The original documents are located in Box C10, folder "Presidential Handwriting, 1/14/1975 (2)" of the Presidential Handwriting File at the Gerald R. Ford Presidential Library.

THE WHITE HOUSE

WASHINGTON

January 14, 1975

ADMINISTRATIVELY CONFIDENTIAL

MEMORANDUM FOR: KEN COLE

FROM: JERRY H. JONES

SUBJECT: White House Organization and Drug Abuse

Your memorandum of January 7 on the above subject has been reviewed and Option 2 -- rely upon the existing Domestic Council Committee, with the new Attorney General and Secretary of HEW as co-chairmen to articulate and coordinate domestic drug abuse initiatives -- was approved.

Please follow-up with the appropriate action.

Thank you.

cc: Don Rumsfeld

1-14-75

6 of 2

THE WHITE HOUSE

WASHINGTON

To Don Rumsfeld

Seems to me this is something that should be looked at from the viewpoint of the new Domestic Council set-up.

Administratively it is probably better to have #2 but there is a perception problem for the White House & the President.

Your suggestions?

1/14

Jerry Jones

Option #2 is approved

~~Approved~~

Dick

THE WHITE HOUSE
WASHINGTON

1/11/75

Mr. President -

I believe option #2
is by far the best
suggestion -

Don

JAN 9 1975

THE PRESIDENT HAS SEEN.

THE WHITE HOUSE

WASHINGTON

January 7, 1975

MEMORANDUM FOR DON RUMSFELD

FROM: Ken Cole

SUBJECT: White House Organization and Drug Abuse

BACKGROUND

In the heyday of the drug epidemic, there was extensive Presidential and staff attention devoted to the issue of drug abuse. This reached its zenith during 1972 when the White House had:

-- The Special Action Office for Drug Abuse Prevention (SAODAP), headed by Dr. Jerome Jaffe, Special Assistant to the President, which was to coordinate all Federal drug abuse prevention, treatment, and educational programs from the White House.

-- The Office of Drug Abuse Law Enforcement, headed by Myles Ambrose, Special Assistant to the President, which was a temporary, high-intensity effort utilizing young attorneys to prosecute heroin pushers at the street level.

-- A Cabinet Committee on International Narcotic Control, whose Executive Director was Bud Krogh of the Domestic Council staff, with three additional staff members working respectively on the areas of law enforcement, treatment, and international initiatives.

With the initial success of Government efforts in this area, more traditional (and less political) organizational concepts have been adopted:

-- A National Institute of Drug Abuse (NIDA) was created in HEW in anticipation of the statutory end of SAODAP this June 30, 1975. Dr. Robert DuPont is head of both SAODAP and NIDA.

-- ODALE was merged by Reorganization Plan with Justice and Treasury drug enforcement agents to create a new Drug Enforcement Administration (DEA) in Justice, with the Attorney General given overall responsibility for drug enforcement.

-- The Executive Directorship of CCINC was moved to the State Department to a Senior Adviser to the Secretary for Narcotics Affairs.

-- An Office of Drug Management was established in OMB to coordinate and aid overall Government programs in this area.

-- A Domestic Council Committee on Drug Abuse, co-chaired by the Attorney General and the Secretary of HEW was established to coordinate interdepartmental efforts.

The attached package argues for the extension of SAODAP, now down to 20 staff members in the NEOB. It represents the anguished cry of Dr. Robert DuPont who fears the final end of SAODAP will banish drug treatment and prevention initiatives to the wasteland of HEW at precisely the time drug abuse is rebounding as a nationwide problem.

Dr. DuPont presents four options, whose common thread is that someone "at the White House" must be publicly in charge of drug abuse or dire political and practical consequences will follow. Dr. DuPont recommends creation of a new 4-year statutory Office of Drug Policy in the Executive Office of the President.

OMB correctly points out that all the major substantive policy decisions concerning drug abuse treatment have already been made, and recommends against continuation or creation of any separate agency in the Executive Office. OMB does, however, recognize the possible need to continue visible White House leadership in this area.

A Special Assistant role has usually been the answer for this type of problem, but naming DuPont would only aggravate the situation by singling out one particular area of drug abuse (in DuPont's case, treatment) for emphasis. Moreover, both OMB and the Domestic Council staff have specialists on drug abuse already doing the non-public policy and management staff work. The need really is for an occasional visible spokesman at the White House to speak to the worsening drug situation.

Yet a candid political analysis would suggest that having President Ford do a significant number of drug abuse statements and initiatives would be too reminiscent of the previous Administration. One promising solution would be to ask VP Rockefeller to chair the existing Domestic Council Committee on Drug Abuse. As a former Governor of the State worst ravaged by heroin, he has both familiarity and experience with the problem. Most advantageous of all, policies or initiatives advocated by Rockefeller could not be attacked as "blindly following the Nixon hard line on drugs."

OPTIONS

1. Ask VP Rockefeller to chair the Domestic Council Committee on Drug Abuse, and forego the establishment or continuation of any other office within the Executive Office.

2. Rely upon the existing Domestic Council Committee, with the new Attorney General and Secretary of HEW as co-chairmen to articulate and coordinate domestic drug abuse initiatives.

3. Appoint a Special Assistant for Drug Abuse who would provide more White House visibility and leadership on this issue.

RECOMMENDATIONS

Cole - "I urge Option 2, which puts the Cabinet out front on a substantive issue where it belongs. Although I think the Vice President could be very helpful in this area, he should have the flexibility to move in and out of issues as Vice Chairman of the entire Domestic Council and not be tied down, unless he so choses, by the responsibilities of a particular chairmanship."

O'Neill - Option 2.

DECISION

Option 1 _____ Option 2_____ Option 3 _____

EXECUTIVE OFFICE OF THE PRESIDENT
SPECIAL ACTION OFFICE FOR DRUG ABUSE PREVENTION
WASHINGTON, DC 20506

December 17, 1974

The President
The White House
Washington, D.C.

Dear Mr. President:

Because of an unexpected worsening in the nation's drug problem, I am asking at this time for a critical review of funding levels and management structure for Federal drug abuse prevention activities. Enclosed are (1) an overview of the drug abuse situation in the United States today, (2) a memorandum which makes recommendations for an increase in the drug abuse prevention budget for FY 1976, and (3) a memorandum recommending the establishment of an Office of Drug Policy within the Executive Office of the President.

Adverse trends in the extent of drug abuse in the United States have become evident in recent months; we can no longer say that heroin addiction and drug abuse in the United States are declining. The supply reduction gains made earlier by the elimination of the "French Connection" have disappeared. We are now experiencing widespread increases in heroin addiction, fed by an influx of Mexican heroin and further threatened by a resumption of opium production in Turkey. During the past year there has been an increase in the street supply, purity, and demand for heroin. One of the consequences has been the apparent spread of heroin addiction to some smaller cities in the nation. Demand for treatment has increased dramatically; by early 1975, virtually all Federal and non-Federal treatment slots will be filled. Waiting lists for treatment have appeared in thirty states, and the list is growing. Nationally, hospital emergency room treatment for heroin overdose has increased each quarter since September, 1973. Paralleling these trends has been an increase in the FBI reported crime rate in almost every state. Attachment (1) provides more details.

Despite this reversal in the national drug situation, there have been successive Federal budget reductions over the past two years, from a FY 1974 high of $300 million for the combined National Institute on Drug Abuse (NIDA) and Special Action Office for Drug Abuse Prevention (SAODAP) budget obligations, to an OMB mark of $210 million for FY 1976. This OMB proposed budget will make it impossible to maintain the current level of treatment, and provides no new prevention or research initiatives. In light of the rise

in the demand for treatment, and the need for an increase in the drug prevention effort, I am presenting a FY 1976 budget recommendation for NIDA of $306 million which will allow us to provide 116,000 Federal treatment slots, and modest increases in demonstration, research, and prevention efforts. The recommended budget also includes an additional $17 million for the Office of Education, Bureau of Prisons, and Law Enforcement Assistance Administration drug treatment and prevention activities.

Drug abuse treatment and prevention activities must necessarily be carried on by a variety of agencies in actual contact with the affected individuals. For this reason, there cannot be an administrative consolidation of these functions in a single agency comparable to that which has been developed for law enforcement. However, a balanced and effective Federal response to the drug abuse problem requires a high level focusing of health concerns in the formulation of government policy. The government also needs a workable mechanism to assure that policy will be implemented in a coordinated fashion by the diverse agencies which must carry it out. Additionally, it is important to the Federal effort that the developing partnership which has been established between the criminal justice system and the health care delivery system be continued. An agency providing the necessary mechanisms can best be provided by establishment of the Office of Drug Policy, as recommended in the enclosed memorandum on that subject (Attachment 3).

The foregoing recommendations have been reviewed with special care. As to the budget, the need for restraint requires no elaboration. In regard to management structure, the desirability of keeping management functions outside the Executive Office of the President is beyond question. But in each case, the unique characteristics of the drug abuse problem seem to dictate the nature of the response. Its recent growth and complexity suggest that an increase in the overall treatment and prevention effort is required. The wide variety of agencies through which that effort is carried out, as well as the necessity for balance with law enforcement, appear to create an overriding need for high-level policy direction.

Faithfully yours,

Robert L DuPont MD

Robert L. DuPont, M.D.
Director

Enclosures

Attachment 1

THE CONTINUING PROBLEM

Major Regional Increases in Heroin Addiction

Once again, the United States is experiencing a significant increase in heroin addiction which is being fed by a continuing influx of Mexican heroin, and further threatened by resumption of opium production in Turkey. Furthermore, heroin use has spread from our large urban centers to smaller cities, specifically affecting localities as diverse as Eugene, Oregon; Des Moines, Iowa; and Jackson, Mississippi.

Nationwide, there is an increased demand for treatment. In February 1974, 55% of all Federally-funded slots were filled; now, more than 80,000 or 78% are filled. At the present rate of increase, all 95,000 Federally-funded community-based treatment slots will be filled early in 1975. Already, Texas, California, and Oregon have requested more funds for additional treatment slots. In FY-74, 13,722 slots were reprogrammed to create new capacity in these areas. Despite reallocations, however, waiting lists are now appearing in California, Florida, Illinois, Indiana, Michigan, New Jersey, New York, Pennsylvania, among others.

Increasing Number of Heroin Overdoses

Nationally, hospital emergency room treatment for heroin has increased dramatically every quarter since September 1973. Specifically, the period July-September, 1974 has shown an overall increase of 66% above the July-September, 1973 level. This reflects an average annual quarterly increase of 13.5%, with a 16.6% jump occurring in July-September, 1974 over the previous quarter. This growth has been most severe in the Southwestern, Central, and Northeastern regions.

Increased Heroin Supply with Greater Demand

These disturbing trends have been accompanied by an alarming increase in the heroin wholesale market. Since the first quarter of 1974, wholesale purity has increased nationally from 22.8% to 32.9%, signaling greater availability and better quality at the distribution level. At the same time, street-level purity has declined from 6.7% to 5.9% while price has increased nationally from $1.03 to $1.15 per milligram pure, demonstrating greater street-level demand for heroin.

Increase in Drug-Related Crimes

Paralleling the higher costs of street heroin has been an increase in income-producing crime in almost every state. FBI reported property crime rates per 100,000 people have increased in varying degrees in 1973 over 1972 in each region:

Northeast	+5%	Southwest	+4%
South	+8%	West	+6%
Central	+7%		

A minimal decline was noted in only six states: District of Columbia, California, New Mexico, Colorado, Idaho, and Utah; however, there are disturbing indications that crime may be on the rise again in at least some of these states. Similarly, drug thefts have increased 23% nationally from the last half of 1973 to the first half of 1974. All regions showed increases:

Northeast	+39%	West	+25%
Central	+19%	Northwest	+15%
South	+14%		

Problems With Other Drugs

The use of marihuana is widespread among the youth, as well as adults. Recent estimates are that thirteen million adult Americans practice regular use. New evidence has been presented indicating significant medical problems encountered from long-term or heavy-to-moderate use of marihuana which include: changes in basic cellular mechanisms; adverse immunologic and genetic effects; accumulation of the active ingredients in the fatty tissues and certain parts of the brain; and more adverse affects than from regular cigarette smoking on the tissues of the lungs. Occasional or light use produces significant temporary effects on memory and coordination sufficient to affect driving and other motor skills. Coupled with this new evidence, existing data show that 15.0% of the persons in all Federally-funded treatment programs are being treated for marihuana or hashish as the primary drug of abuse; this statistic is up from 11.2% of a year ago. At the same time, the nation is divided over appropriate legal sanctions against its use.

Abuse of amphetamines and barbiturates is equally widespread. A recent report from a nationwide survey of schools for the school year 1973-74 indicates that of the students surveyed, over 1/3 had used drugs non-medically (excluding alcohol), and of these, 24% had used barbiturates and 22% used amphetamines. The consequences of such use can be severe; 11% of admissions for treatment in Federally supported programs have been for amphetamine and barbiturate abuse.

Social Costs of Drug Abuse

Although a definitive social cost figure for drug abuse cannot be established because the total magnitude of the human consequences involved is unknown, it is possible to estimate the social cost of drug abuse in economic terms. Components of an economic measure include health costs, lost productivity costs, criminal justice system costs, direct drug abuse treatment and drug traffic prevention costs and property losses attributable to drug abuse. Together, these elements represent a total estimated annual social cost of $10 billion to the citizens of the United States. In view of this estimate, the downward trend in the Federal drug investment from $492.5 M in FY 1974 to $445.2 M in FY 1975 and an estimated $413.9 M in FY 1976 is alarming.

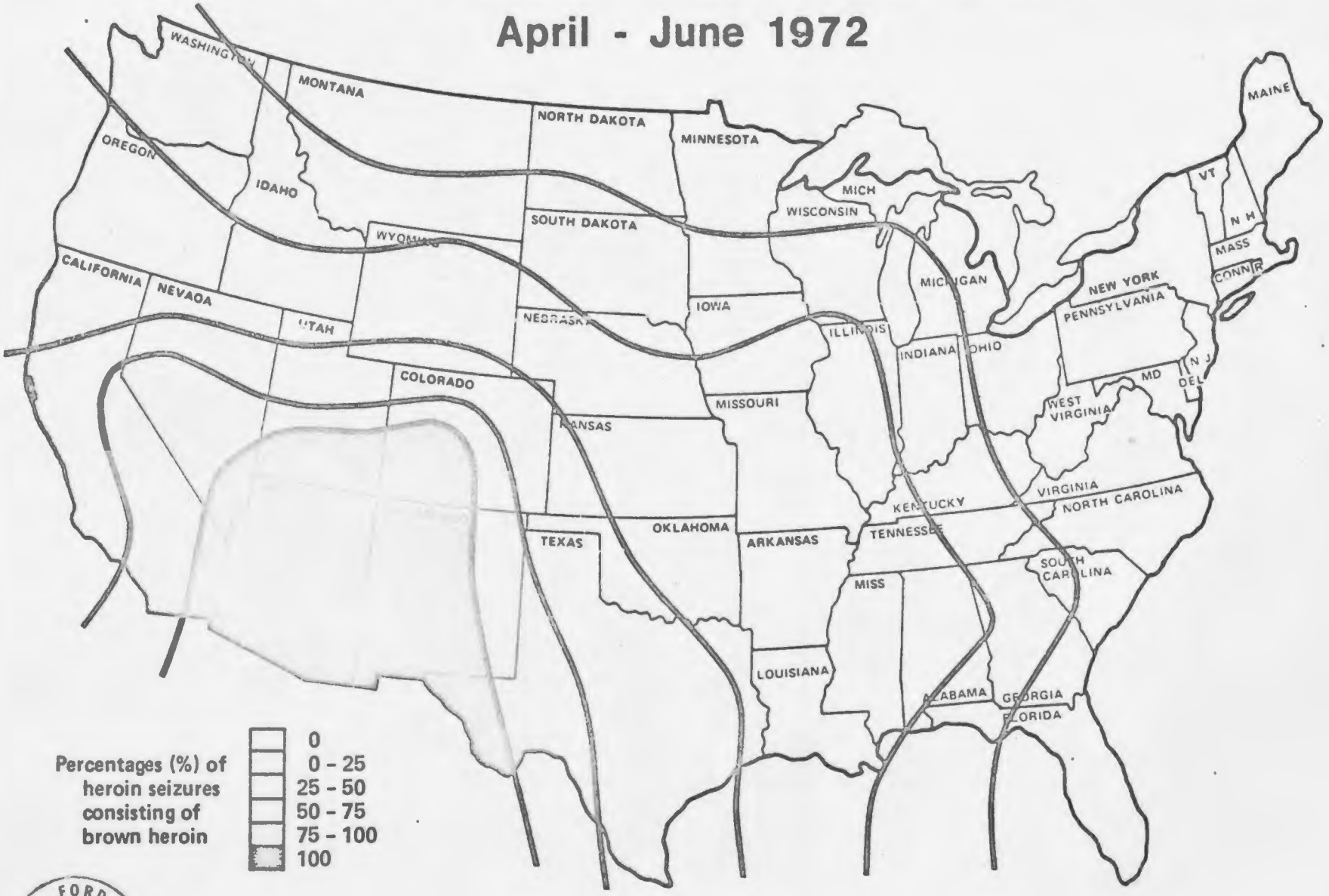
The Armed Services

In 1971 heroin use was rampant among servicemen in Vietnam. A comprehensive Special Action Office study of Army enlisted men who left Vietnam in September 1971 revealed a heroin addiction rate of 20%; 43% of this group admitted having used narcotics while in Vietnam. Subsequent follow-up data, released in May 1974, showed that only 2% of all these returnees were still using narcotics in 1972. The DoD program combination of identification, referral to treatment, return to the United States, coupled with a more limited supply and lower quality of heroin, served to reduce heroin use among former servicemen.

