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DRUG ENFORCEMENT ADMINISTRATION REAUTHORIZATION

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HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE HOUSE OF REPRESENTATIVES

NINETY-SIXTH CONGRESS

SECOND SESSION

ON

H.R. 6700

A BILL TO EXTEND FOR THREE FISCAL YEARS THE AUTHORIZATION OF APPROPRIATIONS FOR THE ADMINISTRATION OF CONTROLLED SUBSTANCES ACT, AND FOR OTHER PURPOSES

MARCH 10, 1980

Serial No. 96-115

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DRUG ENFORCEMENT ADMINISTRATION REAUTHORIZATION

MONDAY, MARCH 10, 1980

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

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 2322, Rayburn House Office Building, Hon. Henry A. Waxman, chairman, presiding.

Mr. WAXMAN. This morning the Subcommittee on Health and the Environment will consider legislation to extend the authorization of appropriations for the Controlled Substances Act. Witnesses will provide testimony concerning the effectiveness and proper focus of the Federal Government's drug abuse law enforcement and regulatory activities.

H.R. 6700, which Dr. Carter and other members of the subcommittee have sponsored with me, provides for a modest increase in authorizations for the activities of the Drug Enforcement Administration in each of the next 3 fiscal years.

The bill also continues in force the important reporting provisions for piperidine required by the Psychotropic Substances Act of 1978.

Without objection the text of H.R. 6700 will be printed in the record. [See p. 3.]

When the subcommittee reviewed the activities of the DEA last year we heard encouraging news about significant reductions in heroin supplies. In fact we heard that heroin availability was at its lowest level in a decade. Purity was down and street prices were up.

We greeted these reports with enthusiasm. Finally a decade long quest to secure a handle on the elusive heroin problem was in sight.

However the optimism was short lived. Reports from several east coast cities soon surfaced calling attention to the presence of a new supplier. Purity was on the rise. Street prices were declining. The reports indicated that our earlier successes might soon be overwhelmed by a flood of heroin from the so-called golden crescent.

Today we hope to learn more about DEA interdiction activities targeted at the golden crescent. We hope to learn what threat heroin from this volatile region of the world poses for the health and general welfare of the United States.

Equally troubling, the subcommittee has noted with alarm the dramatic and indeed frightening increase in availability and abuse

of dangerous drugs. Despite notable reductions in heroin supplies, the drug abuse trends in recent years have been toward licit drugs.

A review of recent reports from hospital emergency rooms and coroners' offices indicate that the drug abuse phenomenon can no longer be defined solely in terms of illicit narcotics. Drugs available by prescription now rank high on drug injury lists.

One factor in the growing incidence of poly-drug abuse may be their abundant supply and easy availability. Amphetamines, mild tranquilizers, and barbituates are staples of our health care delivery system. They are also staples of today's drug culture.

Controlling licit drug abuse poses two unique problems for law enforcement personnel. The first is the wide diversity of potential victims. No economic, sex, age, or ethnic group is immune from the threat of drug related injury. The schoolchild, the housewife, and the business professional are all threatened by the prevalence of drugs in our society.

The second is that the sources of licit drugs are often outside the channels familiar to most law enforcement officials. Today's pusher is not always the stereotype of a seedy, back alley salesman. He or she may well be a highly educated health professional.

Fortunately these pushers in white coats represent only a small fraction of their professions. However, their individual successes in diverting large numbers of drugs from legal distribution channels is staggering.

When the Congress enacted the Controlled Substances Act it recognized that while many drugs had a useful and legitimate medical purpose, they were subject to abuse and therefore their distribution should be restricted. Controls, through the scheduling process, were imposed which were intended to inhibit diversion of the most dangerous, abuse prone substances.

Despite these controls and despite the harsh professional sanctions and criminal penalties imposed for diversion, scheduled drugs continue to find their way into illicit markets. The extent of such diversion is enormous and explains in part why drug abuse is one of our most intractable public health problems.

The effectiveness of Federal and State drug abuse compliance activities is a major focus of our deliberations today.

I hope our witnesses will help to point out whether deficiencies exist, in either the structure or enforcement of the Controlled Substances Act, which if corrected, may aid in reducing the problem of licit drug diversion.

[The text of H.R. 6700 follows:]

96TH CONGRESS
2D SESSION

H. R. 6700

To extend for three fiscal years the authorization of appropriations for the administration of the Controlled Substances Act, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 4, 1980

Mr. WAXMAN (for himself, Mr. CARTER, Mr. SATTERFIELD, Mr. WALGREN, and Mr. GRAMM) introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

A BILL

To extend for three fiscal years the authorization of appropriations for the administration of the Controlled Substances Act, 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 (a) section 709(a) of the Controlled Substances Act (21
4 U.S.C. 904(a)) is amended (1) by striking out "and" after
5 "1979," and (2) by inserting after "1980," the following:
6 "\$225,000,000 for the fiscal year ending September 30,
7 1981, \$260,000,000 for the fiscal year ending September 30,

1 1982, and \$300,000,000 for the fiscal year ending Septem-
2 ber 30, 1983,".

3 (b) Section 203 of the Psychotropic Substances Act of
4 1978 (Public Law 95-633) is amended by striking out sub-
5 section (d).

Mr. WAXMAN. We are pleased to have as our first witness, Mr. Peter Bensinger, Administrator of the Drug Enforcement Administration, Mr. Bensinger, will you please come forward?

Before I call on you, I would like to recognize the distinguished ranking Republican on the subcommittee, Dr. Tim Lee Carter.

Mr. CARTER. I thank the distinguished chairman and I am particularly pleased to join in welcoming the very able Administrator of the Drug Enforcement Administration, Mr. Peter Bensinger, to these hearings.

Under his leadership several steps have been taken to insure that DEA's activities adhere to the highest professional standards and as a result much progress has occurred in reducing the flow of illicit drugs to those who would abuse them.

Mr. Chairman, on several occasions testimony before this subcommittee has indicated that the best way to combat drug abuse is to cut off the supply of dangerous drugs. I submit that the Drug Enforcement Administration has done an effective job in this area but the problems caused by the abuse of drugs will not go away.

We must maintain a strong, effective deterrent against the distribution or manufacture of illicit substances as well as the diversion of licit drugs into illicit channels.

Because of my concern with this problem I want to make sure that our drug abuse law enforcement effort has the tools and the finances it needs to do the job we want it to do. I want to make sure that there is sufficient manpower and funding as well as making sure that the criminal justice system has the authority to deal with violators in an appropriate fashion.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Dr. Carter.

Mr. Bensinger, we have your prepared statement which without objection will be inserted into the record in its entirety. I would like to proceed in any way you wish. You may want to summarize your statement and highlight some of the major points you want to bring to the attention of the members.

We want as much time as possible for questions.

STATEMENT OF PETER B. BENSINGER, ADMINISTRATOR, DRUG ENFORCEMENT ADMINISTRATION, DEPARTMENT OF JUSTICE, ACCOMPANIED BY MARION HAMBRICK, ADMINISTRATOR, OFFICE OF ENFORCEMENT; KENNETH A. DURRIN, DIRECTOR, OFFICE OF COMPLIANCE AND REGULATORY AFFAIRS; AND WILLIAM GORDON FINK, ASSISTANT ADMINISTRATOR, OFFICE OF INTELLIGENCE

Mr. BENSINGER. Thank you very much, Chairman Waxman.

I very much appreciate the opportunity of appearing before you and your subcommittee. I appreciated your opening remarks which I think were on target, as were those of Dr. Carter.

I would like to introduce three of the senior officers of the Drug Enforcement Administration who are here with me today. It may be during the questioning in a specific area of interest that I will call upon them to join me in the response.

The head of our Office of Enforcement is Mr. Marion Hambrick who is to my right. To my left is Kenneth Durrin, the Director of

the Office of Compliance and Regulatory Affairs as well as W. Gordon Fink, Assistant Administrator for Intelligence.

I will take your suggestion, Mr. Chairman, and summarize my statement. [See p. 12.]

I am concerned about the implications of Southwest Asian heroin. You have properly indicated some information is available to us and to you and members of the subcommittee on increased purity in some of the northeastern cities. This is true in New York, Baltimore, and Washington. We are seeing a shift from the steady decrease of heroin availability that has taken place over the last 3 years.

The chart on my right reflects the price purity of retail heroin over the last 3 years as well as, at the bottom of the chart, the deaths and injuries. [See p. 43.] Since 1976 the average overdose death per month has decreased from a high of 150 per month to a low of below 30 at the present time.

Injuries have decreased from monthly figures in the 1,600 range in emergency rooms to less than 800.

At the same time, the purity of the retail level of heroin decreased from 6.6 percent to 3.5 percent.

We have seen a slight increase in availability of heroin as reflected by purity. We are seeing it particularly in the Northeast and the Atlantic coast area. Nationally the last two quarters showed an increase from 3.5 to 3.7 to 3.8.

The injuries are up 26 percent in the Northeast.

Since our last meeting, I am pleased to report that the inter-agency committee on intelligence, the National Narcotic Intelligence Consumers Committee, has had a continued analysis of the sources of heroin. The source in 1975-76 reflected principally Mexico smuggling into our country large amounts of heroin. In Afghanistan and Pakistan a total of perhaps 350 total tons of opium and in the Golden Triangle of Laos and Burma and Thailand 450 tons of opium. Iran was not a major source several years ago for illicit opium. They do have a very large addict population still, and did then, and most of it was consumed locally.

Last year that picture changed. The Government of Mexico has had tremendous success in destroying the poppies at the source and it has reduced their estimated production from 80 tons down to 10 tons which, converted into heroin from opium, would be 1 ton.

Iran had two factors that now contribute to our growing problem. One was a considerable amount of illicit opium available for export and illicit use, and a dramatically increased production.

In Afghanistan, perhaps 300 tons of opium available last year for the illicit market and in Pakistan, as much as 700 tons. In the Golden Triangle, the Thai-Burma area did have a serious drop in production and increased enforcement particularly in Burma and between the Burma and Thai borders.

We saw what was a Southeast Asian heroin market in Western Europe change overnight. Eighty-five percent of the Western European heroin now is Southwest Asian, heroin coming from Iran, Afghanistan, Pakistan through Turkey into Germany being driven in private vehicles being smuggled cargo on TIR carriers, as well as being brought on railroad trains, the Orient Express, and airplanes.

The overdose deaths in Germany now exceed the United States in total number. They had perhaps 600 last year whereas the United States would have had in the neighborhood of 350 and their overdose per population is almost four times that of the United States. The amount of heroin seized in Western Europe increased dramatically in every country.

In Switzerland, a country which has had relatively little drug abuse had major heroin injuries and deaths. In Italy, over 100 and they are not American tourists, but Italian nationals.

The pattern changed very quickly and very dramatically. The purity of the heroin in Europe is perhaps 20 to 40 percent as compared to a purity level in the United States at retail of 3 to 4 percent.

We have seen Iranian nationals arrested extensively throughout Europe and in the United States with both heroin and opium. We have seen conversion labs seized in Italy near Milan, a large one and another one near the border between France and San Remo.

We have seen some shipments to the JFK Airport of up to 24 kilos of pure uncut heroin left in accompanied baggage. We expect some additional arrests from that investigation.

I share the sense of your initial opening statement, Mr. Chairman, of concern. President Carter personally has been briefed on this problem by Attorney General Civiletti. Attorney General Civiletti, in turn, has called together all of the State attorneys general along with another 70 or 80 chiefs of police, district attorneys, and sheriffs. We briefed them on February 28, as you and your committee are aware, on the new Southwest Asian heroin threat.

We do not have offices today in Kabul, as we did up until December of last year, nor in Tehran. The availability of operational intelligence from those two countries has been dramatically reduced.

In addition, the professionalism of the law enforcement officers in those countries we cannot represent to you. A number of the people have been very thoroughly trained in narcotic drug enforcement and have been switched out of their jobs as a change in the political circumstances in that country, and, of course, there are parts of both Iran and Afghanistan in which the Governments themselves do not have firm control. That makes for a much more difficult enforcement assignment for the Western European countries faced with a very dramatic heroin threat, as well as for our own country.

We did operate two intelligence probes in New York to determine the type of heroin being sold. The operations were called Monitor. They were run in Harlem and the Lower East Side. We saw a shift so that, in our most recent retail purchases of heroin, the exhibits on a 2 to 1 basis were Southwest Asian over Mexican or Southeast Asian.

The administration is coordinating at the Cabinet level strong action to blunt this threat. Attorney General Civiletti has met with Prime Minister Cosiga from Italy as well as Minister Baum, the Minister of the Interior of West Germany. We intend to continue to raise at the ministerial level with our European and Middle Eastern/Southwest Asian counterparts the need for a coordinated effort.

The State Department through its liaison and contacts with the interagency financial groups, AID and IMF, is well aware of the need to link our AID package with a nonopium growth provision in future agreements. U.S. Customs and DEA are accelerating our efforts. We have assigned a full time analyst to work with Customs.

We have established a number of target city airport programs, as well as enforcement priority locations which include New York, Philadelphia, Boston, Newark, Baltimore, and Washington.

We expect through the establishment of a Special Action Office for Southwest Asian heroin, which Mr. Hambrick is responsible for, to provide additional funding for intelligence probes and for enforcement operations as well as the placement of agents with particular language skill. We have some very good experienced criminal investigators that speak a variety of these dialects who will be working with our foreign counterparts, as well as in our target cities.

There will be supplemental funding. We will be accelerating our lab analysis of the heroin for signature.

The Office of Intelligence, through Attorney General Civiletti's encouragement, will be increasing their special funded intelligence probes to try to develop more information sooner on where labs are located. We will develop a traffic or cargo profile for use by Customs at airports and points of entry.

Even with an expanded domestic enforcement program and expanded intelligence and personal briefings of our top law enforcement officers as well as the President and our own Cabinet, we are not in the position we were with Mexico where we had a neighbor fully cooperative and committed to destroying an illicit product being grown by criminal organizations in their country.

In Southwest Asia that potential does not exist as it did in Mexico.

Mr. LELAND. Mr. Chairman, if I might ask, on the question of Mexico, what did the United States do to commend Mexico for their cooperation?

Mr. BENSINGER. I think a number of specific items have been taken. I know when President Lopez Portillo came to Washington the first time President Carter made reference to narcotics as one of the very specific programs in which both Governments had cooperated and brought about a specific result.

The International Association of Chiefs of Police has passed a number of resolutions commending the Government of Mexico.

I was pleased to see some editorials in the Texas papers. The Houston Chronicle, perhaps 2 weeks ago, had a major editorial saying this is an excellent example of bilateral commitment to a program that works.

I cannot say enough about the effectiveness of the Government of Mexico's program. They have lost lives. They have had officers killed in the line of duty. They have faced up to the problem that there are Mexican nationals growing illegal products who are going to be hurt economically by the destruction of those products, but they have not waived in their commitment to destroy these fields.

I think our Government, our Ambassador, our President, and the Attorney General of the United States on several different occa-

sions, both Judge Bell and Attorney General Civiletti, as well as our agency, have taken the opportunity to speak out. I would hope these comments in our congressional hearings would reach Mexico City as well.

They have not done this simply because we have asked them to or we have given them the money to do it. The Government of Mexico probably spends anywhere from 5 to 10 times as much direct funded pesos or dollars on narcotic enforcement as they ever get any funding for helicopters or maintenance or spare parts from the U.S. Government.

They have had a number of their officers trained by our special National Training Institute, but they have now established their own National Training Academy and have developed a first-rate enforcement program and prosecutorial program.

It has not been simply because they have wanted to help a neighbor. They have wanted that. I think they were morally and legally committed to doing something in their own country and have set an example for the world.

With respect to the other major problem and, again I think the chairman is right on target, the diversion of retail drugs is a problem. It is generally ignored. I know this subcommittee and under this chairman has not chosen to ignore it. I can tell you our agency does not have the resources nor the congressional mandate really to stop retail diversion.

Our agency has a clear responsibility to set quotas for the manufacture of illicit drugs, to audit and closely supervise the manufacturing and wholesale distribution of those illicit drugs.

At the practitioner level, the pharmacists and the doctors selling or illegally making available drugs at the retail level has not been one of our chartered responsibilities. We have been in a position to assist the States through our Diversion Investigation Units in a leadership fashion and have more recently established targets through our Operation Script program that would strike at the most blatant retail diversion by practitioners. But, with 226 compliance investigators, our principal targeting is at the wholesale distribution and manufacturing level.

The type of drugs that are listed in the drug abuse warning system which, are reflected in the chart to the right, indicate the number of mentions in our drug abuse warning network. [See p. 40.]

If you looked at another chart that showed the prices at retail and at wholesale such drugs as Percodan, Dilaudid, Talwin, Methaqualone, and Preludin, you will see a billion dollar market in which an amphetamine or a dosage unit of Dilaudid can be purchased at retail for 17 cents and sold at a street price of \$4 to \$60. Preludin for 25 cents could sell upwards of \$12. [See p. 41.]

Those type of diversions of amphetamines and barbituates, special drugs in some cases such as Dilaudid and Percodan which are heroin substitutes and opium derivatives, do represent a serious problem that is going on in generally most areas of the country.

The resources to deal with this problem vary. Some States have very professional medical and registration boards with full investigative authority and others do not.

We have established a drug investigative program but there are 20,000 products under control; 600,000 registrants and perhaps 20 billion dosage units diverted annually. Most diversion, as I indicated, is at the retail level. I know Congressman Leland from a professional standpoint is well versed in the pharmacy problems. The pharmacists and doctors I would not indict as a profession. I am sure the vast majority of them, 95 or 98 percent are following the hippocratic oath in their own professional responsibilities.

There are some who do indiscriminately prescribe and who allow scripts to be forged and who accept a feigned medical need and make drugs available. [See p. 42.]

Our policy is to support the States in their efforts through DIU's. We now have 20 units and we expect 2 more this year. We have had a record of significant success in those DIU arrests. There have been a number of them and 10.8 million dosage units have been seized. We have indicated to all of our compliance operations and our regional directors and district officers to target the major blatant retail diversion and we have now 24 target cities and 94 targets who have been identified.

We think this will demonstrate our concern and increase public and professional awareness and encourage States to take action. If we can uncover a rock in a State and say here is a pharmacy or here is a doctor making available hundreds of thousands of dosage units with considerable health consequences, we feel the States will increase resources and amend their laws and take a more active role.

We do feel a need to demonstrate that this availability does exist. We do have a working committee for prescribers. In Pennsylvania and California we are aiding in a pilot program, as detailed on page 27 of my testimony, in methods to help the States.

Pharmacy thefts are up, not as much as bank robberies, but they are up perhaps 9 percent. We think our role is to set an example and to provide a key model, pilot projects which we are doing in 18 cities where we have started pharmacy theft programs.

We work with the mayor and the pharmacy association and the pharmacies themselves and the State and local licensing boards and private associations for greater public awareness.

We have seen pharmacy thefts go down. It would be great if we could have a mayor and a pharmacy board and governor and a law enforcement group get together almost on a uniform basis nationally.

We are not providing money, but we are providing manpower in those 18 cities to help start these programs off.

We have submitted to the Department of Justice and have discussed with FDA and the National Institute of Drug Abuse and the White House a review of the Controlled Substances Act, which has been in effect for 10 years. In some areas we feel the opportunity for revision and amendment presents itself.

We have not had final concurrence from either of the other major Federal agencies with whom we work or the approval of the Attorney General. I will not go into a specific recommendation to you at this time.

I very much appreciate your interest and would like at the earliest opportunity to brief you fully on whatever proposals are authorized on the part of the administration.

Apart from that, Mr. Chairman, the statement that is prepared makes reference to continuing availability of cocaine and marihuana and the problem which we are confronted with with our partners, the U.S. Coast Guard and the U.S. Customs Service, in interdiction of these two drug substances, which have not been decreased in availability.

I think I would conclude my statement with a reference to a continuing problem that relates to the bail of some of the major traffic dealers particularly in cocaine and marihuana as it relates to our own law enforcement effectiveness and the ability to deter traffic.

This is somewhat true in retail diversion also. We had a doctor in New Hampshire or it may have been Vermont, who was responsible for ordering 2 percent of the national amphetamine production capacity. This person ordered more pills than all the other doctors in the State.

In Federal court this person was given, I believe, a 5- or 10-year sentence, but it was suspended. The person did no time in jail at all and really he was the single largest orderer in the United States of a schedule II drug that had serious health consequences.

That is not to say that each and every case we bring to Federal court ends up with a suspended sentence. The injuries of retail diversion are serious and we do feel greater public awareness is needed in that area.

Mr. Chairman, that completes my opening statement. I would be happy as would my associates to answer any questions you or members may have.

[Testimony resumes on p. 55.]

[Mr. Bensinger's prepared statement and attachments follow:]

Statement of Peter B. Bensinger, Administrator, Drug Enforcement
Administration, U.S. Department of Justice

Chairman Waxman, Members of the Subcommittee on Health and the Environment: Good morning. I am pleased to appear before you once again on the occasion of the Drug Enforcement Administration's (DEA) appropriation-authorization. The intervening year since our last reauthorization has been a significant one. In many respects, there has been considerable progress. Several major cases with international implications have been brought to fruition. Many of our foreign counterparts have intensified their efforts against drug trafficking. As a result of the Congressionally-enacted controls on piperidine, there has been a marked decline in the number of clandestine phencyclidine (PCP) labs.

But in some areas of the world, the instabilities of the governments represent a new and serious threat. From our perspective, we are particularly concerned about Southwest Asia--Iran, Afghanistan and Pakistan--because this area is capable of producing many times the amount of opium needed to satisfy world demand.

In order to appreciate more fully the implications of this Southwest Asian opium production capability, I

think it important to reflect on the background of the heroin situation.

Since 1976, all of the indicators we use to trend heroin availability have consistently reflected a downward trend. The purity methodically fell from 6.6 percent, and stabilized at 3.5 percent before beginning a slight upward turn during the third and fourth quarters of 1979, when it rose to 3.7 and 3.8 percent, respectively. The price per milligram of pure heroin has risen consistently from \$1.26 in 1976 to \$2.29 as of the end of 1979.

Medical examiner and emergency room reports are collected from 24 metropolitan areas participating in the Drug Abuse Warning Network (DAWN). Significantly, at the present time, DAWN is recording approximately 35 heroin-related deaths per month in contrast to the 150 per month in 1976. According to DAWN, the number of heroin-related injuries has been declining steadily and since 1978 has returned to the low levels of 1973. The average number of heroin-related injuries per quarter for 1979 is consistent with the average per quarter in the preceeding year.

From the data we have accumulated thus far, the national indicators are now showing some increases in heroin availability. The situation is clearer on a regional level. For example, the East Coast cities in particular are reporting purities well above average for that area. During the same 12-month period in which average retail purity on the East Coast rose from 2.8 to 3.7 percent, heroin-related injuries rose 26 percent. Other indicators such as heroin treatment admissions, retail pharmacy thefts, treatment admission for heroin substitutes, and overdose injuries and deaths related to heroin analogs all suggest a gradual increase in heroin availability and abuse on the East Coast. The picture remains mixed when one examines the trends in any one metropolitan area. An extended period of increased availability in more than one geographic area would have a more profound impact on national indicators.

In addition to using the above mentioned indicators to measure availability, we use the National Narcotics Intelligence Consumers Committee (NNICC), which is chaired by DEA, to analyze the volume of drugs in the country. NNICC has done a thorough analysis of estimated

supplies of heroin coming into this country from 1975-1978. According to the NNICC study, total heroin imports are down from 7.5 metric tons in 1975 to between 3.7 and 4.5 metric tons in 1978. From 1977 to 1978 alone, heroin imports into the United States declined 25 percent.

The study also has analyzed the volume of heroin emanating from principal foreign sources and, in doing so, has clearly highlighted the changing dynamics of the heroin situation.

ESTIMATED SUPPLY OF HEROIN TO THE UNITED STATES FROM PRINCIPAL FOREIGN SOURCES, 1975-1978				
METRIC TONS (Percentage Shares in Parentheses)				
	1975	1976	1977	1978
Mexico	6.5 (87)	4.0 (67)	3.1 (56)	1.7-2.0 (45)
Southeast Asia	1.0 (13)	2.0 (33)	2.0 (36)	1.4-1.7 (38)
Southwest Asia	negligible(0)	negligible(0)	0.4 (8)	0.6-0.8 (17)
TOTAL	7.5 (100)	6.0 (100)	5.5 (100)	3.7-4.5 (100)

Substantially as a result of the continued eradication efforts of the Government of Mexico, joint U.S./Mexican operations, and to some extent as a consequence of an unusually severe drought in late 1977/early 1978 in the northwestern part of the country, Mexico's share of the U.S. heroin market has diminished significantly. The Government of Mexico is to be commended for its dedication to the opium poppy eradication effort.

When I appeared here last year, I expressed optimism regarding the progress in Mexico and I expressed concern about Southeast Asia and the potential of Afghanistan and Pakistan.

Drought conditions directly affected opium production in the Southeast Asian/Golden Triangle area. In a typical growing season, the Golden Triangle can produce between 450-500 tons of opium. As a result of a drought, the 1978-79 growing season yielded only between 160-170 tons of opium. Consequently, estimated shipments of Southeast Asian heroin to the United States dropped about 15-30 percent from 1977 to 1978, and another decline occurred in 1979. The climatic conditions have not improved considerably and so to compensate for the

poor yield of the prior season, the opium farmers have planted more. Based on field reporting, DEA estimates that the increased planting will produce between a minimum of 215-240 tons of opium after the 1980 harvest, which is now being completed.

Several factors have had an impact on the trafficking of Southeast Asian heroin. Two of the largest Southeast Asian heroin trafficking networks, the Ah Kong Syndicate and the Li Ming Siu organization were immobilized as a result of international enforcement efforts. DEA directed its enforcement, international assistance, and intelligence efforts against Southeast Asian heroin with the implementation of the Special Action Office/Southeast Asian Heroin (SAO/SEA). These actions, in concert with many others, led to reduced availability of Southeast Asian heroin.

It is estimated that in 1978 Afghanistan produced 300 metric tons of opium and Pakistan produced approximately 400 metric tons, for a regional total of about 700 metric tons. Iran cannot be included in this total because at that time, opium cultivation in Iran was

legal and controlled. In 1979, opium production in all three of these countries in Southwest Asia is believed to have increased to maximum of 1,600 metric tons.

Of course, these are "guesstimates". As you can well imagine, intelligence gathering in that part of the world is, at best, very difficult. Our agents stationed abroad are a primary intelligence source. However, DEA has had to close its offices in Iran and Afghanistan. Our efforts in Pakistan were disrupted extensively, albeit temporarily, and still have not returned to the levels of previous years.

Foreign governments are often a secondary intelligence source, but we do not have ongoing enforcement and intelligence exchange in Iran and Afghanistan and the countries have lost a number of their career drug law enforcement officials.

The high quality and availability of Southwest Asian heroin has made it a very marketable commodity. By mid-1977, West Germany was inundated with this high-quality Southwest Asian heroin. The problem has since

spread to other West European markets which traditionally have been and continue to be outlets for Southeast Asian heroin. Despite sincere attempts by European governments to control the narcotics addiction problem, the situation has continued to worsen.

Throughout 1979, Western Europe served as a "sponge", absorbing the increased Southwest Asian heroin production. Approximately 2.5 metric tons of heroin were consumed there that year. By way of contrast, the NNICC study estimates that in 1978 Southwest Asia supplied 0.6-0.8 metric tons of Southwest Asian heroin, representing 17 percent of the total market, entered the United States. I expect that proportion to have doubled during 1979.

