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**DRUG ABUSE OFFICE AND TREATMENT
AMENDMENTS OF 1978**

GOVERNMENT

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HEARING

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BEFORE THE

SUBCOMMITTEE ON

HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON

INTERSTATE AND FOREIGN COMMERCE

HOUSE OF REPRESENTATIVES

NINETY-FIFTH CONGRESS

SECOND SESSION

ON

H.R. 11660

A BILL TO AMEND THE DRUG ABUSE OFFICE AND TREATMENT
ACT OF 1972 TO EXTEND THE PROGRAMS OF ASSISTANCE UNDER
THAT ACT FOR DRUG ABUSE PREVENTION, EDUCATION, TREAT-
MENT, AND REHABILITATION, AND FOR OTHER PURPOSES

APRIL 10, 1978

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ORGANIZATIONS REPRESENTED AT HEARING

- Alcohol and Drug Abuse Problems Association of North America:
 Butynski, William, Ph. D., president.
 Hewlett, Augustus L., executive director.
- Executive Office of the President:
 Bourne, Peter G., M.D., Special Assistant to the President for Health Issues.
 Dogoloff, Lee I., Office of Drug Abuse Policy.
- Health, Education, and Welfare Department:
 DuPont, Robert L., M.D., National Institute on Drug Abuse, Alcohol, Drug
 Abuse, and Mental Health Administration.
 Klerman, Gerald L., M.D., Administrator, Alcohol, Drug Abuse, and Mental
 Health Administration.
- National Association for City Drug Coordination:
 Goldberg, Peter, chairman, advisory committee.
 Lewis, David C., M.D., chairman, planning committee.
- National Association of State Drug Abuse Program Coordinators:
 Akins, Carl, executive director.
 Griglak, William, chairman, legislative committee.

DRUG ABUSE OFFICE AND TREATMENT AMENDMENTS OF 1978

MONDAY, APRIL 10, 1978

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 2218, Rayburn House Office Building, Hon. Paul G. Rogers (chairman) presiding.

Mr. ROGERS. The subcommittee will come to order, please.

The subcommittee convenes today for the purpose of reviewing legislation to revise and extend the assistance programs for drug abuse prevention, education, treatment, and rehabilitation. These programs are supported by the National Institute on Drug Abuse.

Today's hearings are on H.R. 11660 to extend these drug abuse authorities, which expire on September 30, 1978. I anticipate that the subcommittee will mark up and report out this legislation later this week.

I recently introduced H.R. 11660, the Drug Abuse Office and Treatment Amendments of 1978, which proposes a 1-year extension of the authorization of appropriations for these programs.

For fiscal 1979, it proposes authorization levels of \$153 million for treatment programs and \$24 million for prevention, demonstration, and other activities. This would provide a total of \$177 million in authorizations for drug abuse project grants and contracts under section 410 of the Drug Abuse Office and Treatment Act. In addition, it proposes \$45 million in authorizations for fiscal 1979 for State drug abuse formula grants under section 409 of the act.

The proposed legislation also requires the Secretary of Health, Education, and Welfare to transmit an annual report to Congress as well as the President describing the problems of drug abuse in the United States and the Department's response to those problems.

This report would contain information comparable to that now required for alcohol abuse and alcoholism programs and information previously provided in other reports which were required to be submitted to the Office of Drug Abuse Policy, which was recently abolished by the President's Reorganization Plan No. 1.

I believe this annual report will increase the evaluation capabilities of both the executive branch and the Congress, provide invaluable information to those working in the field, and serve as an additional mechanism by which the President's drug abuse reorganization measures can be gaged.

We have proposed a 1-year extension of the authorities under the Drug Abuse Office and Treatment Act to permit their timely review by the Congress next year. This will provide the Executive Office of the President the opportunity to demonstrate the drug abuse policy and coordination mechanism which replaced the Office of Drug Abuse Policy under Reorganization Plan No. 1.

I am hopeful that it will succeed. However, if it does not, this subcommittee would seriously consider reporting out legislation to reestablish the Office of Drug Abuse Policy or some comparable policy and coordinating entity in the Executive Office of the President.

I would ask unanimous consent that the text of H.R. 11660 be placed in the record at this point.

[The text of H.R. 11660 follows:]

95TH CONGRESS
2D SESSION

H. R. 11660

IN THE HOUSE OF REPRESENTATIVES

MARCH 20, 1978

Mr. ROGERS introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

A BILL

To amend the Drug Abuse Office and Treatment Act of 1972 to extend the programs of assistance under that Act for drug abuse prevention, education, treatment, and rehabilitation, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That this Act may be cited as the "Drug Abuse Office and
4 Treatment Amendments of 1978".

5 SEC. 2. (a) The first sentence of section 409(a) of
6 the Drug Abuse Office and Treatment Act of 1972 is
7 amended (1) by striking out "and" after "1977," and
8 (2) by inserting after "1978," the following: "and Sep-
9 tember 30, 1979,".

1 (b) Section 410 (b) of such Act is amended by adding
2 at the end the following: "For the fiscal year ending Sep-
3 tember 30, 1979, there is authorized to be appropriated (1)
4 \$153,000,000 for grants and contracts under paragraphs
5 (3) and (6) of subsection (a) for drug abuse treatment
6 programs, and (2) \$24,000,000 for grants and contracts
7 under such subsection for other programs and activities."

8 SEC. 3. (a) Section 502 of the Marihuana and Health
9 Reporting Act (Public Law 91-296) is amended by strik-
10 ing out "annually" and inserting in lieu thereof "biennially".

11 (b) Section 405 (b) of the Drug Abuse Office and
12 Treatment Act of 1972 is amended to read as follows:

13 "(b) The Secretary shall transmit a report to the
14 President and the Congress with respect to each fiscal year
15 on—

16 "(1) the health consequences and extent of drug
17 abuse in the United States,

18 "(2) a description and evaluation of the effective-
19 ness of the drug abuse prevention functions carried out
20 through any entity of the Department of Health, Edu-
21 cation, and Welfare in the fiscal year for which the re-
22 port is made,

23 "(3) a description of the manner in which such
24 functions were carried out and a description and evalua-
25 tion of the coordination within the Department of

1 Health, Education, and Welfare in carrying out such
2 functions,

3 “(4) a description and evaluation of the effective-
4 ness of experimental methods and programs implemented
5 in carrying out such functions, recommendations for im-
6 plementation of such methods and programs by others in
7 carrying out their drug abuse prevention functions, and
8 a description and evaluation of the effectiveness of the
9 means used to disseminate information respecting such
10 methods and programs, and

11 “(5) proposals for changes in the drug abuse pre-
12 vention functions carried out through the Department of
13 Health, Education, and Welfare (including recom-
14 mendations for legislation).

15 The report required by this subsection shall be transmitted
16 not later than January 15 of each year.”.

17 (c) Section 502(b)(3) of such Act is amended by
18 striking out “control and treatment” and inserting in lieu
19 thereof “prevention, control, and treatment”.

Mr. ROGERS. Today we will begin with witnesses representing the administration, and later the subcommittee will hear testimony from other distinguished individuals and organizations in the field of drug abuse.

So we are pleased to welcome Dr. Gerald Klerman, who is the Administrator of the Alcohol, Drug Abuse, and Mental Health Administration, Department of Health, Education, and Welfare, and accompanied by Dr. Robert L. DuPont, who is Director of the National Institute on Drug Abuse.

We welcome you gentlemen to the committee and, if you like, have a place at the table. Your statement will be made a part of the record in full.

STATEMENT OF GERALD L. KLERMAN, M.D., ADMINISTRATOR, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY ROBERT L. DUPONT, M.D., DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE

Mr. ROGERS. You may proceed as you desire.

Dr. KLERMAN. Mr. Chairman, we have an extended statement which includes a progress report [see p. 8], but I would like to make a brief statement.

Mr. ROGERS. Certainly.

Dr. KLERMAN. We are delighted to be here to present the views of the Department of Health, Education, and Welfare on your bill to amend the Drug Abuse Office and Treatment Act of 1972 and to extend the authorizations for programs of assistance under that act for drug abuse prevention, education, treatment, and rehabilitation for the period of 1 year. These authorizations are to expire on September 30, 1978.

Dr. DuPont and I wish to comment in particular on those aspects of the legislation which pertain to HEW in general, in particular to the National Institute on Drug Abuse.

The legislation introduced by the chairman which pertain particularly to HEW includes:

- First, a 1-year extension for fiscal year 1979 of section 409 of the act, which provides for the drug abuse formula grant program at the current dollar amount of \$45 million;
- Second, a 1-year extension of the program authorized by section 410 of the act for fiscal year 1979, under which drug abuse treatment and prevention activities are funded at a level of \$177 million;
- Third, a change in the current reporting requirement on marihuana and the public health contained in section 502 of the Marihuana and Health Reporting Act from every year to every 2 years;
- Fourth, an expansion of section 405(b) reporting requirement to require that the Secretary report each year on the health consequences and extent of drug use in the United States and to provide a description and evaluation of programs within HEW that address the drug abuse problem; and

- Fifth, a requirement that the NIDA Director, in carrying out the section 502 technical assistance authority, provide for the same type of assistance for drug abuse prevention programs as he now does for the control and treatment programs.

Mr. Chairman, with regard to most health authorizations expiring this year, the administration has requested 3-year extensions. With respect to the drug abuse law, the administration would also prefer such a 3-year extension. However, we do recognize that there are several good reasons behind your proposal for a simple 1-year extension of the drug abuse programs at this time; and, for those reasons we, in the administration, do support your 1-year bill.

While a great number of health authorities were given a simple 1-year extension last year, for example, the drug abuse program was not among them. And, despite the fact that the sections expiring this year are the 3-year authorizations, this legislation was, in fact, enacted over 1 year later in the legislative cycle due to controversy over creation of the Office of Drug Abuse Policy. Thus the amendments contained in that legislation have been in effect for less than 2 years.

However, in supporting your 1-year extension, we do note that the administration's budget request for fiscal year 1979 is for \$40 million for section 409 and \$161 million for section 410 rather than the levels contained in your bill.

In addition, we are in agreement with your proposal to change the marihuana and health reporting requirement from its current 1 year to 2 years. However, we would strongly recommend that you go further with this change, consolidating the marihuana report with the other report on other aspects of drug abuse and substance abuse which you have recommended. This recommendation is part of our joint effort with the General Accounting Office to reduce the large number of statutorily required reports.

Finally, the Department supports the new technical assistance requirements of section 3(c) and has already accomplished much of its intention by administrative action.

I recognize, from the chairman's comments at the introduction of this legislation, the concern of the committee about the issue of executive branch coordination of the drug abuse program. I have examined this matter and feel confident that the mechanism the administration has proposed to continue policy coordination through the domestic policy staff and a revitalized Strategy Council on Drug Abuse will be satisfactory to the Congress. I and others in HEW look forward to working with this new system at the White House level for program coordination.

Mr. Chairman, we would like to commend you for your outstanding leadership in the field of drug abuse. We thank you for the opportunity to testify on H.R. 11660 and Dr. DuPont and I will be pleased to answer whatever questions you or others may have about this program.

[Testimony resumes on p. 32.]

[Attachment to Dr. Klerman's prepared statement follows:]

A STATUS REPORT TO THE CONGRESS
ON THE NATIONAL INSTITUTE ON DRUG ABUSE
ADDENDA TO THE TESTIMONY
OF
GERALD L. KLERMAN, M.D.
ADMINISTRATOR
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

before the
House Interstate and Foreign Commerce Committee
Subcommittee on Health and the Environment

Monday, April 10, 1978
10:00 A.M.

INTRODUCTION

The National Institute on Drug Abuse (NIDA) was established in 1973. In the last 5 years, NIDA has developed a national network of drug abuse treatment capacity and undertaken a number of initiatives in the fields of research, training, services demonstration, and prevention.

CURRENT DRUG USE TRENDS

The most significant trend during the last year has been the decreased use of heroin and the increased use of marihuana, cocaine, and phencyclidine. The meaning of the downturn in abuse and availability of heroin is clear; lower availability as a result of the Mexican Government's efforts is visible in the United States.

Twenty-four percent of the population over age 12 have used marihuana at least once, an increase from 4 percent in 1968. The National Survey on Drug Abuse: 1977, reveals that of our Nation's population of slightly more than 170,000,000 over the age of 12, currently 92,300,000 use alcohol, 67,570,000 smoke cigarettes, 16,210,000 smoke marihuana, and 4,870,000 smoke hashish; over 1½ million persons each use cocaine and stimulants nonmedically; and it is estimated that just over a million persons each have used hallucinogens, sedatives, or tranquilizers non-medically within the last 30 days.

THE NIDA BUDGET

The NIDA budget for fiscal year 1978 provides for maintaining the same level of NIDA-supported treatment slots as that established in fiscal year 1977 with a small increase of the maximum allowable treatment cost per slot. The Federal share of all grant and contract awards for drug abuse treatment and rehabilitation services will continue to decrease annually to a minimum of 60 percent. Our fiscal year 1978 budget also remains essentially level in training and research with the only increase being in the size of our prevention program. Although prevention accounts for only 2 percent of NIDA's total budget in fiscal year 1978, fully 19 percent of the new awards made by NIDA during fiscal year 1978 will be in the prevention area.

DRUG ABUSE PREVENTION

The 1978 National Drug Abuse Prevention Campaign began in January 1978. It is targeted on preventing, reducing, or delaying the use and abuse of drugs among young people age 8 to 20. The Campaign materials specifically address the young drug abuser and those who make a difference in a young person's life: peers, parents and family members, teachers, coaches and other adults who work with youth. The message is Drug Abuse Prevention is everybody's business.

The Channel One Project is a program being piloted in Region I and northern New York State in 10-12 local communities. The Gloucester Community Development Corporation of Gloucester, Massachusetts, with assistance from the Prudential Insurance Company of American, has devised and is now testing and disseminating drug abuse prevention strategies.

The purpose of the program is to demonstrate that working ~~through~~ existing community organizations, and given the opportunity and appropriate training and support services, local personnel are capable of being effective disseminators and implementors of prevention strategies within local communities. The word "channel" is synonymous with the broadcasting of information, and that is indeed the ~~base~~ function of this project.

In the six (6) State pilot regions alone, Prudential has four Regional Directors, 75 District Managers, 300 Sales Managers, and 5,500 Sales Agents. All these people are trained in the presentation of ideas, and all have important stakes in the health and well-being of their local communities. The Regional Directors act as mentors for a backup team of District and Sales Managers. Although the focus of this pilot program is 12 District Managers, all 5,879 personnel will be involved with the project. During the next year NIDA plans to help States in their drug abuse prevention efforts by developing a State

Prevention Coordinators Program. This program, which will be similar in structure to the current State Training Support Program, is to be organized around such issues as alternatives, prevention information, prevention education, and early intervention techniques. The State prevention coordinators would focus on gaining greater coordination of local, State, and national prevention activities.

TREATMENT SERVICES

In 1977 over 161,238 persons were served in NIDA-funded treatment slots.

NIDA has planned three manuals dealing with the Statewide Services Contract System (SWSC). First, the Policy and Practice Manual provides a concise policy framework to guide all interested parties in administering Statewide Services Contracts, clarifies the roles and responsibilities of State agencies in performing administrative activities, and provides guidelines for setting the overall direction for subcontract programs and direct treatment activities.

The second Manual, the Program Review Manual, suggests operating procedures for use in implementing State responsibilities on a day-to-day basis. Four regional training conferences are being scheduled for the near future to

help implement this Manual. A third manual will clarify the role of the Program Development Specialists in the monitoring of statewide contracts. Related to these publications is a Records Manual and a Detoxification Manual.

In the past two years inpatient detoxification slots have decreased from over 600 to approximately 200. These slots cost up to \$40,000 each year and in many cases this kind of hospital care is unnecessary. Outpatient detoxification for most clients can be just as effective. NIDA is now funding a new modality that falls between inpatient care and outpatient care--residential detoxification. It is now being tried in two States on a pilot basis. The modality consists of making available a few full-time nurses and having doctor on 24-hour call to those clients who are in the residential facility for detoxification purposes. The doctor visits twice daily and the client receives continued supervision. One of these new detoxification slots costs between \$10,000-\$12,000 and meets the same needs as the more expensive hospital slot. For most clients the new modality will be effective.

In late September NIDA began a 32-week unit cost study. The purpose of this study is to examine eight treatment programs in order to determine units of cost for specific treatment services provided and costs per treatment episode for each treatment modality and environment.

The eight programs selected for the study are divided into four "high cost" programs and four "low cost" programs. The determination of "high" and "low" cost is made initially on the basis of actual total program cost divided by the static treatment capacity for each modality and environment. After program selection, the information collected will be used on unit costs and costs per treatment episode to assist in determining if, in fact, these are actually high- or low-cost programs. In addition to the financial aspects of the study, these programs will be evaluated in terms of client outcome and quality of care measures with respect to unit costs and costs per treatment episode by modality and environment.

NIDA's Treatment Outcome Prospective Study--or TOPS--should begin in fall 1978. TOPS will evaluate treatment by including within the criteria for determining "success" not only abstinence from drug use and lack of criminal behavior, but also community readjustment as determined by employment or other productive activities, living arrangements, family arrangements, and minimal illicit drug use or alcohol or other drug abuse.

SERVICES DEMONSTRATION RESEARCH

The Institute's services research and demonstration program last year published over 30 reports on topics ranging from the use of drugs by older Americans to

drug abuse in rural areas (designed to directly aid service workers in the treatment and rehabilitation field). Demonstration activities last year helped to strengthen services to clients in a number of ways, among them the development of regulations to implement Section 504 of the Rehabilitation Act of 1973 which prohibits discrimination against qualified handicapped persons in any activity receiving Federal funds. Section 504 defines drug abusers as multiple-handicapped individuals, and thus includes them under the scope of the regulations.

The research of Dr. Saul B. Sells and his staff at the Institute of Behavioral Research, Texas Christian University, under a NIDA grant has firmly established the case for effectiveness of methadone maintenance, therapeutic communities, and, to a lesser extent, outpatient drug-free programs. Sells conducted a 5-year followup of a national sample of over 2,000 drug treatment clients and found significant reductions in both heroin and polydrug use for all three modalities. These clients fared better after leaving treatment in terms of drug use, employment, and, except in the case of outpatient drug-free, in declining arrest rates than did those in the comparison group or those whose treatment consisted only of detoxification.

The California Civil Addict Program was founded by researcher Bill McGlothlin to be associated with the

reduction of daily narcotic use among all samples explored. Moreover, parole supervision combined with testing for narcotics use led to lower rates of daily narcotics use than did parole supervision without such testing.

As a consequence of NIDA's services program activity, it has been ruled unconstitutional to deny employment to individuals as a result of their participation in methadone maintenance treatment programs. A manual, which outlines ways in which employment discrimination directed at drug abuse clients can be successfully countered, has been issued to all drug abuse treatment programs funded by the Federal Government and to all Single State Agencies responsible for drug abuse programming and planning.

A supported work program was organized in New York and addict clients were referred to stable work groups composed of fellow clients. Employees were permitted graduated assumption of responsibilities and increased wages. Findings from studies of these programs show that clients establish better employment records than those addicts to whom such opportunities are not made available. With NIDA support, this pilot has been expanded into a major national demonstration project.

Job development and placement projects undertaken in four major cities from 1973 to 1975 suggest that large

numbers of addict clients can be effectively placed in jobs. Treatment programs in those cities referred 1,245 addict clients to job placement units. These clients were both earning more and were more satisfied with their jobs than clients who obtained their own jobs. Ninety percent of those employers who did elect to become involved later reported a willingness to participate in like programs in the future.

Other topics of concern to the services research program included Third Party Payments, joint drug and alcohol treatment, rural programs, special populations, methadone use, hospital emergency rooms, drugs in industry, phen-cyclidine, family counseling, the elderly, and criminal justice activity.

TRAINING

During 1977 the National Training System continued to emphasize teaching of trainers as a way of building drug abuse training capacity at the State and local levels. Last year the five Regional Support Centers trained over 5,000 individuals, State trainers at least 35,000 persons, and Grants have provided training for another 8,000 persons.

In the area of certification, copies of a uniform task description model were provided to all States; also a

number of States passed legislation calling for the certification of drug abuse workers. The American Council on Education reviewed 10 training courses and recommended college credit equivalencies for them. The process of offering continuing education units and/or academic credit for structured training conferences has become an integral part of the annual National Drug Abuse Conference as well as other meetings. Other accomplishments in the training area include the initiation or revision of 12 training courses, work with the National Board of Medical Examiners to develop additional drug abuse materials for the National Medical Board, and specialty examinations and training of selected international drug abuse program officials.

CRIMINAL JUSTICE

During 1977 NIDA took the Federal lead in accelerating cooperative planning between the criminal justice system and drug abuse prevention agencies at the State level. Three regional conferences involving State correction, parole, probation, and drug abuse officials were held and reports issued as a result. In addition, a summary of State parole policies and resource guides for judges, prosecutors, and defense attorneys was the subject of other NIDA publications in the criminal justice field.

This summary clarifies the alternatives to incarceration that may be used as the basis of more therapeutic disposition of cases involving drug-abusing criminal offenders.

FORECASTING

Improved methods for estimating heroin use levels and other drug abuse trends were developed during the last year by NIDA forecasting staff, and as a result, a revised estimate of between 522,000 and 559,000 heroin addicts in 1976 was offered in the publication: A Method for Estimating Heroin Use Prevalence. The report also included estimates of drug abuse prevalence for a number of major U.S. cities. By using this method, NIDA estimated there were 456,000 daily heroin users in 1977. Several States and local communities have adopted this technique for estimating the size of their heroin problem.

RESEARCH

Recent research studies have indicated that individuals from college student populations who have low activity levels of an enzyme (monoamine oxidase, MAO) that affects specific neurotransmitters, score high on personality measures such as the sensation-seeking scale (SSS). Moreover, high scores on this scale have been associated with increased marihuana, hashish, amphetamine, and LSD use. Individual preferences for stimulants or polydrug abuse have also been associated with high sensation-seeking scales. During the past year, NIDA researchers

have shown that platelet monoamine oxidase activity in male marihuana smokers was significantly lower than in a comparable group of nonmarihuana smokers and that the level of current marihuana use was inversely correlated with MAO activity. Although several explanations for this finding are possible, it would appear that MAO activity levels may provide a reliable index of an individual's proclivity to abuse drugs given access to the drugs. NIDA plans to further investigate this problem in the coming year and to include tests for MAO activity levels in study of the effects of long-term marihuana use, so that it can be determined how many individuals with low MAO levels went on to abuse drugs as compared to those with normal MAO activity who avoided drug abuse.

Another line of research which has significance both for looking at the basic causes of drug abuse and treatment is the relationship between depression and opiate addiction. Recent studies have shown that between 20-33 percent of patients in methadone maintenance programs are clinically depressed. NIDA-supported research in the past year has demonstrated that treatment of this group of patients with antidepressants has a beneficial effect on the treatment of the narcotic addiction as measured by time in treatment

and positive change in social functioning. The question of whether the depression in this subgroup of narcotic addicts is an etiological basis of the addiction is an interesting one which will require further study.

Recent results from a variety of studies concerned with the role that personality plays in susceptibility to drug abuse have led to the conclusion that there appear to be similarities in traits within, but not across, various groups of users such as high school students, college students, and addicts in treatment. For example, among college students, drug users tend to be more unconventional, individualistic, and independent, while high school student users tend to be more rebellious and deviance prone and more alienated from their parents. The question of whether these personality traits lead to drug abuse or are caused by drug abuse still remains unanswered. At present, little is known concerning changes in personality following initiation of drug use.

A recently completed analysis of the history of epidemics of drug and substance abuse concluded that advances in communication, medical discoveries, and adverse social conditions are highly correlated with drug abuse episodes, that drug abuse frequently begins with the elite in a

society, and that governments generally try to control abused substances through control of price and supply by passing tax acts.

NIDA's research program over the next few years will continue to develop knowledge concerning the social, behavioral, and biomedical mechanisms underlying drug abuse. Among the many areas to be addressed are the following:

- a. NIDA is interested in developing a comprehensive and practical approach to the treatment of heroin-dependent persons and drug abusers that is based on theoretically sound knowledge of the psychiatric state of such individuals. Emphasis will be placed on the psychodynamics of drug abuse and mechanisms of psychological dependence. NIDA-supported research will seek to assess the psychiatric status of addicts in and out of treatment and will attempt to assess the impact of various types of psychotherapies on treatment outcome.
- b. NIDA will investigate the possible clinical significance of a new drug--buprenorphine--for the treatment of heroin dependence. This compound

seems to have subjective effects that should be acceptable to addicts in treatment; it would require dosing schedules less frequent than methadone; it appears capable of blocking the euphoric and dependence-producing effects of heroin; and it produces minimal dependence, and hence maintenance therapy should be easily terminated.

c. NIDA has launched a major program aimed at understanding the biomedical, psychological, and social factors involved in cigarette-smoking behavior.

d. NIDA research in the next few years will be increased in the area of studies involved with phencyclidine abuse.

e. Another area of interest involves the natural history of drug use. We need to understand more about the various stages of initiation, practice, and final outcomes of drug abuse careers.

f. We need additional information concerned with the factors associated with the onset and cessation of drug abuse behavior--in other words, what variables are common to those individuals

who become drug abusers and what variables are common to those individuals who successfully stop their drug abuse.

g. NIDA will increase research on the prevention of drug abuse. Studies will be initiated which are aimed at (1) a better understanding of the dynamics of peer pressure, (2) how media campaigns can be effectively implemented, (3) understanding the factors of gateway drug use, and (4) identifying those factors that make some individuals "immune" to drug abuse while they live in the midst of a drug abuse epidemic.

Finally, the feasibility of making NIDA's Addiction Research Center responsible for coordinated research on a variety of drugs including opiates, alcohol, and tobacco, and relocating it from Lexington, Kentucky, to within the Washington/Baltimore area is now being reviewed by HEW.

DATA COLLECTION

During the next year NIDA plans to continue the collection of basic data and conduct special studies through the Client Oriented Data Acquisition Process (CODAP) system, and survey the characteristics of all known

treatment service units through the National Drug Abuse Treatment Utilization Survey (NDATUS) effort. NDATUS is now incorporating questions needed to support the Food and Drug Administration (FDA) methadone monitoring mandate. Respondent burden has thereby been reduced by eliminating one federally required report.

NIDA is strengthening its analytic capabilities to make better use of the data collected. For example, it is developing a methodology using CODAP to measure changes in new drug abuse cases in order to identify areas where changes in the number of drug abusers occur. In addition, a National Prevention Evaluation Resource Network is being developed to provide a standardized approach to the assessment of drug abuse prevention programs.

A number of steps are being taken to improve the reliability of the DAWN system. A study of the project is being initiated jointly with the Drug Enforcement Administration (DEA) to assess the reliability of DAWN and to point out areas where improvement may be necessary.

INTERNATIONAL

During the past year NIDA has continued to cooperate with other countries and international organizations in the development of programs for epidemiology, treatment,

prevention, training, and research. NIDA works closely with the State Department to provide information, technical assistance, and training to other countries.

We have seen an encouraging trend toward increased emphasis on demand reduction activities at the international level, as other countries are becoming more aware of their own drug problems and the need for treatment and prevention in their own countries. The international organizations have also given increased attention to demand reduction. The United Nations is now in the process of preparing a Resource Book on Demand Reduction to assist country governments in planning and implementing demand reduction programs. Also, NIDA is collaborating with the World Health Organization (WHO) Drug Dependence Program in two new projects this year. One of these is a conference to exchange information on and evaluate techniques for epidemiological and intervention programs in rural opium-producing regions of the world. The other project involves holding workshops in two of the WHO regional offices to stimulate increased demand reduction activities in the Southeast Asian and Near East regions and the WHO offices in those regions.

DRUG TREATMENT SERVICES FOR WOMEN

We continue to be concerned about improving the access

to drug abuse services for women and expanding the knowledge base about their drug abuse problems. Recently the guidelines for the drug abuse State planning process were amended to require the States to include in their plans an assessment of the needs of women, an action strategy based on this assessment, and assurances that appropriate resources are available for the treatment of women. A resource manual to help State and local policy-makers meet this requirement should be available early next year. Two publications are planned which should be useful; first, NIDA and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) are working to produce a short booklet for people who are delivering drug and alcohol treatment services to point out the unique needs of women in treatment. Second, the report of the NIDA-sponsored process, "An Alliance of Regional Coalitions for Drugs, Alcohol, and Women's Health," should be available in the near future and will provide a state of the art on women's drug abuse issues and make concrete recommendations for future policy and planning.

SELF-HELP

NIDA is eager to stimulate and support local communities and interested citizens in self-help activities and is exploring how to help make more opportunities available

to communities and individuals which are alternatives to government-funded treatment programs for drug abusers. Self-help groups like Alcoholics Anonymous, SmokEnders, and Weight Watchers have been successful in helping people change their behaviors, and NIDA would like to encourage similar programs for drug abusers. Self-help groups can be enlisted in prevention tasks. Individuals who ally themselves in alumni associations of former drug abuse treatment programs can give support and encouragement to clients to remain drug free as they, too, cut their ties to the programs and attempt to invest themselves constructively in their communities. The pressures from the environment to return to drugs and to antisocial behavior where the countervailing force of a self-help group or alumni association is absent are well known.

Self-help groups also can intercede in the community to provide educational experiences designed to inform the community about problems associated with drug abuse and about sources of assistance for such problems.

THIRD PARTY PAYMENTS

The 1977 National Drug Abuse Treatment Utilization Survey found that among treatment service units receiving Federal drug abuse funds, 28 percent make some use of third party

payments accounting for only 9 percent of their total funding. In treatment service units that do not receive Federal money, a little over 44 percent utilize third party payments, amounting to 33 percent of their total funding.

Increased effort is needed so that drug abuse services can continue to move into the mainstream of health funding. Current data show that the trend for most drug abuse treatment programs is to shift increasingly into diverse non-Federal funding sources. The Federal Government stimulated growth in the area of drug abuse treatment and now Federal funding for treatment appears to be stabilizing. For programs to continue to grow in size and services they must increase their third party funding support.

ALCOHOL AND TOBACCO

One promising area is the linkage between the drugs of abuse and the Nation's major drugs of dependence, alcohol and tobacco. Tobacco is beginning to be understood as the Nation's leading addictive drug, and it seems likely that this will be an area of great activity in the future.

HEALTH WARNINGS

One of the most important areas of Federal activity to emerge in the drug abuse field over the last year is the responsibility to protect the public health by providing information about the effects of certain types of increasingly widespread use of illicit drugs. Over the last few months NIDA and other Government agencies have issued reports and provided information to drug consumers, most notably on the use of amphetamines for weight control, certain sedative-hypnotic barbiturates commonly prescribed for insomnia, warnings on the potential danger of Mexican marihuana which might have been sprayed with the herbicide paraquat, and finally, the use of cocaine, phencyclidine (PCP), and inhalants.

INTERAGENCY COOPERATION

NIDA is committed to enhancing cooperation among the three fields of alcohol, drug abuse, and mental health. ADAMHA and the three Institutes were created out of unique historical circumstances which led to legislation creating three relatively autonomous and visible Institutes. We feel that the problems of drug abuse are such that specialized attention is needed and that the current Federal structure allows for this focus while also encouraging program interaction where

appropriate within ADAMHA. We also believe that there are areas which will benefit from closer cooperation and even some merging in the future, including data collection, the State planning process, drug abuse and alcohol research, demonstration, manpower and training.

THE FUTURE

Nearly 35,000 drug abuse workers were employed full time in over 3,000 NIDA funded drug abuse treatment units at a cost of more than \$500 million in 1977. When part-time workers and those working in such closely related programs as school and community-based drug abuse prevention programs plus those engaged in related research and administrative activities are all totalled, it has been estimated that over 150,000 people now work in drug abuse prevention outside the supply reduction area.

The drug abuse field has come a long way since the 1960's, when "the drug problem" was synonymous with "heroin addiction," and the phrase "once an addict always an addict" was common. Today NIDA is still actively involved in treating and preventing heroin addiction but its horizons are broader and it feels a responsibility to respond to other types of drug abuse.

Mr. ROGERS. Thank you very much. When did you last meet with the White House Domestic Council or the Office of Drug Abuse Policy?

Dr. KLERMAN. My understanding is that the proposal is that the ODAP—the Office of Drug Abuse Policy—will cease to exist sometime in the immediate future and that its functioning will be taken over by the Strategy Council on Drug Abuse and by the Domestic Council. I am not familiar with the details of how the White House is proceeding on that plan.

I have met with Dr. Bourne within the past month on some of these issues, and different members of his staff and our staff are involved in preparation of various reports and coordinating efforts, particularly in the area of prevention.

Mr. ROGERS. So you are still meeting with Dr. Bourne?

Dr. KLERMAN. Yes, our understanding is that, even with the reorganization, Dr. Bourne is the key person within the President's staff responsible for coordination within the executive branch.

Mr. ROGERS. What about the Strategy Council?

Dr. KLERMAN. The Strategy Council is a body mandated by, I think, the 1972 legislation which provides for presentation from a number of the executive departments—Justice, State, Labor and HEW—plus a number of distinguished nongovernmental consultants.

That group met with the President about 3 months ago, and I did attend that meeting with the Secretary of HEW.

Mr. ROGERS. So that is continuing?

Dr. KLERMAN. The expectation is that will become a major mechanism for coordination within the executive branch and for bringing into the executive branch the advice of nongovernmental consultants from educational fields, scientific fields, and the public domain.

Mr. ROGERS. Who will assume the lead?

Dr. KLERMAN. I am not familiar with the details but my assumption again is it will be Dr. Bourne, but I think it would be best if you would inquire in detail of the White House as to how they will proceed. The one meeting that I attended was chaired by the President.

Mr. ROGERS. Now, you were appointed as of when?

Dr. KLERMAN. As of December of 1977.

Mr. ROGERS. And you have attended one meeting?

Dr. KLERMAN. Yes; I think the group has met only once. A number of committees have been established to deal with issues such as international coordination, demand reduction, prevention, and we are participating very actively on those committees, which cut across the executive branch.

Mr. ROGERS. About how many individuals in this country currently abuse heroin?

Dr. KLERMAN. I think Dr. DuPont is in the best position to answer that—

Mr. ROGERS. Certainly.

Dr. KLERMAN [continuing]. Since it is his institute that conducts analysis of that data.

Dr. DUPONT. Thank you, Jerry. The current estimate, Mr. Chairman, is that about 450,000 persons are daily heroin users in the country, a decline of 15 or 20 percent from a year or two ago.

Mr. ROGERS. It is down how much?

Dr. DuPONT. About 15 or 20 percent.

Mr. ROGERS. How is that determined?

Dr. DuPONT. We use a fairly complex formula to estimate heroin prevalence taking into account emergency room visits, overdose deaths, demand for treatment and the street level price and purity of heroin. I would not want the committee to take too seriously the precise number, since this is clearly an estimate.

We do feel very strongly that our understanding of the trend and the general magnitude of the heroin use problem is now soundly based on reasonable data. The daily use figure is in the neighborhood of 450,000 persons. The heroin use trend is down; we do feel positive about these facts.

Mr. ROGERS. What is the evidence of its being down?

Mr. DuPONT. All of the heroin indicators, Mr. Chairman, have dropped in the last year throughout the entire country, although I am not sure that the decline is continuing in the last few months. It may be that it has now bottomed out. If we take the longer view of the last year or 18 months, the trend has clearly been down; overdose deaths are down and emergency room visits because of heroin use are down nationally.

Mr. ROGERS. Fifteen percent?

Dr. DuPONT. In some of the indicators it is down even more. I think, if anything, we may be understating somewhat the decline. In many cities the decline is much greater than that.

Mr. ROGERS. Where is the heroin entering the country being produced?

Dr. DuPONT. About 70 percent of the heroin coming into the United States now comes from Mexico, and most of that comes directly across our 2,000-mile border with Mexico. About 25 percent of the U.S. heroin comes from Southeast Asia, and that comes in a variety of ways, including across both of our coasts. The remainder appears to come from Near Eastern sources—Pakistan and Afghanistan.

Mr. ROGERS. How many treatment slots do we have?

Dr. DuPONT. About 250,000 across the country.

Mr. ROGERS. Are they all currently filled?

Dr. DuPONT. The total utilization is about 90 percent, which, for functional purposes, probably constitutes being filled given the fact that programs are starting up and winding down.

Mr. ROGERS. Where are most of the treatment slots located?

Dr. DuPONT. Mostly in the larger cities. About half of all the treatment slots are in two States—California and New York. Treatment is available in all the large cities; however most of the smaller communities of the country now have treatment.

One of the most dramatic changes in the last 6 or 7 years since the original bill, 92-255, was established is that treatment is now available all over the country. If you will recall, in 1971 many cities had no drug abuse treatment at all and most cities had waiting lists.

To my knowledge, Mr. Chairman, there is today not a single city in the country that has a waiting list. Even medium-size cities now have treatment for drug abusers.

Mr. ROGERS. How many of these slots are financed by NIDA?

Dr. DUPONT. About 40 percent of the slots contain some NIDA financing, which totals about a third of the total financing, because we don't pay full costs of the NIDA-funded slots.

Mr. ROGERS. And what does that amount to?

Dr. DUPONT. The total amount of NIDA treatment funding is about \$150 million a year.

Mr. ROGERS. And \$100 million is being added to that amount?

Dr. DUPONT. There is about \$200 million additionally coming from elsewhere in the Federal Government, including medicaid payments in particular, but also Department of Defense and Veterans' Administration. The total the whole country spends on drug abuse treatment is about \$500 million including both Federal and non-Federal funding.

The biggest contribution to the financing of treatment in the United States used to come from State revenues. State investments are now about the same as the NIDA contribution.

One of our most important achievements in the last few years which, I think, is more than anything else responsible for the stability and the positive development of the whole drug abuse treatment effort—and for other important programs, also—has been the emergence of drug abuse prevention single State agencies and particularly the willingness of the States to provide State revenues to support drug abuse prevention and treatment programs.

Mr. ROGERS. Yes. I am not sure but did you say that NIDA paid one-third of the funding.

Dr. DUPONT. Yes, sir.

Mr. ROGERS. That was \$50 million?

Dr. DUPONT. No; \$150 million each year for treatment.

Mr. ROGERS. \$150 million.

Dr. DUPONT. \$150 million. And the total, then, from all sources is about \$500 million for the Nation.

Mr. ROGERS. And the majority of that now is coming from the States?

Dr. DUPONT. Presently no. The majority of the \$500 million used to come from the States.

Mr. ROGERS. What is the contribution of other Federal agencies?

Dr. DUPONT. About \$200 million each year. The major other Federal contributors are medicaid, which is the largest; the Veterans' Administration; the Department of Defense and the Bureau of Prisons. Altogether it is just about \$200 million.

[The following information was received for the record:]

Source of Funding for Drug Abuse Treatment

The information on funding for drug abuse treatment is based on the National Drug Abuse Treatment Utilization Survey (NDATUS) conducted in April 1977. NDATUS is an annual survey through which every known drug abuse facility reports information about their client capacity, staffing and funding. In 1977, 4,357 units responded to the survey of which 3,147 reported that they provide treatment services. The remaining units provide services other than treatment, such as: central intake, training, education or information.

Each of the 3,147 treatment units reported the amount of money received for treatment from various sources of funding and the time period covered by those funds. Using the time period information, estimates were made of the amount of funds received annually from each source. NDATUS estimates that nearly \$511 million were funded for treatment in 1977. The distribution of these funds according to their source was as follows:

All Treatment Units

<u>Source of Funding</u>	<u>Percent</u>
NIDA	23
Bureau of Prisons (BOP)	1
Veterans Administration (VA)	5
Law Enforcement Assistance Administration (LEAA)	1
Other Federal	3
Third Party	14
State	35
Local	10
Private	8

Total Funds -- \$510,719,000

Of the 3,147 responding treatment service units, 42 percent or 1,312 units received funds from NIDA. Generally, NIDA funds only a portion of treatment programs with the remaining costs covered by matching funds from other sources. There were 1,111 units receiving NIDA funds as well as funds from other public and private sources. The funds used in these facilities amounted to \$205 million of which 50 percent were NIDA funds as shown in the following distribution:

Treatment Units With Some NIDA Funding

<u>Source of Funding</u>	<u>Percent</u>
NIDA	50
LEAA	1
Other Federal	3
Third Party	9
State	23
Local	10
Private	5

Total Funds -- \$205,236,000

One hundred seventy-seven units reported receiving all of their funds from NIDA. These funds amounted to \$16,213,000.

Mr. ROGERS. Yes. What are the results of the treatment program now?

Dr. DuPONT. The results are——

Mr. ROGERS. Are they effecting cures or——

Dr. DuPONT. Yes, sir, many people are cured.

Mr. ROGERS. Do you have any idea how many?

Dr. DuPONT. Yes, sir, there are two broad areas of achievement. One is the fact that the drug abuser has somewhere he can come in for treatment. He or she has an alternative to the pusher.

We have conducted followup studies of drug abusers who first came into federally funded drug abuse treatment programs in the early 1970's. We have followed up this group of people over the course of 5 years after they entered treatment. The results of that followup study are quite impressive.

There is on the average a clear evidence of a downturn in illegal drug use, a downturn in criminality and an increase in employment across the board while people are in treatment programs; and, when followed up after treatment, we find that the gains continue and have, in fact, increased in the post-treatment, followup period.

Mr. ROGERS. Would you submit all those figures for the record?

Dr. DuPONT. Yes, sir. I would like to point out that 60 percent of the people dismissed from treatment were readmitted at some point during the period of the 5-year followup and many people do have a chronic and malignant course of drug abuse; but, on the average, I am reporting very strong trends of reduction in illegal drug use and in criminality and modest gains in terms of employment.

Mr. ROGERS. But recidivism amounts to about 60 percent?

Dr. DuPONT. In terms of readmission to treatment; yes, sir.

Mr. ROGERS. So that would be higher than that if you just took recidivism generally?

Dr. DuPONT. It is very high in terms of coming back into treatment and in terms of return to some drug use. We have analyzed the data for the 60-day period immediately prior to coming in for treatment and compared that with the 60-day period immediately before leaving treatment and compared that with 60 days prior to followup an average of 5 years later. We have worked especially at the levels of drug-use, criminality and employment.

During these comparable time periods you see a very strong downward trend, including, for example, daily heroin use reduced about 90 percent between time of prior treatment and 5 years later, occasional heroin use, reduced about 60 percent between the period prior to treatment and followup; and employment up about 10 percent. Crime was reduced about 50 percent.

Mr. ROGERS. Is that crime for people in the treatment?

Dr. DuPONT. Yes; I am talking about arrest rates now.

Mr. ROGERS. Yes. How many people form the basis of these studies? What was your sample?

Dr. DuPONT. The initial sample was about 1,000 people who were admitted to treatment in the period 1969 to 1971. The final sample is being expanded to 5,000 persons who were scientifically selected from a base of about 50,000 people who were admitted to treatment between 1965 and 1973.

Mr. ROGERS. Who is doing this study?

Dr. DUPONT. Dr. Saul Sells at Texas Christian University.

Mr. ROGERS. And what is the amount of the contract?

Dr. DUPONT. I don't remember; I would have to submit that for the record, Mr. Chairman.

Mr. ROGERS. Would you let us know?

Dr. DUPONT. It is a substantial contract.

[The following information was received for the record:]

Evaluation of Treatments for Drug Abuse

Dr. Saul B. Sells of Texas Christian University's Institute of Behavioral Research has studied the results of drug abuse treatment under a grant from the National Institute on Drug Abuse.

The preponderance of the evaluation was performed under a three year grant (1 H81 DA 01598-01) from FY 1974 through FY 1976 (\$749,171 - FY 74; \$922,753 - FY 75; \$127,043 - FY 76; and \$293,213 - FY 76). Samples of approximately 4,000 opiate addict and chronic drug abuser patients treated at agencies that reported to the National Institute of Mental Health supported Drug Abuser Report Program (DARP) were studied.

3,300 persons admitted to treatment during the third year of the DARP system were studied five years after their admission under a subsequent grant from the National Institute on Drug Abuse (2 H81 DA 01598-04) to assess the relative efficacy of treatment in terms of post-treatment functioning with respect to drug use, employment and criminality. The total cost of this grant is \$1,255,478 (\$667,104 - FY 77; \$588,374 - FY 78).

Currently Dr. Sells is receiving a NIDA grant (1 H81 DA 1931-01) estimated to cost \$165,000 in FY 77 and \$5,600 in FY 78. The purpose of this project is to study two treatment modalities (methadone maintenance and outpatient drug free) to assess the effects of organization and staff attitudes and behavior on treatment motivation and outcomes.

Dr. Sells has also received federal grant assistance from the National Institute of Mental Health and the Special Action Office on Drug Abuse Policy.

Summary of the Evaluation:

Evaluation of treatment, both during treatment and post-treatment, indicates positive results. Detailed discussion of these issues can be found in the DARP research reports (Sells, 1974a, b; Sells and Simpson, 1976a, b, c) and in the evaluation literature. The following comments are an overview:

1. During the time that patients are under the surveillance of treatment programs the usage of opioid and nonopioid drugs has been controlled with considerable effectiveness in virtually all treatments for virtually all types of patients. Reduction of criminality associated with drug use has also been observed very generally. Variations by treatment type and patient type have been noted, and for some groups, for example, youthful nonopioid users in drug-free programs, the results have not compared favorably with those of other groups, such as older, hard-core heroin addicts in methadone maintenance programs. Nevertheless, the overall results regarding during-treatment drug use suggest that treatment can be considered as a viable alternative to other forms of social control, such as incarceration. In cost-benefit terms, the outpatient treatments in particular would undoubtedly fare well in the comparisons.

2. Rehabilitation must be considered, as well as control of drug use and crime. In the evaluation of treatment, post-treatment evidence of self-sufficient, productive life styles, reflecting processes initiated either as a result of decisions to enter into treatment or of behaviors initiated during treatment must be weighed along with the during-treatment facts. One of the DARP studies (Demaree et al., 1976) showed that among patients in methadone maintenance 6 months or longer those who do well in employment are also more likely to do well on other criteria. It is necessary therefore to evaluate treatments, such as therapeutic communities and the change-oriented outpatient programs, in which during-treatment employment opportunities have been limited, on the basis of post-treatment employment outcomes. The initial indications of the Cohort 1 followup tabulations are encouraging in this respect, but the data are not yet analyzed.

3. It should be noted, however, that many programs have what appear to be inadequate provisions for employment counseling, training, placement and associated activities. To the extent that such inadequacies may be shown to result in poorer outcomes, in comparison with those of agencies that provide more comprehensive services, the indications for directions of improvement of treatment services will be clear.

Mr. ROGERS. Do you participate in programs with or give any suggestions to enforcement agencies? How do you coordinate enforcement and treatment activities?

Dr. DuPONT. There has been very positive coordination at the White House level, and directly among the various agencies. I meet with Dr. Bourne, Director of the Office of Drug Abuse Policy, and Peter Bensinger from DEA, Mathea Falco of the State Department, and Robert Chassen of Customs every other week to talk about major issues. We work very closely and feel positive about that coordination, so we work very closely.

