F: Ash Council Report

PRESIDENTIAL CONCERN

In his 1968 campaign, President Nixon expressed concern "about narcotics as the modern curse of American Youth."[1/] In order to combat drug abuse the President outlined a 10 point national program on July 14, 1969 noting that:

> "Within the last decade, the abuse of drugs has grown from essentially a local police problem into a serious national threat to the personal health and safety of millions of Americans. A national awareness of the gravity of the situation is needed; a new urgency and concerted national policy are needed at the Federal level to begin to cope with this growing menace to the general welfare of the United States. . .It has been a common over-simplification to consider narcotics addiction, or drug abuse, to be a law enforcement problem alone. Effective control of illicit drugs requires the cooperation of many agencies of the Federal and local and State governments; it is beyond the province of any one of them alone. At the Federal level, the burden of the national effort must be carried by the Departments of Justice, Health, Education, and Welfare, and the Treasury."

Subsequently, on March 11, 1970, the President announced expanded efforts for non-enforcement programs and stated, "There is no priority higher in this Administration than to see that children--and the public--learn the facts about drugs in the right way and for the right purpose through education." (Tab A contains Presidential Statements.)

[1/] Campaign speech September 16, 1968.

The Drug Abuse Menace

There are numerous chemicals which alter man's mood, thought or sensory perception, thus affording escape and pleasure. Drug abuse is the use of these in a manner which deviates from approved medical and legal norms. There is great variation in what constitutes abuse from culture to culture and even from time to time within the same culture. The most commonly abused drugs in the United States today are "hard drugs" (the opiate narcotics) and soft drugs, (the stimulants, sedatives, tranquilizers and hallucinogens.) Tab B contains a complete classification and description of these.

Modern technology has made possible the production of virtually unlimited supplies of narcotics, stimulants, sedatives, and tranquilizers. In 1969 the United States manufactured hundreds of tons of these drugs. which were sold legally and illegally. (See Table 1 in Tab C for data on domestic production.) Mood altering (psychotropic) drugs made up about 17 percent of the prescriptions filled by retail pharmacies in 1967. These 178 million prescriptions had a consumer cost of 692 million dollars. Not included are drugs sold over the counter without prescription.[2/]

A substantial amount of legally manufactured drugs appear on the black market. The Director of the Bureau of Narcotics and Dangerous Drugs has reported that as "high as 75 to 90 percent of the stimulants and depressant pills and capsules which are found in the illicit traffic in the United States were legally manufactured."[3/]

[2/] Balter MB, Levine J: The Nature and extent of psychotropic drug usage in the United States. Psychopharmacology Bulletin. 5:3-13, October 1969.

[3/] Statement by John Ingersoll at Hearings before the Subcommittee on Public Health and Welfare of the Committee on Interstate and Foreign Commerce, House of Representatives, 91st Congress, 2nd Session, March 3, 1970.

The abuse of drugs is a menace which appears to be spreading. In December 1969, there were six times more narcotic addicts in Baltimore than there were in 1960; in the same time period, there was a fourfold increase in Buffalo. In New York City, at the end of 1969, one person in 265 was a narcotic addict. (See Table 2 in Tab C for the ratio of narcotic addicts to population in select cities.)

There are increased reports of deaths attributable to narcotic addiction. There were 4,254 deaths from narcotics abuse in New York City from 1960 through 1969, four times the total in the preceding decade. About 900 of the deaths came in 1969 alone. In New York City narcotic addiction is the greatest cause of death for men ages 18 to 35 (See Chart 1 in Tab C)

Juvenile use of narcotics appears to be on the rise. Figures from the Bureau of Narcotics and Dangerous Drugs show a doubling of the number of new addicts under age 21 (See Table 3 in Tab C). In New York City juvenile deaths from narcotics have shown an alarming rise. "There were no such deaths several years ago; last year 224 teenagers died from drug abuse. The figures for this year show a continuing upsurge. [In the first 4 months of 1970] about 450 drug users have died roughly 75 of them teenagers."[4/]

The users of narcotics pay $225,000 on the streets in the United States for a quantity of narcotics originally costing $350 as opium in Turkey. It is this vast profit potential which motivates traffickers to disregard the risks of imprisonment.

4/ New York Times Editorial May 12, 1970.

Tables 4 and 5 in Tab C show the "Heroin Price Spiral" and the illicit street prices of drugs in three U. S. cities.

Narcotics represent only a fraction of the illegal drugs which are currently abused. Of the others, marihuana has probably received the most widespread use. Experts at the National Institute of Mental Health, believe that 65 percent of the 12 million Americans who have tried marihuana represent "experimenters" who have tried it only a few times.[5/] They estimate that another 25 percent use marihuana socially on a fairly regular basis with a few friends at home or parties. The remaining 10 percent have become habitual users who consider the use of marihuana a major factor in their lives.