Although the heroin picture in Western Europe may be stabilizing, the situation still is not good. Drug overdose deaths in West Germany, for example, are almost double those of this country and their population is one-fourth of ours. In West Germany, street-level purity is currently between 20 and 40 percent and prices in some European cities have dropped to as low as \$25,000-35,000 per kilogram. According to our latest figures, that same kilogram would sell for about six times as much in New York City.

DEA intelligence reflects that some Iranian citizens, unable to move cash out of that country because of the currency regulations, have "converted" their cash to narcotics and have smuggled their assets out in that fashion. The profit motive has enticed numerous Black, Hispanic, Italian, Iranian and other traffickers to enter the Southwest Asian heroin trade in the United States. Although at present this trade should best be characterized as fragmented, there are indications that in the future it will be dominated increasingly by cohesive criminal groups.

Over the past two years, there have been a rising number of seizures and resulting investigations. During 1977 and 1978, small quantities of Southwest Asian heroin appeared in the U.S. and were confined to the New York/Washington, D.C. corridor. Since then, undercover purchases of Southwest Asian heroin also have been made in Chicago, Detroit, San Francisco and Los Angeles.

DEA "Daily Enforcement Reports" document seizures of Southwest Asian heroin which were made both here in the United States and across Europe. For example, recently

on the same day, two unrelated seizures each of three kilograms of exceptionally high purity Southwest Asian heroin were made in Texas and here in Washington, D.C. Seizures of heroin in this quantity and purity have not been experienced in several years.

It is important for DEA to be able to have an idea of the extent to which heroin from Southwest Asia is reaching the retail level here in this country. Consequently, in conjunction with State and local enforcement officials, the DEA New York District Office ran a special street-level buy operation to determine the extent of the retail heroin problem. New York was selected because we believe that this was an entry point for Southwest Asian heroin. The first phase, conducted this past summer in Harlem, found that the average retail purity was 3.0 percent. Based on the results of heroin signature examination, 42 percent of the exhibits collected in this phase were identified as being of the "European/Near Eastern" or "Middle Eastern" type heroin. In this project, these types of heroin are now being referred to as being converted from opium produced in Southwest Asia. The second phase of the

operation, conducted in the fall on the Lower East Side, determined that 60 percent of the samples were of Southwest Asian origin. In this phase of the operation, the average purity of the heroin samples was 8.5 percent and some of the exhibits were as much as 20 percent pure.

Given the magnitude of recent developments, the question then becomes, "What plans are there for coping with this new presence and accelerating problem?" Unfortunately, there are no easy answers.

The United States Government has developed initiatives to attack the Southwest Asian heroin problem. The Administration is making the Southwest Asian heroin effort a high priority and is coordinating efforts of the Departments of Justice, State, Treasury, Defense and Health, Education and Welfare.

The Department of State is seeking international cooperation, not only through contacts with individual nations, but also by raising the issue in international forums such as NATO. We are accelerating the enforcement activities of the U.S. Customs Service and DEA both in the U.S. and abroad. Additionally, New York, Philadelphia,

Boston, Newark, Baltimore and Washington, are being designated target cities where major efforts are needed most to fight the flow of Southwest Asian heroin. The State and local law enforcement agencies are being involved in the anti-heroin effort to the maximum extent. As you can see, the Drug Enforcement Administration is involved in the forefront of this action plan.

On February 28, 1980, President Carter and Attorney General Civiletti hosted approximately 120 law enforcement officials including all State Attorneys General and several police chiefs and prosecutors. At this meeting, the five point program to discuss the threat of Southwest Asian heroin was discussed with these enforcement officials and their cooperation and participation were encouraged.

Our preference is to work as close to the source as possible; but, in the case of Southwest Asia, that door has virtually been slammed shut. Consequently, we have accelerated our efforts as close to the source as we can get--through our agents and country attaches stationed along the transshipment and destination corridor in

Western Europe. Additionally, the State Department has approved a Special Agent position and an Intelligence Analyst position for Frankfurt, Germany, and an additional Special Agent position for Turkey.

Both Attorney General Civiletti and I have met with the Italian Prime Minister and Minister of the Interior of the Federal Republic of Germany to discuss mutual concerns regarding the Southwest Asian heroin problem. We intend to continue to assist foreign law enforcement agencies with support services directed at identifying and immobilizing major drug trafficking networks.

DEA has recently established the Special Action Office/ Southwest Asian Heroin. SAO/SWA, as this office is known, was established to meet the imposing threat of renewed heroin production, transshipment and trafficking in and from Europe, the Middle East and parts of Southwest Asia's opium producing countries. SAO/SWA will address this serious situation on both the European and North American continents in a coordinated, directed high-priority enforcement effort.

Specifically, the DEA Headquarters SAO/SWA program managers will work to ensure that all priority investigations are coordinated and receive sufficient resources. These managers must evaluate investigations and many times shift needed resources from lower priority areas to bolster significant cases that will have an impact on Southwest Asian heroin. In that same vein, they will make certain that field operations receive supplemental funding to continue and accelerate investigations that have a direct impact on Southwest Asian heroin.

Another important facet of SAO/SWA is the intensifying of the State and local law enforcement officials' awareness of the potential and existing threat of Southwest Asian heroin in the major cities and the enlistment of their intelligence, scientific and enforcement resources to be used in conjunction with the Federal effort. The DEA Office of Science and Technology is beginning a program to direct scientific data to State and local laboratories that will assist them with the identification of the components of heroin that originated from Southwest Asian opium.

The DEA Office of Intelligence is intensifying its field intelligence exchange among the various foreign,

Federal, State and local participants to ensure that there is maximum development and distribution of available information regarding Southwest Asian heroin organizations and traffickers. Furthermore, in cooperation with the U.S. Customs Service, we will redirect and intensify the airport/port of entry program to provide better input to the U.S. Customs Service to obtain maximum efficiency from the "interdiction mode". We are developing specific trafficker/cargo profiles for each of the primary Southwest Asian heroin arrival locales.

All of these actions are designed to counter the increasing availability that could cause Southwest Asian heroin to reach epidemic proportions. I believe that, for the present, our initial measures will blunt to the best extent possible the Southwest Asian heroin threat.

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Of course, while we accelerate our momentum against Southwest Asian heroin we must take care to ensure that our efforts to meet the challenge of increasing cocaine,

dangerous drugs and marihuana trafficking are not diminished.

Cocaine continues to be widely abused and, according to all available indicators, its popularity is continuing. In 1979, DAWN emergency room mentions averaged 629 per quarter which is in sharp contrast to quarterly averages of 479 in 1978, 397 in 1977, and 312 in 1976. It is significant to note that these long-range increases are not limited to a few areas, but have been reported in the vast majority of cities from which data is available. Cocaine is readily available in pound quantities in just about every major metropolitan area. There has also been an increased demand for cocaine in Spain, Italy, France, West Germany and the United Kingdom.

NNICC estimates that in 1978, approximately 19-25 metric tons of cocaine were smuggled into the U.S., which was a five percent increase from 1977. The trend for 1979 is in the same direction.

Over the past several years, there has been no statistically significant change in the retail-level price/purity of cocaine. Within each DEA region, price has remained fairly

stable, ranging from \$1,200 to \$3,100 per ounce (depending on the purity and the particular area). In and of itself, this stability indicates that traffickers have been able to consistently meet a rising demand for the drug.

Nearly all of the cocaine in the world is processed from leaves harvested from coca plants grown in Bolivia and Peru. There have been reports in recent years of expanded coca cultivation in these countries and possible expanded cultivation in Colombia. Over half the cocaine that reaches the U.S. is converted from coca paste to base and then to cocaine hydrochloride in Colombia, from where it is transshipped. The remainder comes directly from Peru, Bolivia and other South American countries. Colombia will probably remain the single most important smuggling point for cocaine imported into the United States.

Marihuana is an enforcement priority because of the extensive criminal organized networks involved in its distribution and because of the financial implications associated with its trafficking. Furthermore, our growing body of knowledge regarding the health hazards associated with marihuana use gives us cause for concern.

In 1978, approximately 10,700--16,400 metric tons of marihuana

were imported into this country, generating a retail market worth \$15-23 billion. The U.S. marihuana market has changed radically in recent years. The number of users has expanded and new source areas have emerged. Prior to the mid-1970's, Mexico supplied almost all the marihuana consumed in the U.S.; the remainder was from Jamaica. The balance has swung, however, and now Colombia is the primary source country. This shift is most directly attributable to the success of the Mexican Government's marihuana eradication program. The herbicidal spraying of marihuana fields has reduced production.

I anticipate that the heavy sea and air trafficking of these illicit substances from Colombia will continue. As a result of the large volume of seizures made in the last several years, smugglers have modified their operations. We are seeing continued maritime smuggling not only around Florida, but also north along the Atlantic Coast and along the Gulf Coast. To a much lesser degree, but no less alarming, is the deployment of motherships from Colombia's Pacific coast to the U.S. West Coast.

Patterns in smuggling by air are also changing. The utilization of long-range aircraft is becoming a more distinct

trend. Thus, other areas in the United States besides Florida and the Southeast Coast/Gulf Coast areas are beginning to feel the impact of drug trafficking.

Our greatest hope for control of the cocaine and marihuana problems rests in the drug source countries. I believe that crop eradication is one of the most effective methods of control. We need to help the Governments of Bolivia, Peru and Colombia turn off the faucets of cocaine and marihuana.

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Thus far this morning, Chairman Waxman, I have addressed myself only to the changing heroin, cocaine and marihuana trafficking picture. I do not, however, mean to give short-shrift to the dangerous drug situation. Rather, this facet of drug law enforcement needs to be handled differently, because, for the most part, the United States is its own source country. Although there is substantial clandestine manufacturing activity, most of these drug substances are already subject to control from manufacture through distribution via the mechanics of the Controlled Substances Act (CSA).

Yet, although there is a system for regulating the marketing of these substances, we find that their abuse is extensive. The following chart clearly shows the abuse of dangerous drugs is a phenomenon that must be reckoned with.

DRUG ABUSE WARNING NETWORK Emergency Room Mentions November 1978 - December 1979		
<u>CSA Schedule</u>	<u>Reported Drugs</u>	<u>Mentions</u>
4	Diazepam	18,000
1	Heroin	6,100
2	PCP	5,100
4	Flurazepam	4,800
1	Marihuana	4,300
4	D-Propoxyphene	3,700
2	Methaqualone	3,200
4	Chlordiazepoxide	2,900
4	Phenobarbital	2,700
2	Cocaine	2,700

These represent but a minute sampling of the approximately 20,000 drug products under CSA control. Each year over 20 billion dosage units of these products flow through the distribution chain, which consists of approximately 600,000 registrants. The vast majority of registrants, are practitioners; the balance are manufacturers and wholesalers.

Conservatively, we estimate that each year 250-300 million of the dosage units manufactured legally are diverted. The current value of street sales of diverted drugs is thought

to be over \$1 billion a year. This is easy to visualize when you consider, for example, a single dosage unit of Dilaudid (hydromorphone), which can be purchased retail for about 17 cents, can be resold on the street for up to \$60. In addition to the profit motive, reduced heroin availability contributes to the demand for diverted drugs. Supplements are needed for non-existent or poor quality heroin.

The CSA provides for a "closed" or controlled distribution system from manufacture to use. The system is designed to ensure that there is an adequate supply of controlled substances for legitimate medical, research and industrial needs, while at the same time reduce the diversion of drugs from legitimate channels into the illicit market.

Under the Controlled Substances Act, DEA has clear authority to monitor activities at the manufacturing/distribution levels. And, we have been very successful at reducing diversion at this level. It is at the retail level where 80-90 percent of all drug diversion occurs. Most commonly, this diversion is accomplished via indiscriminate prescribing, forged prescriptions,

thefts and the illegal sale of drugs by registrants. Additionally, individuals who obtain prescriptions and controlled substances by feigning medical need or who obtain multiple prescriptions from different physicians are also responsible for diversion at the retail level.

DEA statutory authority to regulate at the retail level is limited and, consequently, the primary responsibility for enforcement at this level has been left to the States. The general acceptance of this division of responsibility is demonstrated by the fact that 45 states and the District of Columbia have signed Memoranda of Understanding to that effect.

It has been and continues to be DEA's policy to support the states in their efforts to control retail diversion. This support takes many forms and includes both enforcement and non-enforcement initiatives.

The most substantial state assistance effort has been the establishment of the Diversion Investigation Units--DIU's. Through this program DEA acts as the catalyst

to coordinate funding, manpower expertise, and various enforcement units into a cohesive state effort. DIU's are manned and managed by state authorities, although a DEA representative is assigned on a full-time basis for coordination and support. Our objective is to launch the participating state on a sound start by providing direct Federal funding and support and, ultimately, to have a state-sustained, permanent DIU-type program.

DIU's were initiated on a pilot basis by Texas, Michigan and Alabama in 1972. All three pilot states have endorsed the program and are funding their DIU's, as are California, Georgia, Illinois, Massachusetts, Nevada, New Hampshire, New Jersey, North Carolina, and Pennsylvania. DEA still is providing grants to Maine, Washington, Hawaii, Oklahoma, Utah, New Mexico, the District of Columbia, and the newest DIU, Arkansas. Thus far, only one state has declined to support the program at the conclusion of Federal funding. We anticipate that two additional units will be brought on board this fiscal year.

At present funding levels, we anticipate bringing on an additional three units per fiscal year until we reach

an optimal level of 35-40 DIU's. I do not expect that all 50 states will have such a program because in some states (1) there is a sufficient state mechanism in place, (2) the level of diversion does not warrant such a program or, (3) the state will be incapable of sustaining the unit once Federal funding is exhausted.

An important by-product of the DIU program is the public attention given to this often neglected facet of drug abuse. Additionally, the program statistics are impressive. From the DIU program's inception through the end of FY 79, these units with their 200 investigators have made over 2,600 arrests and seized in excess of 10.8 million dosage units at a cost of approximately \$6 million. I believe that this program demonstrates that highly-trained personnel can curtail diversion of drugs on a statewide basis.

In response to the growing threat of retail diversion, six months ago DEA initiated Operation Script. This project supplements existing efforts and concentrates our resources toward specific retail problems. DEA's technical, investigative, intelligence and legal resources

are being channeled to focus on high impact/high visibility investigations of 94 pre-selected targets in 24 cities. Operation goals include:

- decreasing diversion at the retail level;
- demonstrating the Federal Government's concern;
- increasing public and professional awareness of the diversion and abuse of legitimately manufactured controlled substances;
- encouraging more states to take action against practitioner and pharmacy diversion;
- demonstrating the need for and continuation of DIU's;
- supporting possible FDA actions regarding the indications and use of controlled substances;
- obtaining additional information which may be used in establishing or decreasing quotas and/or restricting imports of controlled substances.

Targets for Operation Script action were developed based on specific criteria that established a registrant as a significant violator. Although the Operation is still in its early stages, we expect to have an impact with these investigations. The vast majority of the other targets are still under active investigation.

Another recently developed program designed to have an impact on the availability of legally-produced drugs in

illegal traffic is the Drug Oriented Investigation Program. These drug-specific investigations focus on drugs currently being highly abused nationally, and involve investigations at all levels of the distribution chain. Examination of the entire licit distribution chain enables us to develop accurate profiles of the extent, type and methods of diversion of these drugs. I expect that the information developed from the three DOI's implemented thus far will be very useful in future scheduling and quota actions.

Although thus far I have directed all my comments toward enforcement approaches to minimize retail-level diversion, a major thrust of our efforts are directed at non-enforcement initiatives. For example, DEA participates in four informal "working committees" which are designed to improve communication with health care professionals and the related industry. In this manner we have encouraged the establishment of self-imposed restraints and procedures that go beyond the minimum dictated by law. This past December, "Guidelines for Prescribers of Controlled Substances", a product of the DEA/ Practitioner Working Committee, was agreed upon.

Another non-enforcement approach to retail diversion is being pursued on a pilot basis in both California and Pennsylvania. In these states, DEA has worked to support the improvement of state regulatory and enforcement capabilities. In this manner, by strengthening state boards and authority, remedial action can be taken before the problem becomes significant.

The Pharmacy Theft Prevention (PTP) project is a non-enforcement directed endeavor with proven results. Over the past two years, programs have been established in 18 cities. PTP is an approach wherein pharmacists, police, government and media work together in a joint community action effort directed at reducing pharmacy thefts. In this area, DEA's job is basic and inexpensive--we are the catalyst that gets the community going. Statistics show that since the initiation of the program, pharmacy thefts increased nationwide, while thefts in PTP cities declined.

In addition to the above noted programs, DEA is developing a legislative proposal that will allow us to pursue new avenues. We are currently in the process of looking

towards revisions of the Controlled Substances Act in order to enhance DEA's ability to combat retail diversion.

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Chairman Waxman, thus far this morning I have really touched on only several of our key program elements: those which have an impact on heroin availability and those which effect the control of licit drugs. The other program elements are no less important. Rather than elaborate extensively on each of these operations, I have attached an appendix to my formal statement which details some of DEA's program goals and accomplishments.

For all our accomplishments, we still have tasks of considerable magnitude facing us. The potential of Southwest Asia to flood this country with high-quality heroin is very real. I believe that the five point program outlined earlier will represent a strong U.S. Government response.

Our Federal interagency cooperation is at a high level, and, as a result, I believe we will see strong government programs in force. We appreciate the interest and support of this Committee. Thank you.

CHART 1

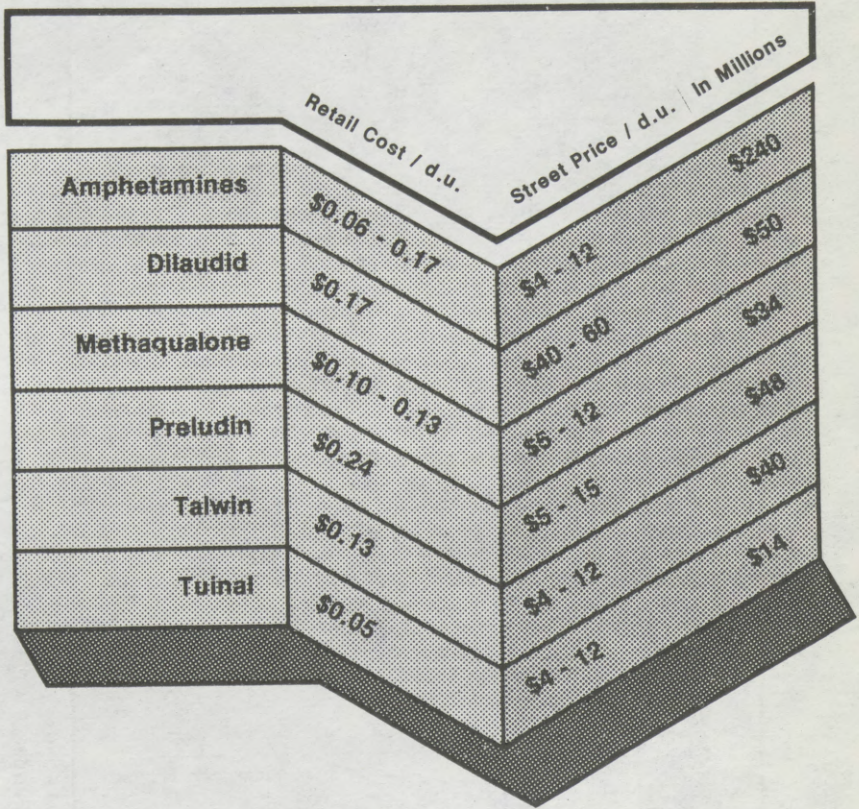
DRUG ABUSE WARNING NETWORK

Emergency Room Mentions
November 1978 - December 1979

CSA SCHEDULE	REPORTED DRUGS	MENTIONS
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1	Marihuana	4,300
4	D-Propoxyphene	3,700
2	Methaqualone	3,200
4	Chlordiazepoxide	2,900
4	Phenobarbital	2,700
2	Cocaine	2,700

CHART 2

SELECTED DIVERTED DRUGS ESTIMATED STREET VALUE



DIVERSION INVESTIGATION UNITS

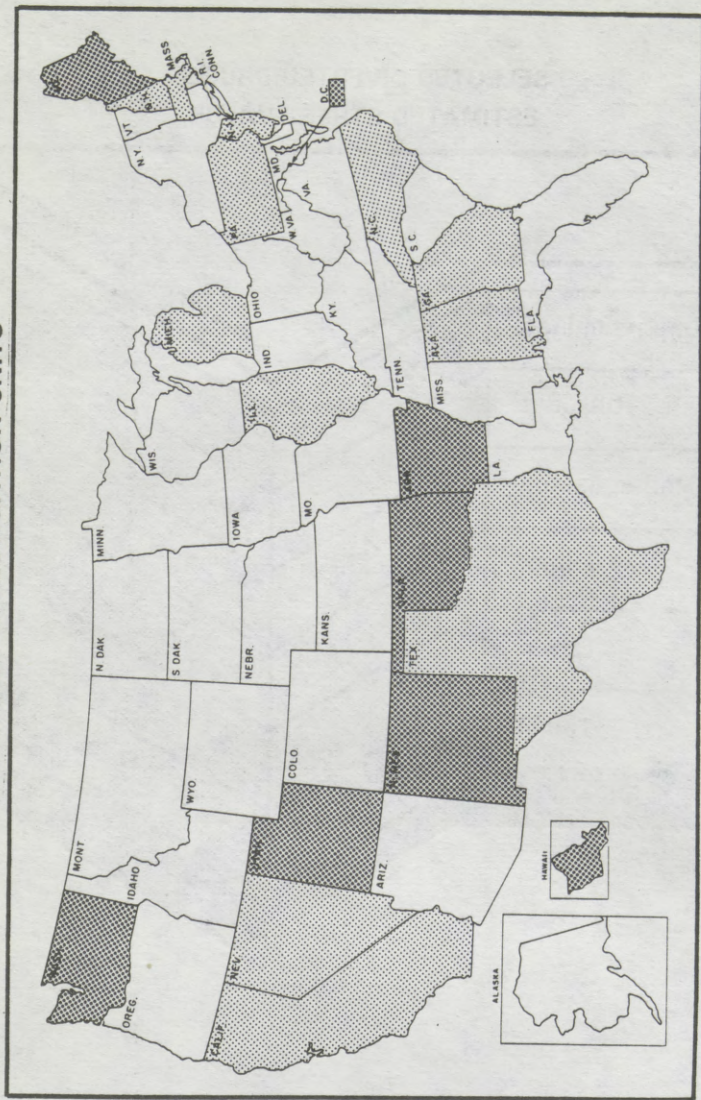
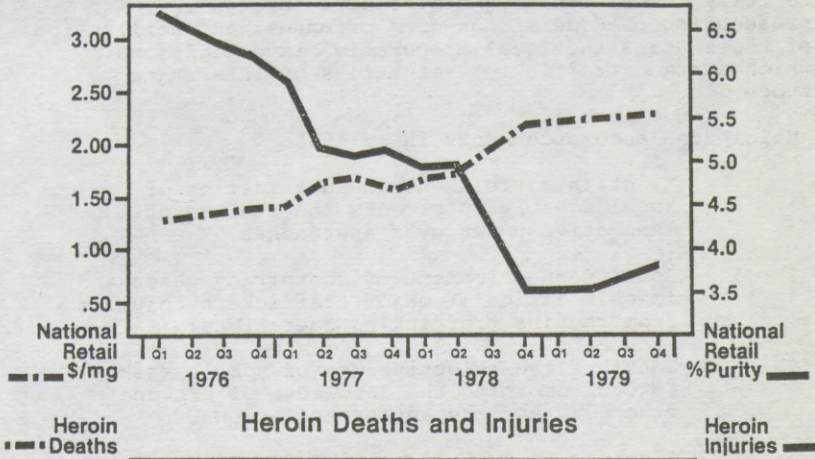


CHART 3

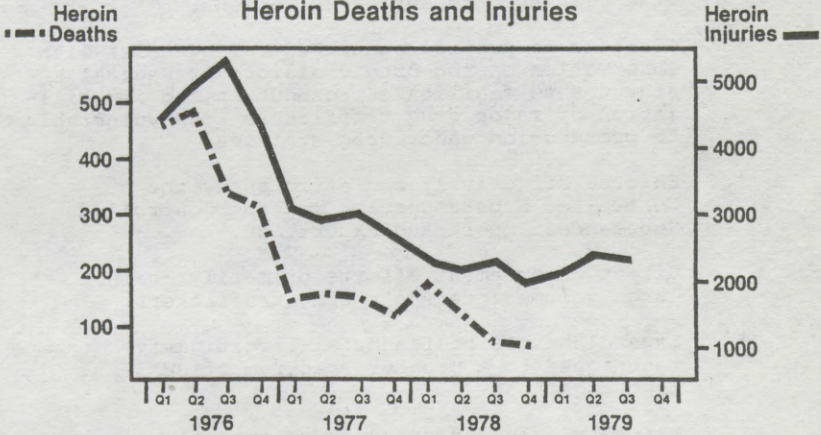
CHART 4

Heroin Availability Indicators

Retail Heroin Purity and Price



Heroin Deaths and Injuries



DOMESTIC ENFORCEMENT PROGRAM

In order to reduce the domestic supply of illicit drugs of abuse to a level with which our society and institutions can reasonably cope, this program encompasses: investigation and preparation for prosecution of major violators of controlled substances laws; cooperation with other Federal law enforcement agencies to fully immobilize drug traffickers through the prosecution of Federal non-drug offenses; and utilization of those State and local cooperative investigations which surface trafficking situations of interstate scope.

Anticipated accomplishments in FY 1981:

- * Maintain recruitment and utilization of knowledgeable informants and the use of innovative undercover approaches.
- * Continue development of conspiracy cases and immobilization of major traffickers insulated from routine trafficking operations.
- * Continue the selective use of Mobile Task Forces combining the knowledge of DEA and other law enforcement organizations.
- * Continue to provide other Federal agencies with information on non-drug violators of Federal statutes to facilitate prosecution and immobilization of major drug traffickers less vulnerable to prosecution under drug statutes.
- * Enforce effectively and efficiently the Controlled Substances Act and the Controlled Substances Import and Export Act.
- * Direct enforcement efforts primarily against large volume interstate drug traffickers.
- * Expand the use of financial investigative techniques to a broader spectrum of DEA investigations.
- * Maintain balanced pressure to immobilize clandestine laboratories.

- * Maintain a viable telecommunications capability by expanding the secure teletypewriter system and replacing obsolete equipment.
- * Improve and redesign the Narcotics and Dangerous Drugs Information System (NADDIS) to provide varied inquiry capability, quicker response time, and enlarge data storage capability.

Program Outputs Include the Following:

	<u>1979 Actual</u>	<u>1980 Est.</u>	<u>1981 Est.</u>
DEA initiated arrests..	4,750	4,900	4,915
Other Federal referral arrests.....	1,550	1,400	1,400

Task Force Program

The Task Forces program is operated under DEA direction to stimulate and provide support to State and local governments in investigations and prosecutions of drug violator cases.

On-the-job training in proven enforcement techniques is provided to State and local officers, and the exchange of drug intelligence between Federal, State, and local enforcement agencies is promoted.

Anticipated Accomplishments in FY 1981:

- * Develop in each task force jurisdiction an effective cadre of State and local officers thoroughly trained and experienced in proven drug enforcement techniques.
- * Focus the task force investigative efforts on all levels of violators of the priority drugs of abuse.
- * Increase the number of State and local officers with on-the-job training through rotation of personnel assigned to task forces.

- * Provide actionable intelligence to task force participants.
- * Develop a structured intelligence exchange mechanism with minimum DEA participation that will be (1) implemented in task force cities once basic task force objectives in the area are accomplished, and (2) established in selected jurisdictions where DEA resources preclude establishment of a State and local task force.
- * Encourage and motivate State and local agencies to plan, program, and budget for greater proportion of support cost for task forces.