Let me give an example of a concern we have in the area of law enforcement right now. It is possible to—I know this sounds very optimistic but I think we have to consider the possibility that our efforts against illegally produced natural drugs—heroin, marihuana, and cocaine—may well be quite successful over the next decade.

I think there is a growing sense of international cooperation. These crops, in particular the cocaine and heroin, are quite vulnerable to interdiction efforts, and I think we are making real progress here. But, as we do, there is a tendency to replace those substances with synthetic drugs produced within the United States, and the most menacing of these from my point of view is phencyclidine or PCP.

As enforcement efforts improve, there is also the tendency to make abuse of prescription drugs, including prescription opiate drugs. DEA, has been very aggressive in the last few years in enforcing the law with those doctors and pharmacists who are involved in essentially the business of selling prescriptions to abuse drugs. And again I think that they have done a very fine job, although obviously much more needs to be done. Thus at a policy level we are increasingly concerned about illegally synthesized prescriptions. This concern has led to greater joint law enforcement and treatment efforts.

Mr. ROGERS. What about cocaine? I thought we had increased amounts coming into the country.

Dr. DuPONT. Yes; we are seeing a growing problem with cocaine. I have a very strong, and not entirely agreed upon, position as to what we ought to do about cocaine, Mr. Chairman. If you will indulge me for 1 minute I would like to put it on the record.

Mr. ROGERS. All right.

Dr. DuPONT. The cocaine plant is a perennial, unlike the marihuana and the poppy plants. Marihuana and poppies take about 120 days from the time they go into the ground until they are harvested. The cocaine plant is a bush that requires 4 years of growing before the first leaf can be picked to make cocaine. It is a relatively difficult plant to grow and very easy to spot.

We need an interdiction plan aimed at killing the coca plant, the coca bushes. I have had an opportunity to visit the two countries where almost all of the cocaine available in the world now is produced—Bolivia and Peru—and there is no effort now being made to destroy those plants in those two countries.

Rather we have focused our U.S. efforts rather on the law enforcement aspects of dealing with cocaine supply, particularly in Colombia. As you know, drug interdiction is much more difficult to contend with after it goes underground. By the time the drug reaches Colombia, it is underground, it is in a concentrated form. We have lots

of guns and lots of corruption and other kinds of problems to deal with at that point in the supply chain.

In Peru and Bolivia, coca plants are growing out in the open where they are easily seen; everybody knows where they are. It would be wise, from my point of view, to destroy those plants, either through use of herbicides or, for that matter to simply go around and pull them up out of the ground.

I watched in Peru as, literally the jungle was being torn down and coca bushes being planted. There was no interdiction whatsoever going on.

My concern is that over the next year or two we need to be much more aggressive about destroying coca plants in those two countries.

Now, we have to be respectful of the fact that there is a legitimate export for some cocaine; there is also legitimate use of it by the local Indians. Having acknowledged that the question is, how much land in Peru and Bolivia is needed to produce coca for those two purposes?

Both of those nations—Bolivia and Peru—have international treaty obligations to totally eliminate the coca crops. I would hope that over the next year or two we will get much more aggressive in encouraging them to meet those obligations. I also hope other nations will join us in these efforts.

Some critics of this proposal point out that the Peruvian and Bolivian farmers now growing coca are poor. They claim that we in the United States have a responsibility to replace the lost income of these farmers. I disagree. Most of these coca farmers are newcomers to the coca growing business. They are not "traditional growers." If we in the United States were to accept the burden of income replacement in Peru and Bolivia, we would be subject to blackmail all over the world. After all marihuana, poppies, and coca bushes can be grown almost anywhere. If we pay the Peruvian farmers not to grow coca why not the farmers everywhere? On the other hand I do recognize the wisdom of helping to pay for crop eradication. I hope that some policies based on the broad goal of eradication will soon be adopted and that, once done, it will reduce the amount of cocaine available in the United States.

Amounts of cocaine coming into the country at the moment are large. Cocaine is one of the three drugs—cocaine, PCP, and marihuana—whose levels of use are now increasing in this country.

Dr. KLERMAN. Mr. Chairman.

Mr. ROGERS. Yes.

Dr. KLERMAN. If I might comment, I think the illustration on cocaine still applies with regard to opiates; namely, total strategy on drug abuse must involve not only treatment and prevention, which are our primary concerns, but also should involve international activities and reduction of the crops and reduction of traffic.

To achieve this we need the kind of program that has been organized by the White House to involve the State Department and other branches of the Government.

Our particular responsibility in HEW is with the reduction of demand through treatment, preventive, and rehabilitative efforts, but we can cooperate with the State Department and Justice on the kind of program that Dr. DuPont proposes.

Mr. ROGERS. Are you a part of the Strategy Council?

Dr. KLERMAN. We are represented on the Council by the Secretary, who is, by statute, a member.

Mr. ROGERS. But does he designate who represents him?

Dr. KLERMAN. There has been only one meeting of the Council. The Secretary has recently looked into the internal coordination of HEW's policy recommendations and a number of possibilities being considered within the Department; but, by statute, he is a member of that Strategy Council.

Mr. ROGERS. I understand. I am saying: Does he attend them? Did he attend that one?

Dr. KLERMAN. Yes; he attended the one meeting that has been held thus far.

Mr. ROGERS. Did you also attend?

Dr. KLERMAN. Yes; I attended.

Mr. ROGERS. Did he designate you to take his place on the Council?

Dr. KLERMAN. He has asked me to look into coordinating programs and policies at HEW along with Mr. Dan Meltzer, who is on his immediate staff.

Mr. ROGERS. Mr. Walgren.

Mr. WALGREN. I don't mean to go over ground you might have already gone over adequately before I was present, but I thought it might be useful to explore the work in prevention.

Mr. ROGERS. Yes.

Mr. WALGREN. Was that covered completely?

Mr. ROGERS. No; we haven't touched it yet.

Mr. WALGREN. It seems to me that the act that we are operating under tries to put some great emphasis on prevention. What are the efforts of your office in that area, how much money is being spent in that area and what kinds of things are you doing?

Dr. KLERMAN. The prevention area is one where we acknowledge there is a need for greater effort and greater coordination. There are two current programs within HEW which have, by statute, an appropriation responsibility for prevention. There is a program within the Office of Education, led by Dr. Helen Nowlis, which, I think, is at the level of appropriation of \$2 million and which mainly focuses on developing programs for children within the primary and junior high and secondary school system.

Within the Public Health Service the responsibility for prevention lies with NIDA, and Dr. DuPont has described the NIDA program, which is currently at the level of about \$5 million for various prevention efforts.

We have a number of thoughts about what the future directions might be to augment those efforts and to make them more effective and more efficient.

Mr. WALGREN. Is it possible to make any judgments about how effective money spent for prevention is?

Dr. DuPONT. The prevention programs that have been looked at have shown benefits; they generally do a good job. I will give you one example of a typical program. An alternative program for youth was started in Gloucester, Mass., which took young people who were having trouble in school and trouble with the law and got them

together and involved in constructive community projects such as rehabilitating parts of the community and building a neighborhood activity center.

A study of the drug use of the young people before and after the project showed a big reduction in their drug use as they got more actively into other things.

That project has now been expanded, with the help of the Prudential Life Insurance Co., into a program called Channel One, which is disseminating the idea throughout New England. We hope to make it a national demonstration in a year from now. This is one example of an extremely successful prevention program.

I think part of our problem in the prevention area is that we have not shown that these programs work. I think we can show that they do work. The problem has been the difficulty in conceptualizing the limits of what we are doing. We have a very large target population with almost a limitless series of alternatives which we confront with a small budget. Accordingly, we are limited to demonstrating techniques that can be useful and disseminating these ideas.

As you know, our national prevention campaign this year has the tagline "Prevention Is Everybody's Business." Basically the message is: Any time you help a young person solve a problem, or to get in touch with his feelings, or do something constructive, you are doing drug abuse prevention.

That message is contained in a series of television spots and booklets that NIDA has published. We feel optimistic about the campaign. I think, though, that realistically we have to recognize that these programs are also certainly not going to make the drug abuse problem go away.

Dr. KLERMAN. If I might comment, Mr. Congressman, as we have looked at the problem, both our successes and our less-than-successes, it seems to vary with the type of drug and with the age group. With barbiturates and amphetamines we think there is evidence that a great deal of progress is being made through a combination of regulatory action by FDA and education of patients and of physicians who are the disbursers of those drugs.

However, when one deals with those drugs which are used by young adults and adolescents, there is a major overlap between the marihuana and cocaine and heroin, and there we have a reasonably complex problem. Not only is control of traffic and production required on an international basis but also the rates of use by young people seem to be influenced by the state of the economy, particularly the level of unemployment in certain cities as it impacts on minority groups. That is not a one-to-one relationship but it has some bearing.

And then there are the specific kinds of educational efforts directed at people in schools or young people on the street. And how to put all those together is something that requires reassessment; and, as I say, this is something that we feel we need to give more attention.

Mr. WALGREN. How much money was targeted for this by the Congress in the past? Is it broken out?

Dr. DUPONT. Yes; we have the funding history for prevention programs, the 1977 amount was \$4.7 million; 1978 was \$6.5 million and the 1979 request is \$5.1 million. Each year NIDA has requested

more money than this but the prevention budget is one that tends to be squeezed and it was squeezed particularly hard in the 1979 budget.

Mr. WALGREN. I see. And the \$150 million figure that you were mentioning earlier—

Dr. DuPONT. Is for treatment.

Mr. WALGREN [continuing]. Is for treatment?

Dr. DuPONT. Right.

Mr. WALGREN. And that is part of, just literally, I guess, a lump target for prevention, treatment and rehabilitation; is that right?

Dr. DuPONT. Yes; that would come under section 410 authority of Public Law 92-255 that we are talking about. One of the goals of this committee this year is to try to separate the authorization for prevention and demonstration from the treatment authorization. I understand that the purpose of that move is to try to keep the amount of money that should go to prevention from being eroded by the larger and generally more stable treatment portion of the NIDA budget.

I think the committee is saying that it wants a higher visibility and higher support levels for prevention and demonstration.

Mr. WALGREN. OK; thank you, Mr. Chairman.

Mr. ROGERS. You say PCP and marihuana use has also increased?

Dr. DuPONT. Yes, sir.

Mr. ROGERS. Would you explain that to us?

Dr. DuPONT. I have been particularly concerned about both of them—PCP because of the dangers of the drug use itself. It is probably the most toxic and malicious of the drugs that we have seen come on the scene in the last decade, producing problems including psychosis, bizarre behavior, violence, suicide and accidental death. Also, a fair percentage of users develop dependency with very bad consequences.

When you see a drug abuser who is "burned out" and unable to function—and some of them are hardly able to speak or think—this person is likely to be a chronic PCP user. PCP is a great menace and we have put our top priority on it. PCP is not just another smoke. Part of the problem with PCP is that it is taken like marihuana and because of the increasing casualness about marihuana smoking PCP or PCP laced marihuana is passed around and casually smoked.

We worked recently with Robert Blake from the Baretta television show putting together a television spot, hoping to get the message across that PCP is dangerous. Marihuana, Mr. Chairman, is a subject you are an expert on having served on the historic Shafer Commission. The levels of use in our society are now higher than any of us would have guessed in 1971, and there has been a tendency toward more regular use than could have been guessed in 1971.

In our most recent survey we found 9.1 percent of high school seniors are now daily marihuana smokers in contrast with 6.1 percent daily alcohol users. The alcohol consumption of this same population has been relatively stable over recent years while the marihuana

consumption has been in a very sharp upswing and shows no signs of stopping at this point, even in quite young populations.

I am at a loss to know precisely what to do about this. Some part of our problem is the legal reform movements, particularly decriminalization which I very much support, which is interpreted as giving a green light to marihuana consumption. To talk to young people about their attitudes on drug use is very frightening to me.

For example, I was talking to a group of 12-year-olds about a year ago, and I asked them what the Government could do to help solve the drug problem and this group said, partly in jest, we should legalize marihuana so they won't have trouble getting it. I think that attitude is dangerous.

Mr. Walgren's point about prevention fits in here if we try to distinguish groups as to marihuana use. I think one could be rather tolerant of adults using marihuana. But when you are talking about 12-, 13-, 14-, 15-year-olds, it seems to me we should be hardline in discouraging drug use and appropriately so.

Part of the problem is that some parents are too permissive and are treating 12-year-olds like they are 20. We at NIDA have been working with groups of parents, including a particularly well-organized group in Atlanta, Ga., helping them deal with drug use in the population under age 16. The hallmark is the parents need to take much more responsibility for their children's behavior and set more limits. This is quite a contrast to our earlier emphasis on understanding and reasoning with children. Now we are saying that parents need to say no to certain behavior, including the use of drugs and alcohol in the early teenage years.

It is interesting what happens when parents do this. They also get more involved with their kids in positive ways, helping the kids have more fun and do more things with recreation. Often parents who are permissive and say anything goes are parents who are neglectful of their children. It is easy to say yes, but it takes work to say no.

We hope to help turn that around, but I think the marihuana trend now with some people, and we now estimate that there are 16 million regular marihuana smokers in the United States, today is quite a concern especially since it is growing at a rapid rate.

Mr. WALGREN. Could I ask—

Mr. ROGERS. Yes.

Mr. WALGREN [continuing]. Whether any of those percentages apply to the 12-year-old; you said 9 percent, and 9.1 percent high school seniors?

Dr. DuPONT. Yes; those were high school seniors.

Mr. WALGREN. What do we know about 12-year-olds?

Dr. DuPONT. In 1977, 4 percent of the 12- and 13-year-olds in the country reported marihuana use, for example. That was a doubling, by age 14 to 15, that 4 percent goes to 15 percent. By the next cohort, 16- to 17-year-olds, it goes to 19 percent. So there is a very rapid increase in levels of marihuana use within the teenage group.

Mr. ROGERS. Is that use on a regular basis you say?

Dr. DuPONT. No; that is use one or more times during the preceding month.

Mr. ROGERS. Just use.

Dr. DuPONT. This is used during the past month.

Mr. WALGREN. How about alcohol, do you have that?

Dr. DuPONT. In general, there are a higher percentage of people who have used alcohol, but they tend to use it less often on an everyday basis. There is a smaller percentage of them who use it on a daily basis.

Current drinking by 12 to 13-year-olds is 13 percent; 14 to 15, it is 29 percent; and for 16- to 17-year-olds, it is 52 percent.

Now, that, too, is any use within the last month. It is interesting that most of the alcohol use in the young population is beer. That one other thing that we find, and Dr. Noble from the National Institute on Alcohol Abuse and Alcoholism (NIAAA) has emphasized this point very strongly that there is a very big misunderstanding on the part of the public that somehow beer is more like a soft drink than it is like whiskey. A beer has the same amount of alcohol in it as a scotch and soda does. The idea that people drinking beer are not drinking alcohol is a very dangerous mistake. Too many parents say, "Well, he is only drinking beer," on the presumption he is not drunk or has not been exposed to alcohol.

Mr. ROGERS. You say one beer has the same amount of alcohol?

Dr. DuPONT. One beer has about as much alcohol as one shot of whiskey.

Mr. ROGERS. As one shot?

Dr. DuPONT. Yes, sir, 12 ounces of beer is about the equivalent of 1 ounce of whiskey, or one 6-ounce glass of wine. There is in this country a tendency to begin drinking wine and beer as opposed to whisky. Overall, beer and wine consumption are up in this country, and the total consumption of distilled spirits is down. This may reflect a misunderstanding of the alcohol content of beer and wine.

Mr. ROGERS. What new initiatives have come from the Council's meeting, if any?

Dr. KLERMAN. You mean the Strategy Council?

Mr. ROGERS. Yes.

Dr. KLERMAN. Well, the Council had only one meeting that I attended, and I think from what details it would be best to hear from Dr. Bourne or members of his staff. Out of that meeting the President reiterated some of the points that he made in the fall in his statement on problems of drug abuse; namely, a desire to extend a concern for abuse of drugs, not only to heroin but to drugs like barbiturates, and also to look at overall problems, including tobacco and alcohol as they may also relate to the drugs, which in the past have been the major concern and he directed Dr. Bourne and his staff and also Government agencies like HEW to look at areas of similarity in overlap with alcohol and tobacco as well as heroin.

He also directed a major effort with regard to barbiturates and sleep drugs, and that was taken up by the Council, and also there were a number of efforts specifically directed toward possible reductions in barbiturates and other hypnotic drugs, which are a cause of death, particularly by suicide attempts.

There are a number of intergovernmental task forces created around issues such as international cooperation, technical assistance to other countries, and also efforts at prevention and rehabilitation.

The next meeting of the Council I think is scheduled for June, but I feel somewhat hesitant to discuss those matters in too much detail since I only know about those parts which impact directly on HEW, and I think there is someone from Dr. Bourne's staff in attendance here who may be in a better position to elaborate upon that.

Mr. ROGERS. Who is here from Dr. Bourne's staff?

Ms. POPE.¹ I am Mazie Pope, Mr. Chairman. The Strategy Council, the Federal strategy is being written now. I don't have any Federal policy decisions within the office. I will be glad to have Dr. Bourne call you or talk to you.

Mr. ROGERS. Well, maybe we ought to have—is Dr. Bourne in town?

Ms. POPE. Yes; he is in town.

Mr. ROGERS. I wonder if we could have him come talk with us this afternoon? I wonder if he could appear at these hearings?

Ms. POPE. I will be glad to talk to him.

Mr. ROGERS. If it is convenient, I think it would be helpful. About 2 o'clock.

Ms. POPE. I will call him and see if he is available.

Mr. ROGERS. That would be helpful.

What are you doing about the use of tobacco?

Dr. KLIERMAN. Well, as you know, Mr. Chairman, the Secretary has made known his great concern with health consequences of tobacco, and there is an HEW-wide initiative on tobacco, which includes an attempt to influence the tobacco consumption throughout the whole Nation. Our particular responsibility within ADAMHA and particularly within NIDA is to continue what we think an excellent program of research which is to demonstrate, one, that tobacco is an addictive substance and has also documented some of the problems in acquisition of that, particularly by young people. It is of interest that each of the behaviors take place very rapidly during the midteens, alcohol, tobacco and marihuana use and sometimes heroin, so the teenage years is the period where there is a rapid acquisition and learning of a series of behaviors which have in common the injection of substances with possible deleterious health consequences and also addictive potential.

Once again, I would turn to Dr. DuPont, who can describe the research and demonstration programs with regard to tobacco within NIDA which are part of a larger program within HEW.

Mr. ROGERS. Yes, what has happened, Dr. DuPont?

Dr. DUPONT. Mr. Chairman, Dr. Klerman has quite properly made the point that we do not have any action programs against smoking at NIDA since our efforts are purely research. Of the Secretary's initiative of about \$30 billion our research program will cost about \$1.5 million by fiscal 1979. So it is a relatively small part of the total HEW initiative, but it is focused specifically on the research questions about the acquisition and the nature of the addiction to tobacco.

¹ Ms. Pope was in the audience and responded to Chairman Rogers' question.

As you know now, we have developed antagonist drugs for opiate addiction, and what we are now looking into is whether or not there might be antagonist drugs for dependence on tobacco. We have one of our best researchers, Dr. A. Goldstein from Stanford University, trying to develop an antagonist. We are also looking to another old friend of yours, Dr. Jerome Jaffe, who has spent the last 5 years specifically dealing with the tobacco dependence problem. One of the interesting things Dr. Jaffe is looking into is what incentives it takes to get tobacco smokers to smoke low tar and low nicotine cigarettes.

One question is whether a tax policy based on what levels of tar and nicotine might entice more smokers to swing to less harmful cigarettes.

At the moment, we do not have a sufficient knowledge base to be able to say how much that price difference would have to be to achieve significant results. Dr. Jaffe is looking into the question of what incentives can be used to get people to use safer cigarettes.

Mr. ROGERS. How long has that contract been in existence?

Dr. DuPONT. It has recently been approved, and I think it is about to start.

Mr. ROGERS. Would you let us know, and the amount of it?

Dr. DuPONT. Yes, sir.

[The following material was received for the record:]

FUNDING FOR GRANT 1 R01 DA01972 ENTITLED "SMOKING SAFER CIGARETTES," JEROME JAFFE, MD PRINCIPAL INVESTIGATOR

Year	Direct costs	Indirect costs	Total
01.....	\$90,787	\$54,594	\$145,381
02.....	79,297	50,905	130,202
03.....	18,670	13,117	31,787
Total.....	188,754	118,616	307,370

NOTE.—The grant, which will attempt to identify the variables which will include heavy cigarette smokers to switch to a low "tar"/low nicotine cigarette, began on April 1, 1978.

Mr. ROGERS. Any other actions being taken regarding tobacco abuse?

Dr. DuPONT. Yes; I would like to submit for the record the entire portfolio of activities Dr. Klerman mentioned. Another important concept is that of gateway drugs. One of the things we find is that young people who do not drink have almost a zero probability of going to use illicit drugs. The issue of using alcohol is a very fateful one for any young person.

[The following information was received for the record:]

PROGRAM ACTIVITIES—TOBACCO SMOKING—SUMMARY

The National Institute on Drug Abuse began carrying out research on tobacco smoking as an addictive disorder in 1975 in conjunction with the Institute's initiative on substance abuse behavior. A panel of scientists convened by the Division of Research (July 1975) recommended that NIDA consider studying cigarette smoking behavior in the context of both its extramural and intramural research efforts. Similar recommendations were made by the National Academy of Sciences (November 1975) and the National Advisory Council on Drug Abuse (May 1976). This latter recommendation that NIDA be involved

in the study of tobacco smoking as a dependence process was endorsed by President Ford's Cabinet Committee on Drug Abuse Prevention, Treatment, and Rehabilitation and was included in its report to the President (October 1976) as a high-priority initiative.

With the above encouragement as a background, NIDA has launched a modest research effort designed to study cigarette smoking as a dependence process. The main impetus for this new thrust is two-fold: (1) recent epidemiological evidence suggests that cigarette smoking may be a "gateway" behavior which leads to multiple substance use (drugs and alcohol), especially in adolescents and youth; and (2) the belief that smoking behavior is the prototypic dependence process and, as such, can provide a window to help in our understanding of the dependence associated with the use and abuse of illicit substances.

NIDA's funding for tobacco-related research has increased during the past 3½ years as follows: fiscal year 1975, \$66,000; fiscal year 1976, \$129,000; fiscal year 1977, \$243,000; fiscal year 1978, \$626,000 (to present), projected—\$1,250,000.

[A complete listing of projects may be obtained from the subcommittee files.]

Mr. ROGERS. What about smoking cigarettes?

Dr. DuPONT. Smokers have about twice the rate of marihuana use as nonsmokers, so smoking isn't quite as powerful a "gateway" drug as alcohol, partly because there are many more nonsmokers than non-drinkers. The percentage of the population, of course, that does not drink at all, is not so great as the percentage that doesn't smoke, but in any event, choices about using or not using legal drugs are powerfully related to decisions about using illegal drugs. We are of the opinion if the percentages of young people who drink alcohol and smoke cigarettes were reduced this would have a beneficial effect on the consumption level of illegal drugs as well.

Mr. ROGERS. All right. Do you have any jurisdiction over tobacco since it is an addictive substance? Do you feel it is addictive?

Dr. KLERMAN. Our responsibilities in the tobacco field are with regard to research.

Mr. ROGERS. On how it affects people?

Dr. KLERMAN. On how it affects health. We are part of the general HEW initiative.

Mr. ROGERS. In the use of other drugs I assume?

Dr. KLERMAN. Yes, sir.

Mr. ROGERS. All right.

Dr. DuPONT. We don't want to get too far out in front on tobacco, Mr. Chairman, NIDA's involvement is with research and knowledge of development about tobacco addiction.

Mr. ROGERS. Well, everybody appears to be afraid to get too far out in front on that.

Dr. DuPONT. Not our Secretary. It seems to me he is way out in front.

Mr. ROGERS. Well, he is not recommending doing away with the funding of support for growing tobacco.

Dr. DuPONT. That is true, but that is not an HEW issue.

Mr. ROGERS. He has not gotten that far out front?

Dr. DuPONT. That is right. But I would point out, Mr. Chairman, that HEW has a long, although I think in general, not a very distinguished history of dealing with this issue in the decade since the first Surgeon General's report. HEW had nothing in our budget at all, year after year on tobacco problems. In fact, Secretary Califano has involved the Department and for the first time organized an

attempt to deal with smoking. It is a very great achievement. I feel very happy for it and very grateful for him for his leadership.

Mr. ROGERS. Well, let us have for the record what is happening, will you please?

Your budget has only been 2 percent for prevention.

Dr. DuPONT. Yes, sir.

Mr. ROGERS. That is changing now to 19 percent?

Dr. DuPONT. Yes, sir, 19 percent of all the new starts in NIDA this year will be in the prevention area, so when we look at the changed budget NIDA is putting its money into prevention in a very substantial way in fiscal year 1978.

Mr. ROGERS. But what is the money figure involved? I understand level percentage-wise, but what is the monetary level?

Dr. DuPONT. The total amount of new awards this year is about \$20 million for all of NIDA.

Mr. ROGERS. What was it previously?

Dr. DuPONT. Prevention is about 20 percent of all new and competing awards of NIDA's total fiscal year 1978 budget.

Mr. ROGERS. Of the total budget and this will be a 19-percent increase?

Dr. DuPONT. That is 19 percent of the new and compensating awards in fiscal year 1978.

Mr. ROGERS. Which is how much money, how much of the budget is it, 3 percent or 4 percent?

Dr. DuPONT. You mean how many dollars for new awards?

Mr. ROGERS. How many and what is the percentage of the budget?

Dr. KLERMAN. I think it remains about 2 percent.

Mr. ROGERS. Well, that is what I wondered.

Dr. DuPONT. Oh, yes, at the end, that is. Yes, that is right.

Mr. ROGERS. So that does not necessarily provide much of a change, then?

Dr. KLERMAN. No, sir.

Mr. ROGERS. Although the way it is stated, fully 19 percent of the new awards will be in the prevention area.

Dr. DuPONT. When I am talking about any increase, I meant from \$4.7 million in fiscal year 1977 to \$6.5 million in fiscal year 1978, if that is the number you are talking about. And, that can be related to the totals for the 2 years.

Mr. ROGERS. Now, what I am asking is if your 1977 budget—

Dr. DuPONT. Yes, sir.

Mr. ROGERS [continuing]. Was \$6.5 million—

Dr. DuPONT. The 1978 budget was \$6.5 for prevention.

Mr. ROGERS. That is \$6.5 million?

Dr. DuPONT. Yes, sir. That is for prevention.

Mr. ROGERS. That is for prevention?

Dr. DuPONT. Yes, sir.

Mr. ROGERS. And, it was \$4.7 million for—

Dr. DuPONT. It was \$4.7 million in 1977 for prevention.

Mr. ROGERS. That was in 1977?

Dr. DuPONT. And the President's request was \$5.2 million for 1979.

Mr. ROGERS. So it has gone down?

Dr. DuPONT. Yes, sir.

Mr. ROGERS. Well, that is not very well indicated in your statement, do you think? Do you read it on page 2?

Dr. DuPONT. I have tried to make very clear that the two areas of our fiscal year 1979 budget which are going down are demonstration and prevention. I have done everything I can and still remain on the administration team to point that out.

Mr. ROGERS. I had not gotten to that yet.

Dr. DuPONT. Well, I was confident you would.

Mr. ROGERS. Because, I will read the statement. How do you read this, Dr. Klerman? "Although prevention accounts for only 2 percent of NIDA's total budget of fiscal year 1978, fully 19 percent of the new awards made by NIDA during fiscal year 1978 will be in the prevention area." I would say the thrust of that would be to indicate increased activity in the prevention area and that simply is not true, is it?

Dr. KLERMAN. That is right. We should not attempt to mislead the committee or the public that there is no substantial increase in the budget.

Mr. ROGERS. Well, it is a reduction?

Dr. KLERMAN. Yes.

Mr. ROGERS. Well, I am not very pleased by that at all. Why did you decide to reduce prevention?

Dr. KLERMAN. Well, when the administration's total budget was prepared, the considerations were given to the President's desire to result in a balanced budget within a few years and also the other competing demands upon the budgets of HEW and the executive branch at large. We at HEW had requested larger amounts.

Mr. ROGERS. What had been requested at the agency level?

Dr. KLERMAN. Dr. DuPont can answer that, or we can provide it for the record.

[The following information was received for the record:]

NATIONAL INSTITUTE ON DRUG ABUSE

Prevention Obligations (\$000)

	1974 (Actual)	1975 (Actual)	1976 (Actual)	1977 (Actual)	1978 (Actual)
Grants:					
New/Competing	\$ 2,108	\$ 1,305	\$ 196	\$ 1,086	\$ 958
Continuations	1,420	1,646	2,182	723	1,162
Subtotal	<u>3,528</u>	<u>2,951</u>	<u>2,378</u>	<u>1,809</u>	<u>2,120</u>
Contracts:					
Total	<u>--</u> <u>3,528</u>	<u>1,240</u> <u>4,191</u>	<u>1,280</u> <u>3,658</u>	<u>2,897</u> <u>4,706</u>	<u>4,373</u> <u>6,493</u>
TOTAL NIDA Obligations (less Program Support)	\$256,816	\$204,721	\$217,125	\$243,986	\$245,139
Prevention (% of total)	1.4%	2.0%	1.7%	1.9%	2.6%

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NEW/COMPETING GRANT OBLIGATIONS

Research:					
Training	\$ 11,535	\$10,163	\$ 7,327	\$ 11,555	\$ 5,954
Treatment/Rehabilitation	2,566	1,627	1,138	1,813	501
Prevention	16,297	1,018	2,084	4,361	2,390
Total	<u>2,108</u> <u>\$ 32,506</u>	<u>1,305</u> <u>\$14,113</u>	<u>196</u> <u>\$ 10,745</u>	<u>1,086</u> <u>\$ 18,815</u>	<u>958</u> <u>\$ 9,803</u>
Prevention (% of total)	6.5%	9.2%	1.8%	5.8%	9.8%

Mr. ROGERS. Well, you must know.

Dr. DuPONT. I have it here.

Dr. KLERMAN. I think we wanted to go to \$10 million.

Dr. DuPONT. Yes; I do not have the precise amount for prevention. It was indeed about \$10 million for fiscal year 1978.

Dr. KLERMAN. As I recall, we had hoped to expand the prevention to 10.

Dr. DuPONT. Yes.

Mr. ROGERS. That is about \$10 million. What did HEW indicate in their budget request? Did they support your \$10 million figure?

Dr. DuPONT. Yes; it was supported until OMB.

Mr. ROGERS. Who in OMB is in charge of this?

Dr. DuPONT. Victor Zafra.

Mr. ROGERS. Who is that?

Dr. DuPONT. That is Victor Zafra.

Mr. ROGERS. How do you spell that?

Dr. DuPONT. Z-A-F-R-A, and do not use my name when you call him.

Mr. ROGERS. Well, surely you are not afraid of Mr. Zafra?

Dr. DuPONT. Yes, sir, I am afraid of Mr. Zafra.

Dr. KLERMAN. Mr. Zafra knows we disagree with his views.

Mr. ROGERS. Well, how does he prevail? Does he have drug abuse authority?

Dr. KLERMAN. I do not believe he has authority on the substantive area.

Mr. ROGERS. But he is making the basic judgment as to the amount of money?

Dr. KLERMAN. My understanding of the process, I am relatively new to the executive branch, is that the decision made for the total budget of the Department between the Department and OMB is part of the President's desire to maintain a budget that is not excessively inflationary.

Mr. ROGERS. What had you requested for treatment programs? What was the Department, your agency request for treatment?

Dr. DuPONT. Again, I do not have it in the table before me. The total for the community programs line of our fiscal year 1979 budget that we had requested was \$175.5 million. And, that request was sustained through ADAMHA, the Public Health Service and HEW, and then it was reduced to \$160 million at OMB. When it was appealed to the President \$1 million was restored, for a total of 161 million dollars in the President's fiscal year 1979 budget.

Mr. ROGERS. Was prevention—

Dr. DuPONT. Prevention is part of that line; yes, sir. But, I am not sure exactly what really happened with that component of line on our budget at each stage of the process, Mr. Chairman. It was settled that it was going to be \$201 million including \$40 million for the State formula grants, and once that happened the treatment money for the 102,000 slots was held firm. The only thing left to give within that was demonstration and prevention. Thus those items just collapsed and that is why we took the big reduction in prevention and demonstration in fiscal year 1979.

It is important to realize, from Mr. Zafra's point of view that the NIDA budget overall for 1979 did show an increase because of our substantial increase in the research area. So, NIDA did show an increase between 1978 and 1979. Our overall fiscal year 1979 budget is very good—except in the prevention and demonstration areas.

Mr. ROGERS. How much was that increase?

Dr. DUPONT. From \$262 million to \$275 million an increase of \$13 million dollars comparing fiscal year 1978 with fiscal year 1979.

Mr. ROGERS. Where is that allocated?

Dr. DUPONT. Almost totally into the research area. Within the community programs line, there was an increase for treatment and a balancing decrease for demonstrations and prevention so that line of our budget was held from fiscal year 1978 to fiscal year 1979.

Mr. ROGERS. What happened on demonstrations?

Dr. DUPONT. It went from \$8.6 million in 1978 to \$6.5 million in 1979. But, demonstration had been \$12.6 million in 1977, so it showed a decrease of nearly one-half in 2 years.

Mr. ROGERS. Have the demonstration programs been effective or not?

Dr. DUPONT. Yes, they have been effective. There has been no question about that. It is just a question, as Dr. Klerman says, of balancing the budget and trying to find a place where these figures could be squeezed. OMB views our budget by first looking at new and competing awards and of course the treatment budget is all locked in. There are no new starts or competing renewals in treatment. Thus, the only "soft" areas of NIDA's fiscal year 1979 were prevention and demonstration.

Those are the places where we proposed new starts so that once a decision was made on research, the only place that could be squeezed to keep the total down was in prevention and demonstration. I do not believe anybody felt prevention or demonstration programs were not effective. They were simply the most vulnerable component of the fiscal year 1979 budget.

Mr. ROGERS. What will have to be done in these programs because of these reductions?

Dr. DUPONT. There would not be any new awards for demonstration or prevention next year under the President's budget.

Mr. ROGERS. None?

Dr. DUPONT. Our fiscal year 1979 budget is a barebones, survival budget in both the demonstration and prevention areas.

Mr. ROGERS. I thought you said 19 percent of the budget was for new awards?

Dr. DUPONT. That is for 1978.

Mr. ROGERS. That is not in 1979?

Dr. DUPONT. In 1979 there will be none, right, no new awards, as I understand.

Dr. KLERMAN. Mr. Chairman, I think that this discussion of the budget indicates some of the advantages that your proposed bill would allow, namely, clarification of the authorizations for specific components of the budget as distinguished between research, training and demonstration programs.

Mr. WALGREN. Can I ask a question?

Mr. ROGERS. Yes.

Mr. WALGREN. Why is it that only new and competing awards are evaluated by OMB and that any reductions would come in those two categories? I guess I do not understand those two categories. What is a competing award?

Dr. DuPONT. A competing award is a program that has been funded for 3 years and is coming back for renewal, or continuation for a 4th year. It must go through the peer review process and has a potential for not being funded. As a matter of fact, about one-third of those are not refunded every year. Such continuations are not OK every time they come up.

In the other parts of the budget, the Government has some obligation to continue the funding of ongoing projects. Now, that does not mean the Government cannot cut those too. The Government has the right to de-fund any of the programs if the money is not there, but ongoing projects are always treated much differently than new or renewal projects. The ones where we have a continuing commitment are always set aside first. We end up with arguing with OMB about increases above what is called the continuation budget. The continuation budget include the projects where the Government has a commitment to continue funding for the next year.

Mr. WALGREN. So, apparently OMB's judgment as to the effort to be allocated to these various programs is not quite a judgment as to the value of the program?

Dr. DuPONT. Not necessarily.

Mr. WALGREN. That is made on the basis that they have a psychological commitment because they would have to de-fund if they would not, it does not have a thing to do with the value, the social value of the program.

Dr. DuPONT. I would not say that. I think Dr. Klerman mentioned OMB does not have final authority on this, the President does. What happens is typically the OMB will give a mark to the Department, and then the Secretary has authority to appeal for the Department about any of those things that he wants. The ultimate decision in the President's budget is not OMB's, but is the President's decision.

Mr. WALGREN. I know, but doesn't this Government have to work on some level other than referring this kind of decision, every decision of this kind, to somebody who is the Secretary of Health, Education and Welfare, responsible for how many bills of dollars expenditures? Do you mean to tell me that we have to have a system that requires Mr. Califano personally to go in and fight for a change, to save a program from being cutoff totally mechanically, without regard to a value judgment about the worth of the program?

Dr. DuPONT. Well, of course we make our appeals first. That would only happen if we have lost at our level. But you are right, ultimately that is the final level of appeal.

Mr. WALGREN. But you are telling me you make your appeal to OMB?

Dr. DuPONT. Yes, sir, in the early and informal stages of the process.

Mr. WALGREN. And to Mr. Zafra and Mr. Zafra does not consider the merits of the program, then he is not someone who is particularly sensitive to the—

Dr. DUPONT. He handles the entire health budget. I think that is the point. He must reconcile all the competing needs of the Public Health Service within definite dollar limits.

Mr. WALGREN. He handles the entire health budget?

Dr. DUPONT. Yes, sir. I should also emphasize that Mr. Zafra, who I know well and who I respect as a professional with a difficult job, does not speak for OMB. He is part of a chain of command with many supervisors over him. The final "OMB mark" reflects the interplay of these levels and people.

Mr. WALGREN. And as far as you can tell, he starts out with the assumption that continuing programs are not to be undercut?

Dr. KLERMAN. I think there were two considerations as, I understand it, which go into the OMB's thinking and once again I am at a disadvantage not wanting to speak for OMB, one is the dollar amounts and second is their judgment along with other parts of the Executive Branch as to the relative merits of various proposals.

One of the major influences on the fiscal year 1979 budget that is not before this Congress is that the President's Commission on Mental Health in its interim report in October of this year made recommendations that there be increases in the research budgets for the three institutes, Mental Health, Alcoholism and Drug Abuse. And, the budgets for research and increased recommendations of the President by about \$40 million.

That, combined with the concern of the administration, with regard to not increasing costs meant that outside of a research area there were no substantial increases projected in programs, and in some instances in the case of the prevention area the net consequence of a series of decisions is as reported by Dr. DuPont, a decrease in the available funds for preventive programs for fiscal year 1979.

Mr. ROGERS. What new research are you going to support?

Dr. DUPONT. Well, this increase in research budget this year is a dramatic departure from previous years, where we had seen a steady decline in our research buying power. It has been a very great boon to us. I think it is important to realize, though, Mr. Chairman, that this will bring us back level roughly to where we were in 1974 in terms of buying power for drug abuse research.

In any event, it will give us an exciting new opportunity to have a variety of new initiatives, including more investigation into the gateway drug problem that we were talking about, phencyclidine, and the inhalent abuse problem among many others.

We are very interested, and you are familiar with the endorphine research. The idea that the brain itself, the normal mammalian brain, produces substances that are morphine-like, and that there are receptors in the brain for these substances.

We are very proud of the fact that all of the initial research in this area was funded in whole or in part by the National Institute on Drug Abuse. This increase in our fiscal year 1979 research budget will allow us to add about \$1 million to endorphin basic research. It

offers us the hope of finding much better treatment both for drug abuse but also perhaps even for the treatment of pain.

Mr. ROGERS. What was your budget in 1978 for research?

Dr. DuPONT. The research budget for 1978 total was \$34 million. And, it is going to \$45.9 million in fiscal year 1979. And I would again, Mr. Chairman, submit for the record the full research plan for fiscal year 1979.

[The following information was received for the record:]

SUMMARY OF RESEARCH PLANS

The Division of Research will continue, over the next 5 years, to investigate the basic sociological, behavioral, and biomedical mechanisms underlying drug abuse with the eventual goal of successfully treating and preventing this public health problem.

During the past year, the Division of Research, NIDA, has extensively evaluated its research priorities with the aim of establishing a basis for determining which new initiatives should be undertaken. This process has generated five major components:

1. The establishment of a NIDA intramural research program in the Washington area;
2. The assumption by NIDA of studies related to drugs and complex human performance which were previously conducted by the Department of Defense;
3. Basic research;
4. Treatment research;
5. Research progress analysis

The entire Forward Plan for Research 1979-83 has been submitted to the subcommittee and is available upon request.

Mr. ROGERS. Yes; would you please do that. What did your agency request for research?

Dr. DuPONT. The agency requested \$41.7 million. The additional money to go above that level came at the initiative of the President's Commission on Mental Health. So, here is an example of where we got more than we had requested.

Mr. ROGERS. Did the President's Commission make any recommendations regarding prevention?

Dr. KLERMAN. I might comment on that. The final report of the President's Commission is due to be released at the end of this month. The interim report released to the public in October only specified research and that was the only part that impacted on the fiscal year 1979 budget.

Although the final report is not yet public, we understand from comments made by the President and his staff that the President was concerned that insufficient attention had been given thus far to opportunities for prevention, not only mental health, but also drug abuse and alcoholism.

What the specific recommendations will be made in that area and what their budgetary consequences will be, we cannot yet determine. We are hopeful that it will result in an increased attention to the preventive programs in NIDA as well as in other parts of the Public Health Services.

Dr. DuPONT. But, Mr. Chairman, one of the things that will happen with this increased amount of funding for research is that we will increase the relatively small prevention research component

of our research budget to a total of about \$1.6 million for fiscal year 1979 from about \$900,000 this year. There will be some additional research in the area of prevention out of the research budget initiated in fiscal 1979.

Mr. ROGERS. Will you let us have for the record a complete run-down of the research projects?

Dr. DuPONT. Yes, sir.

[The material referred to may be found in the subcommittee file:]

Mr. ROGERS. That is either grants or contracts, who is conducting them.

Dr. DuPONT. Yes, sir.

Mr. ROGERS. Who is conducting them, how long they have been in progress and what the results have been shown.

Dr. DuPONT. Yes, sir.

Dr. KLERMAN. Mr. Chairman.

Mr. ROGERS. Yes.

Dr. KLERMAN. I think it is important to realize there is a dissatisfaction within the Public Health Service not only at large but as well as in the area of prevention as you know Dr. Richmond has given this a great deal of his attention, there was a conference initiated on his behalf by the Institute of Medicine and there is talk of a Surgeon General report on prevention.

The hope is that there will be a renewed attention to this. I want to say once again that as we go out to Public Health Service in general, from what Dr. Richmond has said, in our own agency we are not satisfied that we are doing what needs to be done in this area.

Mr. ROGERS. Well, that is what surprises me. OMB makes the judgment to cut the prevention budget, when we have a concern and overwhelming feeling that we need to move the Nation into more effort in prevention.

Dr. KLERMAN. I would hope that future budgets as they come out of the executive branch will reflect that concern, also.

Mr. ROGERS. What about demonstrations, now, will there be no new demonstrations?

Dr. DuPONT. Yes, sir, parts.

Mr. ROGERS. You would continue present demonstrations?

Dr. DuPONT. Yes, sir.

Mr. ROGERS. How many of those would continue, what about those involving technology transfer?

Dr. DuPONT. Some of that would go on in any event, but we would like to pursue a number of new areas especially programs for youths, minorities and women.

Mr. ROGERS. So you cannot even show them how to do anything to stop young people, minorities and women from getting into these problems?

Dr. DuPONT. We are handicapped, although the \$6 million, of course, is in the budget. We will be able to continue all the currently existing demonstration programs. We will just not be able to initiate new ones under this budget for fiscal year 1979.

Mr. ROGERS. Do you have one demonstrating how to prevent drug abuse by young people?

Dr. DuPONT. Oh, yes; we have many aimed at the youth.

Mr. ROGERS. Would you give us a list of all of your demonstration programs?

Dr. DuPONT. Yes, sir.

[A listing of currently active demonstration projects was provided to the subcommittee and are available in their files.]

Mr. ROGERS. Who is conducting them, the amount of money and the results?

Dr. DuPONT. Yes, sir, we will.

Mr. ROGERS. Who evaluates the effectiveness of your treatment programs? Does OMB evaluate it?

Dr. DuPONT. No, sir.

Mr. ROGERS. Who evaluates those?

Dr. DuPONT. It is primarily our responsibility to evaluate the treatment grants and contracts.

Mr. ROGERS. How do you evaluate it?

Dr. DuPONT. Well, there are a number of ways. We started several years ago, actually with a management review of our programs. Touche Ross is the current holder of that contract. We review every NIDA-funded treatment program in terms of its general management capabilities every 3 years. We also have a quarterly review that is done by the NIDA staff. In most cases most of our funds are now jointly administered with the States. The States conduct regular evaluations.

Mr. ROGERS. Are some of the programs ineffective?

Dr. DuPONT. Yes, sir, we find programs that are ineffective and our first attempt when we find that out is to provide them technical assistance to increase their effectiveness. If that fails, we will reduce or eliminate their funding.

Mr. ROGERS. How much of this funding was reduced or eliminated in the 1978 budget?

Dr. DuPONT. I do not know. I would have to submit that for the record.

Mr. ROGERS. Will you let us have a list of all of the projects?

Dr. DuPONT. Yes, sir.

Mr. ROGERS. And their ratings and evaluations and action taken?

Dr. DuPONT. Yes. Maybe I could give—we probably could submit all of the Touche Ross reports, but I think that might be a little too much. Perhaps we can summarize them and give some samples.

Mr. ROGERS. No; I would like to have all of your programs listed.

Dr. DuPONT. Right.

[The following material was received for the record:]

Division of Community Assistance, NIDA Annualized Funding Level by State for treatment serv.