The House of Representatives Select Committee on Crime in 1970 estimated conservatively that there are 600,000 habitual users of marihuana, each of whom consume about an ounce per week.[6/] This demand translates into a daily U. S. requirement of almost 3 tons per day for habitual users alone. Over 85 percent of this marihuana enters the U. S. from Mexico, according to the Bureau of Customs.[7/]

The actual health hazards resulting from drug abuse have been well documented. While there have been no deaths attributed to marihuana,

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[5/] Marihuana. First Report by the Select Committee on Crime. House Report No. 91-978, 91st Congress, 2nd Session, p. 19.

[6/] Ibid.

[7/] Statement of Eugene Rossides before the Subcommittee to Investigate Juvenile Delinquency of the Senate Committee on the Judiciary, 91st Congress, 1st session, p. 567.

there were 1400 case reports of adverse effects in the medical literature in 1969. Tab D contains a compilation of the literature reporting adverse effects from the abuse of various drugs prepared by the National Clearinghouse for Drug Abuse Information, and Tab E contains a list of recent, relevant information and studies on all aspects of drug abuse (materials available on request from PACEO).

SUPPLY AND DEMAND

There are two fundamental approaches for reducing drug abuse: (1) minimize the supply of drugs and (2) minimize the demand for drugs. These approaches have been statutorily achieved through Federal legislation for law enforcement and the criminal justice system; preventive education; the treatment of drug abusers; and research into the causes and pharmocodynamics of drug abuse. Tab F is a compilation of these Federal statutes.

Minimizing the supply or the demand for drugs involves understanding the interface between supply and demand. Most experts agree that an increase in enforcement leads to an increase in the price of narcotics, but may not, in fact, limit demand or supply. Instead, what may result is an inflation in the cost of the narcotic, exacerbating the number of larcenies which addicts commit to support their habits. Some authorities assume that the effective control of narcotic supplies is close to impossible; more effective control only inflates illegal prices, and dealers' profits, but does not significantly affect demand. If this assumption is correct, organizations which emphasize methods of reducing demand will be an effective approach to reducing drug abuse. Table 1 shows the executive organizations controlling supply and Table 2 shows those controlling demand.

Table 1

EXECUTIVE ORGANIZATIONS CONTROLLING SUPPLY

A. Justice Department
   1. Bureau of Narcotics and Dangerous Drugs
   2. Narcotics and Dangerous Drugs Section, Criminal Division
   3. Border Patrol, Immigration and Naturalization Service
   4. Law Enforcement Assistance Administration

B. State Department
   1. Special Assistant to the Secretary for Narcotic Matters.
   2. Desk Officers for particular countries and areas, especially Turkey, France, Mexico, Middle East, and Southeast Asia.

C. Treasury Department

   Bureau of Customs

D. Department of Defense
   1. General Counsel
   2. Criminal Investigation Divisions of the various armed forces

E. Post Office
   Chief Inspector

F. Department of Transportation
   1. U. S. Coast Guard
   2. Federal Aviation Administration

G. Health Education and Welfare
   1. Food and Drug Administration
   2. Joint NIMH-FDA Advisory Committee

H. The Ad Hoc Committee to Keep Narcotics out of the Country

Table 2

EXECUTIVE ORGANIZATIONS CONTROLLING DEMAND

A. Department of Health, Education, and Welfare
   1. National Institute of Mental Health
      a. Division of Narcotic Addiction and Drug Abuse
      b. Office of Communications

   2. Office of Education

   3. Social Rehabilitative Services
      a. Vocational Rehabilitation
      b. Juvenile Delinquency
      c. Medicaid

   4. DHEW Interagency Coordinating Committee

B. Office of Economic Opportunity
   1. Office of Health Affairs--Division of Alcoholism and Drug Abuse

C. Housing and Urban Development
   1. Model Cities

D. Department of Justice
   1. Bureau of Prisons, NARA Coordinator
   2. Law Enforcement Assistance Administration

E. Ad Hoc Committee on Drug Abuse

The functions and statutory authorities of these listed agencies are at Tab G.

OPERATION OF THE STATUS QUO: MINIMIZING SUPPLY

The Ad Hoc Committee to Keep Narcotics out of the Country has devised U. S. international policy designed to control the flow of narcotics and dangerous drugs directed at the U. S. Implementation of this is through two methods: (1) inducing foreign governments to raise their enforcement efforts to a satisfactory level with respect to suppressing illicit drug production which has a potential for entering the U. S.; and (2) providing technical advice and assistance to foreign governments seeking to improve their enforcement efforts.