Program Outputs Include the Following:

	<u>1979 Actual</u>	<u>1980 Est.</u>	<u>1981 Est.</u>
State and local initiated arrests.....	1,592	1,650	1,600
Federal initiated arrests.....	2,560	2,150	1,750

FOREIGN COOPERATIVE INVESTIGATIONS PROGRAM

This program is responsible for: efforts to reduce illicit opium production and the supply of heroin; efforts to curtail the supply of illicitly produced dangerous drugs, cocaine, hashish, and marihuana; monitoring the diversion of controlled substances legally produced in foreign countries; the collection and dissemination of tactical/operational and strategic intelligence; and advising and assisting foreign governments on the creation or improvement of their drug enforcement efforts.

Anticipated Accomplishments in FY 1981:

- * Encourage, advise, and assist host countries in the development and implementation of effective measures to control licit drug crops, disrupt illicit cultivation and conversion, and interdict in-country staging areas and trafficking routes for movement of drugs into the international smuggling channels.
- * Encourage and assist host countries to establish and support effective drug intelligence agencies and promote intergovernmental enforcement cooperation and intelligence exchanges.
- * Promote, advise, and assist source countries in the planning and implementation of effective programs for eradication of illicit opium, coca and marihuana crops; encourage vigorous control of licit cultivation.
- * Cooperate with foreign governments in joint prosecution of major violators of mutual concern.
- * Maintain balanced investigative pressure to contain the influx of Mexican heroin.
- * Direct within the framework of drug priorities increased effort against major suppliers of Southeast Asian heroin now appearing in the retail market and potential increased supplies of Southwest Asian heroin.

- * Encourage development of essential chemicals program to identify laboratory operations and restrict trafficking in essential chemicals destined for illicit use.
- * Support host country institution building process through DEA training of cadres for establishment and operation of cooperative and effective drug enforcement agencies.
- * Promote the adoption of crop substitution and alternate income producing programs.
- * Increase joint investigation and prosecution of international traffickers.
- * Increase efforts to collect money-flow documentation to support joint prosecutive efforts.
- * Interface South American operational efforts with domestic DEA operations and ongoing U.S. Coast Guard and U.S. Customs Service efforts directed towards drug interdiction at sea.

Program Outputs Include the Following:

	<u>1979 Actual</u>	<u>1980 Est.</u>	<u>1981 Est.</u>
Foreign cooperative arrests.....	1,130	1,000	1,000
Trafficking networks developed.....	28	32	32
Trafficker profiles completed.....	152	265	300
Enforcement targets identified.....	1,627	2,000	3,000
Trainee-days.....	13,667	14,000	14,000

COMPLIANCE AND REGULATION PROGRAM

This program involves the regulation of the legal trade in narcotics and dangerous drugs. By authority of the Controlled Substances Act this activity includes the scheduling and classifying of controlled drugs; establishing import, export, and manufacturing quotas for controlled drugs; registering manufacturers, handlers, and dispensers of controlled drugs; and investigating and determining points of diversion into the illicit market.

Anticipated accomplishments in FY 1981:

- * Properly schedule all substances with abuse potential, establish annual production quotas for Schedule I and II substances, and provide required statistical data to the United Nations. Ensure that every registrant adheres to the Controlled Substances Act (CSA) and its implementing regulations through:
 - annual registration of all legitimate handlers of controlled substances.
 - annual investigations of bulk manufacturers of Schedule I and II controlled substances.
 - cyclic investigations once every three years of all other distributors of controlled substances listed in Schedules I and V, and manufacturers of controlled substances listed in Schedules II and V.
 - complaint investigations targeted against registrants whose activities indicate actual or suspected diversion.
 - pre-registrant investigations of all new manufacturers, distributors, importers, and exporters of controlled substances.
 - development of a closed system of drug destruction.

- * Assist states and industries in their regulatory and compliance efforts and promote the Pharmacy Theft Prevention program and State mini-DAWN systems.
- * Identify and evaluate the scope and magnitude of drug abuse in the United States.
- * Maintain information systems that monitor the manufacture, distribution, and inventory levels of controlled substances.
- * Maintain liaison with registrant groups through active meetings and exhibits program.

Program Outputs Include the Following:

	<u>1979 Actual</u>	<u>1980 Est.</u>	<u>1981 Est.</u>
INVESTIGATION			
Regulatory.....	1,120	1,120	1,270
Complaint.....	300	300	150
Pre-registrant (non-practitioner)....	1,300	1,320	1,350

Diversion Investigation Unit (DIU) Program

The purpose of the Diversion Investigation Unit (DIU) program is to coordinate a national program to reduce diversion of controlled substances through the provision of investigative and administrative support to the operating units; conduct liaison activities before, during, and after installation of each DIU to enhance its probability of success; and conduct negotiations within the State milieu leading to the installation of these units.

Anticipated Accomplishments in FY 1981:

- * Establish new DIU's in three states.
- * Maintain the level of activity in existing units through coordinated national program.

Program Outputs from July 1978 through June 1979:

ARRESTS

Registrant Related.....	247
Non-Registrant Related.....	160
	407

Amount of legitimate drugs removed from traffic as reported by DIU states was 736,309 dosage units of controlled substances.

INTELLIGENCE PROGRAM

The purpose of the Intelligence program is to provide a variety of criminal intelligence support to the narcotics enforcement community. This includes the collection, analysis, production, and dissemination of intelligence data; and the development of the PATHFINDER and El Paso intelligence Center (EPIC) capabilities.

The underlying rationale of the Intelligence program is to provide support that will promote the most effective use of Federal drug control resources.

Anticipated Accomplishments in FY 1981:

- * Support DEA, other Federal, State and local drug investigative agencies with tactical and operational intelligence designed to immobilize major drug trafficking networks and subjects through conspiracy, Racketeer Influenced Corrupt Organization (RICO) and other applicable statutes.
- * Collect, analyze, and interpret all source intelligence concerning organized crime's involvement in narcotics trafficking.
- * Continue the El Paso Intelligence Center (EPIC) as a vehicle for exchange of drug intelligence with other Federal, State, and local enforcement agencies.
- * Identify major PCP laboratory operators and traffickers.
- * Disseminate intelligence on the magnitude and direction of the drug threat, and identify major changes in world-wide trafficking patterns.
- * Continue to conduct Special Field Intelligence Programs (SFIP).
- * Continue efforts to fully use the Drug Abuse Warning Network (DAWN). Analysis of DAWN statistics provides trend information on abuse levels and availability in various areas of the

United States. Continue analysis on other information systems such as the System to Retrieve Information from Drug Evidence (STRIDE) and the Offender Based Transaction System.

- * Collect, collate, and evaluate statistical information on DEA operations to assess the drug problem, DEA's impact on it, and trafficking patterns and enforcement activities internationally and domestically.
- * Continue to expand DEA's automated intelligence capabilities via PATHFINDER.

Program Outputs Include the Following:

	<u>1979 Actual</u>	<u>1980 Est.</u>	<u>1981 Est.</u>
Trafficking networks developed.....	200	185	185
Trafficker profiles completed.....	2,285	2,265	2,265
Enforcement targets identified.....	23,641	27,187	27,187
El Paso Intelligence Center (EPIC) watch transactions	120,000	140,000	160,000

TRAINING PROGRAM

The Training program provides entry level training for special agents, compliance investigators, and intelligence analysts; in-service videotape and sound/slide training programs for use throughout DEA; Supervisory and Mid-level Management training programs for appropriate personnel of all disciplines within the agency; and a variety of Advanced and Special Skills programs such as Conspiracy Investigations, Financial Investigations, and Intelligence Collection to improve and update capabilities of the work force.

Anticipated Accomplishments in FY 1981:

- * Continue to provide necessary entry level training for DEA personnel.
- * Provide in-service videotape and sound/slide programs for use by all disciplines within DEA.
- * Continue to provide necessary supervisory and mid-level management, and executive training to enhance management skills.
- * Continue to provide advanced investigative and specialized skills to promote effective and efficient drug law enforcement.

Program Outputs Include the Following:

	<u>1979 Actual</u>	<u>1980 Est.</u>	<u>1981 Est.</u>
Trainee days.....	18,258	18,000	18,000

Drug Law Enforcement Training Program

The purpose of the Drug Law Enforcement Training program is to expand DEA's enforcement and suppression efforts by increasing the cooperation between law enforcement agencies at all levels of government in the United States and convey changes in national priorities and strategies to all levels of drug law enforcement effort; develop required training programs and determine resource requirements to provide increased

skills to Federal, State, and local police agencies; and utilize all available resources where appropriate to gain the benefits from greater expertise and prevent duplication of effort.

Anticipated Accomplishments in FY 1981:

- * Provide training in basic drug law investigative techniques and methodologies plus advanced and specialized skills to State, municipal, military, and other Federal police officers and chemists.
- * Provide training in management, leadership, and training of drug law investigative units for mid-level management to State, municipal, military, and other Federal police professionals.
- * Provide information, publications, films, other materials, and displays on controlled substances, drug abuse, and its problems to the public, community leaders, criminal justice agencies and associations, Controlled Substances Act registrants, and educational and health professions.

Program Outputs Include the Following:

	Number of Students		
	<u>1979 Actual</u>	<u>1980 Est.</u>	<u>1981 Est.</u>
Drug Enforcement Officers Academy (8 Weeks).....	43	50	50
Law Enforcement Training School (2 Weeks).....	3,171	3,000	3,000
Forensic Chemist Seminar (1 Week).....	62	70	70
Diversion Investigations (1 week).....	21	60	60
Conspiracy Investigations (3 Days).....	434	500	500
U.S. Army C.I.D. (5 days)...	144	150	150
Other Training Seminars (1-5 Days).....	2,702	3,000	3,000

Mr. WAXMAN. I thank you very much for your statement.

Let me ask you about the heroin threat from the Middle East. Do we see any evidence that the regimes in Iran or Afghanistan are doing anything to crack down on heroin traffic or to cooperate with our agencies in limiting trafficking?

Mr. BENSINGER. Specifically we have heard at the U.N. meeting in Vienna, the Iranian delegate indicated they saw a four- to fivefold increase in opium and heroin availability in their own country. There has been obviously, as you know, predominate attention within Iran and even more so in Afghanistan to establish, on the part of law enforcement and the military, control of the situation or the investigation of criminal organizations.

As a result of the instability in both countries, it is my opinion that the effectiveness, from a police standpoint or an investigative standpoint, has been considerably diminished. We do not see cooperative training programs. We do not see an exchange of intelligence between the various countries, Pakistan, Afghanistan, Turkey, and Iran as was the case in prior years and hopefully would be the case in the future.

Mr. WAXMAN. You believe the problem is mainly due to the fact that their attention is focused on trying to establish some stability within their countries rather than any intentional desire on their part to not cooperate?

Mr. BENSINGER. I think that characterization is accurate. We are not saying the flood gates of opium from Afghanistan or Iran are a specific political objective of the regimes. On the other hand, we do see, as a result of the activity in those countries, criminal organizations able to smuggle large amounts of opium, morphine base and heroin which is even refined in those countries out of their country without the type of deterrents or interdiction or investigative effort being made that is necessary.

Whether the regimes are just not in a position to divide their law enforcement and military forces to attach a greater priority to this problem or to go into the fields on a consistent basis where the opium is being grown and stop it from being grown, all three of those contribute to this problem.

Mr. WAXMAN. As a result of the emergence of the "Golden Crescent" as a major production region for opium, do you believe a French connection like network is likely to be reestablished?

Mr. BENSINGER. Yes. I think that is possible, probably not so much in France but we do see some of the former French connection personnel who have been in Federal prison for 10 to 12 years now getting paroled. We do see links particularly in Italy, from Italy to New York and tentatively tentacles reaching out to try to get a foothold.

We have not seen large seizures, 200 and 300 pound heroin seizures as we saw in the French connection, but a 24 kilo seizure at JFK Airport is a very large heroin seizure. It means the traffickers are willing to risk large sums of money because that is a \$40 million to \$50 million package and to send it in the air unaccompanied or with direction to pick it up at that point in time is unusual.

I think we are going to find organized criminal groups increasingly interested in heroin. I think in the past it has been too low in

purity. The risk has been high. It has not been available. They have switched to coke and marihuana.

I think now with the increased purity and with the economic advantage of buying it in Germany at \$40,000 to \$50,000 a kilo and selling it in New York for more than \$200,000, they will get into it and get into it in an organized manner.

We have penetrated a couple of organizations that would indicate such a theory is in fact correct.

Mr. WAXMAN. The administration has requested \$208,605,000 in the fiscal year 1981 budget for DEA programs and activities. This reflects a 3 percent increase over fiscal year 1980. H.R. 6700 provides for an authorization of \$225 million for fiscal year 1981.

In view of the serious challenges confronting your agency in the coming year, do you believe the administration's current budget request is adequate?

Mr. BENSINGER. I believe the current budget request will continue our program levels effectively. With Attorney General Civiletti we are closely monitoring the Southwest Asian heroin threat and whether additional funding would be required specifically to blunt this so that we would have major impact, we are studying that very closely.

We are not at this time requesting additional funding. It is a subject that is very much on our mind and the Attorney General's mind. We feel it appropriate to come to you and this committee and the Appropriations Committee at such time as we feel that is essential.

Mr. WAXMAN. The reporting requirements for piperidine are scheduled to expire on January 1, 1981. H.R. 6700 proposes to keep the reporting requirements in force. Do you believe reporting of piperidine distribution has been useful to your activities and therefore should be continued?

Mr. BENSINGER. Yes, we do, Mr. Chairman. We have specific cases that could document the enhanced investigative opportunity that has been made possible by that provision in the law.

We also have not seen a major outcry from the manufacturers or distributors as a result of this law. We feel it has not been onerous on the industry or on those distributing legitimate precursor materials to appropriate medical supply houses.

Mr. WAXMAN. In the General Accounting Office's recent report "Gains Made in Controlling Illegal Drugs," they point out that Federal and State control over the diversion of licit drugs at the retail level is virtually nonexistent.

You commented about the difficulties of DEA in dealing with that area. Do you think the GAO's characterization is a fair one?

Mr. BENSINGER. It would vary in degree. I think GAO would say our contribution is minimal in that it is not at the level, scope, size, or impact that would substantively change this problem.

I do think we are making contributions to the State and local efforts through training and through our DIU program and through our PTP program and through providing State systems with printouts.

The States themselves do not have the resources. That is the key to the problem. Just talking to you as a partner in this battle and we are not asking for this today, but we need the manpower and

the mandate to do the retail diversion program or the States need to have the manpower and the professional expertise and the funding within their own jurisdictions to do it.

There is a vacuum. The Federal responsibility is clear. It is at the manufacturer and distributor level to set quotas and to assist in leadership training and pilot programs. Where we have done this we have had impact.

It has not been as large as I would like it to be, but it has been significant for the resources expended. To effectively monitor 600,000 registrants with 226 compliance investigators and curb retail diversion is not in the cards.

Mr. WAXMAN. Do you believe shifts in drug habits and trafficking patterns are outstripping our efforts to contain or control this problem?

Mr. BENSINGER. One of the things I am encouraged about is from the Southwest Asian threat, we are not in the position we were 3 or 4 years ago with Mexico. For once, the Attorney General has specifically committed ourselves to candor with local law enforcement and State prosecutors and the Cabinet and the public and have said we see something on the horizon instead of already being here.

I think our intelligence and our enforcement assessments strategically is far improved. That is not just because I think DEA is doing a better job, although I think that is also the case. I think it is because we are getting a lot more support from our partners, the Federal, State, and local and foreign area.

We are getting information about seizures in Europe, in London, in Germany, and seizures even in Pakistan and Turkey that give us the type of advance information that is possible to change some of our priorities.

An agents class in March will be sending new agents to parts of the country that will be most affected by the Southwest Asian heroin and the real large bulk shipments have yet to arrive.

We also think in the case of the retail diversion problem that we are able to mount an Operation Script program aimed at 94 targets in this field while they are still operating and not when they have closed up shop.

It is a very fast changing field. I do not minimize the difficulty we have in closing all the doors and making sure all of the drugs that are manufactured actually end up being required medically.

Mr. WAXMAN. Despite the excellent job you are doing, is it a fair characterization to say drug traffic right now is flourishing?

Mr. BENSINGER. Drug trafficking in marihuana and in cocaine certainly is not being abated to the level that you and I would accept. Heroin trafficking, I would not say it is flourishing, but there are signs that it will on the horizon. Barbiturate availability has decreased. PCP availability has leveled off and has started to decrease.

Penalties for heroin trafficking are substantial and we are beginning to get into the seizure of money aspects of our investigations. I would say a great deal of the drug traffic is flourishing despite gains that have been made.

I think the GAO report was accurate in pointing out some of the limitations that we all have in facing this very major threat. I

think some of the comments they made both about retail diversion and bail and sentencing and general overall resource levels are needed.

Mr. WAXMAN. Thank you very much. Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

According to GAO it is easy to smuggle drugs into the United States and distribute them. Is this correct?

Mr. BENSINGER. I think it is relatively easy to smuggle certain drugs into the United States.

Mr. CARTER. What are those drugs?

Mr. BENSINGER. Marihuana; cocaine; some forms of Quaaludes, which is a methaqualone. Those would be the areas I would classify as probably the traffickers' best bets.

Mr. CARTER. Is it true much of the drug traffic occurs in Florida?

Mr. BENSINGER. A great deal of the drug traffic is either controlled from or funds derived from illegal narcotic transactions ending up in Florida. Florida would be the State that traditionally has more than any other State, been an entry point for cocaine and marihuana.

I was pleased to see an initiative Governor Graham of that State took to raise the penalties and provide fines and increase the law enforcement in that State. Florida certainly is the fulcrum of the coke and marihuana market.

Mr. CARTER. Is that one reason why it is said there are more \$100 bills and \$20 bills in Florida than in any other State in the Union?

Mr. BENSINGER. I would guess there are probably more in existence whether they are counted or under mattresses or buried. There is \$2 billion more in cash in Florida at the end of a year than at the beginning of a year according to the Federal Reserve.

Mr. CARTER. It is true that instead of counting the money, they weigh it?

Mr. BENSINGER. We have had two cases, Dr. Carter, where there was so much money that our information indicates the traffickers weighed the money rather than stop to count it.

Mr. CARTER. Recently a medicine called zomepirac has been developed which is nonhabit forming and which is used in place of morphine. It is said to be more effective, yet it is not addictive. Are you familiar with that drug?

Mr. BENSINGER. I am not, Dr. Carter. I do not know if Kenneth Durrin, the Director of our Office of Compliance and Regulatory Affairs is. If he is, I would not want to represent to you as a committee that I would pass judgment from a medical or health standpoint on the viability of a drug.

There are in the field two new developments. One is a narcotic antagonist which is given to addicts, people who want to get off the heroin and narcotic physiological treadmill and this narcotic antagonist in effect breaks that demand.

The drug you are describing sounds more like a medical sedative or treatment that does not have the physiological addictive qualities to it.

Ken, have you heard of this?

Mr. DURRIN. I am not familiar with it.

Mr. FINK. I think it is the product that is being worked on. They do not have an IND for it. It is not based on any narcotic product at all.

Mr. CARTER. That is right. It is not a narcotic. It is not supposedly addictive. It does relieve pain which is really the primary use or the only use for opium as I understand it.

Mr. BENSINGER. As our chief counsel indicates, probably what would happen is a research proposal would be forwarded to FDA and NIDA for review.

Mr. CARTER. It is undergoing that at the present time.

Mr. FINK. It is undergoing that now. The work on it keeps indicating that it does not have an addiction sustaining liability. They keep looking at the nonaddictive aspect and we have had this before. They have not finalized that.

Mr. CARTER. A professor at Georgetown is working on it at the present time.

Mr. FINK. We have a number of news clippings on it and that is about it.

Mr. CARTER. GAO's report states that the Government agencies seize only 5 to 10 percent of all illicit drugs available. They state a major problem is that the control and eradication of illicit drugs is hindered by lack of coordination of the various Federal agencies involved in drug control.

Would you comment on that?

Mr. BENSINGER. I do not think that is an accurate representation. I indicated to GAO I felt in this area that I think they have not put their finger on the principal reason that drugs come into this country and that is because they are not stopped at the source.

When we saw what the Government of Mexico was able to do in its fight against heroin we saw a dramatic decrease in injuries, fatalities, availability, purity as well as the national crime rate. This was not to minimize the efforts of the U.S. Customs Service or DEA or Immigration or Coast Guard from stopping heroin coming into the country.

The fact of the matter was instead of 80 tons of opium being produced in Mexico it went down to 10.

To say we would be able to stop drugs such as coke and marihuana by increased interagency cooperation I think that would be simplistic, as long as Bolivia and Peru specifically have 9 to 10 times as much coke or leaf produced as is needed medically or by the local population and as long as laboratories can be set up in the Andes and in Columbia for the processing of cocaine hydrochloride and these products, the crystal cocaine can be exported to the United States, and large bulk quantities of marihuana, can be imported, even with excellent cooperation.

Even if we had a doubling or tripling of the number of officers assigned at airports, the coast line of this country is very large. One thing that could be considered which Commissioner Chasen recommended 2 weeks ago was some clarification of the Posse Comitatus statute which would, in effect, enable our Armed Forces, the Navy and Air Force, to take a more active role, not a hands-on law enforcement role. That is not what Bob Chasen was asking for; he does not want the military to arrest anybody and neither do I. He is saying some of their resources could be used.

Mr. CARTER. Radar for instance.

Mr. BENSINGER. Radar and ships in the Caribbean or planes on training missions could be deployed in greater numbers. Perhaps with specific intelligence and interdiction and awareness that it would change the odds for the Coast Guard and for Customs on these small planes and on these large ships that are coming into the United States with these drugs.

Mr. CARTER. Since there are 17 Federal agencies involved in drug abuse, do you feel the efforts of DEA will improve under a more coordinated system characterized by a more centralized decision making mechanism?

Mr. BENSINGER. That is a tough question and hypothetical. I have seen DEA get a far better return through cooperation with Customs; the Coast Guard; the FBI, FAA, and ATF without having these agencies merged into one big super police agency.

We have seen at the El Paso Intelligence Center 124 employees from half a dozen different agencies, over half of which are not DEA representatives who effectively are contributing to a far improved intelligence strategic and operational product. Those agencies are able to continue to represent to their directors and to the Congress the principal missions for which they were created but can also contribute on joint investigations or on intelligence or information sharing effectively to the Federal effort.

I do not think I would come to you today and say we ought to be reorganized and you ought to give us control over other agencies. I think reorganization itself is not the answer. I think increased communication and ease and acceptability of that information will be helpful.

The Federal Bureau of Investigation under Director Webster with significant resources in Miami were able to make with DEA a major case, the so-called Black Tuna Organization, documenting 500 tons of marihuana and hundreds of millions of dollars of drugs and money and seize and forfeiture assets.

We had 14 different laws that were broken by this group including aiding and abetting and kidnaping and extortion and conspiracy, continuing criminal enterprise, the RICO statute.

That was a good joint effort. I think we can do that with other agencies without having a formal reorganization plan submitted to Congress.

Mr. CARTER. You think we should continue with those 17 different agencies?

Mr. BENSINGER. I cannot speak for all 17 of them but, the principal law enforcement agencies that are in this fight, I would not propose to disband or combine. On the treatment side, I would not make any representation because that is not my expertise.

Mr. CARTER. What about the penalties on large marihuana and cocaine traffickers and bail permitted them?

Mr. BENSINGER. They are inadequate in my opinion, Dr. Carter. You have hit upon one of the points GAO also stressed.

We have more fugitives than we have special agents or compliance investigators combined. This is particularly true in the coke and marihuana area. We were able to arrest for the second time Jimmy Chagra, the major trafficker who was convicted on a continuing criminal enterprise case, a large cocaine and marihuana

conspiracy out of Colombia into Texas, and who fled on \$400,000 bail.

Prior to the time he had been convicted and he appeared for sentencing, he had fled the jurisdiction of the court. He was arrested in Las Vegas by the Las Vegas Police Department and DEA agents a couple of weeks ago late one night. He had \$187,000 in cash in his car.

The bail situation clearly is an invitation to the traffickers that even if they get caught they can continue to do business.

I am not saying something I have not researched and that we have not looked at and that we have not talked with people about. It was included in the President's message some 2 years ago that this ought to be looked at.

I do think a defendant should be given an opportunity when arrested to have a hearing in front of a judge and to give the Government the responsibility to prove that a person would be a threat to the community and a threat to evidence or witnesses or would flea the jurisdiction of the court and put the onus on us as to why bail should not be granted.

At the present time, judges and magistrates are not setting bail in a way in which to either discourage additional trafficking after the defendant is arrested, or to guarantee that person's appearance at trial or at sentencing.

In sentencing, a marihuana sentence will be an average of 3 years. The maximum you can get is 5 years. For heroin it goes up to 15. The judges are giving between 10 and 12 year sentences on the average for an heroin offense. They are giving 6 years on the average for coke. They are giving 3 years for marihuana. I am talking about large scale. A 3-year sentence means 1 year in jail generally because the person is eligible for parole within a third of the minimum plus you have good time.

Not everybody convicted goes to jail in the first place. In fact, over half the individuals arrested for coke and marihuana offenses are either eligible for parole in a year or likely to become eligible, in the case of cocaine, in shortly more than double that amount of time.

I do think in the area of large-scale trafficking of marihuana that Chairman Drinan's recommendation to increase the penalty for trafficking in marihuana of 1,000 pounds or more from 5 to 10 years is overdue.

Mr. CARTER. I certainly want to see that law strengthened in that area. I think you are right.

The bail situation presents quite a problem but we see how easy it would be for a man such as you mentioned to put it up. What we consider really a high bail bond is \$50,000 and that is nothing to him. He could continue in the traffic.

Mr. BENSINGER. It is a business expense for him.

Mr. CARTER. Yes; then he can jump bail and go somewhere else.

Mr. BENSINGER. That has happened to 2,700 people that are now on our books as fugitives.

Mr. CARTER. Mr. Drinan's criminal code reform bill proposes also the elimination of good time and a general reduction of penalties? Is that correct?

Mr. BENSINGER. It strikes at a different penalty for users versus the large traffickers. We sense no reduction and the chief counsel can correct me on the criminal code revision for the major offenses that our agency principally investigates. Do we, Bill?

Mr. FINK. The scale of years is moved up some but it depends on the term of months and how they are sliding the terms up and down because they are moving the months back and forth as you go through various drafts. They are also moving back and forth on whether you should have parole and/or good time and it changes as you go through the various drafts. It is rather hard to keep track of, frankly.

Mr. CARTER. Thank you. One-third of serious defendants released on bail were free on bond or on their own recognizance from 7 months to more than 1 year, is that correct?

Mr. BENSINGER. That is correct. That is another serious problem. The effectiveness of our criminal justice system depends upon in my view the surety of punishment, the certainty of punishment as well as its speed and not haste but when you have individuals waiting for a year to get to trial you have an immediate signal to the community in which they committed the crime that there was not an immediate action taken.

You age the witnesses and the evidence and give the individual defendant an opportunity to continue in the negotiations and criminal activity that he had been initially arrested for.

One of the points our agents make is after a person has been arrested and is out on bail and if he continues in a criminal activity it is harder for the investigator after he has been arrested to investigate him than before because the defense attorney and the defendant will make serious representations that it is harassment. We do not want to lose a case on the basis of harassment.

I think the length of time to trial is an important factor. It is important in the State courts.

When I was in Illinois we did a study in our criminal courts. It was a year to get to trial for major felonies. They ended up doubling the number of criminal courts and needed to.

Mr. CARTER. How can we deal with the enforcement problem with respect to the diversion of licit drugs?

