PREPARED BY
THE STRATEGY COUNCIL ON DRUG ABUSE

FEDERAL STRATEGY FOR DRUG ABUSE AND DRUG TRAFFIC PREVENTION 1979

Prepared for the President by the Strategy Council on Drug Abuse

Pursuant to

The Drug Abuse Office and Treatment Act of 1972

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Preface

The **1979 Federal Strategy for Drug Abuse and Drug Traffic Prevention** represents a comprehensive approach to the Nation's drug abuse problem and will serve as the foundation from which the Federal Government can proceed with renewed resolve to reduce the serious effects of drug abuse in this country. This Strategy, prepared by the Strategy Council on Drug Abuse, reflects the concerted views of: (1) the Departments and agencies involved in the Federal drug control and prevention effort; (2) the Strategy Council members from the private sector; (3) a number of public interest groups involved in this effort; and (4) key members of Congress who have shown dedicated support to the elimination of drug abuse. A sincere appreciation is extended to all of the individuals representing these offices, for without their expertise and professionalism this Strategy could not have been possible. An additional word of thanks is extended to the Drug Policy Office of the Domestic Policy Staff which provided the professional staff to the Strategy Council in developing this Strategy.

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I. Introduction

The Federal Strategy 1979 is the latest in a series of documents which describe a comprehensive strategy for Federal activities relating to drug abuse prevention and control. The Drug Abuse Office and Treatment Act of 1972 first created the Strategy Council on Drug Abuse, and required that Council to publish a **Federal Strategy for Drug Abuse and Drug Traffic Prevention.** The Strategy Council is composed of the Attorney General; the Secretaries of State, Defense, Treasury and Health, Education, and Welfare; the Administrator of Veterans Affairs; the Director of the Office of Management and Budget; and six members from outside the Federal Government. The first Strategy was published in 1973, and three others followed. In addition, the **White Paper on Drug Abuse**, a report to the President from the Domestic Council Drug Abuse Task Force, was released on September, 1975.

President Carter announced the revitalization of the Strategy Council in his Message to the Congress on Drug Abuse of August 1977, and the Council began to prepare and publish the legislatively mandated Federal Strategy. The formulation of Federal policy for drug abuse prevention and control has been a dynamic process. With the assistance of the Federal agencies and departments, the Members of Congress, private citizens and organizations, we have been able to develop, adjust and refine policy in an evolutionary way, as both the drug abuse situation and our knowledge of how to deal with it have changed. Strategy 1979 builds upon some statements contained in the last Strategy but makes important changes in others, either in response to an altered environment, or as policy redirection.

Strategy 1979 reaffirms the position of earlier Strategies that total elimination of the drug abuse problem is unlikely. President Carter, in his Message on Drug Abuse said:

> "No government can completely protect its citizens from all harm--not by legislation or by regulation, or by medicine or by advice. Drugs cannot be forced out of existence; they will be with us for as long as people find in them the relief or satisfaction they desire. But the harm caused by drug abuse can be reduced. We cannot talk in absolutes—that drug abuse will cease, that no more illegal drugs will cross our borders—because if we are honest with ourselves we know that it is beyond our power. But we can bring together the resources of the Federal Government intelligently to protect our society and help those who suffer."

The Strategy 1979, therefore, sets two realistic policy objectives: first, to discourage all drug abuse—including the abuse of alcohol; and second, to reduce to a minimum the health and social consequences (such as deaths, injuries, crime, broken families and deteriorating neighborhoods) of drug abuse when it does occur.

Strategy 1979 reflects a three-part program to reduce the negative effects of drug abuse: (1) treatment, rehabilitation and prevention; (2) domestic drug law enforcement; and (3) international narcotics control. The overall program is intended to provide balanced and flexible means to reduce the supply of illicit drugs, discourage use, and make treatment available to drug abuse victims.

Early Federal programs for dealing with the drug problem tended to focus on reducing the domestic supply of the "most dangerous" illicit drugs. The following factors were considered in judging the dangerousness of a given drug:

1. The likelihood that a user will become a compulsive user, i.e. either physically or psychologically dependent;
2. Severity of adverse consequences of use; and
3. The size of the core problem in the United States.

The assumption was that if the most dangerous drugs were difficult to obtain, risky and expensive, fewer people would experiment with drugs; the few who did experiment would become chronic, intensive users; and many current users would stop.

Our experience with domestic supply reduction efforts has shown that the lack of availability mainly affects the new user, who behaves much like a consumer of other market items. The user takes drugs in the expectation of personal or social satisfaction of some kind. If a drug becomes too expensive or hard to get, the consumer is inclined to find some other substance or activity to satisfy that goal. By reducing the availability of the more dangerous drugs, and of illicit drugs in general, one can channel new users away from the most hazardous substances which, through their pharmacology, tend to encourage compulsive use. Compulsive, chronic drug users, however, tend to use whatever psychoactive substance is available. When one substance becomes unavailable, they switch to another, or to a combination which they use in the same extreme, self-destructive pattern. Therefore, while domestic supply reduction efforts are critical to our strategy for preventing new use, treatment and rehabilitation programs for chronic drug abusers are also necessary.

Federal treatment, rehabilitation and prevention programs fill this need. Strategy 1979 supports the concepts of previous Strategies that domestic supply reduction efforts must be coupled with domestic treatment, rehabilitation and prevention activities to be effective. Domestic

supply reduction will give priority to those drugs which are pharmacologically most dangerous, or which, because of the extent, intensity and manner of use, cause the most harm in our country. To have a lasting effect and to reach those most in need of assistance, domestic treatment, rehabilitation and prevention, however, should focus primarily on compulsive drug-taking behavior rather than on the drugs themselves. Chronic compulsive drug abusers of any drug are those most in need of treatment and they are distinguished primarily by the behavior they display in relationship to society in general, and only secondarily by the particular drug which happens to be involved.

Strategy 1979 emphasizes an international program as a very important element. Previous Strategies conceptualized the Federal program as "supply reduction" and "demand reduction", with international components of each. We have found, however, that the international program is a critically important part of our long-range strategy, and that priorities within the international arena are set differently from our domestic supply and demand reduction priorities. Therefore, both for clarity and emphasis, the international program merits separate consideration.

To summarize our domestic priority system, domestic supply reduction efforts rank drugs as they are used in the United States according to their potential for harm, particularly in causing deaths and injuries, and assigns priorities to them accordingly. Our domestic treatment and prevention efforts focus on behavior, with consideration of the drug involved and its potential for causing physical or emotional harm. These priorities address only the health and social consequences of psychoactive drugs as they are used in the United States and do not distinguish between drugs manufactured by legitimate pharmaceutical companies and those which originate in the illicit distribution system. In addition, a specific drug may rise and fall in the priority scale following changes in patterns or drug availability.

International supply reduction requires a different orientation. Here two factors must be considered: (1) the probability that the drug will cause severe health and social consequences in the country where it is used; and (2) the economic, political and social damage done to source, transit and destination countries by the illegal drug traffic.

Although other countries probably use pharmacological criteria similar to our own in ranking health consequences, they may arrive at different orders of drugs because use patterns vary. The priorities of destination countries must be considered as part of the first factor. The economic damage done to the world community and the United States resulting from international drug trafficking is a separate factor. The pharmacological distinctions, among heroin, cocaine and marihuana and the patterns of use are only part of the concern when million dollar drug

shipments are being moved from one country to another. The vast profits, whether derived from heroin or marihuana, result in corruption of politicians and law enforcement officers, the undermining of legitimate market economies in favor of drug-based economies, the change in land use from needed food production to narcotic growth, and the creation of an affluent drug trafficking elite immune from the law. All of these factors must be weighed.

For example, heroin is a primary drug of concern because of its likelihood to cause severe health and social consequences to those who use it and those who are affected by it. It is also of concern because of its high price per unit volume, which causes even small amounts to be extremely valuable. The abuse of cocaine and the expanding international traffic in cocaine continue to be of great concern to the Federal Government. Strategy 1979 considers cocaine to be a priority drug exceeded only by heroin and the barbiturates. Large shipments of marihuana are also of concern because of the amount of money generated by the illegal trafficking and smuggling of the drug.

The objectives of our international/supply reduction strategy are: to reduce the production of trafficking in heroin, the most dangerous drug, entering the United States; to eliminate the greatest quantities of illicit drugs at their source; to prevent illegal drugs from entering the United States while assisting other nations to strengthen their own drug controls; to reduce the illegal production and trafficking of the most dangerous drugs by increasing the risks; to reduce the illegal production and trafficking of the drugs which provide the greatest financial incentive and support for the networks which traffic drugs into the United States; to ensure a balanced, orderly market for licit narcotics drugs needed for medical and scientific purposes; and to develop within the international community high priority for cooperative drug abuse treatment and prevention, as well as drug control efforts.

International demand reduction also requires a different orientation. Here again, we must consider the priorities of other nations, and not focus exclusively on those illegal drugs of primary interest to the United States. Each country concentrates on its own priorities. However, if we expect other countries to cooperate with us in combatting production of and trafficking in our domestic priority drugs, then we must also assist them with their priorities. The global nature of the drug abuse problem dictates a need for such cooperation. Priorities vary not only from country to country, but from year to year, and our international strategy must be flexible enough to adjust to these variations, and to work cooperatively with other nations to deal with all of our problems. For example, while the United States views heroin as the most dangerous drug, in Mexico the drugs in current use that

appear to cause the gravest health and social consequences are the inhalants and marihuana.

Finally, Strategy 1979 recommends continuing Executive Office oversight of the three parts of the Federal program which, taken together, span nearly all of the Federal Departments and several independent agencies. The problems of drug abuse in America and around the world are both fluid and complex. A broad spectrum of issues and priorities must be weighed, including domestic and international health, social, medical, criminal justice, and economic considerations. In addition, drug policies must be put in perspective with other national policies and goals. Executive Office oversight has proven the most efficient way to maintain this perspective, as well as consistent policy formulation and interdepartmental coordination.

The Strategy Council on Drug Abuse, composed of seven Cabinet Officers and six public members, shall continue to participate in the planning necessary to acheive the objectives of a comprehensive, coordinated long-term Federal Strategy to combat drug abuse. A special effort will be made in 1979 to increase the participation of the public sector members through supplemental meetings to provide the opportunity for the additional exchange of ideas and their active involvement in the development of Federal policy.

During the past year, the Drug Policy staff which is now part of the Domestic Policy Staff in the Executive Office of the President, has developed an effective on-going policy coordination mechanism called the Meeting of the Principals. These bi-weekly meetings involve the Associate Director for Drug Policy and the heads of the five agencies that are most immediately involved in drug control issues; the Senior Adviser and Coordinator for International Narcotics Matters to the Secretary of State; the Director of the National Institute on Drug Abuse; the Administrator of the Drug Enforcement Administration; the Commissioner of the U.S. Customs Service; and the Commandant of the U.S. Coast Guard. These meetings, chaired by the Associate Director for Drug Policy, provide an opportunity for the exchange of information and advice and the discussion of operating problems and matters of mutual interest. They have also proved to be a highly effective inter-agency coordinating mechanism.

Before moving to a detailed discussion of the Federal Strategy in each area--domestic treatment, rehabilitation, and prevention, domestic drug law enforcement, and the international program—we will review the nature and extent of the drug problem in the United States, and give a brief sketch of selected foreign drug abuse problems to illustrate international trends.

II. Nature and Extent of the Drug Problem

A. The United States

1. **Definitions.** Drug abuse in the United States has evolved from an acute to a chronic problem. The heroin epidemic of the late 1960's has subsided, and the sudden explosion of increasing drug use also seems to have abated. However, the rates of psychoactive drug consumption continue to be high, crossing racial, cultural, social and economic lines, and involving millions of people using hundreds of substances.

It is apparent from the magnitude of annual drug consumption in the United States that the use of drugs, including alcohol, has become an integral feature of our culture. In 1977, 280 million prescriptions for psychoactive drugs were written. The annual per capita consumption of alcohol in 1976 was 2.65 gallons for every American 15 years or older. On the illicit end of the drug spectrum there are an estimated 450,000 Americans who use heroin daily, nearly 10 million Americans who have abused cocaine, and over 43 million who have used marihuana.

Not all of the individuals who use these drugs experience negative health or social consequences, but many do. Strategy 1979 defines the drug problem in terms of "drug abuse" and "drug misuse".

Drug abuse is the non-therapeutic use of any psychoactive substance, including alcohol, in such a manner as to adversely affect some aspect of the user's life.

The substance may be obtained from any number of sources--by prescription, from a friend, over-the-counter, or through the illicit market. The use pattern may be occasional or habitual.

Drug misuse is the inappropriate use of drugs intended for therapeutic purposes.

This includes inappropriate prescribing or use of drugs resulting from: (a) lack of knowledge on the part of the physician; (b) errors in judgment by the physician, including drugs prescribed when there is a preferable or safer alternative treatment (such alternatives may include non-drug treatment); (c) use by a patient of a prescription drug not under the supervision of a physician or not in accordance with the instructions of the physician or the information provided with the drug; and (d) self-

*Updated Excerpt from **Drug Use Patterns, Consequences and the Federal Response: A Policy Review**, March 1978, Office of Drug Abuse Policy.

medication by a patient with a drug (over-the-counter or prescription) inconsistent with the label information.

The drug problem is the sum of the negative medical, social and economic consequences of drug abuse and misuse as they affect the user, the user's family, and the community at large.

2. **Costs to the individual.** A few points should be kept in mind when evaluating the consequences of drug misuse and abuse. There are many different patterns of use for most drugs. Some people use psychoactive drugs only once or twice in a life-time; others use them sporadically; some use them regularly but not in large quantity; some use them regularly in large quantity; and so on. In addition, some drugs, because of their pharmacology and potency, may rarely cause harm; others may have a high probability of producing harmful effects.

For any given drug the consequences of use will vary with these different patterns, and the time-lag between drug use and any evidence of damage can vary from minutes to decades. The longer the time-lag, the more difficult it becomes to establish the link between use and impact. The negative effects often are not universal but are highly probable. For example, not everyone who smokes cigarettes gets cancer but in those who do, the connection between smoking and lung cancer is clear. To discover these connections, researchers may need to study large numbers of users over a long period of time. For example, we are only beginning to understand the possible consequences of marihuana use and will undoubtedly learn more in the next few years. Serious consequences may occur only in certain categories of users, such as heavy users or long-term users.

In addition, the adverse effects of drug use are often due to the use of drugs in combination, particularly depressants and alcohol, and cannot be attributed to a single drug. Negative consequences of drug abuse or misuse range all the way from death or permanent impairment of mental or physical health to more subtle effects. For example, involvement with drugs is likely to affect friendship patterns, which may in turn affect life goals and aspirations, or young people's psychological or social development may be impaired or delayed by chronic intoxication during a period in which they might otherwise have advanced their social skills or knowledge.

3. **Social and Economic Costs.** Another major consequence of the drug problem which must be considered is the heavy financial burden to society. The social burden in terms of economic costs can be quantified by assessing the impact of substance abusers on the health care system, the law enforcement and judicial systems, the employment market, and the general welfare and social services systems. It has been estimated that the approximate social and economic cost of alcohol

abuse alone totals $42.75 billion and the social cost of drug abuse is estimated at $10.2 billion.

These cost estimates do not include the billions of dollars in cash and goods that change hands in the purchase of all types of drugs. Nor do they include the range of intangibles that cannot be priced but which represent the pain of mental and physical debilitation, the destruction of families, the disruption of neighborhoods, and other human suffering associated with drug abuse.

4. **Patterns of Drug Use.** Although there are numerous ways in which individuals can use drugs, there are four primary or basic patterns of drug use:

—Use of medically prescribed or over-the-counter drugs for therapeutic purposes;

—Occasional use of drugs for moderate pleasurable effect;

—Occasional use of drugs for intensive psychoactive effect; and

—Compulsive use of drugs for sustained psychoactive effect and/or to avoid withdrawal symptoms.

In the first category are found those persons who take drugs under a doctor's prescription for legitimate medical reasons and who benefit from so doing. Self-medication of prescription or non-prescription drugs is also included. Self-medication is prevalent among the elderly, and when too many or inappropriate combinations of drugs are taken, it can have negative results. When used correctly, drugs are an essential component of modern medical practice. Of the 1.4 billion prescriptions filled in the U.S. in 1977, approximately 20 percent were for psychoactive drugs. In addition to prescribed medications, billions of over-the-counter drugs are purchased annually for medicinal purposes.

The second type of drug use—occasional use for pleasurable purposes—also involves large numbers of the American population. Such use differs dramatically from use within the medical setting: the environment is different, the motive different, and the individual's perception of his or her activity different. Persons using drugs within the medical context see themselves as patients and the drug as a means of alleviating illness. The occasional drug user, on the other hand, sees himself or herself as a consumer, choosing a drug for its pleasurable effect. This pattern is common to millions of users regardless of the legal status of the drugs involved. Alcohol and marihuana are the obvious examples. Occasional drug use can be harmful, especially if excessive quantities or inappropriate combinations of drugs are taken.