Since worldwide implementation of a mandatory random urinalysis testing program in 1971, the percent of confirmed drug abusing servicemen has remained at approximately 1% and the number of servicemen in treatment remained relatively level at approximately 21,000. However, the Department of Defense suspended all urinalysis on July 18, 1974, a time when available data indicated a significant increase in confirmed drug positives. Since suspension of this identification tool, the number of servicemen in treatment has dropped below 16,000. In performance of its mandated responsibility, the Special Action Office has strongly opposed this suspension on the basis of its probable adverse impact upon the health and combat effectiveness of the Armed Forces.

AVAILABILITY OF BROWN HEROIN

April - June 1972



AVAILABILITY OF BROWN HEROIN

April - June 1973

AVAILABILITY OF BROWN HEROIN

April - June 1974

Percentages (%) of heroin seizures consisting of brown heroin

- 0
- 0 - 25
- 25 - 50
- 50 - 75
- 75 - 100
- 100

Attachment 2

-ATTACHMENT 2-

SPECIAL ACTION OFFICE

FY1976 BUDGET RECOMMENDATIONS

FOR

DRUG ABUSE PREVENTION PROGRAMS

-ATTACHMENT 2-

SPECIAL ACTION OFFICE

FY1976 BUDGET RECOMMENDATIONS

FOR

DRUG ABUSE PREVENTION PROGRAMS

-CONTENTS-

SPECIAL ACTION OFFICE FY 1976 BUDGET RECOMMENDATIONS

PART I - SUMMARY

-SPECIAL ACTION OFFICE POSITION-

°Special Action Office recommendations of $305M for NIDA and $12M for OE are responsive to program requirements; any lesser budget does not meet need.

°The drug abuse situation has changed since formulation of original FY1976 budget request. Law enforcement and international officials agree with this assessment.

°The spread of Mexican brown heroin and the probable resumption of Turkish production contribute to the seriousness of the problem.

°Nationally, availability and price of heroin have increased with a corresponding increase in income-producing crime.

°Opiate and non-opiate use has increased; heroin use has spread to smaller cities.

°Treatment demand is consistently increasing; Federal and non-Federal capacity will saturate at 100% utilization before end of FY1975.

°There is a projected need for 115,000 Federally-funded treatment slots by mid-FY1976.

°We must emphasize research and demonstration projects to develop improved methods of treatment, rehabilitation, prevention, and criminal justice interface.

°We must continue development of Single State Agency capabilities to permit full decentralization of prevention management.

°OMB marks for BOP and LEAA must be increased to permit response to requirements for identification and treatment.

°Funding is required to continue strategy, policy, and planning functions of SAO in a new Office of Drug Policy.

-IMPACT OF OMB-PROPOSED FY1976 PREVENTION BUDGETS-

°The OMB-proposed budgets of $210M for NIDA and zero for OE are unrealistic because they:

- °Give an undesirable signal to the public for the second consecutive year of cutback in Federal committment in one of few social programs where reed is still rising; support is dropped below the FY1975 recision level.
- °Give the appearance but not the reality of maintaining status quo of 95,000 treatment slots; OMB estimates are based on fictional formula grart output and would require unrealizable match rates.
- °Are not responsive to the increasirg national problem; would require cutback in services and force addicts into the street; the heroin-only guideline is not a practical approach.
- °Eliminate new research and demonstration initiatives which produces further imbalance in already austere programs.
- °Return the drug abuse field to law enforcement dominance.

-CONCLUSIONS AND RECOMMENDATIONS-

°Social costs of drug abuse are conservatively estimated at $10 billion per year. The SAO-recommended budget increases are a small fraction of this amount.

°This would be an unfortunate time to reduce our national committment in light of the demonstrated need.

°The SAO and NIDA budget situation is shown in Figure 1; further backup information follows this summary.

°I urge your favorable consideration of my recommendation.

PART II - DETERMINATIONS

-PROBLEM-

How shall we best meet increasing needs for drug abuse treatment and prevention within a framework of extreme budget stringency which has produced preliminary OMB marks well below funding levels required to meet critical requirements?

- LEGISLATIVE AUTHORITY -

The Special Action Office was created in 1971 to focus the comprehensive resources of the Federal government, to bring them to bear on drug abuse, and to significantly reduce the incidence of drug abuse. The Drug Abuse Office and Treatment Act of 1972 (PL92-255) requires the Director of the Special Action Office to provide overall planning and policy for all Federal drug abuse prevention functions. The Act provides legislative authority for the Director (1) to review and modify, where necessary, implementation plans for any Federal program and budget request of any Federal department or agency, and (2) to make funds available from appropriations to Federal departments and to conduct drug abuse prevention functions.

The Act further authorizes the Director to request the President to direct any Federal department of agency to conduct its drug abuse prevention functions under his policy guidelines where he determines effectiveness is impaired.

- DETERMINATIONS -

As Director of the Special Action Office I have determined that the effect of the preliminary FY 1976 budget marks forwarded by the Office of Management and Budget (OMB) to (1) the Department of Health, Education and Welfare (DHEW) and (2) the Department of Justice (DOJ) will impair drug abuse prevention functions within these two departments.

I have also made a determination that funding is required for continuation of the strategy, policy and planning functions of the Special Action Office beyond June 30, 1975 in a new Office of Drug Policy. This requirement is discussed in detail in Attachment 3.

- DEPARTMENT OF HEALTH, EDUCATION AND WELFARE -

The preliminary OMB mark to DHEW impairs drug abuse prevention functions within the National Institute on Drug Abuse (NIDA) and the Office of Education (OE). The proposed funding levels would not permit us to

build the needed treatment capacity nor to adequately support our education/ prevention, research, training and rehabilitation programs. OMB marks for these agencies are shown below together with Special Action Office recommendations:

AGENCY	OMB MARK	SAO RECOMMENDATIONS	
NIDA	$210.5M	$305.9M	$95.4M
. RESEARCH	31.5	41.0	9.5
. TRAINING	3.0	6.8	3.8
. COMMUNITY PROGRAMS	162.0	241.9	79.9
. MANAGEMENT AND INFORMATION	14.0	16.2	2.2
OE DRUG ABUSE PREVENTION	-0-	$12.0M	$12.0M

The Special Action Office recommendations noted above were developed free of the constraints imposed by budgetary limits of competing programs within HEW and are based on (1) requirements of continuing the combined NIDA-SAO program level of FY 1975, and (2) newly emerging requirements for treatment capacity which became apparent after formulation of the NIDA budget request.

- DEPARTMENT OF JUSTICE -

The preliminary OMB mark to the Department of Justice impairs drug abuse prevention functions within the Bureau of Prisons (BOP) and the Law Enforcement Assistance Administration (LEAA).

Bureau of Prisons funding would be insufficient for it to continue its move toward providing treatment for all prisoners during incarceration, for appropriate parolees in aftercare programs, and for probationers assigned by the courts.

LEAA funding would be insufficient for it to maintain the momentum established in its Treatment Alternatives to Street Crime (TASC) program.

OMB marks are shown below together with Special Action Office recommendations:

AGENCY	DERIVED OMB MARK	SAO RECOMMENDATIONS	
BOP	$6.0M	$7.6M	$1.6M
LEAA	$4.6M	$7.7M	$3.1M

PART III - REQUIREMENTS

- PRELIMINARY FY 1976 CONSOLIDATED BUDGET -

The Administration initiated sharp increases in funding and Federal activities to combat drug abuse, specifically from a budget authority of $82 million in FY 1969 to a peak of over $730 M in FY 1974 -- of which over $480 M was for prevention programs (i.e. those other than law enforcement).

Federal funding of prevention programs decreased for the first time in FY 1975 (to about $465 M) in response to indications that our treatment programs had peaked. We no longer expected to see an increasing demand for treatment and felt that the ceiling of 95,000 treatment slots, agreed upon with the Joint Drug Cabinet Committee, would be adequate. We now feel that this FY 1975 funding decrease was premature.

Special Action Office FY 1976 budget recommendations for demand side discretionary programs, shown in Figure 2, call for $439.2 M. This amount is up $90.5 M from FY 1975 and up $34.4 M from FY 1974.

SAODAP recommendations are higher than the OMB mark for NIDA (+ $95.4M) and for the Department of Justice (+ $4.7M). SAODAP and OMB agree on levels for all other discretionary agencies.

A preliminary consolidated drug abuse prevention and law enforcement budget, based on SAODAP prevention recommendations, is shown in Figure 3. Past funding levels are included. These figures will be updated as the FY 1976 President's budget becomes firm.

- NATIONAL INSTITUTE ON DRUG ABUSE -

Treatment Capacity Requirements

After preparation of the FY 1976 budget request for the National Institute on Drug Abuse was completed it became apparent that we faced unexpected continuing demand for treatment and that the Federal share of nationally available treatment slots must be increased above 95,000 if the government is to keep its commitment to share approximately one-half of the load with states, localities, and private institutions.

Records of demand in NIDA-supported grant and contract treatment programs show a consistent and increasing demand for treatment.

- The total number of clients in treatment at any one time in NIDA-supported treatment slots has risen from about

23,000 in July 1972 to over 71,000 in August 1974. Figure 4 shows these increases.

° During the first ten months of 1974, the increase in the number of clients in treatment has averaged about 3,000 per month. We have projected conservatively that this increase will average 2,500 per month during the remainder of FY 1975 and all of FY 1976.

° There are currently waiting lists in over 30 states; Texas California, and Oregon have requested more Federal funds.

° Both Federal and non-Federal treatment capacity will reach 100 % utilization before the end of FY 1975, as shown in Figure 5.

° The continuing demand for treatment will result in a shortfall of (1) 9,500 treatment slots by the end of FY 1975, and (2) about 50,000 slots by the end of FY 1976, as shown in Figure 6.

It is OMB's position that the Federal government is not obligated to increase its response to treatment requirements beyond the current level of 95,000 slots; however, no specific reductions should be made below 95,000. Federal slots should be allocated geographically to meet heroin treatment requirements since heroin is our priority problem. Federal treatment capacity is adequate if we limit treatment to heroin addicts and exclude admission of new, non-heroin abusers from treatment; in addition, normal turnover vacancies should be filled only by heroin addicts. State and local governments should step in and meet projected need (above 95,000 slots and for non-heroin abusers) by additional funding or by increasing the non-Federal share.

The Special Action Office considers this approach to be impractical and that the Federal government is obligated to maintain the approximate 50-50 proportion between Federal and non-Federal treatment capacity, at least until the Single State Agencies have fully developed the capability to deal with the problem.

Other NIDA Requirements

In addition to the need for additional Federal treatment capacity to meet increasing demand for treatment there is need for the following:

- Increased emphasis on rehabilitation--getting the treated abuser back into the mainstream of society.

- A coordinated education and prevention program--to reduce the possibility of new, large scale drug abuse epidemic.

- Continued support of NIDA's regional training infrastructure.

- Continued pharmacological research--to seek new and improved methods of treatment.

- Increased reliance on the Single State Agencies for Drug Abuse Prevention--to continue our move toward decentralization of the management of drug abuse prevention programs.

Special Action Office recommendations for FY 1976 provide for (1) continuation of initiatives begun in these areas through use of special funds appropriated for these purposes (2) full coordination with capabilities developed over the years by the Office of Education (3) increased reliance on our most productive interfaces with the criminal justice system, and (4) increased formula grant funding.

Federal Share of Costs

A major OMB argument for its low mark for FY 1976 is that the states should be required to bear an increased share of the burden of treatment. However:

- The Federal share of treatment costs has already been reduced from 75 % in FY 1974 to 71% in FY 1976; NIDA and SAO feel that any further requirement now would not be possible without program impairment.

- The Federal share of dollars has decreased from 55% to 47% and of slots from 53% to 47% during this period.

Funding Mechanisms and Formula Grants

OMB suggests (1) a rapid switch to contracts and away from grants as the primary mechanism for funding of treatment slots, and (2) that formula grant funding should be held at the FY 1975 level of $35M because (a) we are not realizing an adequate number of treatment slots from this investment, and (b) the Federal government should not set a precedent of regularly increasing formula grant levels which will be difficult to reverse when National Health Insurance

becomes operational and provides for most of future treatment requirements.

In addition, OMB feels that is is equitable that states should be required to apply (a) a local match to all formula grant funds and (b) a certain percentage of formula grant funds to buy treatment. Proposed legislation is being drafted.

SAO agrees with the OMB position wherever direct project funding is desirable; however, a major objective of SAODA has been to move away from direct Federal management of project grants and contracts to a decentralized approach consistent with the New Federalism. This has been accomplished through award of umbrella grants or contracts to Single State Agencies and through increasing the amounts awarded to the states in formula grants.

Figure 7 shows progress against this objective. In 1972 100% of all treatment was conducted by means of direct project grants or contracts. In 1975 this treatment has dropped to about 61%.

The current OMB position appears to be inconsistent with our decentralization objective.

Formula grants were not necessarily intended to provide treatment services. Their initial purpose was to build capability within the Single State Agencies by providing for planning, management systems, and education/prevention activities. National Health Insurance is not yet a reality and its appropriateness for providing reimbursements for drug abuse treatment is in question.

Congress did not intend that formula grants be subjected to match requirements. There is serious question as to (a) where such money would be found, and (b) what effect this action would have on availability of matching funds for treatment projects. No legislation has yet passed through Congress to permit such a requirement.

The Special Action Office recommends that formula grant funding be increased to $45 M for FY 1976 to continue our decentralization efforts.

- OFFICE OF EDUCATION -

It is OMB's position that Office of Education funding for drug abuse education/prevention should remain at zero for FY 1975 and 1976.

In FY 1975 no funds were included in the President's budget for Office of Education drug abuse prevention programs. However, legislation extending the Drug Abuse Education Act, which included funding authorization, was recently approved.

The Special Action Office has clearly defined a role for the Office of Education in school based early intervention projects. OE is the primary Federal link with state and local education agencies and, with NIDA, will play an important supplementary part in our attempts to prevent drug abuse.

Major elements of the recommended OE drug abuse prevention program for FY 1975 and 1976 include (1) continued funding of five regional training centers, (2) training of 500 school teams at the centers, (3) curriculum study and validation, (4) grants to state education agencies.

The Special Action Office recommends a supplemental appropriation of $7.5M for FY 1975 and a budget level of $12.0M for FY 1976. The preliminary OMB mark for FY 1976 is zero. Specific SAO recommendations are shown in Figure 8.

- BUREAU OF PRISONS -

IT is OMB's position that the Bureau of Prisons should operate its FY 1976 drug abuse prevention program at a budget level of $6.0M.

The Bureau of Prisons started FY 1975 with a budget that was $800,000 short of its requirements in community care for parolees and probationers due to pressures from OMB and the Department of Justice. The FY 1975 recision has further impacted this program by reducing available funds by $300,000. It is Special Action Office policy that BOP should continue its move toward providing treatment for all prisoners during incarceration, for appropriate parolees in aftercare programs, and for probationers assigned by the courts. However, the current situation is such that 800 probationers and parolees currently in treatment must be outplaced to alternative projects or dropped from treatment immediately.

The Special Action Office has temporarily resolved the situation with representatives of BOP, LEAA, NIDA and the U.S. Parole Office through the following agreements:

°BOP will accelerate the graduation of good performers.

°Leaders from LEAA's Treatment Alternatives to Street Crime (TASC) will meet with BOP officials and local parole officers in TASC cities to arrange use of vacant slots (both in TASC and in state/local treatment centers) for displaced parolees and probationers or new clients.

°In cities with no TASC programs, clients will be placed in NIDA or state/local projects wherever vacancies exist.

°BOP will reduce the services purchased through contracts to less than the $1,400 current annual level.

°Where a client must be dropped from treatment, parole officer supervision will be increased.

°The situation will be continually reviewed to assure adequate response.

Despite these austerity moves, BOP requirements for FY 1976 will increase due to the increasing number of drug abusers to be treated in the system. Therefore, the Special Action Office supports BOP in its request for $7.6M for FY 1976.

- LAW ENFORCEMENT ASSISTANCE ADMINISTRATION -

It is OMB's position that the Law Enforcement Assistance Administration should operate its overall FY 1976 program at a level lower than the FY 1975 budget level. We anticipate a proportional cut to 4.6 M for drug abuse prevention.

LEAA's primary role is in development and operation of Treatment Alternatives to Street Crime (TASC) projects which serve to identify drug abusers in the criminal justice system and divert them to treatment.

TASC has expanded significantly, both in numbers and in concept. The total number of clients referred to treatment through TASC has increased from 1,000 to almost 7,000 by October 1, 1974. This figure should double by the end of this fiscal year.

The TASC concept has also expanded from the early pre-trial diversion model for heroin addicts to comprehensive pre and post trial models

open to all drug abusers except alcohol abusers and juveniles. Several TASC projects include vocational rehabilitation components designed to facilitate the drug abuser's re-entry and acceptance into the community.