Mr. BENSINGER. I think in a number of ways, Dr. Carter. I think Congress will have to determine whether our Federal responsibilities and by that I mean in funding or even in investigations need to be substantially increased; whether we can proceed at the rate of two to three DIU's a year which is about \$1 million of our budget or whether you want us to move more quickly to set up these DIU's at the rate of six to nine per year.

That would have an impact. Whether the individual States' standpoint of training and standpoint of law enforcement would change some of their present procedures and whether we would have the discretion to deny registration to a practitioner for cause and/or reasons beyond those available to DEA now.

We cannot remove a practitioner's license. One of our authorizations for that person, either a pharmacist or a doctor to prescribe or to store in inventory and make available drugs, under the Controlled Substances Act unless the registrant has falsified their

application or the State has pulled their medical license or the person has been convicted of a felony.

In some cases practitioners will not have lost their State license to practice. We know in effect that practitioner has violated the law and is likely to continue to do so.

One of the modifications in the Controlled Substances Act that we are considering is to look at this authority. We also think maybe we would be able to encourage the States to provide for their own State licensing boards to have investigative responsibility. Some do and some do not. Statute is unclear in this area.

There are a number of other recommendations which I would like to write to the committee particularly with respect to what States could do to improve their opportunity to impact on the problem. It is going to cost some legislation and some time and some money at the State level in terms of not only a revision in the statutes, but, also clear authority for the individual State licensing boards to conduct investigations and to have staff that is trained and able to do those investigations and to have the practitioner's license revoked on the basis of proven ground, not arbitrary causes but not solely because that person may or may not have today lost their right to practice medicine in their State.

Mr. CARTER. Thank you.

Mr. WAXMAN. Thank you, Dr. Carter. Mr. Leland?

Mr. LELAND. Mr. Bensinger, I do have a particular interest in this whole subject primarily because of my training in pharmacy. We were engaged in drug abuse programs during the time I was a student and afterward when I taught for a year in the School of Pharmacy.

I commend your efforts and what you have done thus far. I realize how difficult and complicated and frustrating the problems are.

One of my issues during the time I was in the legislature in the State of Texas was an attempt to outlaw the sale and manufacture of amphetamines in Texas. That interfered with Federal law and therefore I was unable to do anything about that.

Can you comment on the problems we have with amphetamines?

Mr. BENSINGER. Congressman Leland, you are exactly right. Amphetamines and methamphetamines are tremendously abused in this country in a number of ways. The whole issue of the amphetamine prescriptions for anorectic use, weight treatment, has been one of the real sad developments that has taken place.

We have seen Preludin and other amphetamine-like prescribing practices where criminal organizations recruit people who are overweight to go around and just collect a whole bunch of pills and then go out and sell them in the retail diversion market illegally.

We have seen methamphetamine labs. There are probably over 50 that have been seized in the last 2 years in Texas alone; individual chemists; high school; college; graduate school graduates setting up businesses because there is such a large illicit retail methamphetamine and amphetamine market.

An amphetamine, as you know professionally, is a stimulant. It is sold in a manner to the abuser with the impression this would be something great, a kick or a high or accelerated activity.

Amphetamine and methamphetamine abuse and injury is widespread and is growing.

One consideration we have is to put a schedule II drug penalty for nonnarcotics at the same level as narcotics, which we think, in effect, would put the amphetamines in the penalty structure in an appropriate place.

Locally, you do not hear much in the newspapers about amphetamines. You can read about PCP and sometimes about Darvon and Valium and there are other drugs that generally get written about.

Benzedrine is an amphetamine that is well known.

A proposal which we put into the Federal Register last January for P2P, amphetamine-methamphetamine precursors, putting that in schedule II and providing a handle for us to investigate methamphetamine illegal labs the way we did piperidine with PCP. Chairman Waxman was helpful in that area along with Dr. Carter and this committee.

It will give us an added leg in our investigative efforts.

Mr. LELAND. Why can we not just take them off the market? They have no therapeutic use whatsoever.

Mr. BENSINGER. You would have to ask Dr. William Pollin who is the Director of NIDA and Jere Goyan of FDA to answer. I have personally testified that I would like to see methamphetamine indication for anorectic use taken off the market. We have reduced the production of amphetamines from 7,000 pounds to 1,000 pounds over the last 7 years.

We have made those products available for licit legal medical uses. If we took the anorectic indication, FDA-HEW, you would find a significant similar 60- to 75-percent reduction in the authorized availability of amphetamines.

Mr. LELAND. People take the amphetamines to reduce and they get habituated to amphetamines. If patients stop using them, their appetite comes back and people start eating all over again.

Mr. BENSINGER. My representation was similar to what you have said. I am not a doctor or physician to be able to speak with the medical or statutory authority.

We have recommended from a drug abuse standpoint that we should take that off the market on anorectic use.

Ken, you may join us and kind of estimate where we are on that proposal. Dick Crout is Director of the Bureau of Drugs and did have hearings on it. I know he took this issue seriously. Maybe Kenneth Durrin can give a more accurate representation to you just where FDA and NIDA stands on this.

Mr. DURRIN. The Administrator testified before an FDA hearing on this issue in December of 1977. We have done two field surveys with regard to the problem of amphetamine and methamphetamine abuse and diversion. We supplied the results of these surveys and other information to the Food and Drug Administration and have strongly supported their proposal, which is currently pending, to remove the indication for short-term obesity treatment from amphetamines and methamphetamines.

We are certainly looking forward to final action by the Food and Drug Administration to that effect which will as Mr. Bensinger has indicated allow us to cut the quota down on amphetamine and methamphetamine from about 2,900 kilos this year down to around

200 kilos for narcolepsy and hyperkinesis which are the only two indications that would be——

Mr. LELAND. They are not the drug of choice.

Mr. DURRIN. That is correct. They are not the drug of choice. By cutting amphetamines down to that level we would certainly be able to do a much better job along with the States of monitoring where that material is going and it would cut out this fat clinic practice which has been a real troublesome area for us in terms of diversion of amphetamines.

Mr. LELAND. I would like to ask you about cocaine. You indicated the sources are usually Colombia, Bolivia, and Peru, and Colombia for refinement.

Mr. BENSINGER. That is correct.

Mr. LELAND. What can we do to try to stimulate the interest of the governments there to do something similar to what Mexico did with heroin?

Mr. BENSINGER. It is an excellent question. I think the Bureau of International Narcotic matters at the State Department has a solid long-range plan of aid assistance, crop substitution. If committed to by the Congress over several years it would impact on this problem.

In Peru they are starting to pull coca bushes out of the area of Tingo Maria, which is the largest growing area. A lot of my associates said that would never be done like they said the Mexican Government would not destroy all the opium they could find but that happened.

The Peruvian Investigative Police and the Porto Saville of that country, the Attorney General and the Government of Peru can embark upon as could Bolivia a program in which only the authorized amount of coca leave could be produced.

What would happen would be a number of growers and future growers would be unhappy with the prospect of losing a cash crop which they could sell.

Today in Bolivia you can find coca leaves in markets and purchase them. You are not trafficking illegally until you have acetone or kerosene and actually mixing up leaves to develop a coca paste.

In Peru they are proposing, as they are in another Andes' countries, that the government itself be the sole buyer of all the leaf. That would establish anyone who had leaf other than an official government source would be committing a crime.

This is a proper direction to be taken. Those governments will need encouragement and state assistance and maybe some AID or IMF or Inter-American loans to provide coffee or yuca or other type of commodity assistance for the growers in that area that have traditionally got money.

I do not recommend Congress pass a 1-year appropriation for aid to Bolivia or Peru. We are going to need a long-term, several-year, large sum. I am talking \$40 million to \$50 million maybe per country minimum to really effectively accomplish what you want and what I want to accomplish and which I am sure the State Department and those governments want and that is to have a level between production and demand.

That is not going to come about if traffickers can still go to the farmers and pay over the market prices for coca leaves and still not be committing a crime until they buy the acetone and kerosene.

Some of the best cases we have made with the local law enforcement officials in Brazil and Peru and Colombia and Bolivia has been to track the precursors used to make cocaine to small cities on the border which may have 2,000 people. They were buying more chemicals than is sold in Sao Paulo or Rio de Janeiro.

They were being used and sold to traffickers. A number of cases have been made effectively as a result of that type of cooperation. That is hitting at the tip of the iceberg and not the bulk.

I think that type of approach is needed. I know the White House Drug Policy Office under Lee Dogoloff has requested a study by State on that matter. We have reviewed it and made some suggestions. I think that type of long-term effort is what is needed to really bite at that problem.

Mr. LELAND. Because of where we are geographically, Texas is one of your real trouble spots, is it not?

Mr. BENSINGER. It is, although the State of Texas has one of the largest contingents of DEA special agents there, well over 15 percent of our total force domestically. It has a long border. We see a continued improvement in the Mexican enforcement effort so the drugs going into Texas are not now coming from Mexico, but rather from Colombia and are being transshipped through Mexico from other Latin American countries, and brought up the gulf in shrimp boats and via other types of activities that could come into that large gulf coast line, as well as, by small planes through the Caribbean.

Florida would not be the only State that would receive a large amount of smuggling, although the statistical indicators would say Texas has better enforcement and less smuggling per mile of coastline and less drug abuse per capita in its major cities.

It does represent an area that small planes can land and ships can get into pretty quickly.

Mr. LELAND. How is the comparative cooperation within Texas?

Mr. BENSINGER. It is excellent. We have been working very closely with the Texas Department of Public Safety formerly under Wilson Spier and now Jim Adams. We have been working very well with the police departments in the major cities and in the community and rural areas. We have a task force in Lubbock which we work completely with the local law enforcement officials and the U.S. attorney there. I think our working relationships, Federal-State-local-county in Texas are excellent. There is no sense of there being a difference of perspective. We have worked well with the pharmacy boards and the medical and professional community.

Mr. LELAND. I am glad to hear that. I would just like to ask one last question. I appreciate your efforts and the time you have spent with us.

We realize the use of illicit drugs is being seen at lower ages today. We are down beyond the teenagers and we are into the 8- and 9-year-olds in some instances and possibly younger than that for other reasons.

What about the pushers? Are we finding the pushers are getting younger today than they were before?

Mr. BENSINGER. I do not think the major dealers are. I think we are seeing in many metropolitan areas the utilization of juvenile offenders to make that last sale for two reasons.

As you know, there is a considerable problem in direct employment in many of our major cities for the 15 to 18 age group as well as the utilization and recognition by criminal organizations that if you have a 15- or 16-year-old selling and selling to a child that penalty is different than an adult selling to a child and, in many cases, the person at a State court level may be committed to a youth commission or juvenile facility as compared to an adult having a very lengthy sentence at the State or Federal level.

That is a representation I make to you not just based on my job here, but also on my previous experience as chairman of the youth commission in Illinois and director of the correctional system and crime commission in that State and in Chicago.

I think you will find that the use of drugs and marihuana principally has been at a younger age level than was the case. One encouraging factor that Bill Pollin told me was the high school seniors now are decreasing their use of marihuana and increasingly see marihuana as a health hazardous material.

He would be able to give you far better statistics up to date based on the information available to the National Institute of Drug Abuse on what DEA has.

Mr. LELAND. Just comment very briefly on the ethnicity in terms of users. Are black people still disproportionately using heroin?

Mr. BENSINGER. I would say yes. Minority users and those that have registered for treatment are disproportionate to the population. In New York you will find twice as many black and Hispanic registered addicts with the treatment program as a percentage of the total population of that treatment program than would be represented if you just took the percentages that they represented in the population.

Mr. LELAND. Thank you very much.

Mr. WAXMAN. Thank you, Mr. Leland. Mr. Dannemeyer?

Mr. DANNEMEYER. Looking at this map, your conclusions sometimes seem not to follow the facts. One could almost observe that the only reason we do not have a major war in Mexico today is because they do not grow enough opium.

When you look at the recent Southeast Asia triangle a major war has been going on in that area for many years. A major war is going on in Southwest Asia right now. One wonders whether or not opium is somehow related to the unsettled nature of those areas.

Do you have any comment on that?

Mr. BENSINGER. Opium has been used from time to time as a cash crop by insurgent groups. I think drugs can be related. You cannot draw firm conclusions about lawlessness.

We have seen some guns for drug traffic and some specific organizations in Southeast Asia in the "Golden Triangle" specifically which maintain a presence by growing opium. This is particularly true at the Thai-Burma border.

In Afghanistan, someone asked me what impact would the presence of the Russian troops have on the opium availability. That is

a difficult question because you could answer it on both sides of the coin. The choke points and travel roads probably will be more effectively monitored. I have been to that part of the world and have physically gone over the Khyber Pass and there are just too many areas on the borders that cannot be monitored by whatever law enforcement you have unless you just populate that country with people.

The other aspect is the remote areas which generally the governments whether they are new or old, past or present, those remote areas generally have been areas where there has been illicit opium grown over the centuries. In many cases the rebel organizations will use that opium growth for a cash crop to service their own needs as well as to purchase arms.

Mr. DANNEMEYER. Could you give me an example? For instance if somebody is arrested on this bail issue, we have a constitutional right of bail in our system. There is no way we can avoid that except in capital cases. It is not a good policy choice to talk about eliminating the ability to get bail but the amount of bail is always a matter of judgment.

If somebody is arrested for possession of cocaine with a street value of \$1 million, is there any effort made by the magistrate or judge to correlate the amount of bail with the value of the illegal drug that is seized at the time of the arrest?

Mr. BENSINGER. We would make that representation; whether the judge or magistrate would entertain it is another question.

What I am proposing is the following: When you have someone arrested at an airport and, this is an actual case, in which 13 pounds of pure heroin were brought in and that is about 5 kilos and even in those days that would be about \$7 million worth of product. Bank accounts reflecting \$400,000 in deposits in Switzerland; \$10,000 in cash; travel documentation that is extensive. We would represent those individuals should not be let out on a \$10,000 bail.

Mr. DANNEMEYER. What are they let out on?

Mr. BENSINGER. Both were let out on \$10,000 and disappeared.

We would like to go to court and have the judge or the magistrate listen to the evidence we can produce saying this person has been historically in the narcotic traffic and has been previously arrested and convicted.

Mr. DANNEMEYER. The matter of bail is in the judgment of the magistrates. Are there instances where magistrates in this country are attempting to fix bail in an amount that reflects the value of the illegal drugs seized?

Mr. BENSINGER. It happens. The second time we arrested Jimmy Chagra, he got a \$3 million bail and a hearing potential. He is still in jail. We are watching the jail door pretty closely.

Mr. DANNEMEYER. Did he make bail?

Mr. BENSINGER. No.

Mr. DANNEMEYER. After the bail is posted what fine pattern is followed here?

Mr. BENSINGER. That is an excellent question. We are beginning to do two things; go after the assets of the trafficker if we can prove they were derived from an illegal narcotic transaction and have fines levied by the courts.

Nicky Barnes who is a major trafficker in New York got a \$125,000 fine. Jose Araujo out of Los Angeles and San Diego had a \$1.2 million fine levied by the court.

Mr. DANNEMEYER. Did he pay it?

Mr. BENSINGER. He had some \$31 million of assets we are tracking.

Mr. DANNEMEYER. What about a civil suit against these people to attach their entire assets on the grounds civil action is necessary on behalf of all persons damaged and the funds are needed, whatever assets they have, in order to provide funds to cover whatever damage the victims have sustained as a result of taking illegal drugs? Has anybody tried that?

Mr. BENSINGER. That has not been in the statutes. It is intriguing.

Mr. DANNEMEYER. Why should the general tax base pay for the damage done to the victims of these drugs?

Mr. BENSINGER. The one great thing that I think started to be done is we started to worry about the victims in our criminal justice system and they were always the bottom rung of the ladder. Congress passed a Crime Victim's Compensation Act 2 years ago and it was exactly right in doing so and started to have the criminal offenders in the penitentiaries or out in the streets pay for the costs to that victim.

Generally the law would require the victim would cooperate with law enforcement as to ease the prosecution of the case. This has not been thought of traditionally in terms of narcotic offenses; but, philosophically I think you are exactly right that the criminal elements, the organizations, have the tremendous assets that ought to be turned over to the public and to those people who have been hurt and to help pay for the services including law enforcement that are required because of their activities.

Mr. DANNEMEYER. If you need legislation to assist in that directive let me know. I would be interested in pursuing that.

Mr. BENSINGER. Our chief counsel and I will look at this and certainly take you up on it with departmental dialog.

Mr. DANNEMEYER. I think it might be interesting to get a whole series of civil subpena ducas tecums and use them as a vehicle for putting under deposition certain elements of the Mafia who might be inclined to have a little bit less of an interest in answering questions about their assets vis-a-vis their ability to respond to damages than a criminal charge.

Can you give me an example of what kind of penalties are exacted by the criminal law in nations like Mexico and Turkey and Japan for major traffickers of drugs? I have heard it said facetiously that the Mexican system of justice is not hung up on due process. I do not think we want to duplicate that in this country.

Can you compare what fines or what jail sentences were meted out in Mexico for that gentleman who was arrested with all that cocaine, with what that person could expect to get in the States?

Mr. BENSINGER. There are a number of major changes in the system itself. Several of the countries operate under the Napoleonic Code in which the individual does not have a right to have a bail and, in fact, can really be held in interrogation for lengthy periods of time without habeas corpus. I would not advocate that.

I would not advocate our changing our system of due process. I think the defendants have every right to be heard and to have a speedy trial and to have representation at the earliest moment and to go through what is the U.S. criminal justice system.

I just think our system has a squeaky wheel. I think our system does not provide enough recognition to the victim and enough protection to the community.

In Turkey, the sentences for small gram quantities for hash or coke or opium can be up to 15 to 25 years.

Mr. DANNEMEYER. For 15 years in Turkey, how long did they serve? Are they eligible for parole after 5 years?

Mr. BENSINGER. The courts can, upon appeal at the appellant level, review the sentence. Sometimes they extend the sentence. The process is different than the parole board automatic eligibility. Generally you have to bring up new facts about the case to get your sentence reduced.

The penalties in Mexico for marihuana are as serious or as lengthy as they are for heroin traffic. They view marihuana as a more serious problem in that country for them than we do or than they do for dealing in opium derivatives. The sentences could be extended to 15 to 25 years although in some cases they may give 5- or 7-year sentences also and do.

There are cases where people are let out of prison in all of those countries.

In Singapore they have capital punishment for drug traffickers. In Thailand individuals are shot and executed who are involved in sale of even pound quantities of heroin.

It depends upon the country. I do not think we in the United States should adopt another country's system of justice. I just think we ought to make ours work for better protection for the public.

Mr. DANNEMEYER. Thank you.

Mr. WAXMAN. Thank you. Mr. Bensinger, we thank you very much for being with us. We will look forward to other items you wish to have us incorporate in the authorization bill as you work them out with the administration.

We are going to send you some questions for the record if you do not mind.

Mr. BENSINGER. That will be fine, Chairman Waxman. I want to express to you the very positive sense I have from you as chairman and the other members of the committee in their questions. We all appreciate on behalf of our agency the opportunity to appear before you and this committee.

[Testimony resumes on p. 164.]

[The following questions and answers were received for the record:]

QUESTIONS TO AND ANSWERS FROM JUSTICE DEPARTMENT

1. Is the rescheduling of heroin from Schedule I to Schedule II being considered? What evidence exists to support such a decision?

Rescheduling heroin is not being considered at this time. Need for such action would arise if the Food and Drug Administration were to approve the marketing of heroin for therapeutic purposes. Since a New Drug Application has not been filed with FDA, when or if heroin will be found to have an accepted medical use in the United States is not known.

Currently two studies are being conducted to evaluate the efficacy of heroin in treating pain and discomfort in patients with advanced cancer. Information about these studies, which are being conducted at Memorial-Sloan Kettering Institute in New York City and at Georgetown University, may be obtained by contacting Jane Henney, M.D., National Cancer Institute, Division of Cancer Treatment, Building 31, Room 3A49, 1000 Rockville Pike, Bethesda, Maryland 20205. (Telephone: 496-6711)

2. Is paraquat-sprayed marihuana still in circulation in the United States? What steps have been taken to remove this marihuana from the market?

Detection of paraquat in marihuana requires laboratory analysis. The Drug Enforcement Administration's laboratories do not examine confiscated marihuana for this purpose, and therefore, cannot state categorically whether or not paraquat is present in marihuana circulating in the United States. The National Institute on Drug Abuse is not currently funding such research, nor is the Center for Disease Control any longer testing marihuana for the presence of paraquat. Dr. Carlton Turner at the University of Mississippi, however, does routinely analyze confiscated marihuana exhibits for paraquat. His staff reports detecting paraquat in marihuana exhibits which had been seized as late as May 1979. It must be stressed that the nature of Dr. Turner's contact with NIDA precludes him from obtaining exhibits until all litigation surrounding the seizure case is concluded. Thus, there is a long delay between the time an exhibit is seized and when it is analyzed by Dr. Turner's laboratory.

In the absence of current laboratory analysis, it is DEA's opinion that a small amount of paraquat contaminated marihuana is still available in the United States. We believe this because the Government of Mexico, the only country to eradicate with paraquat, is continuing to use this chemical in its efforts to destroy illicit marihuana cultivation; and Mexican marihuana is still being smuggled into the United States.

No specific steps have been taken to detect paraquat-sprayed marihuana nor to remove it from the market. Federal, State and local authorities continuously interdict marihuana which is being imported into the United States from Mexico and other source countries. It is hoped that these seizures will reduce the availability of all marihuana in the U.S. market, including that which has been sprayed with paraquat.

3. What is the success of the CENTAC (Central Tactical Unit) Program in achieving immobilization of drug trafficking organizations?

As one of the priority enforcement programs of the Drug Enforcement Administration, the Central Tactical (CENTAC) Unit Program has achieved considerable success. The establishment of a CENTAC Unit is predicated upon three basic considerations: (1) the targeting of violators and organizations at the very highest level of the criminal hierarchy, (2) whose illegal activities are multi-jurisdictional in nature, and (3) the immobilization and successful prosecution of whom can only occur through the utilization of sophisticated conspiracy-oriented investigative techniques.

The success of the CENTAC Program in immobilizing major trafficking organizations is exemplified by CENTAC indictment statistics for FY 77 through FY 79. CENTAC operations during this period resulted in the indictment of 1,032 defendants, 54.7 percent of whom were at the Class I and II violator level. Qualitatively, the significance of these violators as high-level drug organizers and financiers is demonstrated by the fact that one or more conviction for violation of 21 USC 848 (Continuing Criminal Enterprise) either occurred or is pending for the majority of CENTAC Units operating during the period mentioned. DEA maintains as one of its major enforcement pursuits the collection of evidence to support prosecutions under 21 USC 848. In the CENTAC Program during FY 79, four CENTAC's which were successfully terminated resulted in thirteen indictments under 21 USC 848. Additionally, in FY 79 four indictments under the Continuing Criminal Enterprise Statute were returned in another ongoing CENTAC operation.

The CENTAC Program has also recognized the debilitating effort that forfeiture of assets can have on major offender groups. In one CENTAC initiated almost three years ago, over \$300 million from one major trafficker was traced and \$250,000 seized and forfeited with precedent-setting cooperation from the Swiss and Panamanian Governments.

In another recently-terminated CENTAC operation, \$92,670 in U.S. currency and two business establishments were seized.

In one of several ongoing CENTAC's, seizures of \$2,050,000 in U.S. currency, \$55,000 in automobiles, and \$865,000 in an IRS Jeopardy Assessment have been made totaling \$3,595,000.

4. Does the Bank Secrecy Act (of 1970) hinder DEA investigations of major drug traffickers?

The information of most interest to DEA with regard to the Bank Secrecy Act is contained on Treasury Forms 4789 and 4790. With the U.S. Customs Service, DEA established a line of communication to obtain the data available on the Forms 4789 and 4790. The measured impact on DEA's

program has been erratic and, in truth, minimal on a broad scale. However, information obtained via the Bank Secrecy Act and utilized by DEA has been helpful in several significant cases, the most well-known being Operation BANCO. In that operation, the information from the forms were used as investigative leads. Only one peripheral legal action could be cited in this operation. In general, the 4789-4790's were not associated directly with any arrest, seizure, or civil action.

The other positive use of the forms was in Los Angeles, California during a specific investigation, the Araujo case. Data on the form 4789 was instrumental in expanding and developing a complex conspiracy investigation involving Class I drug violators. One of the principals pled guilty to conducting a continuing criminal enterprise, possession with intent to distribute, two currency violations for failure to file form 4790 and four counts of income tax evasion. The court also levied a \$1.2 million dollar fine plus costs of prosecution. The total amount of fines levied against all defendants was \$1.4 million dollars.

Having cited the above instances, the following points are our assessment of the utility of forms 4789 and 4790:

The information reported on both forms appears to be of greater value to IRS and U.S. Customs than to DEA.

There is a serious question as to whether banking institutions and individuals are complying with the reporting requirements of the Bank Secrecy Act, as evidenced by the sparse information on the forms and actual compliance with filing the forms.

One major area of concern is in the exchange of small denomination currency for large denomination currency which should be reported, but in most cases is not.

Since some traffickers are probably aware of the reporting requirements of banking institutions, corruption of bank employees becomes a real possibility. More investigations should be pursued along this vein by the appropriate agency(s).

Each DEA region was also queried as to recommendations for better utilization of information contained in these forms. Those recommendations include:

A computerized run of form 4789 filed by certain selected banking institutions should be made available.

DEA field offices should be allowed latitude in disseminating the information to other law enforcement entities. In doing so, additional information might be acquired through feedback.

A means for direct distribution of these forms to DEA field offices rather than Headquarters should be implemented. This would allow for a more timely response and a more effective utilization of their forms.

The quality of the copy legibility should be improved.

More resources should be directed toward enforcing compliance with the Bank Secrecy Act.

U.S. Customs field offices should identify to DEA's field offices the individuals under investigation for currency violations with possible drug violation relevancy. Resources of both agencies could then be more effectively utilized, since much investigative duplication would be eliminated.

The current DEA criteria for access to the forms should be re-evaluated in order to increase the volume and ultimate usefulness of the forms.

The wider application of this data is the subject of ongoing dialogue between the U.S. Customs Service, the Department of the Treasury, DEA and the Justice Department. DEA also addresses this topic at various seminars and encourages field agents to request this information.

DEA believes in the potential utilization of these forms in all types of criminal investigations. There is a firm conviction that both forms are an important source of drug trafficking information and a valuable investigative tool. However, timely receipt and convenient access to them must and should be implemented for effective use.

5. Should narcotic violations be considered capital offenses in deciding bail?

No. Rather, DEA recommends to the Congress that a procedure be implemented whereby a judge or magistrate would preside over a hearing in which the government would be afforded the opportunity to represent that the defendant was a threat to the community, or was likely to jeopardize a witness or evidence, or was likely to flee the jurisdiction of the court.

6. Could you enumerate the cases under which convictions have been sought under 1) "continuing criminal enterprise"; 2) RICO; and 3) specific drug violations?

Although at the present time there is no central repository of this information, the Drug Enforcement Administration is in the process of implementing a computerized Enforcement Management Information System (EMIS) which will be capable of retrieving this type of information.

In DEA initiated cases, a wide variety of investigative techniques are employed in the development of substantive and conspiracy cases. Increasing use is being made of the conspiracy statute and the more sophisticated statutory tools such as the Continuing Criminal Enterprise provision and the racketeering statutes. Although automatic retrieval of this information is not now available, the DEA domestic offices identified 57 investigations involving utilization of the RICO statutes and the Continuing Criminal Enterprise provision.