(Dollars in Thousands)	Fiscal Yr. 1977	Fiscal Yr. 1978 (Estimated)			
TOTALS					
1. Alabama	\$ 1,297	\$ 1,315			
2. Alaska	112	110			
3. Arizona	2,508	2,484			
4. Arkansas	779	771			
5. California	22,678	21,837			
6. Colorado	1,182	1,187			
7. Connecticut	3,558	3,807			
8. Delaware	612	594			
9. District of Columbia	788	777			
10. Florida	6,877	6,986			
11. Georgia	2,107	2,047			
12. Hawaii	593	626			
13. Idaho	136	146			
14. Illinois	3,392	3,702			
15. Indiana	1,290	1,163			
16. Iowa	1,033	1,002			
17. Kansas	210	205			
18. Kentucky	616	626			
19. Louisiana	2,517	2,508			
20. Maine	196	236			
21. Maryland	1,115	1,079			
22. Massachusetts	4,436	4,426			
23. Michigan	7,403	7,403			
24. Minnesota	1,064	1,329			
25. Mississippi	279	289			
26. Missouri	1,561	1,554			
27. Montana	442	407			
28. Nebraska	324	324			
29. Nevada	804	829			
30. New Hampshire	469	501			
31. New Jersey	7,687	8,082			
32. New Mexico	1,297	1,252			
33. New York	25,109	25,077			
34. North Carolina	809	851			
35. North Dakota	28	28			
36. Ohio	4,337	4,280			
37. Oklahoma	508	495			
38. Oregon	1,578	1,435			
39. Pennsylvania	7,123	7,387			
40. Rhode Island	1,308	1,268			
41. South Carolina	795	832			
42. South Dakota	51	52			
43. Tennessee	1,164	940			
44. Texas	6,881	7,209			
45. Utah	960	1,009			
46. Vermont	493	478			
47. Virginia	1,899	2,034			
48. Washington	1,970	2,312			
49. West Virginia	209	256			
50. Wisconsin	1,538	1,557			
51. Wyoming	79	79			
52. Guam	39	37			
53. Puerto Rico	1,942	1,952			
54. Virgin Islands	-	-			

Division of Community Assistance, NIDA - Treatment Slots By State

4/17/78

	Fiscal Year 1977	Fiscal Year 1978 (Estimated)				
TOTALS						
1 Alabama	732	806				
2 Alaska	53	53				
3 Arizona	1,674	1,647				
4 Arkansas	461	526				
5 California	13,488	14,147				
6 Colorado	913	983				
7 Connecticut	2,145	2,194				
8 Delaware	491	352				
9 District of Columbia	600	600				
10 Florida	4,634	4,661				
11 Georgia	1,360	1,360				
12 Hawaii	376	376				
13 Idaho	97	97				
14 Illinois	2,511	2,420				
15 Indiana	1,097	1,105				
16 Iowa	862	864				
17 Kansas	105	135				
18 Kentucky	699	650				
19 Louisiana	1,558	1,561				
20 Maine	143	143				
21 Maryland	1,036	1,036				
22 Massachusetts	3,487	3,225				
23 Michigan	6,474	6,329				
24 Minnesota	726	826				
25 Mississippi	173	173				
26 Missouri	1,208	1,332				
27 Montana	331	331				
28 Nebraska	247	251				
29 Nevada	361	433				
30 New Hampshire	303	303				
31 New Jersey	5,538	5,539				
32 New Mexico	996	998				
33 New York	14,725	14,699				
34 North Carolina	567	692				
35 North Dakota	20	20				
36 Ohio	3,386	3,555				
37 Oklahoma	319	364				
38 Oregon	1,135	1,080				
39 Pennsylvania	6,209	6,205				
40 Rhode Island	688	797				
41 South Carolina	623	623				
42 South Dakota	25	26				
43 Tennessee	703	707				
44 Texas	5,403	5,467				
45 Utah	773	801				
46 Vermont	385	385				
47 Virginia	1,537	1,441				
48 Washington	1,315	1,368				
49 West Virginia	199	223				
50 Wisconsin	841	931				
51 Wyoming	30	30				
52 American Samoa	-	-				
53 Guam	20	20				
54 Puerto Rico	1,115	1,115				
55 Trust Territory	-	-				
56 Virgin Islands	-	-				
Total	94,897	96,060				

Mr. ROGERS. I presume you have them on the computer, anyhow.

Dr. DuPONT. Perhaps. But the reports are not computerized and are quite long.

Mr. ROGERS. Just give us a printout of who evaluated them.

Dr. DuPONT. Yes, sir.

Mr. ROGERS. Who evaluated them and what action was taken.

Dr. DuPONT. Yes, sir, we will do that.

Mr. ROGERS. Maybe we should recommend that some of these ineffective programs be discontinued and that money can go into prevention. Was any thought given to that?

Dr. DuPONT. We have thought about doing this. We are committed to maintain the level of funding at 102,000 treatment slots—although we do not have to keep our treatment money in any particular program, so there is a considerable movement from less successful programs to more successful ones. But, I do not think that we have the authority to take money away from treatment and put it into prevention.

Mr. ROGERS. Maybe we should do that. Should you have such authority?

Dr. DuPONT. Well, I think the more treatment we have, probably the better.

Mr. ROGERS. Well, if there are programs that are not good, there is no point in keeping slots there and wasting money. How much do you spend per slot?

Dr. DuPONT. The average in the Federal fund is about \$1,500 per slot, per year.

Mr. ROGERS. That is \$1,500. Overall, what does it cost?

Dr. DuPONT. Our NIDA total is \$150 million overall per year.

Mr. ROGERS. No, overall per slot.

Dr. DuPONT. \$1,500 per slot per year is the average Federal cost for the country.

Mr. ROGERS. Is that of Federal funding?

Dr. DuPONT. That is for Federal funding.

Mr. ROGERS. Total funding is what I am asking for.

Dr. DuPONT. Oh, total funding would be about \$2,500, I believe.

Mr. ROGERS. So, that is \$2,500 a slot?

Dr. DuPONT. Yes, sir.

Mr. ROGERS. And we have how many?

Dr. DuPONT. We have 102,000.

Dr. KLERMAN. Mr. Chairman.

Mr. ROGERS. Yes.

Dr. KLERMAN. Mr. Chairman, I think you identify a very important area, where it is the responsibility of management to survey and monitor how the funds are being spent, particularly with regard to some of the State contracts and elsewhere. And there are numerous instances where specific programs are changed from year to year, particularly in working in concert with the States. I think that is one level of evaluation. The other level—

Mr. ROGERS. Let us have a list of those that were changed and how they were changed and what was the basic change, would you?

Dr. DuPONT. Yes, sir.

[The information requested was not available to the subcommittee at the time of printing.]

Dr. KLERMAN. Then I think there is another level of decisions which are those of this committee and the Congress. They are namely, how much resources at the national level should go into treatment, into research, and into prevention, and part of the intent, I understand, of your recommended bill is to create separate authorization.

Mr. ROGERS. That is the only way I see to do it. Otherwise you are going to continue to cut out prevention and demonstrations.

Now, Dr. Klerman, I have recently read about your proposed changes in peer review, I believe, and that everything is going to be centralized in your office.

Dr. KLERMAN. No; there is a proposal which is under discussion. I think it would be useful to distinguish the principles which we are trying to effect which is to separate the management of one part of peer review, which is the initial review committees, from the program responsibility.

As you know, the peer review process takes place in two steps. There is the initial step, which is done by committees of non-Government experts in various technical and professional areas, and the second step as mandated by law is done by the councils.

I have brought attention to the field what is felt to be some need for some change in effecting a better separation of management between those people who are responsible for the processing of the grants and their review at the first step and the full program end.

There are a number of different original ways in which this particular principle can be affected or improved on. There have been a number of reports reviewing the peer review process within the Public Health Service, and particularly within ADAMHA.

Most of these reports are recommended changes to improve quality and efficiency. This particular proposal that I recommended be considered refers to centralization of levels of the Office of Administrator.

Mr. ROGERS. But, you have initial review there.

Dr. KLERMAN. Management of the initial review, namely, supervision of various secretaries of the committees and actual processing. Other groups have some similar concerns; for example, the President's panel, Commission on Mental Health.

There have been a number of internal reviews of the peer review system by the President's management branch, which have indicated there have been some management problems due to—

Mr. ROGERS. Did they recommend all grants or just research grants?

Dr. KLERMAN. Well, some of the recommendations have called for better management of our total grant and contract procedure, all contracts, in particular. The President's Commission on Mental Health, in its research panel, did make a recommendation with regard to research grants.

Mr. ROGERS. I thought there was some distinguishing feature there.

Dr. KLERMAN. Yes.

Mr. ROGERS. Not applied across the board, I do not think.

Dr. KLERMAN. That is correct. We are now considering various alternative ways of achieving that principal in terms of the proposal

that surfaced for discussion as well as other proposals that have been made by other persons.

Mr. ROGERS. How would you conduct that transfer of people from the various Institutes up to our office?

Dr. KLERMAN. Well, the main persons involved in the first stage of peer review are the executive secretaries of about 30-plus committees. Those are usually professional participants who are knowledgeable in a field such as training or biochemistry or psychology or alcoholism or drug abuse.

There are about 30-plus such peer review committees. Each of them has one or more professional persons, plus some clerical and book-keeping assistants.

One proposal, the one that I recommended to the field and to the Secretary, would be that the responsibility for the management and for the supervision of those individuals would be rested in the Office of the Administrator.

Mr. ROGERS. So that it be transferred up to you, then?

Dr. KLERMAN. That would have to be a transfer, and I think it would require a reprogramming and ultimate approval by the Congress.

Mr. ROGERS. Yes; it probably would require approval by the Congress. Section 502 of the Alcohol Abuse Alcoholism Act might not permit that.

Dr. KLERMAN. Well, there is a question of interpretation of that law, and that is under review. There are other proposals being considered to deal with the same problem by alternative organization management such as centralization at the level of the three Institutes the Office of Director, of those three Institutes.

Mr. ROGERS. Would you let us have an outline of these suggestions, what transfer of personnel would be required, and the savings, if any, or not?

Dr. KLERMAN. I would be glad to.

[The following information was received for the record:]

A Proposal for the Restructuring of the Initial
Review of Discretionary Grants and Research
Contracts in the Alcohol, Drug Abuse, and
Mental Health Administration

The Administrator of ADAMHA has submitted to the Secretary, Health, Education, and Welfare, and the Secretary has approved a proposal for the restructuring of the initial review of all discretionary grants and research contracts in the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). Specifically, the proposal is to centralize, in the Office of each Institute Director, the operation of initial (peer) review for all discretionary grant and research contract programs except those administered in the Regional Offices.

BACKGROUND

The ADAMHA peer review system is based upon two sequential levels of project review, referred to as the "dual review system." The first level involves panels of experts in relevant scientific and technical fields. The panels, called Initial Review Groups (IRGs) have, as their primary function, the review and evaluation for scientific and technical merit of the grant applications submitted to ADAMHA. The second level of review is carried out by the statutorily mandated National Advisory Councils of the three Institutes. It is the responsibility of the Council to review the appropriateness of the technical merit review recommendations made by the Initial Review Groups and to make a final review for scientific and technical merit. Also, the Councils may make recommendations as to program relevance and priorities. The dual review system provides the responsible Federal officials with the best advice possible concerning both scientific and technical, and societal values and needs.

For more than 30 years the discretionary grant programs of the Public Health Service have been largely dependent for the quality assessment of applications on the peer review system. The success of PHS programs can be attributed to a large extent to the strength of and the contributions of this system. Typically, these reviews are carried out by committees comprised of non-Federal experts in the various fields and disciplines required by the nature of the particular program. They meet from one to four times a year, and provide recommendations restricted to the technical/scientific merits of the projects. Typically, such projects are ranked by a priority scheme; and the recommendations are provided to the staff and to the National Advisory Councils of the particular Institutes. This year such review groups will review approximately 23,000 applications for the Public Health Service including 4,500 for ADAMHA.

Historically, the strengths of this system include the availability of the best technically qualified individuals whose expertise is current and is secured by the Government for very modest sums. It provides for the participation of a large number of individuals from the various constituencies, operating in a system of careful, procedural safeguards to assure--to the extent possible--the absence of bias and conflict of interest. Thus, the peer review system, to a considerable extent, defines the quality of the projects supported by the Agencies which in turn constitutes the quality of the programs and thus the accomplishment toward mandated public objectives. It provides simultaneously a model of public accountability with procedural safeguards to assure the absence of conflict of interest and an objective, equitable review. Many organizations, Presidential Commissions, etc., have given full support to this system; and Congress has made the peer review of certain grants and contracts a statutory requirement.

Within the Division of Research Grants of the National Institutes of Health (NIH) such review groups are deliberately organized apart from the programs which they serve and are responsible to the Director, NIH. This organizational separation has been considered a critical characteristic of the peer review system because it assists in isolating it from undue or inappropriate bias which might enter the technical review process as a result of having the same individuals who have award authority over grant applications also serving as the managers of the review. An unbiased technical review of projects is considered essential, whether or not program or other priorities are imposed ultimately by a particular awarding organization.

The principle of the organizational separation of technical review and program management applied to the National Institute of Mental Health until the reorganization of the Public Health Service in 1967, when the National Institute of Mental Health (NIMH) was separated from the National Institutes of Health. Subsequently, through successive organizational development, the review of grant applications has been carried out within the particular Branches and Divisions concerned with individual programs. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) and National Institute of Drug Abuse (NIDA), as organizational progeny of the NIMH, have followed this pattern. Currently, in ADAMHA, peer review activity is carried out in 30 Sections or Branches operating in ten different Divisions of the three Institutes.

The advantages of an organizational arrangement featuring a centralized review include:

1. The opportunity for adequate and consistent training and supervision of staff who are responsible for the review functions.
2. The supervision of staff to assure that the peer review process is carried out, insulated from any bias that other staff may consciously or unconsciously introduce into the process.
3. The opportunity to provide consistent criteria for the selection of review committee members.
4. More consistency in the advice provided to potential applicants regarding applications and review procedures.
5. Appropriate orientation of review committee members and the opportunity to supervise the functions of committees to assure that the committees concentrate on the merit of projects.
6. A more even distribution of workload across committees.
7. The more effective utilization of committees to assure that no unneeded committees are maintained.

8. The implementation of consistent review criteria across similar programs.
9. Reduction of the number of claims by individuals and institutions of the mis-handling of grant applications.
10. Assure better cooperative arrangements including review arrangements with other Federal agencies which assists in guarding against a duplication of effort or disservice to applicants.
11. Maintain the quality of the summary statements that document the basis of the initial review group recommendations, and serve as the chief source of information regarding the merit of applications for recommendations by the National Advisory Councils.

In summary, an organizational arrangement for centralized initial review permits a clean separation of the quality consideration of projects from the many programmatic, budgetary and other considerations that are involved in making award decisions, provides a potential for management efficiencies, and most importantly, allows the opportunity for greatly increased emphasis on the quality of projects, while conducting the public business in the most equitable and responsive fashion.

Mr. ROGERS. And how the system would work? What do you do to coordinate activities within the Government itself, or do you, on drug abuse problems?

Dr. KLERMAN. Well, as I say, the main responsibility for the coordination of drug abuse problems rests with the White House; that is, through what had been ODAP, now through the Strategy Council. I and other members of HEW participate in that conference, but the main responsibility rests with Dr. Bourne.

Mr. ROGERS. Do you coordinate the activities within the Department?

Dr. KLERMAN. Recently, Mr. Califano, the Secretary, has asked that I consider taking on that responsibility, along with Mr. Meltzer who is on his immediate staff, who is an attorney. We have not worked out exact mechanisms of how that coordination would take place.

Mr. ROGERS. When is this to be effected?

Dr. KLERMAN. Probably within the next weeks or months, but that has not yet been determined.

Mr. ROGERS. Wasn't something set up in the Secretary's Office in 1972 to do that?

Dr. KLERMAN. I am not aware of that.

Dr. DUPONT. Yes, sir, Wade Coleman was put in that job in 1972.

Mr. ROGERS. What has happened to that?

Dr. DUPONT. He left to join a banking firm to make a fortune in 1974 or 1975.

Mr. ROGERS. So no one filled that position?

Dr. DUPONT. Yes; that was the end of that. The functions of that office were transferred to NIDA. There was a period of time when NIDA functioned within that role within the Department, but that has not been the case during Mr. Califano's term. I think this coordination responsibility is now just being sorted out again.

Mr. ROGERS. Will you let us have a statement on that, what is happening?

Dr. KLERMAN. Yes; I think the Secretary has been aware that there has been a hiatus the past year of coordination between drug abuse particularly, and he is attempting to attend to that.

[The information requested was not available to the subcommittee at the time of printing.]

Mr. ROGERS. Do you give any advise to other agencies on prevention or treatment of drug abuse; for instance, the Department of Defense?

Dr. KLERMAN. The main mechanism for that is through the various subcommittees and task forces through the White House by Dr. Bourne's office. There is a very active responsibility, liaison, and coordination.

Again I would feel for the details as to the overall coordination of a Federal effort that the most knowledgeable person has been a member of his staff since—

Mr. ROGERS. Does he coordinate through the Strategy Council?

Dr. KLERMAN. My understanding is that the intention is to use the Strategy Council as the policymaking mechanisms for a cross-Cabinet discussion, as well as to bring in outside individuals who are not part of the Federal Government from universities, from labor unions, and from such fields.

Mr. ROGERS. What coordination do you have with the Drug Abuse Education Office, in HEW?

Dr. KLERMAN. Most of that takes place through Dr. DuPont and his contacts with Dr. Nowlis who is Director of that program.

Dr. DuPONT. At the staff level there is quite a bit of contact, Mr. Chairman.

Mr. ROGERS. What should be done?

Dr. DuPONT. Dr. Klerman spoke about the issue of target. I think there needs to be much clear delineation in the specific responsibilities of the various HEW offices, not only the Office of Education, but also the Office of Human Development Programs and the other areas. We need to more clearly specify who is doing what, and what those roles are. I do not think that has happened yet.

Mr. ROGERS. Who is head of that office in the Office of Education?

Dr. DuPONT. Dr. Helen Nowlis, in the Office of Education.

Mr. ROGERS. When did you meet with her last about a coordinating problem?

Dr. DuPONT. Well, I saw her just about a week or so ago, but I have not talked to her about a coordinating problem for over a year. I know at the staff level there has been some discussion.

Mr. ROGERS. Would you outline for us the staff discussions, who participated and on what dates?

Dr. DuPONT. Sure.

Mr. ROGERS. And the subject matters?

Dr. DuPONT. Yes, sir.

[The following information was received for the record:]

NIDA—OFFICE OF EDUCATION INTERACTION ON PREVENTION PROGRAMING

Staff of NIDA's Prevention Branch, responsible for development of models suitable for replication of successful community based drug abuse program efforts, have some limited interaction with the Office of Education Drug and Alcohol Education Project. Dr. Helen Nowlis, Director of OE's primarily school-based drug education program, interacts with the Director and Deputy Director of NIDA principally at Federal drug abuse prevention policy forums such as the Seminar on Prevention Policy sponsored by the Office of Drug Abuse Policy in December 1977 and through joint congressional appearances from time to time.

Mr. ROGERS. Does a contractor or grantee perform a self-evaluation?

Dr. DuPONT. I assume the answer to that is yes, but I am not sure.

Mr. ROGERS. Do you require them to?

Dr. DuPONT. They have to have quarterly and annual reports.

Mr. ROGERS. But then they are evaluated by whom?

Dr. DuPONT. By the staff. There is a NIDA project officer on every grant and every contract.

Mr. ROGERS. Is that from your staff?

Dr. DuPONT. Yes, sir.

Mr. ROGERS. Are State drug abuse plans required to have prevention components?

Dr. DuPONT. I believe they are.

Mr. ROGERS. We do not know?

Mr. AKINS. Yes.

Dr. DuPONT. They are, yes, now I know.

Mr. ROGERS. On an average, what percentage of State drug abuse formula grants has been used for prevention?

Dr. DuPONT. I think about 25-30 percent. Does that sound right?

Mr. ROGERS. Is that—

Dr. DuPONT. It is a lot better than our 2 percent.

Mr. ROGERS. Yes. Why is it that you require States to spend 30 percent?

Dr. DuPONT. We do not require them to spend 30 percent. That is at their option. That is how they do allocate those formula grant funds.

Mr. ROGERS. But you approve of such a plan?

Dr. DuPONT. Oh, yes, absolutely.

Mr. ROGERS. And how much is there for treatment?

Dr. DuPONT. I think about half of the total.

Mr. ROGERS. That is 50 percent. Where does the rest go?

Mr. AKINS. There is about 40 percent for treatment.

Mr. ROGERS. So that is 40 percent for treatment, 15 percent for prevention—maybe you could give us a rundown. Could you identify yourself for the record?

STATEMENT OF CARL AKINS, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF STATE DRUG ABUSE PROGRAM COORDINATORS

Mr. AKINS. Yes. I am Carl Akins, executive director of the National Association of State Drug Abuse Program Coordinators.

Mr. ROGERS. Thank you, sir.

Mr. AKINS. I can give you detailed information for the record, off the top of my head.

Mr. ROGERS. Surely.

Mr. AKINS. It is roughly 40 to 42 percent for treatment, 15 to 17 percent for prevention, about 6 to 8 percent for training area, some 20 percent for planning and coordination, about 2 percent for management information systems and about 2 percent, 2 to 4 percent for criminal justice coordination.

Mr. ROGERS. Is there any for evaluation?

Mr. AKINS. It is approximately 6 percent for research and evaluation efforts.

Mr. ROGERS. Thank you and if you would let us have for the record—

Mr. AKINS. You are welcome.

Mr. ROGERS [continuing]. The specifics.

Mr. AKINS. Yes, sir.

[See attachment B to National Association of State Drug Abuse Program Coordinator's letter of May 3, 1978, p. 150, this hearing.]

Mr. ROGERS. How many contracts do we have vis-a-vis grants?

**STATEMENT OF GERALD L. KLIERMAN, M.D., AND
ROBERT L. DuPONT, M.D.—Resumed**

Dr. DuPONT. I am not sure I can find out. I will submit that for the record, Mr. Chairman.

Mr. ROGERS. Have you any idea?

Dr. DuPONT. In the research area it is about two-thirds of our money is for grants, and one-third is for contracts.

Mr. ROGERS. All right, if you will let us know for the record.

Dr. DuPONT. In the treatment area, of course, we are moving very much away from grants into contracts, particularly the statewide services contracts. In research, the percentages have been about the same for the last several years.

[The following information was received for the record:]

NATIONAL INSTITUTE ON DRUG ABUSE—OBLIGATIONS BY PROGRAMS

	Fiscal year 1977 (actual)	Fiscal year 1978 (estimated)
Research:		
Grants.....	\$24,680	\$23,141
Contracts.....	6,811	7,540
Intramural.....	2,503	3,458
Total.....	33,994	34,139
Training:		
Grants.....	3,654	2,800
Contracts.....	6,052	6,984
Fellowships.....	293	216
Total.....	9,999	10,000
Community programs:		
Treatment:		
Grants.....	39,762	32,734
Contracts.....	102,867	113,080
Subtotal.....	142,629	145,814
Demonstration:		
Grants.....	8,211	6,018
Contracts.....	4,447	2,585
Subtotal.....	12,658	8,603
Prevention:		
Grants.....	1,809	2,210
Contracts.....	2,897	4,373
Subtotal.....	4,706	6,583
Total.....	159,993	161,000
Formula grants.....	40,000	40,000
Program support.....	15,761	16,960
Total.....	259,747	262,099

Mr. ROGERS. Now, you have told me that you have treatment slots of about 102,000?

Dr. DuPONT. Yes, sir.

Mr. ROGERS. How many of those involve methadone?

Dr. DuPONT. About 35 percent of those, so say 36,000.

[The following information was received for the record:]

DRUG ABUSE COMMUNITY PROGRAMS: PROJECT GRANT AND CONTRACT TREATMENT SLOTS BY ENVIRONMENT/
MODALITY, MARCH 1978

[In number per percent]

	Detoxification	Method maintenance	Drug free	Total
Environment: March 1978:				
Inpatient.....	208 (.2)			208 (.2)
Residential.....	163 (.2)	288 (.3)	10,450 (10.9)	10,901 (11.4)
Day care.....		442 (.5)	4,261 (4.4)	4,703 (4.9)
Outpatient.....	2,611 (2.7)	33,780 (34.8)	44,157 (46.0)	80,248 (83.5)
Total.....	2,982 (3.1)	34,210 (35.6)	58,868 (61.3)	96,060 (100.0)

Mr. ROGERS. That is 36,000?

Dr. DuPONT. Yes.

Mr. ROGERS. What are the results of your findings about methadone treatment?

Dr. DuPONT. Of course the methadone population is a little different from the drug-free population. It tends to be an older population that has a criminal record and more evidence of deviance, including lower employment rates at the start. During treatment the methadone people do quite well.

They show, in fact, the biggest gains in any of our programs, comparing where they were at the beginning of treatment to where they were at the end. Of course part of that is because they start from so much worse positions than the others.

In general, the methadone program has been reasonably successful. Methadone has certainly not been a magic bullet, and it has not solved our drug abuse problem by any stretch of the imagination.

Mr. ROGERS. What is the status of abuse of methadone now?

Dr. DuPONT. The use of methadone outside of treatment programs does not constitute a great problem, with one exception, that is, the problem of overdose deaths. That has been a great concern to us and it continues to be a concern. The general trend of that problem has been declining since 1972, year in and year out. And, we think it should go down even further.

Our hope, as you know, Mr. Chairman, we hope to substitute a long-acting methadonelike substance called LAAM for methadone for the majority of methadone programs in the near future. That would essentially eliminate the problem of take-home methadone, which is the source of most of the diversion of methadone in the United States.

We hope to have a submission to FDA in the summer of a new drug application (NDA) for LAAM. If that is approved, and we hope it will be very quickly, we anticipate there would be a very big drop in the problem of methadone diversion in the country.

Mr. ROGERS. How many deaths occur from overdoses of methadone?

Dr. DuPONT. I think the annual figure is now around 400.

[The following information was received for the record:]

DEATHS FROM OVERDOSES OF METHADONE

The following data are based on medical examiner information reported to the Drug Abuse Warning Network:

	<i>Number of methadone involved deaths</i>
1973:	
July to September.....	239
October to December.....	304
1974:	
January to March.....	295
April to June.....	275
July to September.....	266
October to December.....	223
1975:	
January to March.....	269
April to June.....	218
July to September.....	200
October to December.....	180
1976:	
January to March.....	212
April to June.....	218
July to September.....	¹ 157
October to December.....	¹ 27
1977:	
January to March.....	¹ 30
April to June.....	94

¹ Data were not reported by the Office of the Medical Examiner in New York City.

Mr. ROGERS. And how many occur from heroin?

Dr. DuPONT. There are about 2,000. I will submit the exact numbers for the record.

Mr. ROGERS. Yes, if you will. Could you tell us just briefly about the LAAM treatment program?

Dr. DuPONT. Yes, sir, LAAM is a drug that is metabolized in the liver, to produce an active metabolite. Thus it lasts longer than methadone—72 hours compared to 24 hours for methadone. This means LAAM needs to be taken only three times a week. It has enjoined quite a large degree of patient acceptance and clinics have generally gotten along well with it.

There is one hopeful aspect of it in particular, and that is that it appears to be easier for patients to detoxify from LAAM than from methadone. This makes sense because in general longer acting drugs are easier to detoxify from than shorter acting drugs. One of the benefits of LAAM in addition to the reduction in the problem of diversion from take-home is the greater effectiveness in helping patients achieve ultimate abstinence.

Mr. ROGERS. Would you still require close contact with the clinic when you are taking LAAM?

Dr. DuPONT. Oh, yes, three times a week.

Mr. ROGERS. You would come in and receive treatment, it would not be taken home?

Dr. DuPONT. That is correct. There would be no take-home, so everybody would have to come in three times a week for LAAM.

Mr. ROGERS. What has been suggested as a proposal, we understand, is to take methadone home for 6 days.

Dr. DuPONT. Only people——

Mr. ROGERS. Is that to take it home for 6 days?

Dr. DuPONT. That is only under very special circumstances. They would have to be approved by the program and they would have to be showing no evidence of use of illegal drug use. They would have to be employed, have been in treatment 3 continuous years have to be very stable in clinic attendance, and have to be able to demonstrate coming in more frequently would be a hardship to them in terms of employment. Otherwise they would not get this.

Mr. ROGERS. How many would you anticipate would be placed on this 6-day regimen?

Dr. DuPONT. Well, overall in the country, the percentage is not very great. About 90,000 people on methadone in the whole country, and I think probably 10,000 or 20,000 might be eligible for this extended take-home.

Once LAAM is available, Mr. Chairman, I would be much more supportive of a major reduction in methadone take-home rather than liberalization, but particularly for people who have been in to programs for a long time it can create quite a hardship for them. As you know, right now the regulations under the new FDA/NIDA proposal require the patient to come in 6 days a week or 7 days for treatment for the first 90 days with a gradual liberalization after that.

Many States and cities have already adopted more restrictive take-home policies, and our overall principle is not to have the Federal Government set limits that preempt the local and State responses in this area. We are not saying that they must do this, we have been encouraging them to select rules for take home which reflect their needs.

In Boston, for example, and in the District of Columbia, they both have zero take-home. We are certainly supportive of that approach, too.

Mr. ROGERS. Should NIDA be responsible for treatment programs in the prison system?

Dr. DuPONT. This is an area that we have not paid enough attention to, and I would hope that—

Mr. ROGERS. Would you let us have your thoughts in writing on that?

Dr. DuPONT. Yes, sir. I might say, Mr. Chairman, during the period where there was such a need for community-based services, we felt our limited resources were better used in the community than they were in the prisons. But, particularly with the downturn of heroin problem in the country, I think it is time to reevaluate that decision.

[The following information was received for the record:]

STATEMENT ON NIDA VIEW OF TREATMENT IN PRISONS

NIDA's mandate has been to fund community-based drug treatment programs to treat individuals in need who reside in the general community. It has been the mandate of the Bureau of Prisons (BOP) and the Law Enforcement Assistance Administration (LEAA) to fund treatment of individuals within the criminal justice system. The critical point is not physical incarceration, but the responsibility of the criminal justice system for the treatment of individuals within the system. To fund the treatment of such individuals by NIDA would not only be contrary to our mandate, but would also dilute our limited resources from those in need in the community. Accordingly, our policy (established on 2/9/77) on the treatment of individuals in prisons is as follows:

A. A client in a NIDA-funded treatment slot who is incarcerated can continue to be counted as a NIDA client for up to 30 days subsequent to the in-

carceration if the program provides face-to-face treatment services to the individual during this period.

B. A program may provide face-to-face treatment services to an incarcerated individual with this being counted against a NIDA-funded treatment slot up to 60 days prior to the individual's release from incarceration.

C. In a few instances there have been NIDA-funded treatment programs which have provided services to incarcerated individuals for periods in excess of those presented above in sections A and B. As this has occurred prior to this written enunciation of our policy, we will allow for an orderly phase out of these services with the phase out period being determined on an individual, case-by-case basis in order to provide time for plans to be developed to allow for continuity of these services.

Our policy was not intended to impede other forms of cooperation between the Criminal Justice System and the Drug Treatment System, such as technical assistance-training, evaluation, or the provision of service under contract which provides financial compensation. In those few instances where NIDA-funded treatment programs were providing services to incarcerated drug abusers for periods in excess of the time specified, NIDA provided for an orderly phase out of those services, based on an individual case-by-case determination, and entertains requests for waivers in the exceptional circumstances.

In addition, NIDA-funded community-based programs are required by policy to allocate up to ten percent of their slot capability for drug abusers referred from the Criminal Justice System. These referrals constitute 17 percent of all admissions to treatment and are serviced at the cost of approximately \$27 million annually. Therefore, for NIDA to fund the treatment of incarcerated drug abusers is seriously questionable under Public Law 92-255 and may seriously dilute limited fiscal resources from meeting other equally essential community treatment needs.

Dr. KLERMAN. Mr. Chairman, no question there is a sizable proportion of people with heroin and other uses who are in prisons or other parts of the criminal justice system. What is not clear is where initial responsibility for providing that service should be, and what is the balance of responsibility between the health section of HEW, both nationally and locally, and what should be done by the Department of Justice at the national level or by the States, and that is something that is under consideration.

Mr. ROGERS. By whom is that under consideration?

Dr. KLERMAN. We have recently had some discussion that within HEW and there is a group reviewing certain proposals made by Dr. DuPont within HEW.

Mr. ROGERS. Have you had any contact with the Department of Justice's prison program?

Dr. KLERMAN. Yes, Dr. DuPont and his staff have had a good deal of contact with the Department of Justice.

Mr. ROGERS. And what is their reaction?

Dr. DuPONT. They are supportive of our being much more involved. I think the only reluctant partners in this are our friends in HEW. I do not think the Justice Department is trying to keep us out of this area.

On the other hand, they are appreciative of what we do do in this area of interface between treatment and the criminal justice system.

Mr. ROGERS. Who have you dealt with in the Department of Justice?

Dr. DuPONT. Jim Greg, who is soon to be appointed as permanent head of LEAA. He has been acting in that job for 1½ years.

Mr. ROGERS. Is there anybody else you contact at the bureau of prisons?

Dr. DuPONT. Yes, I have talked to Norm Carlson, too, although the Federal prison system has not been an area NIDA was involved in. It has funds for drug abuse programs, and it has done a very nice job.

Mr. ROGERS. What is your assessment of the prison program's expert and physician staff?

Dr. DuPONT. The U.S. Federal Bureau of Prisons has a medical staff and drug abuse treatment staff that is actually quite good.

Mr. ROGERS. Have they had consultation with you?

Dr. DuPONT. Yes. We have a very close relationship.

Mr. ROGERS. Would you set that forth for us?

Dr. DuPONT. I will be glad to.

Mr. ROGERS. As to how that is done, how often?

Dr. DuPONT. Fine.

[The following information was received for the record:]

NIDA Relationship with the Bureau of Prisons

NIDA has always enjoyed a close working relationship with key Federal criminal justice agencies since its inception, to include the Law Enforcement Assistance Administration (LEAA), the United States Bureau of Prisons (US BOP), the United States Probation Office (USPO), and Drug Enforcement Administration (DEA).

Previous cooperative efforts between NIDA and BOP have included collaboration on the repeal of the Narcotic Addict Rehabilitation Act (PL 89-793) in compliance with a recommendation from the White Paper on Drug Abuse, September, 1975. That legislative proposal has been submitted to Congress from both of the cabinet level departments involved, HEW and DOJ. In addition, NIDA and BOP have installed the CODAP System in BOP facilities, continue to monitor their implementation and routinely publish a quarterly printout on the status of BOP drug treatment programs. Also, NIDA, in affiliation with LEAA, BOP, and nine other public and private agencies, conducted a National Symposium on the Drug Arousing Criminal Offender in April, 1976.

The Division of Community Assistance has developed a Detoxification Treatment Manual for use in correctional facilities and treatment programs. Draft copies of this manual were sent to Mr. Norman Carlson, Director of the BOP, for review and comment by BOP staff who have had experience with Federal prisoner detoxification or at Federal jails where they may receive drug addicts.

The Treatment Manual was well received by BOP staff and it has been suggested by BOP that they would adopt the Detoxification Treatment Manual for use in all its institutions.

Several years ago NIDA and BOP had extensive discussions about the termination of the use of Federal prisoners in Lexington, Kentucky, in NIDA intramural drug abuse research.

In addition, the Division of Scientific and Program Information (DSPI) maintains close contact with BOP, primarily through their Assistant Administrator for Community Programs and Detention. DSPI processes CODAP for BOP totalling over 30,000 forms per year, including a specially developed Client Progress Report.

DSPI devotes one person almost full time as an editor and liaison with BOP. This individual is in regular contact with BOP program and clinic staff members responsible for completing CODAP in the approximately 200 BOP reporting units. The DSPI liaison has responsibility for BOP Control File problems, error correction based on the newly automated error procedures, transmits delinquent reporting unit names to BOP, and handles any other issues that relate to BOP reporting.

A number of meetings between DSPI staff and BOP officials over the last several years resulted in the development of a special Quarterly BOP Report which is produced by the Systems and Data Processing Branch under the guidance of the Analytical Studies Branch, DSPI. These quarterly reports reflect the specialized concerns of BOP, such as urinalysis data, required in order to monitor prison clients in drug treatment programs. Any specialized or detailed analysis would be produced for BOP upon request to DSPI.

Continued close liaison with BOP is required, especially in view of recent increases in poor data quality as reported on the CODAP forms. We have requested that a specific BOP staffer be assigned to work with us and the BOP programs to assure meeting appropriate reporting and data quality standards.

Mr. ROGERS. Are State drug abuse plans required to be circulated to local policymakers of counties and cities for their input to submission to NIDA?

Dr. DuPONT. There is a requirement for a sub-State planning process. It is being very unevenly done now. There are two areas with respect to the States that we are working with the States to improve, one is the issue of involving cities in planning and in management and the other is the area of minority participation in processes.

Mr. ROGERS. What about drug abuse, statewide drug abuse service contracts? Do those require local governmental input for section 410 funds?

Dr. DuPONT. Such input from the cities and counties is not required.

Mr. ROGERS. Shouldn't there be?

Dr. DuPONT. Perhaps there is need for a requirement. It needs to be emphasized however that the drug abuse services funded by NIDA through the States services are now being delivered in the cities predominantly. That is not at issue. The issue is what the management responsibility is for the delivery of those services in the cities. Past performance in that area has been uneven.

In some cities it works out very well, in others it does not. We have asked that those areas where it does not work out well, should bring the problem to our attention. We will be happy to exert our influence to try to improve performance on a State-by-State basis.

Mr. ROGERS. Well, we are getting complaints from the cities that they are not being consulted.

Dr. DuPONT. I am aware of some of these complaints.

Mr. ROGERS. And they are right, shouldn't they be consulted?

Dr. DuPONT. Yes; they should be.

Mr. ROGERS. Now, do you require a change of law, or can't you do that with the authority you have?

Dr. DuPONT. We are trying to do that under the current authority. I have proposed this year that we also involve the counties. Typically health services are a county function, not a city function.

Mr. ROGERS. Shouldn't they be included in the planning process?

Dr. DuPONT. Yes.

Mr. ROGERS. Have you taken steps to see that they are?

Dr. DuPONT. Yes, sir.

Mr. ROGERS. Can you require it, do you have authority to require it in the planning?

Dr. DuPONT. I will look into that and submit that for the record. I am not sure what the limits of our authority are.

Mr. ROGERS. Will you let us know right away?

Dr. DuPONT. Yes, sir.

[The following information was received for the record:]

NIDA GUIDELINES FOR LOCAL COUNTIES AND CITIES

(a) The mechanism presently used to address the needs of the cities is contained in the Code of Federal Regulations 42 CFR 54b, Section 111(e) directs the States as follows:

(b) Sub-State planning. The survey of needs and resource allocation plan must include information relating to the needs and current and projected resources of sub-State regional, county, and other local areas. To ensure such inclusion the State plan must incorporate by reference procedures under which the State agency will, as a part of the State planning process:

(1) Solicit such information from elected officials of local units of government (e.g., county and metropolitan) and organizations and individuals engaged in the provision of direct or ancillary drug abuse prevention, treatment, and rehabilitation services; and,

(2) Take such information into account in the preparation of the survey of need and resource allocation plan, particularly with respect to the planning of programs to meet the need for services in the respective sub-State regional, county, and other local areas.

NIDA has interpreted this language as being applicable to the major urban areas. Recently, in letters to States, we made recommendations to the States regarding the most recently submitted State plan. Among these recommendations was a directive to share the State plan with the elected officials of the major cities and ask for their input into the planning development next year. NIDA will monitor this at the 1978 reviews scheduled for September.

(b) Additional legislative authority would assist NIDA on two fronts: First, the task of obtaining State cooperation with the cities would be eased considerably. Secondly, NIDA has been instructed by the OMB Zero-based review of State plans to delete any requirements for SSA/city interface in State planning. If we were to receive such a legislative mandate, the Secretary's OMB Task Force would have to reconsider its present instructions.

In both regards the legislation would have a salutary effect.

Dr. KLIERMAN. I might comment, Mr. Chairman, there is a different set of circumstances with regard to planning and implementation with regard to planning. Each State submits an annual plan and there are proposals before your committee and Senator Kennedy's committee about better relationship between statewide plans on drug abuse and also mental health and also alcoholism and the comprehensive planning under HSA's and any proposals and any plans needed to take this in consideration also, and I think that also bills are before your committee.

Mr. ROGERS. That is correct.

I would like to say we have a number of questions. There is a call for the floor.

Have we any new developments in current findings of research on health effects of marihuana?

Dr. DUPONT. Yes; I would like to submit for the record our latest report to the Congress on that, Mr. Chairman.

[The following information was received for the record:]

RESEARCH ON HEALTH EFFECTS OF MARIHUANA

The 6th Annual Marihuana and Health Report to the U.S. Congress was submitted for the record and is available in the subcommittee files.

The Seventh Annual Report to the U.S. Congress from the Secretary of Health, Education, and Welfare, will be available in Summer 1978.

Mr. ROGERS. What are the developments.

Dr. DUPONT. That is a source of great concern. That issue is probably one of the best current examples of interdepartmental coordination by the White House Office of Drug Abuse Policy. HEW, as you know, did the basic studies to find that paraquat is a common contaminant of marihuana and that it is in the smoke from contaminated marihuana.

The question of what to do raises very important policy issues. This issue is being looked into by the Department of State; complaints of paraquat-related illness are being investigated by the Center for Disease Control in Atlanta. We are delighted that we have that coordination with another agency of the Public Health Service.

Mr. ROGERS. What about use of heroin in terminal cancer patients?

Dr. DUPONT. This is an idea that has received a lot of attention in the last year. Dr. Peter Bourne wrote a letter to the Surgeon General about this subject and set in motion the review committee that is chaired by Dr. Seymour Perry at the National Institutes of Health. NIDA participates in this important work with the National Institute on Aging and other Institutes, I am delighted to say that issue is being looked into for the first time in a very effective way, and that this project has led to the consideration of the larger issues of the medical management of pain and terminal illness, including a new consideration of the hospice movement.

This is one of the few committees I have participated in in the last couple of years, which is really exciting. It seems to be going somewhere. So what started out as a question of the use of heroin in the treatment of terminal cancer patients has now expanded. NIDA has the very best program grant in this area to Ray Houde at Sloan-Kettering Institute. He will for the first time give very clear scientific review to the question whether heroin does offer unique help.

Mr. ROGERS. Better than morphine, whether it is or is not.

Dr. DUPONT. Whether it is or is not. We will have some good evidence on that central question—a question on which there is now a substantial division of scientific opinion.

Mr. ROGERS. What about the review and coordination of your research with alcoholism research?

Dr. DUPONT. Within the last year we began a joint research review that involves both substances.

Mr. ROGERS. Would you give us a rundown?

Dr. DUPONT. Yes, sir.

Mr. ROGERS. What has been accomplished, how often you have met concerning that project?

Dr. DUPONT. Yes, sir.

[The following information was received for the record:]

NIDA-NIAAA SUBSTANCE ABUSE PROGRAM

The NIDA and NIAAA initiated its joint extramural research program in April of 1977 when both Institutes announced the start of the Substance Abuse Program to the scientific community. (see enclosed announcement). Prior to the issuance of this document officials at NIDA and NIAAA developed the administrative mechanisms for the day-to-day operation of the review and award cycle. Basically, the agreement stated that NIDA would have administrative responsibility for the first three review cycles and NIAAA would take over these responsibilities for the second set of three review cycles.

Review of submitted applications is carried out by a committee composed of 13 scientists (6 from NIAAA's Initial Review Group and 7 from NIDA's Initial Review Group) whose expertise ranges over the psycho-social, behavioral, clinical and biomedical aspects of drug and alcohol abuse research.

To date the joint committee has met twice (October, 1977 and February, 1978) and has reviewed a total of 45 applications. A third meeting of the committee is scheduled for June, 1978.

The review by IRG and National Advisory Councils of both NIDA and NIAAA produced the following results:

	<u>October</u>	<u>February</u>
Approvals	8	8
Disapprovals	12	15
Deferrals	<u>1</u>	<u>1</u>
Total	21	24

The analysis shown above indicates that a total of 16 applications were approved (36%) and 27 (60%) were disapproved.

The experience to date concerning this program has shown that the Institutes can work effectively and collaboratively on research problems of mutual interest and we believe that this cooperative effort will continue to be successful in the next review cycle.

Mr. ROGERS. And, is marijuana contaminated by other deleterious substances other than paraquat?

Dr. DuPONT. As far as we know, no. However, phencyclidine is sometimes put on marihuana and that is a major concern.

Mr. ROGERS. We do have additional questions we would want answered for the record, if you would please, and we may want to get together further on this. But, at this time, we will recess the committee until 2 this afternoon.

Thank you for your presence here. Thank you for the information you have given me.

Dr. DuPONT. Thank you.

[Whereupon, at 1 p.m. the subcommittee recessed to reconvene at 2 p.m.]

AFTER RECESS

[The subcommittee reconvened at 2:45 p.m., Hon. Paul S. Rogers chairman, presiding.]

Mr. ROGERS. The subcommittee will come to order, please.

We are continuing our hearings on the Drug Abuse Office and Treatment Amendments of 1978.

We have with us this afternoon Dr. Peter Bourne, who is Special Assistant to the President for Health Issues, and Lee I. Dogoloff, who is a former Deputy Director of ODAP, now in the domestic policy staff assigned to drug abuse.

May I say, first of all, we want to express the appreciation of the committee for your interrupting your schedule to help us this afternoon. You are very kind to appear on such short notice. We have some questions for you, and I was hopeful that we could do all of this in 1 day's hearing.

What we are anxious to know about is how drug abuse efforts will be coordinated; who has that function now that ODAP has been abolished by Presidential reorganization. What is the mechanism to coordinate and make policy, how within the Department is it coordinated, how are priorities set for funding, and who makes these basic judgments.

I think these are questions we would like to go into, if we could.

STATEMENT OF PETER G. BOURNE, M.D., SPECIAL ASSISTANT TO THE PRESIDENT FOR HEALTH ISSUES, EXECUTIVE OFFICE OF THE PRESIDENT, ACCOMPANIED BY LEE I. DOGOLOFF, OFFICE OF DRUG ABUSE POLICY, EXECUTIVE OFFICE OF THE PRESIDENT, THE WHITE HOUSE

Dr. BOURNE. Mr. Chairman, I am happy to have the opportunity to be here. I am aware that some of these issues could be confusing, and I think it provides an opportunity to answer these questions for the record and maybe, hopefully, also communicate our plans to the agencies so they are aware of how I see it or how we in the White House see how the coordination will occur.

There are three primary mechanisms that I see will continue the work that ODAP started. One is a series of policy documents. This

one relating to the treatment-rehabilitation-prevention area, is one of seven documents that we have produced over the last year under the ODAP auspices, analyzing and laying out what we felt should be the policy of this administration in each of those seven areas. We see those documents as the key policy documents for each or for the agencies to follow.

Mr. ROGERS. Now, these have already been adopted and were worked out under the ODAP?

Dr. BOURNE. Yes, sir.

Mr. ROGERS. Now, when were those actually adopted and made official policy?

Dr. BOURNE. At different times. We began with the Border Management study which was completed the end of last year. That one had some specific reorganization recommendations in it, so we have made those recommendations to OMB. It will go forward as part of the total Government reorganization package to the President, and eventually will come here with some legislative recommendations.

Mr. ROGERS. Yes.

Dr. BOURNE. We have made recommendations on law enforcement, narcotic intelligence, international activities, and treatment and rehabilitation. While these do not contain specific reorganization recommendations, on their completion they were transmitted to each of the involved departments, and they were asked to prepare an implementation schedule for the policy recommendations and the policy instructions laid out in the option.

Mr. ROGERS. Would it be possible for the committee to get copies of these?

Dr. BOURNE. Yes.

Mr. ROGERS. Could we have them all?

Dr. BOURNE. Yes.

Mr. ROGERS. Thank you.

Mr. DOGOLOFF. There are about 45 specific recommendations in here giving lead agency responsibility, and we have asked each of the Cabinet officers as we have transmitted this document to them. Either by May 1 or 15, each department is to get back to us with their specific timetable and implementation plan. We look forward to following those very closely over the next year to make sure that each one of those recommendations are followed through.

Mr. ROGERS. Now, those recommendations are to be sent to cabinet officers?

Mr. DOGOLOFF. Yes; they are being transmitted directly to cabinet officers.

Mr. ROGERS. They are to get back by when?

Mr. DOGOLOFF. In some cases, May 1, and others May 15, with specific timetables and implementation plans on each of these recommendations. I might add that none of these will come as a surprise to anyone, because of each of the Cabinet officers have things designated and they have been involved very closely in the formulation of these documents.