A serious concern is the possible lack of treatment slots for TASC clients. Agreement with NIDA is being made so that NIDA treatment programs are required to pick up a larger portion of TASC patients than they are currently picking up so as to accomodate the greatly increased numbers in TASC programs and to eliminate any waiting lists for TASC.

During fiscal year 1975, only about $700,000 of the funding programmed for TASC is expected to be spent on new starts. This ratio may be changed if continuation applications are lower than anticipated. In any case, second year funding commitments will account for the bulk of LEAA funding. LEAA anticipates that $3.7 million will be needed to provide second year continuation funding alone in fiscal year 1976. It is questionable at this time whether additional discretionary funds will be available to expand TASC to new cities unless the overall OMB mark is increased.

LEAA will continue its policy of giving priority consideration to states not yet having a TASC project to use as a model for block grant replication. This is in line with the LEAA policy of creating seed programs with one or two years of discretionary funding which can prove their effectiveness and then seek local or state funding.

The Special Action Office supports an increase in LEAA funding for FY 1976 to $7.7M (to provide a total of $6.8M for TASC) which is up from the $4.6 M resulting from the OMB mark for FY 1976.

FY 1976

SAODAP AND NIDA DRUG PREVENTION BUDGET

(Obligations in Millions)

PROGRAM	F.Y.1974 Actual	F.Y. 1975 Appropriation	F. Y. 1975 Recision Level	F.Y.1976 OMB Mark	F.Y. 1976 SAO Recommendation
NIDA	255.8	237.0	227.9	210.5	305.9
°Community Programs	190.6*	174.1*	173.0*	162.0	241.9
°Research	34.0	34.0	31.5	31.5	41.0
°Training	15.1	14.0	10.0	3.0	6.8
°Mgt. and Info.	16.1	14.9	13.4	14.0	16.2
SAODAP/ODP	27.3	18.0	13.0	-	9.5
TOTAL	283.1	255.0	240.9	210.5	315.4

*Reflects $17.1 of F.Y. 1974 carryover funds used for F.Y. 1975

FIGURE 1

FIGURE 2
DRUG ABUSE PREVENTION DISCRETIONARY AGENCY BUDGET

(Obligations in Millions)

Agency	Actuals FY 1972	Actuals FY 1973	Estimates FY 1974	Estimates FY 1975	FY 1976 Agency Request	FY 1976 OMB Mark	FY 1976 SAO Position
SAODAP	1.5	39.9	27.3	18.0	-0-	-0-	-0-
ODP	-	-	-	-	-	-	9.5
HEW							
NIDA	116.7	179.9	255.8	237.0	238.5	210.5	305.9
OE	13.0	12.3	5.7	7.5	12.0	-0-	12.0
SRS**	2.5	1.4	1.0	0.8	0.2	-	0.2
OEO	18.0	(23.0)	-0-	-0-	-0-	-0-	-0-
VA	16.2	22.0	23.4	21.1	21.1	21.1	21.1
JUSTICE							
BOP	1.9	3.4	5.2	6.5	7.6	6.0	7.6
LEAA**	8.7	3.9	2.3	6.7	4.6	4.6	7.7
DEA	2.7	2.6	2.6	2.7	2.1	2.1	1.9
DOD	58.7	73.0	68.6	66.5	67.5	67.0	67.0
STATE	-	-	0.9	2.1	0.7	-	6.0
TOTAL	239.9	338.4	392.8	368.9	354.3	-	439.2

*Includes OEO funding for FY 1973; FY 1974 and FY 1975 figures adjusted to reflect carryover.
**Discretionary Funds only; LEAA includes TASC

FIGURE 3
CONSOLIDATED FY 1975 DRUG ABUSE PREVENTION
AND DRUG LAW ENFORCEMENT BUDGET

(Obligations in Millions)

Category	Actuals					Estimates		SAO FY 1976 Position
	FY 1969	FY 1970	FY 1971	FY 1972	FY 1973	FY 1974	FY 1975	
Drug Abuse Prevention	46.7	77.0	134.6	363.3	457.7	480.5	465.4	535.5
° Directed Programs	42.8	58.8	89.0	239.9	338.4	392.8	368.9	439.2
° Other*	3.9	18.2	45.6	123.4	119.3	87.7	96.5	96.5**
Drug Law Enforcement	35.5	52.6	81.6	164.1	219.9	250.1	284.2	285.0**
GRAND TOTAL	82.2	129.6	216.2	527.4	677.6	730.6	749.6	820.5

*Drug abuse effort within larger Federal programs, including block and formula grants.
**Estimated

CLIENTS IN NIDA GRANT AND CONTRACT-SUPPORTED
DRUG TREATMENT PROGRAMS

By Month, July 1972 thru October 1974

	Number Entering Treatment	Total Number of Clients	Increase	Total Number Slots Available	Percent Utilized
1972					
July	3,957	22,910			
August	4,214	23,427	517		
September	3,700	23,705	278		
October	4,159	24,909	1,204		
November	4,303	26,046	1,137		
December	4,242	27,332	1,286		
1973					
January	5,653	28,933	1,601		
February	5,875	30,830	1,897		
March	6,364	32,643	1,813		
April	6,794	34,708	2,065		
May	6,794	37,050	2,342		
June	7,140	36,964	(086)		
July	7,682	38,287	1,323		
August	7,851	41,532	3,245		
September	7,753	43,088	1,556		
October	9,322	46,176	3,088		
November	8,658	47,428	1,252		
December	8,700	47,757	329		
1974					
January	10,364	51,287	3,530	94,273	54%
February	9,600	53,536	2,249	94,273	57%
March	11,889	58,217	4,681	94,273	61%
April	11,266	61,220	3,003	94,273	64%
May	11,354	64,320	3,100	94,273	67%
June	12,312	67,148	2,828	94,273	68%
July	13,751	70,063	2,915	87,554	77%
August	14,023	71,393	3,622	87,554	82%
September					
*October					

*Projection

SOURCE: NIDA Grant/Contract-Supported
Drug Treatment Programs

Figure 4.

FIGURE 5

FY 1973

FUNDING SOURCE	Static Capacity	Clients	Utilization
Federal	146927	92250	63%
NIDA/SAO	99302	44026	44
V.A.	8402	8402	100
D.O.D.	22000	22000	100
B.O.P.	2816	2816	100
Other	14452	15006	104
Non-Federal	99880	82861	83%
TOTAL	246807	175111	71%

FY 1974

FUNDING SOURCE	Static Capacity	Clients	Utilization
Federal	141299	112587	80%
NIDA/SAO	100032	71320	72%
V.A.	8927	8927	100
D.O.D.	18000	18000	100
B.O.P.	4340	4340	100
Other	10000	10000	100
Non-Federal	125781	90236	72%
TOTAL	267080	202823	76%

FY 1975

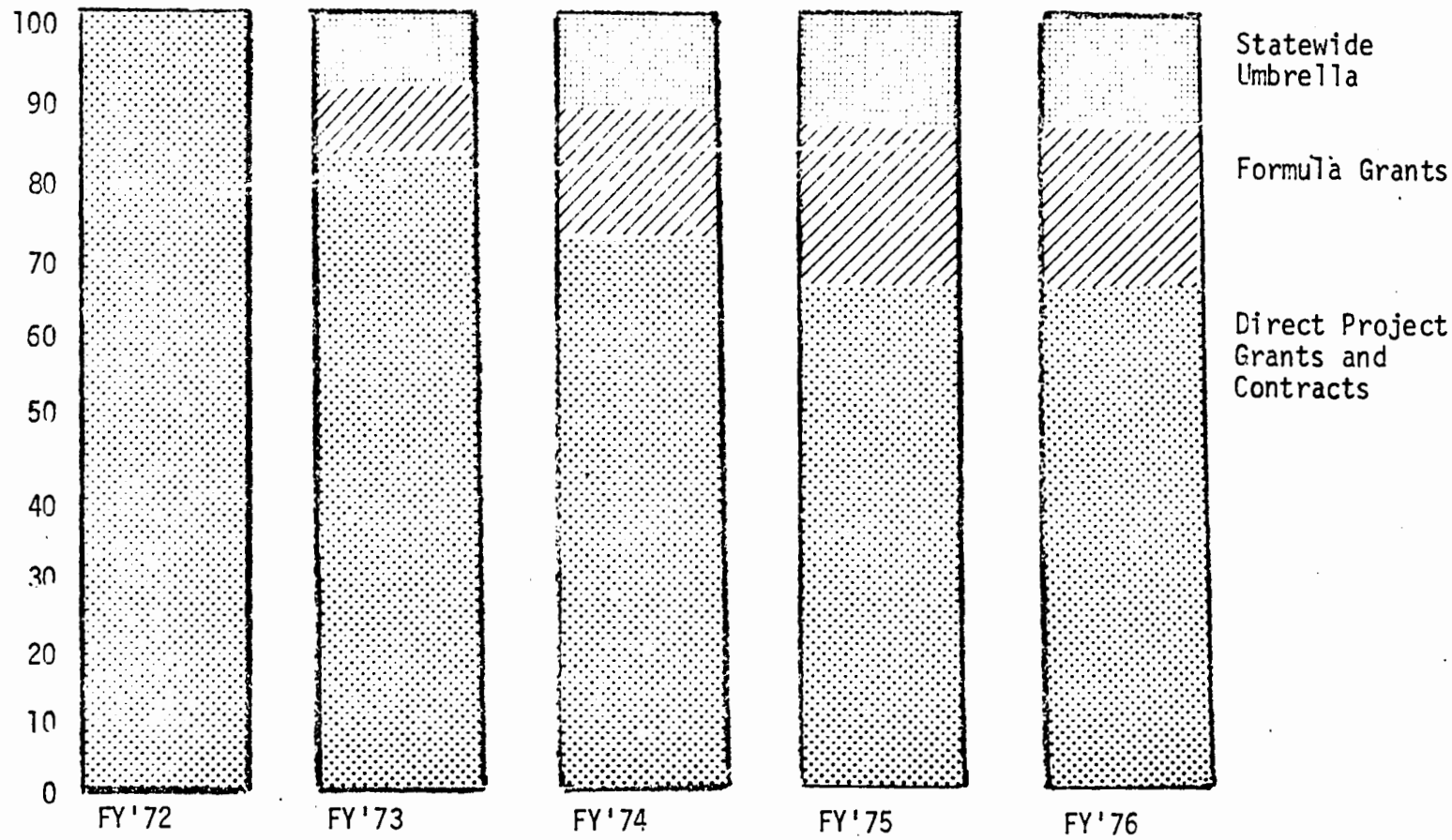
FUNDING SOURCE	Static Capacity	Clients	Utilization
Federal	137050	137050	100%
NIDA/SAO	95000	95000	100
V.A.	8500	8500	100
D.O.D.	18000	18000	100
B.O.P.	5550	5550	100
Other	10000	10000	100
Non-Federal	130000	130000	100%
TOTAL	267050	267050	100%

FY 1976

FUNDING SOURCE	Static Capacity	Clients	Utilization
Federal	136600	136600	100%
NIDA/SAO	95000	95000	100
V.A.	8500	8500	100
D.O.D.	17000	17000	100
B.O.P.	6100	6100	100
Other	10000	10000	100
Non-Federal	130000	130000	100%
TOTAL	266600	266600	100%

Percent of NIDA Treatment Dollars in Statewide, Formula, and Direct Grants/Contracts

FIGURE 6



TREATMENT DEMAND FOR DIRECTLY FUNDED
TREATMENT GRANTS AND CONTRACTS

FIGURE 7

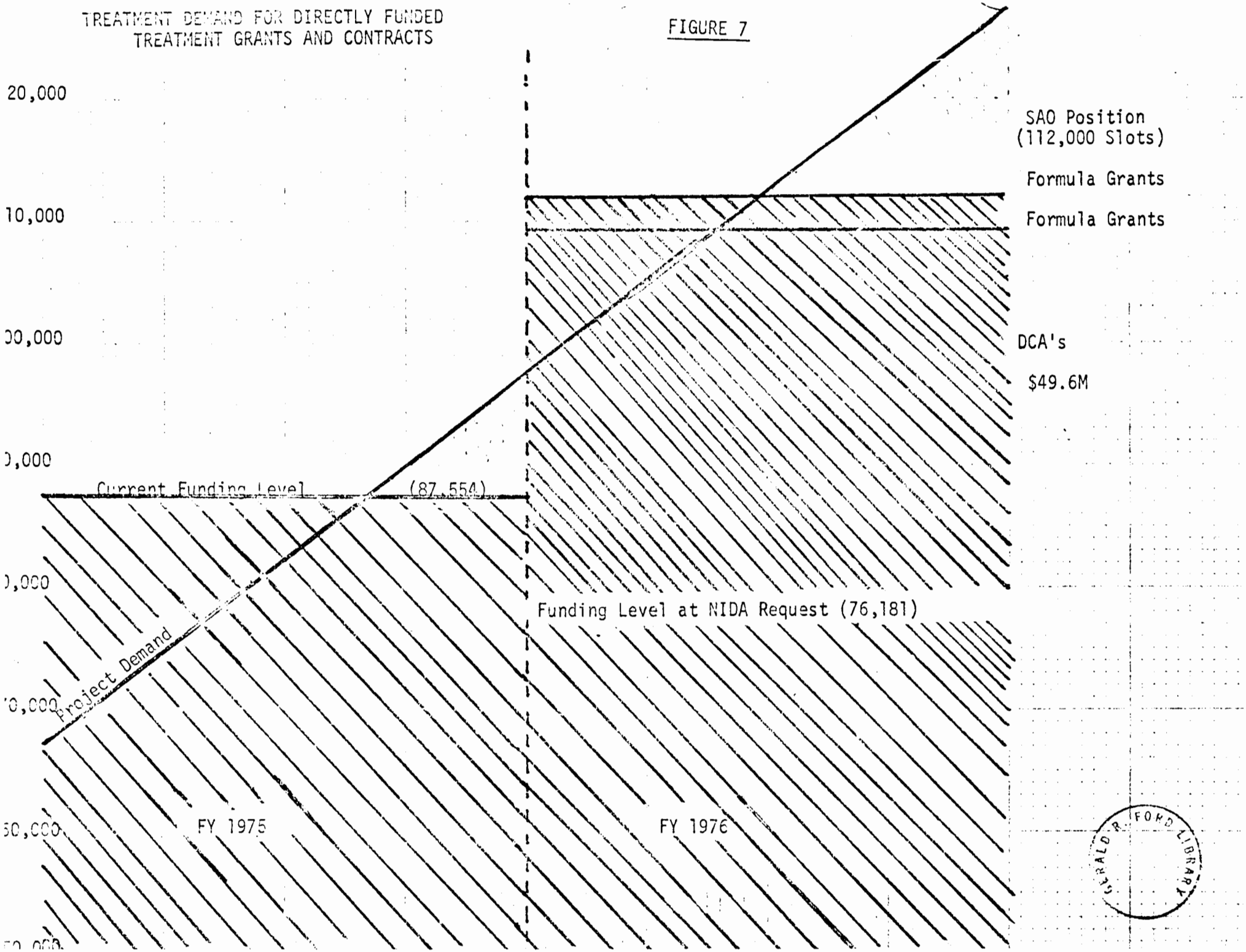


Figure 8.

OFFICE OF EDUCATION FUNDING SUMMARY

PROJECT	SAO FY 1975 PLAN	OMB FY 1976 MARK	SAO FY 1976 RECOMMENDATIONS
Grants to State Education Agencies	750		1,200
Five Regional Training Resource Centers	2,250		2,250
500 School Teams to be Trained at Centers	3,900		6,000
6 Pre-School Demonstration Projects for Elementary and Secondary Schools	375		475
Evaluation	075		125
National Action Committee	150		330
Curriculum Study and Validation	-0-		1,375
TOTAL	7,500	-0-	12,000

Figure 8.

Attachment 3

EXECUTIVE OFFICE OF THE PRESIDENT
SPECIAL ACTION OFFICE FOR DRUG ABUSE PREVENTION
WASHINGTON, DC 20506

December 17, 1974

MEMORANDUM TO THE PRESIDENT

FROM : ROBERT L. DUPONT, M.D. RLD
DIRECTOR

SUBJECT : OPTIONS FOR DIRECTION OF FEDERAL DRUG ABUSE EFFORTS

The legislatively scheduled termination of the Special Action Office for Drug Abuse Prevention on June 30, 1975 has serious consequences for the Administration in terms of its ability to effectively coordinate the Federal drug abuse prevention effort and to maintain the current momentum in dealing with drug abuse in the United States. The successive reductions in the drug abuse prevention budget for FY-75, and 76, coupled with the termination of the White House Special Action Office, would signal a decline in the Administration's attention to the nation's drug abuse problem at an unfortunate time. This paper summarizes the drug abuse situation in the United States today, and recommends that a timely decision be made from available options.

A Presidential message to the Congress more than three years ago blamed "fragmentation, competing priorities, and lack of communication" for the failure of the Federal Government to come to grips with the problem of drug abuse. The message emphasized that enforcement of drug laws must be coupled with a rational approach to treatment of the drug user, and proposed the Special Action Office to provide Federal coordination and policy direction for drug abuse prevention programs. By four unanimous votes, the Congress expressed its emphatic agreement. Over a three year period, the wisdom of that action has been clearly demonstrated; since establishment in March, 1972, some of the significant achievements of this office are:

- Federal treatment capacity has been expanded from 16,000 to 128,000 slots;
- A major restructuring of the Federal Government's response to drug abuse has occurred---the approach has moved from an exclusively law enforcement response to an increased law enforcement effort balanced by a newly created treatment effort;

° Communication and coordination have been established between the criminal justice system and the health care delivery systems at the Federal and state levels.