The third category includes those persons who take drugs for the explicit purpose of creating an intensive psychoactive effect. Snorting cocaine or using PCP or LSD falls into this category. Although it is dif-

ficult to determine the number of these users, this kind of drug use not only affects the individual but also his family and the community.

In the fourth category—compulsive use—obtaining and using the drug become the central focus of an individual's life. Compulsive drug users often use combinations of drugs (including alcohol) or switch from drug to drug depending on what is available. Currently under study is the hypothesis that similar reasons exist for compulsive drug use regardless of the specific drug use.

5. **Trends in Drug Misuse and Abuse.** The total list of substances abused in the United States is very extensive and therefore the Strategy addresses only selected psychoactive substances which are prone to abuse.

The following are the major observable trends of drug use and abuse in the United States:

—**Cocaine.** Most Americans who currently use cocaine use it in small quantities and sporadically. Its relatively high cost, which prohibits easy access to the drug, is a contributing factor to that pattern of use. Serious health consequences are seldom indicated in DAWN* data, yet there are certain facts about cocaine which give policymakers great concern. Cocaine is a powerful stimulant. Even when its strength is diluted the average purity is 30 percent. Because its intense effect causes a user to want more, the drug can result in compulsive behavior. In the past three years there has been a statistically significant upward trend in cocaine use by young adults. We will continue to monitor this use pattern and take the necessary steps to reduce the supply of this illicit drug. Cocaine is discussed in more detail in Section VII.

—**Amphetamines.** While amphetamines account for only 1.6 percent of emergency room episodes within the DAWN system, their non-medical use has been rising among young adults. Furthermore, while medical use of amphetamines is declining, there is evidence to suggest that amphetamines are improperly prescribed by some physicians. An estimated eighty-eight percent of amphetamines are prescribed for weight control. There is little evidence to believe that they are effective beyond a 21-day period for most patients. The Federal Government is currently considering the removal of the obesity indication for the amphetamines. The potential for misuse and abuse is significant since chronic consumption of these drugs can lead to tolerance and psychological dependence.

—**Marihuana.** The use of marihuana has been rising steadily in the past decade, and the age of first use has dropped. An estimated one in twenty-

*A Federal monitoring system which records drug-related emergency room episodes, and drug-related deaths (Drug Abuse Warning Network).

five adolescents between 12 and 13 years old use marihuana monthly.* In the 14-15 year old category, however, this figure rises to an estimated one out of every seven adolescents. Eleven percent of 1978 high school seniors use marihuana daily, which is up from 9.1% last year. These high levels of use among young people are of great concern. Marihuana will be discussed in detail in Section VII.

—**Heroin.** Heroin purity has declined from 6.6 percent in the first quarter of calendar year 1976 to 4.2 percent in the third quarter of 1978. The price per milligram of pure heroin has risen in the same time period from $1.26 to $1.96. This increase in price and decrease in purity is significant because it is generally believed to reflect a decline in availability brought about by international and domestic control efforts. Heroin overdose deaths in 1977 are down 63% from 1976. In more tangible terms, approximately 1,000 fewer people died from heroin overdoses in 1977 than in 1976. During this same time period, emergency room episodes related to heroin declined by 40%. Both heroin-related deaths and emergency room visits are at the lowest reported level since data became available in mid-1973. Current data (September 1978) indicate that the number of heroin addicts has declined since 1975 by 100,000, from 550,000 to 450,000. The data strongly suggest that the heroin problem is decreasing.

—**Methadone:** Methadone began to be widely used for both detoxification and maintenance treatment of narcotic addiction in the early 1970's. Currently some 80,000 clients are receiving treatment. Some clients respond well to methadone, which stabilizes the drug-taking life style of the heroin addict and provides an opportunity for effective counseling and support services. It is important, however, to recognize that methadone treatment is not a panacea, nor is it appropriate for all clients.

Methadone is a factor in a declining but unacceptably high level of methadone-related deaths and emergency room mentions. The total DAWN system reported over 200 such deaths in 1977, of which approximately one-half were in New York City. Also within the past year, DAWN reported an average of 256 methadone-related incidents in emergency rooms each month. It appears that the illegal diversion of methadone does not contribute as much to negative health consequences as it does to the use of methadone in combination with other drugs.

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*Drug Use Among American High School Students 1975-1977", Lloyd D. Johnston, Jerald G. Backman, and Patrick M. O'Malley, University of Michigan under a research grant from the National Institute on Drug Abuse.

—**Alcohol.** Alcohol is the most commonly used and abused psychoactive substance in the United States, and more people abuse it than all other drugs combined. Although it is not known if abuse by women is increasing, alcoholic women are becoming more visible in our society and may be nearly as numerous as alcoholic men. Furthermore, 6.1 percent of all high school seniors consume alcohol on a daily basis. Over 200,000 deaths are reported annually as alcohol-related--a figure which represents nearly 8 percent of all deaths in the United States.*

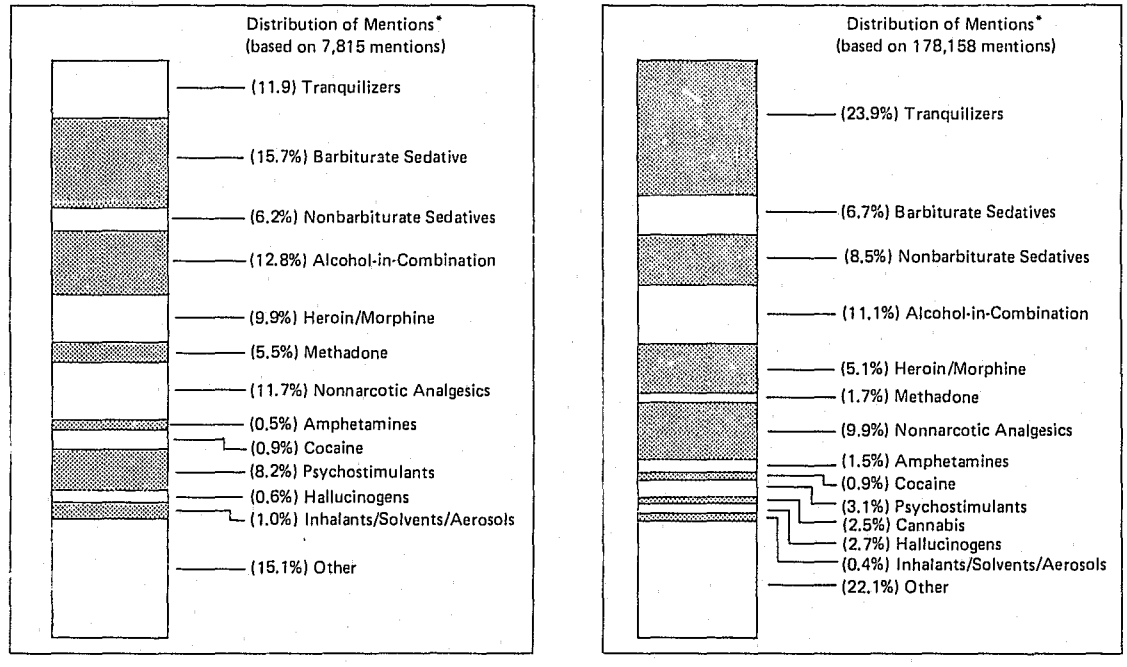
—**Barbiturates.** Twenty percent of the drugs mentioned in connection with deaths, reported to DAWN in 1977, were barbiturates. The category "barbiturate/sedative" is the leading drug mentioned in medical examiner cases, with "alcohol-in-combination" second and "heroin/morphine" third. The major clinical disadvantages of barbiturates include the risk of accidental poisoning or suicide, and the short time required to develop tolerance and physical dependence (addiction). In the case of barbiturates, the physical withdrawal syndrome can be fatal. Many barbiturate-related injuries and deaths involve drugs obtained through a legitimate medical prescription. There is now evidence to show that there are safer, alternative drugs. Since 1972, there has been a 55 percent decrease in barbiturate prescriptions as a result of publicity, reports in medical literature, and a conscious effort on the part of the medical profession and Federal agencies to increase physician awareness of appropriate prescribing practices.

—**Tranquilizers.** Minor tranquilizers are the most frequently prescribed drugs in the U.S.—90 million prescriptions were filled in 1977; however, the trend of use is decreasing. These drugs are considered potent reinforcing substances, with a high potential for misuse and abuse. If abused or misused they can produce emotional or psychological dependence as well as physical addiction.

—**Hallucinogens.** Data show that the use of hallucinogens, especially LSD as used by high school seniors, has steadily declined since 1975. However, recent evidence of increasing supply and demand for the drug PCP is causing concern. PCP will be discussed in detail in Section VII.

*For further information on alcohol and the Federal activities related to alcohol, see **Third Special Report to the U.S. Congress on Alcohol and Health** from the Secretary of Health, Education and Welfare, October 1978.

CHART 1
Dawn Data: Summary of Emergency Rooms and Medical Examiner Reports by Drug January-December 1977



The above percentages are based on data received through August 31, 1978.

*A mention refers to the specific drug or drugs reported per patient on a single visit.

Chart I shows the % of deaths and emergency room mentions, by drugs of abuse: as recorded in DAWN.

Chart 2 illustrates the medical use of each drug, the nonmedical uses, and how many clients are in Federally-funded treatment for abuse.

CHART 2
Fact Chart on Medical and Nonmedical Drug Use and Federally Funded Treatment Clientele

	Medical Use (1977)* (Prescriptions filled annually)	Nonmedical Use (1977)**	Number in Federally Funded Treatment***
Stimulants			
Amphetamines	3,894,000	1,780,000	10,000
Cocaine	13,000[1]	1,640,000	4,000
Cannabis Products			
Marihuana	****	16,210,000	21,000
Depressants-Narcotics			
Heroin	****	550,000	111,000
Other Opiates	52,317,000		10,000
Depressants-Sedatives			
Tranquilizers	89,987,000	1,360,000	4,000
Alcohol	****	92,300,000	17,000
Barbiturates	16,467,000	1,060,000	10,000
Other Sedatives	21,229,000	22,100,000	4,000
Psychedelic/ Hallucinogens		1,400,000 (LSD)	8,000
Others including Inhalants	****	160,000	5,000

*National Prescription Audit.

Nonmedical use of psychoactive substances. National Institute on Drug Abuse, Supplemental Tables: **Population Projections based on the National Survey on Drug Abuse 1977. Washington, D.C., GPO, 1978, 017=024-00748-0.

***CODAP.

****Illegal or data not available.

[1]This is not a reliable indicator since most cocaine is shipped directly to physicians and dentists and not to retail pharmacies.

Chart 3 divides recent nonmedical use by age group and by drug of abuse.

CHART 3
Estimate of Recent Nonmedical Use (in the Past Month) by Age Group, by Drug of Abuse)

	12-17 Years (24,938,000 Persons)	18-25 Years (30,553,000 Persons)	Over 26 Years* (117,266,000 Persons)
Heroin**	***	***	***
Cocaine	200,000	1,110,000	***
Hallucinogens	400,000	610,000	***
Inhalants	160,000	***	***
Stimulants	330,000	760,000	690,000
Sedative/Hypnotics	200,000	860,000	***
Tranquilizers	190,000	730,000	***
Other Opiates	160,000	310,000	***
Over-the-Counter (not reported after 1976)	***	***	***
Alcohol	7,740,000	21,000,000	63,350,000
Marihuana/Hashish	4,110,000	8,300,000	3,800,000

SOURCES: National Institute on Drug Abuse, **Supplemental Tables: Population Projections based on the National Survey on Drug Abuse 1977.** Washington, D.C., GPO, 1978, 017-024-00748-0.

Abelson, H.I., Fishburne, P.M. and Gisin, I., **The National Survey on Drug Abuse: 1977,** Washington, D.C., GPO, Stock no. 017-24-00702-2.

*There are approximately four times the number of persons in this group as in the other two groups. When corrections are made for the size of the group, that is, estimates on a per million basis are made, then the rate of inappropriate use of sedative/hypnotics for the over 26 group becomes approximately 20 percent of that for the 18-25 year old group, and 25 percent of that in the 12-17 year old group.

**This study is based on a household survey. It is believed that many heroin abusers do not live in traditional household settings, and therefore, would be underestimated in this survey. The National Institute on Drug Abuse currently estimates the number of current daily heroin users to be between 430,000 and 470,000.

***Indicates less than 0.5 percent of the population group.

6. **Special Analysis for Youth.** Of continuing concern are the levels of drug use and abuse among young people in the United States. Our society discourages the use of psychoactive substances including alcohol during adolescent development because of the increased adverse effects such use could have on the adolescent's growing and changing physiology. In addition, intoxication can be very harmful for young adults as it can impair their social, educational and emotional development, and leave them without the necessary skills or maturity to cope with adult responsibilities.

Tables 1-4 display four levels of prevalence recorded in a national survey of high school seniors in the U.S. for 1975, 19[illegible]nd 1977. These are: lifetime prevalence, or the percentage of respondents who have ever used the drug; annual prevalence, or the percentage of respondents who have used in the last year; 30-day prevalence, or the percentage who used in the last 30 days; and 30-day prevalence of daily use, those who used daily in the last 30 days.

The tables indicate high levels of experimentation, although daily use of most drugs—with the important exceptions of marihuana, alcohol and cigarettes—remains small, i.e., under one percent. It is very disturbing, however, that 9.1 percent- one out of every 11 high school seniors—used marihuana daily; and 6.1 percent drink alcohol daily. Preliminary results from the 1978 survey show that 11 percent smoke marihuana daily, an increase of 1/3 over last year. These levels of use can cause serious emotional, developmental and physical problems in a significant portion of young Americans.

TABLE 1-1
Trends in Lifetime Prevalence of Eleven Types of Drugs

	Percent ever used			
	Class of 1975 N = (9408)	Class of 1976 (15385)	Class of 1977 (17116)	'76-77 Change
Marihuana	47.3	52.8	56.4	+3.6 ss
Inhalants	NA	10.3	11.1	+0.8
Hallucinogens	16.3	15.1	13.9	-1.2
Cocaine	9.0	9.7	10.8	+1.1
Heroin	2.2	1.8	1.8	0.0
Other opiates[a]	9.0	9.6	10.3	+0.7
Stimulants[a]	22.3	22.6	23.0	+0.4
Sedatives[a]	18.2	17.7	17.4	-0.3
Tranquilizers[a]	17.0	16.8	18.0	+1.2
Alcohol	90.4	91.9	92.5	+0.6

NOTES: Level of significance of difference between 1976 and 1977:
s = .05, ss = .01, sss = .001.
NA indicates question not asked.

[a]Only drug use which was not under a doctor's orders is included here.

SOURCE OF TABLES 1-4

Johnston, Lloyd; Bachman, J.; and O'Malley, P.M., **Drug Use Among American High School Students: 1975 to 1977,** National Institute on Drug Abuse, Rockville, Md. 20857.

TABLE 1-2
Trends in Annual Prevalence of Eleven Types of Drugs

	Percent who used in last twelve months			
	Class of 1975 N = (9410)	Class of 1976 (15345)	Class of 1977 (17047)	'76-77 Change
Marihuana	40.0	44.5	47.6	+3.1 ss
Inhalants	NA	3.0	3.7	+0.7 s
Hallucinogens	11.2	9.4	8.8	-0.6
Cocaine	5.6	6.0	7.2	+1.2 ss
Heroin	1.0	0.8	0.8	0.0
Other opiates[a]	5.7	5.7	6.4	+0.7 s
Stimulants[a]	16.2	15.8	16.3	+0.5
Sedatives[a]	11.7	10.7	10.8	+0.1
Tranquilizers[a]	10.6	10.3	10.8	+0.5
Alcohol	84.8	85.7	87.0	+1.3

NOTES: Level of significance of difference between 1976 and 1977:
s = .05, ss = .01, sss = .001.
NA indicates question not asked.

[a]Only drug use which was not under a doctor's orders is included here.

TABLE 1-3
Trends in Thirty-Day Prevalence of Eleven Types of Drugs

	Percent who used in last thirty days			
	Class of 1975 N = (9404)	Class of 1976 (15377)	Class of 1977 (17087)	'76-77 Change
Marihuana	27.1	32.2	35.4	+3.2 ss
Inhalants	NA	0.9	1.3	+0.4 s
Hallucinogens	4.7	3.4	4.1	+0.7 s
Cocaine	1.9	2.0	2.9	+0.9 sss
Heroin	0.4	0.2	0.3	+0.1
Other opiates[a]	2.1	2.0	2.8	+0.8 sss
Stimulants[a]	8.5	7.7	8.8	+1.1 s
Sedatives[a]	5.4	4.5	5.1	+0.6
Tranquilizers[a]	4.1	4.0	4.6	+0.6
Alcohol	68.2	68.3	71.2	+2.9 s

NOTES: Level of significance of difference between 1976 and 1977:
s = .05, ss = .01, sss = .001.
NA indicates question not asked.