DEA has recently placed increased emphasis on the financial aspects of drug investigations. This increased emphasis will result in the identification and seizure of illicit profits and/or assets of violators and trafficking organizations. This process will enhance investigative and prosecutive efforts from the most basic to complex conspiracy investigations which include use of RICO and CCE provisions.

7. ARCOS (Automated Reports and Consolidated Order Systems) is a computerized data system for monitoring distribution of selected controlled substances.

- a. What criteria is used to require ARCOS reporting for a specific drug?

The requirements for reporting are set by Section 307(d) of the Controlled Substances Act, and implemented by 21 CFR 1304.36 thru 1304.41. The reporting requirements apply to drug classes or schedules rather than specific drug substances. The reportable schedules are: all substances in Schedules I and II and narcotic substances in Schedule III. Manufacturers are also required to report the production of Schedule V narcotics.

b. How is ARCOS data gathered?

The ARCOS data is gathered by means of individual transactions in a standard input format on various media. The media consists of the standard reporting form (DEA Form 333), magnetic computer tape, and punched cards. The reporting industry has the option of selecting the reporting media which best suits their organization. The data is collected from the drug industry on a periodic basis. The regulations state that the data will be supplied on a monthly basis. However, to ease the registrant reporting burden, many firms report on a quarterly basis.

c. How is ARCOS data stored and made available to States?

The ARCOS data is stored in its original input format; all data on the retail registrants is stored on computer tape and sorted by state. The data is made available to states by way of a series of recurring reports. Each report is designed to identify specific information such as:

1. The amount of each base drug distributed during a calendar year to each state and a breakdown of that distribution within the state.
2. The quarterly distribution for each base drug to each state and the per capita consumption of each base drug.
3. The amount of each base drug purchased by each business activity within a state during a calendar year.
4. The amount of each base drug purchased by individual registrants within a state. This report ranks the registrants within each business activity according to the total amount purchased by the registrant.
5. Identifies the registrants purchasing the greatest amount of classes of drugs, i.e., stimulants, depressants, within three digit zip code areas of a state during a calendar year.
6. Identifies the registrants purchasing similar products in excess during a calendar year.
7. Identifies all the registrants in a state that are purchasing a specific base drug or a specific product.

In addition to the above reports, special inquiries are performed which reflect all sales made to an individual registrant or all sales transacted on an individual drug into a state. Should a state have computer capability, the data is also available on computer tape in its original input format.

d. Is access to ARCOS data limited?

Yes, since the ARCOS system is retrievable by name or individual identifier, the data is covered by the restrictions of the Privacy Act of 1974 (5 USC 552a). Therefore, the data may only be released outside of the Department of Justice to those agencies or individuals described under "routine uses" in the Federal Register.

The "routine uses" areas follow:

1. Other Federal law enforcement and regulatory agencies for law enforcement or regulatory purposes.
 2. State and local law enforcement and regulatory agencies for law enforcement and regulatory purposes.
 3. The International Narcotics Control Board as required by treaty obligation.
 4. The news media as permitted by 28 CFR 50.2.
 5. Members of Congress acting on behalf of a constituent who is the subject of the record.
8. Of states with which DEA has Memoranda of Understanding, how many currently use the ARCOS system as a major tool in retail diversion control programs? How many Diversion Investigative Units (DIU) use ARCOS in their enforcement activities?

The ARCOS data is regularly supplied to single state agencies in all 50 states, the District of Columbia and Puerto Rico, which includes the states with which DEA has Memoranda of Understanding. The data is also routinely supplied to all DIU's. To our knowledge, all recipients utilize the data in their activities.

9. Do you believe ARCOS is a useful tool around which to develop retail diversion control activities?

ARCOS is a useful tool in retail diversion control programs; it is useful in identifying the most heavily used substances, plotting their historical trends, identifying potential problem areas and targeting potential excessive purchasers of the controlled substances. However, no information system should be used as the sole basis for identifying a specific drug problem. To gain a complete picture of a state's distribution/diversion/abuse profile, one should also utilize other tools such as the Drug Abuse Warning Network (DAWN), informants, audits and executed DEA Order Forms.

10. States have complained that ARCOS data is not organized or programmed to be effectively utilized in retail diversion control programs. Is this a fair criticism?

Yes and no. The system provides standard output which can be utilized by a large population of users. These users each have unique ideas and needs. The system, therefore, attempts to answer a multitude of questions which should meet the majority's needs. Obviously, everyone will not be completely satisfied with this approach.

The system is hampered in that it has an extremely large data base and limited personnel resources upon which it relies. DEA's computer facility is unable to provide the sufficient programming and machine support required to respond to each individual users unique needs.

11. It has been suggested that the ARCOS program be upgraded to provide annual reports to states evaluating drug distribution patterns. Do you believe this would be a useful service? Can such a program be put in place administratively without significant disruption of current program activities? If not, please explain?

This service would be very useful. The current output provides the basis from which the analysis can be accomplished. Users not familiar with the program could have difficulty in analyzing the data.

Unfortunately, the program does not have sufficient analytical staff with the expertise required to produce these evaluations. The current staff utilizes all of its time responding to inquiries and producing the periodic reports. Additionally, personnel with analytical expertise would be required for this function, as would be additional programming and computer support personnel, if the program would be upgraded.

12. Several bills have been introduced in the 96th Congress which would impose mandatory minimum sentences for violations of the Controlled Substances Act. Would you support the enactment of mandatory minimum sentences for certain drug violations? If so, what drug violations should be subject to minimum sentencing?

No. DEA supports the establishment of a Sentencing Guidelines Commission as contained in the proposed Judiciary Committee's legislation revising the Criminal Code.

13. The Administration has requested \$208,605,000 in the FY 1981 Budget for DEA programs and activities. This reflects a 3 percent increase over FY 1980. H.R. 6700 provides for an authorization of \$225 million in 1981. If funds proposed in H.R. 6700 were made available to you in 1981, in what DEA program areas do you believe they are most warranted and can be most effectively utilized?

A further increase of 7 percent in the resources available to DEA in FY 1981 would enable us to hire additional personnel for domestic and foreign enforcement and intelligence activities; it would also permit us to upgrade selected equipment and improve our ability to carry out our mission.

The personnel would be applied to the Southwest Asian heroin threat, and the enhancement of the capability to investigate the money flow/financial aspects of drug trafficking, clandestine laboratory operations, and organized drug trafficking networks.

The additional resources would be in the following categories:

- Operational costs of special enforcement activities targeted at Southwest Asian heroin..... \$ 2.5 million
- 75 additional positions (45 agents, 15 clerks and 15 intelligence analysts)..... 3.0 million
- Items of adjustment to compensate the increases in costs within the private sector that will provide the necessary funding to maintain and provide for the same level of service as experienced in 1980:
 - * Continuation and maintenance of DEA Field Operations..... .9 million
 - * Continuation and maintenance of DEA Purchase of Evidence/Purchase of Information..... .7 million
 - * Continuation and maintenance of the State and Local Task Force program..... .5 million
 - * Provision for rate increases for utilities, rents, and leases (all programs)..... .4 million
 - * Continuation and maintenance of the 1980 equipment replacement program (all programs).... .3 million
 - * Provision for increased costs related to contracts associated with private firms (DAWN, Training, DIU)..... .2 million
- Replacement of passenger motor vehicles..... 3.0 million
- Standard Level User Charges (SLUC)..... 1.1 million

- Gasoline and travel costs.....	\$ 1.8 million
- Initiation of a phased program for replacement of aircraft.....	.5 million
- Initiation of a phased program for modernization of ADP System.....	<u>1.5 million</u>
Total.....	<u>16.4 million</u>

14. What percentage of DEA's proposed FY-81 budget is allocated for Compliance and Regulatory Affairs activities? Please summarize the activities of the Office of Compliance and Regulatory Affairs.

Approximately eight percent of DEA's FY-81 budget is allocated for Compliance and Regulatory activities, which are summarized as follows:

Register Drug Handlers: The Office of Compliance and Regulatory Affairs processes the annual registration of every individual or firm that desires to handle a controlled substance. Order form booklets are also provided for use in purchasing Schedule I and II substances to ensure that only authorized persons obtain these highly abused substances.

Cyclic Investigations: Manufacturers, distributors, importers, exporters, and Narcotic Treatment Programs are investigated at least once every three years by DEA representatives. Manufacturers in Schedule I and II are investigated every year.

Pre-registrant Investigations: A pre-registrant investigation or check is performed on all individuals or firms requesting registration with DEA.

Complaint Investigations: Complaint or targeted investigations are conducted on serious violators whose products are prevalent on the illicit market or whose history involves actual or suspected diversion. Complaint investigations at the retail level are conducted in coordination with state or local agencies.

DIU: The Diversion Investigative Unit (DIU) is a Federal assistance program designed to be a catalyst to an eventual state self-sufficient, on-going program designed to reduce diversion of legitimately-manufactured drugs. The state provides manpower from its enforcement and regulatory agencies and DEA provides a full-time Special Agent, training, operational support, and seed funding over a 24-month period. There are currently 19 states and the District of Columbia participating in this program. Thirteen states are totally self-sufficient and operating without Federal funds. There will be two additional DIU's started in Fiscal Year 1980. Funds for a third new DIU were requested in the Fiscal Year 1981 budget.

Scheduling Drugs: DEA evaluates currently controlled drugs and new drugs of abuse to make timely and accurate decisions concerning the placement of these drugs in the appropriate CSA schedule. Various information sources are utilized, including the Drug Abuse Warning Network (DAWN) and compliance field surveys.

Establish Quotas: DEA, working jointly with FDA, sets the quantity of Schedule I and II controlled substances which can be produced during any given calendar year to meet legitimate medical and scientific needs.

DAWN: DEA has a contract arrangement, which is also funded by NIDA, and to a lesser extent, the Department of Defense, whereby information is collected from 26 Standard Metropolitan Statistical Areas (SMSA) to provide essential data on drug abuse. This program, called the Drug Abuse Warning Network (DAWN), is designed to monitor trends in drug abuse through the collection of information on drug abuse episodes and populations from over 1,000 civilian emergency rooms, medical examiners and crises centers, and 27 Department of Defense facilities. This system represents a unique data base reflecting abuse of specific chemical substances reported from the above-mentioned facilities and, consequently, is an indicator that enables the government to gauge the extent of drug abuse and the effectiveness of drug scheduling decisions and various enforcement activities. DAWN has also helped to pinpoint the need for regulatory investigations. Accordingly, this program, when used in conjunction with other information sources, is one of the most powerful tools we have to gauge the drug abuse problem.

Distribution Tracking: In support of quota setting, U.N. reporting, and as an indicator which provides possible leads to the Compliance Investigator and state/local agencies, use is made of the Automated Reports and Consummated Orders System (ARCOS). ARCOS, a computerized reporting system of all transactions of wholesale distributors, importers, exporters and manufacturers involving selected controlled substances, provides the capability to track substances from a point of import or manufacture to point of sale, distribution, export or disposition to the dispensing level.

Import/Export Activities: In order to import or to export controlled substances legally into or out of the Customs territory of the United States, the registrant must first either obtain a permit or execute a declaration for each individual transaction. A copy of this DEA permit or declaration must accompany each shipment. When the appropriate documentation and processing does not accompany the shipment, Customs notifies DEA and the shipment is subject to seizure as an illegal importation.

U.N. Reports: To fulfill the requirements of international treaty obligations, DEA must supply the United Nations with statistical summaries of production, manufacture, consumption, imports and exports, utilization, inventories and seizures of narcotic drugs; estimates of narcotic drug requirements; and statistical summaries of manufacture, utilization and inventories of psychotropic substances.

Foreign Activities: Compliance Investigators are assigned to foreign countries to establish and maintain liaison with host country law enforcement officials and pharmaceutical industry representatives. These investigators, experts on regulatory matters pertaining to narcotics and psychotropic substances, serve as advisor/consultants to foreign governments in establishing national compliance programs for these countries. Countries are selected based on the volume of trade in controlled drugs. This program is a cooperative effort to curtail diversion of legitimate controlled substances on an international basis.

Pharmacy Theft Program: The concept of the PTP Program is for DEA to act in the capacity of a catalyst to mobilize area pharmacies, police, government and media in a joint community action approach towards suppressing pharmacy thefts.

State Training and Assistance: Through regional Compliance Investigators, DEA provides assistance to the states in identifying problem areas which are hampering state efforts to curb retail level diversion. Compliance Investigators work closely with state officials in developing an action plan to improve state efforts.

Drug Destructions: In order to eliminate possible sources of diversion, an organized system is maintained for handling and destroying unwanted controlled substances.

Voluntary Compliance: The Office of Compliance and Regulatory Affairs encourages voluntary compliance in the prevention of diversion of controlled substances by supporting and fostering self-regulation and self-enforcement among the regulated industry and professions.

15. What percentage of the Administration's FY-81 budget request for DEA is allocated for activity directly or indirectly targeted at controlling the retail diversion of dangerous drugs? Please provide a brief description of all such activities and include respective manpower and financial allocations?

Complaint Investigations: (Workyears - 27.3; Financial*: \$947) The DEA will initiate in conjunction with state and local investigators approximately 120 investigations into the alleged diversion of controlled substances by retail level practitioners. These cases will only involve the most egregious violators. DEA's computer operations will be merged with field intelligence in order to identify targets for investigation. The 120 practitioners selected for investigation are approximately one percent of the suspected violators in this category.

The workyear estimate includes travel, order form review, telephone inquiries, administrative time, discussion with the U.S. Attorney and court time. These activities are associated with retail diversion investigations.

*In thousands

Diversion Investigative Units: (Workyears - 24.0; Financial*: \$1,944) Twenty-four month seed funding is provided to the states to motivate and assist them in reducing retail diversion to the minimum acceptable level. After the seed period, the state continues this program without Federal assistance.

State Training and Assistance: (Workyears - 4.1; Financial: \$142) DEA assistance to state agencies accounts for approximately two percent of available Compliance Investigator manpower. DEA concentrates its efforts with state lawmakers and regulatory officials to review the state's structure and tools to act against diverters and seeks areas which could be improved.

Pharmacy Theft Prevention: (Workyears - 2.9; Financial: \$101) This program represents the collective involvement of local police, pharmacists, state agencies and wholesalers in an effort to prevent the diversion of controlled substances which takes place via pharmacy thefts.

Drug Destruction: (Workyears - 3.7; Financial: \$128) Each registrant is required to contact DEA before destroying controlled substances. The drugs are inventoried and then destroyed by DEA or other authorized individuals. A receipt is provided for the registrant's records. It is estimated that 75 percent of all drug destruction requests are received from retail level registrants.

Voluntary Compliance: (Workyears - 2.8; Financial: \$97) Through presentations and publications, DEA supports and fosters self-regulation and self-enforcement among the regulated drug industry and professionals. Approximately 70 percent of this effort is aimed at retail level registrants.

ARCOS - Automated Reports and Consummated Orders System (Workyears - 8.0; Financial: \$702) This is a computerized system which provides for the monitoring of drug transactions of selected controlled substances from point of import or manufacture to point of export or distribution to the dispensing level. This type information is particularly useful in identifying targets of retail diversion investigations. It is estimated that 90 percent of ARCOS output is geared to retail diversion activity.

DAWN - Drug Abuse Warning Network (Workyears - 4.5; Financial: \$1,191) DAWN is a nationwide program which assists the Federal Government in identifying and evaluating the scope and magnitude of drug abuse. Utilization of DAWN data in the retail diversion area has been estimated at 60 percent. DAWN, an indicator that enables the government to gauge the extent of drug abuse as well as the types of drugs being abused, has helped in identifying the need for regulatory and drug-oriented investigations.

*All financial data reported in thousands.

16. DEA currently has Memoranda of Understanding with 45 states and the District of Columbia delineating Federal/State roles in drug enforcement. A major thrust of the understanding is that control of retail diversion is a State responsibility. Recognizing the grave extent of retail diversion nationwide, how many states with which you have these Understandings have committed--in your view--sufficient resources and manpower to control retail diversion?

Since retail diversion continues to account for the majority of all instances of diversion, it is clear that most states have not been able to cope with this problem. As a rule, this is because of limited resources. Retail diversion occurs within professional communities when a physician or pharmacist becomes a source for drugs. The proper investigative techniques for these investigations are complex. Additionally, professional boards have a very important role to play in preventing retail diversion. However, many professional boards act only as licensing agencies and historically, have not fulfilled their regulatory responsibilities because of insufficient legal power to deal with members who have become drug diverters. These situations often require an act of the state legislature in order to produce adequate boards. (Also, see answer re: DEA's state assistance program.)

17. It is estimated that 80-85 percent of licit drug trafficking is a result of retail level diversion. Can your agency provide any figures for what percentage of the retail diversion problem is the result of pharmacy theft?

The DEA has estimated that approximately 270 million dosage units are diverted annually from retail-level registrants. In the first six months of 1979, 16.8 million dosage units were reported as thefts from pharmacies. This would be an annual amount of approximately 33.6 million dosage units. Pharmacy thefts would thus account for 12.4 percent of the retail diversion.

18. Is DEA interested in developing a stronger and more visible program of assisting states?

Yes. There are many shortcomings in state statutes that inhibit effective regulatory and enforcement activities, including:

1. Omitting of drugs of abuse from State drug schedules
2. Failure to establish separate registration systems for the handling of controlled substances, which reduces flexibility by not allowing revocation of controlled substances privileges while allowing medical practice to continue

3. Placing of authority to suspend or revoke registrations in state courts rather than a regulatory agency
4. Lack of statutory authority to employ investigators (in 55 percent of State Pharmacy Boards and 80 percent of State Medical Boards)
5. Lack of clarity in statutory provisions concerning grounds for license revocation or suspension
6. Lack of specific authority for professional boards to promulgate rules and regulations concerning licensing processes
7. Lack of specific responsibility for investigation of misconduct
8. Lack of subpoena powers by regulatory boards
9. Statutes that do not authorize full time legal counsel to regulatory boards

Through the expansion of its ability to assist the state's efforts, DEA could provide the necessary resources to correct many of these deficiencies. In many cases, the first step in the process would be to establish an Evaluation Task Force to evaluate current state capabilities and to establish its needs. Based on determined needs, funding would then be provided for such projects as the preparation of improved state legislation regarding controlled substances handlers; revisions in state statutes concerning the authority, duties and responsibilities of state regulatory boards; establishing improved systems of controlled substances licensing; and initiation of programs to establish Administrative Law Judge provisions to adjudicate actions against registrants.

In many states, even where there are adequate legislative provisions and regulatory boards, resources are not adequate to provide for effective controls. Regulatory boards often have no investigators or an inadequate investigative staff. Similar situations exist in state and local enforcement agencies where little or none of their resources are dedicated to practitioner diversion.

The law enforcement oriented DIU program will continue to be an important part of the Federal assistance approach. Additionally, there exists a need to expand the types of investigative programs at the state level, especially in the regulatory area. The establishment of regulatory task forces can be a viable alternative to DIU's in some states, and complement the DIU's in others. These regulatory task forces would utilize the civil, administrative, and educational avenues to reducing practitioner diversion.

To support the regulatory and law enforcement efforts, funds will also be provided to establish intelligence and information gathering systems to facilitate the collection, analysis, and exchange of information concerning violative actions by registrants. Another system for which funds could be made available is the establishment of mini-DIU's within the states. This would allow for the collection of drug injury and health data for the purpose of evaluating the drug abuse situation within a state, and to assist state planning agencies in the allocation of health related resources.

There exists a recognized need for training of state and local officials in the area of practitioner diversion. Currently, the bulk of this training is provided through the DIU Program. The establishment of on-going regulatory training programs at the state level are necessary if the states are to sustain an effective retail diversion and prevention program. These training programs will have to provide training to state investigators on the techniques associated with practitioner diversion cases. Training for state prosecutors will also be an important factor. Funding will be provided to establish curricula and to hire and train instructors. DEA will also step up its training of state/local officials in the regulatory area.

19. H.R. 5985 would grant State and local law enforcement officers, designated by the Attorney General, the authority to enforce the Controlled Substances Act of 1970. Would passage of this legislation have any affect on state sponsored retail diversion control activities?

No.

20. The Psychotropic Substances Act of 1978 (P.L. 95-633) placed reporting controls on the PCP precursor piperidine. How has this provision affected the abuse and trafficking of PCP? What is the status of the Attorney General's report to the Congress required by Section 203(c) of the Act?

Passage of the Psychotropic Substances Act of 1978 (P.L. 95-633) late in that year and the implementation of its provisions for reporting piperidine sales, coupled with DEA's overall Precursor Liaison Program, contributed to a decrease in the number of PCP laboratory operations. Only 51 PCP laboratories were seized in 1979 as compared to 79 in 1978.

The requirements of the "Piperidine Reporting Act" assisted the DEA Precursor Liaison Program, a cooperative program between chemical suppliers

and special agents, by making the chemical industry and individual suppliers more aware of the cooperation required to locate and stop clandestine laboratory operations. The results of this effort led to the seizure of 235 clandestine laboratories of all kinds in 1979. The Precursor Liaison Program provided the initial investigative leads in almost half of these cases.

There is little doubt that the reporting requirements of the Act have resulted in a decreased supply of piperidine available through legitimate channels; however, this reduced availability has spawned a black market in this chemical. In a recent case, a DEA undercover agent was offered a barrel of piperidine for the sum of \$57,000. The trafficker, who owned a small chemical company, had paid a legitimate source \$2,000 for the barrel. In Los Angeles, piperidine has been reported for sale "on the street" for \$1,500 to \$2,000 per gallon. Thefts and attempted thefts of the chemical also have been reported.

As required by Section 203(c) of the Act, the DEA Office of Enforcement has prepared and forwarded the Attorney General's report to the Congress.

21. Does PCP currently have any legitimate medical uses? If so, please describe.

For a number of years, PCP has been approved only for veterinary use as an analgesic and anesthetic particularly in non-human primates. In 1979, Parke-Davis and Philips Roxane, the only FDA approved producers of PCP, voluntarily surrendered their New Drug Applications (NDA's) to the FDA because newly imposed CSA Schedule II controls made the marketing of PCP unprofitable. The Bureau of Veterinary Medicine states that, because of the surrendering of these NDA's, PCP has no current legitimate medical use.

22. Is the abuse, production and trafficking of PCP geographically widespread or is it concentrated in select regions of the country? Please explain.

The trafficking and abuse of PCP in the United States is geographically widespread, but is most heavily concentrated in urban areas and large metropolitan centers. Hospital emergency room reports of PCP cases in reflect the widespread abuse of this deadly and unpredictable hallucinogen. For the past three years, hospitals in the Drug Abuse Warning Network (DAWN) system have shown a steady or increasing rate of "bad trips" or overdose reactions from PCP abuse.

Those cities reflecting the least amount of PCP abuse include Atlanta, Boston, Dallas, Denver, Kansas City, Norfolk, Oklahoma City, Phoenix, San Antonio, San Francisco, and Seattle. The heaviest abuse of PCP as indicated by DAWN reports has been occurring in Buffalo, Chicago, Cleveland, Detroit, Indianapolis, Miami, Minneapolis, New Orleans, New York, Philadelphia, San Diego and Washington, D.C., with Los Angeles reflecting, by far, the highest prevalence of abuse in the country. Although PCP abuse has risen dramatically during the past few years, a combination of publicity, education, and an apparent diminishing supply appear to have stemmed the rise in the last few months. According to DAWN reports, there has been a gradual decline in the number of emergency room PCP mentions in all areas since August 1979 with the exception of Detroit, Los Angeles, and Minneapolis. (See Attachments I and II).

PCP abuse mentions have slowly decreased from the highs recorded during 1978, declining from more than three percent of all drug mentions to 2.3 percent. This decline was recorded throughout the 24 DAWN metropolitan areas and the DAWN National Panel of Emergency Rooms.

The Los Angeles metropolitan area during December 1979 contributed approximately one out of every three mentions of PCP. During the latter part of 1978, Los Angeles contributed one out of four PCP mentions. Approximately 11 percent of all drug abuse mentions reported from Los Angeles DAWN emergency rooms involved PCP.

A single hospital in Los Angeles contributes one out of every nine mentions of PCP recorded by the DAWN System, indicating that the PCP problem may possibly be restricted to a particular district within the metropolitan area. Seventy percent of all drug abuse episodes handled by this hospital involve PCP.

PCP production has been encountered on the East Coast, in the mid-West, and on the West Coast with the greatest concentrations of clandestine laboratory seizures occurring especially in Southern California and in the Washington, D.C., Detroit, and Chicago areas. There were 15 PCP clandestine laboratory seizures reported to DEA in 1975. This figure rose to 30 in 1976, to 66 in 1977, and to a high of 79 in 1978. The rise in the number of these seizures can be attributed both to an increase in the overall number of laboratories and to more vigorous efforts on the part of DEA, as well as state and local investigators. (See Attachments III and IV).

23. Other than piperidine, are there any other precursor chemicals used in the manufacture of abuse prone drugs to which the Subcommittee should consider extending reporting requirements?

Control of precursor chemicals should be done on a case-by-case basis. DEA has the authority to control immediate precursors but the need to control non-immediate precursors may become necessary. They should be

essential ingredients and shown to be used so extensively in clandestine manufacture as to be a serious problem. Factors for evaluation include: the chemical's uses, extent of use, volume produced or needed, imports/exports, the size of the economy involved, and peripheral industries which could be effected.

In recent years, two PCP immediate chemical precursors were controlled by regulation (43 FR 21324, 3-20-78) in Schedule II of the CSA. These were 1-piperidine-cyclohexanecarbonitrile (PCC) and 1-phenyl-cyclohexylamine (PCH). More recently, as the number of methamphetamine and amphetamine laboratory seizures increased dramatically, their common immediate precursor, phenylacetone (P2P) was controlled in Schedule II (44 FR 71822, 12-12-79). The following precursor chemicals may be considered in the future for some kind of control or reporting action. Although DEA can presently control the immediate precursors listed (by Section 102(22) of the CSA), adding a reporting provision would make it less burdensome to legitimate industry than full controls which would result from CSA scheduling. For all non-immediate precursors, the enactment of further legislation would be needed to provide some form of control. (See Attachment VI)

24. I understand DEA has been active in drafting a model state law to restrict the sale of drug paraphernalia. How does the model law work? Have the states been receptive? How has DEA avoided constitutional problems in the law's preparation?

This proposed Model Act makes the possession of paraphernalia, when accompanied by an intent to use it with illicit drugs, a crime with the range of penalties left up to each state. The Act is framed so a first offense can be made the subject of a fine rather than a jail term. Manufacturing and delivering paraphernalia under circumstances which clearly indicate it will be used with illicit drugs is also made a crime. The delivery of paraphernalia to a child by an adult is made a special offense. The publication of commercial advertisements promoting the sale of paraphernalia is made unlawful--an alternative is also possible relative to the advertising section which provides that the advertisement would not be a criminal offense but rather the basis for a search warrant. Innocent citizens with no intent to violate the drug laws have nothing to fear from this proposed Act; but, drug devotees, and merchants with guilty knowledge, will be penalized.

Paraphernalia dealers will be especially hard hit. For years, they have studied the statutes, determined to violate the spirit, if not the letter, of this country's drug laws. For these merchants, the proposed Model Act contains a civil forfeiture section which provides for the seizure and condemnation of their inventories.

The civil forfeiture of drug paraphernalia will, by itself, have a major impact on this industry. We cannot emphasize the importance of the civil forfeiture section too strongly--it will allow the stocks of paraphernalia manufacturers, wholesalers, and retailers to be seized. The impact of such seizures is immediate. The state can seize the stocks and hold them pending the completion of the civil forfeiture under the applicable statutes.