The first method is achieved through diplomacy under the direction of the Secretary of State. Further inducements are offered through the Agency for International Development (AID) which, for example, has given Turkey a financial loan for the purpose of assisting local farmers to substitute other cash crops for the opium poppy. A more subtle inducement occurs through the deployment of BNDD agents in select foreign countries. These agents not only provide the police of these foreign governments with intelligence relating to clandestine drug operations in their countries, but may also accompany

and assist in raiding these operations.

The second method is achieved through the technical assistance provided by BNDD, including its training school in Washington for foreign enforcement personnel. Additionally, its overseas agents also provide technical assistance to local police when requested The Bureau of Customs offers comparable training for foreign customs personnel. Recently Customs alleged that this training program has been hindered by BNDD which has represented itself as the sole U. S. agency to provide technical assistance relating to drugs. These interagency difficulties will be resolved through the recently drafted interagency guidelines.

Interdiction of illicit drugs at the Border is the prime responsibility of the Customs Bureau. Persons, cargo, or mail passing through the ports of entry are routinely under Customs surveillance. The Border Patrol in the Immigration and Naturalization Service watches for smuggling of persons between ports of entry on the continental border while the Coast Guard and the Federal Aviation Administration detect smuggling via sea or air. Offenders are referred to the Bureau of Customs.

There is another jurisdictional conflict between BNDD and Customs relating to "convoy cases." In these, a courier of contraband drugs is permitted to bring the drugs to their ultimate destination in order that the more important trafficker can be apprehended. Prior approval of the U. S. Attorney must be obtained since the convoy allows the commission of an offense against the U. S. BNDD maintains that it should approve and control all convoys because they relate to domestic drug control.

Customs argues that convoys are actually an extension of their sole jurisdiction at the borders. Resolution of this dispute will follow from BNDD Customs guidelines.

BNDD is primarily responsible for federal domestic drug law enforcement. It actively investigates major drug conspiracies, and works closely with State and local enforcement agencies for the concerted enforcement of all drug control statutes. Prosecution of all U. S. offenses are handled by the U. S. Attorneys with the supervision of the Justice Department's Criminal Division (Narcotics and Dangerous Drug Section).

Currently, BNDD has the authority to designate those drugs which have a potential for abuse and place them under control. The need to control manufacture and distribution of these is recommended by Director's Scientific Advisory Council.

Because research activities using controlled dangerous drugs offer an opportunity for diversion to illegal usage, strict controls have been imposed. Available supplies can be given only to bonafide researchers after approval by a joint PHS-NIMH joint advisory committee.

The organizational complex of enforcement programs poses a number of important and difficult questions. None the less, it does permit the gathering of information necessary for policy formulation and the operation of substantial ongoing enforcement programs. On balance, the non-enforcement programs for minimizing demand evidenced a far greater organizational deficit.

Operation of the Status Quo: Minimizing Demand

Treatment, preventive education, and research are the three primary means for minimizing the demand for abusable drugs. Organizationally, these activities are spread among several departments and agencies. Detailed programs descriptions are compiled in Tabs G, H, and I. Analyses of these techniques follow.

I. Treatment

Federal treatment responsibilities are threefold: 1) to provide drug abuse treatment to federal beneficiaries; 2) to stimulate the development of state and local treatment resources; and 3) to develop new and improved techniques for treating drug abusers.

Almost all drug abuse treatment provided directly by the U. S. is authorized by the Narcotic Addict Rehabilitation Act of 1966. Organizationally, it is administered by the National Institute of Mental Health and the Bureau of Prisons. Patients civilly committed receive inpatient treatment at hospitals administered by the National Institute of Mental Health; prisoner patients receive inpatient care at Federal Correctional Institutions operated by the Bureau of Prisons. There would be no possible organizational gain from combining these two inpatient programs as they are currently administered because they only provide care to a small number of patients in existing facilities. It is likely, however, that a new, much enlarged, comprehensive treatment program would benefit from collocating these two programs within a single organization.

There is duplication of efforts in the after-care phase of NARA treatment. Following inpatient care, the patient returns to his home community where he receives continued "aftercare" treatment services. NIMH and BOP contract with local community agencies to provide these aftercare services. While NIMH has a large field staff to survey communities and contract with agencies, BOP lacks a comparable staff; and therefore, they automatically contract with the same community agency as NIMH. Thus, two separate, yet identical, contracts are negotiated and supervised by two Federal agencies where one contract would suffice. While the Bureau of Prisons has indicated that they would prefer to let NIMH handle all contracts for purpose of efficiency and economy, NIMH has opposed this arrangement because they don't want to treat "prisoner" patients.