[a]Only drug use which was not under a doctor's orders is included here.

TABLE 1-4
Trends in Thirty-Day Prevalence of Daily Use of Eleven Types of Drugs

	Percent who use daily in last thirty days			
	Class of 1975 N = (9404)	Class of 1976 (15377)	Class of 1977 (17087)	'76-77 Change
Marihuana	6.0	8.2	9.1	+0.9
Inhalants	NA	0.0	0.0	0.0
Hallucinogens	0.1	0.1	0.1	0.0
Cocaine	0.1	0.1	0.1	0.0
Heroin	0.1	0.0	0.0	0.0
Other opiates[a]	0.1	0.1	0.2	+0.1
Stimulants[a]	0.5	0.4	0.5	+0.1
Sedatives[a]	0.3	0.2	0.2	0.0
Tranquilizers[a]	0.1	0.2	0.3	+0.1
Alcohol	5.7	5.6	6.1	+0.5

[a]Only drug use which was not under a doctor's orders is included here.

The levels of experimentation are also of concern, since they imply a growing public tolerance to drug use. It is interesting to contrast the 1977 "ever used" percentage to the percentages recorded in a 1969 national survey of male high school students only.

Ever Used—High School Seniors

	1969 (males only)	1977 (males & females)
Marihuana	20%	56%
Stimulants	9%	23%
Cocaine	*	11%
Hallucinogens	5.8%	14%
Sedatives	6%	17%
Heroin	1.1%	1.8%

Although experimentation seems to have leveled off in the last three years for all drugs except marihuana, it has more than doubled since 1969. In addition, in 1969 the perception was that we were in the middle of a drug epidemic, concern was at its height and there was a great public response. Most Americans would probably say that the drug abuse situation was worse in 1969 than it is today. This apparent increased tolerance to drug use is troubling, since for many young people the most effective prevention of drug abuse involves pressure for a non-drug using life style from peers, educators, religious leaders, parents, and other significant figures in the life of young people.

B. International Drug Abuse Problems

One of the lessons learned over the past several years is that, despite apparent similarities, different countries must contend with different ranges of drugs and social consequences because of variations in drug availability and use patterns.

Thailand experiences both traditional opium smoking by older people with reasonable social controls and few social consequences, and a simultaneously growing heroin problem. The former is relatively benign in terms of social impact, the latter is contributing to the weakening of the social, political and economic infrastructure.

The domestic impact of drug trafficking on producer countries is seen clearly in Thailand. In 1958, opium production and use were outlawed. At that time, the addict population numbered well under 100,000 and consisted largely of elderly opium smokers. However, when drug refineries appeared within the Golden Triangle during the late 1960's, an epidemic of heroin addiction swept across Thailand.

Estimates of the number of addicts in Thailand now run as high as 400,000 to 600,000. Most alarming of all, drug smoking has given way to intravenous injection as the preferred procedure. This shift has been felt especially among the 15-25 age group--that segement of the population most important to Thailand's future.

Geography makes raw opium available to drug traffickers in Northern Thailand; economics make it expedient to refine this opium into heroin as close to the producing areas as possible. Thailand pays a heavy price for its geographic location and economic attraction since a steady stream of cheap, pure heroin is readily available to the Thai society. The result is a burgeoning Thai addict population.

In response, the Thai Government is developing a plan for providing treatment services on a voluntary basis throughout the country. Detoxification clinics are being opened; existing treatment centers are being

linked with referral networks; preventive education materials are being developed; media campaigns are underway.

These efforts reflect the Government's appraisal of the domestic challenge of international drug trafficking. It is not uncommon to hear Thai leaders describe drug abuse as a threat to the very survival of their nation.

Geography also contributes to high levels of opiate use in **Iran**, where opium has been smoked for centuries. After a brief experiment with prohibition, Iran in 1964 adopted an opium maintenance program for a number of its addicts. At present, over 100,000 addicts receive their opium supplies through licit government channels. Hundreds of thousands more maintain their heroin and opium habits through illegal sources.

The immediate challenge for Iran is to contain opium availability within legal channels, and to control the spread of new addiction. The government's opium maintenance program provides for addicts over 60 and for those too infirm to tolerate withdrawal. For others, the government has launched a program of outpatient treatment. Funding for this program comes from revenues generated by the opium maintenance program. Authorities hope that the outpatient approach will prove particularly attractive to the growing number of Iranian heroin addicts.

Opium/heroin is not the only drug that creates domestic health problems for the countries in which it is trafficked; coca and cocaine-producing countries also face a threat to their public health. A particularly worrisome development is the smoking of cocaine paste. One intermediate product in the chain from coca to cocaine is a gummy paste that results from the soaking of coca leaves in a solvent such as kerosene. This processing step is designed to extract the cocaine alkaloid from the plant material in a state that is relatively concentrated and amenable to further purification.

Drug users in several Latin American countries have learned that the "pasta" itself has strong psychoactive properties when smoked. Since cocaine is an expensive export commodity, drug users in Bolivia, Peru and elsewhere have turned to the more affordable cocaine paste.

The health consequences of cocaine paste smoking—as well as the abuse of a variety of other drugs—are a growing concern to officials in Latin America. Bolivia has operated a drug treatment facility in La Paz for a number of years. Peru recently allocated resources to establish a treatment unit near Lima. This emergence of treatment facilities for drug abusers is direct evidence of the domestic impact of drug trafficking upon the public health in coca-producing countries.

Marihuana also creates different kinds of problems around the world. While of a somewhat long-standing nature, marihuana use in Colombia and Mexico, for example, is considered by the governments of these

countries to have a very important impact on their respective societies. The use has become very widespread and intensive with the result that many young people need clinical intervention and social rehabilitation. This apparent need for health and social services for marihuana users appears to be different than in the United States. Therefore, we cannot assume that the patterns of drug use are similar in different cultures.

Nearby production, however, is not a necessary condition for the development of widespread drug problems. As the United States clearly demonstrates, a sufficient condition is simply a degree of affluence that makes it attractive for drug traffickers to market their products. Not surprisingly, the most active marketplace for refined drug products during the past five years has been Western Europe. Since 1975, France, Italy and the Federal Republic of Germany have acknowledged their growing drug abuse problems in significant ways. Italy passed a landmark law which obligated the government to provide treatment and rehabilitation privileges to any citizen who needed them. France undertook a major policy review in 1977 of all of the drug abuse activities, culminating in the "Pelletier Report" which has been receiving serious review within the French Government. The Federal Republic of Germany has acknowledged its growing heroin problem and has encouraged local and State governments to develop treatment and rehabilitation responses to complement the existing law enforcement efforts.

As these examples show, the social impact of drug abuse is not limited to the United States. More and more countries are being affected by this problem.

III. Drug Abuse Treatment, Rehabilitation and Prevention

Federal domestic drug abuse treatment, rehabilitation, and prevention programs in the United States encompass treatment, rehabilitation, education/prevention, training and research. A variety of Federal agencies perform these functions, but the National Institute on Drug Abuse (NIDA) in the Department of Health, Education, and Welfare (DHEW) has the lead for the treatment of civilians, and the Department of Defense (DoD), the Veterans Administration (VA), and the Bureau of Prisons (BOP) conduct treatment for their specialized clientele.

The strategy for drug abuse treatment, rehabilitation, and prevention has several broad goals: to provide effective treatment and rehabilitation for compulsive drug abusers who are or should be primary clients of Federally-funded, privately financed or publicly funded drug abuse treatment programs; to reach a wider variety and larger number of people

who have problems with drugs, but are not necessarily appropriate clients for traditional drug abuse programs; to support service delivery by co-ordinated research and by trained professionals and paraprofessionals; and to assist communities to prevent drug abuse through positive alternatives and effective programs for youth.

In our discussions of Federal strategy, alcohol is mentioned along with other drugs, since alcohol and drug related problems are often generally similar and many clients have problems with both. It must be noted however that the Federal response mechanisms to the specific problems of a alcohol and alcoholism are presently administered separately in many instances.

A. Federal Strategy for Treatment

Drug abuse treatment provides services to those people whose health and social functioning is seriously impaired by drugs. The programs include basic health services to allow the client to overcome the physical problems of addiction or serious drug abuse, and psychological and social counselling services to promote mental well-being and an ability to cope without drugs.

Federal treatment programs were originally intended to help those people in the most severe difficulties; those for whom drug abuse had become the central problem in their lives. An extensive system of treatment services has been created to serve these clients. Last year, NIDA, the lead agency for Federal civilian treatment, supported drug abuse treatment programs that gave care to over 235,000 persons, offering a variety of treatment modalities ranging from drug-free residential to outpatient detoxification. The clients who are currently served by the Federal drug abuse treatment system are considered the "traditional" clients.

However, there are also other kinds of people who get into trouble with drugs. The "non-traditional" clients are those whose drug or alcohol consumption is contributory to other problems. They do not compulsively consume drugs, but they have problems with them. These people are currently underserved because they are not appropriate clients for many of our traditional drug and alcohol programs. Further, the health and social service systems where they do show up are not always sensitive to drug/alcohol issues and may not recognize that drug and/or alcohol may be contributing to their client's difficulties.

There are two main thrusts to the Federal treatment strategy; to enhance the services available to the traditional clients of Federal drug treatment; and to raise the awareness of a wide variety of professionals to

recognize and serve the needs of all persons in our society who suffer the consequences of drug abuse or misuse.

For the traditional client, the Strategy underlines the importance of service linkages among Federal health and social service programs. Drug abuse programs should work aggressively on behalf of their clients to obtain needed services which are available in the community, such as family services, vocational rehabilitation, and emergency housing. This should be particularly emphasized as a part of aftercare planning. For example, Strategy 1979 encourages such collaborative efforts as the joint NIDA/Indian Health Service technical assistance project, the Secretary of HEW's American Indian Initiative, and the collaboration between the Office of Human Development Services and NIDA in the areas of vocational rehabilitation, the elderly, child abuse, and runaways. Because of the psychological and economic importance of employment in the rehabilitation of drug abusers, linkages between the Department of Labor, the Department of Health, Education and Welfare, and other involved agencies should be emphasized. The Veterans Administration is in the process of establishing a formal agreement with the Department of Labor which will identify and provide mechanisms for effecting program linkages for employment services for drug dependent veterans.

B. Federal Strategy for Rehabilitation

Strategy 1979 strongly supports the notion that effective rehabilitation goes hand in hand with treatment, and encourages increased opportunities for drug abusers to participate in job training and placement programs.*

Effective employment and rehabilitation services are key factors in ensuring that the treatment experience will be successful. The Federal government must make a concerted effort to develop training programs for those soon to graduate from drug programs and for those in the preventive stages who do not have the skills necessary for certain employment fields.

As a long-term goal, however, Strategy 1979 supports the inclusion of family counseling within drug treatment and rehabilitation programs. Childhood drug abuse often can be seen as a symptom of an inadequate or malfunctioning family system, and that whole system must be worked with if the symptomatic problems are to be treated. In addition, drug abuse by one family member affects the entire family, which must learn

*For additional information see **"Supplementary Report and Analysis"**, submitted by the Department of Health, Education and Welfare, February 1978, to the House Labor Appropriations Subcommittee for hearings on the FY79 budget request.

how to adjust and cope. The Veterans Administration provides family counselling, when appropriate, for drug dependent veterans, and Strategy 1979 encourages this type of family therapy.

The Federal treatment and rehabilitation strategy emphasizes sensitivity to the needs of special populations represented in all treatment and rehabilitation settings. These include ethnic/racial minorities, women, youth, the elderly, and rural clients. For example, Federally-funded treatment programs have 48 percent minority clientele and it is important that the programming and counselling be responsive to the cultural needs of minorities. One way of ensuring responsiveness is to insist that minorities are represented on the professional and paraprofessional staffs of programs, planning and administrative agencies. Currently, minorities lack representation, particularly in the professional categories.

The **1978 Report of the President's Commission on Mental Health** drew particular attention to the problems of minorities.

> "Opiate users in treatment are predominantly Black and Hispanic, and are frequently faced with glaring poverty, massive unemployment, and discrimination in a rigidly stratified society which leaves them undereducated and underskilled, with little future and little hope. Within this context, the use of drugs is frequently seen as a viable alternative to unending despair. While the Black and Hispanic population represent only 11 percent and 5 percent of the national population, respectively, they comprise two-thirds of the opiate users in treatment. Nearly three-fourths are male, nearly one-half have had less than a high school education, and 60 percent are 26 years old or over. Slightly more than one-half have been arrested within the past 24 months; of those with an arrest record, about one-half have two or more arrests.
>
> Minority communities have often viewed drug treatment as a form of social control, particularly that treatment which initially substitutes one chemical dependency for another. This concern becomes even stronger when long-term maintenance programs are proposed. However, many minority group leaders are now concerned with the quality of programs and the need for staffing patterns which reflect cultural differences and can provide a diversity that will fit a range of clients. This greater emphasis on the quality of the treatment services being delivered is as important as the initial objections regarding particular modalities." (p. 2121-2122)

The Strategy 1979 will concentrate on strengthening affirmative action mechanisms at all appropriate levels of policy and programming in order to reflect appropriate socio-cultural variations. In addition, assessments of the ethnic, cultural and other special needs of clientele will be em-

phasized, and strategies and materials will be tailored to special populations. For example, NIDA will amend their Statewide Service Contracts to recommend that drug treatment programs provide special planning and counselling for pregnant women and women of child-bearing age. Strategy 1979 encourages such planning and sensitivity for all special populations.

The interface between the criminal justice system and treatment will be continued and treatment alternatives to incarceration will be supported. The Law Enforcement Assistance Administration currently operates three programs: Treatment Alternatives to Street Crime (TASC), Treatment and Rehabilitation for Addicted Prisoners (TRAP), and the Correctional Programs Standards Implementation Program (Drug/Alcohol Treatment). A recent independent evaluation of the TASC program has produced a number of favorable findings on the effectiveness of that program. The Bureau of Prisons currently operates Drug Abuse Units and Alcohol Treatment Units in the 38 Federal correctional institutions, as well as three Chemical Abuse Units. Training will be deveioped for criminal justice personnel to increase their understanding of community drug abuse and to encourage agreements between the criminal justice and drug abuse treatment systems to enhance closer working relationships. This strategy underlines that all Federal programs providing medical services to incarcerated narcotics addicts should provide a full range of humane treatments, and local officials responsible for maintaining jails should be encouraged to do so as well.

Finally, for the "non-traditional" client, Federal treatment strategy emphasizes increasing the sensitivity to drug abuse issues within the general health and social service delivery systems. Adequate treatment for drug abusers must be available in the delivery system that is most appropriate for them.

For example, Federally-funded Community Mental Health Centers (CMHC's) are required to provide a program of prevention, treatment and rehabilitative services to populations with drug abuse problems in their service area unless they can document that no such need exists or that it is otherwise being met. Improvement of the drug abuse component of the CMHC's is urgently needed, including training in how to differentiate drug abuse from drug misuse, how to refer clients to drug abuse services, and when and how to provide the client with treatment within the CMHC. Strategy 1979 strongly supports such cooperative efforts to improve services for drug abusers and misusers within the CMHC's, as does the Alcohol, Drug Abuse, and Mental Health Administration/National Institute on Mental Health/National Institute on Drug Abuse Task Force which has been established to study the issue and to make and implement recommendations.

Adequate financing mechanisms for treatment in any setting are also necessary. Financing for the medically-related services to abusers should be linked to the financing mechanisms of the rest of the health care delivery system.

It is encouraging to note that recent long-term follow-up studies have shown that the Federal commitment to providing treatment for drug abusers has been successful.* While experience has taught us not to expect total, immediate abstinence as the result of drug abuse treatment, the evidence demonstrates that, with each succeeding treatment experience the client is able to sustain a socially productive lifestyle for longer periods of time. Favorable changes are found in all of the outcome measures which include illicit drug use, alcohol consumption, employment and criminality.

C. Federal Strategy for Training

A wide variety of service organizations and high quality personnel are essential to effective service delivery. Paraprofessional resources should be developed and fully utilized. The Strategy encourages the associations of paraprofessional health practitioners to include drug and alcohol treatment courses in their curricula and certification requirements. The Strategy supports efforts to work with States to upgrade the skills of drug treatment paraprofessionals and life-experienced professionals through in-service training so that they can obtain appropriate credentials. Highly qualified nurses should most certainly be incorporated into future training plans. NIDA is developing training courses, and will disseminate to the States successful models which suggest criteria for granting these credentials.

The training strategy also emphasizes that efforts to improve drug and alcohol abuse education currently underway in one-third of the nation's medical schools should be expanded to all schools. The Federal Government will continue to work with the American Medical Association, the National Board of Medical Examiners, and the specialty boards toward these goals, and will continue to support efforts to include specific questions related to alcohol in Comprehensive Qualifying Examinations.