Many other significant improvements have been achieved by the Special Action Office in its short existence; some of these accomplishments are listed at TAB A. However, the critical point is that despite these accomplishments, much remains to be done. The drug abuse problem is not like other social problems; it is much more dynamic and the government's appropriate long-term role has not been fully determined. At this time, the Federal drug abuse response is not a routine, on-going function, suited for management through traditional and well-defined operations. Instead, it is determined by a series of complex issues, and stimulated by a high degree of unabated public concern compared with other social and health problems. The drug abuse situation in the United States fluctuates rapidly and requires high level, sophisticated attention. The heroin problem cannot be ignored; once thought to be decreasing, it now appears to be on the rise, being fed by an influx of Mexican heroin and further threatened by resumption of opium production in Turkey. These disturbing trends have been accompanied by an increase in the purity of heroin distributed in the wholesale market, an increased supply of heroin on the street, and an increased demand for heroin addiction treatment. Paralleling these activities has been a significant increase in FBI reported income-producing crime in almost every state. National crime rates and heroin rates turned down in 1972 for the first time, after a decade of sharp increases. The third quarter of 1973 saw the end of these favorable trends. Rates of both crime and heroin use are now rising. The drug abuse problem and the demand for drug abuse treatment are not limited to the heroin addiction problem. The abuse of other drugs has also led to a need for treatment.

The drug abuse problem is exceptionally broad in scope, affecting many agencies and programs. For example, drug abuse contributes to increased adult crime and juvenile delinquency, increased police and criminal justice costs, in addition to further burdening welfare, unemployment, and medical and mental health treatment services. These social costs of drug abuse in the United States are conservatively estimated at $10 billion. The inter-agency diffusion of the drug abuse prevention function must also be considered. Whereas the law enforcement function is centralized under the Drug Enforcement Administration, the treatment and prevention effort functions exist among several parts of the Department of Health, Education and Welfare; the Departments of Defense and Labor; the Veterans Administration; and other agencies. This necessary diffusion precludes comparable consolidation on the treatment and prevention side. If the Special Action Office is not continued, the prevention function would have only the fourth level National Institute on Drug Abuse within HEW to attempt to coordinate the vast effort.

While popular concern about drug abuse has remained high, public fear has in fact declined in the past three years, partly due to the impact and successes of the Special Action Office. In effect, the problem has been put in perspective by a balanced approach between treatment and law enforcement. Nonetheless, drug abuse is a potentially explosive issue. Without a sustained interest in its treatment and control, the situation will deteriorate rapidly.

Although much has been accomplished in the last three years, many important issues are not resolved. Major remaining tasks are discussed in detail at TAB B; a few of the more important are: 1) the allocation of resources among various claimants in the treatment and prevention area; 2) closely monitoring the increase in heroin use at a time when the Federal treatment capacity has been exhausted; 3) the coordination and assignment of appropriate roles to various agencies in drug abuse prevention activities; 4) continued high level coordination between law enforcement and treatment functions; 5) the Federal Government's response to the marihuana problem; 6) and the development of an international health initiative to assist other countries in becoming aware of and responding to their drug problems.

A full range of alternatives have been analyzed and evaluated; these are presented in detail at TAB C. Briefly, the most viable of the alternatives are 1) propose legislation to extend the Special Action Office in an expanded form for four years; 2) propose legislation to maintain the present organization and function of the Special Action Office for four years as the Office of Drug Policy within the Executive Office of the President; 3) vest drug abuse prevention policy-making and coordination authority in NIDA, and appoint the Director of NIDA as an Advisor to the President on drug abuse matters.

A fourth option, that of placing some portion of the policy and coordination role of the Special Action Office in the Office of Management and Budget, can be implemented concurrently with any of the above-mentioned options.

Conclusions

Although the heroin epidemic of 1970-71 has been contained, more complete data shows that a new and serious situation has evolved. Reduction of Executive Office level attention reduces your ability to impact upon the United States' drug abuse problem. Given the data available from all sources on the current status of drug abuse in the United States, and the growing social cost of drug abuse in the nation, a weakening of present emphasis and actions appears unwise.

There is a clear requirement to continue coordination among the Federal Departments and agencies to resolve complex issues and direct the Federal response to unmet needs. The Special Action Office is an established organization fully equipped to deal with these issues. Its forthcoming expiration dictates speed in selecting an option for future coordination of the Federal drug abuse program.

The current drug abuse situation, unfinished business, and the diffuse structure of the Federal drug abuse prevention program require strong leadership. Objective analysis of the options advances a compelling argument that the preferred action is to continue drug abuse coordination through an Office of Drug Policy within the Executive Office of the President.

Recommendation

That you approve Option #2, proposing continuation for four years of the Special Action Office as the Office of Drug Policy, and sign the attached Message to the Congress transmitting proposed legislation (TAB D).

APPROVE _____ DISAPPROVE _____

A

ACCOMPLISHMENTS

RESTORED POPULAR CONFIDENCE IN THE FEDERAL GOVERNMENT'S ABILITY TO RESPOND TO A NATIONAL HEROIN EMERGENCY

In 1971, the Federal Government recognized that heroin addiction had reached epidemic proportions and that the current piecemeal response was no longer adequate. Up to that point, national policy emphasized law enforcement, with a token treatment effort hampered by fragmentation, multi-agency competition for limited resources and duplication of efforts in service delivery and research. Not only did this situation reinforce the punitive stance toward drug abusers espoused since the 1920's, but it fostered imprisonment as a sole solution to the problem by failing to provide effective alternatives. With the establishment of the SAO in March 1972, the inequity between law enforcement and treatment was rectified. The new balance between sanctions and rehabilitation was welcomed by law enforcement and treatment officials alike. The advent of SAO freed enforcement to concentrate on the supply side of the drug abuse equation while it placed demand responsibility fully in the medico-social sphere. In order to align available facilities with the demand for treatment services, SAO initiated an expansion in Federal treatment capacity from 16,000 slots in 36 Federally-supported drug treatment programs to 128,000 slots in over 1,000 programs; a move which subsequently reduced waiting lists as high as 30,000 in several large cities to zero within a short period of time.

To bolster state and local governments in their efforts to deal with the drug problem, SAO developed and implemented a single state agency approach to the administration and management of prevention functions. The reprogramming of discretionary funds to statewide contracts, formula block grants, and a national technical assistance program to improve statewide management planning were SAO initiatives to assure that the single state agencies could execute their responsibilities.

To expand research endeavors in the field of heroin addiction, Federal and privately sponsored efforts were developed which led to improved understanding of pharmacologic action, the development of such long-acting treatment agents as LAAM (L-Alpha-Acetylmethadol), and the improvement of treatment techniques.

In 1971, public reactions to the heroin problem were stimulated by drug abuse prevention campaigns of dubious value. The Special Action Office responded by imposing a moratorium on all Federally-supported drug abuse prevention literature. When specific guidelines for educational materials were drawn up with the publication of "Federal Guidelines for Drug Abuse Prevention Materials", and with the implementation of early intervention efforts targetted at high-school age children, a reasonable prevention policy emerged and is currently being adopted on a city-by-city basis.

STREAMLINED FEDERAL MANAGEMENT IN DRUG ABUSE PREVENTION ACTIVITY

Organizationally, since SAO's formation the number of agencies involved in Federal drug abuse prevention has been reduced from 14 to 9 and duplication of Federal funding of drug abuse treatment has been virtually eliminated. Recently, the Special Action Office guided the organization of the National Institute on Drug Abuse (NIDA) and designated it as the primary resource for technical support to Federal, state and local drug abuse prevention and community-based treatment activities--- an action which eliminated the confusing splintering of programs among NIMH, LEAA, OEO and HUD. (Federal responsibility to support or provide drug abuse treatment is now limited to NIDA, VA, DOD, and BOP.)

To further emphasize the need for consistent direction among agencies, the Special Action Office has instituted an objective-based management program that has been incorporated by all involved agencies into their management process. Through this vehicle, Federal drug abuse prevention priorities and policies articulated by the Office in the 1974 National Strategy for Drug Abuse and Drug Trafficking Prevention and fiscal year 1975 budget policy guidance have been translated into action objectives to be achieved by the end of the current fiscal year.

To assure that Federal funding of community-based treatment programs has been both efficient and effective and that funds are properly managed and expended, the Special Action Office is overseeing the on-site management reviews of drug treatment centers supported by the National Institute on Drug Abuse. Data pertaining to program organization, fiscal practices, personnel and client treatment is reviewed by the Special Action Office and the National Institute on Drug Abuse (NIDA) to evaluate the management efficiency of Federally funded treatment programs, to modify the funding level of programs so that it is in line with their client load, and to improve programs found deficient by providing technical assistance.

A recently completed review of eight such drug treatment centers has yielded a dollar saving of $17 for each dollar spent on the review. This savings was accrued by reducing funding of programs either underutilizing their available treatment slots or eliminating projects or subcontracts which did not benefit the drug treatment mission of the center.

REDUCED THE CRIMINAL STIGMA ATTACHED TO FORMER DRUG ABUSERS

The criminal stigma previously attached to drug addiction has been eased through SAO's mobilization of health resources and introduction of non-discriminatory policies and practices in public employment. Specific actions have included:

- Acceptance of drug abuse as principally a health problem, to be dealt with through expanded national treatment capacity.

- Initiation within the Department of Defense of an exemption policy, freeing military drug abusers from punitive actions if they volunteer for treatment services.

- Establishment of a national program for referral of arrested drug abusers to treatment within the criminal justice system, through the Treatment Alternatives to Street Crime (TASC) program model.

- Institution of new policies and practices by the Civil Service Commission to provide appropriate prevention, treatment, and rehabilitation programs and services for drug abusers among Federal civilian employees.

- Elimination of discriminatory employment policies against former drug abusers within the United States Postal Service.

GUIDED DEVELOPMENT OF AN EFFECTIVE WORLD-WIDE DOD RESPONSE TO DRUG ABUSE IN THE MILITARY SERVICES

SAO has aided in the development of all components of the Department of Defense's worldwide drug abuse control program; including: identification; in-service treatment/rehabilitation; multi-level education; professional and paraprofessional training; evaluation; research; and management, coordination, program planning and support. Furthermore, SAO provided direct input to the DOD drug abuse policies, which brought the much publicized "heroin epidemic" in Vietnam under control, and made the appropriate treatment available for affected servicemen.

Since initiation of its Drug Abuse Control Program in 1971, DOD has identified over 75,000 servicemen as drug users through urinalysis testing and referred them into treatment. In addition, over 86,000 servicemen have volunteered for the Exemption Program, which frees the serviceman from punitive actions if he seeks treatment.

From a small number of programs in 1971, DOD has developed a network of over 500 treatment and rehabilitation centers worldwide, including hospitals, centralized treatment facilities, and base-level programs. DOD has averaged approximately 21,000 clients per month in treatment in FY-74, of whom approximately 50% return to duty.

PROVIDED LEADERSHIP IN FASHIONING LEGAL GUIDELINES FOR TREATMENT WHICH ACCOMMODATE SOCIETAL INTERESTS AND THE RIGHTS OF THE INDIVIDUAL

In response to Presidential and Congressional concerns for safeguarding drug abuse clients' rights to privacy, the Special Action Office prepared regulations which defined and protected the confidentiality of client treatment records. The Special Action Office has developed similar regulations for alcoholics pursuant to the 1974 amendments to the Comprehensive Alcohol Abuse Act of 1970.

IMPROVED THE QUALITY OF DRUG ABUSE TREATMENT IN THE UNITED STATES

Significant improvements in the quality of treatment services have been effected through SAO initiatives. These include:

- The development of minimum standards for treatment services which apply to all community-based treatment programs receiving Federal support.
- Promulgation of Federal regulations guiding the dispensing of methadone.
- A national program of technical assistance to local treatment programs.
- Directing the initiation by the Veterans Administration of a large-scale demonstration study of combined treatment for alcohol and drug abusers to determine the effectiveness and economic benefits of a combined approach.

PROVIDED A BALANCED AMERICAN POSTURE IN INTERNATIONAL DRUG MATTERS

Through its efforts in conjunction with the State Department to balance international law enforcement initiatives with treatment and rehabilitation activities, SAO has changed foreign perceptions of America's interest in drug abuse as purely enforcement oriented. Specific SAO actions include development of drug abuse prevention models in a number of State Department communities overseas such as Bangkok and Singapore and a similar joint venture with DOD in the establishment of a Special Youth Health Center in Frankfurt, West Germany for military dependents.

The Special Action Office has also taken a prominent role in the Cabinet Committee on International Narcotics Control (CCINC). The Director of the Special Action Office has been the key representative for the treatment side of drug abuse on such pressing issues as Turkish opium growth, distribution and control; this is the first time that Cabinet-level foreign drug abuse policies have contained integrated input from the health community.

In addition, SAO has been effective in introducing balance to other foreign countries' drug abuse control policies. As an example, the Director of the Special Action Office met recently with leaders of the Mexican government and provided specific advice and recommendations resulting in policies which emphasize treatment and prevention as new complements to the strictly punitive law enforcement policy accepted previously.

B

UNFINISHED BUSINESS

POLICY IMPLEMENTATION

The report of the President's Advisory Council on Executive Organization (the Ash Council) on social and economic programs concluded that the fragmentation and functional alignment of Executive Branch programs providing assistance to the individual leaves the Government ill-equipped to meet the challenges of the present and to achieve its long range purposes. Traditionally within a bureaucracy, problems are defined to fit within the limits of organizational authority, resulting in piecemeal approaches to solutions by separate departments and agencies. A problem such as drug abuse transcends traditional boundaries of agency activities and requires a multi-faceted response. As reported by the Ash Council, the basic Executive branch structure:

- Inhibits integration of related program activities.
- Results in inconsistent policies and prevents use of comprehensive strategies.
- Results in the creation of numerous inter-agency mechanisms for coordination with little effect.
- Results in overlapping mandates, jurisdictional competition and conflicts in administration.
- Prevents accountability for performance.
- Breeds confusion and frustration on the part of both recipients and state and local officials who deal with these programs.

In Federal drug matters, drug supply interdiction functions have been largely consolidated within the Drug Enforcement Administration in the Department of Justice. However, current Executive Branch organization provides a necessary diffusion of the bulk of prevention and treatment functions among several parts of the Department of Health, Education and Welfare; the Departments of Defense, Labor and Justice; and the Veterans Administration. This precludes a comparable consolidated organization on the demand side of the supply demand equation. Prior to application of the "capstone" program authorities of the Special Action Office, Federal drug program coordination was cosmetic and essentially nonfunctional.

Because of its stature as a special program coordination unit within the Executive Office of the President, the Special Action Office actively intervened in policy issues in which existing agency practices have been either dysfunctional or inadequate responses to the demands of the drug

abuse problem. This situation had developed as a result of overlapping general mandates, jurisdictional conflict and confusion, and inconsistent program policy formulation in the Executive Branch. One policy coordination tool used by the Office has been the annual issuance of specific program policy guidance governing agency expenditures in each fiscal year. As a result, fragmented Federal support for drug abuse treatment services has been curbed and continuing responsibility for treatment among the appropriate agencies precisely defined.

This complex sorting process is far from complete. The vast resources of Government rehabilitation and manpower development programs to service the post-treatment needs of the drug patient are unresponsive. A breakthrough has been achieved in a developing partnership with drug law enforcement, but a national imbalance in the total response remains; divisive controversy over the legal sanctions against marihuana persists nationally in many quarters of public office and private life; Federal departmental roles and relationships in international drug matters are not defined; and the concomitant dependence upon alcohol and drugs among an increasing number of Americans cannot be dealt with effectively under current traditional organizational strategies. This list goes on.

NATIONAL IMBALANCE BETWEEN DEMAND AND SUPPLY PROGRAMS

Termination of the Special Action Office impairs further maturation of the developing partnership between the supply and demand sides of the drug equation at the Federal, state, and local levels of Government. The National Institute on Drug Abuse (NIDA) has assumed technical leadership in drug abuse prevention; it is, however, inherently precluded from providing Government-wide program leadership because of its organizational location in the fourth tier of DHEW. In FY-76, no high-level full-time mechanisms will exist to provide demand sector representation in Federal drug program issues and policy and define an integrated demand position. This will result in diffusion of policy and priorities in the demand sector of Federal drug program activity. Current emphasis on improving the criminal justice and correctional systems' collaboration with offender treatment and rehabilitation initiatives will abate. Similarly, budgeting for demand programs will receive far less emphasis, because of the submerged location of the drug abuse prevention functions in the traditional health functions of departments and agencies.

INSUFFICIENT PROGRESS IN REHABILITATION

There is an urgent need for specific vocational-rehabilitation programs for ex-addicts. Current program data show that almost half (47.6%) of the Federal treatment clients are neither employed nor in training or education programs. Since more than 80% of Federal treatment clients are over 18 years old, and most are males, the fact that half of all clients in treatment are not employed or in the process of gaining skills suitable for employment causes considerable concern.