Mr. ROGERS. All right, first of all you have your documents.

Dr. BOURNE. Yes.

Mr. ROGERS. To establish policy. Now, are all departments bound by these?

Dr. BOURNE. Well, they are to the extent that the ODAP legislation placed the authority in my hands as the Director of ODAP to set that policy.

Mr. ROGERS. And this was all done before ODAP was terminated?

Dr. BOURNE. Yes; and these studies, or at least a summary of them, were transmitted individually to the President as my recommendations to him as to what the policy should be in each of these areas.

Mr. ROGERS. Yes. When were they transmitted?

Dr. BOURNE. Well, it was done as each one was completed.

Mr. ROGERS. Yes.

Dr. BOURNE. So, it was done really over a 4-month period of time.

Mr. ROGERS. And he has not rejected any of them?

Dr. BOURNE. No.

Mr. ROGERS. And has in effect accepted them?

Dr. BOURNE. Yes; and in some of them, off the top of my head I cannot recall which ones, he has specifically written back to me showing that.

Mr. ROGERS. Yes; if you will let us have that for the record, I would like to. All right.

[Testimony resumes on p. 109.]

[The following material was received for the record:]

PRESIDENTIAL TRANSMITTAL LETTERS AND EXECUTIVE SUMMARIES OF THE ODAP
POLICY REVIEWS

THE WHITE HOUSE

WASHINGTON

February 28, 1978

Dear Mr. President:

I am pleased to forward to you the policy review on "The Role of Intelligence in Narcotics Control and Interdiction." It is the result of one of several drug policy reviews conducted at your request.

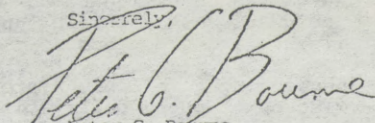
This comprehensive review of the Federal narcotics intelligence collection and production effort was conducted by an interagency team representing the principal Federal Departments and agencies involved in the narcotics intelligence process. The team included representatives from the Departments of State, Treasury and Justice, the Drug Enforcement Administration, the U.S. Customs Service, the Internal Revenue Service, the Central Intelligence Agency, the National Security Agency, the Federal Bureau of Investigation and an observer from the Office of Management and Budget.

The recommendations in this report are now being implemented. When completed, these actions will result in (a) a clarification of the narcotics intelligence collection and production roles and responsibilities of certain Federal agencies and Departments; (b) increased Federal agency participation in narcotics intelligence collection and production; (c) more effective use of foreign and domestic narcotics information sources and methods; and (d) a system to forecast worldwide licit and illicit opium poppy cultivation.

The findings and recommendations of the report will be presented to the Strategy Council on Drug Abuse Prevention for the appropriate follow-up and consideration in the preparation of the 1978 Federal Strategy for Drug Abuse Prevention. Additionally, the report will be furnished to the Office of Management and Budget for consideration in its reorganization studies.

Thank you for your continued interest in and dedication to the reduction of drug abuse.

Sincerely,



Peter G. Bourne

Director

Office of Drug Abuse Policy

The President
The White House
Washington, D. C.

THE ROLE OF INTELLIGENCE IN NARCOTICS CONTROL
AND INTERDICTION

EXECUTIVE SUMMARY

Experience during the past decade has demonstrated that hard and reliable intelligence is the lifeblood of an effective narcotics control and interdiction program. Without such information, narcotics enforcement would operate only on a target of opportunity basis and diplomacy would lack the convincing evidence with which to persuade foreign governments to take more forceful action against indigenous narcotics production and trafficking.

Under the auspices of the Office of Drug Abuse Policy (ODAP), an interagency team was assembled consisting of representatives, from the Departments of State, Treasury and Justice, the Drug Enforcement Administration (DEA), the U.S. Customs Service, the Internal Revenue Service (IRS), the Central Intelligence Agency (CIA), the National Security Agency (NSA), the Federal Bureau of Investigation (FBI), and an observer from the Office of Management and Budget (OMB). The team was asked to identify deficiencies in the narcotics intelligence system and to make recommendations as to how to improve the quantity and quality of narcotics intelligence available to Federal agencies and the White House.

Six key issues were raised in discussing the Federal narcotics intelligence collection and production process:

1. defining the intelligence collection and production roles and responsibilities within the Executive Branch,
2. establishing an interagency coordination mechanism for narcotics intelligence activities,
3. improving the quantity and quality of narcotics interdiction intelligence,
4. improving the exchange of financial intelligence related to the narcotics traffic,
5. establishing procedures to ensure maximum use of narcotics intelligence not otherwise obtainable and derived from sources abroad by U.S. foreign intelligence agencies, and
6. developing a reliable system for forecasting worldwide opium poppy cultivation.

Specific roles and responsibilities for the State Department, DEA, Customs, CIA, NSA, IRS and the FBI were recommended

with particular emphasis on the interagency aspects of these roles and the specific parameters under which each agency could operate. The recommended statement of roles and responsibilities further encouraged each Federal agency to collect within its capabilities the narcotics intelligence necessary to support Federal narcotics control policies and programs.

A committee system was recommended to coordinate narcotics intelligence activities within the Executive Branch and to ensure the complete separation of foreign intelligence collection, analysis and production by U.S. foreign intelligence agencies from any involvement in domestic intelligence and law enforcement activities. The committees will participate in the formulation and coordination of narcotics intelligence collection and production requirements as well as ensure the timely dissemination and evaluation of information and analytical products. Once operational, the Federal agencies can look to these committees for standardized collection and production requirements.

To improve the volume and flow of narcotics interdiction intelligence, it was determined that U.S. Customs should have an increased role in the narcotics intelligence process. Toward this end the report recommends that:

"Customs should collect information from foreign customs services and foreign trade communities on all smuggling activities, including narcotics. Customs should also participate on an initiative and bilateral basis in debriefings of narcotics violators arrested at the U.S. borders and ports of entry, provided that all information collected by Customs concerning narcotics is made immediately available to DEA, and that any further initiatives (e.g., investigations) by Customs beyond the collection of the information be undertaken only with DEA concurrence under mutually agreed procedures."

In the area of financial intelligence related to the narcotics traffic, the Narcotics Intelligence Study proposed a five-part course of action which included recommendations to (a) consider amending the disclosure and summoning provisions of the Tax Reform Act of 1976; (b) vigorously apply the Racketeer Influenced and Corrupt Organizations (RICO) Statute in narcotics investigations; (c) direct the State Department to respond to coordinated Justice/Treasury requests to negotiate mutual assistance agreements with selected countries used by narcotics traffickers as financial havens; (d) expand the IRS Narcotics Traffickers Tax Program to prosecute drug traffickers for violations of the Federal income tax laws; (e) increase the collection of financial intelligence available from the various Federal reporting forms which must be filed under the (Foreign) Bank Secrecy Act, and (f) set narcotics-related financial intelligence collection requirements and coordinate the cross training

of investigators in the methodology and use of financial intelligence.

Procedures and guidelines were also recommended to permit more effective exploitation by Federal policy officials and law enforcement agencies of narcotics intelligence acquired abroad by U.S. foreign intelligence agencies. The Study also recommends the development of a tactical system to support an active eradication program and the development of a strategic capability to analyze all-source information which would provide policy officials with accurate assessments of worldwide opium poppy cultivation.

The report was completed in February 1978 and the recommendations are currently being implemented.

THE WHITE HOUSE

WASHINGTON

December 19, 1977

Dear Mr. President:

I am pleased to forward the report on the policy review of Drug Law Enforcement. This is the result of one of several drug policy reviews being conducted at your request.

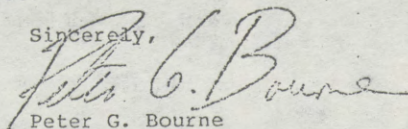
The report summarizes the observations and findings resulting from a comprehensive review of Federal drug law enforcement policy. The review was conducted by an inter-agency team representing the principal Federal Departments and agencies involved in drug law enforcement, in coordination with the Office of Management and Budget. The team membership included the Department of Justice, the Department of the Treasury, the Drug Enforcement Administration, the U.S. Customs Service, the Federal Bureau of Investigation and the Criminal Division in the Department of Justice.

The report represents the conclusions and findings of the review team and will be presented to the Strategy Council on Drug Abuse. Additionally, it will be furnished to the Office of Management and Budget for consideration in their reorganization studies.

Upon completion of the current series of policy reviews, a 1978 Federal Strategy for Drug Abuse will be prepared by the Strategy Council.

Thank you for your continued interest in and dedication to the reduction of drug abuse.

Sincerely,



Peter G. Bourne
Director

Office of Drug Abuse Policy

The President
The White House
Washington, D.C.

DRUG LAW ENFORCEMENT

EXECUTIVE SUMMARY

The Office of Drug Abuse Policy, at the direction of the President and in accordance with its Congressional mandate, has undertaken a series of comprehensive reviews of drug abuse policies. As part of this effort, a review of drug law enforcement was conducted by an inter-agency team representing the principal Federal Departments and agencies involved in drug law enforcement. This report reflects the conclusions and recommendations of the Review Team and will be considered in developing the Federal Strategy for Drug Abuse Prevention in 1978.

The Review Team reconfirmed the need for a single purpose drug law enforcement agency charged with the major responsibility for enforcing Federal narcotics laws. It also recognized that the task of reducing the supply of illicit drugs in the United States is complex and involves the coordinated efforts of many international, Federal, State and local agencies. In addition, the law enforcement effort must be supported by a variety of diplomatic, intelligence, interdiction and liaison functions overseas in source countries, at entry points along the U.S. borders and in domestic distribution areas. The review found that cooperation and coordination between Federal, State and local agencies is essential for effective drug control programs and emphasized the importance of the interagency aspects of the overall drug law enforcement efforts. Finally, the need for Executive Office policy coordination and review was reaffirmed.

The report presents a brief history of the Federal commitment to drug law enforcement, an assessment of the extent and nature of drug abuse in the United States, and a description of the principal components of present drug supply reduction strategy. The major components of this strategy discussed in the report are international initiatives, domestic drug investigations, drug smuggling interdiction, regulation and compliance, and support programs such as intelligence, training, and science and technology.

Several major problems which hamper effective drug law enforcement are also identified:

- . Insufficient judicial and prosecutorial resources and practices;
- . Inadequate supporting legislation;
- . Relative ambiguity in the policy implementation process;
- . Inadequate coordination and cooperation among government agencies involved in the illicit drug supply reduction activities; and

- . Inadequate clarification of national priorities and the respective roles of State and local governments.

Although there was not universal agreement on each issue, the following major findings and conclusions represent the consensus of the Review Team:

- . The Federal Government should reaffirm its policy of attacking major producers, importers and distributors of all illegal drugs, particularly those drugs that have the greatest potential for social and personal harm.
- . The Federal Government should not focus on the low to mid-level intrastate drug traffickers, but should stimulate local drug law enforcement capabilities in this area. Where local resources and skills are lacking, the Federal Government should provide funding support, training, and technical assistance to State and local law enforcement agencies.
- . The Federal Government should continue to support a single purpose, lead agency responsible for the enforcement of all Federal narcotics laws, but should require the lead agency to increase its interagency coordination and cooperation. Possible areas for emphasis are border interdiction support, organized crime involvement in drug trafficking, financial intelligence programs, and State and local task forces.
- . The Federal Government should ensure that adequate legislation is passed to support timely and equitable drug prosecutions.
- . The Executive Office should continue to provide a central policy making, coordination and review capability so that interagency competition and friction can be minimized.

THE WHITE HOUSE
WASHINGTON
March 31, 1978

Dear Mr. President:

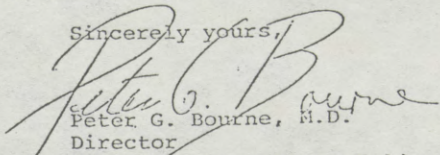
I am pleased to forward to you the Office of Drug Abuse Policy report, Drug Use Patterns, Consequences and the Federal Response: A Policy Review. This review highlights the health and social problems associated with drug abuse and the Federal approach to reduce the number of drug abusers in our society and the human suffering associated with drug abuse.

The review was conducted with the assistance of an interagency team representing those Federal Departments and agencies which have a major role in drug abuse prevention and treatment: the Departments of Health, Education, and Welfare; Defense; Justice; Labor; Transportation; and the Veterans Administration.

The report contains forty-five recommendations which are in the process of being implemented. The Strategy Council on Drug Abuse will monitor the implementation and receive periodic status reports from the appropriate agencies. We expect the implementation to result in (a) enhanced treatment services available to alcohol and drug abusers including improving the access by these persons to the major, non-categorical health and social service systems; (b) the development of a broader base of knowledge about the fundamental causes of drug abuse; and (c) more effective efforts at the Federal, State, and community level to prevent drug abuse by young people.

Thank you for your continued interest and dedication to the reduction of drug abuse in society.

Sincerely yours,


Peter G. Bourne, M.D.
Director
Office of Drug Abuse Policy

The President
The White House
Washington, D.C.

EXECUTIVE SUMMARY

The report, Drug Use Patterns, Consequences and the Federal Response, is an interagency policy review of Federal drug treatment, prevention, rehabilitation and research efforts conducted by the Office of Drug Abuse Policy. The following Departments and agencies participated in the review: the Departments of Health, Education, and Welfare; Defense; Justice; Labor; Transportation; and the Veterans Administration.

Significant among the recommendations are those calling for improved collaboration between substance abuse treatment programs and other support service programs. Federal leadership is requested in designing and promoting access by alcohol and drug abusers to the major health, social service, and employment and training systems. Other recommendations cite the need for the development of a broader base of knowledge about the fundamental causes of drug abuse and call for a government-wide research plan which will identify gaps in knowledge, establish priorities for future research, and assign research responsibilities to appropriate agencies. Recommendations to improve systems for data collection on the nature and extent of drug abuse and misuse in society are also included.

One of the most pressing concerns in the drug abuse field is how to keep people, particularly young people, from abusing drugs. The report endorses the concept of promoting drug abuse prevention through community-based programs which offer positive non-drug alternatives for young people. The report concludes that current Federal prevention programs are fragmented and address only limited aspects of youth development. An analysis is recommended to develop a more rational, coordinated approach to federally-funded efforts to improve the healthy development of young people.

In addition to the recommendations, the report discusses the recent history of Federal involvement in problems of domestic drug use and summarizes Federal activities in the field. The report reviews currently available data on the patterns of drug taking in society and the negative consequences associated with the use of specific drugs. Some attention is also paid to the health and social consequences of drug abuse and misuse by higher risk persons such as women, youth, elderly and ethnic minorities.

This report sets a new tone for the Federal effort in drug abuse by focusing concern on the negative health and social consequences to the individual and society which result from the abuse or misuse of any psychoactive substance, whether from illicit or from therapeutically-intended sources. The findings and recommendations will be incorporated in the 1978 Federal Strategy for Drug Abuse Prevention and will serve as guidelines in future drug policy decisions.

THE WHITE HOUSE

WASHINGTON

March 31, 1978

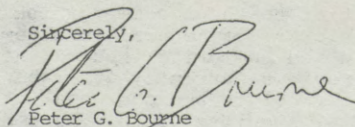
Dear Mr. President:

I am pleased to forward to you the report on International Narcotics Control Policy which is one of the several drug policy reviews conducted at your request. The review was conducted by the Office of Drug Abuse Policy with the assistance of an interagency working group drawn from the Departments of State, Treasury, Justice, Defense, Health, Education, and Welfare, Agriculture, the Central Intelligence Agency, the Drug Enforcement Administration and the U. S. Customs Service.

The report proposes policies (1) to encourage the substitution of narcotics producing crops with other agricultural commodities; (2) to actively engage in the worldwide reduction in the demand for illicit drugs; and (3) to increasingly look to international organizations to achieve many of these objectives. These and other recommendations pertaining to better management of U. S. efforts in the control of narcotics overseas will assist in achieving the objectives outlined in your Message to the Congress of last August on drug abuse and will be incorporated in the 1978 Federal Strategy to be prepared by the Strategy Council on Drug Abuse.

Your continued interest in and dedication to our international narcotics control effort is appreciated.

Sincerely,



Peter G. Bourne

Director

Office of Drug Abuse Policy

INTERNATIONAL NARCOTICS CONTROL POLICY REVIEW

EXECUTIVE SUMMARY

As the world becomes increasingly pluralistic and the interdependencies of nations become more numerous and more sensitive, we find that many of our most important problems are no longer clearly "domestic" or "foreign." The domestic U.S. drug abuse problem has always had international implications in that many of the serious drugs of abuse originate in foreign countries. This report examines current U.S. international drug control policies and proposes several initiatives designed to further improve efforts to reduce the illicit supply and demand for drugs.

International conventions and treaties have recognized the international implications of the drug abuse problem since The Hague Opium Convention of 1912. To enhance these international efforts, the United States assigned law enforcement personnel abroad in the late 1930's to work with host countries in stemming the flow of opium, its derivatives and cocaine into this country. While enforcement measures directed against the illicit traffic involve a great number of foreign police and customs officers and have achieved notable successes, further significant control of illicit drugs calls for an increased emphasis on three other broad but interrelated areas: (1) the reduction of supply through the curtailment of opium poppy and coca bush cultivation; (2) the initiation of international programs to reduce the demand for drugs; and (3) the increased use of international organizations to encourage, plan and finance these measures with foreign governments.

The strict control measures imposed by the Government of Turkey and the poppy eradication program enforced by the Government of Mexico have been effective in reducing the supply of opium and heroin available for the worldwide illicit market. However, the potential for an increased cultivation of the opium poppy and the coca bush in other parts of the world cannot be ignored. Enforcement actions alone can never be completely effective when pitted against an unlimited production of raw materials. Consequently the report recommends that the United States place an increased emphasis on income substitution programs to reduce or eliminate the dependency of certain farmers on poppy, coca and cannabis cultivation. Large scale efforts will require firm development planning and resource commitment by the producing country, together with financial and technical assistance from international organizations, international financial institutions and interested countries. Income substitution programs are, of necessity, long term, in that they involve major economic and social change, and must be accompanied by strong enforcement measures to be effective.

The production and supply of illicit narcotics and psychotropic drugs are, to a significant degree, a function of demand for without drug consumption, there would be no incentive to produce and little profit in trafficking. The importance of demand reduction as part of a balanced international drug control program should be emphasized as a means of convincing other governments of the immediacy and seriousness of the worldwide drug abuse problem. The increasing illicit use of drugs in other countries supports the need for strong and forceful international action. The fact that assistance from international organizations is often more welcome by some nations than bilateral aid led to the recommendation that the U.S. increasingly look to United Nations agencies and regional organizations to focus world attention on continued production and trafficking practices and to assist in financing international narcotics control programs.

The report recommends initiatives to (1) reduce supply by (a) seeking international commitments and financial support for projects to reduce poppy and coca cultivation, (b) in developing measures to improve an attack on the financial aspects of trafficking and procedures for arrest and prosecution of offenders overseas through further mutual assistance and extradition treaties; (2) reduce demand through (a) providing greater assistance to foreign governments in developing demand reduction programs, (b) reviewing drug treatment services provided to U.S. citizens abroad; (3) exploring the feasibility of greater use of regional efforts to control drug trafficking and abuse; (4) developing specific Narcotics Action Plans for countries affected by the supply of and/or demand for drugs; (5) assessing the scope of the drug control problem through a comprehensive compilation of all existing data; and (6) improving the conduct of U.S. overseas programs through (a) systematic communication of drug-related policies to key embassies and missions, (b) developing an improved DEA foreign personnel system, (c) evaluating U.S. training programs provided foreign drug control personnel, and (d) sensitizing narcotics control personnel to demand reduction techniques and opportunities.

The implementation of these recommendations will be the responsibility of those departments and agencies primarily accountable for the areas addressed in the report. The Drug Abuse Policy office and the Special Assistant to the President for Health Issues will monitor the implementation process and present periodic program reports to the President.

September 7, 1977

BORDER MANAGEMENT AND INTERDICTION

EXECUTIVE SUMMARY

An interagency Review Team, under the leadership of the Office of Drug Abuse Policy, conducted a comprehensive review of Federal border control and associated law enforcement activities. The basic assumption is that improved effectiveness of border control will enhance all related programs (drugs, aliens, guns, revenue, etc.), as opposed to the traditional, but self-limiting response of dedicating resources to a single purpose.

The report describes the vastness and distinctness of our border areas, as well as the operation of land, sea and air ports of entry. Many problems associated with effective law enforcement at ports of entry and with patrolling between ports are attributed to past and present practices of dealing with border management in a fragmented manner. The current organizational structure contributes to the problem with personnel from eight agencies representing seven different departments directly involved in border operations.

The two principal functions of border control are inspection of persons and goods at ports of entry, and patrolling between ports to prevent surreptitious entry. The principal agencies involved in these key functions are the U.S. Customs Service (Treasury) and the Immigration and Naturalization Service (Justice). Other agencies provide support and specialized skills in their areas of responsibility.

After a thorough problem analysis, two major issues are identified; overall lack of coordinated border management, and the overlap and duplication of effort in the principal border control functions. The principal overlap and duplication is in the patrolling between land ports of entry (Immigration and Customs) and in the primary inspection at ports of entry (Immigration and Customs). Massive workloads and duplicate management systems compound the problems.

Several options are considered, ranging from assigning budget priority to selected functions to creation of an expanded border management agency. The report concludes that a revised management structure is needed which can achieve maximum effectiveness with available resources, respond to changing priorities, and provide adequate border control, as well as better service to the public. Further, the first phase of any reorganization should be directed at correcting the fundamental problems. From this basic foundation, border management can evolve toward further improvements in effectiveness and efficiency.

The Review Team recommends a consolidation of the Customs Service and the Immigration and Naturalization Service into a border management agency to provide central management over the key border functions and resources. Specific criteria are suggested to minimize opposition and turbulence associated with reorganization.

Comments received from the departments and agencies involved in border operations reflect general agreement with the findings, but lack agreement regarding which department should have responsibility for a new border management agency.

The President's Reorganization Project in the Office of Management and Budget (OMB) has responsibility for developing specific reorganization plans and the Office of Drug Abuse Policy will assist OMB in developing any reorganization plan related to this review. Additionally, the report will be used in conjunction with other policy reviews in preparing a new Federal drug abuse strategy.

DRUG ABUSE ASSESSMENT IN THE DEPARTMENT OF DEFENSE:
A POLICY REVIEW
EXECUTIVE SUMMARY

This report is the result of an initial review of the assessment and identification functions performed as a part of the drug abuse prevention efforts of the Department of Defense (DoD) which was conducted on July 14, 1977. The review was undertaken by Robert L. DuPont, M.D., Director, National Institute on Drug Abuse, Chairman; Professor John O'Donnell, University of Kentucky; Professor Mark Moore, Harvard University; and Mr. Charles V. Yarbrough, Veterans Administration.

The review was carried out at the request of the White House Office of Drug Abuse Policy. The Group's charter indicated that the review should cover the effectiveness of current policies and programs of DoD and the Military Departments regarding the methods by which the Armed Services identify and assess the nature and extent of their drug abuse problems.

The Review Group was asked to provide conclusions regarding the ability of the current identification process to reflect changes in the drug-using patterns of servicemen and to provide early detection of the hidden use of opiates, stimulants, or sedative-hypnotics, and to make

appropriate recommendations for improving the overall assessment capability of DoD.

DoD and each Military Department presented a briefing which followed the outline which had been requested. Each of them spoke to the organizational structure of their drug abuse prevention activities, described the identification process and subsequent review process, and discussed the issue of the use of such information by senior managers within DoD and the Military Departments.

CONCLUSIONS

Several general conclusions were reached after review of DoD's presentation:

1. Drug use in the military often has risk implications beyond those normally associated with drug use in society in general. Unlike the general social concern which focuses on the narrower patterns of chronic, intensive drug use, the Armed Services are concerned with not only those patterns of use, but also with what is often referred to as "recreational" drug use. Even occasional use in the Armed Services can have an important impact on the ability of the force to function. The Review Group accepts the fact that different standards of conduct may be necessary

for the proper functioning of a military force, and that the Armed Services have a special obligation to know the extent and understand the impact of its drug use.

2. Levels of illicit drug use have been relatively constant in the military since the Vietnam era. That the rates are not higher is due, in the judgment of the Review Group, to the 7 years of intensive effort on the part of DoD in developing drug abuse prevention programs. What is certain is that drug use within the military will continue to be a special problem and only by continued, persistent efforts will DoD be able to moderate the adverse consequences of such drug use.
3. DoD and the Military Departments have developed programs which give senior managers and commanders a variety of information related to drug use in the Armed Services. This information, however, is often disparate from the standpoint of definition or comparability of data, both within each of the Services and among the Services.
4. All information presently used by DoD and the Military Departments as the basis for management decisions regarding drug abuse prevention is subject to bias. There is no process to validate

current information. The former random urinalysis program of DoD--now prohibited by Congress--did provide a reliable independent indicator of drug use. This lack of a validating mechanism makes it impossible to measure or audit with assurance the current level of drug use within any of the Military Departments or to identify and compare levels of drug use by type of drug, Service, Command, geographical area, and so forth.

5. DoD and the separate Military Departments must have and use the option of drug monitoring/surveillance programs (i.e., random urinalysis, sample surveys) where circumstances warrant. The operational benefits of these programs are too great to deny their use to commanders who face a drug abuse problem.
6. Management emphasis regarding drug abuse appears to be waning. This lessening of emphasis may lead to a false sense of security by senior Defense managers and commanders regarding the nature of drug abuse in the Armed Services.
7. DoD programs for civilian employees appear to vary widely and should be enhanced. There are no separate service-wide programs for dependents, especially overseas. The absence of such programs represents

a serious shortfall in the existing drug abuse programs of DoD.

8. The current prohibition on DoD "drug abuse research" by Congress clearly hinders the development of a better understanding of those patterns of drug use which most adversely affect the readiness of the military force.

RECOMMENDATIONS

1. Congress should be asked to reconsider its current opposition to DoD using random urinalysis as a management tool. The present prohibition denies both DoD and the Military Departments a reliable method of independently assessing drug use. The current restriction on DoD severely limits its ability to confidently know the nature and extent of drug abuse within the Armed Services.
2. DoD and the Military Departments should review their existing drug abuse indicators and select a limited number (three or four) of standardized data elements and reporting requirements which are most needed in the making of drug abuse policy. DoD should establish clear guidelines for the Military Departments on the standardization and collection of such information.

3. An independent drug abuse assessment/program should be established within DoD to validate other indicator systems. This program should include a modified random urinalysis effort and an integrated survey effort which would serve as the lynchpins of this independent system. The information developed in this program would be used for trend analysis only, and would not be used as an identification and referral process. Identification and referral can continue through existing programs.
4. DoD should identify those areas of "basic research" which are valuable for a better understanding of drug abuse, and encourage HEW to give priority support to such research. Further, DoD should identify those areas of applied research which will help it better understand the nature and extent of drug use in the military and the consequences of such drug use on the force readiness. A research program should be developed on a priority basis and should be integrated into existing DoD research plans. Further, an inter-agency drug abuse research committee, with membership to include DoD, VA, and HEW, should be

established to identify those research areas of common interest and make recommendations to the respective departments and agencies regarding the development of such efforts, including joint projects. The chairmanship of this committee should be rotated on an annual basis.

5. The DoD should assess the drug abuse problem of its civilian force and dependent contingent, particularly overseas, and develop and expand special programs for these populations
6. Greater emphasis to the drug abuse programs must be given by DoD. In addition to those reviews now completed by DoD managers, special trend reports should be made quarterly to the Secretary of Defense and the Service Secretaries. Further, DoD should initiate a program of concentrated field visits to not only learn about local program operations, but to evaluate their ability to reliably reflect drug abuse trends and levels. Each area overseas should be visited at least once a year, and major CONUS (continental United States) components should be visited at least biannually.
7. Current resource levels should be reviewed with a view toward reversing the downward trend in

personnel and budget support. Areas such as drug and alcohol abuse, race relations, and other human resources programs are always vulnerable in times of budget restrictions. The current resource commitment to the drug abuse prevention effort must not be allowed to deteriorate any further. Adequate staffing and funding must be maintained to ensure that an aggressive, viable drug abuse program can exist.

Dr. BOURNE. Now, the second one most important, on a day-to-day basis, is what we call a principals meeting, which is a meeting we convene once every 2 weeks and includes myself; Mr. Dogoloff; Mr. Bensinger, the Administrator of the DEA; Mr. Chasen, the Commissioner of Customs; Miss Falco, the adviser to Secretary of State Vance on narcotic matters; and Dr. DuPont, more recently also Mr. Meltzer who is a special assistant in Secretary Califano's Office.

We meet every 2 weeks, and each of those people submits ahead of time a list of the agenda items which they feel have cross-agency consequences. And, we use that as a forum in which to discuss policy, to coordinate policy, to air any differences, to seek resolution if it is appropriate, and to plan any other activities that seem to be appropriate in interagency coordination in this area.

I think that all of the participants would agree that this, of all the mechanisms that we have had in operations, has been the most effective. It enables us to resolve differences at the top very, very rapidly. And, I think it has been a highly successful mechanism over the last year in coordinating overall Federal policy.

Mr. ROGERS. May I ask, do you have a representative from the Department of Defense?

Dr. BOURNE. We do not, on a regular basis.

Mr. DOGOLOFF. We have been working directly with the Department of Defense on issues of drug use in the military, and I met with some people in the European command there within the last 2 months, and we are following up with that. There are some specific recommendations we communicated. One of the seven studies dealt with assessment of drug use in the military, and so we are in an active ongoing relationship with the military and working with them, although they are not involved in the principals meeting because they do not have the sort of primary responsibility on a day-to-day basis for drug programs.

Mr. ROGERS. What about the Federal Prison System?

Dr. BOURNE. We have not included the VA, the prison system, or Defense, largely because the bulk of the issues that are discussed would touch them rather peripherally, and although we are happy for them to come they would spend most of their time probably sitting around somewhat bored.

We had a relatively similar situation with Customs, I initially thought that Mr. Chasen might not feel it was worth his time to come to the meeting because Customs is involved in so many other activities.

He said no, he did want to come, that in actual fact an enormous amount of his time was involved in the drug area, and that he would feel it would be a very useful expenditure of his time to come to those meetings, so he comes.

I do not think we have any desire to exclude anybody, and we really would be happy to have anybody included who felt their appearance would help, because our feeling in the past has been in the smaller the group the easier it is to get tough decisions made, the more intimately every member of the group is involved, the easier to get resolution, and the informality of it and relatively close personal relationship between the present players is one of the reasons for the success of it.

If you increased it up to a half dozen or eight people, it would become a rather formalized meeting, and I think it would lose a lot of its effectiveness. Certainly if it looked appropriate to include any one of these other representatives, we would be only too happy to do it.

Mr. DOGOLOFF. But the VA, Bureau of Prison and LEAA are all involved with this formation of the policy review documents and there are specific recommendations which relate to them, so they will clearly be involved at that level in the coming year.

Dr. BOURNE. The third mechanism which is statutorily established is the Strategy Council, which dates back to the 1972 act, but which, in fact, had never met until this November. It will be continued as one of the formal mechanisms we place in ODAP or stays in existence for some of the assistants to pick up ODAP responsibility.

We have had one meeting of that umbrella group, which includes six or seven cabinet members, and six members from the private sector who have been selected to represent various different areas of interest in the drug field.

Under that umbrella or that Strategy Council we have formed two groups, subcommittees, to deal with specific areas. I have been very reluctant to create, as there has been in the past, a large number of standing committees, that meet just for the sake of meeting, because I felt that that would just fragment the policymaking, decision-making focus.

And, I have insisted that any committee that sets up will be set up to deal with specific problems and have a time-limited life span, with the expectation that they do their work and go out of existence, and we would recreate another one when it was appropriate.

We have established one in the international area that the State Department is chairing to deal with some of the complicated issues dealing with trafficking on the high seas and the responsibility between Customs, the Coast Guard, the military, the State Department, particularly out of Latin America. Now there are some difficult legal problems about who has jurisdiction over what and that committee is looking at that and some other related issues.

We are just this week asking DEA to establish another short-term committee to look at the issue of international money flow, which we have identified as perhaps one of the major current problems in the drug area. There are literally hundreds of millions of dollars flowing around the world at the present time relating to the drug traffic, much of it in and out of south Florida, and it is a very, very serious problem.

First, we have not been terribly effective in dealing with it in the past. The American public, I think, does not understand the implications of what this means. I am not sure that a lot of people in the Government do, either. And, we felt that to establish a subcommittee with all of the key law enforcement agencies involved and representatives from the Treasury; IRS involved in that committee, we could look at a strategy to deal with that particular problem.

Both of those groups will do their job, which may be 3 months or 6 months, whatever, then they will go out of existence and we will recreate new committees as we feel it is appropriate.

Now, under the umbrella Strategy Council, we also have the legal requirement to produce this June, a strategy document and this will be essentially a summarization of this administration's policies in this area. It will of necessity draw rather heavily on the documents from the individual areas that we have already been into. It will be a summary document that will say, in one place, this is what our strategy is, and will be a document that will have been approved by the Strategy Council.

One other element that I might just mention is that ODAP is also required to produce an annual report, in that ODAP existed for only 1 year it is essentially a summarization of everything that ODAP did. That is at the printers at the present time, and we will have it available in 2 or 3 weeks. And it will essentially say here is the history of ODAP, here is what we set out to do, here is what we accomplished, and here is where we are going from here.

Mr. ROGERS. Now, let me ask this, if I may. What is the relationship and who is involved on the Domestic Council, as far as drug abuse is concerned?

Dr. BOURNE. Well, all of the people other than myself who were involved with ODAP or who worked for me in the past are now being paid from the ODAP payroll or from the Domestic Council payroll. However, all of those people still report directly to me.

Mr. ROGERS. Yes.

Dr. BOURNE. We have a very close working relationship on a personal basis with the rest of the Domestic Council, and in many ways this is a kind of a safety arrangement because there are a number of overlapping areas where this kind of forced moving together has in fact turned out to be rather helpful. Things like the crime message, the urban policy and a number of other areas that the intimacy of this new arrangement I think has been beneficial to both sides and has maybe given us an opportunity to have great input made which perhaps otherwise we would not have had as a completely separate entity.

Mr. ROGERS. How many people are assigned to drug abuse on the Domestic Council?

Dr. BOURNE. There are six.

Mr. ROGERS. That is six. Who are they, now?

Mr. DOGOLOFF. There would be myself.

Mr. ROGERS. Yes, Mr. Dogoloff.

Mr. DOGOLOFF. Sybil Halper.

Mr. ROGERS. Sybil.

Mr. DOGOLOFF. Halper, H-a-l-p-e-r. Dick Williams, and Bob Angarola are the four professionals.

Mr. ROGERS. Bob Angarola.

Mr. DOGOLOFF. Angarola. And then there are two clerical.

Mr. ROGERS. And two clerical?

Mr. DOGOLOFF. Yes.

Mr. ROGERS. Now, where are your offices?

Mr. DOGOLOFF. They are in the Old Executive Office Building.

Mr. ROGERS. Exactly where you had the ODAP office, in effect?

Mr. DOGOLOFF. Yes.

Mr. ROGERS. So it is continued in effect, it is operating as part of the Domestic Council now, rather than ODAP, is that correct basically, and you as Assistant to the President are heading up that effort?

Mr. DOGOLOFF. The change on the day-to-day basis really is rather minimal.

Mr. ROGERS. Yes.

Mr. DOGOLOFF. We just have a smaller staff and the mechanism for getting bills paid is probably different, but other than that there is little change in operations.

Mr. ROGERS. And my understanding is that staff members are willing to come before the committees of the Congress, and so forth.

Now, who decides the budget policy? Is this turned over to OMB? Do you allow, for instance, the National Institute on Drug Abuse to submit its request up the normal channels? Do you have any input, does Domestic Council have any input on this budget?

Mr. DOGOLOFF. Well, in the normal, this is kind of two parallel things going on. One is the normal budget cycling. We then, also, have independent input. For example, we will attend a spring budget review that OMB will chair.

Mr. ROGERS. Yes.

Mr. DOGOLOFF. We often attend the director's budget review and work directly with the OMB personnel, both in formulating budget issues, as well as having some direct input on budget levels, and those sorts of things.

Mr. BOURNE. Mr. Chairman.

Mr. ROGERS. Yes.

Mr. BOURNE. We have had an extremely good cooperative working relationship with NIDA in the past.

Mr. ROGERS. Yes.

Mr. BOURNE. We have also had a good relationship at the top of HEW once the budget is coming over formally to OMB. We do have some concern about changes going on internally in HEW at the present time and what might happen between NIDA and the Secretary.

And, I do not think we have quite yet figured out how we are going to be able to monitor that process as it moves its way up the ladder and that is a concern. We are going to have to work on with HEW to make sure we have appropriate input at each of those decision-making levels.

Mr. ROGERS. Now, what are those steps now, and how has it changed since ODAP? In other words, your budget process.

Mr. DOGOLOFF. I do not think the budget process itself has changed since ODAP. A change, if it occurs, may be relative to other changes within HEW. These will have to be worked out.

Mr. ROGERS. What changes are those?

Mr. DOGOLOFF. They may involve the kinds of authorities and responsibilities at each level of budget development and how we are going to be effective in working with each of these levels.

Mr. ROGERS. Has there been any change in that relationship?

Mr. DOGOLOFF. Only to the extent that the Secretary has designated Mr. Meltzer as his personal representative, and who now attends the

principal's meetings held by Dr. Bourne. We are in the process of working out a satisfactory arrangement. We welcome this appropriate involvement by the Secretary's representative. However, we must, at the same time, relate very personally to people at the agencies and institutes, without becoming involved with internal HEW issues.

In terms of participation in working groups and information exchange, we are in the process of working out how these will work.

Mr. ROGERS. In dealing directly with the Institute?

Mr. DOGOLOFF. With the Institute, with people at FDA, and with other people throughout HEW.

Mr. ROGERS. What is the difficulty?

Mr. DOGOLOFF. The difficulty has to do with attempting to filter everything through one person. We are trying to work out an agreement whereby all policy issues would be cleared through the Secretary's office but routine information matters and routine kinds of working agreements could be handled directly between the people at the working level and our staff.

Mr. ROGERS. Is this a normal relationship with the Domestic Council that you would go through people other than the designated persons, designated by the Secretary of that Department?

Mr. DOGOLOFF. I think it might work differently on the Domestic Policy staff, per se, because they are involved on a major issue basis and it is likely that task forces may be designated for these. We are involved on a much more regular basis with things in much greater detail.

Dr. BOURNE. I think also that drug abuse matters leave a legislative mandate that is quite different from other areas. It may be that in other areas there are more routine matters which are handled entirely within one department and would not need to be addressed by the Domestic Council.

But, because of the problems that have existed with the drug field in the past and the fragmentation among different agencies, I think it has been seen that you have to deal with a whole series of different levels and ODAP and its predecessor, SAODAP, were set up with this in mind. It is clear that the intent was not that it would be exclusively a relationship just between the White House and the Secretary.

Mr. ROGERS. I presume that is set forth in the law, is it not?

Dr. BOURNE. Yes.

Mr. ROGERS. Even though the actual offices of ODAP or SAODAP do not exist, I think the provisions of law might still exist, do they not?

Dr. BOURNE. Yes, they do, and they were transferred rather explicitly. I think Secretary Califano has been very cooperative with us. I think that his willingness to designate somebody in his own office as a special assistant is a unique and positive step. No previous Secretary has done something like this, and I think it does reflect his own personal interest and desire to be responsive. I have communicated to him, however, that while we welcome this new approach, to do our job effectively as the law requires we need continued direct access and could not wait for the delay for relatively mundane matters

to filter all the way down through HEW and all the way up again. I have communicated with him in writing on the need to deal with people on a whole series of different levels. I think, for instance, the bi-weekly meetings of the principals would lose their effectiveness almost entirely if the National Institute on Drug Abuse was not able to be present.

Without the Director of NIDA, the meetings would be largely ineffective, because comparable level people from Justice or the State Department and with Treasury attend and exchange ideas.

Mr. ROGERS. Now, in making up the 1979 budget, it appears there is a reduction from 1978 in prevention. I wondered how that evolved and who recommended that?

Mr. DOGOLOFF. I think that was an internal HEW issue, and that is the way the budget came up to OMB, as I understand it.

[The following information was received for the record:]

BUDGET PROCESS FOR THE PREVENTION/DEMONSTRATION BUDGET FOR FISCAL YEAR 1978 FOR NIDA AND WHAT CAN BE EXPECTED FOR FISCAL YEAR 1979

The National Institute on Drug Abuse's request for prevention/demonstration in fiscal year 1979 was \$20.928 million. The Public Health Service level was \$20.928 million and the DHEW to OMB level was the same. The President's budget allocated \$11.568 million. The OMB decision process was to look at community programs, or service, as a whole and then set the number for community programs to allow continuation funding for direct services, but no increases for prevention/demonstration. Future specific decisions regarding prevention funding should await DHEW's prevention strategy, which should be ready for the 1980 budget cycle, as well as the President's Reorganization Project's recommendations regarding the implementation of the various prevention recommendations contained in the policy review "Drug Use Patterns, Consequences and the Federal Response", and in the President's Commission on Mental Health report. The Drug Policy Staff places a high priority on following up on these recommendations.

Mr. ROGERS. According to our understanding, I do not think that is correct. I think HEW recommended \$10 million, but it came out at \$5 million, which is less than we are spending in 1978.

Mr. DOGOLOFF. I know at the time that that decision was made I spoke with some people to make certain that—particularly in the demonstration areas which is where it seemed that the cuts might come—that that could be worked out so that programs would not in fact be reduced, particularly given the substantial increase in funding that occurred in the research area. And, I was assured informally from within the NIDA management something could be worked out to maintain in 1979 the same level of services as in 1978.

Mr. ROGERS. That was not the testimony this morning from NIDA.

Mr. DOGOLOFF. Yes; that could have changed, that was quite some time ago.

Mr. ROGERS. Well, this is what I want to know. How are these judgments made and do they stick or don't they stick and who makes the judgment? For instance, on prevention, should we do less this year than we did last year, when the President, I think, has stated he wanted prevention stressed and I think Secretary Califano also said he stressed prevention, also?

Yet, when the budget comes out, there is a reduction, rather than an increase.

Mr. DOGOLOFF. We could trace that back and see what their steps were, and provide you with a chronology as to where that decision was made and it could have been made——

Mr. ROGERS. But, how does it prevail, that is what I want to know. The President says prevention, the Secretary says prevention, and I presume the Domestic Council agreed that prevention should continue. But, I understand there are no new starts at all on prevention, none. Nor any for demonstration.

The only increase was some \$13 million in research because the mental health study said they ought to do more in research. Overall they simply took the increases out of prevention and demonstrations, I presume, and out of the cost of treatment which went up some. How do we make these judgments?

Mr. DOGOLOFF. I would assume that if it held up through HEW then that decision was made by OMB, and then——

Mr. ROGERS. Well, I understand, but what I am asking is what input does the Domestic Council have, where ODAP before had an obligation to see that we received a sufficient budget and we gave them that authority to do so. Now, you tell me you no longer have that authority to make sure that the budget is consistent with the needs of the program.

Mr. DOGOLOFF. To the extent that those properties were then transferred by Executive order to the domestic policy staff, we would maintain those.

Mr. ROGERS. But I do not see you doing that. You say you do, but I do not see that in action. So, do you or don't you?

Dr. BOURNE. We do not have the final say on the vouchers, we do have a final opportunity to have input as far as our recommendations in carrying out policy. But, the final decision rests between the President and OMB. We will still, however, continue to be able to make recommendations every year to OMB's writeup to the Presidential scene.

And, that will not change at all. Off the top of my head, I do not recall the details of what went on. But, I do know we were involved in this issue, there was a feeling at the time that this was an issue we did not feel that strongly about, and there was some sense that it could be worked out.

I do not recall why we did not push more vigorously on it.

Mr. ROGERS. Your demonstration budget goes down from \$12.6 million in 1977 to \$8.6 million in 1978, down to \$7.5 million in 1979. Your prevention budget in 1977 was \$4.67 million, then it went up to \$6.4 in 1978, back down to \$5.1 in 1979. In spite of the fact that NIDA and HEW suggested a greater effort on prevention, that occurred.

Now, would you let us know for the record how this happens, should it continue that way, or should there be a change.

How much does the Domestic Council now get into the budget?

Mr. DOGOLOFF. It is very much on an advisory role. The Domestic policy staff is welcome to sit in on the Director's review with the Office of Management and Budget, and it is an advisory role and that is the extent of it.

Mr. ROGERS. So?

Mr. DOGOLOFF. The final authority still would lie with the Office of Management and Budget to make a recommendation to the President, then make a decision which could then, of course, be appealed by the Department's Secretary.

Mr. ROGERS. You would not get into the appeal?

Dr. BOURNE. Yes; we can.

Mr. DOGOLOFF. We can.

Dr. BOURNE. In other areas last year we were actively involved in a number of issues where OMB recommended one thing and we recommended something else. For instance, we were fairly involved in a number of issues relating to DEA's budget and were able to reverse some decisions with regard to the State Department. A Presidential decision was made as far as the number of slots allocated to the State Department's narcotic program. The President made a decision one way, on the recommendation of OMB.

I went to the President and appealed that and he reversed his decision, based on our representation to him. So, I think that we have been effective in other areas where we felt that it was something of major concern to us, and we were willing to really push on it.

Again, you know, I think that we made a determination either rightfully or wrongly that this was not the issue to go to the mat on, the prevention issue, but I think when we wanted to the opportunity was there for us to do so, and will be in the future.

Mr. DOGOLOFF. And part of that decision was based on internal assurances that the current level of effort could be maintained given the increases in research that the level both in demonstrations and in prevention could be maintained through the year. Now, that may have changed since then, but we felt fairly comfortable with it at that time.

Mr. ROGERS. I do not know how you could, if he refused the money, and you only had your moneys for research. I think it might be well for us to have for the record your comment on each of these issues: what input the Domestic Council or ODAP has in the budget process, if there was effort by the Domestic Council or ODAP to bring any reversal of the OMB decision contrary to the departmental recommendation and to the Institute's recommendation, and, the Domestic Council's judgment as to the importance of the prevention programs.

Now, let me ask you this, are you monitoring what is happening in treatment programs? In other words, how much money is being spent in evaluation of treatment programs, should there be changes in the treatment programs, should some of them not be funded, do you make that judgment or at what level is it made?

Mr. DOGOLOFF. We primarily leave that judgment at the Institute level, although we monitor and certainly keep current with treatment evaluation outcome studies, and those sorts of things.

Mr. ROGERS. Are any treatment programs unfunded, as a result of a poor evaluation?

Mr. DOGOLOFF. There is a program within the Institute which does an audit and program review function for treatment programs. I know through the years funding has been reduced to programs where they were not performing and there have been instances over the last several years where programs have actually been closed. I do not think that is a usual occurrence.

Mr. ROGERS. Should we do more on that in relating it to evaluation and changing the funding where we are not having any results?

Mr. DOGOLOFF. Well, the evaluation that has been done has not been done on a program-by-program basis. Most of the treatment outcome evaluation—that is what happens to the patients in treatment relative to certain kinds of behavioral patterns like criminality and employment and reduction in drug use, and so forth, on programwide basis.