*For additional information, see "Evaluation of Drug Abuse Treatment Based on First Year Follow-Up, National Follow-Up Study of Admissions to Treatment in the DARP During 1962-72", published in 1978, NIAAA Service Research Monograph of the Department of Health, Education and Welfare based on a grant to the Institute of Behaviorial Research, Texas Christian University.

D. Federal Strategy for Research

Strategy 1979 underlines the importance of relevant, coordinated research, with an assessment and dissemination mechanism. The Secretary of the Department of Health, Education, and Welfare has called for and is developing principles for research planning so that a national health research strategy can be developed in 1979, Strategy 1979 strongly endorses such research coordination, and particularly supports the on-going efforts to coordinate and collaborate among the three institutes of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA)—the National Institute on Drug Abuse (NIDA), the National Institute on Mental Health (NIMH) and the National Institute for Alcohol Abuse and Alcoholism (NIAAA).

Strategy 1979 encourages mechanisms to review and assess the research of NIDA, NIMH and NIAAA to determine the additional questions that need to be asked in order to gain an accurate understanding of research problems and results. The inclusion of other health and social science disciplines and of members of ethnic minorities in the review group is advisable to ensure the relevance and applicability of research to other agencies dealing with human development and special populations.

Finally, the Strategy suggests a review of health data systems for scope, validity and reliability, and recommends a study of opportunities for coordination, consolidation and standardization. For example, NIDA and NIAAA, with NIMH concurrence, are developing a workable approach for establishing a joint substance abuse client data system.

E. Federal Strategy for Prevention

Strategy 1979 defines prevention in positive terms, as methods of promoting healthy development both physically and socially. Although it is attractive to talk about prevention in terms of preventing the specific undesirable behavior associated with drug abuse, it is not a realistic way to conceptualize "prevention". Drug abuse, like juvenile delinquency, does not occur in a vacuum; it occurs within a general behavioral context. When we talk about prevention we must think in terms of promoting healthy alternatives to replace a wide variety of undesirable behaviors—which may include drug abuse.

Prevention focuses on groups or individuals before observable health or behavior problems come to the attention of parents, peers, educators or employers, and during the onset of these problems: in the drug abuse field, prevention is concerned most with the non-users, experimenters and recreational users. Because the onset of inappropriate drug use usually

occurs early in life and because new learning skills are most easily developed at this stage, the young are the primary target of prevention strategies.

The latest survey data suggest that the vast majority of young people are at some time presented with an opportunity to experiment with some kind of abusable mind-altering substance. In that sense, most American young people must be considered to be potentially vulnerable and therefore should be the legitimate target of prevention activities.

Key elements of prevention are:

—A focus on rewarding a positive non-drug-using lifestyle, rather than an emphasis on punishing drug use.

—The provision of healthier and more attractive alternatives to drug use.

—Programs to develop an individual's ability to rely on his own inner resources, skills and experiences; the individual's constructive relationship with his parents or family; and his relationship with his peers, school and community.

—Reliance on peers, parents, schools and the community as the most effective channel for informing and guiding young people.

—The provision of clear, factual, honest and relevant information about drugs, with special materials developed for parents, for teachers, and young adults.

—Planning and developing material for the special challenges facing women, ethnic minorities, the poor, the elderly, those in rural areas, and other special populations.

—An evaluation component included as part of every prevention effort.

The Federal role in prevention is necessarily limited, because each community must develop prevention programs which are relevant and appropriate for its own unique conditions. The Federal Government, however, will support State and local efforts to find effective drug abuse prevention programs within the broad conceptual framework of providing positive alternatives and effective programs for youth. The goal of the Federal involvement in drug abuse prevention has been, and will increasingly be, to help local community groups learn how to utilize local resources; to stimulate and respond to a community's awareness of ethnic, regional or other needs; to distribute examples of successful prevention programs and to encourage coordination between drug abuse prevention, allied prevention, and youth service programs.

The Strategy will emphasize prevention coordination among the involved Federal agencies, and evaluation and research. The Strategy supports activities to review the existing authorities and resources currently specified by various agencies for "prevention" programs for young people, to ascertain the extent to which the program philosophies and funding

criteria can be better defined, coordinated, and if needed, reorganized. For example, the DHEW has undertaken a major review of total prevention activities in all health and health-related fields. This review has been underway since the beginning of 1978 and is part of the new emphasis on behavior and health which is underway throughout the Public Health Service.

The evaluation of prevention programs is an essential aspect of the Federal Strategy, as illustrated by NIDA's efforts to develop methodologies to evaluate the impact of prevention programming, both centrally and at State levels. NIDA is also emphasizing and providing support for similar State efforts. FDA, in its capacity of licit drug regulator, is in the process of developing new approaches to monitoring trends in legitimate drug use, abuse and misuse.

Research on possible causes of drug abuse and on the differential characteristics of users and non-users will be encouraged. Evaluation of prevention strategies and programs through process, outcome and impact studies can be improved dramatically with an increased commitment to intensified measurement and particularly to long-term evaluation. The emphasis on evaluation should extend to programs for the prevention of alcohol abuse, cigarette smoking, juvenile delinquency, mental illness, and other social problems.

NIDA is currently funding four broad studies on prevention strategies and two studies on the interrelationships between drug use and the changing variables which affect this use. These efforts are encouraged.

F. The Military Sector

All of the concerns and approaches to prevent drug abuse and treat the abusers among the population at large have a special urgency in the U.S. Armed Forces. In the military sector, even low-level recreational drug use has greater potential for harm and national hazard. The Strategy recognizes the special needs of the military services for a force that is capable of maintaining high and consistent levels of readiness and job performance.

To maintain this high state of readiness in the military requires a reliable and sensitive system of drug monitoring and assessment, incentives for servicemen and women to enter treatment and rehabilitation programs, carefully drawn policies regarding penalties for the use and misuse of drugs, and a treatment and rehabilitation system designed primarily to return military personnel to duty as fully functioning members of the Armed Forces. During the past year, the Department of Defense (DoD) and the separate military departments have been involved in a comprehen-

sive evaluation of their drug abuse assessment efforts. As a result of this on-going review, the DoD has instituted a number of initiatives which are designed to improve the overall effort of the military services against the continuing problem of drug abuse. They include:

—The development of a more refined drug abuse assessment system to include the development of a DoD-wide survey of drug abuse;

—An investigation into the performance and readiness levels resulting from drug abuse;

—A reappraisal of the minimum drug abuse education requirements for all members of the armed services;

—A review of criteria for measuring treatment and rehabilitation success as used by each of the services and other Federal agencies designed to result in development of a standard criteria for success in drug abuse treatment to be used by the Department of Defense; and

—The increase of DoD and headquarters military department drug abuse officials visitations to the military field activities.

—The improvement of measures for detecting drug abusers in the military populations to include the establishment of minimum urine testing levels and the examination of portable test kits for the detection of possible drug use in a number of various environments.

--An increase in the DoD headquarters drug abuse staff and a review of the adequacy of the Military Departments' staff and resources.

—The establishment of a Berlin Task Force to better coordinate and operate the anti-drug abuse program in that city.

—A review and upgrading where necessary of the drug abuse programs for DoD civilians and military dependents overseas.

—A review of the adequacy of the Military Departments' law enforcement staffs and efforts.

The Strategy recommends continued development and refinement of the drug monitoring and assessment efforts, with particular emphasis on improved measures for drug abuse identification and treatment outcomes. Each military service will continue to carry out its responsibilities in these areas and the DoD shall coordinate military drug abuse control activities with other Federal and civilian agencies at home and abroad.

IV. Domestic Drug Law Enforcement

Domestic drug law enforcement or domestic supply reduction is a key part of the Federal drug abuse prevention and control program. The major objectives of drug law enforcement are: to reduce the supply of illegal drugs; to control the supply of legally manufactured drugs in order to prevent diversion into illegal channels; and to achieve the highest possible

level of risk for drug trafficking by investigating major drug trafficking organizations and securing sufficient evidence so that successful prosecutions can be brought which will lead to prison terms for the violators and the forfeiture of their assets. In addition, a strong domestic drug law enforcement program convinces other nations of our national commitment to control drug abuse, adds to our credibility in international negotiations, and encourages other nations to cooperate with us in achieving our international goals. Strategy 1979 recognizes that domestic supply reduction efforts have the most deterrent impact on new or experimental users of drugs.

There are two major areas of drug law enforcement activities: at the borders, and within the United States proper.

A. Federal Strategy at the Border

The land, sea and air borders of the United States, including ports of entry, provide a unique opportunity for illegal drug interdiction. A policy review of Federal border management conducted in 1977 found that there is significant overlap and duplication of effort in border inspection and patrolling activities. The review recommended a consolidation of the U.S. Customs Service and the Immigration and Naturalization Service into a border management agency to provide more effective border control through a central management of key border functions and resources. Such a reorganization would further set the foundation for improving all border management functions. The President's Reorganization Project in the Office of Management and Budget is currently developing an appropriate reorganization plan based on this recommendation. Strategy 1979 strongly supports all efforts to strengthen the border interdiction effort to prevent illegal entry of drugs into this country.

Development of a comprehensive border strategy is a long-term goal. Strategy 1979 underlines the need for full cooperation and coordination among Federal border law enforcement agencies and with other Federal, State and local agencies. Border control should be approached as a coordinated Federal effort, and not as separate, autonomous activities.

Cooperative efforts which capitalize on the full capabilities of the Federal, State and local law enforcement authorities are an integral part of the Federal border strategy. Current coordinated efforts to curtail illegal drug trafficking in the Southeastern United States are a good example of cooperation. There has been growing concern over the illegal drug trafficking in marihuana and cocaine into and through Florida and other States along the Eastern seaboard and Gulf Coast. Originating in South America and Caribbean countries, huge quantities of marihuana

are being smuggled by sea and air into the United States. Statistics from all sources indicate that approximately 5.6 million pounds of marihuana were seized from October 1, 1977 through September 30, 1978, compared to less than 1.5 million pounds seized during the same period last year while seizures of multi-ton loads are commonplace, they represent only a small fraction of the marihuana entering the U.S. The amount of cocaine seized also has increased significantly. Federal, State and local law enforcement agencies and prosecutors in Florida report being overloaded with pending drug cases.

The U.S. economy is directly affected by the large sums of money paid to the sources of the drugs. The financial dealings connected with the illegal drug traffic through South Florida alone are estimated at several billion dollars a year.* It is reported that corporations, sponsored by illegal drug profits, have been set up to purchase businesses to provide the mechanism for placing the illegal profits back into legitimate channels. The potential for a major expansion of criminal organizations and corruption is obvious.

In response to the need for aggressive coordinated action, the Administration established a working group to develop a specific law enforcement initiative. The group includes the Drug Enforcement Administration (DEA), the Criminal Division of the Department of Justice, the U.S. Customs Service, the U.S. Coast Guard, and the Department of State, with consultation from other involved Departments. It developed a comprehensive response to drug smuggling in the Southeastern U.S. while placing a continuing emphasis on seeking longer-term solutions through legislative, judicial and diplomatic initiatives.

It is recognized that increased seizures alone cannot stop the large volume of drugs entering the U.S., therefore, efforts designed to penetrate and disrupt the organized criminal groups engaged in illegal drug trafficking will continue to receive greater emphasis.

Border enforcement agencies will be charged with increasing their cooperative efforts in enforcing existing laws and regulations governing the flow of carriers, persons and goods across the borders of the United States. We will seek more stringent application of criminal, civil and administrative sanctions against violators. New legislation, such as an amendment to the Bank Secrecy Act which will make it against the law to **attempt** to transfer unreported money outside of the U.S., will be considered to strengthen the authorities of the border enforcement agencies.

*On the basis of street value of marihuana seizures alone, this sum exceeds $1.5 billion.

Strategy 1979 places greater emphasis upon interdiction at the borders based upon prior information. To make this possible, we will seek a greater volume of reliable and timely drug-related information for use by border enforcement agencies.

Strategy 1979 underlines the role of technology in the detection capabilities of the border enforcement agencies. Research activities and application of technology will be emphasized. The detection, tracking and communications resources of the Armed Forces, insofar as statutes and regulations will permit, should be utilized to complement the capabilities of the civilian agencies.

Finally, the Federal strategy stresses the importance of attacking the financial base of drug trafficking. Enforcement efforts will concentrate on the assets of known suspected drug traffickers and the application of banking laws and regulations. The Internal Revenue Service will continue its program to investigate high level drug traffickers and financiers. In addition, the flow of currency and other negotiable instruments across our borders for the financing of illegal drug trafficking will be a major target of enforcement activities.

B. Federal Strategy within the United States

1. **The Federal Role.** Drug law enforcement within the borders of the United States is carried out by Federal, State and local law enforcement agencies. Although several agencies are involved, the December 1977 policy review supported a single purpose lead agency for the enforcement of all Federal narcotics laws. Therefore, Strategy 1979 supports the continuation of DEA as the lead agency for the enforcement of these laws. Close cooperation among the Federal investigative agencies, the Criminal Division of the Department of Justice, the United States Attorneys, and the border interdiction forces is necessary to fully effect this strategy. For maximum effectiveness, the program should concentrate on each level of the illegal distribution chain. The strategy against illegal supply systems involves attacking these systems at every possible point: at the wholesale level, whether the drugs are smuggled or diverted from legal channels; in interstate commerce; and at the street level where drugs are delivered by the dealer to the user.

The Federal investigative agencies will place primary emphasis on investigating, arresting and providing sufficient evidence to prosecute major violators of drug and drug-related statutes, focusing on those traffickers at the top of the organizations. State and local agencies will concentrate on the local violations in their area.

Federal agencies will continue their cooperation with State and local agencies, and will participate in State and local law enforcement operations when appropriate within the constraints of resources and priorities. State and local agencies will be encouraged to participate in appropriate Federal operations. This coordination and cooperation with State and local law enforcement officials on mutual drug enforcement efforts will enhance such efforts by exploiting potential interstate and international investigations beyond local jurisdiction and resources.

DEA will continue its cooperative efforts with State and local governments by continuing programs such as the DEA/State and Local Task Forces and the Diversion Investigation Units. In addition, the Federal agencies will continue their support to State and local authorities in the form of intelligence gathering, information exchange, financial support, training, logistics and technology.

Cooperation among Federal agencies will also be stressed. All law enforcement agencies with a potential role to play will be involved. Joint efforts, such as the DEA/FBI task forces against organized crime, will be evaluated to determine their effectiveness.

Strategy 1979 will place increased emphasis on the prosecution of major violators under the Controlled Substances Act and Conspiracy Laws. Federal law enforcement will employ undercover and informant techniques in an attempt to build strong substantive cases and will use these cases as the basis for conspiracy and other major violations (either actual, on-going, or proposed) which will, when successfully prosecuted, shut down important trafficking networks. The Federal effort directed at major traffickers and the heads of major trafficking organizations must emphasize the utilization of conspiracy laws with Title III investigations, when appropriate, and the application of the Continuing Criminal Enterprise sanctions. Within this framework, therefore, the immobilization of the trafficking networks must involve not only the direct attack on the substantive channel but also the essential supporting advisory, financial and logistical elements. DEA, State and local police, and other investigative bodies will cooperate in the investigation and intelligence-gathering aspects of these cases. They will emphasize information sharing, planning and legal preparation for prosecution.

Strategy 1979 also places increased emphasis on investigations of the financial aspects of drug trafficking. These investigations, involving DEA, the FBI, the Customs Service, the IRS, the Criminal Division and the U.S. Attorneys are aimed at the identification and prosecution of upper echelon traffickers and financiers, generally isolated from the traffic, for violations of its various conspiracy, racketeering, currency control and tax laws.

2. **Prosecution and Penalties.** The prosecution and sentencing of drug law violators is a critical part of the Federal enforcement strategy. U.S. Attorneys in 22 cities have and will continue to use special teams of attorneys and support staff to coordinate investigations and prosecutions of major drug violators. Federal agencies will make greater use of civil and administrative penalties where criminal prosecution is inappropriate or unattainable. Such penalties will be imposed in addition to criminal penalties when warranted.

In addition, the professional and business associations of organizations or professions related to drugs will be encouraged to intensify the monitoring of their professions and industries, and to impose swift and adequate penalties upon those members who violate their codes of ethics, laws or regulations.

3. **Control of Legally Manufactured Drugs.** Those agencies responsible for licensing and regulating the manufacture, distribution and dispensing of legally produced controlled drugs will intensify their efforts, and focus on the upper levels of the drug distribution chain. State and local agencies should concentrate on local retail violators. Inspections and audits will be concentrated more heavily on problem drug manufacturing and distribution facilities to uncover violations of law and regulation. More stringent application of penalties to these violators will be employed, including increased emphasis on prosecutions under the civil statutes. Specific problem areas will continue to be targeted. For example, as part of an Administrative initiative to reduce the morbidity and mortality associated with barbiturate use, the Drug Enforcement Administration, in 1978, conducted audits of all 120 barbiturate manufacturers in the United States.