The need for specific vocational-rehabilitation programs for ex-addicts is not being met by the general Federal, state and local providers of manpower services. In the legislative history of the Vocational Rehabilitation Act of 1973, for example, specific reference was made to addicts and alcoholics as being provided for by other Federal programs and thus not to be considered as target populations for that Act's funds. The Department of Labor, the Social and Rehabilitation Service, Law Enforcement Assistance Administration, Bureau of Prisons, and the Veterans Administration, all fail to specify ex-addicts as a priority target group for vocational-rehabilitation programs. The Comprehensive Employment and Training Act of 1973 furthered the decentralization of responsibility for job training and employment opportunities to locally elected officials, but failed to specify ex-addicts as a target group. Legislative and administrative practices have clearly left responsibility for provision of vocational-rehabilitation services for ex-addicts to drug abuse treatment programs.

Much remains to be done in this area. Innovative models are being tested in New York City, Philadelphia, Detroit, Boston and the District of Columbia. But innovation without follow through is not sufficient, nor is a wealth of departmental resources effective, if not properly coordinated and directed. The problem data is current and the alarming percentages will remain constant unless the rehabilitation resources currently available are made more responsive.

THE URINALYSIS ISSUE

Suspension of all urinalysis testing on July 18, 1974 has left the Department of Defense without a scientific measure of the level of drug abuse within the Armed Forces and has eliminated the urinalysis test as a means of early detection and referral to treatment. The net effect has been to encourage experimental or other drug use by eliminating the deterrent power of the testing screen. Because of this Office's broad program authority and role of budget advisor to DoD, a prompt response to the recission of this critical element in DoD's program was possible and momentum to the decision process has resulted. At this time, the issue of resumption of the urinalysis testing program within the Department of Defense is not resolved.

INTERNATIONAL EFFORTS

The international arena, although penetrated by the Special Action Office, still lacks development in many critical areas. The most important unresolved issue is definition of the posture and responsibilities of the Federal health community in international drug matters. This is necessary to maintain and advance the balance which should exist between the demand and supply policies of the United States regarding international drug abuse efforts. Clarification is also required of the international drug abuse role of DHEW, the State Department, and the Department of Defense.

In addition, a greater sharing of knowledge and expertise in the drug abuse health arena between the United States and foreign governments is required, not only to promote a balanced position of the United States in drug matters, but also to aid foreign governments in instituting similarly balanced drug control programs.

POSSIBLE CONSOLIDATED MANAGEMENT OF FEDERAL DRUG AND ALCOHOL ABUSE PREVENTION PROGRAM ACTIVITY

In publishing its findings in the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1974, Congress found that:

- Alcohol is one of the most dangerous drugs and the drug most frequently abused in the United States.

- Alcohol abuse is found with increasing frequency among persons who are multiple-drug abusers and former heroin users who are being treated in methadone maintenance programs.

Responding to a growing awareness of the relationship of drug and alcohol abuse among individuals, and at the request of the Special Action Office, the Veterans Administration initiated a sizable pilot project to test the feasibility of treating alcohol and drug dependent patients together in the same setting. Results of these projects will have great implications for not only the Veterans Administration, but also the Department of Health, Education, and Welfare, the states, and local units of Government in planning the treatment of drug or alcohol dependent persons. If the outcome of the combined treatment is favorable, the results will carry program and fiscal implications for the entire alcohol and drug dependence treatment field in planning future treatment approaches. Federal management of alcohol and drug abuse prevention program activity is separate in spite of the organizational capstones in DHEW, VA, and DoD which combine the two organizationally. If consolidation is desirable, executive-level coordination will be necessary to assure responsive action in the existing bureaucracies.

RURAL DRUG ABUSE

Drug abuse in rural areas is becoming increasingly severe; this is another striking example of the urgent need for stepped-up prevention activities to respond to the changing phenomenon of drug availability. For the past three years, the Federal focus, of necessity, has been directed toward epidemic heroin use in our cities. As efforts to promote a Federal-state partnership in drug abuse have succeeded, different kinds of drug abuse problems have been revealed in rural areas. For example, in one state where treatment is largely unavailable because of community attitudes, known abusers are given a bus ticket to an adjacent state where treatment services are provided.

Treatment models tested in urban environments are not generally successful when applied to rural settings. Geography in terms of distance, and terrain make stationary treatment inaccessible. New approaches which recognize the transportation, limited manpower and abuse pattern factors involved in rural drug abuse service delivery must be developed and applied.

C

OPTIONS

The full range of alternatives has been reviewed to determine if each provides the requisite authority to direct Federal action, the organizational flexibility to identify and respond to major changes in Federal program direction, and the management capability to coordinate responsive program action. There are variations and combinations of options which might be acceptable; those analyzed below represent the major approaches:

OPTION #1: Propose legislation to extend the Special Action Office in an expanded form for four years, mandating a wider range of policy, program, and technical responsibilities in the area of drug abuse prevention.

Advantages:

- Signals a higher priority for drug abuse prevention than currently exists.
- Continues function under direction of a Presidential appointee within the Executive Office of the President.
- Provides both the visibility and authority necessary for a policy and coordination role.
- Reestablishes a capability for detailed program authority to respond to local requirements.
- Preserves a capability to closely monitor and quickly respond to specific changes in the drug abuse problem.
- Balance which has been created between drug abuse law enforcement and prevention functions is more nearly maintained.

Disadvantages:

- Agency functions would need to be clearly defined to prevent overlap with the National Institute on Drug Abuse.
- Maintains an additional organization within the Executive Office of the President.
- Requires additional staffing and budget authority.
- Renewal legislation requires Congressional approval.

OPTION #2: Propose legislation to maintain the present organization and function of the Special Action Office for four years as the Office of Drug Policy within the Executive Office of the President.

Advantages:

- Sets forth national drug abuse matters as a continuing priority of the Administration.
- Continues function under direction of a Presidential appointee within the Executive Office of the President.
- Retains authority necessary to make policy and coordinate Federal level responses to complex issues.
- Existing organizational capability is retained.
- Ability to monitor and respond to national drug abuse trends is preserved.
- Modest budget required to maintain capability and function; special program budget authorities are eliminated.
- Balance which has been created between drug abuse law enforcement and prevention functions is more nearly maintained.

Disadvantages:

- Maintains additional organization within the Executive Office of the President.
- Renewal legislation requires Congressional approval.

OPTION #3: Vest drug abuse prevention policy-making and coordination authority in the National Institute on Drug Abuse (NIDA) and appoint the Director, NIDA, as Special Advisor to the President on Drug Abuse Matters.

Advantages:

- Maintains some visibility for the problem of drug abuse and assures a degree of input into national policy decisions.

° Publicly designates an identifiable spokesman for drug-related issues.

° Establishes policy-making and coordination authority in the agency which currently has major civilian treatment, research and demonstration functions.

Disadvantages:

° Signals a lower priority for drug abuse prevention matters.

° Increases difficulty in effecting important policy and coordination activities outside of DHEW because of lead agency's relatively lower position in the Federal structure, e.g., DEA, LEAA, VA, DoD and DoL are on higher levels.

° Developing and proposing the required legislation is time consuming.

° Discards the organizational expertise of the Special Action Office in policy development and multi-agency coordination.

OPTION #4: Vest some portion of the policy-making and coordination role of the Special Action Office in the Office of Management and Budget.

Advantages:

° Can be implemented concurrently with other options.

° Maintains policy and coordination functions within the Executive Office of the President.

° Establishes the function in the same agency where budget decisions are made, providing an overview helpful in coordinating program efforts and assigning priorities.

Disadvantages:

- Signals lower priority for drug abuse matters by relegating policy responsibility to a unit within OMB not headed by a Presidential appointee.
- Policy and program authorities are contrary to the traditional legislated functions of OMB.
- Requires legislation to provide policy and program direction authority for OMB.
- Discards the organizational expertise of the Special Action Office in policy development and multi-agency coordination.

OPTION #5: Establish an inter-agency committee or special task force to deal with drug abuse coordination and policy.

Advantages:

- Can be established administratively.
- Provides forum for information exchange.
- Eliminates drug abuse prevention policy hierarchy and retains traditional program automomy in participant departments and agencies.

Disadvantages:

- Committee tactic signals a lower priority for the drug abuse problem.
- Committees or task forces usually have only advisory authority.
- Committees or task forces which meet intermittently cannot effectively implement policy or assume continuing program coordination responsibility in long-term complex and dynamic problems.

° Committee tactic usually precludes prompt and effective action because of requirement for scheduled and lengthy deliberation and decentralized review.

OPTION #6: Appoint the Director of the National Institute on Drug Abuse to the position of Special Advisor to the President (or Secretary of DHEW) for drug abuse prevention matters.

Advantages:

° Maintains some visibility for the problem of drug abuse and assures a degree of input into national policy decisions.

° Can be executed administratively.

° Publicly designates an identifiable spokesman for drug-related issues.

Disadvantages:

° Signals a lower priority for drug abuse prevention.

° Increases difficulty in effecting important policy and coordination activities outside of DHEW because of NIDA's relatively lower position in the Federal structure, e.g., DEA, LEAA, VA, DoD, DoL are on higher levels.

° Discards the organizational capability of the Special Action Office in policy development and multi-agency coordination.

OPTION #7: Incorporate Federal drug abuse prevention program direction within the Office of the Vice-President.

Advantages:

° Maintains a high level of visibility for the problem of drug abuse and assumes a degree of input into national policy decisions.

° Can be administratively achieved.

° Has necessary overview position to recommend program priorities and informally assure coordination of agency efforts.

Disadvantages:

° Requires staff knowledgeable of complex drug abuse issues to assist in policy formulation and coordination.

° Enlarges the staff of the Office of the Vice-President.

° Discards the organizational expertise of the Special Action Office in policy development and multi-agency coordination.

OPTION #8: Establish a special committee for drug abuse prevention matters which would function under the aegis of the Domestic Council and be chaired by the Director of the National Institute on Drug Abuse.

Advantages:

° Can be administratively achieved.

° Provides some visibility and has access to a decision-making and policy-setting group.

Disadvantages:

° Signals a lower priority for drug abuse prevention.

° Committee tactic does not respond promptly and effectively to the rapidly changing drug problem because of intermittent meetings.

° Policy implementation and coordination would be difficult to achieve without specific authority and mandate to intervene in inter-agency issues and program operations.

° Discards the organizational capability of the Special Action Office in policy development and multi-agency coordination.

OPTION #9: Let the Special Action Office for Drug Abuse Prevention's legislation expire on June 30, 1975 and take no action to provide for continuation of its functions.

Advantages:

- Elimination of an office from the Executive Office of the President.

Disadvantages:

- Signals a drastic reduction in the priority of the drug abuse problem.
- Leaves Federal and state drug abuse prevention efforts without a national leadership office to set policy, provide coordination and respond to changes in the drug abuse situation.
- Without coordination and direction, agencies might become fragmented and duplicative in their drug abuse prevention efforts.
- Further development of the balance between law enforcement and prevention in the coordinated attack on drug abuse would be impeded by splintering drug abuse prevention program direction and leadership among departments and agencies.
- Since drug abuse impacts on other Federal program functions (police, courts, hospitals, welfare, unemployment, treatment, etc.) and fluctuates rapidly, the diffusion of program authority will probably be reflected in disjointed patchwork priority setting and increasing costs in other programs.

D

MESSAGE

From

THE PRESIDENT OF THE UNITED STATES

Transmitting

A draft of proposed legislation to provide for continuing coordination of Federal policy in drug abuse prevention, including research and treatment, and for other purposes.

To the Congress of the United States:

In a Presidential message transmitted to the Congress more than three years ago, "fragmentation, competing priorities, and lack of communication" were blamed for the failure of the Federal Government to come to grips with the problem of drug abuse. As an alternative, the creation of a Special Action Office for Drug Abuse Prevention was proposed to provide high level coordination and policy direction. By four successive, unanimous record votes, the Congress expressed its emphatic agreement with this concept.

Now, on the basis of three years' experience, there seems little doubt that the concept is indeed a sound one. The relatively modest costs of operating the Office have been returned many times over in improvements in the effectiveness and efficiency of Federal and State drug abuse prevention programs. In order to preserve and build on this achievement, however, legislation is needed to authorize the continued operation of the Office, a need which recent trends make felt with special force.

The programs of the Federal Government dealing with drug abuse fall into two distinct categories. One, often referred to as the supply side, is aimed at reducing the availability or supply of drugs by interdicting the illicit drug traffic. The other, involving the so-called demand side, is concerned with supporting treatment, rehabilitation, and prevention measures aimed at reducing the demand for drugs. The supply interdiction functions have been substantially consolidated within the Drug Enforcement Administration of the Department of Justice. But the

necessary diffusion of the prevention and treatment responses among the Departments of Health, Education and Welfare, Defense, Labor and other agencies, precludes a comparable consolidated administrative structure on the demand side. Even the consolidation of civilian treatment and education programs within HEW would not permit the exercise of effective and necessary leadership with regard to comparable programs operated by the Department of Defense, Veterans' Administration and the Bureau of Prisons, as well as the important roles of agencies such as the Civil Service Commission and the Department of Labor. Some central office must continue to assume responsibility for demonstrating new methods of treatment, rehabilitation, and prevention; coordinating the adoption and implementation of worthwhile programs by the other Departments; and providing a high level marshalling of health concerns in the formulation of government policy.

Past experience has amply and repeatedly demonstrated the need for such leadership, a need which constitutes a compelling rationale for the extension, with modifications, of Public Law 92-255. Without it, a reversion to the chaos which characterized the response of the State and Federal governments alike prior to 1972 seems all but inevitable. The accomplishments of the Special Action Office over the past three years, some of which are only now coming to fruition, have been substantial. But in part because of their novelty, their viability if suddenly deprived of high level support and leadership is open to question. The more significant of these achievements may be summarized as follows:

Directed expansion of the Federal treatment capacity from 16,000 slots in 36 Federally-supported treatment programs to 128,000 civilian and military slots in over 1,000 Federally-supported programs.

Provided leadership in fashioning legal guidelines for treatment which accommodate societal interests and the rights of the individual.

Established communication and coordination between the criminal justice system and the health care delivery system at the Federal as well as the State levels.

Sponsored or developed Federal and private research capabilities leading to development of long-acting treatment agents and improved treatment techniques for heroin addiction.

Improved responsiveness and efficiency with which Federal treatment assistance is authorized and distributed.

Successfully promoted development of effective state mechanisms for management of prevention functions at the State and local levels.

Improved the effectiveness of international efforts, both civilian and military, for reducing the incidence and spread of drug abuse among American citizens overseas.

Developed innovative and effective public education and prevention programs and guidelines.

Consolidating the gains described above and building on a solid foundation of institutional experience are tasks which call for steady, continuing effort rather than the initiation of a crash program. Reflecting this change of emphasis in the primary mission of the Office, the legislation submitted herewith would change its name from "Special Action Office for Drug Abuse Prevention" to "Office of Drug Policy." Consistent with this concept, programmatic responsibility for pharmacological research would be eliminated, although the responsibility for policy would, of course, remain. The direct spending limitation of 10 per centum of funds appropriated for the Special Fund for development and demonstration would be replaced by a flat dollar limitation of $2,000,000, thereby maintaining an effective prohibition on substantial programmatic operations without crippling the capacity to innovate.

An overall ceiling of $20,000,000 per year would be established on appropriations authorized for the Office for succeeding fiscal years, as contrasted with authorizations totalling $82,000,000 which existing law provides for the current (1975) fiscal year. Finally, the life of the Office (and of the authorizing legislation) would be extended to September 30, 1979. Without legislative action, the Office and all statutory authority now conferred on it will terminate on June 30, 1975, with no provision for the transfer of such authority to any other agency.

The need for legislative action is underlined by ominous trends which have become increasingly apparent in recent months. As contrasted with what appeared to be hopeful trends a year ago, we can no longer say that heroin addiction and drug abuse in the United States are declining. In various regions of the country, heroin addiction is on the rise, being fed by a continuing influx of Mexican heroin, and further threatened by a resumption of opium production in Turkey. Texas, California, and Oregon have had to request more Federal funds for additional treatment capacity. Illinois, Pennsylvania, and Massachusetts, identified by the Drug Enforcement Administration as major Mexican brown heroin trafficking centers, report increased demand for treatment. Waiting lists for treatment are appearing in California, Colorado, Florida, Illinois, Pennsylvania, Tennessee, Texas, Minnesota, Michigan, and Montana.

Nationally, and in every region of the United States, hospital emergency room treatment for heroin overdose has increased dramatically every quarter since September, 1973. Specifically, the period July-September, 1974 has shown an overall increase of 66% above the July-September, 1973 quarterly level. In the Northeast, Central, and Southwestern regions, this growth has been the most severe.

These disturbing trends have been accompanied by an alarming increase in the purity of heroin distributed in the criminal wholesale market. Since the first quarter of 1974, wholesale purity has increased from 22.8% to 32.9%. At the same time, street-level purity has declined while price has increased nationally, thus signaling greater

street-level demand for heroin. Paralleling the higher costs of street heroin has been an increase in income-producing crime in almost every state.

In June and July, 1974, the Special Action Office dispatched teams to investigate the spread of heroin use in smaller population centers. It was known that heroin use had peaked in some of the larger cities in 1968-69, but from treatment data, it appeared that heroin use might now be spreading to smaller cities. The investigation showed this to be true in a disturbing number of instances. New heroin use is increasing in cities as widely separated as Eugene, Oregon, Des Moines, Iowa; and Jackson, Mississippi. If this situation is common to a large number of similar cities throughout the country, and if it is fed by a continuing influx of Mexican heroin, the United States is experiencing a significant increase in incidence of heroin addiction.