I do not think there is a program in existence which looks at that on a grant-by-grant basis and says how——

Mr. ROGERS. How can you really evaluate it if it is not on a grant-by-grant basis?

Mr. DOGOLOFF. I think the way evaluation is done on a grant-by-grant basis is to look at how the money is being used and whether treatment is provided in accordance with the standards relating to Federal funding rather than an outcome basis.

Mr. ROGERS. The evaluation then does not consider whether we are being successful or not?

Mr. DOGOLOFF. That is correct.

Mr. ROGERS. Shouldn't it?

Mr. DOGOLOFF. Only in the past year are we getting our first results of the 4-year followup study. We have some basic parameters as to what might be reasonably expected from a treatment experience. So, up until this point, we have only been able to establish what we might consider a baseline. I think now that we have that baseline it is appropriate to go back and to see how different treatment programs come out relative to what the norm is.

And then, I would think it is quite reasonable to make funding decisions based on failure of programs to fall within certain given tolerances.

Mr. ROGERS. Would it be possible to get a memorandum explaining that, and when this evaluation will be made, and when action might be taken as a result of those evaluations?

[The following information was received for the record:]

MEMORANDUM REGARDING TREATMENT OUTCOME EVALUATIONS

THE WHITE HOUSE

WASHINGTON

April 27, 1978

Dear Bob:

The Federal Government has invested considerable resources over the last decade toward the development of a nationwide system for the care and treatment of drug abusers. It is timely to inquire about the operation of this system and to provide objective criteria for determining the effectiveness of treatment programs.

The ultimate purpose of designing and implementing such an action plan would be to assist those responsible for the various facets of the nationwide treatment system to make individual decisions regarding the continuation and/or needed improvements in programs that make up this system.

The type of criteria that come to mind could encompass client outcome, client utilization, community impact, cost of treatment services, social cost of drug abuse, number and types of professionals providing the services, program management reviews, accreditation and licensing requirements, and State plans and statewide services contracts. In addition, NIDA has a number of independent and interlocking data systems which can be examined to provide a general framework within which treatment service units may be examined to determine whether or not they should continue to be funded. These data systems--Client Oriented Data Acquisition Process (CODAP), National Drug Abuse Treatment Utilization Survey (NDATUS), Drug Abuse Warning Network (DAWN), Treatment Outcome Prospective Study (TOPS), the National Surveys, Drug Abuse Reporting Program (DARP), and others--designed for developing improved management and fiscal responsibility, could yield objective criteria of treatment program performance.

Perhaps most importantly, the criteria ultimately developed could be applied across the data bank that NIDA possesses on outcome in treatment and post treatment which spans several years. Merging the two and assessing how programs across the country have performed with different types of clients could evolve "reasonable expectations". Applying these statistical expectations to existing treatment clinics could assess how well they were doing on the criteria relative to nationwide performance.

If a program fell below the standard of "reasonable expectations", it could signal the need for a review of the program. The standards should not be taken as hard and fast gauges of a program's merit since many other factors outside of the program's control can also affect client outcome. A review board must bear in mind the importance of such external influences as unemployment, community unrest, proximity to the Mexican border, racial problems, and sudden cases of drug supply, among others. The statistical expectations, however, would provide a valuable management tool and a warning system for the need for more in-depth review.

Please provide us with a timetable and milestones for this project within the next 30 days. I would like to target a completion date toward the end of 1978 and am available to assist in any way you might wish.

Sincerely,



Lee I. Dogoloff
Deputy Special Assistant
to the President

Robert L. DuPont, M.D.
Director
National Institute on Drug Abuse
Parklawn Building, Room 10-05
5600 Fishers Lane
Rockville, MD 20857

cc: D. Meltzer
G. Klerman

Dr. BOURNE. Mr. Chairman.

Mr. ROGERS. Yes, sir.

Dr. BOURNE. I think there is a reasonable limit below which our office should not go in evaluating programs on some of these broader issues.

Mr. ROGERS. Yes.

Dr. BOURNE. Certainly we should be involved in evaluating major policy decisions, as far as where money goes and treatment, and one of the decisions that we have made in the last year was that more money should go into programs other than those dealing with heroin.

When it gets down to evaluating the success of individual programs or individual grants, I am not sure that it is appropriate for our office to be involved in that.

Mr. ROGERS. I would think you are probably correct. As I understood you were having some evaluation system worked out to see that that is brought about. From what I understand, we have no real good evaluation presently in being.

And, I presume that is a very heavy policy decision, as to whether individual projects should be evaluated and if they do not receive a positive evaluation, whether they should have their funding denied.

Mr. DOGOLOFF. I think we could provide something to you which could set out—

Mr. ROGERS. I realize the agency may do some of the evaluation, but I would think its a decision you might be involved in. That is all. That is what I understand.

Mr. DOGOLOFF. Yes.

Mr. ROGERS. What is the extent of the abuse in the armed services?

Mr. DOGOLOFF. I do not know that we have a good, a real knowledge of what the use is. I think it differs from place to place, depending on availability. At some places it is considerably higher than others.

One of the things we are concerned about is that there can be more urinalysis going on for detection. As you know a couple of years ago the congressional decision was made to dispense with random urinalysis. This has made it very difficult to get a good understanding of the nature and extent of use. In Europe, for example a typical unit commander may have two to three tests that he can perform per day on his unit and he has not had the flexibility always to, for example after a weekend, perform a unit sweep where he can have urinalysis performed on everyone.

We have discussed this with the military, and there are programs going on particularly in Europe to increase the number of tests, and to take advantage, of portable testing equipment on site, so that they do not have to send it to a centralized laboratory.

In fact, today, there is a meeting of three military component commanders for Europe and someone from DOD in Washington to look at the whole program.

And General Haig has been very interested in this and has taken it quite seriously and communicated it down to the command level. So we feel certain that within the next 6 months there are going to be some real changes and improvements in that whole system.

Mr. ROGERS. Would you let us know what is being done there?

Mr. DOGOLOFF. Surely.

[The following material was received for the record:]

EXTENT AND NATURE OF DRUG ABUSE IN THE MILITARY

The following information was provided to us by the Department of Defense:

"We no longer have the epidemic proportions of drug abuse of the Vietnam days. We do consider that we still have a serious problem, and generally the seriousness of the problem is proportional to the availability of drugs in a given area and inversely proportional to the effective attention given the problem by the local commander.

"In general, the military drug abusing population is the young enlisted man or woman in the 18-25 year old age grouping. They seem to use drugs primarily for recreational purposes while off duty. The most prevalent drugs of abuse, after alcohol, are the cannabis derivatives, marihuana, hashish and hashish oil. Thereafter, the drug of choice depends on the availability in the part of the world in which the servicemember is stationed. For example, in Korea it is barbiturates; and in Germany, it is heroin and methaqualone that the Army finds available, and amphetamines on Air Force bases. In the United States we see nearly everything; use of LSD seems to be down, but use of PCP and cannabis seem to be on the rise.

"There is more abuse among the military outside the United States. We find that when young servicemembers are moved to a location where drugs are cheap and readily available, where they are lonely and separated from the restraints of their families, where living conditions are different--and sometimes dangerous, the conditions for drug abuse are present, and in many locations outside the U.S., these are the conditions that prevail.

"The ability to assess trends is hampered by the loss of random urinalysis, so we're not as knowledgeable as we'd like to be. However, we expect that a survey effort which DoD recently initiated will give definitive data on trends, by service and by geographic area, from 1971 through the present.

"DoD's assessment now is this: the problem is still serious enough to cause DoD and the military services continuing concern and effort. The more dangerous drug use is holding steady or slowly declining, while cannabis use may be on the increase."

What is being done about drug abuse in the military?

The following information was provided to us by the Department of Defense:

"First, there is an effort to prevent drug abuse through education. Supervisors are trained to recognize the signs of drug use. In addition, each service conducts drug education classes which emphasize DoD and service policy regarding drug abuse and which stresses alternatives to substance abuse. The education effort also addresses the non-user, urging that if he has a friend who is abusing drugs to attempt to turn him from his drug abusing habit.

"The identified abuser is referred for medical evaluation to determine whether he is drug dependent. If he is dependent, he is detoxified, processed for discharge and transferred to a VA hospital for a minimum of 15 days. It should be noted that the Navy, unlike the other services, continues to operate a residential treatment facility for the drug dependent abuser. Those identified in the Navy as drug dependent are referred to the Navy Drug Rehabilitation Center in Miramar, California. After completing treatment and rehabilitation at the Center, they are re-evaluated for suitability.

"Individuals found not to be drug dependent are referred to the local service drug abuse office where a staff of trained para-professionals determine a non-residential treatment and rehabilitation regimen which ordinarily consists of both individual and group counseling for a period of time appropriate to the degree and type of drug involvement. Aftercare may last for up to one year. If the abuser successfully completes rehabilitation, he is restored to duty. If the rehabilitation effort proves unsuccessful, the abuser may be discharged.

"If the abuser is identified through means other than exemption or urinalysis, he is entitled to treatment but he is not exempt from disciplinary action or other administrative actions should either be deemed appropriate.

"A number of steps have been taken to improve the drug abuse control effort in the military services:

. A survey instrument is being developed which will be used to measure the prevalence of abuse.

. A contract has been awarded to develop an index of drug abuse trends.

. A portable test kit for detection of drugs in the urine has been field tested and is now in the very early stages of being introduced into the field for use.

. A monograph entitled, Diagnosis and Evaluation of the Drug Abusing Patient has been distributed to all military physicians.

. A Supervisors Handbook on Substance Abuse has been distributed service-wide to encourage and guide supervisors in dealing with drug and alcohol abusers.

. A pamphlet on phencyclidine has been distributed to alert all military members to the dangers of this widely available drug.

. There is a continuing trend toward less costly non-residential treatment for drug and alcohol abusers."

More specifically, what is being done about drug abuse among U.S. military personnel in Europe?

The following information was provided to us by the Department of Defense:

"Actions taken by USEUCOM and the three component commands (USAREUR, USNAVEUR and USAFE) in response to General Haig's guidance regarding drug abuse control.

. General Haig directed that a seminar be convened of component representatives to:

a. Develop a coordinated special drug abuse report to the CINCEUR (General Haig).

b. Establish standard USEUCOM procedures for the testing, identification and reporting of drug abusers.

c. Draft a USEUCOM Directive that will promulgate agreed upon positions.

. Each component command was then directed to provide an assessment of the extent, seriousness and trends in drug abuse over the past year.

a. Extent--report identification by urinalysis testing to include target population, number of urinalyses, number of positives and rate per 1,000.

b. Seriousness--report number of drug related incidents, deaths, overdose situations, hospitalizations, Serious Incident Reports, court-martials, discharges, estimate of man years lost, estimate of dollar cost, and also comment on impact of drug abuse on combat readiness.

c. Trends--report changes in types of drug abused and positive identifications.

. Each component was also asked to provide the following additional information.

a. Number of drug abusers identified and method by which identified.

b. Programs to treat abusers.

c. Criterion whereby individuals are admitted to rehabilitation facilities.

" d. Programs to eliminate abusers and traffickers.

e. A narrative describing legal problems, time involved and program areas.

. The component representatives met, reformatted the information required above into a standard form and prepared the forwarding documentation to transmit the information to the CINCEUR.

. The component representatives also prepared a draft USEUCOM Directive which included the following provisions:

a. Directed the components to purchase a limited number of portable urinalysis test kits and designated the areas in which they would be located.

b. Designated the target population for drug abuse urinalysis at those servicemembers 25 years old and younger.

c. Set a minimum for urinalysis testing of 25% of the target population per year.

d. Promulgated a standard set of definitions.

e. Promulgated a standard set of report formats and required a standard set of quarterly reports from each of the components.

. Finally, USEUCOM initiated the action to have the draft USEUCOM Directive staffed through the component commands."

Mr. ROGERS. And the extent of the problem as it is estimated?

Dr. BOURNE. Both Mr. Dogoloff and myself have been to Europe in the past year and have spent time with our military command there. One of these studies that we are providing to you is a study of this issue in the military and since Mr. Dogoloff's recent trip a month ago, we have written to Secretary Brown and asked for a complete review of the internal procedures in the Department of Defense.

And, they have responded to us orally that they are undergoing a extensive internal reevaluation themselves of their current procedures. And, I think we are concerned particularly in Western Europe that there is an undetected problem developing and we want to get on top of that before it assumes major proportions and I think that we are moving to head off the problem before it becomes much worse.

Mr. ROGERS. If you would let us know of something on that.

Now, do you have any input as to what the State Department is doing in working out arrangements with other nations, particularly in trying to stop the production of illicit drugs?

Dr. BOURNE. This was one of the specific mandates in the original ODAP legislation and we have been very actively involved in that. We have directly participated in some of those activities and have worked very closely with the State Department.

Mr. ROGERS. Does the State Department lead a committee on that?

Dr. BOURNE. Yes.

Mr. ROGERS. Is this the Committee on International Affairs that you have set up on the Strategy Council?

Dr. BOURNE. Yes.

Mr. ROGERS. How often does that committee meet?

Dr. BOURNE. Well, it has had a couple of meetings although it was set up to deal with some specific problems. Most of the other international activities are dealt with between the principals, or just directly between our office and the State Department.

Mr. ROGERS. Would you give us a rundown on what has happened in the international field, for the record?

Dr. BOURNE. OK.

Mr. ROGERS. And what has been the effort, if any, to try to get Peru and Bolivia to destroy excess production of the cocoa plant?

[The following material was received for the record:]

INTERNATIONAL FIELD ACTIVITY OVER THE LAST YEAR

International initiatives and cooperation are essential if we are to reduce the harm caused by drug abuse around the world. Opium and coca, the plant sources of heroin and cocaine, are both grown outside of the U.S. Effective control of the supply of these two drugs in the United States can best be achieved by interdiction at, or as near to the point of cultivation as possible.

We must work with the involved countries to attack illicit supplies of drugs at every point in the distribution chain--from the fields, to the processing laboratories, to the transshipment, and finally, the sales networks. We have found that cooperative efforts with foreign countries to attack the distribution networks as close to the source of the drugs as possible and to help in the development of substitute sources of income for the local population are most productive. These efforts take advantage of additional border and law enforcement forces for interdiction and concentrate on long-term development to reduce cultivation. In addition, the health and social consequences of drug abuse are felt worldwide with drug abuse occurring more and more among the indigenous populations in previously exclusively producer countries. And, cooperation is needed to share treatment and prevention expertise. Awareness of their own endemic drug problem and appreciation of our willingness to help them solve that problem has helped dramatically to increase the motivation of many countries to deal aggressively with drug trafficking.

ODAP's international role involved bilateral diplomatic negotiations and missions, working with the United Nations and other international organizations, working with the international financial institutions, and working toward ratification of the Psychotropics Convention.

1. Diplomatic Negotiations and Mission

Last year the Director of ODAP visited Mexico on two occasions to discuss the impressive drug control efforts being undertaken in that country, particularly the opium poppy eradication program, and to ensure that the close working relationships existing between our two governments are continued and where possible increased. The Director met twice with President Lopez-Michelsen of Colombia to discuss the drug problems affecting both his country and the United States. The Director also travelled to the Golden Triangle--visiting Burma, Thailand and Laos--to assess the situation and conduct high-level negotiations.

* The Deputy Director of ODAP participated in the South American Study Mission conducted by the House Select Committee on Narcotics Abuse and Control in August 1977. The group held meetings with officials of executive departments of individual governments throughout South America, with special emphasis on the coca growing countries of Bolivia and Peru, and the cocaine trafficking networks through Ecuador and Colombia. This joint mission, conducted by members of both the Executive and Legislative Branches of the U.S. Government, demonstrated the solidarity of the U.S. commitment to working with other nations to reduce the cultivation of and trafficking in illicit drugs, and increased the impact of U.S. negotiations.

Members of the ODAP staff conducted missions to Afghanistan and Pakistan, another area where opium poppies are grown illicitly. As a result of this trip, the U.S. Government policy was formulated requiring the insertion of anti-narcotics cultivation provisions in loans approved by the international financial institutions. Following this policy initiative, the World Bank has decided that it will seek to obtain assurances from countries that are prospective recipients of rural development assistance that they will take all reasonable actions to prevent the cultivation of opium or coca in project areas. This policy statement is consonant with President Carter's August 2 Message to the Congress on Drug Abuse in which he instructed U.S. representatives to Regional Development Banks to encourage well-designed rural development and income substitution programs aimed at reducing the production of dangerous drugs. The World Bank's view also complements similar covenants the U.S. Agency for International Development (AID) inserted in an agreement for an irrigation project in Afghanistan which bans poppy cultivation in the project area. In late 1977, the Asian Development Bank also agreed to include an anti-opium clause in a loan agreement with Afghanistan. All of these measures reflect positive management decisions aimed at tying rural development assistance to efforts to prevent the cultivation of opium and coca.

In addition, ODAP conducted missions to Singapore, Burma and Thailand to discuss regional narcotics issues. Particular emphasis was placed on diplomatic and other actions necessary to interdict the heroin processing and trafficking activities which take place in the Burma/Thailand border area.

Finally, the Deputy Director of ODAP travelled to four western European countries including the Federal Republic of Germany to conduct high level discussions on the narcotics abuse problem. The problem is particularly severe in the Federal Republic of Germany, where there are reports of dramatic increases in heroin overdose deaths, coupled with high street heroin availability and purity.

2. Work with the United Nations and Other International Organizations

Over the past year ODAP has worked closely with the United Nations Fund for Drug Abuse Control and the U.N. Commission on Narcotic Drugs to coordinate U.S. policy decisions that will affect member countries. In addition, the United Nations Development project has funded drug-related projects in Hong Kong, Israel and India.

Because of the growing concerns of nations that have been previously untouched by drug abuse among their citizens, the Office of Drug Abuse Policy made every effort, through the United Nations system, to help these countries learn from our past experiences. The Director of ODAP, in a meeting with the Secretary-General, raised the issue of narcotic abuse and discussed some strategies for the future.

Last February, at the 27th Session of the U.N. Commission on Narcotic Drugs, the Director of ODAP delivered a message from President Carter. That message, the first ever from a head of government, stressed Carter's concern over the global problem of drug abuse and urged international cooperation to eliminate the world supply of illicit drugs.

The ODAP also worked with the international financial institutions, in particular the World Bank, to encourage them to consider giving priority attention to rural development and income substitution projects in areas which now grow illicit drugs, as well as ensuring that assistance is not used to foster the growth of crops like opium and coca. These projects are long-range general development projects with a broader aim than merely crop substitution. Consideration is given to cultural, as well as economic issues and work is done in close cooperation with the host country and the international financial institution.

3. Psychotropic Convention

The ratification of the Convention on Psychotropic Substances has been a high priority for this Administration. In February 1971, the United States signed the Convention on Psychotropic Substances. This treaty places under international control a number of drugs such as amphetamines, barbiturates and hallucinogens which are widely abused throughout the world. Full implementation of this Convention would permit international bodies to monitor the manufacture and trade of these drugs and reduce their diversion into illicit channels. Although the United States was one of the main supporters of adoption of this treaty, after seven years we are still not a party to it.

Our international drug control efforts are hampered by not having ratified this treaty. It has validly been charged that we are willing to demand that governments of narcotics producing countries should adhere to the relevant treaties while we are unwilling to be bound by a Convention on controlling those drugs manufactured within our own borders. ODAP worked closely with Members of Congress, and legislation implementing the Convention has been introduced in both Houses. We are hopeful of prompt passage

Dr. BOURNE. Well, just two weeks ago, Miss Falco from the State Department and Mr. Arellano, the Deputy Assistant Secretary for Latin America, went to Ecuador, met with various people in the Government there and with people in our Embassy and also with Lieutenant Admiral Pevada, the head of state in Peru, and talked with him about dealing with the problem, the whole range of problems, from corruption to production to trafficking and so forth.

Following their return, at my suggestion, President Carter has sent a letter to Admiral Pevada expressing his concern and asking for his follow-up. The Ecuadorians have been quite responsible over the last year.

They have passed a law setting much stricter penalties on traffic, they have been going after traffickers and trying to eliminate cultivation.

Mr. DOGOLOFF. I visited both Peru and Bolivia this summer and was impressed with the commitment on the parts of both governments to move—it is a long-range issue, we recognize that. But, for example, in Bolivia they are now undergoing a process of identifying where all the coca fields are.

Mr. ROGERS. Are we helping in that effort?

Mr. DOGOLOFF. Yes; we are, through the State Department.

Mr. ROGERS. In what way?

Mr. DOGOLOFF. We are providing some funding to look at that, and to look at ways of tightening up on the licensing procedure. But, first you have to find out where the fields are, which is now being completed. Then with licensure and destruction of excess crop production and gradually shrinking the available coca crops, and at the same time getting involved more and more in basic agricultural development to help the farmers find substitute crops for coca but it is a very difficult issue.

The areas of growth are sometimes quite remote and fairly primitive, and there is, of course, the indigenuous chewing of coca which goes back for a long time. There are some problems and we are certainly involved in working toward resolving them.

Mr. ROGERS. Could you state for us in a memo what you feel the progress has been in a more precise way? It would be helpful.

[The following information was received for the record:]

NARCOTICS CONTROL PROGRAM IN PERU DURING THE LAST YEAR

The most significant development in the past year was the enactment of a new narcotics law which is indicative of the Peruvian Government's enhanced commitment to control drug trafficking and consumption.

The law, promulgated in early March, prohibits plantings of coca in new areas; establishes state control over all varieties of coca, poppies and cannabis and reserves for the state (represented by ENACO, the Government coca enterprise) the cultivation of coca, once private and cooperative production has been eradicated or substituted; provides that coca-producing lands not occupied and managed by their owners be immediately expropriated as part of the agrarian reform; reserves exclusively for ENACO the internal and external commercialization of coca leaves; and establishes stricter controls over the import and production of drugs and their prescription.

Individual owners of ten hectares or more of land legally dedicated exclusively or partially to coca must proceed, within two years of date of the new law, to substitute or eradicate coca plants or risk losing their land. Owners of legal 5-10 hectare plots have three years to substitute, eradicate or lose their plots to landless peasants. The timetable for substitution/eradication on legal plots smaller than five hectares (the overwhelming majority) is to be determined by the Ministry of Agriculture and Food. The Guardia Civil is charged with enforcement of these substitution/eradication provisions of the law. Coca producers cooperating with the Peruvian Government in eradicating coca plantings will have priority in state-sponsored colonization schemes.

In addition, the law revamps the sentences and other sanctions for drug-related offenses and establishes a multi-sector Minister-level committee for drug control.

The Peruvian Investigations Police (PIP), which has primary responsibility for narcotics law enforcement, has accelerated efforts at suppressing cocaine trafficking, and has been chalking up an impressive record in recent months. In March, it announced that it had broken up two important cocaine trafficking organizations with international connections. Fifteen arrests were made. One of the bands, over the last

seven months, had produced 210 kilos of high quality cocaine for shipment directly to the U.S. The second network provided cocaine paste for shipment to Colombia. In the preceding weeks, several hundred kilos of cocaine paste were seized and 120 arrests made.

In view of the greater commitment on the part of the Peruvian Government, we are embarking on an expanded bilateral cooperative program, the thrust of which is set forth in our FY 1979 Congressional presentation.

BOLIVIAN NARCOTICS CONTROL AREA IN THE LAST YEAR

During the past twelve months, the Government of Bolivia has carried out a registry of all coca growers in the country. On November 30, it banned new plantings of coca on unregistered lands. This is the first step toward an eventual phased reduction of existing cultivation down to the level required for traditional use by indigenous coca chewers. To offset the impact on coca farmers by the reduction, work is proceeding on a basic rural development program in the major growing areas--the Yungas and Chapare.

Bolivia has also expanded its territorial enforcement coverage to 17 locations of the country. The principal areas of La Paz, Oruro, Cochabamba, and Santa Cruz now have well manned and equipped narcotics units.

The Bolivian Government's enforcement agency (the DNSP) has been devoting its attention to major traffickers and to laboratories processing the coca, rather than petty offenders. A number of laboratories have been seized. Operations carried out in October and November 1977 alone prevented a potential 125 kilos of cocaine from entering the international market.

The Bolivians have made progress in speeding up the trial process on a number of Americans, many of whom are young, petty offenders, who had been in jail for up to three years.

The Bolivian Government has been active in the international area. Narcotics cooperation agreements were signed with neighboring states such as Brazil and Chile, and others are contemplated.

Mr. ROGERS. What about the effort or your concern with the shipment of narcotics into the country? Do you have liaison with the Drug Enforcement agencies, and would you comment on that?

Dr. BOURNE. I think it is one of the clear conclusions over the last several years that the most vulnerable point in the chain coming to this country is the beginning where the substances are being grown. The nearer one gets to our own borders, the harder it is to intercept drug substances. Even though the overwhelming majority of heroin coming into this country is coming from Mexico, our success rate in identifying at the border and stopping at the border heroin as it comes across, is extremely low.

Indeed, the Customs and DEA are the first to admit this, that it is extraordinarily difficult, given the length of the border, its proximity to the United States, and the flow of people across with legitimate business, to interdict heroin at all.

We have worked very closely with Customs in their effort to plan new strategies for dealing with the problem along the Mexican border. Our border management study recommended some substantial changes in the original structure, including the creation of a new border management agency.

I think there is also a feeling in Customs that they need a major shift in the future direction of that agency away from just hiring new personnel and more toward development of new technology.

The future of Customs is tied to the development of sophisticated technology that can detect drugs in shipments of legitimate material on persons as they come across, and in a variety of other ways that does not just require additional personnel. I think this is an important part of an overall strategy, and we have worked very closely not only in the development of the strategies in those individual agencies, but to overcome some of the traditional interagency problems and coordination, and I think that we are further along now than at any time in recent years in terms of achieving cooperation between the various agencies operating on the border.

Mr. ROGERS. It is my understanding the Coast Guard often has difficulty in getting clearance through the State Department in an instance where a ship may be outside U.S. jurisdictional waters.

Dr. BOURNE. Yes.

Mr. ROGERS. Where the ship has been followed, and its activity would indicate that it is engaged in drug activities. Coast Guard then must clear with State, State then tries to get an agreement with the Nation from which the ship is registered, to board the ship. I understand sometimes it takes 2, 3, or 4 days, and it is too late.

Is there any reason why we could not negotiate directly with those countries from where most of this material is coming, and I understand maybe there are about 10?

Dr. BOURNE. Well, we are doing——

Mr. ROGERS. Particularly cocaine and marihuana?

Dr. BOURNE. Well, we are doing that, and in addition this committee chaired by the State Department was set up primarily to deal with this specific problem. It is not as simple as it might seem, because there are apparently some rather complex issues of international law that have to be dealt with.

Mr. ROGERS. But what I was thinking, why couldn't we make the necessary arrangements so that the consulate here could give approval if the facts presented to them by the State Department would warrant such approval, which then oviate the time-consuming necessity to go back to the nation involved. Why couldn't it be done through their Embassy or consulate here?

Dr. BOURNE. Yes; it can be. On one of the trips I made to Colombia, we arranged for them to put somebody, a law enforcement person in their Embassy specifically to serve in a liaison role on the drug issue. That is the kind of thing that this person would do, that we wanted them to help us deal with major trafficking networks to expedite or extradition or other transfer of information and to deal exactly with issues like this.

One of the problems is that that person is not yet in place. But, we now have a very high level of cooperation with the Colombians, and I think that that kind of thing is going to be worked out ultimately.

Mr. ROGERS. Yes. Would you let us know which countries have been asked to do this, and what progress has been made?

[The following information was received for the record:]

COUNTRIES APPROACHED TO COOPERATE IN COAST GUARD INTERDICTION PROJECTS
AND STATUS OF THESE COOPERATIVE EFFORTS

The following information was provided by the Department of State:

"The Coast Guard informs us that the following countries have been approached: Honduras, Venezuela, Panama, United Kingdom, Canada, Mexico, Bahamas, Cuba, Colombia, Haiti, Jamaica, Netherlands, Belize, Trinidad and Tobago, and Guyana.

"Most issues have been handled on an ad hoc basis which we do not consider the best approach. Therefore, steps are underway to work toward regular arrangements with countries of registry of ships most often found carrying narcotics cargo. An interagency committee, including the Coast Guard, has been established to coordinate these activities. We expect that by September a team of legal experts will open discussions with at least three countries; Colombia, Panama and Honduras."

Mr. ROGERS. It is my understanding Panama has made that arrangement, that the Ambassador here is giving that approval, rather than having to go back through Panama.

It seems to me that might be a good pattern to try and get established.

It is my understanding now that heroin is being researched as a possible aid to those who are terminally ill, at Sloan-Kettering. Are you monitoring this?

Dr. BOURNE. Yes; there is a committee established with our Institute at NIH and stimulating additional research requests and monitoring those that are ongoing with regard to the use of heroin and marihuana.

Mr. ROGERS. Is there any problem in the law on that?

Dr. BOURNE. There actually is not from our standpoint. It is more a question of facilitating the bureaucratic process that there has been a move to legislatively reschedule heroin. I am not sure that is any great advantage at this point.

Mr. ROGERS. Yes; are there any investigational studies on heroin maintenance programs?

Dr. BOURNE. No; we have taken the position, some time ago, that if somebody wished to submit an application for a study of heroin

maintenance that that study would be given the same kind of consideration as any other research application, but in fact no such application has been submitted as of the last time I talked to Dr. DuPont about it.

I felt that perhaps it was an appropriate course to pursue at a time when it looked like we were going to be unable to deal with the flow of heroin into the country and we were going to be swamped from illegal heroin. We have achieved what I regard as extraordinary success in the last year in dealing with the heroin problem, and I would be very, very reluctant at this stage to see us even look at the heroin maintenance issue.

I just do not think it is appropriate at a time when we seem to be drying up rather successfully the sources of illicit heroin. Overdose deaths have gone down, the number of new people getting addicted has gone down, and I think we need to get people out of the patient pool, not keep it in the heroin maintenance.

Mr. ROGERS. So, we are cutting down the amount of heroin coming in from Mexico?

Dr. BOURNE. At the moment; yes. It is a situation where it can reverse itself very rapidly, but at the moment we seem to be extremely successful. It is being aided this year by the fact that there has been a severe drought in north Mexico that seems to further help prevent the cultivation.

Mr. ROGERS. Has there been a shift to Southeast Asia to pick up these decreases?

Dr. BOURNE. Well, there is still a lot coming out of Southeast Asia. The bulk of it is being absorbed in Europe. The amount coming to this country appears to be something in the region of 15 to 20 percent of our total heroin being from other than Mexico.

On the other hand, this is 15 to 20 percent of a smaller total than we were dealing with previously. There may be some beginning indications that there is an increase in the actual amount of heroin coming from Asia, but we have at the same time been quite successful in Asia in reducing the amount of heroin coming out of the Global Triangle Area.

The problem is it is so large that even though we have reduced it, it is still a significant problem. Just today, this week, I think there are some new activities underway in that area of the world to really increase our effort to deal with the problem, and I am quite optimistic at the progress that we are making.

Mr. DOGLOFF. We share that concern in learning from past experience, that sometimes when you are successful on one front, there is another that moves in, and we have asked the intelligence community, composed of a number of different agencies, to begin as of 30 or 60 days ago to really get at this very question to see how much we know and how we can monitor to make sure that Southeast Asian or other white heroin does not replace that from Mexico.

We are very sensitive to the need to continue to monitor. Even though things look very good right now, we are not relaxed about it in any way.

Mr. ROGERS. What about the Middle East?

Dr. BOURNE. There is no indication that any sizeable amount of Middle East origin heroin coming into this country, but again that is an area that is of concern.

Mr. ROGERS. What is the situation with Turkey?

Dr. BOURNE. There have been several Turkish nationalists arrested in the last several months involved in heroin trafficking. We have no evidence to suggest that the heroin itself was of Turkish origin, although we cannot absolutely prove that it is not.

But our belief is that even though there are Turkish nationalists involved, the heroin is coming from some place other than Turkey. That remains a constant problem, constant threat, and we are trying to carefully monitor the potential sources of a new problem development so that we can deal with it as rapidly as possible.

Mr. ROGERS. What about marihuana? Why can't we be more successful in stopping marihuana if we have so much success in heroin?

Dr. BOURNE. For a variety of reasons. One is that the marihuana grows in this country very widely. A substantial portion of that consumed is grown domestically. There is an increasing level of cultural condonation of marihuana that makes it substantially harder to monitor and control traffic than with heroin.

The amounts being cultivated overseas are really enormous. In Colombia at the present time, by their estimates, there are 60,000 acres under cultivation of marihuana, and this is a matter of—

Mr. ROGERS. Where is that?

Dr. BOURNE. In Colombia—Guahira region of Colombia. 60,000 acres is a very substantial amount of marihuana. The Colombian Government is very eager to do something about it. There are substantial quantities being grown in Mexico. The Mexican Government is actively spraying with herbicides.

We are just dealing with a large problem in terms of volume of marihuana and its acceptance here. Although we have made a distinction between marihuana and heroin at the user level, we feel that internationally marihuana poses just as big a threat as heroin in the vast amount of money involved in trafficking.

Mr. ROGERS. Thank you very much for your presence here.

Next, I believe, we will have a panel of State drug abuse programs. Dr. William Butynski is president of the Alcohol and Drug Abuse Problems of North America; and William Griglak is chairman of the Committee on Legislation, National Association of State Drug Abuse Programs. He is accompanied by Carl Akins, executive director.

We welcome you to the committee. We are pleased to have you with us, and I believe Dr. Butynski will start.

STATEMENTS OF WILLIAM BUTYNSKI, PH.D., PRESIDENT, ALCOHOL AND DRUG ABUSE PROBLEMS ASSOCIATION OF NORTH AMERICA, ACCOMPANIED BY AUGUSTUS L. HEWLETT, EXECUTIVE DIRECTOR; AND WILLIAM GRIZLAK, CHAIRMAN, LEGISLATIVE COMMITTEE, NATIONAL ASSOCIATION OF STATE DRUG ABUSE PROGRAM COORDINATORS, ACCOMPANIED BY CARL AKINS, EXECUTIVE DIRECTOR

Dr. BUTYNSKI. Thank you, Mr. Chairman. I would like to introduce the executive director of the Alcohol and Drug Abuse Problems Association, who is also here, Augustus L. Hewlett.

Mr. ROGERS. Yes; we welcome you.

Dr. BUTYNSKI. Thank you. Mr. Chairman and members of the committee, I am pleased to bring testimony in support of your bill, H.R. 11660, to extend the much needed and productive programs of the National Institute on Drug Abuse. I am also pleased to share the witness stand with friends representing our sister organization, the National Association of State Drug Abuse Program Coordinators—NASDAPC.

The Alcohol and Drug Problems Association of North America—ADPA—which I am privileged to represent, is exclusively involved in the full range of professional interest concerning issues related to both alcohol and other drugs. Members include public programs at all levels of government; private programs, voluntary, profit and nonprofit; and individuals with professional interest in the field.

NASDAPC is a close ally with whom ADPA shares many common interests and concerns. Most of the State alcohol and drug abuse authorities are members of both organizations. It is fitting, therefore, that we are together this morning.

Whereas we would much prefer to see Congress enact a full 3-year extension of NIDA this year and of NIAAA in 1979, we understand your reasons for proceeding with a 1-year extension of NIDA. We understand that this is being done at a time when the phase out of the Office of Drug Abuse Policy and other actions resulting from the President's Reorganization Plan No. 1 create some uncertainties on the part of Congress concerning coordination and policy direction of all Federal drug abuse programming.

We also understand that a 1-year renewal of NIDA is not being done now with the idea that NIDA and NIAAA should be merged next year. This, in our view, would be premature.

It is essential that the categorical delivery systems of NIDA and NIAAA be maintained for the foreseeable future until the alcohol and drug abuse fields can compete with the other, more well established and accepted health and human need problem areas at the State and local levels for an equitable share of public funds.

The maintenance of integrity of NIDA and NIAAA as identifiable focal points for national policy direction within ADAMHA is most important. Policy and procedural differences in the Institutes' handling of grants and contracts, data collection, et cetera, however, need to be resolved so that the increasing number of combined alcohol and drug abuse agencies which deal with both Institutes will not continue to be burdened with two such disparate systems.

There is now close communication between the Institutes and much has been done in recent months to rectify some of these differences. They are to be commended for this and encouraged to continue in this direction.

We are particularly pleased that you have included separate authorizations for the prevention and treatment programs. This will clearly result in raising the priority level for prevention efforts, a most timely and positive position.

Monetarily, we feel that the levels you propose are realistic, although we would prefer to see more in each category.

Since we are in agreement with Mr. Griglak's testimony which addresses specific provisions of H.R. 11660, I shall not belabor the points he will make with duplicate testimony.

Finally, Mr. Chairman, our organization is well aware and appreciative of your own keen understanding of the complex issues in this field and your dynamic leadership and that of your distinguished colleagues on the committee in securing sound Federal programming for this field. Thank you for this, and thank you for the opportunity to be heard today.

Mr. ROGERS. Thank you, Dr. Butynski. As you say, we are keeping the two separate and apart, although we hope they will work together as often as possible and certainly in research. Mr. Griglak.

STATEMENT OF WILLIAM GRIGLAK

Mr. GRIGLAK. Mr. Chairman and members of the committee, I am William Griglak, representing today the National Association of State Drug Abuse Program Coordinators as chairperson of the legislative committee.

As Dr. Butynski said, it is fitting that we appear together since we are concerned as two national groups with the same issues. It is also fitting that we appear before you to show the cooperation of the field since NASDAPC at its annual meeting next month will amend its bylaws and corporate charter to include in its membership the directors of State alcohol agencies as well as drug agencies.

The testimony which I am presenting today follows the principles approved by the membership at its annual meeting last summer [see p. 142]. This testimony was specifically approved by the board of directors of NASDAPC at its meeting last week in Seattle.

There are several points in the proposed legislation which NASDAPC feels will contribute to strengthen the field of drug abuse. I feel it is important that there be continued separate focal points for the problems of alcohol abuse and drug abuse at the Federal level.

A 1-year extension for NIDA now and consideration of the 3-year extended authorization for both NIDA and NIAAA next year is an acceptable way to proceed. NASDAPC is requesting that you foster further cooperation by amending the proposed legislation to allow July 31 to be the common due date for submission of State plans. This, we feel, can be accomplished by simply amending the first sentence of section 409(e) of the current statute to read "July 31" instead of "July 15."

Mr. ROGERS. I might say we see no problem in doing that.

Mr. GRIGLAK. NASDAPC shares your concern, Mr. Chairman, stated when you introduced this legislation about the continuing need for cooperation for all Federal activities in the drug abuse prevention area. With the demise of the Office of Drug Abuse Policy, the burden is now squarely on the administration to live up to the

promises it has made to Congress and to the public that Federal efforts in the field will not diminish and that there will continue a high level of attention so that the many Federal agencies involved will work together in a complementary fashion rather than at cross purposes.

This 1-year extension will allow the administration time to show its good faith and will give us all an opportunity to see that such cooperation continues. If it does not, it will be incumbent upon us to take steps to assure that the extension to be considered next year provides again the coordination that is required.

NASDAPC is especially pleased that the proposed legislation provides for greater emphasis on prevention and demonstration programming by NIDA. The addition of the 1-year extension proposed in section 3(c) of the bill is an example of the increased congressional emphasis on prevention.

Likewise, the provision in this legislation for separate authorization for treatment programs and for all other programs funded under section 410 of the Drug Abuse Office and Treatment Act makes clear the intention of Congress both that treatment programs be adequately funded and that prevention and demonstration efforts also be adequately funded.

NASDAPC is also pleased that the Congress is once again affirming a commitment to the Federal-State partnership which has developed by recommending that the formula grant funds in section 409 be authorized for an additional year.

NASDAPC notes that the \$45 million level proposed is greater than the administration's request for \$40 million and thus believes that there is room for adequate growth. However, NASDAPC also notes that the \$45 million authorization level has now remained static for 5 years. If the Federal-State partnership is to continue to develop and adequate attention be paid to the problems of drug abuse, this level will also need to be increased when the authorizations are considered next year for a 3-year period.

Mr. Chairman, in light of the exchange earlier today with the Director of the National Institute of Drug Abuse concerning involvement of the sub-State planning process and the input of local units of government in that process, we would note that the current National Institute of Drug Abuse State planning guidelines encourage such involvement, and I would like to quote from their guidelines:

These States with unusually large urban areas should include in the sub-State planning a full description of how the elected officials of these metropolitan areas have contributed to the development of the State plan. It is the hope that we would involve such officials based upon the recommendations of NIDA.

The amendments in this bill which will allow the report on marijuana and health every 2 years rather than annually are also a positive step.

Finally, Mr. Chairman, the requirement that the Secretary of HEW make a report to the Congress each year to replace that report which now must be presented by the Director of ODAP is also appropriate. This change reflects the administration's desire to transfer some of the coordination responsibilities to the Cabinet level and it serves

notice to the administration that Congress does expect such coordination to continue. The requirement that the Secretary of HEW present to Congress an annual report will provide you and the public the sort of information which should be available.

Mr. Chairman, the National Association of State Drug Abuse Program Coordinators commends you for your leadership in the area of chemical dependency concerns and issues and we thank you for the opportunity of appearing before this committee.

[Mr. Griglak's prepared statement follows:]

National Association of State Drug Abuse Program CoordinatorsSuite 900 • 1612 K Street, N.W. • Washington, D. C. 20006 • (202) 659-7832

April 10, 1978

TESTIMONY OF WILLIAM GRIGLAK
ASSISTANT COMMISSIONER FOR ADDICTION SERVICES
STATE OF INDIANA, DEPT. OF MENTAL HEALTH
CHAIRPERSON, NASDAPC LEGISLATIVE COMMITTEE,
TO THE HOUSE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
INTERSTATE AND FOREIGN COMMERCE COMMITTEE

Mr. Chairman and Members of the Committee:

I am William Griglak, representing today the National Association of State Drug Abuse Program Coordinators as Chairperson of the Legislative Committee. I am pleased to be joining my colleague, Dr. William Butynski, President of the Alcohol and Drug Problems Association (ADPA), testifying in support of H.R. 11660, the bill introduced on March 20, 1978 to amend the Drug Abuse Office and Treatment Act of 1972.

It is fitting that I join Dr. Butynski in appearing before you since he was formerly a member of NASDAPC when he served as director of the State of Vermont Alcohol and Drug Abuse Agency. It is also fitting since NASDAPC at its annual meeting next month will amend its bylaws and corporate charter to include in its membership the directors of state alcohol agencies as well as drug agencies. The testimony which I am presenting today follows the lines approved by the membership at its annual meeting last summer and was specifically approved by the Board of Directors at its meeting last week in Seattle.

There are several points in the proposed legislation which NASDAPC feels will contribute to strengthening the field of drug abuse. While I join Dr. Butynski in affirming our support of a one year extension at this time, I too feel that it is important that there be continued separate focal points for the problems of alcohol abuse and of drug abuse at the federal level. A one year extension for NIDA now and

consideration of three year extended authorizations for both NIDA and NIAAA next year is thus an acceptable way to proceed. NIDA and NIAAA are now co-ordinating their efforts in many endeavors, which is appropriate. NASDAPC is requesting that you foster further co-operation by amending the proposed legislation to allow July 31 to be the common due date for submission of State plans. This can be accomplished by amending the first sentence of Section 409 (e) of the current statute to read "July 31" instead of "July 15." However, NASDAPC feels there is continued need for two separate institutes.

NASDAPC shares the concern which Chairman Rogers mentioned when introducing the legislation about the continuing need for coordination for all federal activities in the drug abuse prevention area. With the demise of the Office of Drug Abuse Policy, the burden is now squarely on the Administration to live up to the promises it has made to Congress and to the public that federal efforts in the field will not diminish and that there will continue to be high level attention paid so that the many federal agencies involved work together in a complementary fashion rather than at cross purposes. This one year extension will allow the Administration time to show its good faith and will give all of us an opportunity to see that such coordination continues. If it does not, it will be incumbent upon us to take steps to assure that the extension to be considered next year provides again the coordination that is required. The studies which the Office of Drug Abuse Policy has completed represent an important beginning. The momentum must not be lost and we expect to be monitoring what is done in the coming months which will assure the States that the momentum continues.

NASDAPC is especially pleased that the proposed legislation provides for greater emphasis on prevention and demonstration programming by NIDA. The addition of the one word "prevention," proposed in Section 3 (c) of the bill, is an example of the increased Congressional emphasis on prevention.

Likewise, the provision in this legislation for separate authorizations for treatment programs and for all other programs funded under Section 410 of the Drug Abuse Office and Treatment Act makes clear the intention of Congress both that treatment programs be adequately funded and that prevention and demonstration efforts also be adequately funded. NASDAPC joins in this desire for adequate funding for the entire spectrum of drug abuse prevention, treatment, and rehabilitation efforts. The amounts which your legislation proposes are large enough to allow the Appropriations Subcommittee to make the necessary additions in the Administration's proposed levels for FY 79.

NASDAPC is also pleased that the Congress is once again affirming a commitment to the Federal-State partnership which has developed by recommending that the formula grant funds in Section 409 be authorized for an additional year. NASDAPC notes that the \$45 million level proposed is greater than the Administration's request for \$40 million and thus believes that there is room for adequate growth. However, NASDAPC also notes that the \$45 million authorization level has now remained static for five years. If the Federal-State partnership is to continue to develop and adequate attention be paid to the problems of drug abuse, this level will also need to be increased when the authorizations are considered next year for a three year period. Such increases will be needed simply to keep pace with the increase in costs due to inflation.

There have been some requests from others that substantive changes be made in Section 409 because of allegations that their special interests are not being served by the current planning process. NASDAPC opposes any such changes in the Section 409 language without a thorough study by the committee of all relevant issues. In this broad area of planning relationships, NASDAPC also wishes to go on record as opposing any changes in the Health Planning Act, P.L. 93-641, which would not continue equal status for alcohol, drug abuse, and mental health.

The amendments in this bill which will allow the report on marijuana and health every two years rather than annually, are also positive ones. As Congressman Rogers noted in his remarks when this bill was introduced, the research findings on marijuana have not changed so rapidly that a report on an annual basis is required. Marijuana, however, remains a drug abuse problem which deserves attention and to require a report every two years is fitting.

The requirement that the Secretary of HEW make a report to the Congress each year to replace that report which now must be presented by the Director of ODAP is also appropriate. This change reflects the Administration's desire to transfer some of the coordination responsibilities to the cabinet level and it serves notice to the Administration that Congress does expect such coordination to continue. The requirement that the Secretary of HEW present to Congress an annual report will provide to you and the public the sort of information which should be available.

I thank you for your time.

Mr. ROGERS. Thank you. Let me ask if you could give us for the record an indication of what you think about the prevention programs, demonstration programs, the effectiveness of prevention programs, what appear to be the most effective avenues, also some evaluation of our treatment programs if you could let us have that for the record.

Mr. GRIGLAK. Yes, Mr. Chairman. [See attachment A, p. 147.]

Mr. ROGERS. Mr. Hewlett.

Mr. HEWLETT. Yes. Am I to respond to that question?

Mr. ROGERS. No; if you had anything to say.

Mr. HEWLETT. No; I think Mr. Akins and I are both here to respond to any questions.

Mr. ROGERS. Mr. Akins.