In addition to inspections of currently authorized manufacturers and distributors, new applicants for registration must be subjected to a pre-registrant investigation to ensure their registration is consistent with public health and safety.

Annual production quotas for Schedule II controlled substances, based on legitimate medical needs, continue to be aimed at preventing overproduction thereby reducing the quantities of dangerous drugs available for nonmedical uses. Smaller inventories, combined with strict enforcement of security requirements, will help reduce the potential for diversion of legally-produced drugs into illicit channels. Recent studies have shown that diversion at the manufacture level has been minimal compared to diversion at the retail or practitioner level.

While Federal emphasis will be at the upper-level of the distribution chain, assistance to State and local agencies to impact retail level diversion is vital to the Federal strategy. The Federal Government will, therefore,

continue to provide information, financial support, training and technology to the State and local agencies to reduce this kind of diversion.

Sixteen Diversion Investigation Units (DIU's) are currently in effect to control legitimately manufactured drugs at the State level. Four of these units were established in 1978 with Federal seed-funding through cooperative agreements. This type of seed-funding will be used to continue expansion of the DIU program. Additional support to the State and local governments will include supplying investigative leads at the retail level and support to State agencies in making necessary changes to upgrade their efforts.

Using the statutory authority to schedule drugs which have abuse potential, drugs found to be abused will be controlled by placing them in the appropriate drug schedule. Drugs already scheduled as controlled substances will be placed in higher schedules where stricter controls are found to be necessary. This will increase enforcement priority and prosecutive follow-up.

4. Clandestine Manufacture. The clandestine manufacturing of illicit drugs in the United States continues to pose serious enforcement problems requiring special investigative techniques and resources. The animal tranquilizer and hallucinogen, phencyclidine (PCP), has replaced other hallucinogens such as LSD as the most abused of this type of drug. Because of the serious psychological effects of using PCP, including at times violent and irrational behavior, clandestine manufacturing of this drug must receive a major enforcement emphasis. The Drug Enforcement Administration will continue its Special Action Office/PCP program and continue its efforts to involve the legal manufacturers of precursor chemicals in the voluntary reporting of unusual or excessive orders. Because of the importance placed on suppression of the clandestine manufacturing of this drug, other issues, including scheduling and legislative actions and requests, are dealt with in depth in a special PCP section of this report.

V. The International Program

International cooperation is essential if we are to reduce the harm caused by drug trafficking and abuse in the United States, and assist other countries with their drug abuse problems. More and more nations worldwide are perceiving the seriousness of drug abuse problems and consider themselves victims of drug abuse and trafficking. Increasingly, nations are placing a high priority on combatting illegal drug use, production and trafficking. Strategy 1979 places great emphasis on encouraging this interest and working in international and regional fora to address these

problems. International narcotics control goals have also become an integral part of bilateral relations conducted by the Department of State. Only within the past few years has narcotics become one of the major aspects of our bilateral diplomacy in key producing countries, and Strategy 1979 supports the continuation of this emphasis. Strategy 1979 continues to accord the Department of State the coordination and policy responsibility for all international narcotics efforts. The State Department is fulfilling these international narcotics control responsibilities through a newly created Bureau, under the direction of the Assistant Secretary of State for International Narcotics Matters.

Our international program has several major objectives: to reduce the production or trafficking in heroin, the most dangerous drug pharmacologically entering the United States; to reduce the greatest quantities of illicit drugs at their source; to prevent illegal drugs from entering the U.S. while assisting other nations to stengthen their own drug control capabilities; to reduce the illegal production and trafficking of the most dangerous drugs by increasing the risks; to reduce production and trafficking of the drugs which provide the greatest financial incentive and support for the networks which traffic drugs into the U.S.; to ensure a balanced, orderly international market for licit narcotic drugs needed for medical and scientific purposes; and to develop within the international community high priority for cooperative drug abuse treatment and prevention, as well as drug control efforts.

Strategy 1979 will rely heavily on diplomacy to achieve U.S. objectives, with particular attention to countries in which narcotics are produced or trans-shipped as well as those in a position to provide financial and other forms of assistance to the international control of narcotics. This diplomatic effort is supported with foreign assistance funds appropriated to the Department of State by the Congress for international narcotics control. The important anti-narcotics activities of Federal law enforcement agencies abroad must be fully integrated with and supported by the diplomatic effort.

Strategy 1979 will continue to direct U.S. international program resources into four primary areas to achieve narcotics control objectives. These areas are: (1) efforts to reduce illicit narcotic supplies at their sources; (2) participation in international drug control organizations; (3) cooperation with foreign narcotics enforcement agencies; and (4) international drug abuse treatment and prevention.

A. Efforts to Reduce Supply at the Source

First, we will stress efforts to reduce the supply of illicit drugs at their source. The plants that produce some of the drugs we are most concerned with — heroin, cocaine, and to a large degree marihuana — grow in foreign countries. The laboratories for processing these drugs are overseas while the flow of drugs into this country passes through many nations. Increasingly, the people of source, as well as destination countries, are experiencing drug problems of their own.

There are ten countries in the world which we view as top priority targets for diplomatic, economic and technical cooperation in an attempt to work with the governments to reduce the production of drugs. More than a hundred other nations figure significantly in our international drug initiatives, but these ten are the major sources of "problem drugs." (The figures given below are, of course, estimates of production.)

Burma: Approximately 500 metric tons of illicit opium are produced every year; from this amount an estimated 20 tons of opium are processed into 2 tons of heroin which are largely directed to the U.S. market.

Thailand and Laos: Approximately 50 tons of opium are produced in each country annually.

Mexico: Approximately 50 tons of opium are produced of which 40 tons are converted to 4 tons of heroin, most of which makes its way into the United States.

Afghanistan and Pakistan: A combined 800-1000 metric tons of opium are produced each year, most of which is consumed within the region.

Bolivia and Peru: Approximately 55,000 metric tons of coca leaf can be produced. It is estimated that 14-19 tons of cocaine produced from this amount are annually available for the illicit U.S. market.

Ecuador and Colombia: The major processing and trafficking countries for the cocaine flow to the U.S.; extremely large quantities of marihuana are produced in Colombia.

In most of these countries, the production and local consumption of opium or coca leaves are old traditions and integral parts of the culture and economy of the nation. The production of these drug crops provides an important source of income to farmers in many of the developed countries. For many, these crops provide their only cash income. Only Mexico, among the opium-producing nations does not have an extensive history of poppy cultivation and opium use.

Strategy 1979 supports a range of approaches involving the United States in partnership with other countries and the international organizations to reduce the supply of drugs at their source.

1. Diplomatic Initiatives. Through existing foreign policy mechanisms, American political, economic and moral influence is used to encourage international narcotics control cooperation. High-level U.S. political and diplomatic representations to foreign governments by both the Executive Branch and the Congress have been instrumental in increasing foreign commitment to international narcotics control cooperation. For example, two years ago, narcotics control represented only a small part of U.S. bilateral relations with Colombia; yet today, as a result of intensive diplomatic efforts, narcotics control is key to bilateral relations with that country. Similar bilateral diplomatic efforts have resulted in raising narcotics control cooperation to primary importance in U.S. relations with other countries, such as Burma, Thailand and Mexico. Strategy 1979 will continue to explore ways to use political and diplomatic influence to further international narcotics control objectives.

2. Eradication. Crop eradication has proven to be the most efficient and cost-effective way to reduce the illegal cultivation in those countries which do not have an extensive history of poppy cultivation and opium use. In those countries crop eradication is the most efficient way to curtail the entry of narcotic drugs into the international market place. When asked to do so and when consistent with U.S. law, the United States will consider appropriate assistance to foreign governments in their attempts to eradicate illegal drugs within their countries. When drug cultivation is a traditional part of a country's culture and economics and supports a large number of otherwise law abiding farmers, rural development and crop substitution are the first stages of a program to reduce supply at the source, and may be combined with an eradication program.

The opium eradication program in Mexico provides an example of success. The eradication program, started in late 1973 as a cooperative U.S.-Mexican effort, in which the U.S. provided technical assistance and equipment for the opium eradication, has had a progressive impact on the American heroin problem.

Mexico has been the major supplier of heroin for the U.S. market since the early years of this decade. Since the inception of the eradication program in Mexico, the heroin abuse indicators in the U.S. have begun to decline. Heroin availability in the U.S. is at the lowest level in seven years, with a national average retail purity of 4.2 percent and a price of $1.96 per miligram pure. Heroin overdose deaths in 1977 are down 63% from 1976. As mentioned earlier this represents 1,000 fewer heroin overdose deaths in 1977 than in 1976. During this same time period, emergency room episodes have declined by 40%. The latest data indicate a decline in the U.S. heroin addict population from 540,000 in 1975 to 450,000 in 1978.

3. **Rural Development.** The U.S. will encourage and support, where possible, programs to replace illicit drug crops with other crops or activities that provide adequate and stable incomes for the people in the growing regions. These regions are typically among the least developed areas of narcotics producing countries and almost always meet the criteria for outside assistance.

Integrated rural development is, however, a costly and long-term response well beyond the resources which have been appropriated specifically for the international narcotics control program. Assisted by the Agency for International Development (AID) and the U.S. Department of Agriculture (USDA), the Department of State continues to support crop substitution research, pilot extension efforts, and rural development projects to determine what these programs may accomplish on a long-term, fully-supported basis. If these pilot projects demonstrate sufficient promise consideration will be given to providing integrated rural development assistance on a large scale in primary narcotics producing areas. Moreover, these same projects can be used to demonstrate to various international financial institutions, development organizations, and other nations the feasibility of investing their resources in the integrated rural development effort.

Therefore, on a bilateral basis, the U.S. continues to encourage development assistance in primary narcotics-producing areas as a means of providing alternatives to opium poppy and coca bush cultivation. The Agency for International Development is currently involved in such projects in Thailand and Bolivia and will be considering similar programs in other producing countries.

Paralleling the U.S. efforts, the United Nations Fund for Drug Abuse Control (UNFDAC) has supported pilot projects in Thailand, Pakistan and Afghanistan and has begun to develop specific plans which could be funded by multilateral institutions such as the U.N. Development Program (UNDP) and the International Financial Institutions. These projects would assist the farmers, who have become dependent on narcotics producing crops, in reducing their reliance on this particular source of income.

The Administration has consulted Western European and other industrialized nations regarding the possibility of providing technical and financial assistance for narcotics control efforts in those lesser developed countries and regions where illicit narcotics are produced. Certain European countries, primarily the Scandinavian countries and the Netherlands, have accepted the principle that integrated rural development in primary narcotic-producing regions is an appropriate use of their foreign developmental assistance funds. The Federal Government will encourage

the acceptance of this foreign developmental approach in its discussion with other developed countries and international assistance organizations.

Strategy 1979 recognizes not only the need to identify substitute crops, but also the need for integrated rural development efforts to create the social and economic infrastructure in which they can be produced. As farmers acquire the knowledge and the means with which to grow alternative crops or to acquire alternative non-agriculture means of livelihood, it will be increasingly important to apply enforcement measures aimed at halting the cultivation of narcotics as governments are required to do under the international treaties.

The role that the U.S. plays in various international aid donor consortia provides another vehicle for supporting projects in narcotics-growing regions through relating commitment of development funds to narcotics control efforts.

4. Anti-narcotics Provisions for International Lending. The United States representatives to the loan committees of the Regional Development Banks and other international financial institutions will use their votes and influence to (1) encourage well designed rural development and income substitution projects in countries which now produce dangerous drugs; and (2) ensure that assistance is not used to foster the growth of crops such as coca and opium.

Where appropriate, U.S. representatives to institutions such as the World Bank, the Asian Development Bank (ADB), the African Development Fund (AFDF) and the Inter-American Development Bank (IDB), will support loan provisions making assistance conditional upon the borrower's agreement not to assist narcotics production in any way. This past year, U.S. efforts have been largely responsible for the inclusion of such a provision in an upcoming ADB loan to Afghanistan.

Efforts with international financial institutions are a particularly promising part of the Strategy. Strategy 1979 will emphasize meeting with other bilateral and multilateral funding sources to promote projects in narcotics producing regions to reduce the reliance of farmers on these illegal crops.

B. Participation in International Drug Control Organizations

The United States will place a high priority on participating in international organizations and activities which further the cause of global health and control of drugs, and will encourage other governments to work with us in these agencies.

Numerous international organizations and institutions contribute to control efforts involving both licit and illicit narcotics. Agencies working within the framework of the United Nations, such as the International Narcotics Control Board (INCB), the Commission on Narcotic Drugs (CND), the Division of Narcotic Drugs (DND), and the United Nations Fund for Drug Abuse Control (UNFDAC), are already actively addressing worldwide narcotics-related problems. The United States will continue its efforts to strengthen these organizations and give them a greater role in international narcotics control, as well as continue our financial support for the work of the U.N. and its specialized agencies. At the same time, the Federal Strategy will seek to increase participation of other international organizations in drug abuse control. Particular attention will be given to encouraging the U.N. Economic and Social Council (ECOSOC), the U.N. Development Program (UNDP), UNESCO, the Customs Cooperation Council (CCC) and the World Health Organization (WHO) to devote full attention and, where appropriate, additional resources to international narcotics control.

The control of production and trade of narcotics, particularly opiates, for licit medical purposes is an important activity of these international organizations, particularly the International Narcotics Control Board. Orderly production and marketing is essential to ensure adequate supplies of needed medicines for world health needs and is important to the economies of legitimate opiate exporting countries, such as India and Turkey. The Federal Strategy seeks a worldwide balance of international supply and demand from considerations of both illicit and licit use. A large surplus in licit narcotic supplies will bring economic hardships to producers and provide possible incentives for diversion into illicit channels. Yet, a shortage of supply will result in needless suffering by those in legitimate medical need of narcotic-derived drugs.

World licit narcotic supplies currently exceed demand which presents a situation with substantial political, economic and law enforcement implications for both producers and consumers. In response to intense international concern last year, the U.S., after careful interagency coordination and review, decided to refrain from commercial production of **Papaver bracteatum,** a plant which can be used to produce narcotics, so as not to further exacerbate existing over-supply of narcotic raw materials. We are also cooperating with other major consumers and the INCB to provide producers with better estimates of our needs for narcotics over the next few years.

In his 1977 Drug Abuse Message to the Congress, President Carter urged the prompt ratification of the Convention on Psychotropic Substances. Enabling legislation was enacted in 1978 and the Administration has placed a high priority on the prompt ratification of the Treaty itself. This

is an important element of the Federal Strategy. Federal narcotics control strategy continues to give high priority to U.S. adherence to this international agreement regulating the production and trade in dangerous psychotropic substances, such as barbiturates and amphetamines, which also have legitimate medical uses. This is particularly important in U.S. relations with developing nations where misuse of psychotropic substances manufactured in developed countries presents major health and social problems.

Regional cooperation will also be emphasized. It is often more efficient and effective for governments in a particular region to work together to solve their common problems. The Federal Government will continue working with regional groupings of nations to further their commitment toward international narcotics control efforts, and to encourage the development of new regional groups when appropriate, such as in Latin America. The U.S. Government is already working closely with the Association of Southeast Asian Nations and the Colombo Plan in prevention and education efforts. Through support from other governments and international organizations, these regional groups can be encouraged to expand their cooperation to include narcotics law enforcement, as well as health programs. International Central Police Organization (ICPO)/ Interpol has already taken a number of steps in this area. The U.S. will work to promote narcotics cooperation among other regional groups such as the Organization of American States (OAS) and in Europe through the appropriate multilateral organizations.

C. Cooperation with Foreign Narcotics Enforcement Agencies

The 1979 Strategy emphasizes the need to continue the strong United States efforts in strategic overseas locations that have been an integral part of the current reductions in the availability of heroin. The on-site efforts of DEA personnel as an essential element of the United States Embassy Country Team are now enhancing the capability, interest and activities of foreign enforcement officials in anti-drug trafficking efforts.

We are witnessing ever increasing enforcement cooperation on an international scale. The continued presence of United States narcotic officials is essential to continued development of this spirit of cooperation and to the development of fully professional anti-drug trafficking programs.

We must strengthen United States cooperation with foreign narcotics enforcement and customs agencies. We intend to disrupt illegal manufacturing and trafficking networks by continuing productive on-going cooperation programs, such as:

—The development and sharing of intelligence and information with foreign enforcement agencies regarding illicit drug trafficking at the international level.

—The planning and development of international cooperative enforcement efforts for the immobilization of key violators and trafficking organizations on an international basis.

—The development and promotion of joint prosecution efforts.

—Promotion of bilateral and multilateral international cooperation in the development of enforcement programs to control the illicit traffic in drugs.

—Cooperation between enforcement agencies in the documentation and tracing of the illicit international money flow related to drug trafficking.