Other drug problems also merit our concern. Thirteen million Americans are estimated to be regular users of marijuana. Recently, new evidence has been presented indicating potentially significant medical problems which may be encountered from long-term or moderate to heavy use of marijuana. Specifically, this research has indicated scientific evidence of changes in basic cellular mechanisms; adverse immunologic and genetic effects; accumulation of the active ingredients of marijuana in the fatty tissues and certain parts of the brain; and more adverse effects than from regular cigarette smoking on the tissues of the lungs. Occasional or light use produces significant temporary effects on memory and coordination sufficient to affect driving and other motor skills. Coupled with this new evidence, existing data show that more than 15% of the persons in all Federally-funded treatment programs are being treated for problems with marijuana or hashish; this statistic is up from 11.2% a year ago.

Reliable nationwide studies show that stimulants and depressants are widely used by the young as well as adults. A recent report from a national survey for the school year 1973-74 indicates that of the students surveyed, over one-third had used synthetic drugs non-medically, and of these, 24% had used barbiturates and 22% used amphetamines. The consequences of such use are severe; consistently, 11% of the total admissions for treatment in Federally-supported programs have been for amphetamine and barbiturate abuse.

In the light of such widespread evidence of the continuing and in some cases growing seriousness and extent of drug abuse, this would be a most unfortunate time to abandon a working institutional framework to assure continuing high-level attention to the problem. Accordingly, I urge early and favorable consideration by the Congress of the attached draft legislation.

The White House, January , 1975

__ Congress
__ Session

A B I L L

To provide for continuing coordination of Federal policy in drug abuse prevention, including research and treatment, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 104 of the Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1104) is amended by striking "June 30, 1975" and inserting "September 30, 1979" in lieu thereof.

Sec. 2. (a) The following provisions of law are each amended by striking "Special Action Office for Drug Abuse Prevention" and inserting "Office of Drug Policy" in lieu thereof:

(1) The heading of title II of the Drug Abuse Office and Treatment Act of 1972 (21 U.S.C., chapter 16, subchapter II), and sections 201, 302, and 408(g) of such Act (21 U.S.C. 1111, 1162, and 1175(g)).

(2) Sections 5313(21) and 5315(95) of Title 5, United States Code.

(3) Sections 303(b)(1) and 303(d) of Public Law 93-282 (88 Stat. 138, 139).

(4) Section 454 of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3750c).

(5) Section 206(a) of the Juvenile Justice and Delinquency Prevention Act of 1974 (42 U.S.C. 5616(a)(1)).

(b) The redesignation provided for in subsection (a) of this section shall not otherwise affect the regulations, grants, contracts, personnel, property, or unexpended balances of appropriations of the agency so redesignated.

Sec. 3. Section 223(c) of the Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1133(c)) is amended by striking "10 per centum" and inserting "$2,000,000" in lieu thereof.

Sec. 4. (a) Section 224 of the Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1134) is repealed, and the table of sections at the beginning of chapter 2 of title II of such Act (21 U.S.C., chapter 16, subchapter II, part 2) is amended by striking the following item:

"224. Encouragement of certain research and development.

(b) The repeal made by subsection (a) of this section shall not affect the continuing validity of any grant or contract made thereunder prior to its repeal, and shall not affect the authority of the National Institute on Drug Abuse or any other agency to carry on research.

Sec. 5. Section 214(a) of the Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1123(a)) is amended by adding at the end thereof the following new paragraph:

"(4) For the purposes of carrying out the provisions of this title, there are authorized to be appropriated $20,000,000 for the fiscal year ending June 30, 1976; $5,000,000 for the period July 1, 1976, through September 30, 1976; and $20,000,000 for each of the fiscal years ending September 30, 1977, September 30, 1978, and September 30, 1979."

THE WHITE HOUSE

ACTION MEMORANDUM WASHINGTON LOG NO.:

Date: January 4, 1975 Time:

FOR ACTION: Jack Marsh
Bob Hartmann
Ken Cole
Bill Baroody

cc (for information):

FROM THE STAFF SECRETARY

DUE: Date: Monday, January 6, 1975 Time: NOON

SUBJECT:

O'Neill memo (12/30/74) re:
Special Action Office for Drug Abuse Prevention extension

ACTION REQUESTED:

____ For Necessary Action

____ Prepare Agenda and Brief

__X__ For Your Comments

__X__ For Your Recommendations

____ Draft Reply

____ Draft Remarks

REMARKS:

1/6 - Cole, Hartmann, Baroody
no answer
1/7 3p Hartmann - Should be back
by 5:30p today

PLEASE ATTACH THIS COPY TO MATERIAL SUBMITTED.

If you have any questions or if you anticipate a delay in submitting the required material, please telephone the Staff Secretary immediately.

K. R. COLE, JR.
For the President

Dick - Marsh/ Scott to Haldeman's Domestic Council etc.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

December 30, 1974

MEMORANDUM FOR DON RUMSFELD

SUBJECT: Special Action Office Extension

FROM: Paul H. O'Neill

When we met with the President last week, he asked that I consult with you on the question of what to do about the Special Action Office for Drug Abuse Prevention.

The Office was created in 1972. It is scheduled to go out of existence on June 30, 1975.

My recommendation is that we let the SAO authorization expire and (in order of preference) designate the Director of the National Institute on Drug Abuse as:

-- Chairman of a Domestic Council Committee, or,

-- Special Advisor to the Secretary of Health, Education, and Welfare.

Attachments

1976 Budget

Special Action Office for Drug Abuse Prevention

Issue Paper

Issue: What, if any, special White House or Executive Office of the President unit is necessary for drug abuse advocacy and program coordination?

Dr. DuPont's Recommendation: In the attached package, Dr. DuPont, Director of the Special Action Office for Drug Abuse Prevention, states his belief that the Special Action Office has made a considerable contribution to the government's drug abuse prevention effort since its creation in 1972, and that its legislatively scheduled termination on June 30, 1975 "has serious consequences for the Administration in terms of its ability to effectively coordinate the Federal drug abuse prevention effort...." Further, he is concerned that termination would signal a lowering of national priority at a time when the drug abuse problem appears to be increasing again. He proposes a four-year extension of the Special Action Office in the form of an "Office of Drug Policy" within the Executive Office of the President.

Options: Dr. DuPont poses four major "viable" options:

1. Extend, for four years, the Special Action Office, in an expanded form;

2. Create a new four-year statutory Office of Drug Policy;

3. Vest drug abuse prevention policy-making responsibility and coordination in the National Institute on Drug Abuse (NIDA) in HEW and appoint the NIDA Director as "Special Advisor to the President on Drug Abuse Matters"; and

4. Vest some portion of the policy and coordination role of the Special Action Office in OMB.

Dr. DuPont recommends Option 2.

There are, however, other options which should be seriously considered. These include:

5. Designating an Executive Director of a Domestic Council Committee;

6. Designating a Special Assistant to the Secretary of HEW; or

7. Allowing the Cabinet officers and agency heads to discharge their statutory responsibilities for program management and coordination through normal mechanisms.

OMB Recommendation: We recommend against extension of the Special Action Office. We have canvassed Defense, HEW, Labor, VA and Justice at the policy level on extending the Special Action Office. The agencies are in uniformly strong opposition to extension and generally favor Option 5. On the merits, we recommend Option 6 or 7; Option 5, however, would meet the political need.

The Office was created to oversee and coordinate the rapid increase in the Federal support for drug treatment capacity; it did that job reasonably well. Treatment capacity is, however, stabilizing. Moreover, virtually all civilian drug abuse programs are located in HEW and the major substantive policy decisions concerning drug abuse treatment have already been made. We see no need for a separate agency in the Executive Office of the President. The "serious consequences" referred to by Dr. DuPont are not specified in his materials.

Nevertheless, we recognize the possible need -- for political reasons, as well as to handle whatever coordination functions remain -- to continue visible White House leadership of the drug abuse prevention program.

Decision:

/___/ Approve Option _____

/___/ See me

EXECUTIVE OFFICE OF THE PRESIDENT
SPECIAL ACTION OFFICE FOR DRUG ABUSE PREVENTION
WASHINGTON, DC 20506

December 17, 1974

MEMORANDUM TO THE PRESIDENT

FROM : ROBERT L. DUPONT, M.D. RLD
DIRECTOR

SUBJECT : OPTIONS FOR DIRECTION OF FEDERAL DRUG ABUSE EFFORTS

The legislatively scheduled termination of the Special Action Office for Drug Abuse Prevention on June 30, 1975 has serious consequences for the Administration in terms of its ability to effectively coordinate the Federal drug abuse prevention effort and to maintain the current momentum in dealing with drug abuse in the United States. The successive reductions in the drug abuse prevention budget for FY-75, and 76, coupled with the termination of the White House Special Action Office, would signal a decline in the Administration's attention to the nation's drug abuse problem at an unfortunate time. This paper summarizes the drug abuse situation in the United States today, and recommends that a timely decision be made from available options.

A Presidential message to the Congress more than three years ago blamed "fragmentation, competing priorities, and lack of communication" for the failure of the Federal Government to come to grips with the problem of drug abuse. The message emphasized that enforcement of drug laws must be coupled with a rational approach to treatment of the drug user, and proposed the Special Action Office to provide Federal coordination and policy direction for drug abuse prevention programs. By four unanimous votes, the Congress expressed its emphatic agreement. Over a three year period, the wisdom of that action has been clearly demonstrated; since establishment in March, 1972, some of the significant achievements of this office are:

- Federal treatment capacity has been expanded from 16,000 to 128,000 slots;
- A major restructuring of the Federal Government's response to drug abuse has occurred---the approach has moved from an exclusively law enforcement response to an increased law enforcement effort balanced by a newly created treatment effort;

° Communication and coordination have been established between the criminal justice system and the health care delivery systems at the Federal and state levels.

Many other significant improvements have been achieved by the Special Action Office in its short existence; some of these accomplishments are listed at TAB A. However, the critical point is that despite these accomplishments, much remains to be done. The drug abuse problem is not like other social problems; it is much more dynamic and the government's appropriate long-term role has not been fully determined. At this time, the Federal drug abuse response is not a routine, on-going function, suited for management through traditional and well-defined operations. Instead, it is determined by a series of complex issues, and stimulated by a high degree of unabated public concern compared with other social and health problems. The drug abuse situation in the United States fluctuates rapidly and requires high level, sophisticated attention. The heroin problem cannot be ignored; once thought to be decreasing, it now appears to be on the rise, being fed by an influx of Mexican heroin and further threatened by resumption of opium production in Turkey. These disturbing trends have been accompanied by an increase in the purity of heroin distributed in the wholesale market, an increased supply of heroin on the street, and an increased demand for heroin addiction treatment. Paralleling these activities has been a significant increase in FBI reported income-producing crime in almost every state. National crime rates and heroin rates turned down in 1972 for the first time, after a decade of sharp increases. The third quarter of 1973 saw the end of these favorable trends. Rates of both crime and heroin use are now rising. The drug abuse problem and the demand for drug abuse treatment are not limited to the heroin addiction problem. The abuse of other drugs has also led to a need for treatment.

The drug abuse problem is exceptionally broad in scope, affecting many agencies and programs. For example, drug abuse contributes to increased adult crime and juvenile delinquency, increased police and criminal justice costs, in addition to further burdening welfare, unemployment, and medical and mental health treatment services. These social costs of drug abuse in the United States are conservatively estimated at $10 billion. The inter-agency diffusion of the drug abuse prevention function must also be considered. Whereas the law enforcement function is centralized under the Drug Enforcement Administration, the treatment and prevention effort functions exist among several parts of the Department of Health, Education and Welfare; the Departments of Defense and Labor; the Veterans Administration; and other agencies. This necessary diffusion precludes comparable consolidation on the treatment and prevention side. If the Special Action Office is not continued, the prevention function would have only the fourth level National Institute on Drug Abuse within HEW to attempt to coordinate the vast effort.

While popular concern about drug abuse has remained high, public fear has in fact declined in the past three years, partly due to the impact and successes of the Special Action Office. In effect, the problem has been put in perspective by a balanced approach between treatment and law enforcement. Nonetheless, drug abuse is a potentially explosive issue. Without a sustained interest in its treatment and control, the situation will deteriorate rapidly.

Although much has been accomplished in the last three years, many important issues are not resolved. Major remaining tasks are discussed in detail at TAB B; a few of the more important are: 1) the allocation of resources among various claimants in the treatment and prevention area; 2) closely monitoring the increase in heroin use at a time when the Federal treatment capacity has been exhausted; 3) the coordination and assignment of appropriate roles to various agencies in drug abuse prevention activities; 4) continued high level coordination between law enforcement and treatment functions; 5) the Federal Government's response to the marihuana problem; 6) and the development of an international health initiative to assist other countries in becoming aware of and responding to their drug problems.

A full range of alternatives have been analyzed and evaluated; these are presented in detail at TAB C. Briefly, the most viable of the alternatives are 1) propose legislation to extend the Special Action Office in an expanded form for four years; 2) propose legislation to maintain the present organization and function of the Special Action Office for four years as the Office of Drug Policy within the Executive Office of the President; 3) vest drug abuse prevention policy-making and coordination authority in NIDA, and appoint the Director of NIDA as an Advisor to the President on drug abuse matters.

A fourth option, that of placing some portion of the policy and coordination role of the Special Action Office in the Office of Management and Budget, can be implemented concurrently with any of the above-mentioned options.

Conclusions

Although the heroin epidemic of 1970-71 has been contained, more complete data shows that a new and serious situation has evolved. Reduction of Executive Office level attention reduces your ability to impact upon the United States' drug abuse problem. Given the data available from all sources on the current status of drug abuse in the United States, and the growing social cost of drug abuse in the nation, a weakening of present emphasis and actions appears unwise.

There is a clear requirement to continue coordination among the Federal Departments and agencies to resolve complex issues and direct the Federal response to unmet needs. The Special Action Office is an established organization fully equipped to deal with these issues. Its forthcoming expiration dictates speed in selecting an option for future coordination of the Federal drug abuse program.

The current drug abuse situation, unfinished business, and the diffuse structure of the Federal drug abuse prevention program require strong leadership. Objective analysis of the options advances a compelling argument that the preferred action is to continue drug abuse coordination through an Office of Drug Policy within the Executive Office of the President.

Recommendation

That you approve Option #2, proposing continuation for four years of the Special Action Office as the Office of Drug Policy, and sign the attached Message to the Congress transmitting proposed legislation (TAB D).

APPROVE _____ DISAPPROVE _____

A

ACCOMPLISHMENTS

RESTORED POPULAR CONFIDENCE IN THE FEDERAL GOVERNMENT'S ABILITY TO RESPOND TO A NATIONAL HEROIN EMERGENCY

In 1971, the Federal Government recognized that heroin addiction had reached epidemic proportions and that the current piecemeal response was no longer adequate. Up to that point, national policy emphasized law enforcement, with a token treatment effort hampered by fragmentation, multi-agency competition for limited resources and duplication of efforts in service delivery and research. Not only did this situation reinforce the punitive stance toward drug abusers espoused since the 1920's, but it fostered imprisonment as a sole solution to the problem by failing to provide effective alternatives. With the establishment of the SAO in March 1972, the inequity between law enforcement and treatment was rectified. The new balance between sanctions and rehabilitation was welcomed by law enforcement and treatment officials alike. The advent of SAO freed enforcement to concentrate on the supply side of the drug abuse equation while it placed demand responsibility fully in the medico-social sphere. In order to align available facilities with the demand for treatment services, SAO initiated an expansion in Federal treatment capacity from 16,000 slots in 36 Federally-supported drug treatment programs to 128,000 slots in over 1,000 programs; a move which subsequently reduced waiting lists as high as 30,000 in several large cities to zero within a short period of time.

To bolster state and local governments in their efforts to deal with the drug problem, SAO developed and implemented a single state agency approach to the administration and management of prevention functions. The reprogramming of discretionary funds to statewide contracts, formula block grants, and a national technical assistance program to improve statewide management planning were SAO initiatives to assure that the single state agencies could execute their responsibilities.

To expand research endeavors in the field of heroin addiction, Federal and privately sponsored efforts were developed which led to improved understanding of pharmacologic action, the development of such long-acting treatment agents as LAAM (L-Alpha-Acetylmethadol), and the improvement of treatment techniques.

In 1971, public reactions to the heroin problem were stimulated by drug abuse prevention campaigns of dubious value. The Special Action Office responded by imposing a moratorium on all Federally-supported drug abuse prevention literature. When specific guidelines for educational materials were drawn up with the publication of "Federal Guidelines for Drug Abuse Prevention Materials", and with the implementation of early intervention efforts targetted at high-school age children, a reasonable prevention policy emerged and is currently being adopted on a city-by-city basis.

STREAMLINED FEDERAL MANAGEMENT IN DRUG ABUSE PREVENTION ACTIVITY

Organizationally, since SAO's formation the number of agencies involved in Federal drug abuse prevention has been reduced from 14 to 9 and duplication of Federal funding of drug abuse treatment has been virtually eliminated. Recently, the Special Action Office guided the organization of the National Institute on Drug Abuse (NIDA) and designated it as the primary resource for technical support to Federal, state and local drug abuse prevention and community-based treatment activities---an action which eliminated the confusing splintering of programs among NIMH, LEAA, OEO and HUD. (Federal responsibility to support or provide drug abuse treatment is now limited to NIDA, VA, DOD, and BOP.)