Stimulate State Programs

A basic complaint of state and local authorities is that they are unaware of which Federal agency to turn to for assistance. The White House Ad Hoc Committee on Drug Abuse has attempted to resolve this by recommending that all information about different Federal programs be placed within the computer retrieval system of the National Clearinghouse for Drug Abuse Information in the NIMH. While this would make relevant programs more visible to interested authorities, NIMH will maintain the advantageous position of being able to pre-screen and, possibly to select for itself the most desirable projects.

Grantees' requirements for the several agency programs are significantly different, and are partially responsible for leaving community needs unfill-d. NIMH's special drug abuse programs do not permit the treatment of non-narcotic drug abusers. Furthermore, applicants seeking funds from NIMH must agree to furnish the same specific, comprehensive services to narcotic addicts which Community Mental Health Centers provide for the treatment of psychiatric patients. Some local agencies have indicated that they do not believe that narcotic addict treatment should be confined to a model designed for the treatment of psychiatric patients. Even though OEO has the authority to fund broader, more innovative programs, OEO's authorizing legislation does not permit the treatment of individuals whose income is above the poverty level. Also, because OEO is attempting to provide the maximum distribution of its funds, it limits the duration of funding of programs to the initial innovative phase of three to four years. Consequently, organizational biases detract from either NIMH or OEO developing innovative or on-going programs specifically designed for treating drug abusers.

Because LEAA works through the State Planning Agency, and Model Cities Programs, works with local planning agencies, both have greater contact with local needs, and, as such, have permitted greater variety in the forms of treatment services they support. Linkage between OEO and NIMH treatment experts and LEAA and Model Cities programs has been almost non-existent. In fact, LEAA looks to BNDD to provide technical assistance on evaluating grant proposals relating to drug abuse education or treatment. Because

of the lack of LEAA and Model Cities' technical expertise for evaluating drug abuse treatment proposals, the net result to the communities has been a less than optimal utilization of financial resources.

Medicaid reimbursement will assist in the support of local drug treatment program costs in the near future. Similarly, Vocational rehabilitation funds can fund those rehabilitative services provided by the states to their addicts under treatment. What appears to be needed here, as is the case with the LEAA and Model Cities programs is an organization which can provide gridance as to the many ways that treatment can be provided, and how any locale can best tailor its resources to its needs.

Development of New Treatment Techniques

Research on the best ways to offer effective treatment is conducted by each involved Federal agency. There has been almost a complete lack of data sharing by the agencies, although LEAA has recently funded a research program analyzing the success of an NIMH program using a methadone maintenance. It appears imperative that close data sharing be available for comparison of the success of different types of treatment programs, both between Federal programs and between the Federal Government and State and local programs. Without it, the Federal government would appear unable to assume a leadership role in demonstration to the States. While there is considerable merit in permitting independent research by each treatment organization, substantial interface is necessary at some organizational level for these separate results and conclusions to have validity. So far, this has not happened.

Although each of the current organizations could possibly perform the necessary analysis of research, leaving this task to any of the existing treatment agencies, would most likely build in an undesirable agency bias. Accordingly, a new agency primarily concerned with drug abuse treatment seems to be a better organizational alternative for analyzing research on treatment.

II Education and Training

Preventive education aims at discouraging drug use. In addition to developing and distributing its own materials, the Federal Government must also stimulate State and local resources and interests. Similarly, Federally sponsored training programs should not only develop skilled professionals for Federal institutions but should also be available to all relevant State and local agencies.

The Ad Hoc Committee on Drug Abuse has been unable to integrate the disparate educational programs of its constituent agencies. Rather, it has resulted in co-locating the responsibility for supervision of these educational activities and actual program responsibility in the White House Staff. The net result has been an inappropriate drain on White House staff resources, and, unfortunately, the continuance of these disparate educational efforts. For example, BNDD and NIMH plan to independently develop and disseminate new educational materials. These will have the same target audience as materials developed by the Ad Hoc Committee on Drug Abuse, and, accordingly, will continue inter-agency competition and the proliferation of materials. To date, educational materials created by NIMH and BNDD have presented facts in a significantly different manner with contrasting emphases. These differences in Federal publications not only confuse the public but also prevent the development of a coherent Administration opinion.