Mr. AKINS. I do have those figures you requested this morning, which I will present for the record. [See attachment B, p. 150.] I was incorrect on one item which is important; 25 percent of the section 409 formula grant funds are now being expended for prevention in education rather than the 15 to 18 which I gave you this morning. That amount is about \$10 million a year.

[The following material was received for the record:]

Attachment A

National Association of State Drug Abuse Program Coordinators

Suite 900 • 1612 K Street, N.W. • Washington, D. C. 20006 • (202) 659-7632

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Congressman Paul G. Rogers
 Room 2407
 Rayburn House Office Building
 Washington, D.C. 20515

Dear Congressman Rogers:

Thank you again for the opportunity which you afforded NASDAPC to testify before the Subcommittee on Health and the Environment on April 10, 1978 concerning the renewal of the Drug Abuse Office and Treatment Act of 1972. At that time you asked for our thoughts on some additional matters. I have provided the information to you in the form of this letter. In addition, a copy of this letter will be furnished to the clerk of the Committee.

You first asked what we thought about prevention and demonstration programs. NASDAPC has always been a strong supporter of prevention programs and has been disappointed in the past that NIDA has not had sufficient funding to provide funding for prevention efforts throughout the country. Your legislation will provide a beginning base for such funding. Prevention programs are obviously difficult ones to design and to have a truly national effort will be difficult, since the most effective programs appear to be those that are based strongly in the community in which they operate.

There are several recent efforts of NIDA which NASDAPC applauds. NIDA has developed, through a contractor, a prevention planning workbook for states to use and plans to get a contract to implement the use of that workbook. In addition, NIDA is choosing states to develop models for evaluation of prevention programs and will be letting contracts for at least half the states to have prevention coordinators. All these are positive steps. A representative of NASDAPC recently testified before the House Select Committee on Narcotics and Drug Abuse Control concerning prevention, and I have enclosed a copy of his testimony to further explain the Association's position concerning prevention.

The demonstration programs of NIDA, especially those funded through its Services Research Branch, cover many and wide-ranging topics. Many of them have been quite strong, have disseminated valuable information, and have developed valuable models which States and treatment programs have been able to adapt for their own use. It is crucial that these demonstration efforts be continued so that knowledge is developed in a way that can be used by those in the front lines. The Association strongly supports additional funding for demonstration efforts. The Association is also quite pleased that NIDA has recently sought a contract to evaluate its dissemination of demonstration information. The results which NIDA gets from that effort will enable it to better target its demonstration efforts.

NIDA has also adopted the practice of each year announcing the general areas in which it is looking for demonstration projects. The announcement of these areas is disseminated to all the States and they are asked to respond with suggestions for additional areas and changes or sharper focus. This effort on the part of NIDA shows its commitment to building a strong system for demonstration projects and thus NASDAPC wants to see demonstration efforts continued.

You also asked for information concerning the effectiveness of prevention and what appeared to be the most effective programs. It is probable that such information will be best developed through the current NIDA efforts mentioned above. At present, it is easy to cite limited examples of small programs which a community thinks are effective. Limited hard data is available, however, concerning the general effectiveness of prevention programs. In this regard NIDA's evaluation of its own media efforts is also to be commended. It is NASDAPC's understanding that NIDA's future media efforts will be based on the evaluation of the current year's effort. Thus, evaluation appears to be an important component of all prevention efforts. It will probably be a period of several years before the field can adequately say what are the most effective methods of prevention.

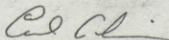
Finally, you asked about evaluation of treatment programs. Treatment programs can be, and are, evaluated in two different ways. To date, most treatment programs have been evaluated in process terms. That is, they are examined, monitored and evaluated periodically to determine how well they are doing the various tasks which they say they do. Client records are examined to see that they are complete and financial records are examined. Minutes of program Boards are read to assure that there is Board input and that they are not simply staff-run operations. These sorts of process evaluations are on-going and continuous ones. They are carried out increasingly by the Single State Agencies under the NIDA state-wide services contracts. It is the Association's belief that this process monitoring and evaluation has greatly strengthened the operations of treatment programs throughout the country.

The second type of evaluation is outcome evaluation. It is in a much more limited stage of development. Through the work of Dr. Sol Sells and others at Texas Christian University, a solid data base has been developed which enables expectations to be set for various types of clients in various types of programs. With these bases it is possible to have norms against which to measure other programs. In addition, it will be possible to try to do follow-up studies on clients who have left other treatment programs and thus begin the long, arduous process of strengthening the weaker programs and assuring that the stronger ones get even stronger--and in those instances when it is necessary, closing or defunding programs which are not effective.

As you are aware, follow-up studies which trace clients after they have left programs are very expensive. To date, neither the State nor the Federal Government have the resources for extensive follow-up in all programs. It is doubtful that such resources will be available in the near future. Thus, the Association expects the general focus to continue to be on process evaluation and that there will be limited outcome studies that will provide information which others can use to strengthen all programs.

I hope that this information is sufficient and answers the questions which you asked. If there are other questions, please do not hesitate to contact either any member of the Association or its staff.

Sincerely,



Carl Akins
Executive Director

cc: Clerk
Robert L. DuPont

National Association of State Drug Abuse Program Coordinators

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State Spending of Section 409 Formula Grant Funds By Category (Percentage of Total 409 Allocation)

	Reported Expenditures <u>in FY 77</u>	Projected Expenditures <u>for FY 78</u>
Treatment	43%	42%
Prevention/ Education	25%	25%
Planning/ Coordination	13%	13%
Administration	6%	4%
Training	5%	4%
Research/ Evaluation	5%	6%
Criminal Justice	2%	4%
Management/ Information	<u>1%</u>	<u>2%</u>
	100%	100%

April 10, 1978

Mr. ROGERS. I see. Thank you so much, and we probably will be in touch with you as we proceed. Thank you for being here and for your patience sitting with the committee.

We now have Dr. David C. Lewis, chairman of the Boston Coordinating Council on Drug Abuse, on behalf of the National Association for City Drug Coordination. We welcome you, Dr. Lewis.

STATEMENT OF DAVID C. LEWIS, M.D., CHAIRMAN, PLANNING COMMITTEE, NATIONAL ASSOCIATION FOR CITY DRUG COORDINATION, ACCOMPANIED BY PETER GOLDBERG, CHAIRMAN, ADVISORY COMMITTEE

Dr. LEWIS. Thank you, Mr. Chairman. I brought with me Mr. Peter Goldberg, who is chairman of our advisory committee.

Mr. ROGERS. Mr. Goldberg, we welcome you.

Mr. GOLDBERG. Thank you.

Mr. ROGERS. I might say the Speaker called to say he welcomes you to the Congress and is pleased to have you with us.

Dr. LEWIS. Thank you. I appreciate the opportunity to appear before you today on behalf of our member cities to offer you our perspectives on the reauthorization of the Drug Abuse Office and Treatment Act of 1972, Public Law 92-255. I prefer not to read the written testimony but I would like to highlight a couple of points from it [see p. 154].

Mr. ROGERS. It will be made part of the record.

Dr. LEWIS. My concerns for these issues stem, in part, from my experience of the past 5 years as chairman of the city of Boston Coordinating Council on Drug Abuse, an advisory board, whose members serve by mayoral appointment.

By way of background information, we are forming a National Association for City Drug Coordination to more effectively represent the concerns of large cities and their elected officials regarding urban problems of drug abuse.

The member cities of the National Association for City Drug Coordination believe that there must be more sustained and systematic urban government input into the State planning system and in Federal drug policymaking.

It is in the large cities of this country where we have the greatest social costs of drug addiction. Congress and the administration created a State-oriented system in 1972 for the planning and ultimately the delivery of drug treatment and prevention services. The cities and their elected representatives were bypassed altogether.

Significantly, the results have been to give a disproportionately strong influence to State governments, where the needs of city populations and particularly minority populations are least represented.

The current system maintains State planning for use of Federal dollars without requiring local government input. This has effectively eliminated the ability cities with major drug problems from responding directly to the substance abuse needs of their residents.

The Association endorses a 1-year reauthorization of this act, providing next year the Congress undertakes an even more comprehen-

sive review of the system established for planning and delivery of drug treatment and prevention services.

As examples of consequent planning and funding problems, I offer the experiences of Philadelphia, New Orleans and Gary.

Philadelphia provides us with an example of the potential benefits which can be derived when the city and State work in concert. But, as we point out in our written testimony, there is nothing which guarantees or institutionalizes the stability of this relationship other than the good will of the people involved.

In New Orleans the working relationship with the State has not been stable. Previously the State allowed the city considerable discretion in the planning and implementation process. Then, when the State withdrew its support and its 409 funds, the city of New Orleans had no administrative or legal recourse by which to contest the decision.

Gary, Ind., provides the most difficult situation. In Gary, where the State previously declined any assistance to the city methadone program, the city was left with no choice but to seek direct funding from NIDA. NIDA is now pressuring the Gary program to become part of a statewide services contract. Although the State will control the program, it still wants Gary to provide the matching funds.

Incidentally, in the present situation, where the State should be providing technical assistance to that program, I am told it does not do so.

It is important to assert that cities are not looking to dismantle the process which Congress established in the act. The cities are aware that the system was never intended to shut them out of the planning and programming roles and that, with appropriate legislative amendment, the current intergovernmental imbalance can be redressed and city residents can be more efficiently and appropriately provided the services they need.

For the record, I would supply the committee with two documents; one is a copy of the Philadelphia plan [see p. 165], which really indicates the way in which the city and the State have worked together to establish a drug abuse treatment plan. The other is a chapter by Peter Goldberg which explores the concepts and issues we are addressing. That chapter is entitled "The Role of the City in Responding to the Problems of Drug Abuse." (Rehabilitation Aspects of Drug Dependence, edited by Arnold Schecter, CRC Press, Cleveland, 1977.)

Mr. ROGERS. Without objection, it will be made part of the record.

Dr. LEWIS. Specifically, with respect to the issues before you today, we would urge you to consider adjustments to the State planning process, within section 409, to:

First, insure that large cities with the most severe concentrations of drug and drug-related problems be guaranteed the opportunity to review and approve the relevant sections of the State drug abuse plan;

Second, cities with major concentrations of drug abuse and which have demonstrated capabilities should be recognized as the authorities to develop and coordinate their sub-State component of the State plan; and

Third, provide that such cities receive planning funds for drug abuse to carry out functions similar to those assigned the State governments under section 409.

With respect to section 410, we question the utility of relying exclusively upon statewide services contracts. Such reliance further aggravates the problems which larger cities face with respect to section 409. We are asking the committee to review the manner in which the administration has applied the legislative intent of section 410(c) (1), "In carrying out this section, the Secretary shall . . . not give precedence . . . to State agencies over local agencies." I would suggest that this intent has not been followed.

Again I stress that the cities have no interest in dismantling the present system. If 409 capability for cities were provided, 410 funds could be logically distributed as block grants to local government for efficient administration and program implementation.

An effective result of local 409 planning would be to stimulate local initiative and encourage cities with the need and capability to commit additional local resources to develop comprehensive programs.

It is also important to note that not all cities will have the need or capability to respond to drug problems in the manner outlined.

Support for development of local planning and administrative capabilities to address the urban drug problems grow increasingly important with the growth of planning activities under Public Law 93-641. Not only must cities relate to designated SSA's but they must also begin to relate to their local health systems agencies—HSA's.

As a physician involved in some public health planning in the cities of Boston and Providence, I very much appreciate the emergence of these advisory groups and the role they are going to play in the future in all of our activities in the health field.

If the experience of the Boston metropolitan HSA is a model, it may well be the staff of the substance abuse office of local city government who takes the initiative to guide the HSA's in planning and setting priorities for drug and drug-related services.

In conclusion, the National Association for City Drug Coordination will seek to more aggressively offer an urban perspective to Congress, to the administration, and to the SSA's and their organization. We appreciate your request for our testimony so soon after our formation. I and our member cities interpret that as a positive sign of encouragement and we look forward to the development of a strong, mutually beneficial working relationship on addiction issues.

Cities join with many of you on this committee who are deeply worried about the responsiveness of the existing Federal-State system to those areas and populations in greatest need. We hope to lend the political powers of local elected officials and their appointed representatives to your own authority to seek changes in the current system so it becomes more responsive to the needs and concerns of our urban citizens. It would be a mistake for the current disenfranchisement of the cities to continue for it weakens the response of all levels of government to drug abuse problems.

Thank you for this opportunity to appear before you on behalf of the National Association for City Drug Coordination.

[Testimony resumes on p. 218.]

[Dr. Lewis' prepared statement and attachments follow:]

NATIONAL ASSOCIATION FOR CITY DRUG COORDINATION

PLANNING COMMITTEE

Chairperson:

David C. Lewis, M.D.
Chairperson, City of Boston
Coordinating Council on Drug Abuse

Members:

Megan De Camp
Phoenix, Arizona
Barbara Gross
Gary, Indiana
Douglas Morgan
Newark, New Jersey
Claude Reese
New Orleans, Louisiana
John Riggan
Philadelphia, Pennsylvania
Paul Robinson
Boston, Massachusetts
Michael Thompson
Los Angeles, California

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STATEMENT BY

DAVID C. LEWIS, M.D.

**Chairperson
Planning Committee**

NATIONAL ASSOCIATION FOR CITY DRUG COORDINATION

on

REAUTHORIZATION OF THE DRUG ABUSE OFFICE AND TREATMENT ACT OF 1972

and

Related Issues

Before the

**INTERSTATE AND FOREIGN COMMERCE COMMITTEE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
U.S. HOUSE OF REPRESENTATIVES**

April 10, 1978

Good afternoon, Mr. Chairman and members of the Committee.

I am Dr. David C. Lewis, Chairperson of the Planning Committee of the National Association for City Drug Coordination.

I appreciate the opportunity to appear before you today on behalf of our member cities, to offer you an urban perspective on the re-authorization of the Drug Abuse Office and Treatment Act of 1972.

The National Association for City Drug Coordination is a consortium of city drug program coordinators representing mayors of cities with major drug-involved populations. The goals of the Association will include:

- 1) To present to the public and to the federal government the appropriate role for cities with large concentrations of drug abuse;
- 2) To establish more beneficial governmental relationships in the drug planning process, including the relationship of cities to federal policymaking and cities to state planning in the drug, including alcohol, abuse and health fields;
- 3) To initiate policy development and appropriate funding perspectives for the problem of urban drug abuse;
- 4) To identify those cities with the highest concentrations of drug, alcohol or similar substance abuse problems, and to support initiatives to ameliorate drug abuse in those areas;
- 5) To investigate, analyze and disseminate information to the public concerning the causes, effects, and societal consequences of the misuse of drugs, including alcohol, in cities; and

- 6) To provide technical assistance, training and research support to member cities.

Mayoral support of these goals was affirmed last week in Seattle, Washington at the 1978 National Drug Abuse Conference by Richard G. Hatcher, Mayor of Gary, Indiana, when he stated in his plenary address, "I, and my fellow mayors, expect this Association to be an organization upon which we can rely to effectively document, present and pursue the urban perspective in drug abuse planning, policymaking and services delivery on a sustained and systematic basis."

This perspective has been missing under the state-oriented drug abuse planning and funding mechanism as presently administered by the National Institute on Drug Abuse (NIDA), and yet it is in the large cities where the social costs of drug addiction are most intense.

Although Congress created the legislative framework for the Single State Agency (SSA) planning and funding mechanism employed by NIDA, it noted in findings to both P.L. 92-255 and the 1976 re-authorization, P.L. 94-237, that local drug concerns must be taken into account because of the impact of drug abuse on our country's urban centers. It is appropriate, during this re-authorization hearing on H.R. 11660, to review the application of the Act and to query whether this legislative intent has been effectively addressed. The Association suggests that it has not.

The current system maintains state planning, for use of federal dollars, without requiring local government input. This has effectively eliminated the ability of cities, with major drug problems, to respond directly to the substance abuse needs of their residents.

The National Association for City Drug Coordination endorses a one year re-authorization of this Act, provided that next year the Congress undertakes an even more comprehensive review of the system established for the planning and delivery of drug treatment and prevention services.

As examples of planning and funding problems resulting from the present system, I offer the Committee the experiences of Philadelphia, New Orleans, and Gary.

I begin with Philadelphia, because it is an example of positive results when a state and its major city work cooperatively.

The City of Philadelphia established its Coordinating Office for Drug and Alcohol Programs (CODAAP) in 1972, several months before Pennsylvania formed its SSA. [This is not an unusual instance. Many large cities established coordinating and management offices for drug abuse prior to their states' development of an SSA.]

CODAAP used non-categorical City, State and LEAA revenues to develop a capable, professional staff of 60 people. As LEAA revenues diminished, the City's support of CODAAP has increased to a commitment of \$2 million. This staff has managed the development of a comprehensive treatment and rehabilitation network currently serving 7,500 addiction clients at any given time, through 45 community-based and community-operated facilities. It is a well-managed responsive system that has demonstrated the capability to meet new needs and the changing demands for treatment.

CODAAP has also developed a pro-active planning process in order to move the Philadelphia treatment network in responsible directions. This planning process involves all levels of treatment, from clients up through the Mayor's appointed Executive Commission. CODAAP's planning process is to be contrasted with the State-mandated 409 planning process, which barely scratches the surface of the planning necessary to properly manage a diverse

system. CODAAP has been required to spend City monies to surround the 409 process with a stronger planning and implementation structure.

The Pennsylvania-Philadelphia planning and management partnership has several strengths and weaknesses. It has allowed the City to develop a comprehensive system that NIDA Director Dr. Robert DuPont has described as "a unique model". However, this partnership is entirely based upon a fortunate set of circumstances early in its development, and some solid interpersonal relationships between the State and the City bureaucracies which have evolved into an informal delegation of local planning responsibility.

None of the local control granted to Philadelphia is based on P.L. 92-255. It is entirely dependent upon the personal relationships currently extant. At any time, those relationships could deteriorate, upon a change in City or State administrations or with a new policy direction at NIDA.

The City of Philadelphia is confident that the \$2,000,000 it contributes to substance abuse is well-managed. This confidence is vulnerable to abuse, due to the tenuousness of State-City political realities.

New Orleans, through its Bureau of Drug Affairs, at one stage received 409 planning funds directly from the State of Louisiana. This funding pass-through enabled the City to develop, and to an extent implement, programming on a cooperative basis with the State, assured that the needs of its citizens were being served. This process was never insitutionalized, however, and because it was based on an informal arrangement the City had no recourse when the State decided arbitrarily to change its modus operandi and retain federal 409 funds for sole use of its SSA. This effectively complicated the City's capability to plan for its residents and to ensure that their urban priorities would be addressed by a rural-oriented State administration.

The City of Gary, Indiana, offers perhaps the most distressing example of the problems which can occur under the present interpretation of the Act. NIDA has been pressuring Gary to enter into a statewide services contract with the Indiana SSA, effectively turning the operation of the City's methadone program over to the State. Gary's reluctance to surrender its current direct-funded status is understandable, insofar as the State's capricious refusal to fund the program in the past was the basis for the City's assumption of operational responsibility in the first place. Rather than see the program close, depriving patients of needed services, the City contracted directly with NIDA for operational funds, and has since developed a comprehensive program with linkages to vocational and other supportive services to promote effective rehabilitation. Indeed, not only has the SSA demonstrated no commitment in the past to provide quality services to meet the City's needs, but it has consistently refused to provide the program with technical assistance while the City contracts directly with NIDA.

Member cities would never have joined the National Association for City Drug Coordination if there had been satisfactory, and guaranteed, local government participation in the planning process. It is important to assert that cities are not looking to dismantle the process for which Congress provided in the Act. They are aware that the system was never intended to shut the cities out of the planning and programming roles, and that with appropriate legislative amendment, the current intergovernmental imbalance can be redressed, and city residents can be more efficiently and appropriately provided the services they need.

Individual mayors and their drug coordinators have regularly and often expressed their discontent with the non-urban approach to addiction demonstrated by recent Administrations, and have discussed these problem

areas since 1973 with the Special Action Office for Drug Abuse Prevention (SAODAP), NIDA, and the Office for Drug Abuse Policy (ODAP). [The Committee has been provided some of this documentation.]

As an example of these mayoral concerns, I would cite a resolution adopted by the National Black Caucus of Local Elected Officials in 1974, which was introduced by Mayor Richard G. Hatcher: "The problems of drug abuse have disproportionately affected large numbers of black and spanish-speaking Americans; these minority populations tend to be most under-represented at the state level where drug abuse policies are being increasingly formulated, thus creating a large discrepancy between those most afflicted by the problems, and those establishing the policies and procedures to solve the problems."

This same view was echoed in 1975 when, after a two-year study, the Mayors' Task Force on Drug Abuse Treatment and Prevention of the National League of Cities and U. S. Conference of Mayors released its final report. Today, it is as pertinent as it was in 1974 and 1975.

Cities have made the attempt to restore a local, urban role in making and implementing drug policy through administrative recourse, and this process has been unproductive. States continue to demonstrate a near-unanimous reluctance to directly involve city governments in the planning process. State political realities have effectively produced a non-urban drug services orientation, which serves to ignore or avoid the states' major problem sites, their large cities. Administrative appeal over the past several years has failed to increase the states' sensitivity to this issue.

The seeming intransigence of the federal and state governments to make needed and appropriate modifications to the current system now leads

the National Association for City Drug Coordination to select the legislative process as likely to be most responsive and productive for resolution of the major problems related to fair distribution of state-managed (409 and 410) funds, state support for city coordination of drug and drug-related services, cash flow, and state and federal recognition of local needs and priorities. We know, from the examples of New Orleans and Gary, and others, that state and city cooperation cannot be left to a spirit of good will. Instead, we are asking the Congress to legislatively mandate that cities, with concentrations of drug abuse, have the major voice in setting priorities and managing funds and services within their jurisdictions.

Specifically, with respect to the issues before you today, we would urge the Committee to consider adjustments to the state planning process, within Section 409, to:

- 1) ensure that large cities with the most severe concentrations of drug and drug-related problems be guaranteed the opportunity to review and approve the relevant sections of the state drug abuse plan;
- 2) recognize cities, with major concentrations of drug abuse and with the demonstrated capability, as the authorities to develop and coordinate their substate component of the state plan; and
- 3) provide that such cities receive planning funds for drug abuse to carry out functions similar to those assigned the state governments under Section 409.

With respect to Section 410, we question the utility of relying exclusively upon statewide services contracts. Such reliance further aggravates the problems which larger cities face with respect to Section 409.

We are asking the Committee to review the manner in which the Administration has applied the legislative intent of Section 410 (c) (1), viz, "In carrying out this section, the Secretary shall . . . not give precedence . . . to State agencies over local agencies." The Association would suggest that this has not been the case.

Again, I stress that the cities have no interest in dismantling the present system. If 409 capability were provided for cities, 410 funds could be logically distributed as block grants to local government for efficient administration and program implementation.

An effective result of local 409 planning would be to stimulate local initiative and encourage cities, with the need and capability, to commit additional local resources to develop comprehensive programs.

It is important to note that not all cities will have the need, or capability, to respond to drug problems in the manner outlined. The Association is interested in providing the option for such local government activity.

To proceed with developing city drug coordination and services management capability, Congress might wish to reflect upon the \$5 million in Section 409 funds which it has regularly authorized, but never appropriated. (Authorizations have frequently been \$45 million, while only \$40 million have been given to the states for planning.) That additional \$5 million would be well-expended if provided to those cities meeting the need/capability criteria, to assist development of their planning, administrative and services coordination potential, much as Philadelphia has used its funds.

If the cities which demonstrate the greatest drug and drug-related problems are welcomed into systematic and sustained planning and programming partnership with the federal and state governments, it is reasonable to expect that state funding and priorities will be revised to focus on critical urban

needs. It is true, as Peter Goldberg remarks in a chapter in Rehabilitation Aspects of Drug Dependence, that "federal funds routed to local governments have an entirely different complexion than federal funds that come direct to municipal governments." [I submit that chapter, "The Role of the City in Responding to the Problems of Drug Abuse", to the Committee for its record.]

Support for development of local planning and administrative capabilities to address the urban drug problems grow increasingly important with the expansion of planning activities under P.L. 93-641 (the Health Planning and Resources Development Act of 1974). Not only must cities relate to designated SSAs, but they must also begin to interface with their local Health Systems Agencies (HSAs). If the experience of the metropolitan Boston HSA is a model, it may well be the professional addiction coordinator of local government who must guide the HSAs in planning and setting priorities for drug and drug-related services.

In conclusion, the National Association for City Drug Coordination will seek to more aggressively offer an urban perspective to Congress, to the Administration, and to the SSAs and their organization. We appreciate the Committee's request for our testimony so soon after our formation. I, and our member cities, interpret that as a positive sign of encouragement, and we look forward to the development of a strong, mutually beneficial working relationship on addiction issues. Cities join with the members of this Committee who are deeply worried about the responsiveness of the existing federal-state system to those areas, and populations, in greatest need. We hope to lend the political powers of local elected officials, and their appointed representatives, to your own authority to seek changes in the

current system so it becomes more responsive to the needs and concerns of our urban citizens.

It would be a mistake for the current disenfranchisement of the cities to continue, for it weakens the effective response of all levels of government to drug abuse problems. In dealing with the problems we face where we live, it is our cities which must play a primary role.

Thank you for this opportunity to appear before you on behalf of the National Association for City Drug Coordination.



City of Philadelphia

Drug & Alcohol Abuse Treatment & Prevention

Coordinating Office for
Drug and Alcohol Abuse Programs

1976-1977

Frank L. Rizzo, Mayor
Hillel S. Levinson, Managing Director
John E. Riggan, Executive Director

Mayor's Drug and Alcohol Executive Commission Members

Mrs. Hattie Kalish, Chairperson
Chief Inspector John Craig, Vice Chairperson
Mrs. Margie Brown, Secretary
Mr. Irving W. Shandler, Past Chairperson
Mr. Salvatore J. Barbuto
Sister Marie Madeleine Boyd
Benjamin Cuebas
James C. Guiffre, M.D.
Arthur W. Howe III
Philip D. Jackson
Jonathan A. Kane, Esquire
Ms. Barbara Stetto
Mr. Arnold D. Wallace, Sr.
Ms. Joan M. Watts
Mr. John E. Riggan, Executive Director

(The Commission, mandated by GCDAA Regulation 271, is a provider and consumer group appointed by the Mayor. It provides policy guidance to CODAAP and approves the Annual Plan.)



City of Philadelphia
Frank L. Rizzo, Mayor

Mayor's Drug and Alcohol
Executive Commission
1405 Locust Street, 2nd floor
Philadelphia, Pennsylvania 19102

January 1, 1978

Mayor Frank L. Rizzo
City of Philadelphia
Room 215 City Hall
Philadelphia, Pennsylvania 19107

Dear Mayor Rizzo:

On behalf of the Mayor's Commission on Drug and Alcohol Abuse, it is a pleasure to forward the Annual Report for 1976 and 1977.

This has been a year of significant accomplishment and change for drug and alcohol treatment and prevention. A major shift in emphasis has taken place in the coordination of the treatment and prevention system as the focus of efforts has shifted from expansion to improvement of the existing system. The support of these efforts by the City, in terms of both resources and commitment, has been exemplary. The continued support of City government as well as State and Federal governments will be needed to attain the levels of achievement we earnestly envision.

The Commission would like to express its sincere appreciation to you, and your administration, and to the City Council for the strong support given in 1976 and 1977. We are pleased to share with you our sense of pride in the record of achievement Philadelphia has earned in this field, and to share our sense of hope for the future.

Sincerely yours,

John E. Riggan
Executive Director



City of Philadelphia
Frank L. Rizzo, Mayor

Mayor's Drug and Alcohol
Executive Commission
1405 Locust Street, 2nd floor
Philadelphia, Pennsylvania 19102

January 1, 1978

Mr. Gary F. Jensen
Executive Director
Governor's Council on
Drug and Alcohol Abuse
2101 North Front Street
Harrisburg, Pennsylvania 17110

Dear Mr. Jensen:

On behalf of the Mayor's Executive Commission on Drug and Alcohol Abuse, and pursuant to State Regulation, it is my pleasure to forward the Annual Report for 1976 and 1977.

As the Report indicates, the drug and alcohol treatment and prevention system in Philadelphia charted important new directions in 1976 and 1977. As the growth of resources has slowed and the rate of expansion has dropped, increased emphasis has been placed on improvement of the existing system. Increased efforts have been made in management, planning, data collection and analysis, evaluation, and resource allocation. Central to the success of those efforts has been the cooperative relationship of State and City governments. We acknowledge with gratitude the enlightened leadership of the Governor's Council on Drug and Alcohol Abuse and the firm support of the Legislature in this concerted effort to improve an important public service.

As we look to the future we anticipate that our chances for success depend heavily on a continuation of the spirit of partnership between State and City governments that has been so productive in the past.

Sincerely,

A handwritten signature in dark ink, appearing to read "J. E. Riggan".

John E. Riggan
Executive Director

Overview

The human race has used and abused drugs for thousands of years. At no time in history, however, has substance abuse been a greater problem than it is right now.

In the United States a legal drug, ethyl alcohol, kills more people than does any other cause of death except heart disease and cancer. Ten million Americans are alcoholics or problem drinkers. Alcohol figures in most highway accidents and in most violent crimes.

Illicit drugs constitute a smaller problem but a more highly charged one. Perhaps 500,000 Americans are addicted to heroin. Yet public attention is riveted to heroin abuse, because it suggests criminal, deviant activity; because heroin addiction reflects societal malaise, and contributes to it.

Substance abuse in Philadelphia involves at least 154,000 persons with drinking problems, 15,000 to 20,000 heroin addicts, and 30,000 to 50,000 citizens engaged in the use of other illicit substances. To the extent that limited budgets permit, services are offered to these citizens through a variety of public and private programs. These programs once operated independently of one another. In 1972 the Mayor of Philadelphia established the Coordinating Office for Drug and Alcohol Abuse Programs and directed its staff to channel the energies of Philadelphia's drug and alcohol practitioners into developing for the city's substance abusers the best system of resources possible.

For several years CODAAP concentrated on expanding and adding new services. Unprecedented growth resulted. The system today can accommodate more than twice as many addicts as it could in 1972. Three times as much money has been committed to preventing and treating substance abuse in 1978—\$34 million—as was available in 1972.

We diversified services to answer needs which for years had gone unmet. Vocational services for addicts, treatment for drivers with serious drinking problems, programs for addicted mothers, programs for Spanish-speaking abusers, residential care for public inebriates, day care for children with parents in treatment, counseling for city employees with substance abuse problems, and programs to steer young citizens away from substance abuse are all services available today in Philadelphia which didn't exist in 1972.

We are pleased with these accomplishments. We are proud that on a visit to Philadelphia in 1976, Dr. Robert L. DuPont, Jr., Director of the National Institute of Drug Abuse, described Philadelphia's service system as the most sophisticated and comprehensive in the nation.

Yet substance abuse has not disappeared in Philadelphia, any more than it has disappeared elsewhere. As one aspect of the problem diminishes, others intensify. Increasingly, CODAAP must concern itself with the practice of mixing drugs; with use of new drugs; with teenage alcohol abuse. The challenges we face as we begin our sixth year are massive.

Drug abuse is an extremely complex phenomenon. It is not simply a medical problem, though medical treatment saves many lives. It is not simply a behavioral problem, though thousands of addicts seek to modify their behavior through counseling and psycho-therapy. It is not simply a product of social and economic deprivation, though jobs often play a crucial role in rehabilitation. It is not simply a problem of social deviance, though some addicts seem committed to their deviant lifestyles.

Drug abuse is a human problem. Human problems have individual solutions. CODAAP subscribes to the principle of individual solutions. But we don't have the money to fully rehabilitate every substance abuser in Philadelphia.

Drug abuse is a societal problem. Society demands a "cure" for addiction. Yet the community often obstructs a cure. Neighborhoods reject rehabilitation centers, fearing a decline in property values and in safety. Employers refuse to hire individuals who have been rehabilitated, though studies prove that such individuals are good employment risks and that a job often makes the difference in whether an ex-addict stays off drugs. Societal bias against the substance abuser contributes to his sense of hopelessness and lack of self-worth and thus to the addiction itself.

We have our work cut out for us. We have spent five years building the best system we could devise. We have tapped all the resources we could discover. Our highest priority now, as we enter our sixth year, is to improve the system, concentrating on the training of staff, the upgrading of skills, and careful management and planning.

CODAAP's goal is to provide Philadelphia with the soundest and most flexible system of treatment possible. Until the root causes of substance abuse become known, until we learn how to meet the problems of addiction at its source, we can do no less.

The Service System—Treatment

By far the greatest amount of money spent in Philadelphia each year on drug and alcohol services is spent on treatment, which will mean, in FY '78, \$30 million of the \$30 million available.

Forty-six agencies comprise the treatment system in the nation's fourth largest city. These agencies run 120 separate projects having a total ideal capacity of 7,500 persons at any one time and 24,000 a year. In the twelve months ending October 31, 1977, the agencies reporting statistics to CODAAP recorded a total of 20,253 separate admissions. In addition to providing services to all the clients included in that figure—which may not represent separate individuals—these agencies also served another 7,617 clients who were already in the system at the beginning of that twelve month period. These figures clearly show that Philadelphia's treatment system receives heavy use.

The goal of treatment is to ensure that people return to or remain in the position of having control over their lives. Being in trouble with drugs or alcohol limits a person's choices. Ideally, treatment should restore the possibility of choice, enabling people to lead lives which are not interfered with by substances.

CODAAP's role in treatment is many-faceted. We provide money. We lend guidance and support to agencies seeking fund from many sources. We give technical assistance. Since projects must have CODAAP approval to be eligible for state, city, and some federal funds, we review project proposals. Finally, we monitor programs to make sure that they are well run, that standards are high, and that the system as a whole serves the most important needs of the client population and the community at large.

The system coordinated by CODAAP offered the following range of services in 1976 and 1977:

Hotlines

Four telephone services operating in Philadelphia provided callers with information, conversation, advice, crisis intervention, and referrals. Number of calls in 1976 and 1977 averaged 85 daily.

Emergency Services

In addition to the emergency care available in any hospital, two programs were particularly geared to give immediate medical attention to address the effects of adverse reactions to drugs and alcohol. In 1976 and 1977 these programs together averaged 27 emergency care admissions daily.

Case Management

A process by which practitioners assess a client's needs, develop a treatment plan, and monitor treatment, case management ensures that drug abusers get the maximum possible benefit from the treatment system. Although all agencies do case management, most adult drug clinics enter treatment through, and are monitored by, one diagnostic and referral service. CODAAP has also established less intensive case management projects for the Probation Department and for adolescent drug abusers entering the Multi-Agency Adolescent Polydrug Program. During 1976 and 1977 case management services were provided to 350 adult drug abusers, 23 adolescent drug abusers, and 190 probationers entering the treatment system each month.

Inpatient Hospital Detoxification

Two hundred hospital beds in Philadelphia are earmarked for detoxification: the process by which clients acutely addicted to drugs or alcohol are assisted in discontinuing use of the substance in an environment which minimizes the danger of withdrawal. During 1976 and 1977 CODAAP monitored one-half of these hospital beds and found 83 percent daily utilization. We also found that 22 percent of those admitted for detoxification were successfully referred for ongoing treatment.

Inpatient non-Hospital Programs

A number of drug and alcohol services are offered twenty-four hours a day and are housed in environments which clients use as residences. These residential services include:

28-day Program for Alcohol Abusers

Two such programs in the city provide temporary shelter and treatment for persons already detoxified who have no place to live or are not yet ready to return home. Clients completing the program are referred to longer-term residential or outpatient counseling programs. An average of 60 clients a day received such interim care during 1976 and 1977.

Public Inebriate Program

Two agencies provide five-day residential detoxification to alcoholics brought in from the streets intoxicated but not in need of acute medical care. Clients receive vitamins, food, lodging, light counseling, and referrals. This program is designed to bring dysfunctional alcoholics into treatment. An average of 37 clients a day received services in two 20-bed facilities during 1976 and 1977. Approximately 24 percent of all those admitted were successfully referred to ongoing treatment.

Therapeutic Communities

A therapeutic community is a place where clients can spend 6 to 18 months evaluating their attitudes, behaviors, lifestyles, and aspirations through confrontation and group therapy. Discipline, positive and negative reinforcement, and other techniques are used to stimulate and support growth and maturity in a client. Philadelphia has 13 therapeutic communities, 9 for drug abusers, 4 for alcoholics. During 1976 and 1977 these programs provided services to an average of 320 clients daily, a utilization rate representing 92 percent of total capacity. Approximately 18 percent of those clients successfully completed treatment.

Halfway Houses

A halfway house is a home for people with alcohol problems who have cut off ties to their own homes. The clients may hold regular jobs but need shelter, a stable environment, and, possibly, counseling. One halfway house operating in Philadelphia during 1976 and 1977 served as a residence for a daily average of 63 individuals.

Outpatient Programs

Outpatient treatment provides clients who live and/or work away from the treatment setting regular or periodic services totaling less than five hours per day. Five major kinds of outpatient treatment programs operate in Philadelphia:

Outpatient Detoxification

Opiate addicts receive decreasing doses of methadone daily for 5 to 21 days. Three agencies providing outpatient detoxification served an average of 185 clients each day in 1976 and 105 clients a day in 1977.

Methadone Maintenance

Primarily for persons with a long-term heroin addiction, this program provides clients with prescribed doses of methadone to achieve stabilization and prevent withdrawal symptoms. The ultimate goal of a maintenance approach is to assist the client to stabilize his life and to discontinue permanently the use of any opiate. Twelve programs served an average of 2,461 clients daily during 1976, and eleven programs served an average of 2,280 clients daily during 1977, a decrease being closely monitored by CODAAP.

Outpatient Drug-Free Programs

These programs stress counseling and psychotherapy. Clients receive treatment in 60-to-90-minute sessions one or more times each week. thirty-five centers were providing outpatient counseling to an average 4,335 clients at any one time in 1976 and 1977. Approximately 30 percent of these clients successfully completed treatment during these years.

Day Care

These programs provide scheduled, managed client activity at least fifteen hours a week. This kind of treatment is for clients who live elsewhere, need some structure, and are not quite ready for an outpatient program. Clients receive a meal, counseling, and educational and vocational opportunities. Six centers provided vocationally-oriented day care services to an average of 254 clients a day during 1976 and 1977. Vocational services are further described below.

Correctional Programs

The three institutions comprising Philadelphia's prison system provide drug detoxification services to prisoners. A person entering prison who acknowledges a drug problem at intake goes into a special cell block, is examined by a doctor, and, if detox is called for, is started on decreasing doses of methadone. Counseling, group therapy, and educational presentations are available during the period of incarceration, as is a therapeutic community which operates on a cell block in the House of Correction. Prisoners leaving jail may also receive referrals into community programs. During 1976 and 1977 the prison drug programs received a monthly average of 241 clients and 204 clients respectively.

Along with coordinating this system of services, CODAAP itself manages three specialized services relating to treatment. These are:

Vocational Rehabilitation

Since jobs are so vital to complete recovery from substance addiction, we consider vocational rehabilitation one of the most important aspects of treatment. Relatively few of the clients in Philadelphia's drug and alcohol system have the skills and motivation to get jobs on their own. Most need varying degrees of assistance to become job-ready. The service system offers the following kinds of assistance:

Early Screening and Diagnosis

Through testing, specialists evaluate the vocational capabilities of clients entering the treatment system and determine what further training would make each client job-ready.

Support Services

Clients who are nearly job-ready may get help learning such skills as filling out applications, covering gaps in employment resulting from substance involvement, and selling themselves to employers.

Supported Work

Clients needing some structure may improve skills, earn a living, and establish employment credentials by working in special projects structured to provide maximum support while encouraging increasingly high performance levels. This program utilizes actual contracts; for example, clients have been engaged to paint suburban railroad stations and to clean and seal or demolish abandoned buildings.

Sheltered Workshops

Clients not ready for supported work may earn money at piecework rates in highly-structured, in-house programs. Work includes assembling government manuals and packing and shipping for the Red Cross.

Vocational Day Care

Especially for the person who has dropped out of school, this program offers courses leading to a high school diploma as well as basic skill training in such fields as auto mechanics, clerical work, and electronics.

Job Development and Placement

A job bank has been established for recovered drug abusers in Philadelphia. Twenty agencies in the city's treatment system have donated the part-time services of twenty vocational specialists who seek out employment opportunities for ex-addicts in both the public and private sector under a project called the JOBS CO-OPERATIVE.

In addition to its other activities, CODAAP's Vocational Rehabilitation Department has assisted a number of treatment facilities to improve their utilization of vocational services and continues to offer training in the vocational aspects of treatment to treatment personnel.

Alcohol Highway Safety Program

Philadelphia's Safe Driving Clinic, run in four locations by the Philadelphia office of the National Council on Alcoholism under contract to CODAAP, involves twelve and a half hours of class over a five-week period and includes at least one family session. Participants must pay a fee. This program is an alternative to criminal action. Six thousand persons are arrested each year in Philadelphia for driving while intoxicated. Of these, some 4,000 persons who are determined to be good risks are referred by the courts to the Safe Driving Clinic. Those who don't complete the course are referred back to the courts.

Every individual reporting for the Safe Driving Clinic must undergo a diagnostic evaluation. Persons assessed as problem drinkers are referred for treatment to one of Philadelphia's forty alcohol treatment centers. CODAAP funds four specifically for this purpose.

The significance of the program is early intervention in alcohol problems. Most persons arrested for drunk driving hold jobs, are less alcoholic than persons who ordinarily present themselves for treatment, and, unlike the latter group, have most of their personal resources intact. The results are good: 79.6 percent of these clients placed in treatment successfully completed the individual treatment programs designed for them.

While the arrest rate has remained constant since the Alcohol Highway Safety Program began operation five years ago, the number of vehicular fatalities in Philadelphia has declined steadily, from 218 deaths in 1973 to 147 in 1976.

Nexus

This program is a distillation of earlier efforts to link the criminal justice system with treatment programs. Basically, certain persons with drug problems who have been arrested for crimes are diverted to NEXUS, which refers them into the treatment system. NEXUS works with two kinds of clients: persons arrested but not charged for minor crimes who are released on their own recognizance with the stipulation that they complete treatment, and persons charged with crimes who have been held in pre-trial detention because they could not make bail and are released from jail on the condition that they get treatment.

Each client in both groups is seen and evaluated by NEXUS staff and referred into an appropriate treatment program. NEXUS then monitors each person's attendance in treatment and tries to find anyone who leaves treatment. Though the conditional-release population in particular is high-risk, many of the drop-outs in both groups resume and complete treatment, often in a different program, once they are tracked down.

Of 866 pre-indictment clients referred to NEXUS so far, 71.4 percent have successfully completed the term of diversion; they have remained in treatment for the specified period and have not been re-arrested. Of 508 individuals referred to treatment under the conditional bail release program, 61 percent remained in treatment until the criminal case on which they were arrested was closed and were not re-arrested during that same period.

NEXUS also tracks, by telephone, clients involved in the Alcohol Highway Safety Program and monitors them, through court computers, for the entire period of their probation.

In the last two years, a number of changes have taken place in Philadelphia's drug and alcohol system. It has grown from a limited array to a wide spectrum of treatment alternatives. Its funding, once primarily federal, has become diversified, relying increasingly on health insurance, medical assistance, and other third-party payments. An evaluation mechanism has been established to assure that standards are met. From a system heavily committed to drug treatment, we have begun to recognize the importance of committing more and more resources to addressing the large problem of alcohol abuse in Philadelphia.

The Service System—Prevention

Prevention is the key to decreasing drug and alcohol abuse. In the long run, preventing abuse is considerably less expensive than treating abusers. CODAAP accords prevention a high priority. In fact, CODAAP pioneered substance abuse prevention in Pennsylvania; and our prevention effort today—which served more than 50,000 youth, parents, teachers, and community residents in the last year alone—ranks as one of the largest in the nation.

Prevention is activity aimed at the total population promoting lifestyles likely to exclude substance dependency. Studies reveal that many addicts exhibit low self-esteem, minimal ability to control their lives or take responsibility for their actions, lack of clarity about their values, and high susceptibility to the influence of friends involved in substance abuse. CODAAP has structured its prevention programs to reverse or inhibit these characteristics in the at-risk populations. These programs have demonstrated, through a variety of approaches, that there are techniques which do help prevent substance abuse and dependency, and that citizens of all ages both want and need such programs in their communities and schools.

There have been several recent developments in prevention services. The most important is the addition of a new program in North Philadelphia which seeks to divert young people from substance involvement through a full schedule of cultural, educational, and vocational activities and group and family counseling. The establishment of this project brings to five the number of ongoing programs funded by CODAAP which constitute the heart of prevention efforts in Philadelphia.

The other four also strive to discourage substance involvement by providing young persons with a wide variety of alternative activities including individual and family counseling. These programs operate in community centers and in elementary, junior high, and high school in both the public and parochial systems. Several of these programs have received local or national recognition as models of their kind.

Another development in CODAAP's prevention efforts was several small projects in prevention consultation. Such consultation operates on the theory that the problems in a given organization or setting adversely affect the program of that environment, and that if an organization is healthy, its program will benefit. By extension, it is possible to postulate that the healthier a school or community environment, the less likelihood there is of widespread substance abuse. Consultation identifies the problems and seeks ways to resolve them. This year CODAAP funded three short-term consultation projects. Two have already ended and the third will continue to provide technical assistance to any school or community requesting service through the end of the fiscal year.

One purpose of the prevention consultation approach is that while we cannot afford new prevention programs, we can spread existing expertise to schools and communities needing help. This past year three prevention agencies funded by CODAAP extended consultation services to some 5000 persons in Philadelphia schools and community groups who otherwise would not have received prevention services.

A third recent development has been CODAAP's support of the Commonwealth Prevention Alliance, a new statewide organization of prevention professionals. CODAAP also paid for the development, printing, and distribution of a multi-ethnic comic workbook promoting alternatives to substance abuse. The workbook, "Quadrus and Friends," is being used as a teaching tool in Philadelphia schools.

In addition to its prevention efforts, CODAAP's Prevention and Training Unit provides and arranges training for Philadelphia's entire drug and alcohol system. We run some workshops directly. Through a bi-monthly listing distributed throughout the system, we also keep service personnel apprised of the training opportunities available from other sources.

Besides these activities, we have devoted a substantial effort in the last year to the production of a comprehensive training strategy. We began this project by surveying a sample of Philadelphia's service providers to find out what training they needed and were not getting. Using the information gained from the survey, we have developed a grant proposal which, if funded, would allow us to offer a wide spectrum of training experiences to the personnel in Philadelphia's drug and alcohol system, enabling them to upgrade their skills so that they can better serve clients. Among the skills covered by the proposal are those necessary for interviewing, counseling, referral, case management, and program management. We are working to implement this program in the coming year.

Planning

A formal planning process became a priority for CODAAP in 1976. There were several reasons. CODAAP's budget, after several years of continued growth, reached a plateau. It currently is not adequate to accommodate even cost-of-living increases for existing programs. The proliferation of drug and alcohol services in Philadelphia has stiffened competition for the monies that are available. CODAAP is now in the position of having to decide how best to use scarce resources, or, to put it another way, what the community as a whole needs most.

