and lost productivity -- was $10 billion to $17 billion per year.*

Still another way to look at the social cost of drug abuse -- one which is of particular interest in this discussion of drug priorities because it can be broken down by drug -- is to look at drug users' appearances in the various institutions we have established to deal with people in trouble.

Among the largest and most important of these institutions are the welfare system, the criminal justic system, and the health care delivery system. Drug users often appear in these institutions, and may be identifie as users. If we assume that at least part of the reason for their appearance is drug use, the frequency

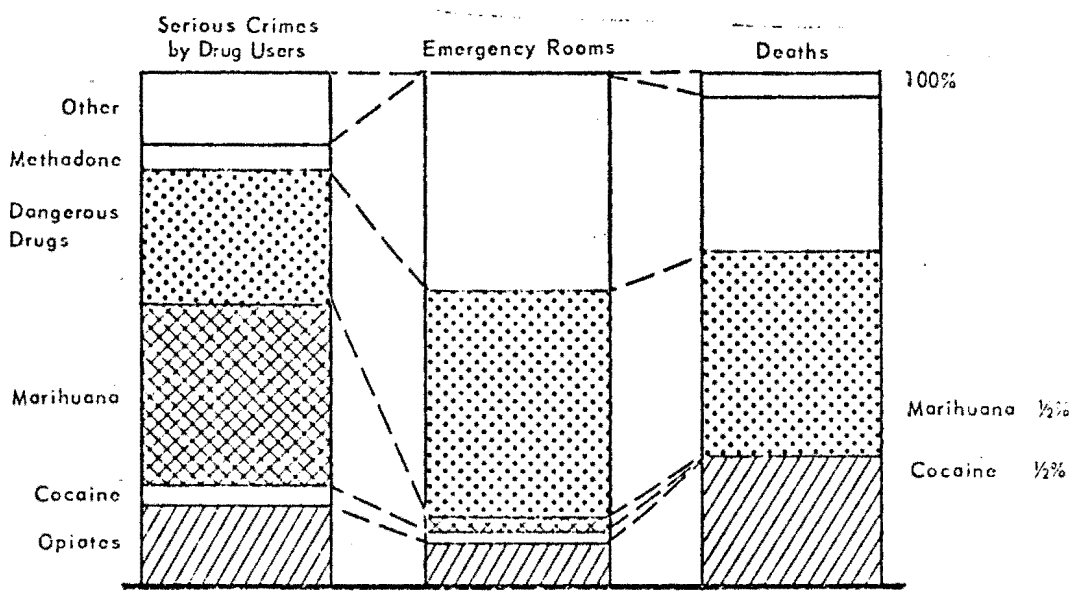
* Social Cost of Drug Abuse, Special Action Office for Drug Abuse Prevention, 1974: This excellent survey is summarized in the Federal Strategy, 1975.

of appearance provides one rough indicator of the magnitude of the social cost of drug abuse.

Our capability to monitor these appearances is irregular and limited in scope, but some data exist. Chart 11 illustrates the fraction of drug users who had used various drugs prior to their appearance in three different places where people in trouble show up: the criminal justice system (serious crimes only);* emergency rooms and medical examiners' offices.

Chart 11

INCIDENCE OF DRUG MENTIONS IN VARIOUS INSTITUTIONS



Source: DEA

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* The large proportion of marihuana mentions is probably a reflection of its widespread use in society.

SUMMARY: DRUG PRIORITIES

Chart 12 ranks the various drugs according to the following criteria: (1) likelihood that a user will become physically or psychologically dependent; severity of adverse consequences, both (2) to the individual and (3) to society; and (4) size of the core problem.

Chart 12

SUMMARY OF DRUG PRIORITIES

		DEPENDANCE LIABILITY	SEVERITY of CONSEQUENCES		SIZE OF CORE PROBLEM
			PERSONAL	SOCIAL	
HEROIN		HI	HI	HI	HI 400,000
AMPHETAMINES	NEEDLE	HI	HI	HI	HI 500,000
	ORAL	LOW	MED	MED	
BARBITURATES	MIXED	HI	HI	HI	MED 300,000
	ALONE	MED	HI	MED	
COCAINE		LOW	LOW	MED	LOW
MARIHUANA		LOW	LOW	LOW	LOW
HALLUCINOGENS		MED	MED	MED	LOW
INHALENTS		MED	HI	MED	LOW

Though the data are flawed and the rankings therefore imprecise, a clear pattern emerges.