Community officials have told us that they are unaware of which agency to turn to for educational or financial assistance. While the National Clearinghouse for Drug Abuse Information will become a locus for the distribution of relevant educational materials,

there is no comparable existing directory of Federal agencies which can help finance community preventive education programs. In addition, LEAA and Model Cities, which both have funds available for community anti-drug abuse efforts, have not had the expert assistance available to determine whether a grant proposal is of good quality. The net result has been an inadequate stimulation of State and local community resources and interests.

To date, most training programs have been designed especially for medical and paramedical personnel (NIMH activities) or law enforcement personnel (BNDD activities). New, proposed training programs for high school teachers, principals, social workers, pharmacists,and other professionals will serve a useful purpose, but represent only an initial step. Again, these several, new training programs reflect the special interests of the sponsoring agency, and, as such, will not eliminate gaps or prevent duplication. The optimum allocation of staff and financial resources will only occur when a clear delineation of responsibilities for controlling the supply of and the demand for drugs is obtained.

FEDERAL DRUG ABUSE RESEARCH

Because of its financial and scientific resources, the Federal Government has assumed the major responsibility for directing and supporting basic and applied public health research. The objectives of these research efforts and their relevance to controlling supply and demand follows:

--Prevalence of Drug Abuse: Information relevant both to controlling supply of and demand for the optimal deployment of resources and personnel.

--Abuse potential of new drugs: This information is of particular relevance to the agency responsible for controlling abusable drugs. It has a minor importance to the agency responsible for controlling demand through preventive education.

--Drug actions--psychological, biochemical, physiologic, and genetic: Not relevant to the control of supply. Not relevant to the control of demand except for inclusion in preventive educational materials. Obtaining this information composes the interests of pharmacologists and psychopharmacologists, who then usually relay any information on the deleteriorious or toxic effects of commercially prepared drugs to the FDA. There has been some confusion as to who needs and should therefore support this type of research on the effects of non-commercially prepared drugs, e.g., marihuana, hashish, mescaline, psilocin, LSD, STP. This will be discussed below.

--Metabolic degradation of drugs and identification of the drug or its metabolites in body fluids: This information is relevant to the control of supply because of the need for rapid police laboratory determination of abusable drugs. Similarly, this information is relevant to a treatment agency which evaluates the success of its treatment by determining whether an individual is "drug free."

--Mechanisms/motivations responsible for drug abuse: This information is particularly relevant to the control of demand.

--Mechanisms/motivations which can reverse or eliminate drug abuse:

a) Treatment--relevant to the control of demand

b) Preventive Education--relevant to the control of demand

c) Legal sanctions--relevant to the control of supply and demand.

Each agency involved in reducing drug abuse conducts applied, evaluative research on how well they are achieving their mission and how they can improve their efforts. For example, BNDD is developing an "early warning" system on the abuse potential of new drugs, whereas NIMH or OEO are interested in defining which treatment technique will be most successful for the largest number of drug abusers. Since such research is essential for gauging the efficiency and effectiveness of agency programs, it is not surprising that large pools of data have been collected by the several agencies involved in reducing drug abuse. It is also not surprising that much of this research has been duplicative because the involved agencies have developed similar programs, especially those involved in treatment and preventive education. Logically, the amount of duplicative

research will decrease when the present overlap of agency responsibilities and functions is reduced or eliminated. By organizaing around the control of supply and the control of demand a more logical and complementary assignment of research interests and priorities will be accomplished with a resultant improved utilization of resources and personnel.

With respect to the control of supply, BNDD has assumed the bulk of the research effort and has assigned reasonable research priorities. With respect to the control of demand, the diffusion of responsibility among heterogeneous agencies has resulted in significant duplication and haphazard assignation of research priorities. The result has been major gaps in our information about drug actions and mechanisms/motivations responsible for drug abuse. Consolidation of the responsibility for controlling demand would obviate the duplication and the gaps produced by the independent and fragmented agency research efforts.

Special mention should be directed to the research on the effects of non-commercially prepared drugs, e.g. marihuana, hashish, mescaline, psilocin, LSD, STP, because there has been significant duplication of research by NIMH and BNDD. For example, both BNDD and NIMH are supporting separate studies to determine the acute and chronic deleterious effects of marihuana intoxication. Both have supported research on the chromosomal damage resulting from LSD ingestion. Neither has determined the chromosomal damage resulting from mescaline ingestion. The resulting duplication, information gaps, and confusion over research priorities have probably resulted from the fact that this type of information is not essential for controlling supply or demand,

and, as such, an ordered research program for elucidating the effects of these drugs has not been forthcoming from either BNDD or NIMH. Since this type of information is not essential, we believe that there is little value in continuing the responsibility for supporting this basic pharmacological and psychopharmacological research with any organization directed to reduce drug abuse.