Certain demands for services were going unmet, raising the question of just exactly where the city's most crucial needs lay. The public and its elected and appointed officials—not just in Philadelphia, but nationally—had begun to grow uneasy about the amount of time and money being spent on a problem that was not going away, and to press for better management, more accountability, and results. A formal plan would assess community needs, provide a rationale for spending, and serve as a benchmark against which progress could be measured.

CODAAP's planning process draws from a number of planning models, but it relies most heavily on the agency's own experience and role. The process takes into consideration the kinds of decisions CODAAP is called upon to make, the amount of influence CODAAP has in given situations, the staff resources which can be brought to bear, and our mandate to preserve and build upon the constructive relationships between CODAAP and the provider agencies.

Planning begins with a request for information, or RFI. This form is mailed out to all service providers and a number of other people in and out of the field. It asks them to tell CODAAP what they consider to be the critical needs in the prevention and treatment of substance abuse in Philadelphia and to suggest courses of action.

CODAAP's Plan Development Committee sorts the replies into nine program areas: prevention, pretreatment intervention, which is outreach to unidentified substance abusers; alcohol treatment; drug treatment; ancillary services such as child care and legal aid which make treatment possible; vocational services; research; training; and system administration. The committee then assigns priorities to those needs which CODAAP is capable of addressing.

Other needs are figured in: the need to strengthen services which are weak, the need to satisfy oversight demands of elected officials, and the need to fill gaps in services. Each need becomes a goal. Each goal assumes a priority. The planning committee also forms task forces utilizing available expertise to develop information and recommend particular courses of action. Producing a draft plan requires the full-time efforts of four staff members over six weeks, an indication of the degree of importance CODAAP places on careful deliberations.

The draft plan is then read by CODAAP's Executive Planning Committee. Chaired by the agency's executive director, this committee reviews the document for its consistency with agency policy and political reality. Final review is the responsibility of the Mayor's Drug and Alcohol Executive Commission, which holds public hearings to consider the plan. Once the Commission has approved the draft, the plan is printed and becomes a program document.

Meanwhile, in March and April, CODAAP entertains proposals for new programs and continuing applications for existing programs. We then hold face-to-face meetings with each service provider involved. The programs finally selected for support are those which go most directly to the needs as identified in the comprehensive plan. In other words, we consider what we can afford only after we have determined what we should support.

This separation of programming from budgeting makes CODAAP's planning process extraordinary. It changes our point of reference from what would most benefit the service providers to what would most benefit the community as a whole. It means that the value of each service is recomputed each year, taking into account a changing environment. It attempts to confront the fundamental conflicts which invariably arise whenever funding decisions are made in the substance abuse field: drugs vs. alcohol, prevention vs. treatment, ongoing programs meeting established needs vs. new responses to a complex and changing environment. We believe that this approach will permit CODAAP and the service system to remain responsive to our clients and to society as the needs of each change.

System Management

The rapid expansion of drug and alcohol services in Philadelphia which marked CODAAP's early years was critical to the ability of this city to cope with its problems of drug abuse. The challenge CODAAP faces now, in a period of consolidation, is to make certain that the care provided by these services is of the highest possible quality.

In the last two years, therefore, CODAAP has made a major effort to improve the care by improving the management of the system. Management means the functions involved in making sure that:

- the array of Philadelphia's drug and alcohol services is appropriate and adequate to the needs of Philadelphia's clients;
- the system as a whole is responsive to changing trends;
- the relationships between service providers operate in a way which guarantees clients not only a continuum of care but also smooth transitions within the network;
- the care delivered conforms to established standards;
- the personnel involved are qualified to carry out their responsibilities;
- the funds supporting the systems are adequate and appropriate and flow with continuity;
- the services purchased are the best available for the least money, and that the services paid for are the services received;
- each provider agency adheres to sound management principles.

The major elements contributing to the improved management of Philadelphia's drug and alcohol services system are as follows:

Planning

The comprehensive plan, and the formal planning process instituted in 1976 which produces that document, provide direction and a rationale for all major decisions made about drug and alcohol programming in Philadelphia.

Uniform Data Collection System

UDCS is the information-gathering mechanism of the Governor's Council on Drug and Alcohol Abuse. Every treatment program in Pennsylvania which receives public money must report to UDCS every month. Based on client admission and discharge forms and a form summarizing the use of each facility each month, these reports show, in the aggregate, how clients are utilizing the drug and alcohol services available in Pennsylvania. Among other things, the reports tabulate information on program census, on treatment outcomes—how many clients complete a given treatment program, how many go on to other kinds of treatment—on client employment, and on drug use patterns. UDCS reports constitute the most comprehensive source of information available on Philadelphia's service utilization.

Until 1975, UDCS reports from Philadelphia service providers were sent directly to the Governor's Council in Harrisburg. Since 1975 the reports have come first to CODAAP. A unit within the Research and Evaluation Division collects the data, monitors its validity, processes the information by computer, and issues reports monthly and annually. These reports are a valuable management tool at both the project level and at the system-management level. UDCS has become a cornerstone of our planning and evaluation processes.

Along with monthly data summaries, CODAAP's UDCS unit also prepares a monthly Executive Profile for use by CODAAP staff. Each issue of the Profile features an analysis of one specific aspect of the service system, as suggested by the UDCS findings for that month.

Funding

In the past two years, two important shifts have occurred in the funding of drug and alcohol services in Philadelphia.

One is a shift away from the federal government as the primary source. Federal money was the system's chief means of support before CODAAP's inception, and federal funds played a major role in the expansion initiated by CODAAP. Much of this money came to Philadelphia in the form of grants which had to be matched by state or local funds, with the federal share decreasing each year. This meant that in order to maintain the system of drug and alcohol services already in operation, we had to find more money each year from non-federal sources.

We are happy to report that our efforts to do this have been successful. Through increasing reliance on Medical Assistance and other forms of third-party payment, we have broadened the service system's financial base so that the federal contribution, which once accounted for close to 80 percent of the total budget, now accounts for less than one-fourth. This diversification of funding makes the system as a whole less vulnerable and more flexible.

The second shift concerns the route by which money flows into Philadelphia's drug and alcohol programs. At one time, service providers received funds directly from local, state, or federal sources. Increasingly, drug and alcohol funds are channeled through CODAAP as the single-county authority for Philadelphia County. This routing permits CODAAP to coordinate spending with an eye to the needs of the entire system.

These two general shifts involve the following specific changes in drug and alcohol funding:

Medical Assistance

MA has become a major funding source. CODAAP provides system-wide training and technical assistance in the best utilization of MA and other third-party reimbursements.

Social and Rehabilitation Services

As provided by Title XX of the Social Security Act passed by Congress in 1975, a portion of the funds available to Pennsylvania for social services is allocated to drug and alcohol services. The Act specifies which kinds of clients and services are eligible for support from these funds. In Philadelphia CODAAP keeps track of the eligible services given to eligible clients and reports this information to the state, which reimburses CODAAP directly, as the single-county authority, for a certain percentage of the cost of delivering those services. In the past two years, CODAAP has used this money to expand and improve the service system.

Statewide Services Contract

From a system of funding service providers directly, the National Institute of Drug Abuse has begun to enter into Statewide Services Contracts with individual states. Such a contract accounts for most of the NIDA treatment funds now coming into Pennsylvania. The state in turn contracts for specified services with individual single-county authorities. This means that increasingly, CODAAP manages the NIDA funds coming into Philadelphia.

State Grants and Contracts

Nearly all state grants and contracts in Philadelphia now funnel through CODAAP as the single-county authority. Again, this routing allows both for consistency in the administration of funds and for a balanced system of services.

Program Management

Over the period of this report, CODAAP has provided technical assistance and training in program management to drug and alcohol personnel and has instituted a unique system of management by objectives, by which the 1978 Philadelphia County Plan for drug and alcohol services was developed and is monitored.

Evaluation

In addition to using the Uniform Data Collection System described earlier, CODAAP has instituted several mechanisms for assessing Philadelphia's drug and alcohol programs. These are:

Problem-Oriented Record-Keeping (PORK)

CODAAP has encouraged all service providers to improve their client records. Toward this end, we have sponsored a pilot training program in a particular system of record-keeping that will give the agencies a valuable clinical tool—an ordered way of looking at a client's progress through treatment—as well as giving CODAAP a means by which to evaluate the services provided. A number of programs now use this system, and others are being trained in its use.

Performance Audit Review Team (PART)

A multi-disciplinary CODAAP team is currently conducting intensive site visits, lasting an average of two to five days, to all programs receiving CODAAP money. PART reports assess contract compliance and are utilized by CODAAP to effect more efficient resource management, technical assistance, and fiscal allocations.

Ongoing Monitoring

Representatives of CODAAP's operating divisions visit all service providers at least monthly, preparing full reports and following up on critical issues raised.

Coordination

Management of any system is predicated on the broadest possible understanding of the clients involved and of the services available to them in the larger community. This understanding in turn is predicated on communication among practitioners representing those services. To ensure that problems of substance abuse receive consideration by others dealing with the same client populations, and to enrich CODAAP's knowledge of community resources, CODAAP staff members meet regularly with all drug and alcohol program directors and with personnel from a number of public and private sector coordinating offices.

Training

In the interest of better services to clients, CODAAP has sponsored and will continue to sponsor training to service personnel in such areas as treatment, prevention, management, record-keeping, third-party payment, and industrial assistance programs.

Future

At best, predicting future need for drug and alcohol services in Philadelphia—or anywhere else—is difficult. Too little is known about today's need. We and other practitioners in the field are attempting to cope with a phenomenon we do not fully understand. No general agreement exists about the causes of or cures for substance abuse.

Even its form and patterns remain largely a mystery. In the case of drug abuse, we are dealing mainly with illegal activity. Those involved have a high stake in remaining anonymous. In the case of alcohol abuse, we are dealing with a legal activity whose true dimensions may be camouflaged either by the acceptability of social drinking or by the refusal of problem drinkers themselves to acknowledge a drinking problem. The upshot is that the information available to drug and alcohol practitioners on who abuses which substances and how and when is neither complete nor fully reliable.

We do know that patterns of abuse change, and to some extent the characteristics of abusers change. There are shifts in the drug of choice. The amount of abuse appears to move in cycles. Some people feel that media attention to certain kinds of abuse affects trends. We clearly do not know whether or when changes in abuse patterns will occur. Since we don't know what Philadelphia's future problems in drug and alcohol abuse will be, it's impossible to predict what the solutions will be.

That there will continue to be a need for drug and alcohol services in some form seems beyond doubt. We base this judgment on history—substance abuse is centuries old—and on our close monitoring of current indicators. The most reliable indicator is the utilization of existing services. Statistics accumulated as part of the Uniform Data Collection System show that the demand for drug and alcohol services in Philadelphia continues unabated. In fact, our experience shows that when services are expanded or increased, new treatment slots are filled as soon as they are created.

Other indicators to which we pay close attention include national trends, statistics on abuse-related arrests and hospitalization, and the replies to CODAAP's own Request for Information, the poll of Philadelphia's drug and alcohol practitioners which forms the basis for our comprehensive planning process. As best we can determine from all the information available, while the patterns and character of abuse may change, the need for programs to prevent and treat substance abuse will continue well into the future.

Therefore, we will need to maintain the service capacity in Philadelphia. To do that, we will need to maintain the existing funding streams and to tap new sources of funding. This in turn means convincing legislators and the public at large that drug and alcohol services are worth funding, or that citizens involved in drug and alcohol abuse are worth treating. To get the public's support, we will have to reduce the level of public bias against the abusers themselves. We anticipate that reducing public bias will require major effort, and that we will have to exert that effort.

Our long-range goal is containment—containment of the social costs, and containment of the financial costs of abuse. Our long-term strategy is to focus on prevention. This strategy presumes that the problem of substance abuse has environmental origins in the family, peer groups, school, and other community influences, and that modifying the environment can reduce the problem. Focusing on prevention reflects not only a philosophical commitment at CODAAP but also a practical appraisal of how we can use our resources most effectively. This approach is supported by a growing belief that the way to control rising health costs in general is to prevent disease rather than to attack the costs of curing people who are sick.

In the meantime, as long as substance abuse remains the problem it is, we at CODAAP plan to work toward meeting the needs of future clients in three ways. First, we need to develop more knowledge and sophistication about drug and alcohol abuse. If we do not now know what causes it, we can learn much more than we have learned about trends and patterns. Second, we want to use this knowledge to increase the responsiveness of the service system to clients. Finally, we intend to do everything possible to end discrimination against drug and alcohol abusers and especially to see to it that persons in need of and eligible for welfare or vocational rehabilitation or any of the other human services available to the general population shall not be denied those services because of substance involvement.

In conclusion, this report has detailed a massive local response to large and complex social and human problems. Addicts and alcoholics must receive treatment and rehabilitation: there is no real choice in this respect. We are making substantial progress in treating substance abuse. We must continue our treatment efforts even as we learn more about preventative measures which will ultimately minimize the staggering costs to society.

Financial

Program Statistics and Expenditures Philadelphia Drug and Alcohol Services System, Fiscal Year 1978

	Anticipated Admissions	Allocation
Treatment		
Drug		
Outpatient	5,600	\$ 5,695,999
Drug-free Methodone maintenance	6,800	6,987,503
Residential	1,245	2,991,091
Criminal justice	9,500	1,226,185
Hospital	1,625	1,698,555
Alcohol		
Outpatient	10,500	3,954,076
Residential	6,200	2,732,946
Criminal justice	3,223	479,022
Hospital	5,860	4,744,178
Prevention	60,275 *	1,584,086
System Administration		
CODAAP Operations		1,568,944
Research and Evaluation		158,534
Training		223,567
Totals		<u>\$34,044,686</u>

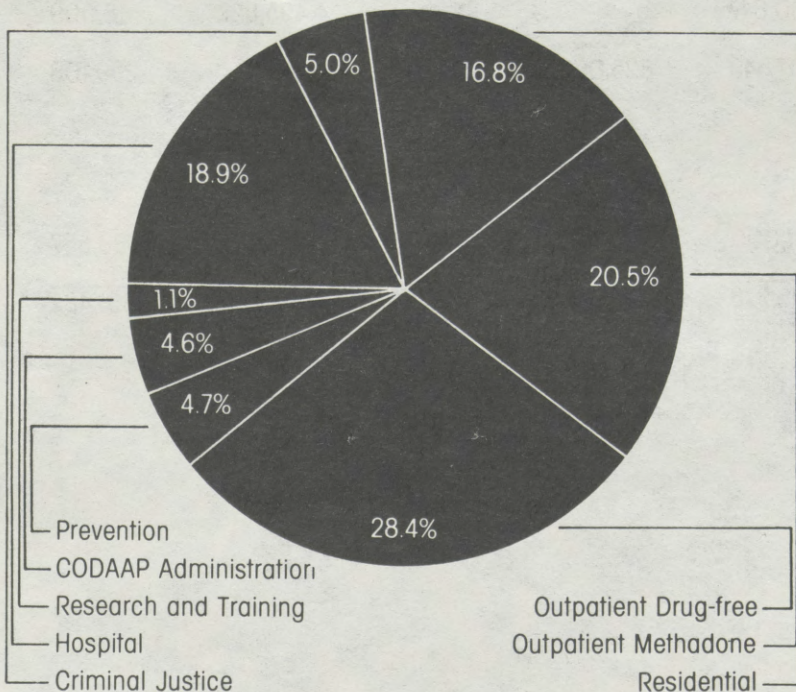
* Anticipated number of persons served.

Origin of Funding

Federal	State	City	Medical Assistance	Non-Public
\$1,665,125	\$ 504, 838	\$ 595,031	\$1,399,220	\$1,531,785
2,153,356	244,946	661,436	3,707,997	219,768
1,099,034	983,369	127,610	424,208	356,870
615,840	33,502	576,843		
90,524			1,608,031	
867,878	1,253,244	264,250	1,236,739	331,965
667,595	942,564		67,395	1,055,392
156,736	56,186	266,100		
230,647			4,495,522	18,009
307,543	825,063	152,374		299,106
	27,698	1,541,255		
	158,534			
161,000	21,600	2,400		38,567
<u>\$8,015,278</u>	<u>\$5,051,535</u>	<u>\$4,187,299</u>	<u>\$12,939,112</u>	<u>\$3,851,462</u>

Income**Philadelphia Drug and Alcohol Services System, Fiscal Year 1978**

Major Funding Source	Amount
Federal	\$ 8,015,278
Governor's Council on Drug and Alcohol Abuse	3,309,206
Social and Rehabilitation Services (Title XX, Social Security Act)	1,272,464
Other State Funds	469,865
City of Philadelphia CODAAP Appropriation	1,736,929
Other City Funds	2,450,370
Medical Assistance	12,939,112
Non-Public Funds	3,851,462
	<u>\$34,044,686</u>

Expenditures by Environment

CODAAP

Coordinating Office for
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Rehabilitation Aspects of Drug Dependence

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Chapter 7
THE ROLE OF THE CITY IN RESPONDING TO THE PROBLEMS OF DRUG ABUSE*

Peter Goldberg

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... The major providers of service have long recognized their inability to provide treatment if services are predicated on the precious tax dollars large urban cities are able to allocate.

The financial crisis confronting Detroit is the same burdensome problem of declining revenue sources as expressed by every mayor of other cities. Treatment and prevention of drug abuse is a very costly service which cannot be adequately provided by current city budgets...

In the event the Federal Government continues to play a passive role with respect to our monetary crisis, the number of heroin addicts in Detroit could approximate 40,000 in a year.

Gentleman, our services to the citizens of Detroit have been drastically curtailed. The failure to provide medical/social services for drug dependency will become unmanageable without adequate Federal Revenue.

Roman S. Gibbs
Mayor of the City of Detroit

*The views and recommendations stated in this paper are those of the author and not necessarily those of the Drug Abuse Council, Inc.

INTRODUCTION

The remarks of Mayor Roman Gribbs were contained in a June 1971 letter to Congressman Claude Pepper, then Chairman of the U.S. House of Representatives Select Committee on Crime, which at the time was holding extensive hearings on narcotics research, rehabilitation, and treatment. These congressional hearings were but one of many held during 1971, which was a peak year in the cyclical rise and fall of drug abuse as an issue of national concern.

Drug abuse is a problem of a continuously changing nature, but since World War II it has been viewed in this country as a largely urban phenomenon and an urban problem. With the possible exception of marijuana, heroin is the drug of potential abuse that has consistently evoked the greatest public concern over the past 30 years.

The incidence and prevalence of drug use, in general, and of heroin, in particular, are highest in our largest urban areas. In part, this is a simple function of population. But again, concentrating on heroin, its rate of use per thousand in the general population tends to be higher in large cities. Many suspect a correlation between heroin addiction and such urban ailments as overcrowded and dilapidated housing, unemployment and underemployment, inadequate educational opportunities, and insufficient recreational opportunities, all of which seemingly cause or are caused by (or both) crime, fear, hatred, despair, poverty, and alienation. One major reason heroin addiction is seen as an urban problem is because of its close association with so many other urban problems.

By 1971 drug abuse had basically become a synonym for heroin addiction. At that time it was widely believed that the incidence and prevalence of heroin use, which was then equated with addiction, were rising sharply. Public concern soared as the crime rate soared, and heroin addiction was held largely responsible. Added to this were the reports of dramatic increases in the rate of heroin addiction among U.S. soldiers in South Vietnam. Public fear was further exacerbated by the thought of "soldier-junkies" trained in guerilla warfare returning to terrorize the citizens of urban America. Drug abuse in 1971 was

heroin addiction, and heroin addiction was largely an urban problem.

Anxiety and fear inevitably translated into public demands that something be done. These pressures were felt more at the national than the local level: It was to the President and Congress that the country turned rather than to the mayor and city council. In fact, it was often the leaders of city government who led the delegations urging increased federal assistance. Although the massive federal domestic aid programs of the 1960s had conditioned many to turn automatically to Washington for solutions — mostly financial — to all urban problems, the impression remains that by 1971 the scope and extent of the problems associated with addictive drug use had far transcended the ability of urban government to respond. Mayor Kevin White of Boston explained his city's problem to Congress this way:

With no financial assistance from the Federal government, insufficient funding from the state, Boston — which gets its resources solely from the property tax in a city where over 50 percent of the property is tax exempt — is struggling to pay for the vast majority of patients now in treatment, and to provide services for hundreds more who want to be cured.¹

The remarks of Mayors Gribbs and White also reflect the theme which underlies this chapter. The role of the city in responding to the problems of drug abuse is now, has generally been in the past, and will probably continue to be in the future, limited. The nature of the problem under discussion, the limited taxation powers of local government, and the prevailing governmental approach to domestic problem solving all heavily influence this conclusion which can be codified in a series of five statements:

Statement 1 — When there exists a problem peculiar to an urban area, the local citizenry turns first to its elected city government to respond to that problem.

Statement 2 — Drug abuse is primarily an urban problem. The social costs of drug abuse* are estimated to be in excess of \$10 billion annually; these costs are concentrated in our nation's cities.

Statement 3 — Heroin is the primary drug of abuse. Its social costs are greatest, and these costs are highest in the central city.

*As used in this paper, the term "social costs of drug abuse" or simply "social costs" refers to the rough economic estimates made of the direct and indirect costs of drug abuse. These costs include health costs, productivity losses, criminal justice system costs, property loss, and direct program costs. Obviously, many other "costs" such as loss of life or fear of drug abusers cannot be ascribed any monetary value.

Statement 4 — City governments have been unable to cope effectively with the problems of heroin addiction. The costs of treatment and rehabilitation are prohibitive for already strained municipal budgets. The law enforcement aspects far transcend city boundaries. Education/prevention programs, if they are effective at all, are long-range solutions not applicable to immediate problems.

Statement 5 — The federal government has largely assumed responsibility for dealing with the problems of drug abuse. It pays the piper; it calls the tune. The role of the cities, when they are included in this tune at all, is that of musician not bandleader.

This chapter will review the past and present city role in responding to the problems of drug abuse. Following this review, recommendations will be offered which would effectively enhance the city's role, thus lodging greater responsibilities for responding to the problems of drug abuse in the level of government closest to, and whose constituents are most affected by, the problem.

BACKGROUND

City governments can seek to control the actual or perceived problems of drug addiction primarily through: (1) law enforcement efforts designed to control the supply of illicit drugs and (2) the use of treatment and rehabilitation programs for those people already addicted. These efforts need not be mutually exclusionary. In fact, the traditional public health model for dealing with drug addiction views them as the critical elements which, with careful coordination, can contain an epidemic spread of heroin use and reduce it to manageable proportions.

The strategy calls for law enforcement agents to maintain heavy pressure on the sources of supply, and for treatment programs that are both adequate and accessible for every addict who wants treatment.²

As far as education and prevention programs are concerned, they are long-range efforts with little relevance to immediate problems. And one important point to remember is that school systems, through which education programs are generally implemented, often operate independently of city government, thus defying coordination.

With the exception of New York City, local governments have made little direct contribution

to drug abuse research. The costs of most research projects are prohibitive, particularly when measured against the immediacy of the benefits derived, if there are any. Research is simply not an area in which local governments can afford the luxury of investment.

Consequently, this chapter proceeds from the assumption that neither education and prevention nor research provides viable avenues of response for local governments confronted with problems associated with drug addiction.

With respect to law enforcement, city government efforts to control the supply of illicit drugs and to arrest the users of illicit drugs can be traced back as far as 1875 when the city of San Francisco enacted an ordinance against opium smoking.³ As long as there are illegal drugs and therefore illegal users of drugs, local police, usually an arm of the city government, will have a role to play in dealing with drug addiction, whether through a special unit of their department or through the normal course of their police work. Wes Pomeroy, author of *Police Chiefs Discuss Drug Abuse* and himself a police chief, sums it up most simply:

Police see themselves, of course, as enforcers of laws — all the laws. Thus they see enforcing the drug laws as a normal and natural thing, little different from enforcing laws against bank holdups, reckless driving, homicide or any other prohibited behavior.⁴

Both Helmer and Vietorisz,⁵ and Waldorf and Reinerman³ contend that the 1875 San Francisco ordinance against opium smoking was racist in nature. Inasmuch as this activity was largely confined to the Chinese population their contention is probably valid. However, since the passage of numerous state and federal laws against the sale and possession of many addictive drugs, the role of the city in determining law enforcement policies with respect to illicit drugs and drug users is curtailed. City laws cannot be less restrictive than the state or federal laws; they can be more restrictive, though that hardly seems necessary. Musto writes of the never-ending and unsuccessful efforts of law enforcement.

The peddler had been present from an early day; he was not considered an extremely difficult enforcement problem until the most restrictive legislation and court interpretation cracked down on licensed purveyors of narcotics. Once maximum legislative control was applied to the peddler or pusher, it became evident that narcotics would remain available in the largest American cities.⁶

The local police are compelled to uphold the law whether that law is initiated at the local, state, or federal level. Yet local police departments, through the determination of their own priorities, can uphold some laws better than others. This has become increasingly obvious in recent years with respect to marijuana.

For the purposes of this chapter, it is sufficient to acknowledge that law enforcement efforts against those trafficking in illicit drugs, those possessing such drugs, and those committing crimes as a result of either the use of drugs or the need to raise money to obtain an addictive drug are mandated responsibilities. A review of the performance of local police departments would largely result in a statistical compilation of arrests and quantities of drugs seized without contributing much to an understanding of the role of the city in responding to the problems of drug abuse. These local law enforcement efforts will not be discussed in great depth in this chapter. We will assume, however, that police departments have developed a more sophisticated understanding of drugs and drug users since the early 1900s when southern police departments switched from .32- to .38-caliber bullets because they feared that Blacks, when under the influence of cocaine, would be able to withstand the impact of the lesser caliber bullets.⁷

Regarding treatment, until the development of methadone as a maintenance modality, there was little opportunity for city governments to become significantly and actively involved in treatment and rehabilitation programs. The only treatment services a city government could have conceivably offered directly were emergency medical care for drug overdoses and possibly inpatient detoxification on a short-term basis in cases where the local public hospital was operated by the city government. The one exception was during the period from 1912 to 1923 when a number of morphine maintenance clinics, some of which operated under the direct auspices of local government, provided legally prescribed dosages of morphine to addicts.

Between the periods of morphine maintenance and methadone maintenance the primary treatment modality for drug addiction was long-term, inpatient abstinence. The major efforts in this area were sponsored by the federal government, which

opened "narcotic farms" in Lexington, Kentucky in 1935 and in Fort Worth, Texas in 1938. Although later considered treatment, the "farms" seemed to have been originally conceived as a means of relieving overcrowded conditions in the federal penitentiaries, which in 1928 had a cell capacity of 3738 and an actual population of 7598, of whom 1600 were addicted.⁸ Musto writes, "The institutions provided segregation and the best in medical treatment, but they were by no means rural retreats for the unfortunate addict, supposedly to be restored to health and permanent abstinence." Musto goes on, "Not until the late 1960s were the bars removed from the Lexington facility and the cells turned into rooms."⁹ One could further add that shortly thereafter the use of both facilities as voluntary treatment centers was discontinued.

Nevertheless, in the 30 years during which Lexington and Fort Worth were in operation, an increasing number of addicts were "voluntarily" enrolled. Ball compared 1962 demographic characteristics of the addict patients at Lexington and Fort Worth with data analyzed by Pescor on addicts in the Lexington facility in 1937 and found that "the major change has been the increasing preponderance of heroin addicts from the minority groups of our largest cities."¹⁰ This reflected the prevailing theory of drug addiction treatment during this time, which was to remove the urban addict from his/her environment during the period of treatment.

In 1962 perhaps only New York City had a large enough known addict population seeking treatment to justify the maintenance of its own inpatient abstinence program removed from the urban environs. In fact, New York City did support its own program for adolescent addicts from 1952 to 1962 at Riverside Hospital. This was based on the Lexington-Fort Worth model but located within the city. Riverside Hospital had also been used without success for a similar purpose in 1920 for clients referred to it from the New York City Heroin Clinic. Other than this program there was little a city government could do under the then prevailing concept of drug addiction treatment.

The emergence in the 1960s of therapeutic communities based on the Synanon* model also allowed for little direct involvement of city gov-

*Established in 1958, Synanon, the first self-supporting, drug-free, residential, therapeutic community, uses group living and encounter techniques to reeducate and reorient drug addicts.

ernments. Although usually located in the center of the urban area, they were, at least initially, wholly independent of local government funding and pressures. The operations of these programs were the antithesis of the bureaucracies (and bureaucrats) which necessarily characterize government. However, in the mid-1960s New York City under Mayor John Lindsay began putting funds into drug-free programs such as Daytop, Exodus, and Phoenix; and certainly other cities now supply local matches to federal grants for drug-free residential programs. City funds, however, are usually insufficient to allow for much leverage in the operations of these privately run programs.

MAINTENANCE CLINICS: 1912 TO 1923

The first of the narcotic maintenance clinics to be established by a government agency was opened in 1912 in Jacksonville, Florida.^{*11} The clinic was originated by Dr. Charles E. Terry, then the city health officer for Jacksonville, which in 1912 was the largest city in Florida. Terry's action was taken in response to the movement then already underway to control and restrict the use of addictive drugs for nonmedical purposes. Skeptical about the regulation of narcotics consumption through legislative or administrative mandate, Terry opted instead to provide drug users with free narcotics prescriptions if deemed advisable by a health officer. He reasoned that this medical model would insure more frequent contact between the addict and the medical profession. Terry approached the Jacksonville City Council for permission to open a narcotic clinic under city sponsorship, received it, and after 1 year of operation had about 1% of Jacksonville's total population registered with the program.

A widespread need for narcotics clinics like Terry's did not really materialize until March 1915 when the Harrison Act took effect. Before that it was a relatively simple matter for an addict to obtain his/her drug legally. Actually, the Harrison Act was not designed to prevent individual use of addictive drugs, but rather to more carefully regulate their distribution and thus use by requiring those involved in the distribution of these drugs to register with the authorities and to maintain careful records. One result of controlling

distribution was to raise the price. The maintenance clinics that emerged shortly after the passage of the Harrison Act were created chiefly to meet the needs of the poorer addict; others could still maintain their addiction legally — more expensively but also more surreptitiously — through their registered physician.

It was through the regulations promulgated by the U.S. Treasury Department pursuant to the enforcement of the Harrison Act that the federal government actually began its attempt to eliminate use of addictive drugs. By 1919 the Treasury Department campaign to prohibit physicians licensed under the Harrison Act from prescribing drugs to addicts for maintenance purposes had proved successful. As the legal supplies of addictive drugs became tight because of the Treasury Department's actions, it occurred to officials that drug addicts would not stop taking drugs simply because some administrative fiat had been issued. The question of what to do with the addict cut off from his/her legal supplier because of Treasury Department action was not easily resolved.

Initially the Treasury agents encouraged the opening of "public clinics" to temporarily supply addicts left stranded by Treasury Department prosecution of physician-suppliers who, though legally registered under the Harrison Act, were found to be technically not in compliance with some aspect of the regulations pertaining to that Act. Inasmuch as Congress did not provide for federal sponsorship of treatment clinics for nearly a decade, the term "public clinics" in 1919 presumably refers to some type of local control. Musto reports that some 40-odd clinics opened and were at least briefly operational during this period. Many of these clinics were specifically opened to meet the need created by the actions of the federal government, and some were opened as a direct result of federal persuasion.

There was soon a change of heart, however, as federal officials began to realize the inconsistency in allowing public clinics to offer addicts a medical treatment that licensed medical doctors could not. Add to this the antidrug sentiment which swept the country during the prohibition era, and the "red scare" of 1919 to 1920. During this period public opinion and government response were less tolerant of all antisocial acts, as drug addiction was

*Much greater detail on the maintenance clinic era, 1912 to 1923, is provided in the text by Musto, Reference 11. The discussion of this era presented in this chapter is largely based on Musto's account.

perceived to be. In fact, Musto reports that in an act characteristic of the period, the Mayor of New York City established in 1919 a Committee on Public Safety "to look into two specific problems which he saw as related: the heroin epidemic among youth and the bombings by revolutionaries."¹²

There is a dearth of detailed information about the operations of the narcotics clinics of this era. About half of the 40 clinics that existed were located in New York State and New England.* The clinics operated under a variety of auspices. Some, such as many in New York State, operated as franchises awarded and monitored by the New York State Narcotic Control Commission. Others operated under direct control of city governments. In New Haven, for example, the police department ran the city maintenance clinic from 1918 to 1920. In Atlanta the clinic was operated by the city health office and was located in city hall. In Cleveland, too, the maintenance clinic was operated by the local health department.

The maintenance clinic for which the most information is available during that era was that operated in Shreveport, La. from 1919 to 1923 by Dr. Willis P. Butler. Butler, who is still alive and now in his mid-80s, provided invaluable records and recollections for Waldorf et al.¹⁴ to reconstruct a history of the Shreveport Clinic and a description of its operations. Dr. Butler started the clinic as a State Board of Health Narcotic Dispensary after the two private physicians who had been prescribing drugs to addicts primarily for profit were asked to leave town. The clinic opened in 1919 at the largest hospital in the city and enjoyed the support of the Shreveport Medical Society. Succumbing to federal pressure, the state of Louisiana ordered Butler to close the clinic in 1921. Butler did, but he reopened the very same day as a hospital operating under city authority. This transition was supported by the mayor, the city council, and the city attorney; not only did it enact an ordinance allowing the hospital to "treat" clients on an outpatient basis, the city also agreed to reimburse the hospital for part of the cost of its operation. Butler continued the maintenance program until February 1923, when under what

can only be interpreted today as "harassment," he was finally persuaded by federal authorities to halt the program.

The closing of the Shreveport Clinic marked the beginning of a 40-year period during which there were no legally operating narcotic maintenance programs in this country. There are lessons to be learned from these experiences. In fact, the methadone programs of the present, if adjusted for 40 years of technological advances, seem in many ways to be similar to the maintenance programs of 1912 to 1923. While too little is known about the morphine maintenance clinics to make a definitive judgment about their success or failure, it seems likely that they were closed not because they failed as a form of treatment, but for a combination of social and political reasons which could not tolerate the maintenance of addiction, regardless of whether or not it was medically prescribed. Maintenance was discontinued not because of its ineffectiveness but because of a societal demand that the addict give up his addiction or be punished.

The involvement of city governments with the morphine maintenance clinics is also not completely clear. Some cities funded and, in some instances, operated such clinics, often in response to federal suggestion. Shortly thereafter, these clinics were closed down, also under federal pressure. The city's role in setting and implementing drug treatment policy was certainly constrained. On the other hand, Musto says that Philadelphia, Boston, and Chicago never had a clinic system. Why not? Was there no need (this seems unlikely) or did these cities conclude, unlike Atlanta, Cleveland, and New Haven, that it was not in the *whole* city's best interest to provide services to addicts under municipal sponsorship? To know the factors that determined these decisions would contribute substantially to our knowledge of the city's role during this period of time.

METHADONE MAINTENANCE: 1964 TO THE PRESENT

The second major opportunity for city govern-

*Musto (see Reference 13) listed the following clinic locations: Port Jervis, Saratoga, Watertown, Binghamton, Corning, Elmira, Hornell, Middletown, Oneonta, Utica, Albany, Buffalo, Rochester, Syracuse, and New York City, N.Y.; Hartford, Meriden, Norwalk, Waterbury, New Haven, and Bridgeport, Conn.; Providence, R.I.; New Orleans, Shreveport, and Alexandria, La.; Augusta, Atlanta, and Macon, Ga.; Los Angeles and San Diego, Calif.; Cleveland and Youngstown, Ohio; Knoxville and Memphis, Tenn.; Clarksburg, W.V.; Paducah, Ky.; and Houston, Tex.

ments to exercise some significant role in responding to the problems of drug abuse began in 1964, when the potential of methadone for maintenance purposes was uncovered. Until then, beginning in the late 1940s, methadone, a synthetic narcotic, was used only to help detoxify heroin addicts. In 1964, however, Drs. Dole and Nyswander of the Rockefeller Institute in New York City found that they were able to successfully maintain six heroin addicts on a stable and consistent dosage level of methadone without the addicts craving heroin. The doctors sought additional funding from New York City to continue, evaluate, and expand the program. The city responded positively:

Dr. Dole just wanted six beds and all we had was about 20,000! We were very glad to accommodate him . . .

In addition to housing the new program, Dr. Trussell [then New York City Commissioner of Hospitals] found money to finance it. The Mayor [Robert F. Wagner] gave me \$80,000 one day on a car ride . . . and Dr. Perkins gave me \$300,000 of Mental Health money and the Deputy Mayor gave me \$1 million of anti-poverty money because addicts are certain impoverished . . .¹⁵

The successful program was launched in 1965 as a large-scale demonstration of methadone maintenance with \$1.4 million of New York City funds. In addition, the Columbia University School of Public Health was engaged to evaluate the Dole-Nyswander program. Looking back, the New York City funding of this approach constitutes the most significant and valuable city contribution to the treatment and control of drug addiction to date.

As the city funds for the Dole-Nyswander program began to expire in the fall of 1967, the program was refunded by New York State. New York City, under Mayor Lindsay, did not begin additional efforts in methadone maintenance for more than another year. However, by 1968 there were methadone maintenance programs in Chicago and Philadelphia as well as in New York. By 1969 methadone programs were operating in 23 cities; the Dole-Nyswander program reported 1866 clients on October 31, 1969. It was clear by then that a whole new era in the treatment of drug addiction had been ushered in.

From the perspective of city (or state or federal) governments, concerned as much with the social costs associated with addiction as with the problems of the individual addict, the emergence of methadone maintenance as a viable form of

treatment provided cities with a realistic opportunity to become directly involved. Although methadone maintenance was frequently objected to as simply the substitution of one addiction for another, it was used as an effective way to reduce addict-related crime, and this more limited goal of drug addiction treatment superseded the moral public insistence on total abstinence. Methadone maintenance was defended as preferable to heroin addiction in four other important respects: Methadone is taken orally and is thus safer than heroin, which is usually injected; the effects of methadone last about 24 hr as opposed to the 4 to 6 hr for heroin, thus significantly reducing the number of times it need to be taken; one can become stabilized on methadone, whereas with heroin, one needs increasingly larger dosages in order to feel the effects; and finally, the physiological effects of methadone are less telling than heroin, thus allowing the addict to resume a more socially functional life. These arguments, combined with the hope of reducing addict-related crime, proved attractive to many city governments.

With respect to government funding, methadone has certain advantages over the therapeutic community. Methadone allows for the treatment of a greater number of people in fewer programs. Moreover, its cost per client in treatment is substantially less than in a therapeutic community. Finally, methadone programs can be more easily understood by politicians and government bureaucrats, to whom the encounter sessions and generally heavy psychological trip of the therapeutic community are frightening, even though the drug-free orientation is commendable.

Methadone itself is not very expensive, costing perhaps a dime per dose. Nevertheless, according to federal equations it costs up to \$1700 per year to maintain one person in a methadone maintenance program. The primary sources of these costs are the regulations designed to prohibit abuse of the programs (e.g., diversion of methadone) and to assure quality standards (so that the program does not simply maintain an addiction, but treats and rehabilitates the addict). Most of these regulations were promulgated by the federal government. While no one can quarrel with their intent and purpose, they have escalated the costs of methadone maintenance to a point beyond the financial capabilities of most municipal governments to handle by themselves, as the earlier remarks of Mayors Gribbs and White suggest.

Thus by the late 1960s the situation demanded considerable federal involvement. The incidence and prevalence of heroin addiction in the large cities of the country were increasing, and, equally important, public fear of drug addicts and addiction had risen dramatically. A new, potentially attractive, but still somewhat costly treatment for heroin addiction was emerging. Municipal government appeared financially and programmatically incapable of coping with the problem. Few state governments cared about the problem because it was generally concentrated in only one or two of their many jurisdictions. Under these circumstances the federal government's response was predictable.

The federal government's drug budget began its remarkable climb, most noticeably in treatment, in 1970.* In Fiscal Year (FY) 70 (July 1, 1969 to June 30, 1970) the federal government spent \$33.5 million on treatment; 1 year later the figure jumped to \$86.8 million. By then the federal role with respect to treatment was taking shape. The original federal budget for drug treatment in FY 72 was \$101 million. However, when former President Nixon proposed the establishment of the Special Action Office for Drug Abuse Prevention in June 1971, he also submitted a supplemental budget request which increased treatment funding by \$95.1 million for a total of \$196.1 million in FY 72. At the height of the federal government's involvement with treatment and rehabilitation programs (FY 74), the budget reached \$266.4 million.

THE ROLE OF THE CITY SINCE THE PASSAGE OF THE DRUG ABUSE OFFICE AND TREATMENT ACT OF 1972

The President's proposal to establish a Special Action Office for Drug Abuse Prevention (SAODAP) and subsequent congressional passage of the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255) established the framework for the delivery of drug treatment services which is still in effect. There are two issues regarding Public Law 92-255 of particular interest to this study. The first is the use of SAODAP to establish more methadone programs more quickly across the country. The second concerns the intergovernmental system created for the funding and delivery of drug treatment services.

Underlying the proposal to establish SAODAP was a growing presidential frustration with the resistance of the National Institute of Mental Health of the U.S. Department of Health, Education and Welfare (DHEW) to expanding methadone treatment. SAODAP, as a part of the Executive Office of the President, was to provide a bureaucratic way of short-circuiting the DHEW bureaucracy which had been too slow to respond. The President's goal was to enable any bona fide heroin addict wanting methadone treatment to be able to get it, and without delay. Logically, this meant the placement of methadone programs in every major urban center, since that was where addiction was concentrated. When SAODAP began operations in mid-1971, there were 135 federally funded drug treatment programs; 18 months later the number had increased to 394. Much of this expansion was for methadone treatment programs.

To some mayors SAODAP's rapid actions proved to be a godsend. By targeting substantially more federal funds and effort to the drug problem, SAODAP in effect relieved local leaders of the responsibility of trying to solve what appeared to them an unsolvable problem. To other mayors the actions of SAODAP created a dilemma; the funds and programs were much wanted and needed, but the process by which they were provided kept local elected officials out of the mainstream of basic decision making in an area that vitally affected the communities they were elected to govern. Finally, to other mayors SAODAP's actions were unwanted and threatening. Methadone, as an addictive drug, was a controversial form of treatment. In some communities methadone, rightly or wrongly, was viewed in the extreme as a form of genocide, and the community was adamantly opposed to it. Yet cities sometimes became recipients of federally initiated methadone programs whether they wanted them or not.

In each case, however, the rapid federal expansion of methadone left the urban administrator addicted to future federal support for continuance of the program. Citizens become upset when services are cut back or discontinued. In particular, it is difficult to cut back or terminate a treatment program which is legally maintaining a person's addiction. And, as some suspected from the beginning, the federal commitment waned.

First, the armies of addicted Vietnam veterans

*The federal budget figures used in this chapter are taken from the sources cited in References 16 to 16b.

never really materialized. Studies have shown that most soldiers who used heroin in Vietnam never became addicted to the drug and most gave it up upon returning to the United States. Nor did addict-related crime approach the levels some had feared. With the two original motivating reasons for a "war on drugs" diminishing, it was inevitable that unless other reasons could be found for its continuance, the "war" would have to be deescalated.

Moreover, the rapid federal expansion of treatment programs for drug addiction in 1971 to 1972 quickly eliminated the waiting lists that had built up. In fact, the quick reduction led many people to question the accuracy of those reported waiting lists. In any case, supply of treatment quickly caught up with and passed demand, and treatment programs soon found themselves with an embarrassing number of vacant slots.

The combination of these factors ultimately led to the now famous "turn the corner" statement. The budget followed the policy statement, and in the President's FY 75 budget request, treatment and rehabilitation funds were cut for the first time during the Nixon Administration. In order to maintain a level of 95,000 treatment slots, the nonfederal match — those funds which must be provided at a designated percentage to match federal funding — had to be accelerated in certain cases beyond the normal rate of progression. Thus, in a period of a few short years, state and local governments found they had to supply increasing funds in order to continue the programs initiated by the federal government. This unfortunately came at a time when municipal budgets were already severely strained.

The strain on municipal budgets has particularly affected the role of city government with respect to the employment of former drug addicts. Clients in treatment programs have often been unable to get jobs, and employment is vital to the rehabilitation process. Writing in the foreword to *Employment and the Rehabilitated Addict*, Dr. Thomas E. Bryant, president of the Drug Abuse Council, said, "It is our feeling that the failure to adequately address the rehabilitative needs of the population already in treatment tremendously diminishes the effectiveness of the vast amounts of resources we have so far ploughed into treatment."¹⁷ Successful treatment normally must be accompanied by successful rehabilitation, and in the past few years the entire process has been

impeded by a generally deteriorating economic situation, far beyond the control of treatment program directors. Municipal governments have been unable to help with jobs, as SAODAP had once hoped and even expected. In a period of combined inflation and recession, with local budget deficits mounting and requiring that municipal workers be laid off, it has simply been impossible to provide municipally sponsored employment for former drug addicts. If the economic situation improves, this area may emerge as an important municipal function in the treatment and rehabilitation of drug addicts.

The second issue of importance resulting from Public Law 92-255 is the intergovernmental system required for the funding and delivery of drug treatment services by Section 409 of that law. This section authorized formula grants to the states based on a need factor, but it required in return that each state submit to DHEW "a State plan for planning, establishing, conducting, and coordinating projects for the development of more effective drug abuse prevention functions in the State."¹⁸ Section 490(e)(1)-(e)(12) lists various requirements of the state plan, including designation of a Single State Agency to assume responsibility for preparing and administering the state plan, and which notably must "provide for coordination of existing and planned treatment and rehabilitation programs and activities, particularly in urban centers."¹⁹

Under the legislation, the bulk of the federal drug treatment funds remains to be granted and contracted directly at the discretion of DHEW without giving "precedence to public agencies over private agencies, institutions, and organizations, or to State agencies over local agencies."²⁰ The envisioned dominance of the Single State Agency has been clear however. Initially, the Single State Agency would set up a planning, coordinating, and evaluating mechanism for the state. While this was being done the federal government would continue funding drug treatment efforts directly. As the state agencies matured, however, the federal intention was increasingly to turn over administrative and funding responsibilities to the state. The ultimate intention is for the National Institute on Drug Abuse (NIDA) to give what amounts to a block grant to the state for further disbursement within the state according to the state plan submitted to NIDA.

In fact, many state coordinating agencies have

already developed into strong administrative and decision-making units. In some cases the state is now the recipient of all federal funds for drug treatment programs awarded by NIDA for further disbursement within the state according to its State Plan. In some cases this "umbrella" mechanism works well. In other cases potentially serious problems between the state and local governments impede the effective flow of funds and delivery of services. Singleton has reported on problems that have occurred intermittently between New Orleans and Louisiana;²¹ Mayor Paul Jordon of Jersey City has complained about his city's unsuccessful attempts to participate in the state planning process;²² in Boston, the city and the state of Massachusetts have not always seen eye-to-eye.* The city of Gary, heavily populated by Blacks, urban in nature, and with a Black Democratic mayor, has different predispositions with respect to drug abuse than the state of Indiana, which is dominated by rural, white, and Republican influences (see, for example, Reference 23). In San Francisco we find the city charging that "the state made program decisions which are at least the internal affairs of the city . . ."²⁴ One cannot reasonably argue that the city is always right and the state is always wrong. However, since the state has the power, it acts as judge and jury in many of these situations, and the results often severely constrain the city's role in the treatment of drug abuse.