—Encouragement of foreign officials in the development of programs to identify laboratory operations involved in illicit production and to restrict the commerce in essential chemicals used in illicit drug manufacturing.

—Cooperation in negotiating mutual assistance treaties in criminal matters to include an emphasis on narcotics violations.

The bilateral and multilateral cooperation aspects of Strategy 1979 are long term efforts. The Strategy envisions that in the long term, narcotics enforcement by foreign authorities will be sufficiently strengthened and developed to ensure 1) a more successful international cooperative effort, 2) the enhancement of their ability to act unilaterally on their domestic enforcement activities, and 3) a concomitant reduction in U.S. presence overseas.

1. Foreign Enforcement Assistance. U.S. Government personnel will continue to assist foreign law enforcement agencies with support services aimed at identifying and stopping criminal networks and major narcotics violators at their base of operations and at interdicting narcotics at transit points. In keeping with the provisions of U.S. law, U.S.. personnel abroad will continue to refrain from direct involvement in foreign police actions.

A key factor in America's international narcotics law enforcement program is that the U.S. agencies, primarily, DEA, the Criminal Division of the Department of Justice, Customs and the Coast Guard, cooperate with their foreign counterparts, with the guidance and support of the Department of State. Areas for study and improvement in 1979 are: procedures for extradition and prosecution of narcotics traffickers, cooperation on enforcement matters, legal advice on the drafting of foreign narcotics legislation and the exchange of intelligence, particularly regarding the international movement of funds which fuel the international drug traffic. This latter area is of particular concern, as disruption

of the enormous cash reserves of narcotics traffickers will not only help suppress their illicit activities, but will also help return their funds to legitimate enterprise and economic and social progress.

The U.S. will promote financial disclosure and compliance, and will employ whatever statutes and procedures are available to make illegal drug financing subject to scrutiny, seizure and disruption.

2. Training. The U.S. Government, primarily DEA and Customs, will continue to provide technical and management training to foreign enforcement personnel, through foreign assistance funding by the Department of State, and will examine closely the results and effectiveness of such training to ensure relevance to the objectives of the international narcotics control program. Training is conducted both within the United States and abroad, and is keyed to five goals.

—Upgrading the drug law enforcement capability of foreign law enforcement personnel through training in investigative techniques and the management of drug law enforcement units.

—Motivating foreign police officials to initiate and continue higher level drug investigations.

—Increasing cooperation and communications between foreign police and U.S. personnel and among foreign police stationed along international trafficking routes.

--Providing programs of specialized training to selected countries in order to refine their already existent narcotic enforcement capabilities.

—Encouraging and assisting key countries in the development of self-sufficient narcotic investigative training programs.

This last point deserves special emphasis as an exemplary case of institution-building. For example, of the five advanced international drug enforcement schools conducted in the United States during the past year, four were designed to train instructors and training managers from other countries. Eighty-six officers from 27 different countries participated in these schools.

In addition to these U.S. initiatives, Strategy 1979 supports all efforts to rely on the international organizations such as ICPO/Interpol and the Customs Cooperation Council for law enforcement training and the exchange of information among cooperating members. U.S. international drug control efforts, such as training, should complement the activities of the U.N. and other international organizations. Increased efforts will be made to encourage the expansion of international organization activity, particularly in those areas where these efforts would better serve to control the supply of and demand for illicit drugs.

Commodity assistance, such as aircraft, communications equipment and vehicles, is an important part of foreign enforcement assistance and provides other governments with enforcement resources otherwise beyond

their own means. Companion training and advisory services to create the basic skills and technical infrastructure required for the proper use of equipment provided are essential. This assistance has achieved notable success in countries such as Burma, Colombia, Mexico and Thailand where seizures of heroin, cocaine and other drugs have increased dramatically since the inception of cooperative narcotic control efforts with the United States. Strategy 1979 encourages such efforts and the necessary safeguards to ensure that the assistance is used for the purposes intended.

3. **Increased Cooperation and Involvement Among U.S. Agencies.** The Federal Strategy underlines the need for increased cooperation among U.S. agencies involved in foreign enforcement assistance and training. The Strategy further emphasizes cooperation and coordination in the exchange of intelligence among the U.S. agencies, which could potentially contribute to the international program. For example, the U.S. Coast Guard, the U.S. Customs Service, the Criminal Division of the Department of Justice, the DEA, and the Department of State have begun an initiative to improve international cooperation in combatting vessel smuggling and interdiction on the high seas.

D. International Drug Abuse Treatment and Prevention

The U.S. will emphasize and support promising treatment and research projects in other countries, at the invitation of and in close cooperation with host governments.

Strategy 1979 recognizes the importance of U.S. support for foreign government initiatives to treat and prevent drug abuse for several reasons:

—For humanitarian concerns, since millions of people worldwide suffer from drug involvement;

—Because our help with a foreign country's drug problem can lead to that country's participation, with the U.S., in broader programs of international narcotics control; and

—Because the continued presence of a market for illicit drugs in other countries confounds attempts to reduce or eliminate production.

Target countries for international demand reduction efforts include many of the drug producing nations mentioned earlier as targets for supply reduction, but also an increasing number of affluent, developed nations. Serious drug abuse problems appear to be developing both in drug source countries because of ready availability, and in affluent "market" countries. The growing heroin problem in Western Europe is a good example. The needs of countries with well established social and welfare systems, of course, differ from those of lesser developed nations, and

approaches will differ also. Developing countries may need financial assistance to support pilot projects. Information sharing, liaison, and the exchange of research and program expertise are more appropriate methods of cooperation with the more developed countries.

Drug abuse is a global problem, and Strategy 1979 recognizes fully the interrelationships between international and domestic aspects of addressing such abuse. It is clear that greater use of diplomatic, political, economic, and law enforcement resources is essential to developing greater international commitment to narcotics control by foreign governments and international organizations. Worldwide commitment provides the best hope for lasting international narcotics control achievements. Recognizing that the international effort cannot do the job alone, Federal strategy integrates it fully with U.S. domestic programs.

VI. Intelligence

Intelligence is a key element in both our international narcotics control program and our domestic drug law enforcement efforts. The intelligence function encompasses the collection, production and exchange of relevant information on drug producers, crop production, illegal financing of drug shipments, traffickers, trafficking networks, and other elements of information useful for our narcotics control and interdiction strategies.

Federal strategy will continue to emphasize the importance of collecting, evaluating and sharing timely information which helps to support diplomatic policy initiatives and pinpoint targets for enforcement.

The strategy underlines the importance of financial intelligence revealing the details of monetary transactions of major drug traffickers. As violations of currency and financial statutes come to light, this intelligence could lead to prosecutions and convictions of traffickers who might not themselves be directly involved in drug movement.

Specific recommendations for increasing the quality and usefulness of financial intelligence related to the narcotics traffic have been developed and put into effect during the past year. The Executive Branch will therefore continue to: (a) increase the number of reports analyzed for the purpose of identifying apparent criminal or questionable financial activities; (b) set narcotics-related financial intelligence collection requirements and coordinate the cross-training of investigators in the methodology and use of financial intelligence; and (c) evaluate the impact of the Tax Reform Act of 1976 to ensure that certain provisions do not impede unnecessarily the investigation of upper echelon narcotics traffickers and financiers. In addition to these efforts, the Executive Branch will continue to seek the valuable intelligence by-products derived from the following

enforcement programs: (a) Narcotics investigations in which the Racketeer Influenced and Corrupt Organizations (RICO) statute is applied; (b) the coordinated Justice/Treasury/State plans to negotiate mutual assistance agreements with selected countries used by narcotics traffickers as financial havens; and (c) the IRS Narcotics Traffickers Tax Program designed to identify and prosecute high level drug traffickers for violations of the Federal income tax laws.

The strategy emphasizes the collection, analysis and dissemination of drug movement intelligence which could trigger investigations leading to the prosecutions and convictions of major traffickers and the immobilization of their networks. The strategy notes the role of the El Paso Intelligence Center (EPIC) as an interagency clearinghouse for the analysis of acquired information and timely intelligence support to facilitate international interdiction, U.S. border interdiction and domestic interdiction.

Strategy 1979 recommends an increased role for U.S. Customs in gathering intelligence for drug interdiction purposes, including greater participation of Customs, in coordination with DEA, in debriefing narcotics violators arrested at the U.S. borders and ports-of-entry. In addition, Customs will collect information from foreign customs services and foreign trade communities on all smuggling activities, including narcotics.

Strategy 1979 places particular emphasis on the need for interagency coordination of drug information. During the past year, the narcotics intelligence collection and production roles and responsibilities of the involved agencies have been defined and clarified. These agencies which include the Department of State, DEA, Customs, the Central Intelligence Agency (CIA), the National Security Agency (NSA), the Internal Revenue Service (IRS), the Federal Bureau of Investigation (FBI), as well as the Immigration and Naturalization Service (INS), and the U.S. Coast Guard will continue to work together through two committees which have been established to coordinate the narcotics intelligence activities of the Executive Branch. This dual committee structure is designed to ensure the complete separation of U.S. foreign intelligence activities from any involvement in domestic intelligence and law enforcement activities. These committees (the National Narcotics Intelligence Consumers Committee, chaired by DEA, and the appropriate committee of the U.S. foreign intelligence community) will formulate and coordinate narcotics intelligence collection and production requirements, as well as ensure the timely dissemination and evaluation of information and analytical products. The Federal agencies will look to these committees for standardized collection and production requirements.

During the past year, new procedures and guidelines were developed to permit more effective use by Federal policy officials and law enforce-

ment agencies of narcotics intelligence acquired abroad by U.S. foreign intelligence agencies.

Strategy 1979 supports these initiatives and supports the continued development and employment of a crop forecasting system to monitor international opium poppy cultivation. The crop forecasting system, when fully implemented, will provide more accurate information on the amount and sources of illegal opium available for the international market.

VII. Special Analyses

Marihuana, PCP and cocaine all present unique problems to policy-makers and merit special attention. The Federal policy on the use and trafficking of marihuana has been subjected to such misinterpretation in recent years that there is a need for the Strategy to delineate clearly our position on marihuana. PCP, which is easily and cheaply manufactured, may well represent the drug abuse wave of the future. The marketing and use of such drugs pose special treatment and law enforcement problems. Finally, cocaine also may well be a serious concern in the future. At present it causes few severe health consequences in this country, but it easily could if use patterns and availability alter.

A. Marihuana

According to the latest survey data, 43 million Americans have tried marihuana, and 16 million are current users in that they used it in the month preceding the survey. This aggregate figure includes groups within which use is much higher. The 1977 national survey of high school seniors reports that 56 percent of high school seniors have tried marihuana or hashish, and 48 percent report having used in in the prior year. Thirty percent used it in the last month, and 26 percent report about weekly use. Daily use of marihuana is reported by 9.1 percent of the sample.*

The use of marihuana continues to increase across the United States. The trend of daily marihuana use among American high school seniors increased from 6 percent in 1975 to 9.1 percent in 1977 while the age of first use has decreased. Preliminary results from the 1978 survey report 11 percent daily use, i.e., in three years, daily use of marihuana has almost

*"Drug Use Among American High School Students 1975-1977," Lloyd D. Johnston, Jerald G. Bachman, and Patrick M. O'Malley University of Michigan, under a research grant from the National Institute on Drug Abuse.

doubled. Use and the frequency of use are more pronounced among non-college bound students. Eleven percent of the college bound students report use 40 times or more in the previous year, versus 18 percent of the non-college bound.

Most scientists agree that marihuana use, however, is not harmless. Research has proven that marihuana intoxification clearly impairs motor coordination, reaction time and visual perception which would affect driving or operating machinery. The National Highway Safety Council has found an alarming incidence of marihuana use linked to highway traffic accidents. A recent study of 300 fatal car accidents in the Boston area also discovered an increased presence of marihuana: at the time of the fatal crash, 39% of the drivers had used alcohol and 16% had been under the influence of marihuana.

Marihuana is also widely used by adolescents and young adults during a time of rapid psysiological and psychological change. Chronic marihuana intoxication could seriously impair physical and emotional maturation and impede the individual's acquisition of intellectual and social skills. Heavy marihuana use can significantly inhibit good study habits and can have a detrimental effect on an individual's motivation to strive for long-term goals. Since our society discourages the use of all psychoactive drugs during adolescent development, including cigarettes and alcohol, it is inappropriate to proceed differently with marihuana.

There are additional risks associated with marihuana use even though marihuana research is far from complete. The amount of research on chronic use remains small, and research on marihuana's effects on those in poor health or older, and on females, has not been adequate. Nonetheless, clinical studies show that heavy marihuana smoking may be harmful to lung functioning — with resulting serious health consequences. Preliminary research has shown possible adverse impact of marihuana on such areas as the body's immune response, basic cell metabolism, and sexual functioning. All of these findings give cause for caution in any public policy on marihuana.

Strategy 1979 discourages marihuana use. The approaches are to continue supply interdiction efforts towards reduced availability, and to discourage use through positive educational efforts to explain the effects and through the application of appropriate sanctions.

Federal enforcement is directed against major domestic distributors, importers and international financiers; overseas efforts are aimed at foreign growing areas and international supply routes.

The past use of incarceration as a sanction against marihuana use has been erratically applied, often with an extremely harsh punishment doing more harm to the individual than the drug itself. Therefore, Federal strategy supports a reduction in the severity of the Federal criminal

penalties for personal possession and use. The penalties should not be lifted altogether, however, as this could be misconstrued to mean we condone marihuana use and could, furthermore, undermine our Federal policy which is to discourage marihuana use.

Federal penalties for trafficking would remain in force and the States would remain free to adopt whatever laws they consider appropriate.

Federal Strategy underlines the importance of continuing marihuana research, especially on chronic marihuana use and the effects upon young people, older people and women. The picture of marihuana is by no means complete for while we know marihuana use harmful, we do not know to what degree.

Accurate information about marihuana is also a critical part of the Federal strategy. Clear information must be made available to parents and teachers to enable them to deal with marihuana use by their children or pupils and to give a clear message discouraging use. Special informative materials should be developed for high risk groups, such as women of child-bearing age, or pregnant women, for whom even occasional marihuana use may have serious adverse consequences. In addition, all drug abuse prevention strategies for young people should include information on marihuana.

The Federal strategy against marihuana traffickers should create the greatest amount of legal and economic risk possible at all levels of the trafficking network. Our concern from the enforcement standpoint is with those drugs which provide financial support to illegal trafficking networks, as well as the pharmacologically most dangerous drugs. Trafficking networks often switch from drug to drug, depending on which is perceived to carry the least risks, and large marihuana shipments are as valuable as smaller amounts of heroin or cocaine. The strategy is to immobilize the trafficking organizations involved with drugs by increasing the risk of arrest and making it more costly and inconvenient to do business.

Great quantities of marihuana are grown in foreign countries, particularly Colombia and Mexico. It is important to recognize that illegal cultivation has the greatest impact on the country where the drug is produced. This illicit cultivation can seriously damage the economic and political stability of the country, as well as its relationship with other nations. These consequences are recognized by all of the signatories to the Single Convention and other international treaties on drug control. The United States, both bilaterally and within the United Nations, has a commitment to fulfill its international treaty obligations.

The strategy supports cannabis crop eradication as an appropriate activity for both bilateral and multinational efforts. We consider the U.N. to be the most appropriate organization to advise on such assistance.

However, if a foreign government requests aid we would consider giving it, with two caveats prescribed by law:

--The proposed method of eradication would have to be evaluated for possible health and environmental consequences; and

--If a chemical herbicide were to be used, an easily distinguishable marker would have to be added, indicating that the marihuana plants had been sprayed.

In summary, the rising levels of marihuana use in our country are of great concern. Continued research on possible health consequences is a high priority and Federal strategy is to discourage use of marihuana.

B. PCP

Phencyclidine (PCP) presents a new and difficult problem in the area of drug abuse. PCP is a veterinary tranquilizer which is not approved for human use. When used by humans, it can cause severe and long-lasting behavioral problems with effects ranging from mental dullness and misperceptions to paranoia, psychosis, hostility and violence. Its use can cause death either directly by overdose or indirectly by violent behavior and accidents. Reported deaths from PCP have doubled in the past year, use by the 12-18 age group has doubled (up to 5.8 percent), and use by the 18-25 age group is up by 50 percent (up to 13.9 percent). It is easy and inexpensive to manufacture in illicit laboratories, and there is no evidence of diversion from licit sources. With an investment of a few hundred dollars the common chemicals and equipment for PCP manufacture can be purchased. Using relatively unsophisticated chemical techniques, the manufacturer can concert his investment into tens of thousands of dollars worth of PCP.

As the marketing and use of PCP have been increasing, concern within the Federal Government has been rising. The Administration has developed and coordinated a response to this problem which addresses both health and law enforcement issues.