- heroin ranks high in all four categories;
- amphetamines, particularly those injected intravenously, also rank high in all four categories;
- mixed barbiturates rank high three out of four categories;
- cocaine,* hallucinogens, and inhalants rank somewhat lower; and
- marihuana is the least serious.

On the basis of this analysis, the task force recommends that priority in Federal efforts in both supply and demand reduction be directed toward those drugs which inherently pose a greater risk to the individual and to society -- heroin, amphetamines (particularly when used intravenously), and mixed barbiturates -- and toward compulsive users of drugs of any kind.

This ranking does not mean that all efforts should be devoted to the high priority drugs, and none to the others. Drug use is much too complicated and our knowledge too imprecise for that. Some attention must continue to be given to all drugs both to keep them from exploding into major problems and because there are individuals suffering severe medical problems from even a low priority drug, such as marihuana.

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* This ranking is on the basis of current use patterns. As mentioned earlier, if intensive use patterns develop, cocaine could become a considerably more serious problem.

However, when resource constraints force a choice, the choice should be made in favor of the higher priority drugs. For example:

- In choosing whom to treat, we should encourage judges and other community officials not to overburden existing health facilities with casual users of marihuana who do not exhibit serious health consequences. (But, a person who is suffering adverse consequences because of intensive marihuana use should have treatment available.)

- In assigning an additional law enforcement agent, preference might be given to Mexico, which is an important source of both heroin and "dangerous drugs", rather than to Miami, where an agent is more likely to make a cocaine or marihuana case.

This drug priority strategy is essential to better targeting of limited resources and it will be further addressed in relation to supply and demand reduction activities in chapters 3 and 4. Further, the process of assessing the current social costs of drug abuse should be a continuing one, to ensure that resources are allocated on the basis of priorities which reflect current conditions and current knowledge.

3 - SUPPLY REDUCTION

Chapter 1 summarized the basic objective of supply reduction efforts: to make obtaining drugs inconvenient, expensive, and risky, so that fewer people will experiment with drugs, fewer who do experiment will advance to chronic, intensive use, and more of those who currently use drugs will abandon their use and seek treatment. The effectiveness of supply reduction as a means of reducing drug abuse has been illustrated earlier and supply reduction will remain a basic part of the Federal strategy.*

Unfortunately, total elimination of illicit drug traffic is impossible. Participants at each level of the distribution network are replaceable, as are the drugs removed from the illicit pipeline through seizure. Sufficient resources are not available to eliminate all illicit drug traffic; nor would a free society tolerate the encroachment on civil liberties which such a policy

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* This benefit is not gained without costs and adverse effects -- direct program costs, stigmatization of casual users through arrest, deteriorating health of continuing users, encouragement of black markets, crime to meet black market prices and the possibility of corruption. To partially offset these disadvantages, we recommend a complementary demand reduction effort, discussed in the next chapter.

would require. The realistic goal of supply reduction efforts, then, is to contain and disrupt the distribution system, and hopefully to reduce the quantity of drugs available for illicit use. From this perspective, supply reduction efforts must be selective, and scarce enforcement resources must be used in a way which will produce the greatest disruptive effects in the supply of those drugs which cause the most severe social consequences.

Allocation of resources should focus on two areas:

- Highest priority drugs. Chapter 2 discussed the risk associated with the use of various drugs and suggested that highest priority be given to those drugs causing the greatest social cost. Many supply reduction techniques cannot be focused on specific drugs, and some attention must be given to all drugs to keep them from exploding into larger problems; but when a choice is necessary, efforts should be devoted to reducing the illicit supply of high priority drugs.
- Greatest disruption of distribution systems. The total variety of supply reduction techniques -- law enforcement, regulatory programs, crop eradication, etc. --must be weighed and resources concentrated on the combination of techniques which has the greatest overall impact on supply. Efforts should focus on that portion of the supply system which appears to be most vulnerable at the time.

This concept of causing the greatest disruption of the distribution system has been useful in targeting efforts in the past. It has motivated agents to develop cases against financiers, chemists, and managers of major trafficking organizations; it has led the Cabinet Committee

on International Narcotics Control (CCINC) to direct its primary attention to countries producing raw materials and harboring major traffickers; and it has resulted in greater emphasis on the regulatory program to combat the growing problem of retail diversion of amphetamines and barbiturates.