The application of intent based on the surrounding facts and circumstances to forfeit objects used to conceal and distribute drugs is not a new concept--it is included in Federal law and most current state laws. The best example is the forfeiture of containers such as suitcases which are used to conceal drugs. Similarly, under state and Federal laws, drug manufacturing equipment such as test tubes, flasks, burners, scales, etc., are forfeited when used or intended to be used to manufacture or distribute drugs. The Model Paraphernalia Act merely extends these principles to devices intended to possess or use drugs.

Considerable time was spent in the development of the Model Law. Careful analysis was made of the potential constitutional problems. See the comments appended to the Model Law for full explanations of each of the constitutional considerations.

25. As drug abuse is a serious national problem, shouldn't restrictions on paraphernalia sales be considered a Federal legislative issue?

The Drug Enforcement Administration has limited resources to target against major suppliers of illegal substances both domestically and internationally. DEA believes that remedies at the state and local level are far more appropriate than those at the Federal level, not because of the dollar value of the merchandise in question, but because it is really up to the local community, the citizens of a given area, to decide what kind of environment they want to have. Localities must decide whether they want to subject their young people to the enticement of drug paraphernalia stores which sell commodities with only one clear use--the abuse of substances we know to be harmful and unsafe for human consumption. Localities also have the additional levers of licensing and zoning restrictions to control the opening and location of businesses selling drug paraphernalia.

26. Please submit a copy of the Model Law for the hearing record.

See Attachment VII

27. Please supply for the record a detailed breakdown of concluded scheduling actions undertaken by the Department from FY 1979 to the present.

a) Effective 10/25/78, the ethylamine and pyrrolidine analogs (PCE and PHP) of phencyclidine (PCP) were placed under Schedule I control. With the rescheduling of PCP in Schedule II and the monitoring of the sales of piperidine, a necessary ingredient in the synthesis of PCP, many abusers turned to the above analogs in place of PCP. The abuse and clandestine synthesis of these PCP analogs resulted in their Schedule I control by DEA.

b) The control of pentazocine in Schedule IV, effective February 2, 1979, was the culmination of work which included separate scheduling recommendations to HEW in 1974 and again in 1978. Pentazocine, an analgesic marketed as Talwin, has been abused both alone and in combination with antihistamines, as a heroin substitute with increasing frequency.

c) Reports of extensive smuggling and abuse of fenethylamine, an amphetamine-like stimulant not marketed in the U.S., prompted a review of this drug. A Schedule I recommendation was submitted to HEW on April 4, 1979, based on its actual potential for abuse. No response from HEW has been received as yet.

d) Nitrazepam, a depressant not marketed in the U.S., was reportedly smuggled from Mexico in large quantities and abused in a manner similar to diazepam (Valium). A review of this substance resulted in a recommendation to place nitrazepam under CSA control. This was submitted to HEW on October 23, 1979, with no response from HEW received thus far.

e) Phenylacetone (P-2-P) an immediate precursor in the manufacture of amphetamine/methamphetamine, was controlled in Schedule II, effective February 11, 1980. After weighing the possible economic impact of such an action, it was felt that control of P-2-P was one of the most effective means available to combat the increasing number of clandestine amphetamine and methamphetamine laboratories and amounts of illicit amphetamine in the U.S. No HEW recommendation was necessary for this action.

f) A petition to transfer dextropropoxyphene from Schedule IV to Schedule II was received from the Health

Research Group. Dextropropoxyphene, marketed primarily as Darvon, is a widely used analgesic and has been controlled in Schedule IV since March 1977. HEW denied the petition to reschedule dextropropoxyphene on September 7, 1979 but recommended its classification as a narcotic. DEA requested further information from HEW supporting a narcotic classification and received it on November 13, 1979. A Federal Register notice was published by DEA on January 21, 1980, proposing a narcotic classification for dextropropoxyphene.

g) A review of the Schedule III and IV anorectics was initiated in 1979. It has been found the diethylpropion, phentermine and phendimetrazine are abused in a manner and scope similar to amphetamine. Due to this similarity in abuse potential, a recommendation concerning the appropriate schedule for diethylpropion, phentermine and phendimetrazine will be prepared for submission for HEW's medical and scientific evaluation.

h) A group (American Citizens for Honesty in Government) sponsored by the Church of Scientology, requested that DEA place BZ (3-quinuclidinyl benzilate), a military incapacitating agent, under the CSA. An extensive review of BZ has been completed with no instances of actual abuse or real abuse potential found.

i) A review of 3-(para-chlorophenyl)-2-methyl-4(3H)-quinazolinone, a mecloqualone analog, was undertaken following receipt of reports of clandestine laboratory synthesis of this compound. Insufficient information concerning its abuse potential was found, thus a decision was made not to control this material at this time.

28. Please supply for the record a list of all pending requests to the Secretary of HEW for scientific and medical evaluations pursuant to Section 201(b) of the CSA. The list should include a description of the proposed scheduling action and the date of the DEA request.

The following requests for scheduling decisions were made to HEW over the past two and a half years. For pentazocine and dextropropoxyphene, the earlier requests and recommendations for control are also included.

<u>Drug</u>	<u>Request to HEW</u>	<u>Response (HEW)</u>	<u>Federal Register Publication of Proposal</u>	<u>Effective Date</u>
Marihuana, Synthetic THC (decontrol)	06/27/77	06/04/79	-	06/20/79
PCT (CIII to CII)	08/29/77	12/10/77	12/19/77	02/24/78
PCE (CI)	01/11/78	08/07/78	08/11/78	10/25/78
PHP (CI)	01/11/78	08/07/78	08/11/78	10/25/78
Pentazocine (CIV) Pentazocine	07/10/74 02/02/78	01/23/76 08/30/78	Recommended no control 09/13/78	02/09/79
Mazindol (decontrol)	05/25/78	Pending	-	
Dextropropoxyphene " (CIV) " (CII)	06/29/73 03/02/76 02/12/79	01/23/76 08/12/76 09/07/79	HEW needs more data 09/29/76 01/21/80 classify as a narcotic	03/14/77
Fenethylline (CI)	04/04/79	Pending	-	
Loperamide (decontrol)	07/10/79	Pending	-	
Nitrazepam	10/23/79	Pending	-	

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1. A petition to decontrol marihuana was filed on September 14, 1972 with BNDD (DEA) by the National Organization for the Reform of Marihuana Laws (NORML). It was felt that DEA could act on this petition without a recommendation from HEW. However, the U.S. Court of Appeals for the District of Columbia Circuit on April 25, 1977, ruled that DEA must refer this petition to HEW for its scientific and medical evaluation. As published in the Federal Register on June 20, 1979, this petition was denied.
2. A PCP Action Coordination Group was formed with representatives of DEA, FDA and NIDA. At a meeting of this Group on January 11, 1978, data was presented on PHP and PCE. At this meeting, HEW agreed to review the data and thus no formal request to HEW for the scheduling of these substances was made.
3. A petition from Sandoz Pharmaceuticals, manufacturer of Sanorex (mazindol), to decontrol mazindol was received by DEA. This petition plus pertinent data was forwarded to HEW.
4. A petition from Ortho Pharmaceutical Corporation, manufacturer of Imodium (loperamide), to decontrol loperamide was received by DEA. This petition plus pertinent data was forwarded to HEW.
5. A petition to place dextropropoxyphene in Schedule II was received by DEA from the Health Research Group. Upon denial of this petition, HEW, on September 7, 1979, recommended classifying dextropropoxyphene as a narcotic. As requested by DEA, further evidence in support of classifying dextropropoxyphene as a narcotic was received on November 13, 1979. PCC and PCH, phenacyclidine precursors, and P-2-P, amphetamine precursor, were controlled as immediate precursors in Schedule II without the necessity of HEW recommendations. Difenoixin plus atropine preparations were scheduled by HEW in CIV and CV in 1978 upon NDA approval and DEA concurrence.

29. Last year, in response to a question from the Subcommittee, you testified that FDA's scientific and medical evaluations could be more effective if they were received in a timely manner. Does this problem of FDA timeliness still persist? If so, do you have any suggestions as to how the process can be expedited?

Based on the premise that action must be timely if the obstruction of clandestine manufacture and distribution of abused substances is to be beneficial to society, the Department of Health, Education and Welfare and DEA have striven to reach and process scheduling decisions expeditiously. From our vantage, and we assume from HEW also, further improvements should be made. While both agencies continually strive to increase the efficiency of data collection and analysis, other factors must be considered. Factors such as the delegation of authority, the number of administrative levels involved and the priority given scheduling decisions at each level are relevant also.

Within DEA, scheduling decisions flow through approximately six administrative levels. In contrast, we have been told that somewhere between 16 and 40 administrative levels are involved within HEW. A considerable amount of time can be lost before a proposed decision is presented to the Assistant Secretary for Health. An HEW evaluation of the process it follows in arriving at medical and scientific evaluations, in relation to the CSA, might provide a mechanism for reducing the time which elapses between the solicitation of a recommendation and its receipt by DEA.

30. Under what circumstances may heroin and marihuana be used in the practice of medicine? Please describe the process.

Heroin and marihuana may be used in clinical research if the investigator has filed an IND (i.e., a Notice of Claimed Investigational Exemption for a New Drug) with the Food and Drug Administration and has obtained a Schedule I research registration from DEA. After the FDA and DEA requirements are met, the National Institute on Drug Abuse will supply the investigator with the substance being evaluated. DEA and FDA have worked closely to make the registration process for clinical research studies as efficient as possible, while at the same time maintaining proper controls against diversion of these dangerous substances.

Two clinical research studies which involve heroin are currently being conducted and 43 which involve marihuana and/or THC. Neither heroin or marihuana has been approved for marketing by the Food and Drug Administration, therefore, neither is available for use in the practice of medicine.

The attached monograph, distributed by the Interagency Committee on New Therapies for Pain and Discomfort describes the mechanisms available to the researcher in order to comply with the FDA regulations. The Committee, whose function in part is to facilitate research of the therapeutic qualities of Schedule I drugs, is currently chaired by Diane J. Fink, M.D., Associate Director for Medical Applications of Cancer Research, National Cancer Institute. (See Attachment VIII)

31. It has been suggested that pharmacy thefts be made a Federal crime. Would you endorse such a proposal? Is it likely such a revision in the criminal statute would have a deterrent effect on pharmacy burglaries and robberies? Does DEA have the capability to effectively enforce such a law? If not, what additional resources would be necessary to fully administer such a provision?

The Drug Enforcement Administration opposes efforts to make pharmacy theft a Federal crime for the following reasons:

A. Making pharmacy thefts a Federal crime will not have any effect on this problem. Bank robberies are Federal crimes, however, this type of crime increased by 25 percent in 1979. Total figures are not yet available, however, DEA forecasts an increase of pharmacy thefts of around 10 percent in 1979, except in Pharmacy Theft Prevention (PTP) cities, where a prevention program is actively underway.

B. Local police departments are best equipped to respond to this type of crime. Every known enforcement statistic indicates that successful burglary/holdup arrests are directly related to the time it takes to respond to the initial alarm. The Los Angeles Police Department studied this problem and discovered the following correlations between response time and apprehension rates. See below:

<u>Response Time</u>	<u>Apprehension Rate</u>
30 sec. or less	100%
1 minute	90%
2 minutes	75%
4 minutes	50%
10 minutes	20%

C. The DEA has approximately 200 Compliance Investigators who are responsible for investigating instances of diversion from all legitimate sources. There are around 55,000 retail pharmacies registered with DEA. These investigators cannot possibly investigate the seven to eight thousand annual pharmacy thefts reported by these pharmacies.

D. In most instances pharmacy theft cases will not have appropriate level violators for DEA and will not be accepted for Federal prosecution. Federal court calendars are already crowded. Moreover, since the passage of the Speedy Trial Act, Federal prosecutors are even more selective in accepting cases for prosecution.

E. There is no evidence that pharmacy theft defendants receive stiffer penalties in Federal court than in State court.

F. Making pharmacy thefts a Federal crime may actually harm pharmacists by giving them a false sense of security.

32. Please provide a detailed description of the programs and activities sponsored during FY 1980 and FY 1981 to assist states and localities in controlling pharmacy thefts. Include specific manpower and financial allocations?

DEA provides no direct financial assistance to Pharmacy Theft Prevention (PTP) cities. However, DEA field personnel provide substantial technical assistance to communities which desire to initiate these programs. Field representatives organize groups in interested cities and provided executive committees with information regarding the nature of pharmacy crimes. DEA personnel assist in presentations and provide initiatives for activities which have been successful in other PTP cities. Additionally, DEA has prepared PTP publications and encourages the preparation of additional private publications.

There are currently 12 PTP cities with active Pharmacy Theft Prevention programs. In 1979, four PTP programs were disbanded. Pharmacy representatives in these cities either lost interest or felt that the programs had accomplished their objectives. Two additional programs are underway and will be operational in 1980.

PTP Cities

<u>Active</u>	<u>Developing</u>	<u>Disbanded</u>
Philadelphia, PA	Louisville, KY	Waterbury, CN
Milwaukee, WS	Pittsburgh, PA	Buffalo, NY
Nashville, TN		Miami, FL
Johnson County, KS		Cleveland, OH
Dallas, TX		
Denver, CO		
Seattle, WS		
San Diego, CA		
Rhode Island State		
Clark County, NV		
Utah State		
San Juan, PR		

Additional funding and manpower could improve the scope and quality of coverage.

To date, funding has not been a significant problem. The DEA widely distributes information regarding this program through the Voluntary Compliance Program and pharmacy working committees. However, only a limited number of communities have come to DEA and requested assistance.

DEA's Pharmacy Theft Prevention programs are developing in many areas. Some programs are establishing "hot lines" to deal with forged and xeroxed prescriptions. Other programs are considering actions for state legislation such as mandatory sentences and triplicate prescriptions. The direction of the program is limited only by the nature of the problem in the locality and the imagination of the participants.

DEA has applied for, and received, a \$50,000 grant from the Law Enforcement Assistance Administration (LEAA) for the purpose of assisting pharmacists who are victims of pharmacy theft by producing a professional film to educate pharmacists in prevention and protection techniques in the event of an armed robbery. It is anticipated copies of the film will be distributed to all PTP cities and State Boards of Pharmacy. (See question 15)

33. Please provide a detailed chart illustrating the experiences of cities in the Pharmacy Theft Prevention (PTP) program. The chart should include comparison of pharmacy thefts since FY 1977 to the present.

Pharmacy Thefts: PTP Cities

	June-Dec 1977	Jan-June 1978	June-Dec 1978	Jan-June 1979	
Waterbury	7	2	2	2	- 71.4%
Buffalo	23	12	16	30	+ 30.4%
Philadelphia	33	28	11	14	- 57.6%
Miami	44	30	22	57	+ 29.5%
Cleveland	36	18	13	11	- 69.4%
Milwaukee	7	6	4	6	- 14.2%
Nashville	10	24	41	52	+ 420.0%
Johnson Co., KS	5	2	6	5	-0-
Dallas	13	26	40	20	+ 53.8%
Denver	31	31	22	33	-0-
Seattle	33	3	4	2	-155.0%
San Diego	8	11	12	16	+100.0%
Total	250	193	193	248	-0.8%
Nationally	3,677	4,175	3,429	4,150	+12.8%

34. What are the nationwide statistics on the number of pharmacy thefts during 1978 and 1979? In providing data for each year, please distinguish between burglaries and armed robberies. If possible, please include figures on the number of dosage units diverted.

Pharmacy Thefts: National Statistics v. PTP Statistics

<u>National Statistics</u>	<u>PTP Cities</u>
<u>1st half of 1978</u>	<u>1st half of 1978</u>
Total thefts - 4,175	Not available
64.1% Night break-in	
17.2% Armed Robbery	
18.6% Other	
<u>2nd half of 1978</u>	<u>2nd half of 1978</u>
Total thefts - 3,429	Total thefts - 228
61.4% Night Break-in	38.4% Night Break-in
18.4% Armed Robbery	46.9% Armed Robbery
20.2% Other	14.9% Other
<u>1st half of 1979</u>	<u>1st half of 1979</u>
Total thefts - 4,150	Total thefts - 308
55.9% Night Break-in	45.8% Night Break-in
23.5% Armed Robbery	34.1% Armed Robbery
20.6% Other	20.1% Other (See Attachment IX)

35. Could retail pharmacies do more to protect themselves through modest improvements in better security systems?

This is a major thrust of the PTP program--"prevention." Security is the answer, of course. Increases in security undoubtedly result in reduced theft. Thefts at the wholesaler and manufacturer level are infrequent, however, these firms are required by law to provide substantial drug security.

Pharmacists cannot afford to install large amounts of security, however, modest improvement can result in decreased vulnerability. The store should have adequate lighting and all merchandise should be cleared to allow a clear view of the pharmacy counter. Potential sites for entry should be

scrutinized. Doors or locks may be upgraded. Many burglars enter through the roof. This should be considered. Silent alarm systems are expensive, but effective. High volume stores should consider using them. Local alarms also act as a deterrent. Each pharmacist should be encouraged to actually evaluate his store's security. Vulnerable points should be identified and, where possible, upgraded. Additionally, pharmacies should stock minimal levels of controlled substances necessary to supply customer needs, and should work with local police to establish close relationships and solicit their active assistance in prevention programs.

The DEA continues to review information regarding drug security for pharmacists. Useful and pertinent ideas are passed on through the Voluntary Compliance Program, PTP field liaison and pharmacy working committees.

36. Since 1976, the United States has experienced a decrease in heroin supplies. Is there any evidence to suggest that a shortage of heroin increases demand for other dangerous drugs? Is so, please explain.

All information available consistently points to a marked rise in the use of drugs other than heroin, with notable increases having been seen in the cocaine, hallucinogen, stimulant, and cannabis categories. These increases are clearly indicated in the chart below which stratifies the average number of injuries per quarter for each of these drugs over a four year period.

Average Injuries Per Quarter

<u>Drug Area</u>	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>1979</u> <u>(9 mos.)</u>	<u>% Change</u> <u>1976-1979</u>
Heroin	4,780	3,075	2,373	1,779	-63%
Cocaine	311	397	479	561	+80%
Cannabis	700	972	1,211	1,229	+76%
Hallucinogens	785	1,249	2,362	2,441	+211%
Stimulants	1,449	1,624	1,671	1,712	+18%

Current data also shows that in the last few years, as heroin has become less available, heroin addicts have increasingly turned to other drugs as supplements to, and substitutes for, poor quality heroin. For example, the number of mentions* of the heroin analogs Dilaudid and Talwin have risen substantially.

For 1976 through mid-1979 Dilaudid mentions have risen by 70 percent and Talwin mentions have increased by 71 percent. Also, pharmacy thefts have increased 36 percent since 1976, and armed robberies of pharmacies have risen by over 60 percent since 1977.

One of the clearest pieces of data showing that heroin substitution and supplementation has been more prominent comes from Federally funded treatment center (CODAP) statistics. In the last three and one half years, growing proportions of heroin users have indicated use of secondary drugs with heroin. In 1976, only 29 percent of heroin users indicated secondary drug use. In the first six months of 1979, the percentage had grown to 53 percent.

It is important to recognize, however, that the practice of heroin substitution/supplementation on the part of heroin users is not a phenomenon unique to the current shortage. Studies and surveys on addict behavior prior to 1976 have continually shown that use of other drugs in combination with or in place of heroin is common and that the practice becomes frequent during times of heroin shortage.

37. In FY 1980 and FY 1981 what do you see as the most significant challenge confronting the agency?

During the next several years, DEA will face many challenges to our efforts to control drug trafficking. There are three serious sources of drugs of abuse: Southwest Asian heroin, Colombian marihuana and cocaine, and the retail diversion of legitimate drugs from the retail level. Each of these threats will be difficult to meet because: (1) resource constraints on DEA will not permit an increase in enforcement personnel during the next two years, (2) current U.S. Government policy does not support herbicidal spraying of marihuana, (3) State and local governments either are not resolved or not prepared to address the retail diversion problem on a large scale, and (4) enforcement successes are not adequately supported by uniform sentencing appropriate to the egregiousness of the crimes.

Southwest Asian Heroin Situation. The United States has enjoyed a tremendous reduction in the heroin problem, largely due to the opium eradication efforts in Mexico. Opium produced this year in the Southwest Asian countries of Iran, Pakistan and Afghanistan is likely to be 100 times that produced in Mexico. Western Europe is already experiencing an alarming

*Injury incidents reported in hospital emergency rooms.

increase in heroin-related deaths and injuries. Intelligence indicates significant quantities of Southwest Asian heroin could be in this country within the year. DEA anticipated the increase in Southwest Asian heroin production and developed special initiatives to deal with it. However, we are limited in part by the political instability of the area. Unlike Mexico, where there is political stability and a commitment on the part of the Government to cooperate on this international problem, the serious situation in Southwest Asia precludes even accurately assessing the problem, much less developing solutions.

Uncontrolled Marihuana and Cocaine Traffic in the Caribbean. DEA, in cooperation with the Coast Guard, Customs and other agencies, has been seizing unprecedented tonnage of marihuana from vessels transiting the Caribbean destined for the United States. As extraordinary as the seized amounts have been, there is every reason to believe they have not inflicted even a dent in the traffic. In the past few years, we have experienced the spread of marihuana use into increasingly younger elements of the school age population. The National Institute on Drug Abuse (NIDA) estimates that the number of marihuana users rose about ten percent in 1978 to 26.5 million Americans. The overriding trend has been one of increased acceptance of marihuana use.

While no other drug compares with marihuana as to the volume coming into this country, we are also aware that a large traffic revolves around cocaine, which also comes from South America.

Effect of the Paraquat Amendment. In the one area that could perhaps have the most impact on the volume of marihuana entering the country, the United States has been frustrated. We are fortunate in having a willing and cooperative partner in the Government of Colombia. Colombia is estimated to be the source of at least 70 percent of the marihuana in the United States. The Colombians can effectively control marihuana production by the use of the herbicidal spray paraquat, and they have given some indication that they would consider taking this step. This possibility was seriously reduced, however, with the passage of the "paraquat amendment" in the United States Senate. This amendment intended to prohibit the Government of Mexico from using U.S. funds (originally provided for opium eradication) in the spraying of marihuana. The prohibition reflected a concern for the unknown health consequences of paraquat-sprayed marihuana. The effect has been to signal to the Government of Colombia that the U.S. Government is, in fact, not interested in and not supportive of marihuana eradication with herbicides.

Diversion of Legitimate Drugs into the Illicit Traffic at the Retail Level. Emergency room data shows that most abused substances are primarily of legitimate origin. These drugs present a much greater health hazard to the general public than drugs wholly illegal in origin. Under the Controlled Substances Act, DEA has effectively regulated the legitimate industry at the wholesale level to prevent the diversion of legitimate drugs. Control of

diversion at the retail level is primarily a state responsibility. It is a vast problem, and as a rule, the state regulatory boards assigned this function are not oriented or equipped, or in some instances, even empowered to carry it out. Although DEA does not possess resources to monitor the retail level, several programs are conducted to upgrade state capabilities.

Reconsideration of Fiscal Constraints on DEA. Along with most other government agencies, DEA has been operating with a virtual no-growth budget for the past three years. During this time, DEA has achieved a demonstrated record of success in meeting the responsibilities before it through innovation, managerial responsibility and disciplined application of proven methods. The significant complications and threats represented by Southwest Asia, retail diversion and the dimensions of the Caribbean situation are realistically going to require some new investment. DEA cannot meet these problems without resources concomitant to the job and we will be addressing this in greater detail in the future.

Bail and Sentencing Reform. DEA is becoming increasingly sophisticated in developing successful cases against the highest levels of the drug traffic, in applying complex conspiracy statutes, and in utilizing new tools and methods to attack the financial assets amassed by traffickers. The effectiveness of these efforts in deterring drug traffickers is diminished by bail and sentencing practices that minimize the risks traffickers face. An October 1979 General Accounting Office (GAO) assessment clearly recognizes the problem with the current bail law in that it does not provide for "danger to the community" as a criteria to be used in setting conditions of pre-trial release on non-capital offenses. A related issue is that of sentencing. Current sentencing provisions of the Controlled Substances Act make it plain to traffickers that the risk lies in dealing in heroin, not marihuana. Penalties for trafficking in large quantities of marihuana should be increased.

38. What is the single biggest drug problem confronting state and local law enforcement officials?

There is no single biggest drug problem common to state and local law enforcement officials.

In addition to those drug problems faced by all law enforcement officials, certain geographical areas within the United States have major problems which are unique to that locality. The Eastern Seaboard and the State of Florida, in particular, are experiencing great difficulty in interdicting air/marine smuggling of marihuan., cocaine and dangerous drugs. In the New York metropolitan area, the influx of Southwest Asian heroin, which is rapidly spreading to other locales, is one of the most serious problems to be addressed. On the West Coast, the eradication of high-potency, domestically cultivated marihuana constitutes an area of great concern.

Possibly the greatest threat at the present time is that posed by the introduction of Southwest Asian heroin into the United States. DEA has taken the initiative in augmenting enforcement efforts and alerting state and local authorities to this growing problem.

39. Please submit for the record a description of how DEA arrives at comparable assessments of heroin availability.

A persistent and often stated concern in calculating the heroin price/purity index has been the size of the heroin retail sample. Obtaining a representative cross-section of the retail market is difficult, due to the fact that, since 1976, almost all enforcement operations have concentrated upon wholesale, upper-level traffickers.

During DEA's continual monitoring of the price/purity system, it was observed during 1976 that the number of retail purchase exhibits was decreasing. In order to increase the data base, beginning with the 2nd quarter of 1977, seizures of heroin which met the retail criteria were included in the computation of the index. Since then, heroin purchase exhibits have averaged 46 percent of the total number of exhibits per quarter. As a result of this inclusion, the average combined quarterly number of exhibits has increased substantially, rising to 277 for the final quarter of FY 1979.

This increase in the number of exhibits has been accomplished without changing the selection criteria of the exhibits; i.e., no samples above 14 percent purity or 14 grams gross weight and no purchases which exceeded \$5.00 per milligram have been included. Thus, we have been able to maintain a consistent standard of measurement throughout the period and continue to exclude low-level wholesale exhibits and fraudulent transactions ("burns").

The Mann-Whitney U-Test was used to test the hypothesis that DEA retail heroin exhibits and state and local retail exhibits come from the same population. The test was applied to various DEA regions over several time periods. Eleven of the fourteen tests resulted in the rejection of this hypothesis. That is, the conclusion was that DEA and state and local exhibits come from two different probability distributions.

The only assumptions made in order to apply the Mann-Whitney U-Test are that the distributions of the populations (here, the heroin purity) are continuous and that the observations are independent. The Mann-Whitney test performs particularly well as a test for equal means since it is sensitive to location differences. The hypothesis, again, is that the distributions of DEA and state and local retail heroin purities are identical; the alternative is also very general--the distributions are unequal. The Mann-Whitney test is a very efficient test and is used frequently in a nonparametric situation (i.e., where no assumption is made re: type of distribution--normal, uniform, etc.).

The regions selected for testing were those which have a consistent number of DEA and state and local heroin exhibits. It should be noted that in each region where the hypothesis was rejected, a more specific conclusion could be drawn--that the state and local retail heroin exhibits were stochastically smaller than the DEA exhibits. That is, it is more likely for a state and local exhibit to be of lower purity. Thus, the state and local exhibits mean purity would be lower than the DEA mean even though the sample distributions of DEA and of state and local purities, when plotted, were of the same general shape.

The fact that 80 percent of the time periods tested resulted in a rejection of the hypothesis argued rather persuasively for not including the state and local exhibits in DEA's system.

As important as the above tests were to our decision to exclude these state and local samples, another major consideration was the importance of maintaining a consistent data base. Specifically, had we incorporated these exhibits, the longitudinal nature of our system might have suffered to the extent that baseline data would have no longer existed. Since this system is far more valuable as a trend indicator than as a measurement of absolute price or purity, the tradeoff of increasing our data base to the detriment of consistency over time was not compelling.