On the law enforcement side, PCP has been moved from Schedule III to Schedule II of the Controlled Substances Act. Two of its precursors have also been put into Schedule II. Two analogues have been recommended for scheduling by DEA and the Department of Health, Education, and Welfare (DHEW), and other precursors and analogues are being investigated. DEA is working with chemical manufacturers and distributors to scrutinize unusual orders or purchases of chemicals and equipment needed to manufacture PCP. In October 1978, the Congress passed an amendment to the Controlled Substances Act which establishes a requirement to report to the Attorney General all transactions involving piperidine (a chemical used in making PCP).

On the health side, letters to treatment programs and emergency rooms, public service spots on TV, fact sheets and summaries for lay and professional people, posters, pamphlets, etc., have been developed to increase public and professional awareness of the dangers of PCP. DHEW is conducting further research on the demographics of abuse and is developing treatment manuals and clinical studies. In addition, PCP was included in the 1978 Drug Abuse Prevention Campaign.

The control of cheap and easily manufactured synthetic drugs is difficult and may well be a major concern of the future. It is quite possible that the marketing of PCP will serve as a model for further illegal synthetic drugs. Law enforcement efforts can make the manufacture and trafficking of such drugs a risky business by encouraging active investigation and prosecution, swift and appropriate sentencing, and by making acquisition of manufacturing materials more difficult, and easier to detect. Control efforts must be coupled with both treatment and prevention initiatives. Information dissemination to treatment programs, hospitals and other service delivery systems is essential, so that they can recognize and appropriately treat synthetic drug incidents. Accurate information must also be made available to young people, parents and teachers, as part of the more generalized positive prevention strategy.

C. Cocaine

The abuse of cocaine and the expanding international traffic in cocaine continue to be of great concern to the Federal Government and, therefore, deserve special attention in this section of the Strategy. We estimate that approximately ten million Americans abused cocaine during the past year. A nationwide survey in 1977 showed that nearly one in five 18-25 year olds, (19.1 percent) the peak age group for illicit drug use, report having ever used cocaine and of those who have, nearly one in five used cocaine (3.7 percent of the entire group) in the month preceeding survey.

Cocaine is the principal psychoactive ingredient of the coca bush which unlike marihuana and opium, has been geographically restricted to the Andes Mountains of South America. The production and shipment of cocaine have been largely limited to Peru, Bolivia, Colombia, and to a lesser extent Ecuador. In cooperation with the governments of these countries, Strategy 1979 encourages all efforts to control the drug within these source and primary transit countries.

Though the health consequences of cocaine use have been explained in a number of documents such as "Cocaine, 1977", published by the Department of Health, Education, and Welfare, many users still believe that cocaine is relatively free from markedly undesirable side effects and

is generally safe. Cocaine's reputation for safety, however, is overstated since it is, in part based on diluted doses of the drug taken relatively infrequently due to its high cost. Furthermore, its use and consequences are often difficult to detect by current reporting systems since it produces few "traditional" overdose deaths and emergency room episodes. For example, cocaine is used frequently by some celebrities, "folk heroes" and certain high income groups who can afford the drug, who do not often appear in the traditional clinic or treatment center but who would turn to their own personal doctor whenever their cocaine use becomes a serious problem. Consequently, these individuals would not appear in any national surveys or reporting systems which address the extent of cocaine use and its consequences.

There are, however, several important things we do know about the health consequences of cocaine use. We know, for example, that cocaine can kill — not commonly but occasionally and not predictably. Despite the street lore to the contrary, death can occur even when the drug is snorted rather than injected. We also know that cocaine is the most powerfully reinforcing of all abused drugs. Although not physically addictive in the sense that opiates are, there is good evidence to show that the desire to continue using cocaine is remarkably strong if the drug is available.

There is also good evidence that cocaine in moderate doses (10-25 mg. i.v. and 100 mg. intranasally) significantly increases both heart rate and blood pressure. Large doses of cocaine, particularly when taken frequently, can cause mental aberrations and destruction of the nasal linings. As we have also noted in this report, (p. 31) Bolivian health officials have expressed serious concern over the extent of coca paste smoking, a pre-cocaine substance readily available in Bolivia.

Despite these consequences, many still consider cocaine to be a "safe" drug. Unfortunately a lack of adequate information is sometimes misinterpreted as indicating that a drug is "safe" when it would be more accurate to admit that our knowledge is simply insufficient to specify the full parameters of risk.

Though we have emphasized the serious health consequences of cocaine abuse, a word should be said about the legitimate medical uses of cocaine in order to present a balanced Federal Strategy. Cocaine is still used today in otolaryngology (ear, nose and throat medicine) and anesthesiology as an effective local anesthetic when applied topically or injected near the nerves. It constricts blood vessels and thereby limits the amount of bleeding brought about by surgery.

Strategy 1979 is to continue to inform the American public of the health and social consequences of cocaine use as the information and the results of laboratory experiments become available. We emphasize the

importance of continuing to conduct research to increase our knowledge of the effects of compulsive cocaine use as well as the patterns of cocaine use. The Strategy will also continue to support all efforts to reduce the availability of illicit cocaine. Our current law enforcement efforts towards cocaine have made the drug expensive and that in itself has contributed to a reduced availability. Strategy 1979, therefore, supports these efforts, and looks to programs designed to affect the cocaine production system and distribution networks near the source of the drug, before it dissipates and disappears in our domestic illegal market.

The difficulties in accomplishing this control at the source are many. However, Strategy 1979 supports two efforts which should reduce the availability of cocaine: attacking the trafficking networks and reducing coca bush cultivation. The tremendous profits in the cocaine traffic support organized crime and criminal elements both in the United States and abroad and insulate the trafficking networks. This illicit cocaine traffic could seriously undermine the political and economic stability of a number of countries, as well as corrode the independence and integrity of their criminal justice systems, making prosecution and conviction difficult. Furthermore, the criminal networks which distribute cocaine can also distribute other drugs virtually interchangeably, and thus can change routes, approaches and markets with ease which could, in all, further prove detrimental to a nation's stability.

Attempts to reduce coca plant cultivation present several additional problems. Most of the coca bushes are grown legally and almost exclusively in Bolivia and Peru. The illegal processing into cocaine takes place mainly in Colombia and on a smaller scale in Ecuador, Peru and Bolivia. Coca cultivation and production does occur in other South American countries and in other parts of the world; however, this production and any diversion of pharmaceutical cocaine are minimal compared to the quantity produced in Peru and Bolivia. Chewing coca leaves has long been an accepted cultural practice of many of the peoples native to these countries and many of these people are currently dependent upon the coca bush for income. Reducing coca cultivation, therefore, will entail comprehensive and carefully designed programs to provide for income and crop substitution. Such programs may require the development of an entire new agricultural economy and could improve the economic status of the farmer as well as his social welfare. Strategy 1979, therefore encourages projects designed to reduce coca cultivation through income substitution and integrated rural development programs.

During the past year, significant efforts have been made to reduce the availability of cocaine. Colombian President Turbay made a personal commitment to assign a high priority to stopping the cocaine traffic in Colombia. Additionally, Bolivia is now considering the establishment of a

state monopoly over the licensing and production of coca leaves. This would permit the Bolivian government to control and limit the production of coca leaves to meet only domestic chewing needs. The remainder would be declared illegal and destroyed. The Strategy will continue to encourage the development of similar cooperative arrangements with the other involved Latin American countries. The Strategy further seeks a close working relationship with the United Nations and the international financial institutions in these efforts to reduce coca cultivation to achieve both long-term and lasting progress.

In conclusion, the Strategy considers cocaine to be a priority drug exceeded only by heroin and barbiturates. The Strategy recognizes that the effort to reduce coca cultivation and cocaine trafficking in the source and processing countries is the most effective way to prevent an increase in cocaine-related deaths and injuries at home. The Strategy further recognizes that these efforts alone will not suffice and therefore encourages the research and scientific efforts necessary to adequately inform the American public of the health and social consequences of cocaine use.

VIII. Summary

The **Federal Strategy for Drug Abuse and Drug Traffic Prevention, 1979** describes a three-part program consisting of domestic treatment, rehabilitation and prevention; domestic drug law enforcement; and the international drug control program. The Strategy emphasizes the need for coordination among these three so that they are complementary to each other, within a broad, consistent framework of Federal policy. The Strategy supports a policy oversight function within the Executive Office of the President, and close coordination with the Cabinet Departments, the involved committees and members of the United States Congress.

The Strategy sets forth two broad policy objectives: first, to discourage all drug abuse; and second, to reduce to a minimum the health and social consequences of drug abuse when it does occur.

In setting priorities for Federal action, the Strategy makes an important distinction between drugs as items of consumption within the United States, and drugs as commodities in the illicit market. In our country we focus on those drugs that cause the gravest health and social damage to individuals, to communities and to our nation. Some drugs are addicting, others not, some likely to cause death by overdose, others not, and so on. In the United States, we want to keep people from harm—and so we naturally focus on the drugs with the highest probability of causing injury or death. In the international criminal marketplace, however, money counts as much as pharmacology. Any drug which provides financial

incentive to illegal traffickers is important to us, because the illegal business itself does great harm to the social fabrics and economies of the countries involved. Therefore, we look at both economics and health in determining international program priorities.

The Strategy broadens the focus of domestic treatment and prevention. In the past Federal programs have concentrated—and justifiably so—almost exclusively on heroin addiction, since heroin was judged to be the drug of greatest individual and social concern. At that time resources were limited and the heroin situation was critical. Strategy 1979 no longer focuses primarily on individual drugs, but looks instead at drug-taking behavior. Chronic, compulsive drug abusers—of any substance—are those most in need of treatment and should receive Federal priority. The Strategy also recognizes that negative consequences can result from a wide variety of drug-taking behaviors—from occasional, recreational use to the misuse of prescription drugs—and recommends an increased sensitivity throughout Federal health and social service delivery systems to drug-related problems. The Strategy recommends more specificity in treatment and prevention programs and planning, with increased attention paid to the unique needs of special populations, including youth, the elderly, ethnic minorities, rural populations and women.

In the area of prevention, the Strategy expresses deep concern over the high levels of daily drug use by adolescents, in particular the daily use of marihuana and alcohol. Daily intoxication by a young person is a serious issue. Chronic intoxication, using any drug, can seriously impair physical and emotional maturation and impede the individual's acquisition of intellectual and social skills. Many students agree that smoking marihuana and drinking do not "go with" studying or striving for long-term goals. The resulting loss of skills and abilities can cripple the individual for the rest of his or her life. The Strategy discourages all psychoactive drug use by adolescents.

For the domestic drug law enforcement program, the Strategy highlights the cooperation among Federal, State and local law enforcement agencies. The need for a comprehensive approach to border management is underlined as is the need for close coordination and cooperation among current border agencies. The Strategy underlines the importance of improved technology, rather than increased manpower for interdiction. The Federal role in domestic drug law enforcement highlights an emphasis on the pharmacologically most dangerous drugs, a focus on high level traffickers and on intelligence investigations and conspiracy cases as a means of disrupting whole trafficking networks. The Strategy supports financial investigations as a way to prosecute traffickers who are so high level that they never actually handle the drugs, and as a way to cripple trafficking networks.

The Strategy stresses the importance of the international program, both to reduce the supply of illicit drugs before they are smuggled into the United States, and to reduce worldwide demand. International cooperation is essential if we are to achieve either of these goals. There is a growing concern among nations around the world over the health, social and economic damage done by drug abuse and trafficking. Many of the producing countries are developing drug problems of their own as are an increasing number of countries with industrial economies and long histories of social service programs. On an average the countries of the world are from two to ten years "behind" the United States in either experiencing or recognizing the social phenomenon known as drug abuse, but several of them are catching up very fast. In a number of European countries, sophisticated health-delivery and other social systems have not yet addressed the drug problem, though drug abuse has, in fact, become a major concern.

The United Nations, and other international and regional bodies, are ideally positioned to stimulate the kind of leadership and regional collaboration that is required to deal with these problems. As other countries move to a confrontation with their drug problems, there are opportunities for the United States to share what it has learned and learn from those countries as they take steps of their own. The U.N. should be urged to assume this role of international facilitator and convenor.

The Strategy places a high priority on developing within the international community a strong interest on drug abuse treatment and prevention, as well as drug control efforts.

Drug abuse and drug trafficking are both complex, fluid phenomena—and the strategy is to maintain a flexible response, involving a wide variety of approaches. We have established and maintained over time a multifaceted approach to drug abuse and trafficking—involving law enforcement pressures, international initiatives, and the provision of treatment services for users. Federal, State and local governments have all participated.

Strategy 1979 underlines the need to continue to commit resources for these programs, to reassess and adjust them as necessary, and to place great emphasis on reducing the harm done by drug abuse and drug trafficking in our country.

Appendix A

DRUG ABUSE PREVENTION DISCRETIONARY AND NON-DISCRETIONARY PROGRAMS
Total
(Dollars in Millions)

AGENCY	FY 1975			FY 1976			FY 1977			FY 1978			FY 1979		
	BA	OBL	OUTL	BA	OBL	OUTL	BA	OBL	OUTL	BA	OBL	OUTL	BA	OBL	OUTL
SAODAP/ODAP	10.1	10.1	10.1	–	–	–	1.1	1.1	1.1	1.2	1.2	1.2	.65	.65	.65
HEW:															
HCFA. (Medicaid/Medicare)	(79.0)	(79.0)	(79.0)	(88.0)	(88.0)	(88.0)	(94.0)	(94.0)	(94.0)	(-)	–	–	(-)	–	–
NIDA	220.2	219.8	246.9	232.2	232.1	211.1	259.8	259.8	249.0	262.1	262.1	259.5	275.3	275.3	267.0
NIMH	2.1	2.1	2.1	2.5	2.5	2.5	2.8	2.8	2.8	3.4	3.4	3.4	3.8	3.8	3.8
NIH															
OE	4.0	4.0	0	2.0	2.0	2.6	2.0	2.0	2.6	2.0	2.0	2.6	2.0	2.0	2.1
SSA	1.34	.2	.06	6.83	.17	.11	.9	.64	.64	.38	.38	.38	.4	.4	.4
OHD	9.8	9.8	9.8	10.9	10.9	10.9	10.4	10.4	10.4	10.6	10.6	10.6	11.0	11.0	11.0
OEO/CSA															
VA	34.8	34.8	34.8	36.7	36.7	36.7	37.8	37.8	37.8	38.6	38.6	38.6	39.3	39.3	39.3
JUSTICE															
BOP	6.0	6.0	6.4	5.3	5.3	6.1	5.8	5.8	5.8	6.1	6.1	6.1	4.8	4.8	4.8
LEAA	24.1	24.1	19.5	12.8	12.8	16.9	9.6	9.6	19.4	12.1	12.1	16.0	10.1	10.1	12.7
DEA	2.9	1.2	1.2	2.9	1.2	1.1	1.7	1.4	1.3	1.0	1.0	1.1	.6	.6	.6
DOD	45.5	45.5	45.5	45.9	45.9	45.9	31.8	31.8	31.8	33.9	33.9	33.9	34.6	34.6	34.6
STATE	–	–	–	.1	.1	0	.3	.3	.2	.8	.8	.7	.5	.5	.4
CSC															
DOL	.1	.1	.1	–	–	–	.02	.02	.02	.03	.03	.03	.04	.04	.04
DOT FAA	.2	.2	.2	.1	.1	.1	.2	.2	.2	.3	.3	.3	.3	.3	.3
DOT NHTSA	0.5	0.5	0.5	0.7	0.7	0.7	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6
DOT Coast Guard	.6	.6	.6	.7	.7	.7	.8	.8	.8	.8	.8	.8	.9	.9	.9
USDA	.2	.2	.2	.2	.2	.2	.6	.6	.6	.6	.6	.6	.6	.6	.6
ACTION	1.4	1.4	1.0	1.7	1.7	1.7	1.9	1.9	1.8	2.0	2.0	2.0	0.3	0.3	0.3
TOTAL	361.9	360.6	378.9	361.5	353.1	337.3	368.1	367.6	366.9	376.5	376.5	378.4	385.8	385.8	380.1

DRUG LAW ENFORCEMENT PROGRAM FUNDING
Total
Excludes Drug Abuse Prevention Activities
(Dollars in Millions)