This intergovernmental system for the funding and delivery of drug treatment services is consistent with former President Nixon's principles of "new federalism." Interestingly, however, the original presidential bill did not detail an explicit state role. This was added during congressional considerations by former Senator Harold Hughes (D-Iowa), who was chairman of the Senate Subcommittee on Alcoholism and Narcotics.²⁵

The result, however, has been the same. The system for funding and delivery of drug treatment services has increasingly become a state responsibility. City governments will in the future have to present and justify their needs to the state government rather than to the federal government. After having almost unilaterally expanded drug treatment programming efforts, the federal govern-

ment now intends to buffer itself with the Single State Agencies during the period in which federal support of the local programs decreases.**

Unfortunately, any city desperately needing funds cannot be too selective about its donor. The funds must nearly always be accepted, regardless of who attaches strings and what those strings may be. Federal funds routed to local governments through the states have an entirely different complexion than those funds that are channeled directly to municipal governments. In either case, however, they must be accepted if indeed they are offered.

1972 SURVEY OF CITY DRUG ABUSE ACTIVITIES

The numerous congressional hearings on drug abuse held in 1971 prior to the passage of Public Law 92-255 included only a smattering of testimony from local elected officials. The legislation which passed in early 1972 was accomplished without any systematic understanding of the extent of the problem in most American cities, the philosophies of local governments on drug abuse response, or the actual local government efforts undertaken in response to the problem. For these reasons in 1972 the Drug Abuse Council commissioned the Urban Data Service Center of the International City Management Association to conduct an extensive survey (100 questions) of city and county drug abuse activities (see Reference 26). The goal of the survey was to develop a general understanding of program needs and policy objectives and to uncover unrecognized or unsubstantiated problem areas as they pertained to local government. Also by comparing certain questions from this survey with a similar survey of state drug abuse activities,²⁷ insight was developed on state-local government relations in the drug field and on the perceptions each unit of government had of the other.

Inasmuch as the results of this 1972 survey offer some documentation of the involvement of local governments in drug abuse treatment, prevention, and control efforts on a broad and uniform basis for the first time, a brief review of some of the findings is merited.

*However, through the efforts of Mayor White's Coordinating Council on Drug Abuse, Paul Robinson, its executive secretary, reports that a much stronger relationship is now developing between the city and the state.

**For Fiscal Year 77 the Administration does propose an increased treatment budget, however, federal match will continue to increase, thus putting increased funding pressure on state and local governments.

TABLE 1
Survey Response Rates by Size and Region

	Total surveyed	Respondents							
		Treatment and rehabilitation		Education		Law enforcement		Coordination and funding	
		#	%	#	%	#	%	#	%
Cities	409	227	56	235	57	238	58	229	56
Population:									
over 500,000	26	14	54	16	62	17	65	15	58
250,000-500,000	30	23	77	21	70	25	83	23	77
100,000-250,000	98	57	58	58	59	98	56	52	53
50,000-100,000	255	133	52	140	55	255	55	139	55

From Drug Abuse Council, Inc., *Survey of City/County Drug Abuse Activities: 1972*, Drug Abuse Council, Inc., Washington, D.C., 1973. With permission.

The survey was sent to all 409 cities with populations over 50,000. There were four separate parts to the survey: treatment and rehabilitation; education; law enforcement; and coordination and funding. The survey response rates were broken down by city size and survey component; in every case the return rate exceeded 50%, which was surprisingly good considering the length of the questionnaire (see Table 1).

Perhaps the most basic measure of a city's involvement in the drug abuse problem was whether or not the city specifically designated a person (or office) to assume overall responsibility for coordinating or guiding the jurisdiction's response to the problem. Such an office would be comparable to the Single State Agencies required by Section 409 of Public Law 92-255. Of the responding cities, 60% reported having such a person or office; surprisingly, the most frequent positive response was not in the largest cities, as might be expected, but in cities with populations between 100,000 and 250,000. Most of the coordinators reported some previous experience in the drug abuse field, with a general emphasis on administrative backgrounds. Only 14% of the coordinators reported a law enforcement background, and all came from cities with populations under 250,000.

A more exact measure of city involvement could, of course, be determined from budgetary information. Unfortunately, however, such budgetary analysis is generally hindered by in-

exactitude in terms of where the funds for drug abuse projects come from and where they go. Nonetheless, 97 cities were able to provide at least some budgetary information.

As Figures 1 to 5 show, the absolute dollar value of the sources and expenditures of the drug abuse budgets declined as the population of the jurisdiction declined. The relative composition of these sources and expenditures, however, varied. The smallest cities received the least external support; in these jurisdictions the local contribution constituted over 25% of the annual drug abuse budget. By comparison, local contributions in the larger cities made up only about 13% of their respective drug abuse budgets. Functionally, expenditures for treatment and rehabilitation constituted the majority of funds spent in every city, regardless of size. It should also be noted that the fraction of the total drug abuse budget allocated for treatment and rehabilitation increased as city size increased. In the area of law enforcement the survey returns suggested a greater relative emphasis on this function as the city size decreased.

Also with respect to budgets, the year in which funds were first earmarked in a city budget for drug abuse response is a useful indicator of when that jurisdiction first acknowledged drug abuse as a problem. As Figure 6 indicates, specific earmarking of local funds is a fairly recent phenomenon; 70% of the reporting cities did not have such funds allocated until 1970 or later.

In this 1972 survey, treatment and rehabili-

All Cities
N = 97

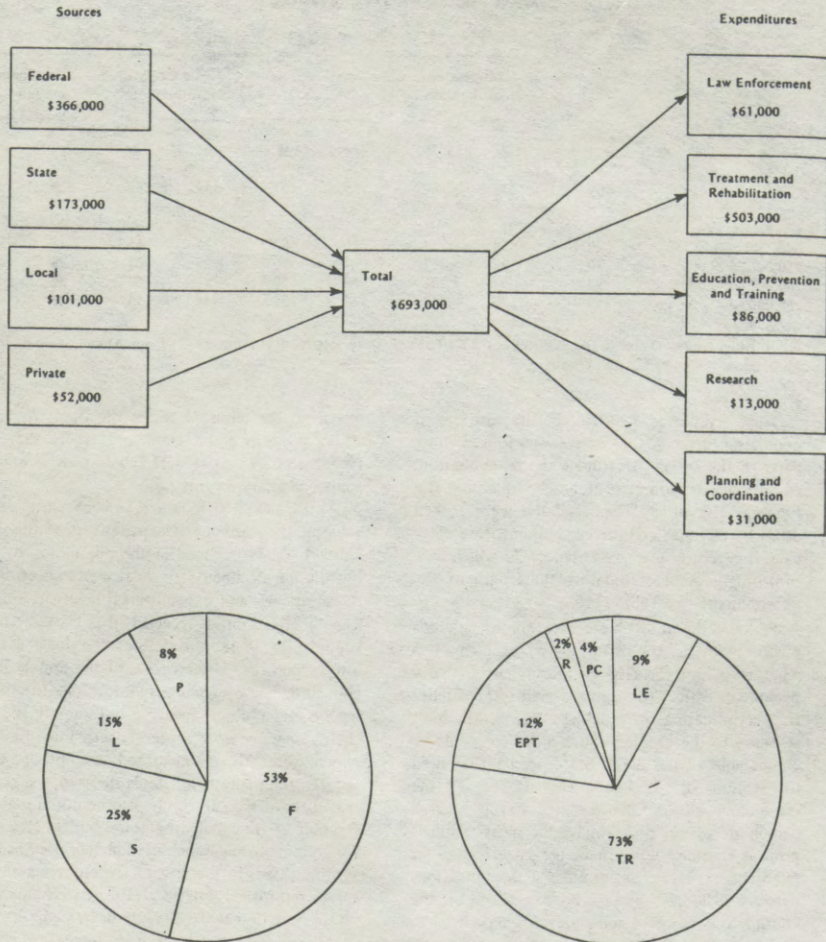


FIGURE 1. (From Drug Abuse Council, Inc., *Survey of City/County Drug Abuse Activities: 1972*, Drug Abuse Council, Inc., Washington, D.C., 1973. With permission.)

Cities: over 500,000
N = 9

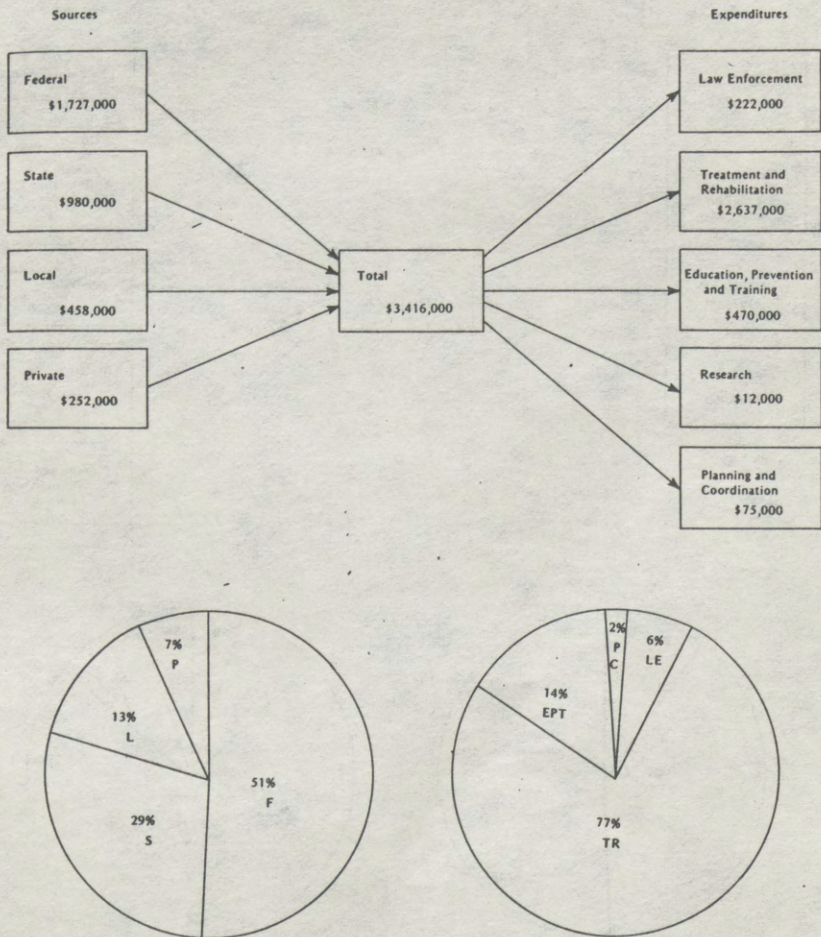


FIGURE 2. (From Drug Abuse Council, Inc., *Survey of City/County Drug Abuse Activities: 1972*, Drug Abuse Council, Inc., Washington, D.C., 1973. With permission.)

Cities: 250-500,000
N = 12

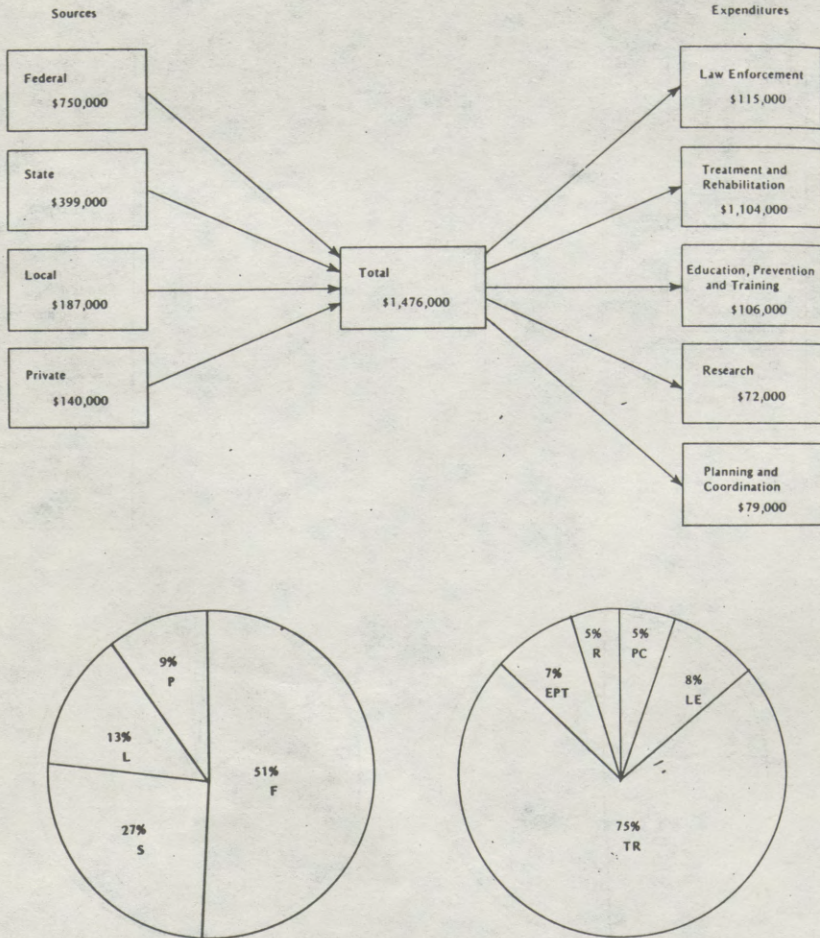


FIGURE 3. (From Drug Abuse Council, Inc., *Survey of City/County Drug Abuse Activities: 1972*, Drug Abuse Council, Inc., Washington, D.C., 1973. With permission.)

Cities: 100-250,000
N = 23

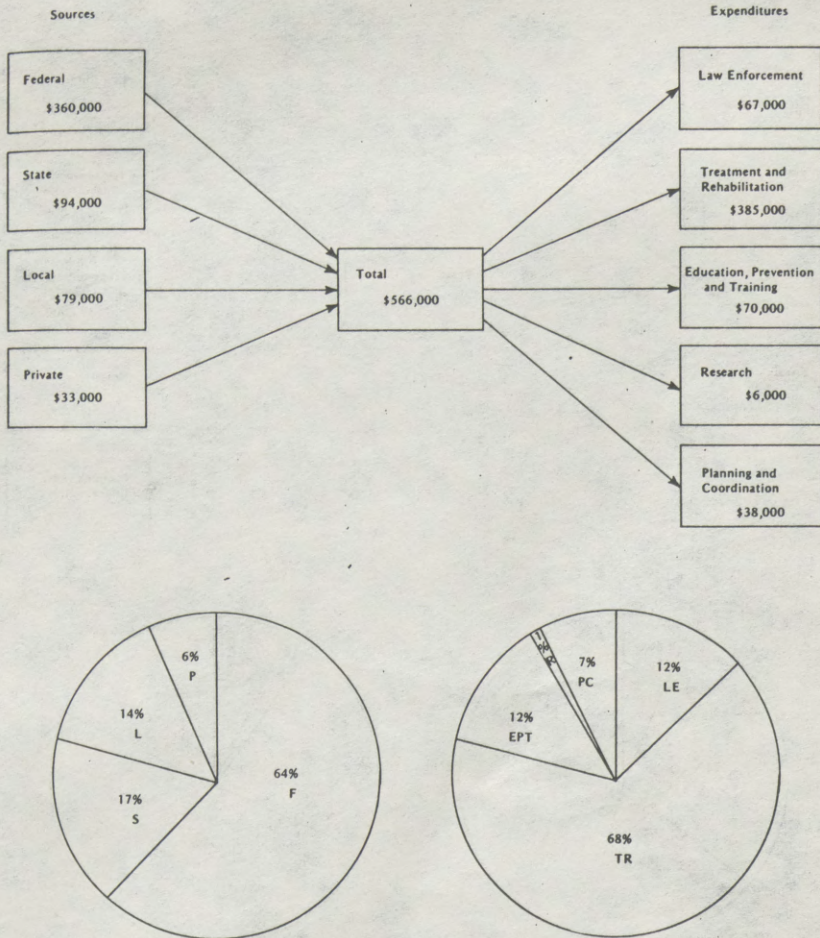


FIGURE 4. (From Drug Abuse Council, Inc., *Survey of City/County Drug Abuse Activities: 1972*, Drug Abuse Council, Inc., Washington, D.C., 1973. With permission.)

Cities: 50-100,000
N = 53

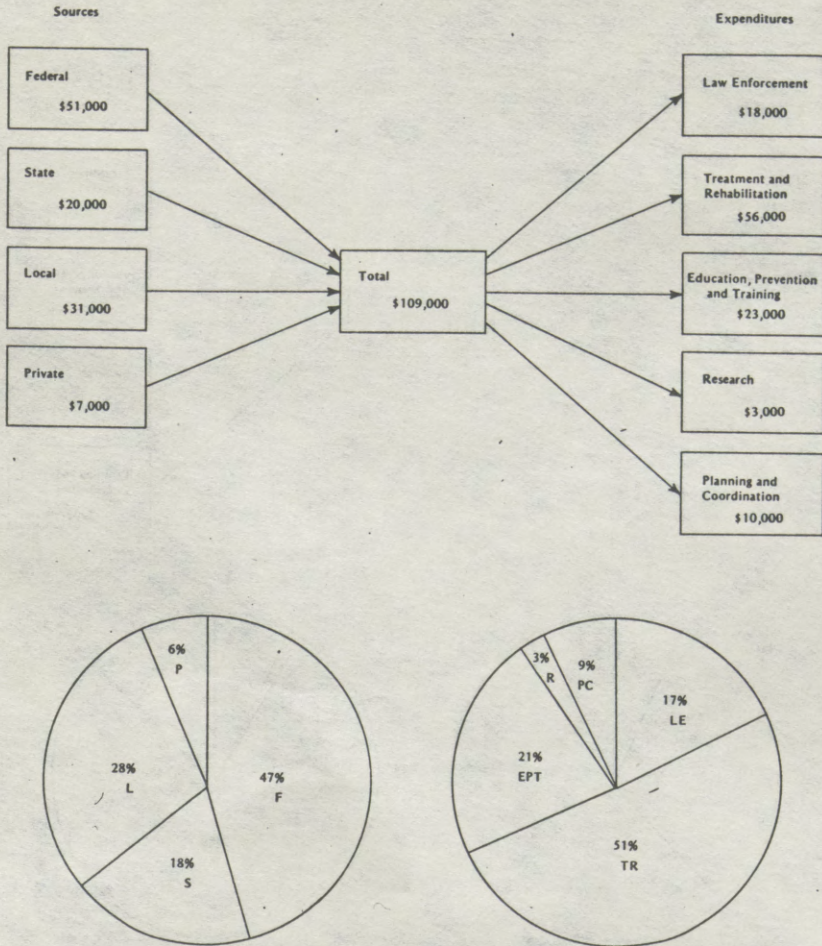


FIGURE 5. (From Drug Abuse Council, Inc., *Survey of City/County Drug Abuse Activities: 1972*, Drug Abuse Council, Inc., Washington, D.C., 1973. With permission.)

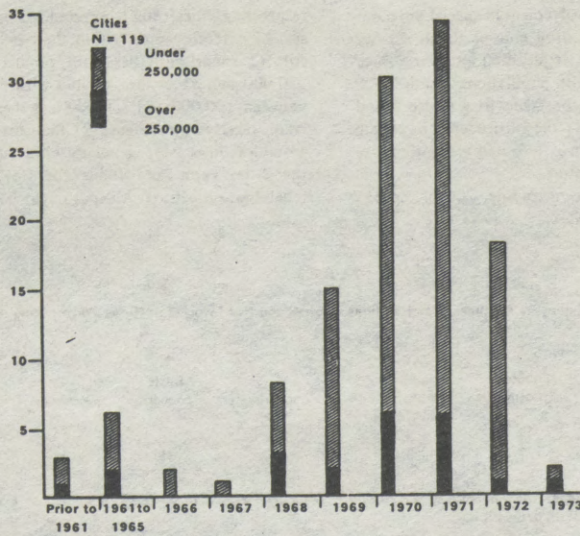


FIGURE 6. Year when funds were first allocated for drug abuse. (From Drug Abuse Council, Inc., *Survey of City/County Drug Abuse Activities: 1972*, Drug Abuse Council, Inc., Washington, D.C., 1973. With permission.)

TABLE 2

Employers Attitudes Toward Hiring Former Drug Abusers

	Number reporting	% Enthusiastic	% Cooperative	% Little concern	% Resistant	% Opposed
Cities Total	171	1	13	33	51	2
Population:						
over 500,000	12	0	8	33	58	0
250,000-500,000	20	5	20	25	45	5
100,000-250,000	40	0	18	28	55	0
50,000-100,000	99	0	10	37	49	3

From Drug Abuse Council, Inc., *Survey of City/County Drug Abuse Activities: 1972*, Drug Abuse Council, Inc., Washington, D.C., 1973. With permission.

tation programs were found to be in operation in 170 of the 214 responding cities (79%). Of those cities with treatment programs, 72, or 42%, reported that they were directly operated by the local government. As might be expected, the smaller cities tended to operate fewer programs.

Because of the importance of employment in

the rehabilitation process, the local drug abuse program coordinators were asked to characterize the generally prevailing attitudes among private employers toward hiring former drug abusers. The respondents did not paint a bright picture, as Table 2 indicates.

Approximately 25% of the responding cities

reported an active involvement in special programs to hire rehabilitated drug abusers. Such activity was greater in the larger jurisdictions; over 50% of the reporting cities with populations over 500,000 were engaged in such programs. It was also found (see Table 3) that the attitudes of private employers in these areas reflected a slightly more cooperative hiring posture.

On the law enforcement side, 206 of the 235

responding cities (88%) reported the existence of special narcotics units within their police forces. All 42 reporting cities with populations over 250,000 and 51 of the 52 cities with populations between 100,000 and 250,000 had these units. It is of interest (see Figure 7) that these specific narcotics units were generally established before the cities earmarked funds for treatment and rehabilitation efforts. Also, as might be expected,

TABLE 3

Contrast Between Employers Attitudes in Jurisdictions Involved and Not Involved in Hiring Former Drug Abusers

	Number reporting	% Enthusiastic	% Cooperative	% Little concern	% Resistant	% Opposed
Cities: Involved	44	2	23	30	43	2
Not involved	127	0	9	35	54	2

From Drug Abuse Council, Inc., *Survey of City/County Drug Abuse Activities: 1972*, Drug Abuse Council, Inc., Washington, D.C., 1973. With permission.

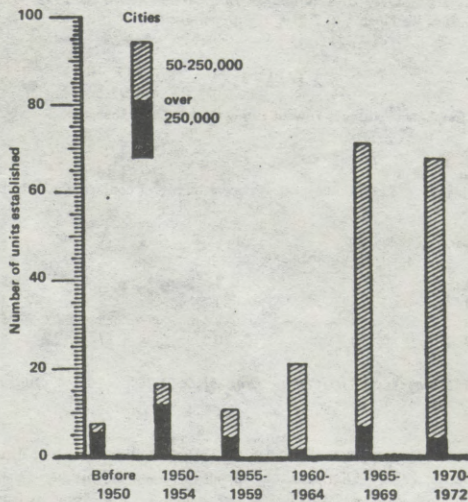


FIGURE 7. Years of establishment of special narcotics units. (From Drug Abuse Council, Inc., *Survey of City/County Drug Abuse Activities: 1972*, Drug Abuse Council, Inc., Washington, D.C., 1973. With permission.)

Figure 7 indicates that these special units were generally established earlier in the larger cities than in the smaller ones.

THE CITY ROLE: ISSUES AND RECOMMENDATIONS

The routing of federal funds through the states for the treatment of drug abuse, particularly heroin addiction, has a certain administrative appeal. The theory is that by awarding block grants and umbrella contracts to the states, the federal government can ultimately reduce its number of grants and contracts from the hundreds to the 56 Single State Agencies. This is designed to reduce the voluminous amounts of administrative paper work at the federal level. The system of funding through the states is also consistent with the concept of the new federalism, which is to reallocate power from the federal government to units of government closer to the people, principally through forms of revenue sharing.

As envisioned by Congress and the President in Public Law 92-255, funds for drug treatment and prevention would be allocated to the states according to need, with further disbursement of the funds from the state level made in accordance with the needs set forth in the state plan. However, since no commonly accepted definition of "need" in the drug field has been agreed upon, and since there is still no reliable method by which to measure need along whatever criteria are developed, great discretion has been allowed the states in the allocation of funds to programs and to problem areas.

Large cities, where the needs and problems are greatest, must face the fact that many state legislatures are dominated by rural and suburban interests. Drug abuse issues in rural and suburban areas are often different from those in the central city. While heroin may be the major drug of abuse in the one or two largest cities, other parts of the state are usually concerned with other drugs. And while treatment for heroin addiction may be the most pressing need in the central city, the emphasis desired or demanded by the rest of the state may be for education and prevention programs. Although the cities may advocate increased funding for methadone programs, those areas of the state where heroin is not a problem

are generally unsympathetic to the use of one addictive drug to treat another. Different units of government are bound to have different needs, priorities, and philosophies, all justified from their own perspectives.

If one accepts the contention that the major drug abuse problem in the United States in terms of its social costs is heroin (with the possible exception of the legal drug, alcohol), and that these social costs are largely concentrated in a limited number of cities, then the inescapable conclusion is that strict adherence to the principles of revenue sharing for drug treatment and prevention funding is likely to lead to great mismatches between where the problems are and where the funds go. Awarding block grants and umbrella contracts to the states for further disbursement to drug program efforts makes administrative sense. It is in the actual practice, however, that the problems occur. The first purpose of any funding system should be to target the funds to the problem and problem areas where they are most needed as efficiently as possible. Efficient administration of funds directed to the wrong problem and problem areas is just as undesirable as inefficient administration of funds channeled to the right problem and problem areas. Whoever administers the disbursement of federal funds for drug treatment and prevention has the opportunity to define the problems and to determine how funds will be used to respond to those problems. The substitution of state decision making for federal decision making does not augur well for the large cities where the social costs of drug abuse are most severe.

Blacks and other minority populations have an additional concern with state drug abuse administration systems. This was most clearly articulated in a resolution passed by the National Black Caucus of Local Elected Officials in June 1974:

Whereas, unfortunately, the problems of drug abuse have disproportionately affected large numbers of Black and Spanish-speaking Americans, these minority populations tend to be most underrepresented at the state level where drug abuse policies are being increasingly formulated thus creating a large discrepancy between those most afflicted by the problems and those establishing the policies and procedures to solve the problems.*

Other problems also plague the system created

*Resolution passed by the National Black Caucus of Local Elected Officials, June 1974, in San Diego at the Annual Meeting of the U.S. Conference of Mayors.

under Public Law 92-255. Under that legislation every state was required to establish a Single State Agency to plan, coordinate, and ultimately direct that state's drug abuse response. The activities were to be and still are conducted with federal funds. The result is that nonurban states, like North Dakota, Maine, and Montana, with negligible drug problems are now required to plan and conduct drug abuse response efforts, while cities like Philadelphia, Boston, San Francisco, Chicago, and Atlanta are ignored in the legislation. The inconsistency between the approach and the problem is glaring.

An additional inconsistency lies in the fact that with a few exceptions, notably New York, California, and Illinois, most states were not actively involved in drug abuse treatment and prevention efforts before the passage of Public Law 92-255. Whatever expertise there was in the field before 1972 was likely to be found either at the local community level or in the federal government. Yet for administrative efficiency, Congress and the President chose to predicate their much expanded drug abuse treatment and prevention efforts on the role and responsibility of the state. Adding further to the difficulty of understanding this choice is that the problems of drug abuse, particularly heroin addiction, are generally of less intensive concern at the state level than they are to a few cities within the state. Drug abuse, for example, is of far greater concern to New Orleans than it is to the rest of Louisiana; this is equally true with respect to Gary and Indiana. Yet the system established by Public Law 92-255 serves, in effect, to stand between the cities with problems and the federal government with funds — all in the name of administrative ease and efficiency.

Inasmuch as the Single State Agencies have been in existence for 4 years, it makes little sense to dismantle and replace them now when they are just beginning to show signs of effective professional development. Rather, what needs to be done is to consider modifications in the system which would insure a more precise targeting of federal drug abuse funds to the most severe drug problems and the most severely affected areas.

The most important step in this direction would obviously be to reach an agreement about what a drug problem is, how to measure it, and what to do about it. Work on the social costs of drug abuse and the recent White Paper on Drug

Abuse, prepared by the Domestic Council's Drug Abuse Task Force, strongly suggest that heroin addiction and its associated costs still constitute the primary drug problem in this country (alcohol excepted). Work is continuing on methods to measure more accurately the incidence and prevalence of all illicit drug use, including heroin, but there is a long way yet to go. Agreement on what should be done about the drug problem is also still far away. Given these problems of measurement and disagreements over how to respond, it seems to make sense that the areas considered most severely affected by the primary drug problem — heroin addiction — ought to have a more significant voice in the state determination of needs, priorities, policies, and resource allocations.

Any number of changes in this direction could be considered. At the very least, representatives from the local elected government of the two or three cities with the most severe drug problems in each state should be more directly and actively incorporated into the state planning process. At a minimum, each of these jurisdictions should have the opportunity to review and comment on the sections of the state plan that directly affect it before that plan is finalized and submitted to the Secretary of Health, Education and Welfare for funding approval.

A more forceful step would be to require the state to allow those two or three most severely affected cities to prepare their sections of the state plan and to finance them accordingly. This would insure that the local elected representatives from the affected jurisdictions could formally offer to the state an official statement of their drug problems, needs, and priorities. As in the first suggestion, of course, the state would still exercise final judgment on what is submitted to DHEW.

A further step to rectify the current intergovernmental imbalance would be to introduce a double veto mechanism into the state planning process. Basically this scheme would require that all pertinent sections of the state drug abuse plan be explicitly and officially approved by the two or three most severely affected cities in the state before the plan is submitted to DHEW for approval. Such a double veto system would create the dynamics whereby a state plan would have to be negotiated in the fairest possible bargaining sense between the state and those few jurisdictions in the state where the problems are most concen-

trated. The double veto would eliminate those situations in which the state exercises excessive controls over what is a particularly unique urban, central city problem. If the state and the cities involved are unable to reach agreement on the annual state plan by a predetermined date, DHEW, as the funding source, would be required to arbitrate the differences. The result in either instance should insure that large city drug abuse needs are not sacrificed in the traditional city-state political entanglements.

Two questions immediately arise. Why should cities rather than counties or regional governments be selected for the double veto powers? And how does one select the cities to be included? The answers are obviously more complex than can be presented here.

As it happens, legal city limits geographically match up most closely with the most severe drug problem areas. Counties and regional governments tend to incorporate broader areas and thus a broader array of concerns. Where heroin is a significant problem, it is usually the elected city government that is pressured to come up with solutions. Neither counties nor regional governments have shown much inclination to become involved in this problem area. The argument that counties generally are responsible for health care problems is valid only insofar as one perceives heroin addiction as only a health care problem. The available evidence suggests a need for a far broader orientation to understand the problem and its associated social costs and to plan programs that will minimize both. Especially since the social costs of heroin addiction impact on community development, there is a need, even a responsibility, for the direct and active involvement of city government.

The selection of the cities to be awarded veto power over the state plan would have to be made by DHEW. The primary criteria would have to be the social costs of drug abuse, even though these measurements greatly need refinement. In most instances, however, it should not be too difficult to select the appropriate cities, which should be limited to a maximum of two or three in any state, so as not to inextricably tie up the planning process. The selection of the cities should be reviewed annually.

In addition to the proposed modifications to the state planning process, there are three other possible changes which, if accepted, could foster

more active participation by elected city governments. First, if the states do not begin to do so, then NIDA should initiate a program to fund city drug-coordinating agencies with responsibility for developing citywide drug abuse plans in a limited number of cities with the highest concentrations of drug-related problems. These plans should provide for interaction with the state government. Philadelphia needs such an agency and plan far more than Idaho; Atlanta's drug problems and needs far surpass those of Vermont. The examples are numerous. A system which dictates funding only state drug abuse plans and state drug abuse agencies focuses solely on administration and is blind to the actual problems. Plans need not uncontrollably proliferate across the country; but if the federal government is to require planning, it should at least make certain that there will be direct participation from those areas most affected and most concerned. An additional benefit of funding city agencies would be that it would give local elected officials a dependable and developed local source of advice and assistance on drug issues and problems. This is needed.

The second suggestion is a bureaucratic one. It is my opinion that NIDA should establish an Office of Urban Services as a visible part of its bureaucratic structure. The purpose of this office would be to develop closer relationships between NIDA and a greater number of local elected officials, especially regarding the development of drug abuse policy. This proposal should not interfere with the federal-state-local funding system. However, one by-product of divorcing the cities from the federal government with respect to funding has been to buffer these two governmental entities with respect to policy development. Both the federal government and the cities need to communicate more and to learn from one another. NIDA needs to be more aggressive in seeking large city government input for its deliberations, and the cities need to develop a better understanding of why NIDA does what it does. By consolidating and then building upon some ongoing activities in NIDA, the proposed Office of Urban Services could accomplish both aims at a minimal additional cost. Moreover, where appropriate, the proposed Office of Urban Services could be involved in administering and/or monitoring the changes proposed with respect to the state planning process.

The final suggestion might to the purist violate

the sanctity of the federal-state-local flow of funds. The proposal is to allow perhaps no more than the two dozen cities burdened with the highest social costs of drug abuse the option of receiving block grant funding directly from NIDA. As already acknowledged, one major purpose of awarding block grants and umbrella contracts to the states was to reduce NIDA's grants and contracts from the hundreds to 56, and to reduce the federal administrative work accordingly. However, what is so magical about 56? Is 76 or 80 any less magical? Would the principle be so violated as automatically to compel opposition to the proposal? One would think not. Admittedly block grant funding to the cities could create problems for the state planning process. However, some increase in the problems of coordination would be an acceptable cost, especially if more efficient and effective drug programming efforts resulted. After all, the federal involvement was initiated to solve a problem, not to demonstrate a model administrative concept. The principal benefits of block grant funding to a relatively few selected cities would again be the more accurate and direct targeting of funds to problems and problem areas; the elimination of one step in the funding flow process and therefore a reduction in administrative overhead; and the investiture of greater local decision-making authority in an elected government closer to the people. All three benefits are in accord with the goals and purposes of revenue sharing and new federalism. It seems to make more sense to allow direct federal funding to a few selected city governments with particularly severe drug problems and the desire and capability to coordinate their overall programmatic response than it does to reject such funding simply because the theory tells you so.

A NOTE ON THE ROLE OF CITY ORGANIZATIONS

A majority of city governments in this country are directly and indirectly represented in Washington by two closely affiliated organizations, the National League of Cities and the U.S. Conference of Mayors. The activities of these two organizations in the area of drug abuse was minimal until 1973. When Public Law 92-255 was under congressional consideration in 1971 and 1972, the lobbying arms of the National League of Cities and the U.S. Conference of Mayors were not

involved at all. Accordingly, the resulting legislation reflected the more organized and persistent efforts on behalf of state governments.

Real involvement in the drug abuse area did not begin until mid-1973 when SAODAP awarded a grant to the National League of Cities and U.S. Conference of Mayors to enable these organizations to form a task force of mayors to specifically consider drug abuse issues. Under the chairmanship of Mayor Paul T. Jordon of Jersey City, himself a doctor and former director of a methadone program, the task force made up of mayors from 20 cities first met in October 1973. They decided that their purpose would be twofold. They would:

1. Develop model community support projects in their cities which would be described to mayors throughout the country
2. Provide the local perspective on the impact of federal drug abuse treatment and prevention programs and policy at the municipal level

In its first year, the project produced a book, *Drug Abuse: The Role of the Mayor*. The book offers 25 specific case examples of how cities, and particularly their mayors, have dealt with various aspects of the drug abuse problem. The conceptual basis underlying these examples is that there are four possible roles for mayors: (1) as *conveners* of disparate groups and factions within their jurisdiction; (2) as *implementers* of drug policies through directives issued to city-run or city-sponsored programs; (3) as *solicitors* of funds to support community drug abuse efforts; and (4) as *influencers* utilizing the prestige of the Office of the Mayor.

The case example approach is open to criticism. It conveys an impression of greater city interest, involvement, and activity in the drug area than is generally found. The cases emphasize success stories in a field beset by lack of success. And the reported cases result from a set of circumstances peculiar to one locale and therefore not generally replicable.

On the other hand, the cases offer food for thought, which was exactly the intention. They emphasized actions and directions, particularly in the area of policy development that cities and mayors can move in without having to commit significant amounts of funds, which is a realistic approach. The implied message is that the mayor

and the city *can do*, and the examples of such are loosely grouped into six divisions: planning and coordination; treatment; personnel policy; job training and placement; community awareness; and criminal justice. Some of the case examples are worthy of review. The report on the development of Baltimore's Personnel Policy on Alcoholism and Drug Abuse (November 1973) was one particularly good example of a positive and valuable municipal action which could be adopted by other jurisdictions.

With respect to policy considerations one must conclude that the mayor's task force is necessarily restrained by the fact that it operates solely with federal funds. This is not to imply any wrongdoing, or even subtle coercion, on the part of the federal funders. It is simply an acknowledgment of a basic fact of life: You don't bite the hand that feeds you — or at least you are extremely careful about how you bite. The easy, simple, and logical solution would be for the task force to represent city interests in the drug abuse field with city funds. This is not likely to happen, however, in the foreseeable future.

The National Municipal Policy, which is the formal policy statement developed and adopted by the membership of the National League of Cities, does have a section on drug and alcohol abuse. Subsections therein delineate the local perspective on what the federal, state, and local government roles should be. Inasmuch as this is the official statement by local government on the city role, the pertinent subsections are reprinted in the appendix of this chapter. Basically, the policy calls for continued federal funding of treatment programs, including the options of awarding block grants to local general-purpose governments and

enabling local elected officials to exercise greater decision-making authority over drug abuse efforts within their communities. A sense of discomfiture with the current roles of state government permeates the entire statement.

CONCLUSION

Graham Finney spent 2 years as commissioner of New York City's Addiction Services Agency, the largest city drug abuse agency in the country and perhaps the world. Finney later wrote a book about his experiences. He chose to title that book *Administering Catastrophe*.

Drug abuse, heroin addiction in particular, is intricately interwoven into the broader urban crisis. There are no easy solutions. Not even money alone will suffice.

Theodor Herzl wrote, "Whoever would change men must change the conditions of their lives." Drug abuse contributes to and is a consequence of the problems of modern urban living. The best way to "solve" the drug abuse problem is to "solve" the urban crisis — to change the conditions of our lives.

Short of this we must continue to patch as best we can. As our system of government has evolved, the responsibility for patching has largely become a federal one. It is the only level of government with sufficient resources.

The theme of this chapter may perhaps best be characterized as "help them help themselves." The suggestions offered in this chapter are designed to channel more funds and more responsibilities to the large cities of this country where the social costs of drug abuse are most severe.

APPENDIX: EXCERPTED FROM THE NATIONAL MUNICIPAL POLICY OF THE NATIONAL LEAGUE OF CITIES

DRUG AND ALCOHOL ABUSE*

4.500 Goals for Drug and Alcohol Abuse Treatment and Prevention

Drug and alcohol abuse represents one of the nation's most serious health and social problems. To a considerable extent, these problems have increased because of society's pre-occupation with addressing their symptoms rather than causes.

Greater emphasis must be placed upon prevention, treatment and rehabilitation, particularly with regard to hard drug use. Yet, any response to this social problem must provide for the safety of the community. Only with such dual concern can public support be gained for the community-based treatment and prevention programs which are needed to successfully cope with this urgent problem.

*National League of Cities, Resolutions Committee Report, mimeographed, Washington, D.C., 1975.

The ultimate goals for drug abuse and alcohol abuse treatment and prevention are

- A. To gain public recognition that drug abuse includes the abuse of alcohol, and that many individuals who are prone to drug abuse need supportive services and modified work and living situations on a long-term basis;
- B. To devise a system that will allow communities to respond with flexibility to a variety of drug abuses, rather than concentrating on only a single form of drug abuse;
- C. To utilize public health facilities to their fullest extent to treat and prevent drug and alcohol abuse; and
- D. To make treatment and rehabilitation available for drug abusers at all stages of the criminal justice process, with emphasis on early diversion for treatment.

4.501 The Federal Role

The federal government has the funds and the technical resources to provide for the development of prevention and treatment programs at the local level. Its data collecting and analyzing capacity enables it to fund and direct especially needed research. It is the appropriate level at which drugs should be regulated. The federal government should:

- A. Tailor all federal drug abuse treatment and prevention programs to enable elected officials of local general purpose government to exercise decision-making authority over the planning, allocation of resources, and administration of drug abuse efforts within their communities;
- B. Make available block grants to local general purpose governments, accompanied by available technical assistance, to develop treatment and prevention programs which have flexibility to respond to a variety of drug abuses;
- C. Require approval by elected city officials of the section of the state plan for drug abuse treatment and prevention which pertains to their jurisdictions, and representation on the state advisory council for drug abuse prevention.
- D. Revise civil service regulations to allow the hiring of rehabilitated addicts, including those who have committed drug-related offenses;

- E. Pool funds for supportive services to facilitate comprehensive program development at the local level;
- F. Fund research to develop means to measure extent of addiction and effectiveness of treatment, as well as new approaches to treatment and preventive education;
- G. Guarantee that no one who voluntarily seeks treatment for drug-related problems shall be denied treatment; and that when cutbacks in drug abuse funds are made, every effort shall be made to protect current treatment program quality;
- H. Guarantee that federal policies will continue to reflect and emphasize drug treatment and prevention services;
- I. Guarantee that adequate urban and minority representation and input into the state drug abuse planning and implementation process shall be enforced; and
- J. Guarantee that funds for the delivery of drug abuse prevention services be channeled to those areas and populations most in need of it, and that where and when necessary, that those cities where drug abuse problems are most severe will receive sufficient funding to plan for and implement a satisfactory drug abuse treatment and prevention system.

4.502 The State Role

The states should:

- A. Coordinate state plans, guidelines, and legislation to allow cities to develop, with a minimum of effort, comprehensive treatment and prevention programs;
- B. In planning and administering state drug abuse programs, use only those sub-state units which represent areas where drug abuse is concentrated;
- C. Augment the role of the federal government in providing technical assistance to develop and manage programs; and
- D. Revise civil service regulations to allow the hiring of rehabilitated addicts, including those who have committed drug-related offenses.

4.503 The Local Role

The major role of local government is to assess the problem, determine the approach needed and

gain the public support necessary to develop community-based programs. The cities should:

- A. Centrally coordinate and evaluate local public and private resources and programs;
- B. Develop comprehensive treatment and prevention programs which include central intake, vocational rehabilitation, employment placement and counseling, evaluation, education, outreach, followup, health care, judicial diversion and specialized treatment;
- C. Encourage public recognition and acceptance of the need to locate treatment and counseling centers in areas accessible to drug abusers' residences and/or places of employment;
- D. Revise civil service regulations to allow the hiring of rehabilitated addicts, including those who have committed drug-related offenses;
- E. Work with private industry to employ rehabilitated addicts; and
- F. Act to eliminate the illegal sale of controlled substances.

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Mr. ROGERS. Thank you very much.

Dr. Lewis, I would like for you to comment on the record for us what you have found in the cities to be the most effective treatment programs, what should be an appropriate division of funds, also your feelings on treatment programs evaluation and what you feel have been the most successful.

Mr. GOLDBERG. OK.

[The following information was received for the record:]

NATIONAL ASSOCIATION FOR CITY DRUG COORDINATION

PLANNING COMMITTEE

Chairperson:

David C. Lewis, M.D.
Chairperson, City of Boston
Coordinating Council on Drug Abuse

May 5, 1978

TELEPHONE CONTACT:
617-725-3262

Members:

Megan De Camp
Phoenix, Arizona
Barbara Gross
Gary, Indiana
Douglas Morgan
Newark, New Jersey
Claude Reese
New Orleans, Louisiana
John Riggan
Philadelphia, Pennsylvania
Paul Robinson
Boston, Massachusetts
Michael Thompson
Los Angeles, California

Congressman Paul Rogers
Chairman, Subcommittee on
Health and the Environment
Room 2415 Rayburn House Office Bldg.
Washington, D.C. 20515

Dear Congressman Rogers:

Regarding the questions you raised at the hearings on April 10, 1978, being a new organization, we have not yet adopted formal positions on the questions of the division of funding, treatment, or evaluation. I would, however, like to briefly address the latter two questions from my perspective based on fifteen years of experience in the addiction field.

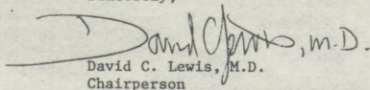
There are a wide range of acceptable treatment modalities. Within each modality, program performance ranges from excellent to disgraceful. Since clients needs differ it is essential that a variety of treatment approaches be encouraged. The role of the government, I feel, should not be to favor one modality over another. Clients will gain more if they have a choice of different types of treatment programs since a proper match between client and program staff interests and goals should insure a better chance of recovery. For this reason it is appropriate for the federal government and other units of government to support a variety of treatment modalities and to insure both their accessibility and a minimum standard of program performance. In insuring this minimum standard, the form of support should not be so constrained as to stifle innovation or excellence. In this regard, the rigid reliance on the funding per treatment slot method which is now widely used has been a negative influence on program innovation. Also, regulations which should not be so burdensome to adversely affect our best programs. The recent suggestions for amendments in the methadone regulations allowing more flexibility are a positive step.

The question of evaluation is a difficult one for two reasons. First, we still do not have an adequate picture of the natural history of addiction and rely almost entirely on our experience with clients who appear for treatment. We have minimal information on the number of controlled vs. uncontrolled users, how many spontaneous remissions occur without treatment, and how different episodes of treatment affect the long term history of an individual's addiction. Second, we conduct our program evaluations in the face of changing client populations, major shifts in treatment approaches and significant

changes in social attitudes regarding addiction and its treatment. Furthermore, it is typical for addicts to have several treatment experiences and for control over excessive drug use to be achieved only after a number of these experiences. The use of short term evaluations which are usually directed at measurable program goals (i.e. decreased drug usage, crime reduction, increased employment) have limited usefulness and have led to an unrealistic expectation that such evaluations will give us the answer for the treatment of chronic addictive disorders. The longer term evaluation of treatment outcomes are now assessing the impact of programs developed in the early 1970's in an era of hasty program expansion. Because we expect more of the evaluative process than it can provide, our expectations that such evaluations will yield the answers have not been fulfilled.

I believe there have been reasonable though incomplete efforts to assess the level of drug use and addiction in our communities. Also, there have been efforts, which need improvement, to require of government supported programs an accounting of their costs related to program goals and performance. A number of the programs which are federally funded now specify the goals they wish to achieve and gather data which measures the degree with which these goals have been successful, and we need more of these efforts. There has also been federal support for the longer term evaluative studies. The best general discussion of the issues of evaluation that I have seen thus far is contained in the chapter now being prepared by John Sessler of the Drug Abuse Council for a book that the Drug Abuse Council is now readying for publication. I believe that you will find this chapter informative, and I will send it to you as soon as it is completed.

Sincerely,

 M.D.
David C. Lewis, M.D.
Chairperson

DCL:bsg

Mr. ROGERS. Thank you so much. We are grateful for your presence here today.

That concludes the list of witnesses today. The subcommittee stands adjourned.

[Whereupon, at 4:15 p.m. the subcommittee adjourned.]

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