To further emphasize the need for consistent direction among agencies, the Special Action Office has instituted an objective-based management program that has been incorporated by all involved agencies into their management process. Through this vehicle, Federal drug abuse prevention priorities and policies articulated by the Office in the 1974 National Strategy for Drug Abuse and Drug Trafficking Prevention and fiscal year 1975 budget policy guidance have been translated into action objectives to be achieved by the end of the current fiscal year.

To assure that Federal funding of community-based treatment programs has been both efficient and effective and that funds are properly managed and expended, the Special Action Office is overseeing the on-site management reviews of drug treatment centers supported by the National Institute on Drug Abuse. Data pertaining to program organization, fiscal practices, personnel and client treatment is reviewed by the Special Action Office and the National Institute on Drug Abuse (NIDA) to evaluate the management efficiency of Federally funded treatment programs, to modify the funding level of programs so that it is in line with their client load, and to improve programs found deficient by providing technical assistance.

A recently completed review of eight such drug treatment centers has yielded a dollar saving of $17 for each dollar spent on the review. This savings was accrued by reducing funding of programs either underutilizing their available treatment slots or eliminating projects or subcontracts which did not benefit the drug treatment mission of the center.

REDUCED THE CRIMINAL STIGMA ATTACHED TO FORMER DRUG ABUSERS

The criminal stigma previously attached to drug addiction has been eased through SAO's mobilization of health resources and introduction of non-discriminatory policies and practices in public employment. Specific actions have included:

- Acceptance of drug abuse as principally a health problem, to be dealt with through expanded national treatment capacity.

- Initiation within the Department of Defense of an exemption policy, freeing military drug abusers from punitive actions if they volunteer for treatment services.

- Establishment of a national program for referral of arrested drug abusers to treatment within the criminal justice system, through the Treatment Alternatives to Street Crime (TASC) program model.

- Institution of new policies and practices by the Civil Service Commission to provide appropriate prevention, treatment, and rehabilitation programs and services for drug abusers among Federal civilian employees.

- Elimination of discriminatory employment policies against former drug abusers within the United States Postal Service.

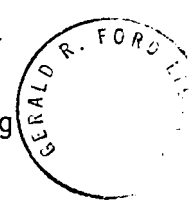
GUIDED DEVELOPMENT OF AN EFFECTIVE WORLD-WIDE DOD RESPONSE TO DRUG ABUSE IN THE MILITARY SERVICES

SAO has aided in the development of all components of the Department of Defense's worldwide drug abuse control program; including: identification; in-service treatment/rehabilitation; multi-level education; professional and paraprofessional training; evaluation; research; and management, coordination, program planning and support. Furthermore, SAO provided direct input to the DOD drug abuse policies, which brought the much publicized "heroin epidemic" in Vietnam under control, and made the appropriate treatment available for affected servicemen.

Since initiation of its Drug Abuse Control Program in 1971, DOD has identified over 75,000 servicemen as drug users through urinalysis testing and referred them into treatment. In addition, over 86,000 servicemen have volunteered for the Exemption Program, which frees the serviceman from punitive actions if he seeks treatment.

From a small number of programs in 1971, DOD has developed a network of over 500 treatment and rehabilitation centers worldwide, including hospitals, centralized treatment facilities, and base-level programs. DOD has averaged approximately 21,000 clients per month in treatment in FY-74, of whom approximately 50% return to duty.

PROVIDED LEADERSHIP IN FASHIONING LEGAL GUIDELINES FOR TREATMENT WHICH ACCOMMODATE SOCIETAL INTERESTS AND THE RIGHTS OF THE INDIVIDUAL



In response to Presidential and Congressional concerns for safeguarding drug abuse clients' rights to privacy, the Special Action Office prepared regulations which defined and protected the confidentiality of client treatment records. The Special Action Office has developed similar regulations for alcoholics pursuant to the 1974 amendments to the Comprehensive Alcohol Abuse Act of 1970.

IMPROVED THE QUALITY OF DRUG ABUSE TREATMENT IN THE UNITED STATES

Significant improvements in the quality of treatment services have been effected through SAO initiatives. These include:

- The development of minimum standards for treatment services which apply to all community-based treatment programs receiving Federal support.
- Promulgation of Federal regulations guiding the dispensing of methadone.
- A national program of technical assistance to local treatment programs.
- Directing the initiation by the Veterans Administration of a large-scale demonstration study of combined treatment for alcohol and drug abusers to determine the effectiveness and economic benefits of a combined approach.

PROVIDED A BALANCED AMERICAN POSTURE IN INTERNATIONAL DRUG MATTERS

Through its efforts in conjunction with the State Department to balance international law enforcement initiatives with treatment and rehabilitation activities, SAO has changed foreign perceptions of America's interest in drug abuse as purely enforcement oriented. Specific SAO actions include development of drug abuse prevention models in a number of State Department communities overseas such as Bangkok and Singapore and a similar joint venture with DOD in the establishment of a Special Youth Health Center in Frankfurt, West Germany for military dependents.

The Special Action Office has also taken a prominent role in the Cabinet Committee on International Narcotics Control (CCINC). The Director of the Special Action Office has been the key representative for the treatment side of drug abuse on such pressing issues as Turkish opium growth, distribution and control; this is the first time that Cabinet-level foreign drug abuse policies have contained integrated input from the health community.

In addition, SAO has been effective in introducing balance to other foreign countries' drug abuse control policies. As an example, the Director of the Special Action Office met recently with leaders of the Mexican government and provided specific advice and recommendations resulting in policies which emphasize treatment and prevention as new complements to the strictly punitive law enforcement policy accepted previously.

B

UNFINISHED BUSINESS

POLICY IMPLEMENTATION

The report of the President's Advisory Council on Executive Organization (the Ash Council) on social and economic programs concluded that the fragmentation and functional alignment of Executive Branch programs providing assistance to the individual leaves the Government ill-equipped to meet the challenges of the present and to achieve its long range purposes. Traditionally within a bureaucracy, problems are defined to fit within the limits of organizational authority, resulting in piecemeal approaches to solutions by separate departments and agencies. A problem such as drug abuse transcends traditional boundaries of agency activities and requires a multi-faceted response. As reported by the Ash Council, the basic Executive branch structure:

- Inhibits integration of related program activities.
- Results in inconsistent policies and prevents use of comprehensive strategies.
- Results in the creation of numerous inter-agency mechanisms for coordination with little effect.
- Results in overlapping mandates, jurisdictional competition and conflicts in administration.
- Prevents accountability for performance.
- Breeds confusion and frustration on the part of both recipients and state and local officials who deal with these programs.

In Federal drug matters, drug supply interdiction functions have been largely consolidated within the Drug Enforcement Administration in the Department of Justice. However, current Executive Branch organization provides a necessary diffusion of the bulk of prevention and treatment functions among several parts of the Department of Health, Education and Welfare; the Departments of Defense, Labor and Justice; and the Veterans Administration. This precludes a comparable consolidated organization on the demand side of the supply demand equation. Prior to application of the "capstone" program authorities of the Special Action Office, Feceral drug program coordination was cosmetic and essentially nonfunctional.

Because of its stature as a special program coordination unit within the Executive Office of the President, the Special Action Office actively intervened in policy issues in which existing agency practices have been either dysfunctional or inadequate responses to the demands of the drug

abuse problem. This situation had developed as a result of overlapping general mandates, jurisdictional conflict and confusion, and inconsistent program policy formulation in the Executive Branch. One policy coordination tool used by the Office has been the annual issuance of specific program policy guidance governing agency expenditures in each fiscal year. As a result, fragmented Federal support for drug abuse treatment services has been curbed and continuing responsibility for treatment among the appropriate agencies precisely defined.

This complex sorting process is far from complete. The vast resources of Government rehabilitation and manpower development programs to service the post-treatment needs of the drug patient are unresponsive. A breakthrough has been achieved in a developing partnership with drug law enforcement, but a national imbalance in the total response remains; divisive controversy over the legal sanctions against marihuana persists nationally in many quarters of public office and private life; Federal departmental roles and relationships in international drug matters are not defined; and the concomitant dependence upon alcohol and drugs among an increasing number of Americans cannot be dealt with effectively under current traditional organizational strategies. This list goes on.

NATIONAL IMBALANCE BETWEEN DEMAND AND SUPPLY PROGRAMS

Termination of the Special Action Office impairs further maturation of the developing partnership between the supply and demand sides of the drug equation at the Federal, state, and local levels of Government. The National Institute on Drug Abuse (NIDA) has assumed technical leadership in drug abuse prevention; it is, however, inherently precluded from providing Government-wide program leadership because of its organizational location in the fourth tier of DHEW. In FY-76, no high-level full-time mechanisms will exist to provide demand sector representation in Federal drug program issues and policy and define an integrated demand position. This will result in diffusion of policy and priorities in the demand sector of Federal drug program activity. Current emphasis on improving the criminal justice and correctional systems' collaboration with offender treatment and rehabilitation initiatives will abate. Similarly, budgeting for demand programs will receive far less emphasis, because of the submerged location of the drug abuse prevention functions in the traditional health functions of departments and agencies.

INSUFFICIENT PROGRESS IN REHABILITATION

There is an urgent need for specific vocational-rehabilitation programs for ex-addicts. Current program data show that almost half (47.6%) of the Federal treatment clients are neither employed nor in training or education programs. Since more than 80% of Federal treatment clients are over 18 years old, and most are males, the fact that half of all clients in treatment are not employed or in the process of gaining skills suitable for employment causes considerable concern.

The need for specific vocational-rehabilitation programs for ex-addicts is not being met by the general Federal, state and local providers of manpower services. In the legislative history of the Vocational Rehabilitation Act of 1973, for example, specific reference was made to addicts and alcoholics as being provided for by other Federal programs and thus not to be considered as target populations for that Act's funds. The Department of Labor, the Social and Rehabilitation Service, Law Enforcement Assistance Administration, Bureau of Prisons, and the Veterans Administration, all fail to specify ex-addicts as a priority target group for vocational-rehabilitation programs. The Comprehensive Employment and Training Act of 1973 furthered the decentralization of responsibility for job training and employment opportunities to locally elected officials, but failed to specify ex-addicts as a target group. Legislative and administrative practices have clearly left responsibility for provision of vocational-rehabilitation services for ex-addicts to drug abuse treatment programs.

Much remains to be done in this area. Innovative models are being tested in New York City, Philadelphia, Detroit, Boston and the District of Columbia. But innovation without follow through is not sufficient, nor is a wealth of departmental resources effective, if not properly coordinated and directed. The problem data is current and the alarming percentages will remain constant unless the rehabilitation resources currently available are made more responsive.

THE URINALYSIS ISSUE

Suspension of all urinalysis testing on July 18, 1974 has left the Department of Defense without a scientific measure of the level of drug abuse within the Armed Forces and has eliminated the urinalysis test as a means of early detection and referral to treatment. The net effect has been to encourage experimental or other drug use by eliminating the deterrent power of the testing screen. Because of this Office's broad program authority and role of budget advisor to DoD, a prompt response to the recission of this critical element in DoD's program was possible and momentum to the decision process has resulted. At this time, the issue of resumption of the urinalysis testing program within the Department of Defense is not resolved.

INTERNATIONAL EFFORTS

The international arena, although penetrated by the Special Action Office, still lacks development in many critical areas. The most important unresolved issue is definition of the posture and responsibilities of the Federal health community in international drug matters. This is necessary to maintain and advance the balance which should exist between the demand and supply policies of the United States regarding international drug abuse efforts. Clarification is also required of the international drug abuse role of DHEW, the State Department, and the Department of Defense.

In addition, a greater sharing of knowledge and expertise in the drug abuse health arena between the United States and foreign governments is required, not only to promote a balanced position of the United States in drug matters, but also to aid foreign governments in instituting similarly balanced drug control programs.

POSSIBLE CONSOLIDATED MANAGEMENT OF FEDERAL DRUG AND ALCOHOL ABUSE PREVENTION PROGRAM ACTIVITY

In publishing its findings in the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1974, Congress found that:

- Alcohol is one of the most dangerous drugs and the drug most frequently abused in the United States.

- Alcohol abuse is found with increasing frequency among persons who are multiple-drug abusers and former heroin users who are being treated in methadone maintenance programs.

Responding to a growing awareness of the relationship of drug and alcohol abuse among individuals, and at the request of the Special Action Office, the Veterans Administration initiated a sizable pilot project to test the feasibility of treating alcohol and drug dependent patients together in the same setting. Results of these projects will have great implications for not only the Veterans Administration, but also the Department of Health, Education, and Welfare, the states, and local units of Government in planning the treatment of drug or alcohol dependent persons. If the outcome of the combined treatment is favorable, the results will carry program and fiscal implications for the entire alcohol and drug dependence treatment field in planning future treatment approaches. Federal management of alcohol and drug abuse prevention program activity is separate in spite of the organizational capstones in DHEW, VA, and DoD which combine the two organizationally. If consolidation is desirable, executive-level coordination will be necessary to assure responsive action in the existing bureaucracies.

RURAL DRUG ABUSE

Drug abuse in rural areas is becoming increasingly severe; this is another striking example of the urgent need for stepped-up prevention activities to respond to the changing phenomenon of drug availability. For the past three years, the Federal focus, of necessity, has been directed toward epidemic heroin use in our cities. As efforts to promote a Federal-state partnership in drug abuse have succeeded, different kinds of drug abuse problems have been revealed in rural areas. For example, in one state where treatment is largely unavailable because of community attitudes, known abusers are given a bus ticket to an adjacent state where treatment services are provided.

Treatment models tested in urban environments are not generally successful when applied to rural settings. Geography in terms of distance, and terrain make stationary treatment inaccessible. New approaches which recognize the transportation, limited manpower and abuse pattern factors involved in rural drug abuse service delivery must be developed and applied.

C

OPTIONS

The full range of alternatives has been reviewed to determine if each provides the requisite authority to direct Federal action, the organizational flexibility to identify and respond to major changes in Federal program direction, and the management capability to coordinate responsive program action. There are variations and combinations of options which might be acceptable; those analyzed below represent the major approaches:

OPTION #1: Propose legislation to extend the Special Action Office in an expanded form for four years, mandating a wider range of policy, program, and technical responsibilities in the area of drug abuse prevention.

Advantages:

- Signals a higher priority for drug abuse prevention than currently exists.
- Continues function under direction of a Presidential appointee within the Executive Office of the President.
- Provides both the visibility and authority necessary for a policy and coordination role.
- Reestablishes a capability for detailed program authority to respond to local requirements.
- Preserves a capability to closely monitor and quickly respond to specific changes in the drug abuse problem.
- Balance which has been created between drug abuse law enforcement and prevention functions is more nearly maintained.

Disadvantages:

- Agency functions would need to be clearly defined to prevent overlap with the National Institute on Drug Abuse.
- Maintains an additional organization within the Executive Office of the President.
- Requires additional staffing and budget authority.
- Renewal legislation requires Congressional approval.

OPTION #2: Propose legislation to maintain the present organization and function of the Special Action Office for four years as the Office of Drug Policy within the Executive Office of the President.

Advantages:

- Sets forth national drug abuse matters as a continuing priority of the Administration.
- Continues function under direction of a Presidential appointee within the Executive Office of the President.
- Retains authority necessary to make policy and coordinate Federal level responses to complex issues.
- Existing organizational capability is retained.
- Ability to monitor and respond to national drug abuse trends is preserved.
- Modest budget required to maintain capability and function; special program budget authorities are eliminated.
- Balance which has been created between drug abuse law enforcement and prevention functions is more nearly maintained.

Disadvantages:

- Maintains additional organization within the Executive Office of the President.
- Renewal legislation requires Congressional approval.

OPTION #3: Vest drug abuse prevention policy-making and coordination authority in the National Institute on Drug Abuse (NIDA) and appoint the Director, NIDA, as Special Advisor to the President on Drug Abuse Matters.

Advantages:

- Maintains some visibility for the problem of drug abuse and assures a degree of input into national policy decisions.

- ° Publicly designates an identifiable spokesman for drug-related issues.
- ° Establishes policy-making and coordination authority in the agency which currently has major civilian treatment, research and demonstration functions.

Disadvantages:

- ° Signals a lower priority for drug abuse prevention matters.
- ° Increases difficulty in effecting important policy and coordination activities outside of DHEW because of lead agency's relatively lower position in the Federal structure, e.g., DEA, LEAA, VA, DoD and DoL are on higher levels.
- ° Developing and proposing the required legislation is time consuming.
- ° Discards the organizational expertise of the Special Action Office in policy development and multi-agency coordination.

OPTION #4: Vest some portion of the policy-making and coordination role of the Special Action Office in the Office of Management and Budget.

Advantages:

- ° Can be implemented concurrently with other options.
- ° Maintains policy and coordination functions within the Executive Office of the President.
- ° Establishes the function in the same agency where budget decisions are made, providing an overview helpful in coordinating program efforts and assigning priorities.