Identification of the most vulnerable parts of the illicit distribution system, and re-allocation of resources as necessary, should be a continuing activity of program managers. At various times, raw materials, processing facilities, inventories, wholesale distribution capacity, entrepreneurial skill, or capital will be in short supply. Any of these constraining factors which determine the capacity of the system should be the target of supply reduction efforts. For example, illicitly produced raw materials can be intercepted by locating and destroying lab facilities, or by arresting illicit chemists; distribution systems can be upset by aggressive investigative activity, interdiction efforts, and action by State and local authorities.

Strategic calculations about where to focus supply reduction efforts must recognize that major segments of both licit and illicit supply systems operate in foreign countries. For example, all of the opium used to produce heroin that is consumed in the United States is grown abroad; and a significant fraction

of the processing facilities which supply methamphetamines and amphetamines are located in foreign countries. Thus, our strategy to control supply must often rely on foreign governments' capabilities to control drugs, and foreign commitment and capability may place an upper limit on this Nation's ability to control the supply of drugs at home.

Continued attention to this process of continually identifying the most vulnerable parts of the illicit distribution system -- isolating current bottlenecks in terms of resources, capabilities, or activities in short supply -- should be an on-going activity of program managers. Reallocation of resources should follow as necessary.

The balance of this chapter discusses the Federal supply reduction effort in five sections. Although these activities can be isolated for convenience in discussion, it is important to recognize that they are interdependent and mutually supportive, and that they must be continually balanced against each other in designing the supply reduction program appropriate at a given time. They are:

- Enforcement. The enforcement program is designed to deter, immobilize, and inconvenience illicit producing and trafficking organizations, to discourage potential new trafficking organizations from forming, to reduce smuggling, and to remove drugs from the illicit market.

- Intelligence: The worldwide intelligence program provides information needed to make strategic and tactical decisions with respect to design of the overall supply reduction program, and deployment of enforcement resources.

- International: The purpose of the international program is to enlist the cooperation of foreign governments in worldwide drug control efforts, and to encourage those governments to intensify their efforts by providing them with training, technical assistance and material resources, and through suitable diplomatic initiatives.

- Regulatory: The regulatory program focuses on the diversion of legitimate domestic production to illegitimate use. Devices available to the Federal Government include scheduling drugs, establishing production quotas and auditing firms to ensure compliance with the security and recordkeeping provisions of the Controlled Substances Act.

- Science and Technology: Science and technology essentially serve a supporting role by increasing the effectiveness and efficiency of operating programs. This area includes not only engineering and hardware, but also operations research and program analysis.

ENFORCEMENT

Drug law enforcement is often assumed to be supply reduction, and vice versa. As discussed previously, that impression is not correct; law enforcement is but one of many activities which limit the supply of illicit drugs. Nonetheless, drug law enforcement has been, and probably will continue to be, the single most important and most visible part of the overall supply reduction effort.

Reorganization Plan 2 of 1973 consolidated the principal drug investigative and intelligence resources in the Drug Enforcement Administration (DEA) for the purpose of ensuring optimal utilization and integration of these resources. While the task force did not undertake a comprehensive review of Reorganization Plan 2, all members concur in the basic concept of an integrated drug law enforcement agency charged with lead responsibility.* DEA is that lead agency and has made considerable progress in its two-year existence.

The concept of a "lead agency," however, does not denigrate in any way the vital roles played by other agencies in the drug law enforcement effort. For example, Justice's Federal Bureau of Investigation (FBI) and Treasury's Internal Revenue Service (IRS) and Alcohol, Tobacco, and Firearms Bureau (ATF) have important supportive roles in investigation. The Central Intelligence Agency (CIA) has a vital supportive role with respect to intelligence regarding international trafficking. Treasury's U.S. Customs Service ~~and Justice's Immigration and Naturalization Service~~ perform an invaluable interdiction function at our

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* Reorganization Plan 2 is perhaps the most misunderstood and misinterpreted issue in drug law enforcement, and is therefore discussed more completely later in this chapter. There is fundamental agreement and acceptance of the central concept; the disagreement which exists revolves around the relatively narrow question of how DEA and Customs interact in performing their respective missions.