AGENCY	FY 1975			FY 1976			FY 1977			FY 1978			FY 1979		
	BA	OBL	OUTL	BA	OBL	OUTL	BA	OBL	OUTL	BA	OBL	OUTL	BA	OBL	OUTL
Dept. of Justice:															
FBI	.4	.4	.4	.4	.4	.4	.3	.3	.3	2.5	2.5	2.5	3.4	3.4	3.4
INS	2.3	2.3	2.3	2.7	2.6	2.6	3.1	3.1	3.1	3.2	3.2	3.2	3.8	3.8	3.8
DEA	132.8	134.6	131.0	152.1	149.8	131.6	166.5	166.7	165.5	187.5	190.0	189.0	192.4	192.4	192.9
LEAA	35.0	35.0	43.5	32.1	32.1	30.4	24.6	24.6	25.1	18.1	18.1	19.3	18.3	18.3	16.9
Justice (Criminal Division)	1.1	1.0	.99	.98	.90	.90	1.12	.95	.94	1.0	1.0	1.0	1.3	1.3	1.3
U. S. Attorneys	8.21	8.21	8.04	10.25	10.25	10.05	10.17	10.17	10.17	11.3	11.3	11.3	12.0	12.0	12.0
Dept. of State and AID	32.1	31.7	14.8	46.4	43.6	44.2	35.2	35.2	27.8	41.9*	41.9	33.9	40.0	40.0	38.7
Dept. of Transportation:															
FAA	.7	.7	.7	.8	.8	.8	.9	.9	.9	1.0	1.0	1.0	1.1	1.1	1.1
Coast Guard	N/A	N/A	N/A	8.6	8.6	8.6	9.0	9.0	9.0	13.6	13.6	13.6	13.9	13.9	13.9
Dept. of Treasury:															
IRS	13.0	13.0	13.2	8.3	8.3	8.4	6.7	6.7	6.6	13.4	13.4	13.4	13.4	13.4	13.3
Customs	40	40	39	57	57	55	62	62	58	66	66	65	73.0	73	73
USDA	1.4	1.6	1.4	1.4	1.3	1.1	1.4	1.9	1.6	1.7	1.7	1.4	1.7	1.7	1.4
DOD-Civil (Unavailable)															
CIA/NSA (Unavailable)															
FDA	1.8	1.8	1.8	1.8	1.7	1.8	2.2	2.2	2.2	2.4	2.4	2.4	2.4	2.4	2.4
Bureau of Prisons: Incarceration of drug** law offenders	48.2	48.2	48.2	*** 43.5	43.5	43.5	45.9	45.9	45.9	53.4	53.4	53.4	60.94	60.94	60.94
TOTAL:	317.0	318.5	305.5	366.6	360.9	339.4	369.1	369.6	357.1	417	419.5	410.4	437.6	437.6	435.0

*Includes 4.8 carry-over

**About 6,000 offenders @ FY '77, $21; FY '78, $24; FY '79, $27 a day per offender.

***Drop due to early release provisions

Appendix B

President Carter's Message to the Congress

The White House

To the Congress of the United States:

Drug abuse continues to be a serious social problem in America. The lives of hundreds of thousands of people are blighted by their dependence on drugs. Many communities remain unsafe because of drug-related street crime, and the immense profits made in the illicit drug traffic help support the power and influence of organized crime. Among young American men aged 18-24 years, drugs are the fourth most common cause of death: only automobile accidents, homicides, and suicides rank higher. The estimated cost of drug abuse in America exceeds 15 billion dollars each year. Among some minority groups, the incidence of addiction and the harm it inflicts are disproportionate.

Drug addiction, which in recent years was viewed as a problem peculiar to America, now affects people throughout the world. We can no longer concern ourselves merely with keeping illicit drugs out of the United States, but we must join with other nations to deal with this global problem by combatting drug traffickers and sharing our knowledge and resources to help treat addiction wherever it occurs. We must set realistic objectives, giving our foremost attention domestically to those drugs that pose the greatest threat to health, and to our ability to reduce crime. Since heroin, barbiturates and other sedative/hypnotic drugs account for 90 percent of the deaths from drug abuse, they should receive our principal emphasis.

My goals are to discourage all drug abuse in America—and also discourage the excessive use of alcohol and tobacco—and to reduce to a minimum the harm drug abuse causes when it does occur. To achieve these goals with the resources available, effective management and direction are essential. Because the federal effort is currently divided among more than twenty different, and often competing, agencies, I have directed my staff to coordinate Federal action and to formulate a com-

prehensive national policy. This will end the long-standing fragmentation among our international programs, drug law enforcement, treatment and rehabilitation, prevention, and regulatory activities. I will also seek the counsel and active involvement of members of the Cabinet and heads of major independent agencies on all drug abuse policy questions, through a revitalized Strategy Council on Drug Abuse. My staff will examine the functions of the various agencies involved in this field and will recommend to me whatever organizational changes are appropriate.

International Cooperation

For certain drugs originally derived from plant sources outside the United States, especially heroin and cocaine, diplomatic agreements against cultivation and trafficking are indispensable. Turkey—once virtually the sole source of heroin supply in this country—is now gone from the illicit market as the result of such an agreement. The enormous profits generated by the illicit drug traffic distort the economies of many smaller countries, aggravating inflation and draining tax revenues; they also engender corruption and corrode political stability. We must work closely with other governments to assist them in their efforts to eradicate the cultivation of drugs, and to develop legitimate alternative sources of income for the impoverished farmers who have for generations raised and sold crops such as opium.

We have made significant progress in the last few months. In February, I discussed with President Lopez-Portillo of Mexico my deep concern about the illegal cultivation of opium in his country. Under his strong leadership, the eradication program has been intensified and is producing dramatic results, significantly reducing the availability of heroin in many American cities. In addition, President Ne Win of Burma and Prime Minister Thanin of Thailand have shown a resolute determination to control drug cultivation and trafficking in their countries. Most recently I have received strong assurances from President Lopez-Michelsen of Colombia that he plans to give the problem of drug trafficking his highest priority. We are establishing a commission made up of government officials from our two countries to coordinate a stepped up effort to deal with the major international trafficking of cocaine and marihuana between our two countries, and the devastating economic impact of that traffic.

As a result of these efforts and those of the Drug Enforcement Administration, the purity of heroin in our country has dropped in the last six months to 4.9%, the lowest level in 4 years.

There is, however, more that we can do:

(1) I am directing the Secretary of State to give greater emphasis to the international narcotics control program and to reiterate to foreign governments our strong desire to curtail production of, and traffic in, illicit drugs.

(2) To this end, I am directing the Administrator of the Agency for International Development to include such measures as crop and income substitution in its development programs for those countries where drugs are grown illicitly. I expect the Secretary of State to continue to call on other agencies and departments, such as the Drug Enforcement Administration, the U.S. Customs Service, the U.S. Department of Agriculture, and the National Institute on Drug Abuse, to assist in the international narcotics control program according to the special expertise of each.

(3) I am directing the intelligence community to emphasize the collection and analysis of information relating to international drug trafficking.

(4) I strongly support the work of the United Nations Fund for Drug Abuse Control (UNFDAC), the United Nations Commission on Narcotic Drugs, the International Narcotics Control Board, the World Health Organization, and other organizations working within the framework of the United Nations in their efforts to help drug-producing countries find alternate crops, improve drug control measures, and make treatment resources available.

(5) I am instructing the United States representatives to the loan committees of the Regional Development Banks and other international financial institutions to use their votes and influence to encourage well designed rural development and income substitution projects in countries which now produce dangerous drugs, and to ensure that assistance is not used to foster the growth of crops like opium and coca.

(6) Because of the need to improve international controls over dangerous drugs which have legitimate medical uses, like barbiturates and amphetamines, I urge the Congress to adopt legislation implementing the Convention on Psychotropic Substances, and I urge the Senate to ratify this treaty promptly.

(7) In my communications with foreign leaders, I will emphasize international cooperation among drug law enforcement agencies, so that intelligence and technical expertise can be shared. I will encourage them to send law enforcement officials to work with us to stop the flow of drugs through other countries. This kind of cooperation has already begun in Bangkok among French, German, British, Dutch, American and Thai officials.

I will, in addition, promote the international sharing of knowledge and expertise in the treatment of drug abuse. We will make a special effort to share our experience, especially with those nations which have

serious drug problems and which are working with us in the effort to control drug sources and prevent drug abuse. Our program will encompass training, research and technical assistance projects, including providing American experts as consultants.

Law Enforcement

We must vigorously enforce our laws against those who traffic in drugs, so that the attraction of large profits is outweighed by the risk of detection and the likelihood of conviction. The Federal Government's job is to deter, and where possible prevent entirely, illegal importation and major trafficking of controlled substances. Often large-scale financiers of the illegal drug trade never come into direct contact with drugs. Through the cooperative efforts of the various agencies involved, we will attack the financial resources of these traffickers who provide the capital needed to support the smuggling of drugs into the country. Drug traffickers must understand that they face swift, certain, and severe punishment; and our law enforcement and judicial systems must have the resources to make this prospect a very real threat. We must allocate our resources intelligently, revise our penalty structure where necessary to concentrate on the actions (and the drugs) that are most dangerous, and improve the administration of justice.

Therefore:

- I am directing the Attorney General to intensify investigations of the link between organized crime and the drug traffic, and to recommend appropriate measures to be taken against these organizations.
- I am directing the Department of Justice in conjunction with the Departments of State and Treasury to study arrangements with other countries, consistent with Constitutional principles, to revoke the passports of known major traffickers, and to freeze assets accumulated in the illegal drug traffic.
- To ease the burden on the United States District Courts, which must hear major drug cases, I support legislation widening the jurisdiction of U.S. Magistrates under certain circumstances to include misdemeanor offenses which carry sentences of up to one year.
- In 18 United States Attorneys' Offices, special units devoted to the prosecution of major drug traffickers exist. The Department of Justice is now expanding this program to include additional units.
- I support legislation raising from $2,500 to $10,000 the value of property which can be seized and forfeited from drug violators by administrative action, including cash within the definition of seizable property. Amounts above this figure will continue to require court proceedings.

- I am directing my staff to recommend to me the appropriate Federal drug law enforcement role in the light of currently available resources—state, local and Federal. For nearly a decade, Federal support of state and local enforcement activity has steadily expanded. The time is ripe to evaluate the results of this effort, to determine whether federal participation should be altered, and to determine the proper division of responsibility between Federal and local officials. The Office of Drug Abuse Policy has already begun the first phase of this review, which includes consideration of border security and drug trafficking intelligence.
- I am directing the Attorney General to study the necessity for and constitutionality of proposals which would deny pre-trial release to certain persons charged with trafficking in drugs posing the greatest threat to health, and to give me his recommendations within 90 days. At the present time, some persons charged with major drug offenses can use their immense wealth to post bail and escape justice. If enactment of such proposals appears to be necessary and constitutional, their application should be tightly restricted and they should include a provision granting the accused an expedited trial.
- I am directing the Attorney General to review the adequacy of the penalties for major trafficking offenses and to give me his recommendations within 90 days.
- I also have considered requesting changes in the Tax Reform Act of 1976. Some of its provisions—such as those for disclosure and summonsing—were designed to protect the privacy of citizens but may also impede unnecessarily the investigation of narcotics trafficking cases. I am asking the appropriate Federal agencies to determine the difficulties these provisions present to effective law enforcement. If it appears they can be amended to improve law enforcement without infringing upon legitimate privacy interests, I will submit legislation to the Congress.

Marihuana

Marihuana continues to be an emotional and controversial issue. After four decades, efforts to discourage its use with stringent laws have still not been successful. More than 45 million Americans have tried marihuana and an estimated 11 million are regular users.

Penalties against possession of a drug should not be more damaging to an individual than the use of the drug itself; and where they are, they should be changed. Nowhere is this more clear than in the laws against possession of marihuana in private for personal use. We can, and should, continue to discourage the use of marihuana, but this can be done without defining the smoker as a criminal. States which have already removed

criminal penalties for marihuana use, like Oregon and California, have not noted any significant increase in marihuana smoking. The National Commission on Marihuana and Drug Abuse concluded five years ago that marihuana use should be decriminalized, and I believe it is time to implement those basic recommendations.

Therefore, I support legislation amending Federal law to eliminate all Federal criminal penalties for the possession of up to one ounce of marihuana. This decriminalization is not legalization. It means only that the Federal penalty for possession would be reduced and a person would receive a fine rather than a criminal penalty. Federal penalties for trafficking would remain in force and the states would remain free to adopt whatever laws they wish concerning the marihuana smoker.

I am especially concerned about the increasing levels of marihuana use, which may be particularly destructive to our youth. While there is certain evidence to date showing that the medical damage from marihuana use may be limited, we should be concerned that chronic intoxication with marihuana or any other drug may deplete productivity, causing people to lose interest in their social environment, their future, and other more constructive ways of filling their free time. In addition, driving while under the influence of marihuana can be very hazardous. I am, therefore, directing the Department of Transportation to expedite its study of the effects of marihuana use on the coordination and reflexes needed for safe driving.

Drug Treatment

My immediate objective will be to widen the scope and improve the effectiveness of Federal drug treatment programs. In conception and in practice, they have been too narrow. Drug addiction can be cured; but we must not only treat the immediate effects of the drugs, we must also provide adequate rehabilitation, including job training, to help the addict regain a productive role in society. In the past, Federal programs have given disproportionate attention to the heroin addict while neglecting those who are dependent on other drugs.

To improve the quality of Federal drug treatment, I am recommending these steps:

- In recognition of the devastating effects that certain nonopiate drugs can have if abused, I am directing the Secretary of Health, Education, and Welfare to expand resources devoted to care for abusers of barbiturates, amphetamines, and multiple drugs used in combination, including alcohol.

• To help drug abusers return to productive lives, I am directing the Secretary of Labor to identify all Federal employment assistance programs which can help former drug abusers and to give me, within 120 days, his recommendations for increasing the access of drug abusers to them.

• A sustained effort must be made to identify the reasons that people turn to drugs, including alcohol and cigarettes. We should seek more effective ways to make people aware of the health problems associated with such substances (particularly cigarettes and alcohol) and to respond in more constructive ways to the human and psychological needs they satisfy.

Drug Research

In the past, there has been no serious attempt to coordinate Federal research on opiates and alcohol despite the many similarities in the effects of these two drugs. A joint Federal research center might not only save money, but also lead to greater scientific understanding of addiction problems. Therefore I am directing the Secretary of Health, Education, and Welfare to study the feasibility of making the Addiction Research Center responsible for coordinated research on a variety of drugs, including opiates, alcohol, and tobacco.

Administrative Action

Improved treatment and prevention programs should be accompanied by appropriate changes in Federal regulations, administrative practices, and enforcement, among which are these:

• **First,** I am recommending a conscious and deliberate increase in attention throughout the Federal Government to the problems related to the abuse of drugs that come originally from legitimate medical sources. Of particular concern are barbiturates, which despite their recognized medical use, are responsible for many deaths and are frequently used in suicide attempts. The withdrawal reaction of patients addicted to barbiturates can be more difficult and more dangerous than that associated with heroin withdrawal. They are frequently oversold, overprescribed, and overused.

Therefore, I will:

—Instruct the Secretary of Health, Education, and Welfare to undertake a study of barbiturates and other sedative/hypnotic drugs to determine the conditions under which they can be most safely used.

—Instruct the Secretary of Defense, the Secretary of Health, Education, and Welfare, and the Administrator of Veterans' Affairs to review the prescribing practices of physicians under their jurisdiction, and to discourage the medical use of barbiturates and sedative/hypnotics except in cases where it is unmistakably justified.

—Continue the program, already begun at my direction, by which the Drug Enforcement Administration has instructed its regional offices and regulatory task forces to give priority attention to barbiturate cases. DEA has also begun to investigate the "street" market in order to determine the source of illegal supplies so that suitable Federal action may be taken. In the near future, DEA will conduct a special accelerated audit of the 120 companies lawfully manufacturing barbiturates in this country and will also notify foreign governments of our desire to see them control their barbiturate exports strictly.

- **Second,** I am directing the Secretary of Health, Education, and Welfare to review those sedative/hypnotic drugs particularly subject to abuse to determine whether any should be removed from the market, taking into consideration not only their safety to the individual but also the dangers they pose to the public at large.
- **Third,** I support legislation giving the Food & Drug Administration the authority to apply standards of safety and efficacy to all drugs, by repealing those laws which exempt a variety of drugs because they were placed on the market before a certain date. A number of barbiturates fit into this caregory.
- **Fourth,** Some physicians still knowingly overprescribe a wide variety of drugs. Although, as a result of careful education, physicians have voluntarily reduced their prescriptions for barbiturates by 73 percent during the last five years, a few are continuing to misprescribe these and other drugs deliberately. I am directing the Attorney General, in full cooperation with State officials, to begin a concerted drive to identify and prosecute these violators.

No government can completely protect its citizens from all harm—not by legislation, or by regulation, or by medicine, or by advice. Drugs cannot be forced out of existence; they will be with us for as long as people find in them the relief or satisfaction they desire. But the harm caused by drug abuse can be reduced. We cannot talk in absolutes—that drug abuse will cease, that no more illegal drugs will cross our borders—because if we are honest with ourselves we know that is beyond our power. But we can bring together the resources of the Federal Government intelligently to protect our society and help those who suffer. The sufferers include the overwhelming majority of the public who never abuse drugs but for whom drug abuse poses the threat of broken families, a lost child or fear to walk the streets at night. Beyond that, we must

understand why people seek the experience of drugs, and address ourselves to those reasons. For it is ultimately the strength of the American people, of our values and our society, that will determine whether we can put an end to drug abuse.

JIMMY CARTER

THE WHITE HOUSE
August 2, 1977.

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