Disadvantages:

- Signals lower priority for drug abuse matters by relegating policy responsibility to a unit within OMB not headed by a Presidential appointee.
- Policy and program authorities are contrary to the traditional legislated functions of OMB.
- Requires legislation to provide policy and program direction authority for OMB.
- Discards the organizational expertise of the Special Action Office in policy development and multi-agency coordination.

OPTION #5: Establish an inter-agency committee or special task force to deal with drug abuse coordination and policy.

Advantages:

- Can be established administratively.
- Provides forum for information exchange.
- Eliminates drug abuse prevention policy hierarchy and retains traditional program automomy in participant departments and agencies.

Disadvantages:

- Committee tactic signals a lower priority for the drug abuse problem.
- Committees or task forces usually have only advisory authority.
- Committees or task forces which meet intermittently cannot effectively implement policy or assume continuing program coordination responsibility in long-term complex and dynamic problems.

° Committee tactic usually precludes prompt and effective action because of requirement for scheduled and lengthy deliberation and decentralized review.

OPTION #6: Appoint the Director of the National Institute on Drug Abuse to the position of Special Advisor to the President (or Secretary of DHEW) for drug abuse prevention matters.

Advantages:

° Maintains some visibility for the problem of drug abuse and assures a degree of input into national policy decisions.

° Can be executed administratively.

° Publicly designates an identifiable spokesman for drug-related issues.

Disadvantages:

° Signals a lower priority for drug abuse prevention.

° Increases difficulty in effecting important policy and coordination activities outside of DHEW because of NIDA's relatively lower position in the Federal structure, e.g., DEA, LEAA, VA, DoD, DoL are on higher levels.

° Discards the organizational capability of the Special Action Office in policy development and multi-agency coordination.

OPTION #7: Incorporate Federal drug abuse prevention program direction within the Office of the Vice-President.

Advantages:

° Maintains a high level of visibility for the problem of drug abuse and assumes a degree of input into national policy decisions.

- Can be administratively achieved.
- Has necessary overview position to recommend program priorities and informally assure coordination of agency efforts.

Disadvantages:

- Requires staff knowledgeable of complex drug abuse issues to assist in policy formulation and coordination.
- Enlarges the staff of the Office of the Vice-President.
- Discards the organizational expertise of the Special Action Office in policy development and multi-agency coordination.

OPTION #8: Establish a special committee for drug abuse prevention matters which would function under the aegis of the Domestic Council and be chaired by the Director of the National Institute on Drug Abuse.

Advantages:

- Can be administratively achieved.
- Provides some visibility and has access to a decision-making and policy-setting group.

Disadvantages:

- Signals a lower priority for drug abuse prevention.
- Committee tactic does not respond promptly and effectively to the rapidly changing drug problem because of intermittent meetings.
- Policy implementation and coordination would be difficult to achieve without specific authority and mandate to intervene in inter-agency issues and program operations.
- Discards the organizational capability of the Special Action Office in policy development and multi-agency coordination.

OPTION #9: Let the Special Action Office for Drug Abuse Prevention's legislation expire on June 30, 1975 and take no action to provide for continuation of its functions.

Advantages:

- Elimination of an office from the Executive Office of the President.

Disadvantages:

- Signals a drastic reduction in the priority of the drug abuse problem.
- Leaves Federal and state drug abuse prevention efforts without a national leadership office to set policy, provide coordination and respond to changes in the drug abuse situation.
- Without coordination and direction, agencies might become fragmented and duplicative in their drug abuse prevention efforts.
- Further development of the balance between law enforcement and prevention in the coordinated attack on drug abuse would be impeded by splintering drug abuse prevention program direction and leadership among departments and agencies.
- Since drug abuse impacts on other Federal program functions (police, courts, hospitals, welfare, unemployment, treatment, etc.) and fluctuates rapidly, the diffusion of program authority will probably be reflected in disjointed patchwork priority setting and increasing costs in other programs.

D

MESSAGE

From

THE PRESIDENT OF THE UNITED STATES

Transmitting

A draft of proposed legislation to provide for continuing coordination of Federal policy in drug abuse prevention, including research and treatment, and for other purposes.

To the Congress of the United States:

In a Presidential message transmitted to the Congress more than three years ago, "fragmentation, competing priorities, and lack of communication" were blamed for the failure of the Federal Government to come to grips with the problem of drug abuse. As an alternative, the creation of a Special Action Office for Drug Abuse Prevention was proposed to provide high level coordination and policy direction. By four successive, unanimous record votes, the Congress expressed its emphatic agreement with this concept.

Now, on the basis of three years' experience, there seems little doubt that the concept is indeed a sound one. The relatively modest costs of operating the Office have been returned many times over in improvements in the effectiveness and efficiency of Federal and State drug abuse prevention programs. In order to preserve and build on this achievement, however, legislation is needed to authorize the continued operation of the Office, a need which recent trends make felt with special force.

The programs of the Federal Government dealing with drug abuse fall into two distinct categories. One, often referred to as the supply side, is aimed at reducing the availability or supply of drugs by interdicting the illicit drug traffic. The other, involving the so-called demand side, is concerned with supporting treatment, rehabilitation, and prevention measures aimed at reducing the demand for drugs. The supply interdiction functions have been substantially consolidated within the Drug Enforcement Administration of the Department of Justice. But the

necessary diffusion of the prevention and treatment responses among the Departments of Health, Education and Welfare, Defense, Labor and other agencies, precludes a comparable consolidated administrative structure on the demand side. Even the consolidation of civilian treatment and education programs within HEW would not permit the exercise of effective and necessary leadership with regard to comparable programs operated by the Department of Defense, Veterans' Administration and the Bureau of Prisons, as well as the important roles of agencies such as the Civil Service Commission and the Department of Labor. Some central office must continue to assume responsibility for demonstrating new methods of treatment, rehabilitation, and prevention; coordinating the adoption and implementation of worthwhile programs by the other Departments; and providing a high level marshalling of health concerns in the formulation of government policy.

Past experience has amply and repeatedly demonstrated the need for such leadership, a need which constitutes a compelling rationale for the extension, with modifications, of Public Law 92-255. Without it, a reversion to the chaos which characterized the response of the State and Federal governments alike prior to 1972 seems all but inevitable. The accomplishments of the Special Action Office over the past three years, some of which are only now coming to fruition, have been substantial. But in part because of their novelty, their viability if suddenly deprived of high level support and leadership is open to question. The more significant of these achievements may be summarized as follows:

Directed expansion of the Federal treatment capacity from 16,000 slots in 36 Federally-supported treatment programs to 128,000 civilian and military slots in over 1,000 Federally-supported programs.

Provided leadership in fashioning legal guidelines for treatment which accommodate societal interests and the rights of the individual.

Established communication and coordination between the criminal justice system and the health care delivery system at the Federal as well as the State levels.

Sponsored or developed Federal and private research capabilities leading to development of long-acting treatment agents and improved treatment techniques for heroin addiction.

Improved responsiveness and efficiency with which Federal treatment assistance is authorized and distributed.

Successfully promoted development of effective state mechanisms for management of prevention functions at the State and local levels.

Improved the effectiveness of international efforts, both civilian and military, for reducing the incidence and spread of drug abuse among American citizens overseas.

Developed innovative and effective public education and prevention programs and guidelines.

Consolidating the gains described above and building on a solid foundation of institutional experience are tasks which call for steady, continuing effort rather than the initiation of a crash program. Reflecting this change of emphasis in the primary mission of the Office, the legislation submitted herewith would change its name from "Special Action Office for Drug Abuse Prevention" to "Office of Drug Policy." Consistent with this concept, programmatic responsibility for pharmacological research would be eliminated, although the responsibility for policy would, of course, remain. The direct spending limitation of 10 per centum of funds appropriated for the Special Fund for development and demonstration would be replaced by a flat dollar limitation of $2,000,000, thereby maintaining an effective prohibition on substantial programmatic operations without crippling the capacity to innovate.

An overall ceiling of $20,000,000 per year would be established on appropriations authorized for the Office for succeeding fiscal years, as contrasted with authorizations totalling $82,000,000 which existing law provides for the current (1975) fiscal year. Finally, the life of the Office (and of the authorizing legislation) would be extended to September 30, 1979. Without legislative action, the Office and all statutory authority now conferred on it will terminate on June 30, 1975, with no provision for the transfer of such authority to any other agency.

The need for legislative action is underlined by ominous trends which have become increasingly apparent in recent months. As contrasted with what appeared to be hopeful trends a year ago, we can no longer say that heroin addiction and drug abuse in the United States are declining. In various regions of the country, heroin addiction is on the rise, being fed by a continuing influx of Mexican heroin, and further threatened by a resumption of opium production in Turkey. Texas, California, and Oregon have had to request more Federal funds for additional treatment capacity. Illinois, Pennsylvania, and Massachusetts, identified by the Drug Enforcement Administration as major Mexican brown heroin trafficking centers, report increased demand for treatment. Waiting lists for treatment are appearing in California, Colorado, Florida, Illinois, Pennsylvania, Tennessee, Texas, Minnesota, Michigan, and Montana.

Nationally, and in every region of the United States, hospital emergency room treatment for heroin overdose has increased dramatically every quarter since September, 1973. Specifically, the period July-September, 1974 has shown an overall increase of 66% above the July-September, 1973 quarterly level. In the Northeast, Central, and Southwestern regions, this growth has been the most severe.

These disturbing trends have been accompanied by an alarming increase in the purity of heroin distributed in the criminal wholesale market. Since the first quarter of 1974, wholesale purity has increased from 22.8% to 32.9%. At the same time, street-level purity has declined while price has increased nationally, thus signaling greater

street-level demand for heroin. Paralleling the higher costs of street heroin has been an increase in income-producing crime in almost every state.

In June and July, 1974, the Special Action Office dispatched teams to investigate the spread of heroin use in smaller population centers. It was known that heroin use had peaked in some of the larger cities in 1968-69, but from treatment data, it appeared that heroin use might now be spreading to smaller cities. The investigation showed this to be true in a disturbing number of instances. New heroin use is increasing in cities as widely separated as Eugene, Oregon, Des Moines, Iowa; and Jackson, Mississippi. If this situation is common to a large number of similar cities throughout the country, and if it is fed by a continuing influx of Mexican heroin, the United States is experiencing a significant increase in incidence of heroin addiction.

Other drug problems also merit our concern. Thirteen million Americans are estimated to be regular users of marijuana. Recently, new evidence has been presented indicating potentially significant medical problems which may be encountered from long-term or moderate to heavy use of marijuana. Specifically, this research has indicated scientific evidence of changes in basic cellular mechanisms; adverse immunologic and genetic effects; accumulation of the active ingredients of marijuana in the fatty tissues and certain parts of the brain; and more adverse effects than from regular cigarette smoking on the tissues of the lungs. Occasional or light use produces significant temporary effects on memory and coordination sufficient to affect driving and other motor skills. Coupled with this new evidence, existing data show that more than 15% of the persons in all Federally-funded treatment programs are being treated for problems with marijuana or hashish; this statistic is up from 11.2% a year ago.

Reliable nationwide studies show that stimulants and depressants are widely used by the young as well as adults. A recent report from a national survey for the school year 1973-74 indicates that of the students surveyed, over one-third had used synthetic drugs non-medically, and of these, 24% had used barbiturates and 22% used amphetamines. The consequences of such use are severe; consistently, 11% of the total admissions for treatment in Federally-supported programs have been for amphetamine and barbiturate abuse.

In the light of such widespread evidence of the continuing and in some cases growing seriousness and extent of drug abuse, this would be a most unfortunate time to abandon a working institutional framework to assure continuing high-level attention to the problem. Accordingly, I urge early and favorable consideration by the Congress of the attached draft legislation.

The White House, January , 1975

__ Congress
__ Session

A B I L L

To provide for continuing coordination of Federal policy in drug abuse prevention, including research and treatment, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 104 of the Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1104) is amended by striking "June 30, 1975" and inserting "September 30, 1979" in lieu thereof.

Sec. 2. (a) The following provisions of law are each amended by striking "Special Action Office for Drug Abuse Prevention" and inserting "Office of Drug Policy" in lieu thereof:

(1) The heading of title II of the Drug Abuse Office and Treatment Act of 1972 (21 U.S.C., chapter 16, subchapter II), and sections 201, 302, and 408(g) of such Act (21 U.S.C. 1111, 1162, and 1175(g)).

(2) Sections 5313(21) and 5315(95) of Title 5, United States Code.

(3) Sections 303(b)(1) and 303(d) of Public Law 93-282 (88 Stat. 138, 139).

(4) Section 454 of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3750c).

(5) Section 206(a) of the Juvenile Justice and Delinquency Prevention Act of 1974 (42 U.S.C. 5616(a)(1)).

(b) The redesignation provided for in subsection (a) of this section shall not otherwise affect the regulations, grants, contracts, personnel, property, or unexpended balances of appropriations of the agency so redesignated.

Sec. 3. Section 223(c) of the Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1133(c)) is amended by striking "10 per centum" and inserting "$2,000,000" in lieu thereof.

Sec. 4. (a) Section 224 of the Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1134) is repealed, and the table of sections at the beginning of chapter 2 of title II of such Act (21 U.S.C., chapter 16, subchapter II, part 2) is amended by striking the following item: "224. Encouragement of certain research and development."

(b) The repeal made by subsection (a) of this section shall not affect the continuing validity of any grant or contract made thereunder prior to its repeal, and shall not affect the authority of the National Institute on Drug Abuse or any other agency to carry on research.

Sec. 5. Section 214(a) of the Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1123(a)) is amended by adding at the end thereof the following new paragraph:

"(4) For the purposes of carrying out the provisions of this title, there are authorized to be appropriated $20,000,000 for the fiscal year ending June 30, 1976; $5,000,000 for the period July 1, 1976, through September 30, 1976; and $20,000,000 for each of the fiscal years ending September 30, 1977, September 30, 1978, and September 30, 1979."

THE WHITE HOUSE

ACTION MEMORANDUM WASHINGTON LOG NO.: due 1/6

Date: January 4, 1975 Time:

FOR ACTION: Jack Marsh ✓
Bob Hartmann
Ken Cole
Bill Baroody

cc (for information):

FROM THE STAFF SECRETARY

DUE: Date: Monday, January 6, 1975 Time: NOON

SUBJECT:

O'Neill memo (12/30/74) re:
Special Action Office for Drug Abuse Prevention extension

ACTION REQUESTED:

____ For Necessary Action
____ Prepare Agenda and Brief
__X__ For Your Comments
__X__ For Your Recommendations
____ Draft Reply
____ Draft Remarks

REMARKS:

Agree with OMB view on expiration, and prefer options 5 or 6. Would like to study more material in re these two choices (Dem Council v. HEW)

JM

PLEASE ATTACH THIS COPY TO MATERIAL SUBMITTED.

If you have any questions or if you anticipate a delay in submitting the required material, please telephone the Staff Secretary immediately.

Jerry H. Jones
Staff Secretary

[redacted]

THE WHITE HOUSE
WASHINGTON

January 7, 1975

TO: JERRY JONES

FROM: WILLIAM J. BARODY, JR.

I agree with Ted's comments on the attached memo.

THE WHITE HOUSE

WASHINGTON

January 7, 1974

MEMORANDUM FOR: BILL BARODY, JR.

FROM: TED MARRS

SUBJECT: Special Action Office for Drug Abuse Prevention Extension

The arguments and option are well displayed.

There is undue hazard in the assumption that "major substantive policy decisions have been made." In my opinion this is a volatile and potentially explosive issue on a day to day basis. Option 7 would be inadequate. To have that day to day responsibility at a reasonably high level and insure coordination without concurrently involving the White House on a day to day basis, we could live with Option 6 with a charter designed to overcome the described disadvantages insofar as possible.

To solidify recent gains, eliminate public criticism and involve Congress in the decision (as I think they should be) Option 2 is the best.

Attachment

LOG NO.:

Date: January 4, 1975 Time:

FOR ACTION: Jack Marsh
Bob Hartmann
Ken Cole
Bill Baroody ✓

cc (for information):

FROM THE STAFF SECRETARY

DUE: Date: Monday, January 6, 1975 Time: NOON

SUBJECT:

O'Neill memo (12/30/74) re:
Special Action Office for Drug Abuse Prevention extension

ACTION REQUESTED:

____ For Necessary Action

____ Prepare Agenda and Brief

__X__ For Your Comments

__X__ For Your Recommendations

____ Draft Reply

____ Draft Remarks

REMARKS:

PLEASE ATTACH THIS COPY TO MATERIAL SUBMITTED.

If you have any questions or if you anticipate a

THE WHITE HOUSE

ACTION MEMORANDUM WASHINGTON LOG NO.:

Date: January 4, 1975 Time:

FOR ACTION: Jack Marsh
Robert T. ~~Bob~~ Hartmann ✓
Ken Cole
Bill Baroody

cc (for information):

FROM THE STAFF SECRETARY

DUE: Date: Monday, January 6, 1975 Time: NOON

SUBJECT:

O'Neill memo (12/30/74) re:
Special Action Office for Drug Abuse Prevention extension

ACTION REQUESTED:

____ For Necessary Action
__X__ For Your Recommendations
____ Prepare Agenda and Brief
____ Draft Reply
__X__ For Your Comments
____ Draft Remarks

REMARKS:

I concur with O'Neill

RTH

PLEASE ATTACH THIS COPY TO MATERIAL SUBMITTED.

If you have any questions or if you anticipate a