A concern in calculating the heroin price/purity index has been the size of the heroin retail sample. Obtaining a representative cross-section of the retail market is difficult, due to the fact that DEA enforcement operations concentrate upon the wholesale, upper-level trafficker. This problem has become even more acute in the past few years.

To overcome this, beginning in 1977, retail level seizures meeting retail exclusion criteria were also included in the purity data base. This decision was based upon the fact that analysis similar to those made on state and local exhibits showed that quarterly purity distributions of retail seizures and purchases were very similar and produced almost identical purities.

Exhibits from these three areas totaled approximately 70 percent of the retail sample in only one quarter since 1977. In the 4th quarter of 1978, San Diego, New York City and South Texas contributed 58 percent of the total number of exhibits and 75 percent of the purchase exhibits. Overall, the average number of exhibits per quarter from these three areas comprised 32.4 percent of the total exhibits in 1977, 43.7 percent in 1978, and 39.9 percent in 1979.

Given the large proportion of heroin users estimated to be in New York City and the proximity of the other two areas to the Mexican border, these percentages are not surprising.

More importantly, however, DEA's price/purity system has been designed so that it is not affected by fluctuations in the number of exhibits from any one geographic area. As has been pointed out in various DEA publications, the figures from geographic regions are weighted by using a national index which reflects the relative heroin problem in each area.

Thus, the contribution of each geographic area to the national figure is in proportion to its heroin problem and not to the number of its heroin exhibits.

ATTACHMENTS

ATTACHMENT I
DAWS Reports - WCP
Emergency Room Incidents

	1977												1978											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
ALL	189	173	165	183	186	204	246	241	219	318	325	315	322	299	495	465	582	521	584	642	533	403	465	443
Atlanta	3	0	1	3	1	1	1	2	1	1	3	3	3	1	2	1	2	3	1	0	5	3	3	2
Boston	2	6	4	12	8	12	10	11	17	29	11	9	3	2	4	12	7	10	7	9	4	6	4	10
Buffalo	1	6	7	7	7	3	9	5	4	5	11	10	9	8	20	17	7	12	11	12	16	6	13	
Chicago	11	22	15	29	21	24	34	23	36	32	56	43	35	47	35	51	38	52	64	71	53	62	50	
Cleveland	2	4	6	2	1	5	2	7	0	1	0	1	2	0	6	1	1	4	10	6	7	8	13	
Dallas	2	0	0	0	0	0	0	0	0	1	0	1	1	1	2	1	2	2	1	3	0	0	0	
Denver	1	1	0	0	2	0	5	1	1	2	0	2	0	1	2	1	2	0	6	1	0	2	1	
Detroit	12	13	3	10	15	25	11	14	13	21	10	7	8	8	7	16	7	9	7	11	10	28	18	
Indianapolis	1	0	0	0	1	2	1	0	0	1	2	0	1	2	4	3	2	4	0	4	4	4	12	
Kansas City	1	3	1	0	0	0	0	2	6	2	6	5	4	2	2	10	5	1	4	4	6	4	3	
Los Angeles	82	64	63	77	66	66	94	101	91	115	110	117	127	112	194	146	257	237	295	320	264	111	154	
Miami	3	1	0	0	0	0	0	1	0	1	3	4	13	13	20	33	21	10	9	10	8	5	10	
Minneapolis	43	14	12	6	11	13	11	11	14	10	8	6	6	11	5	9	8	9	9	10	8	12	15	
New Orleans	0	0	0	1	1	0	1	1	0	1	3	1	2	1	1	0	0	0	0	4	3	6	2	
New York	0	2	2	2	6	7	19	14	7	20	29	38	35	26	82	84	115	83	53	67	73	79	72	
Norfolk	0	3	3	0	1	0	0	0	0	0	0	2	0	0	0	0	0	1	3	1	0	0	0	
Oklahoma City	1	0	0	1	0	5	1	2	1	8	0	0	2	1	0	0	0	1	1	6	4	3	6	
Philadelphia	4	4	11	6	9	8	9	8	6	25	19	23	16	19	25	14	30	21	19	5	11	9	8	
Phoenix	1	2	0	1	0	0	4	2	3	5	8	3	5	1	13	7	5	7	7	11	0	5	12	
San Antonio	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	2	0	0	0	
San Diego	7	3	4	0	7	3	7	3	13	14	18	5	7	10	15	14	11	12	22	27	12	16	10	
San Francisco	43	9	6	6	3	1	2	4	6	3	6	6	2	2	1	3	7	3	11	7	11	8	7	
Seattle	0	1	3	2	7	0	6	3	4	2	2	2	4	3	7	3	12	7	2	1	8	0	2	
Washington	20	14	19	13	18	25	15	21	10	13	14	22	16	17	36	19	20	19	15	26	17	12	18	
Other	2	2	5	5	1	4	5	5	5	15	6	5	21	11	12	10	20	8	20	10	10	14	11	

ATTACHMENT II
DAWN Reports - PCP
Emergency Room Incidents

	1979											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
ALL	444	488	610	587	550	543	534	524	465	483	378	241
Atlanta	6	1	2	3	1	2	2	2	2	2	2	1
Boston	6	4	7	4	5	9	5	1	4	0	1	2
Buffalo	9	12	14	16	27	23	27	27	17	16	18	2
Chicago	38	51	44	50	60	46	53	40	36	69	27	24
Cleveland	10	16	15	11	17	19	16	43	24	12	3	3
Dallas	1	1	2	1	1	3	3	3	0	0	1	0
Denver	1	2	4	2	2	2	5	2	1	2	0	0
Detroit	15	16	12	26	16	20	23	19	11	16	8	17
Indianapolis	3	5	17	8	10	12	5	10	12	5	1	2
Kansas City	0	5	4	3	2	6	5	3	2	6	6	3
Los Angeles	143	193	245	167	207	225	158	165	144	156	150	76
Miami	16	10	19	29	22	20	18	16	20	12	10	9
Minneapolis	5	5	16	14	6	13	16	14	11	10	9	10
New Orleans	9	12	19	13	13	10	15	12	19	16	4	1
New York	88	88	97	118	84	46	58	61	89	61	54	37
Norfolk	0	0	0	0	0	0	1	0	0	0	0	1
Okla. City	1	0	4	7	1	2	2	2	5	3	2	4
Philadelphia	17	17	21	21	15	19	24	12	16	21	18	10
Phoenix	8	5	5	12	6	8	7	5	7	9	7	1
San Antonio	0	0	0	1	0	0	0	3	0	0	0	0
San Diego	14	8	4	19	13	14	33	21	5	12	17	8
San Fran.	12	5	11	5	3	14	7	9	4	4	5	0
Seattle	2	5	8	5	3	7	2	2	2	3	1	1
Washington	15	11	15	22	12	4	11	7	6	16	16	12
Other	25	16	25	30	24	19	38	49	28	33	18	17

ATTACHMENT III

Clandestine Lab Seizures

in the U. S. thru Mar 20, 1980

Type of Laboratory	DEA Region					Total
	NEast	SEast	NCent	SCent	West	
Methamphetamine	6	3	6	9	5	29
PCP	3	3	4	0	7	17
Amphetamine	0	1	4	1	1	7
Methaqualone	2	1	0	0	2	5
DMT/DET	0	0	1	0	0	1
Cocaine	0	0	0	0	1	1
Hashish Oil	0	0	0	0	1	1
Psilocybin	0	0	0	0	1	1
TMA	0	1	0	0	0	1
TOTAL	11	9	15	10	18	63

ATTACHMENT IV

Clandestine Laboratory Seizures
in the U. S. - 1979

Type of Laboratory	DEA Region					Total
	NEast	SEast	NCent	SCent	West	
Methamphetamine	16	13	14	72	22	137
PCP	5	13	13	8	12	51
Amphetamine	2	1	4	2	1	10
Methaqualone	1	2	1	2	3	9
LSD	1	0	0	0	1	2
DMT/DET	1	1	0	1	0	3
MDA	1	2	3	0	0	6
Mescaline	0	0	0	1	1	2
Hashish Oil	2	0	1	1	0	4
Heroin	0	0	0	0	2	2
Psilocybin	0	0	2	1	1	4
Cocaine	10	11	11	10	13	55
TOTAL	29	33	39	88	46	235

ATTACHMENT V

DANGEROUS DRUGS·CLANDESTINE LABS SEIZED

1977	1978	1979
66 PCP	79 PCP	51 PCP
46 METHAMPHETAMINE	67 METHAMPHETAMINE	137 METHAMPHETAMINE
10 AMPHETAMINE	9 AMPHETAMINE	10 AMPHETAMINE
10 METHAQUALONE	7 METHAQUALONE	9 METHAQUALONE
7 MDA/DMA/DMT/DET	5 MDA/DMA/DMT/DET	8 MDA/DMA/DMT/DET
1 LSD	0 LSD	2 LSD
(140)	(171)	(217)

Stimulants

I) Amphetamine

(A) Immediate Precursors

- 1) Phenyl-2-propanone oxime
- 2) 1-Phenyl-2-nitropropene
- 3) Norephedrine

(B) Other Precursors

- 1) Formamide
- 2) Phenylacetic acid
- 3) Benzyl cyanide
- 4) Benzyl chloride

II) Methamphetamine

(A) Immediate Precursors

- 1) Ephedrine
- 2) Methylamine
- 3) N-Formylmethamphetamine

(B) Other Precursors

- 1) N-Methylformamide
- 2) Phenylacetic acid
- 3) Benzyl chloride
- 4) Benzyl cyanide

III) Cocaine

(A) Immediate Precursors

- 1) Methyl ecgonine
- 2) Benzoyl ecgonine

(B) Other Precursors

- 1) Methyl tropinone-2-carboxylate
- 2) Ecgonine

- 3) Succindialdehyde
- 4) Acetone-dicarboxylic acid monomethyl ester

IV) Diethylpropion

(A) Immediate Precursors

- 1) $\mathcal{L}$ -Bromopropiophenone
- 2) Diethylamine

(B) Other Precursors

- 1) Propiophenone

V) Phentermine

(A) Immediate Precursors

- 1) β -Bis(2-phenyl-1,1-dimethylethyl)urea
- 2) β -Chloro- $\mathcal{L}$, $\mathcal{L}$ -dimethylphenethylamine
- 3) N-(Dimethylbenzylcarbinol)-formamide
- 4) p-Aminophentermine
- 5) 2-Methyl-1-phenyl-2-propene

(B) Other Precursors

- 1) β -Phenyl- $\mathcal{L}$, $\mathcal{L}$ -dimethylpropionamide
- 2) β -Phenyl- β -hydroxy- $\mathcal{L}$ -amino- $\mathcal{L}$ -methylpropane
- 3) 2-Methyl-3-phenyl-2-propene
- 4) 3-phenylpropene
- 5) p-Nitrobenzyl chloride
- 6) Isobutyryl chloride
- 7) Isobutyrophenone
- 8) Benzyl chloride
- 9) 1,3-Diphenyl-2,2-dimethyl-1-propanone

Depressants

I) Methaqualone

(A) Immediate Precursors

- 1) N-Acetylanthranilic acid
- 2) o-Toluidine
- 3) 2-Methylbenzoxazone

(B) Other Precursors

- 1) Anthranilic acid
- 2) Isatoic acid

II) Mecloqualone

(A) Immediate Precursors

- 1) N-Acetylanthranilic acid
- 2) o-Chloroaniline

(B) Other Precursors

- 1) Anthranilic acid

III) Phencyclidine (PCP)

(A) Immediate Precursors

- 1) 1-(1-Cyclohexenyl)-piperidine
- 2) Pentamethylene dibromide

(B) Other Precursors

- 1) Bromobenzene
- 2) Cyclohexanone
- 3) Phenyl magnesium bromide
- 4) Pyridine
- 5) α -Piperidone
- 6) Glutaronitrile
- 7) Glutaraldehyde

- 8) Cadaverine
- 9) Putrescine
- 10) 5-Aminovaleronitrile
- 11) Dihydropyran
- 12) 1-Phenylcyclohexanol
- 13) 1-Phenylcyclohexylazide
- 14) Pyrrolidine (PCP analog)

Opiate

- I) Methadone
 - (A) Non-Immediate Precursors
 - 1) Diphenylacetoneitrile
 - 2) 1-Dimethylamino-2-chloropropane

Hallucinogens

- I) Lysergic Acid Diethylamide (LSD)
 - (A) Immediate Precursors
 - 1) Diethylamine
 - 2) Lysergic Acid Azide
 - (B) Other Precursors
 - 1) Ergonovine
 - 2) Ergotamine
 - 3) Lysergic acid hydrazide
- II) Diethyltryptamine (DET)
 - (A) Non-Immediate Precursors
 - 1) Diethylamine
 - 2) Indole
 - 3) Oxalyl chloride

III) Dimethyltryptamine (DMT)

(A) Non-Immediate Precursors

- 1) Dimethylamine
- 2) Indole
- 3) Oxalyl chloride

IV) 3,4-Methylenedioxyamphetamine (MDA)

(A) Immediate Precursors

- 1) Formamide
- 2) 3,4-Methylenedioxybenzyl methyl ketone
- 3) 3',4'-Methylenedioxybenzyl-2-nitropropene

(B) Other Precursors

- 1) Isosafrole
- 2) Piperonal

V) Mescaline

(A) Immediate Precursors

- 1) 3,4,5-trimethoxyphenylacetonitrile
- 2) 3,4,5-trimethoxy- β -nitrostyrene

(B) Other Precursors

- 1) 3,4,5-trimethoxybenzaldehyde
- 2) Gallic acid
- 3) 3,4,5-trimethoxybenzoic acid
- 4) 3,4,5-trimethoxybenzoyl chloride
- 5) Methyl-3,4,5-trimethoxybenzoate
- 6) 3,4,5-trimethoxybenzyl alcohol
- 7) 3,4,5-trimethoxybenzyl chloride

VI) Psilocin

(A) Immediate Precursors

- 1) 4-Benzoyloxy- ω -N,N-dimethyltryptamine

(B) Other Precursors

- 1) 4-Benzoyloxy-indole
- 2) Oxalyl chloride
- 3) Dimethylamine

VII) 2,5-Dimethoxy-4-methylamphetamine (STP)

(A) Immediate Precursor

- 1) 1-(2,5-dimethoxy-4-methylphenyl)-2-nitropropene

(B) Other Precursors

- 1) Methyl-1,4-hydroquinone
- 2) 2,5-Dimethoxy-4-methyl benzyl alcohol
- 3) 2,5-Dimethoxy-4-methyl benzaldehyde
- 4) 2,5-Dimethoxytoluene

VIII) Tetrahydrocannabinol (THC)

(A) Immediate Precursors

- 1) Olivetol
- 2) Citral

IX) 3,4,5-Trimethoxyamphetamine (TMA)

(A) Immediate Precursor

- 1) 1-(3,4,5-Trimethoxyphenyl)-2-nitropropene

(B) Other Precursors

- 1) 3,4,5-Trimethoxybenzaldehyde
- 2) 3,4,5-Trimethoxyphenylpropene

MODEL DRUG PARAPHERNALIA ACT

Drafted by the

Drug Enforcement Administration

of the

United States Department of Justice

August, 1979

With

Prefatory Note and Comments

MODEL DRUG PARAPHERNALIA ACT

Prefatory Note

The Uniform Controlled Substances Act, drafted by the National Conference of Commissioners on Uniform State Laws, has been enacted by all but a handful of states. The Uniform Act does not control the manufacture, advertisement, sale or use of so-called "Drug Paraphernalia." Other state laws aimed at controlling Drug Paraphernalia are often too vaguely worded and too limited in coverage to withstand constitutional attack or to be very effective. As a result, the availability of Drug Paraphernalia has reached epidemic levels. An entire industry has developed which promotes, even glamorizes, the illegal use of drugs by adults and children alike. Sales of Drug Paraphernalia are reported as high as three billion dollars a year. What was a small phenomenon at the time the Uniform Act was drafted has now mushroomed into an industry so well-entrenched that it has its own trade magazines and associations.

This Model Act was drafted, at the request of state authorities, to enable states and local jurisdictions to cope with the paraphernalia problem. The Act takes the form of suggested amendments to the Uniform Controlled Substances Act. The Uniform Act is extremely well-organized. It contains a definitional section, an offenses and penalties section, a civil forfeiture section, as well as miscellaneous sections on administration and enforcement. Instead of creating separate, independent paraphernalia laws, it seems desirable to control Drug Paraphernalia by amending existing sections of the Uniform Controlled Substances Act.

Article I provides a comprehensive definition of the term "Drug Paraphernalia" and includes particular descriptions of the most common forms of paraphernalia. Article I also outlines the more relevant factors a court or other authority should consider in determining whether an object comes within the definition.

Article II sets out four criminal offenses intended to prohibit the manufacture, advertisement, delivery or use of Drug Paraphernalia. The delivery of paraphernalia to a minor is made a special offense. Article II clearly defines what conduct is prohibited, and it specifies what criminal state of mind must accompany such conduct.

ARTICLE I

(Definitions)

1 SECTION (insert designation of definitional section)
2 of the Controlled Substances Act of this State is
3 amended by adding the following after paragraph (insert
4 designation of last definition in section):

5 "() The term 'Drug Paraphernalia' means all equip-
6 ment, products and materials of any kind which are used,
7 intended for use, or designed for use, in planting,
8 propagating, cultivating, growing, harvesting, manufac-
9 turing, compounding, converting, producing, processing,
10 preparing, testing, analyzing, packaging, repackaging,
11 storing, containing, concealing, injecting, ingesting,
12 inhaling, or otherwise introducing into the human body
13 a controlled substance in violation of this Act (mean-
14 ing the Controlled Substances Act of this State). It
15 includes, but is not limited to:

16 (1) Kits used, intended for use, or designed for
17 use in planting, propagating, cultivating, growing or
18 harvesting of any species of plant which is a con-
19 trolled substance or from which a controlled substance
20 can be derived;

21 (2) Kits used, intended for use, or designed for
22 use in manufacturing, compounding, converting, pro-
23 ducing, processing, or preparing controlled substances;

24 (3) Isomerization devices used, intended for use,
25 or designed for use in increasing the potency of any
26 species of plant which is a controlled substance;

27 (4) Testing equipment used, intended for use, or
28 designed for use in identifying, or in analyzing the
29 strength, effectiveness or purity of controlled sub-
30 stances;

31 (5) Scales and balances used, intended for use,
32 or designed for use in weighing or measuring controlled
33 substances;

34 (6) Diluents and adulterants, such as quinine
35 hydrochloride, mannitol, mannite, dextrose and lactose,
36 used, intended for use, or designed for use in cutting
37 controlled substances;

38 (7) Separation gins and sifters used, intended
39 for use, or designed for use in removing twigs and
40 seeds from, or in otherwise cleaning or refining,
41 marihuana;

42 (8) Blenders, bowls, containers, spoons and
43 mixing devices used, intended for use, or designed
44 for use in compounding controlled substances;

45 (9) Capsules, balloons, envelopes and other con-
 46 tainers used, intended for use, or designed for use
 47 in packaging small quantities of controlled substances;

48 (10) Containers and other objects used, intended
 49 for use, or designed for use in storing or concealing
 50 controlled substances;

51 (11) Hypodermic syringes, needles and other
 52 objects used, intended for use, or designed for use
 53 in parenterally injecting controlled substances into
 54 the human body;

55 (12) Objects used, intended for use, or designed
 56 for use in ingesting, inhaling, or otherwise intro-
 57 ducing marihuana, cocaine, hashish, or hashish oil
 58 into the human body, such as:

59 (a) Metal, wooden, acrylic, glass, stone,
 60 plastic, or ceramic pipes with or without
 61 screens, permanent screens, hashish heads, or
 62 punctured metal bowls;

63 (b) Water pipes;

64 (c) Carburetion tubes and devices;

65 (d) Smoking and carburetion masks;

66 (e) Roach clips: meaning objects used to
 67 hold burning material, such as a marihuana
 68 cigarette, that has become too small or too
 69 short to be held in the hand;

70 (f) Miniature cocaine spoons, and cocaine
 71 vials;

72 (g) Chamber pipes;

73 (h) Carburetor pipes;

74 (i) Electric pipes;

75 (j) Air-driven pipes;

76 (k) Chillums;

77 (l) Bonges;

78 (m) Ice pipes or chillers;

79 "In determining whether an object is Drug parapher-
 80 nalia, a court or other authority should consider, in
 81 addition to all other logically relevant factors, the
 82 following:

83 (1) Statements by an owner or by anyone in con-
 84 trol of the object concerning its use;

85 (2) Prior convictions, if any, of an owner, or
 86 of anyone in control of the object, under any State
 87 or Federal law relating to any controlled substance;

88 (3) The proximity of the object, in time and
 89 space, to a direct violation of this Act;

90 (4) The proximity of the object to controlled
 91 substances;

- 92 (5) The existence of any residue of controlled
 93 substances on the object;
 94 (6) Direct or circumstantial evidence of the
 95 intent of an owner, or of anyone in control of the
 96 object, to deliver it to persons whom he knows, or
 97 should reasonably know, intend to use the object to
 98 facilitate a violation of this Act; the innocence of
 99 an owner, or of anyone in control of the object, as
 100 to a direct violation of this Act shall not prevent
 101 a finding that the object is intended for use, or
 102 designed for use as Drug paraphernalia;
 103 (7) Instructions, oral or written, provided with
 104 the object concerning its use;
 105 (8) Descriptive materials accompanying the object
 106 which explain or depict its use;
 107 (9) National and local advertising concerning its
 108 use;
 109 (10) The manner in which the object is displayed
 110 for sale;
 111 (11) Whether the owner, or anyone in control of
 112 the object, is a legitimate supplier of like or related
 113 items to the community, such as a licensed distributor
 114 or dealer of tobacco products;
 115 (12) Direct or circumstantial evidence of the ratio
 116 of sales of the object(s) to the total sales of the
 117 business enterprise;
 118 (13) The existence and scope of legitimate uses
 119 for the object in the community;
 120 (14) Expert testimony concerning its use."

ARTICLE II

(Offenses and Penalties)

1 SECTION (designation of offenses and penalties section)
 2 of the Controlled Substances Act of this State is amended
 3 by adding the following after (designation of last sub-
 4 stantive offense):

1 "SECTION (A) (Possession of Drug Paraphernalia)
 2 It is unlawful for any person to use, or to
 3 possess with intent to use, drug paraphernalia to
 4 plant, propagate, cultivate, grow, harvest, manu-
 5 facture, compound, convert, produce, process, pre-
 6 pare, test, analyze, pack, repack, store, contain,
 7 conceal, inject, ingest, inhale, or otherwise
 8 introduce into the human body a controlled substance
 9 in violation of this Act. Any person who violates

10 this section is guilty of a crime and upon con-
 11 viction may be imprisoned for not more than (),
 12 fined not more than (), or both."

1 "SECTION (B) (Manufacture or Delivery of Drug
 2 Paraphernalia)

3 It is unlawful for any person to deliver,
 4 possess with intent to deliver, or manufacture
 5 with intent to deliver, drug paraphernalia,
 6 knowing, or under circumstances where one rea-
 7 sonably should know, that it will be used to
 8 plant, propagate, cultivate, grow, harvest, manu-
 9 facture, compound, convert, produce, process,
 10 prepare, test, analyze, pack, repack, store, con-
 11 tain, conceal, inject, ingest, inhale, or other-
 12 wise introduce into the human body a controlled
 13 substance in violation of this Act. Any person
 14 who violates this section is guilty of a crime
 15 and upon conviction may be imprisoned for not
 16 more than (), fined not more than (), or both."

1 "SECTION (C) (Delivery of Drug Paraphernalia to
 2 a Minor)

3 Any person 18 years of age or over who
 4 violates Section (B) by delivering drug parapher-
 5 nalia to a person under 18 years of age who is at
 6 least 3 years his junior is guilty of a special
 7 offense and upon conviction may be imprisoned for
 8 not more than (), fined not more than (), or
 9 both."

1 "SECTION (D) (Advertisement of Drug Paraphernalia)

2 It is unlawful for any person to place in
 3 any newspaper, magazine, handbill, or other publi-
 4 cation any advertisement, knowing, or under circum-
 5 stances where one reasonably should know, that the
 6 purpose of the advertisement, in whole or in part,
 7 is to promote the sale of objects designed or
 8 intended for use as drug paraphernalia. Any person
 9 who violates this section is guilty of a crime and
 10 upon conviction may be imprisoned for not more than
 11 (), fined not more than (), or both."

ARTICLE III

(Civil Forfeiture)

1 SECTION (insert designation of civil forfeiture section)
 2 of the Controlled Substances Act of this State is amended

3 to provide for the civil seizure and forfeiture of drug
 4 paraphernalia by adding the following after paragraph
 5 (insert designation of last category of forfeitable
 6 property):
 7 " () all drug paraphernalia as defined by Section
 8 () of this Act."

ARTICLE IV

(Severability)

1 If any provision of this Act or the application
 2 thereof to any person or circumstance is held invalid,
 3 the invalidity does not affect other provisions or
 4 applications of the Act which can be given effect
 5 without the invalid provision or application, and to
 6 this end the provisions of this Act are severable.

COMMENT [ARTICLE I]

Drug paraphernalia laws are most often attacked because they are too vaguely worded. They seldom explain what is meant by the term paraphernalia. They do not indicate whether it is the use, or the possession, or the sale of paraphernalia that is prohibited. Moreover, they are usually silent on the criminal state of mind that must accompany the prohibited conduct. This deprives an individual of fair warning as to what the law forbids. It also vests too much discretion in authorities to determine what property and what activities are controlled.

DEFINITION OF DRUG PARAPHERNALIA

Article I of the Model Act, in contrast, defines "drug paraphernalia" as equipment, products, and materials used, intended for use, or designed for use, essentially, to produce, package, store, test or use illicit drugs. The words "equipment, products and materials" should be interpreted according to their ordinary or dictionary meanings. They can apply to many forms of movable, tangible property. Real property, conveyances, monies, documents and intangible property are, on the other hand, not meant to be included within these terms.

Although this definition may appear too general in its wording, or too broad in its scope, there are so many forms of drug paraphernalia that any attempt to define the term in more specific language would guarantee major loopholes in the Act's coverage. The courts have repeatedly recognized that there are practical limitations in drafting legislation. Where the subject matter of a statute does not lend itself to exact description, the use of general language does not make the statute unconstitutionally vague. United States v. Petrillo, 332 U.S. 1, 67 S.Ct. 1538 (1947). And see United States v. Ryan, 284 U.S. 167, 52 S.Ct. 65 (1931).

To insure that innocently possessed objects are not classified as drug paraphernalia, Article I makes the knowledge or criminal intent of the person in control of an object a key element of the definition. Needless to say, inanimate objects are neither "good" nor "bad," neither "lawful" nor "unlawful." Inanimate objects do not commit crimes. But, when an object is controlled by people who use it illegally, or who intend to use it illegally, or who design or adapt it for illegal use, the object can be subject to control and the people

subjected to prosecution. Article I requires, therefore, that an object be used, intended for use, or designed for use in connection with illicit drugs before it can be controlled as drug paraphernalia.

Hinging the definition of drug paraphernalia on a specific intent to violate, or to facilitate a violation of, the drug laws also provides "fair warning" to persons in possession of property potentially subject to this Act. A statute is not unconstitutionally vague, if it embodies a specific intent to violate the law. Boyce Motor Lines, Inc. v. United States, 342 U.S. 337, 72 S.Ct. 329 (1952); Screws v. United States, 325 U.S. 91, 65 S.Ct. 1031 (1945).

Consider the application of Article I to a spoon, a hypodermic syringe, and a length of surgical tubing. Each object has legitimate uses in the community. None is specifically designed for illegal use. Thus, when these objects are manufactured, delivered and possessed in lawful commerce, they are not considered paraphernalia. But, if these same objects are assembled and used by an addict to illegally melt heroin and inject it into his body, they become drug paraphernalia. As such they become forfeitable under Article III, and the addict becomes subject to prosecution under Section A of Article II.

Actual use of an object to produce, package, store, test or use illicit drugs need not always be shown. An object is considered to be drug paraphernalia whenever the person in control intends it for use with illicit drugs. This intent may be a generalized one, not necessarily pinpointing a specific time and place of future use. See Palmer v. State, 14 Md.App. 159, 286 A.2d 572 (1972). It can be proved directly such as by admissions of the person in control, or indirectly through circumstantial evidence. It should be noted that the person in immediate control of an object need not intend to use it personally in connection with drugs. It is enough if he holds the object with the intent to make it available to persons whom he knows will use it illegally. See United States v. 2265 One-Gallon Paraffined Tin Cans, 260 F.2d 105 (5th Cir. 1958).

Objects whose sole, or at least dominant purpose is to produce, package, store, test or use illicit drugs are considered to be "designed" for such use. A rebuttable presumption exists that these objects are intended for use for the purpose for which they are designed. See Israel v. United States, 63 F.2d 345 (3rd Cir. 1933). As such, they are

presumed to be drug paraphernalia. Isomerization devices designed for use in increasing the THC content of marihuana provide a good example.

COMMON FORMS OF DRUG PARAPHERNALIA

Article I includes a detailed description of common forms of property that can fall within the definition of drug paraphernalia if used, intended for use, or designed for use to violate the drug laws. This list is not intended to be inclusive. Several of these descriptions, such as "chillums" and "bongs," may seem foreign to the lay reader. Nevertheless, these terms are part of the jargon of the drug culture and are understood by both users and merchants of drug paraphernalia. They are not unconstitutionally vague. See Hydgrade Provision Co. v. Sherman, 266 U.S. 497, 45 S.Ct. 141 (1925).

RELEVANT FACTORS IN CLASSIFYING PARAPHERNALIA

In addition to defining drug paraphernalia and describing the common forms, Article I sets out some of the more relevant factors to consider in determining whether an object is paraphernalia. The listing of these factors in the Model Act is not intended to be peremptory; a court or other authority is not obligated to hear evidence on, or to consider, every listed factor. Rather, the factors have been included to guide law enforcement officers, judges, and juries in their determination of what is controlled. Providing guidance on the practical application of the Act minimizes the risk of arbitrary and discriminatory enforcement, sometimes associated with even the most carefully drafted statutes. See Interstate Circuit, Inc. v. City of Dallas, 390 U.S. 676, 88 S.Ct. 1298 (1968).

Conversely, the listing of these factors is not meant to be inclusive. Any logically relevant factor may be considered.

COMMENT [ARTICLE II]

POSSESSION OF DRUG PARAPHERNALIA

Section A makes it a crime to: (i) possess an object; (ii) classifiable as drug paraphernalia; (iii) with the intent to use that object, essentially, to produce, package, store, test or use illicit drugs in violation of the Controlled Substances Act of the State. Section A does not make the mere possession of an object capable of use as drug paraphernalia a crime. Section A does not make the mere intent to violate the drug laws a crime. It is the possession of drug paraphernalia accompanied by an intent to use it to violate the drug laws that Section A forbids. Innocent citizens have nothing to fear from Section A.

It must be noted here that the activities of storing, testing and using illicit drugs are not in themselves violations of either the Uniform Controlled Substances Act or the federal Controlled Substances Act. But each activity necessarily includes the possession of illicit drugs, which is a violation of both laws.

MANUFACTURE OR DELIVERY OF DRUG PARAPHERNALIA

Suppliers who furnish goods or services knowing they will be used to facilitate a crime are not immune from liability. There are no legal obstacles to punishing suppliers who knowingly or recklessly aid their customers to commit crimes. This is true whether the objects or services are restricted, or peculiarly suited for illegal use, such as a still, a gun, morphine or stolen goods. See Direct Sales Company v. United States, 319 U.S. 703, 63 S.Ct. 1265 (1943); Backun v. United States, 112 F.2d 635 (4th Cir. 1940); Israel v. United States, 63 F.2d 345 (3rd Cir. 1933); Weinstein v. United States, 293 F. 388 (1 Cir. 1923); and Commonwealth v. Stout, 356 Mass. 237, 249 N.E.2d 12 (1969).

It is also true when the objects or services have widespread legitimate uses in the community, such as sugar, rye, yeast, grapejuice, rubbing alcohol or a telephone answering service. See United States v. Ragland, 306 F.2d 732 (4th Cir. 1962); Chapman v. United States, 271 F.2d 593 (5th Cir. 1959); United Cigar Whelan Stores Corp. v. United States, 113 F.2d 340 (9th Cir. 1940); Vukich v. United States, 28 F.2d 666 (9th Cir. 1928); United States v. Burnett, 53 F.2d 219 (W.D. Mo. 1931); and People v. Lauria, 251 Cal. App.2d. 471 (1967).

The reasonableness of this rule is clearly expressed in Backun v. United States:

"To say that the sale of goods is a normally lawful transaction is beside the point. The seller may not ignore the purpose for which the purchase is made if he is advised of that purpose, or wash his hands of the aid that he has given the perpetrator of a felony by the plea that he has merely made a sale of merchandise. One who sells a gun to another knowing that he is buying it to commit a murder, would hardly escape conviction as an accessory to the murder by showing that he received full price for the gun; and no difference in principle can be drawn between such a case and any other case of a seller who knows that the purchaser intends to use the goods which he is purchasing in the commission of a felony. In any such case, not only does the act of the seller assist in the commission of the felony, but his will assents to its commission, since he could refuse to give the assistance by refusing to make the sale" 112 F.2d 635 (4th Cir. (1940)).

There are courts which have hesitated to hold a supplier guilty of conspiracy with, or of aiding and abetting a buyer. See United States v. Falcone, 311 U.S. 205, 61 S.Ct. 204 (1940); and United States v. Peoni, 100 F.2d 401 (2 Cir. 1938). A careful reading of these decisions makes clear that they were based upon the court's unwillingness to hold a supplier equally responsible with a buyer based simply upon the supplier's knowledge that the buyer intended to commit a crime. At common law, the punishment is the same for the co-conspirator and the aider and abetter as it is for the actual perpetrator. Nothing in these cases suggests, however, that a supplier enjoys complete immunity from punishment, or that a state cannot make the conduct of the supplier a separate offense. See Note, Falcone Revisited: The Criminality of Sales to an Illegal Enterprise, 53 Columbia Law Rev. 228 (1953).

Section B makes it a crime to: (i) deliver, possess with intent to deliver, or manufacture with intent to deliver an object; (ii) classifiable as drug paraphernalia, (iii) knowing, or under circumstances where one reasonably should know, that it will be used, essentially, to produce, package, store, test or use illicit drugs in violation of the Controlled Substances Act of the State. The term "deliver" has the same basic meaning attributed to it by the Uniform Controlled Substances Act; namely, the actual, constructive, or attempted transfer from one person to another, whether or not there is an agency relationship. The term "manufacture," appearing in the phrase "manufacture with intent to deliver," is used in a general sense to express the entire process by which an object is made ready for sale in open commerce, including designing, fabricating, assembling, packaging and labeling. See Danovitz v. United States, 281 U.S. 389, 50 S.Ct. 344 (1930).

The knowledge requirement of Section B is satisfied when a supplier: (i) has actual knowledge an object will be used as drug paraphernalia; (ii) is aware of a high probability an object will be used as drug paraphernalia; or (iii) is aware of facts and circumstances from which he should reasonably conclude there is a high probability an object will be used as drug paraphernalia. Section B requires a supplier of potential paraphernalia to exercise a reasonable amount of care. He need not undertake an investigation into the intentions of every buyer, but he is not free to ignore the circumstances of a transaction. Suppliers of objects capable of use as paraphernalia may not deliver them indiscriminately. Since each element of Section B must be proven beyond a reasonable doubt, legitimate, prudent suppliers will not be affected by this section.

ADVERTISEMENT OF DRUG PARAPHERNALIA

Section D makes it a crime to: (i) advertise an object; (ii) classifiable as drug paraphernalia; (iii) knowing, or under circumstances where one reasonably should know, that the purpose of the advertisement is to promote the sale of the object for use, essentially, to produce, package, store, test or use illicit drugs.

Only printed advertisements promoting the sale of objects for use as paraphernalia are prohibited. The non-printed media, including radio and television, is not affected. Printed matter criticising the drug laws, glorifying the drug culture, glamorizing the use of drugs, or providing information or instructions on illicit drugs is not affected. The target of this Section is commercial advertising.

Unlike so-called "printer's ink" statutes, which exempt printers and publishers from their coverage, Section D contains no exemptions. It applies to anyone who prints or publishes paraphernalia advertisements, and to anyone who causes these advertisements to be printed or published. For this reason, it uses the general terms "any person" and "to place."

The knowledge requirement of Section D is satisfied when the person placing the advertisement: (i) has actual knowledge it is promoting the sale of objects for use as drug paraphernalia; (ii) is aware of a high probability it is promoting the sale of objects for use as drug paraphernalia; or (iii) is aware of facts and circumstances from which he should reasonably conclude there is a high probability the advertisement is promoting the sale of objects for use as drug paraphernalia. Whether an advertisement promotes the sale of objects for use as paraphernalia is to be determined from its content. Under Section D, one need not look beyond the face of the advertisement.

Section D does not compromise First Amendment rights. The sale of objects for use as drug paraphernalia is made illegal by Section B, and Section D simply prohibits advertisements promoting these sales. Commercial solicitation of illegal activities is not protected speech. Pittsburgh Press Co. v. Pittsburgh Commission on Human Rights, 413 U.S. 376, 93 S.Ct. 2553 (1973); and see Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council, Inc., 425 U.S. 748, 96 S.Ct. 1817 (1976).

COMMENT [ARTICLE III]

Civil forfeiture actions are directed against property and are totally independent of any criminal proceedings against individuals. Section 505 of the Uniform Controlled Substances Act provides for the seizure and civil forfeiture of: (1) illicit drugs; (2) equipment and materials used to make, deliver, import or export illicit drugs; (3) containers used to store illicit drugs; (4) conveyances involved in transporting illicit drugs; and (5) books, records and research connected with illicit drugs. States that have adopted Section 505 can seize these objects without making any compensation to the owners. The legality of civil forfeiture statutes, similar to 505, and their usefulness in helping deter crime, have been repeatedly recognized by virtually every state and federal court, including the Supreme Court of the United States. Calero-Toledo v. Pearson Yacht Leasing Co., 416 U.S. 663, 94 S.Ct. 2080 (1974).

Article III extends the civil forfeiture section of the Uniform Act to include drug paraphernalia. This allows states to keep and destroy drug paraphernalia, rather than returning it after criminal proceedings have ended. It also allows states to keep drug paraphernalia seized during an investigation, in cases where criminal proceedings are not initiated. Finally, since the standard of proof in a civil forfeiture action is simply "probable cause," or "reasonable cause," rather than "proof beyond a reasonable doubt," Article III permits states to seize and forfeit drug paraphernalia in circumstances where an arrest might not seem justified. For example, an officer who encounters a minor in possession of a hypodermic syringe, or in possession of a bong (a device especially designed for smoking marihuana), has reasonable cause to believe these objects are intended for use to introduce illicit drugs into the human body. Subjecting drug paraphernalia to civil forfeiture permits the officer to seize these objects, though he decides not to arrest the minor.

Civil forfeiture can also be an effective deterrent to commercial suppliers. See Utley Wholesale Company v. United States, 308 F.2d 157 (5th Cir. 1962); United States v. 2265 One-Gallon Paraffined Tin Cans, 260 F.2d 105 (5th Cir. 1958); United States v. 1,922 Assorted Firearms, Etc., 330 F.Supp. 635 (ED Mo. 1971); United States v. 600 Bags of Southcoast Jurbinado Brand Sugar, 225 F.Supp. 705 (WD La. 1964); Vinto Products Co. v. Goddard, 43 F.2d 399 (D Minn. 1930); and United States v. Roitman, 36 F.2d 86 (ND Ill. 1929).

Attachment VIII

July 31, 1979 (Revised)

FACT SHEETHEROIN AND TETRAHYDROCANNABINOL RESEARCH FOR RELIEF
IN PAIN AND OTHER DISCOMFORTSStatement from the Interagency Committee on New
Therapies for Pain and Discomfort

I. Heroin

The Division of Cancer Treatment (DCT) has obtained an IND for heroin in order to sponsor studies, within its existing drug testing network, of the efficacy of heroin in treating pain and discomfort in patients with advanced cancer. Dr. Raymond Houde at Memorial-Sloan Kettering Institute in New York City has already obtained a grant from the National Institute of Drug Abuse to study the pharmacology of opiate analgesics, including heroin. His IND for heroin was recently approved by the FDA, and he has given the DCT permission to cross-file.

The Pharmaceutical Resources Branch (PRB) of the DCT is overseeing the formulation of a new dosage form of heroin, and through a resource contractor, it is responsible for the distribution of heroin to approved investigators (for further information in this area, contact Mr. Paul Davignon, Chief, PRB, (301) 427-7346).

The Investigational Drug Branch (IDB) of the DCT is the focal point for the evaluation and review of clinical trials of heroin sponsored by DCT. A phase I-II trial is being carried out by Dr. William Beaver at Georgetown University. The IDB has been responsible for the actual filing of DCT's IND for heroin research which may be submitted by other DCT grantees and contractors (for further information on these matters, contact Dr. Donald S. Paster, Special Assistant to the Chief, IDB, (301) 496-1197).

II. Tetrahydrocannabinol (THC) and Nabilone

At a symposium (March 22, 1979) on research on the control of cancer chemotherapy-induced vomiting, it was evident that both THC and a structurally similar synthetic compound, Nabilone (Eli Lilly & Company), have potential for controlling the nausea and vomiting produced by cancer chemotherapy. Clinical studies with Nabilone have recently been terminated due to adverse chronic toxicity observed in animal models.

The IDB has cross-file on the IND of the Surgery Branch, NCI, for THC in order to sponsor further studies of this drug. Again, these studies will take place through the existing clinical trials network of DCT. The PRB will work to improve the current formulation of THC, and the Cancer Therapy Evaluation Program oversees DCT's involvement in emesis control research and to establish a working group to help coordinate and review proposals and research in this area.

Dr. Jane Henney, National Cancer Institute, Division of Cancer Treatment, Building 31, Room 3A49, 1000 Rockville Pike, Bethesda, Maryland 20205, (301) 496-6711, has the overall responsibility within the Division of Cancer Treatment for coordinating its research in Schedule I drugs. Additional inquiries not resolved by the above information should be addressed directly to her office.

The following investigators are actively conducting research on THC:

CALIFORNIA

Bellflower 90706, Kaiser Foundation Hospital, Southern California, Permanente Medical Group, 9400 E. Rosencrans Avenue, Wheeler, Helen E., M.D., (213) 920-4321.

Los Angeles 90024, Neuropsychiatric Institute, UCLA, 760 Westwood Plaza, Ungerleider, J.T., M.D., (213) 825-0293.

Los Angeles 90015, Southern California Cancer Center, 1414 S. Hope Street, Orr, Leo E., M.D., (213) 748-2411.

COLORADO

Lakewood 80214, AMC Cancer Research Center and Hospital, 6401 S. Colfax Avenue, Garb, Solomon, M.D., (303) 233-6501.

DISTRICT OF COLUMBIA

Washington 20007, Vincent T. Lombardi Cancer Research Center, Division of Medical Oncology, Georgetown University Hospital, Macdonald, John S., M.D. and Goldberg, Debbie, M.D., (202) 625-7081.

GEORGIA

Augusta 30902, Dept. of Ophthalmology, Medical College of Georgia, Roth, Michael, M.D. **

ILLINOIS

Chicago 60637, Hematology-Oncology Section, Dept. of Medicine, University of Chicago, Richman, Carol M., M.D., (312) 947-5024.

KANSAS

Kansas City 66103, University of Kansas Medical Center, Dept. of Clinical Medicine, Clin. Oncology, Rainbow Blvd. at 39th, Stephens, Ronald L., M.D., (913) 588-6029.

MARYLAND

Bethesda 20205, Laboratory of Clinical Studies, NIMH, NIH, Ebert, Michael H., M.D., (301) 496-1891 and Gross, Howard A., M.D., (301) 496-3504.

Bethesda 20205, National Cancer Institute, NIH, Penta, John S., Ph.D., (301) 496-6511.

Bethesda 20205, National Cancer Institute, NIH, Rosenberg, Stephen A., M.D. and Chang, Alfred, M.D., (301) 496-1437.

MASSACHUSETTS

Boston 02114, Dept. of Psychiatry, Massachusetts General Hospital, Cassem, Edwin H., M.D., (617) 726-2972.

Boston 02115, Sidney Farber Cancer Institute, 49 Binney Street, Sallan, Stephen E., M.D., (617) 734-1100, Ex. 6000.

MICHIGAN

Detroit 48201, Dept. of Oncology, Wayne State University, Harper-Grace Hospitals, Baker, Laurence N., D.O. **

Southfield 48075, Providence Hospital, 16001 W. Nine Mile Road, Vaughn, Clarence B., M.D., (313) 424-3000.

MINNESOTA

Rochester 55901, Medical Oncology, Mayo Clinic, Erytak, Stephen, M.D., (507) 282-2511.

NORTH CAROLINA

Chapel Hill 27514, Dept. of Ophthalmology, University of North Carolina, Merritt, John C., M.D., (919) 966-5296, 7.

Durham 27710, Comprehensive Cancer Center, Duke University, Laszlo, John, M.D. **

NEW MEXICO

Albuquerque 87108, V.A. Hospital, Psychiatry Service, 2100 Ridgecrest, S.E., Kellner, Robert, M.D. (Principal Investigator)**

Sante Fe 87503, Substance Abuse Bureau, P.O. Box #968,
Deaux, Edward, Ph.D., (Sponsor) (505) 827-5271 x-228.

NEW YORK

New York City 10029, Mt. Sinai School of Medicine, 100th Street
and Fifth Avenue, Holland, James F., M.D., (212) 348-5855.

Bronx 10467, Montefiore Hospital and Medical Center, Gottlieb,
Richard M., M.D., (212) 920-4796.

PENNSYLVANIA

Hershey 17033, College of Medicine, Penn State University,
Ellenberger, Carl, M.D. and Petro, Denis, M.D. **

Philadelphia 19140, Medical Oncology Section, Temple University,
Smalley, R.V., M.D., (215) 221-4615.

Philadelphia 19130, Wills Eye Hospital, 1601 Spring Garden Street,
Spaeth, George L., M.D. **

TENNESSEE

Nashville 37203, Dept. of Neurology, School of Medicine,
Vanderbilt University, Freeman, Frank R., M.D. **

TEXAS

Lackland AFB 78236, Hematology-Oncology Service, USAF Medical
Center, Goodwin, John W., M.D. **

** Telephone number not available

FACT SHEET

June 11, 1979

MARIHUANA AND GLAUCOMA

A Statement from the National Eye Institute

Glaucoma is an eye disease characterized by increased pressure within the eye (intraocular pressure) and progressive damage to the optic nerve with accompanying impaired visual function. Treatment for glaucoma, either with drugs or surgery, is primarily aimed at lowering the pressure in an attempt to preserve vision.

Marihuana is one of many drugs known to reduce intraocular pressure. Research is underway to determine whether marihuana and its derivatives and other, promising new drugs now under development have potential as safe and effective alternatives to glaucoma medications in current use. As yet, the possible advantages of marihuana over proven glaucoma medications and other experimental drugs—including whether marihuana may be effective in some individuals who do not respond to those other agents—have not been established. Also needed are studies of marihuana's mechanism of action which could clarify whether it represents a new family of glaucoma medications.

Even if such evidence is obtained, before marihuana can be considered for approval by the Federal Government for marketing as a glaucoma drug, it must be removed from the U.S. Drug Enforcement Administration's current list of Schedule I substances. According to the DEA's definition, Schedule I substances have a high potential for abuse and no currently accepted medical use in the United States. In addition, HEW's Food and Drug Administration must determine, as the law requires it to do with any new investigational drug, that there is sufficient experimental evidence that marihuana is both safe and effective for its intended purpose before it can decide whether to approve the drug for legal use in the United States as a glaucoma medication.

Because the medical use of marihuana is still under investigation, the drug's legal use in the treatment of glaucoma is limited to clinical investigations that have been approved by the FDA. In addition, the investigator must be registered with the DEA before he or she can receive either Schedule I or Schedule II drugs for research. HEW's National Institute on Drug Abuse (NIDA), which is the primary supporter of Government sponsored marihuana research, supplies the drug to the qualified scientific investigators who carry out these studies.

Current studies of marihuana's effect on the eye are aimed at determining whether the drug's intraocular pressure-lowering effects last long enough in most patients for it to be considered for further investigation as a possible treatment for glaucoma.

Scientists working under grants from both the National Eye Institute and the NIDA are evaluating the use of marihuana derivatives in lowering

intraocular pressure in laboratory animals. The NIDA has supported the testing of the drug's pressure-lowering effects in humans. Because it is difficult to evaluate the potential medical value of marihuana administered in the form of cigarettes, scientists are trying to develop a safe and effective active derivative of the drug which could be applied directly to the eye in drop form. In this form, drug delivery to the eye could be more precisely controlled than is possible with marihuana that is smoked, and controlled studies would be easier to carry out. It is also hoped that such a derivative would eliminate or at least greatly reduce marihuana's intoxicating effects, a characteristic that may not be desirable for many glaucoma patients.

It is important to emphasize that studies are also needed to show whether visual function is preserved when marihuana is used to reduce the intraocular pressure in glaucoma patients. No such studies of marihuana are underway as yet. Past experience with other purported glaucoma treatments has shown that although a drug may lower intraocular pressure, it does not necessarily follow that visual function will be maintained.

Two FDA advisory groups and one HEW Department-level committee are responsible for examining evidence related to the potential medical use of marihuana and other Schedule I drugs. These advisory bodies are responsible for making recommendations concerning the classification and use of these controlled substances to the agencies which regulate their use. It is hoped that their activities will help ensure that Federal regulatory agencies have continuing access to a wide range of expert opinion and detailed scientific information on which to base any future action with respect to the legal status of currently restricted drugs.

In the meantime, because one of the National Eye Institute's program priorities is to support the scientific evaluation of new methods of treating glaucoma, the NEI welcomes the submission by qualified investigators of applications for research on the therapeutic potential of marihuana as a glaucoma drug. Any such applications received will undergo the same dual level review for scientific merit and program relevance as do all research grant proposals submitted to the National Institutes of Health and will be given full consideration by the National Eye Institute staff. Any investigator contemplating the submission of such an application to NEI may therefore wish to contact the National Eye Institute before developing his/her proposal. Inquiries may be directed to Anita Suran, Ph.D., Director, Glaucoma Program, National Eye Institute, Building 31, Room 6A51, National Institutes of Health, Bethesda, Maryland 20205.

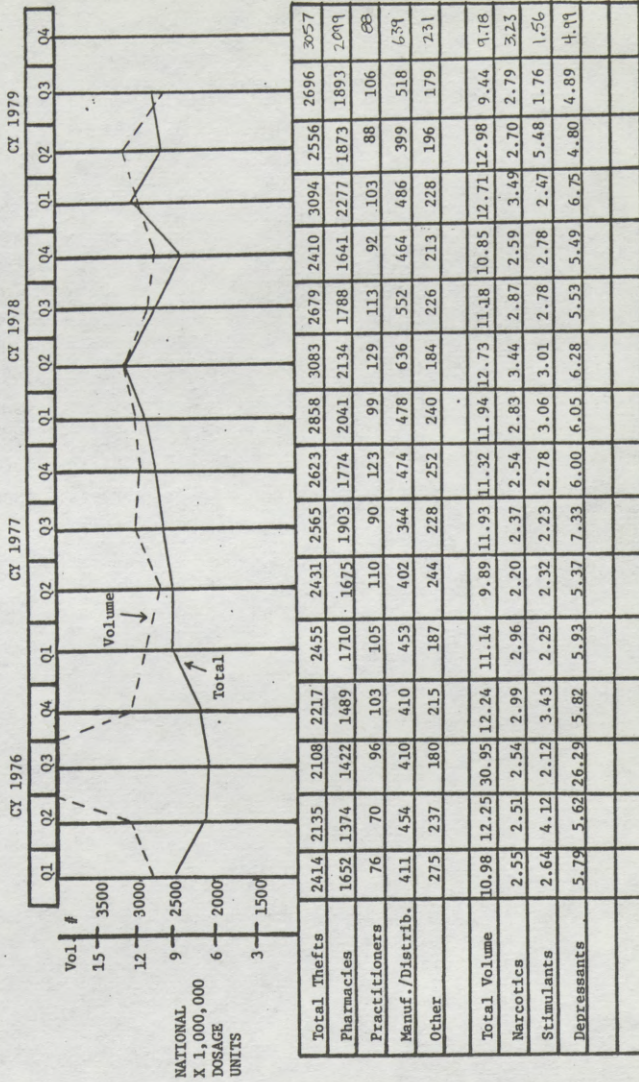
ACTIVE INDs for THC and CANNABIS THERAPEUTIC RESEARCH

<u>I. NAUSEA & VOMITING OF CANCER CHEMOTHERAPY</u>		<u>(33)</u>
*	Palo Alto, CA	
Sallan	Boston, MA	
Cassem	Boston, MA	
Frytak	Rochester, NY	
Holland	New York, NY	
Orr	Los Angeles, CA	
Ungerleider	Los Angeles, CA	
Gottlieb	Bronx, NY	
Vaughn	Southfield, MI	
Rosenberg/Chang/NCI	Bethesda, MD	
Laszlo	Durham, NC	
GARB	Lakeland, CO	
Stephens	Kansas City, KS	
Goodwin	Lackland AFB, TX	
MacDonald	Washington, DC	
New Mexico (State)	Albuquerque, NM	
NCI/Penta	Bethesda, MD	
Wayne State U/NCI/Baker	Detroit, MI	
*	Allentown, PA (single patient)	
Smalley	Philadelphia, PA	
Wheeler/Permanente	Bellflower, CA	
Schnapper	Baltimore, MD	
Illinois (State)	Chicago, IL	
Goodner	Philadelphia, PA	
S.G. Dept. of Army (DiBella)	Aurora, CO	
Louisiana (State)	New Orleans, LA	
Washington (State)	Olympia, WA	
*	Birmingham, AL	
Frytak	Rochester, MN	
Florida (State)	Tallahassee, FL	
*	Winston-Salem, NC	
*	Philadelphia, PA	
*	Houston, TX	
<u>II. EFFECT ON INTRAOCULAR PRESSURE (Glaucoma)</u>		<u>(6)</u>
Wills Eye Hosp. (Spaeth)	Philadelphia, PA	
*	Washington, DC (single patient)	
*	Sierra Vista, AZ (single patient)	
Rotn	Augusta, GA	
Merritt	Chapel Hill, NC	
Salz	Los Angeles, CA (single patient)	
<u>III. SPASTICITY (Including M.S.; etc)</u>		<u>(3)</u>
*	Minneapolis, MN	
*	Fayetteville, NY	
*	Peoria, IL	
<u>IV. ANOREXIA & WEIGHT LOSS</u>		<u>(1)</u>
*	Palo Alto, CA	
TOTAL NUMBER OF STUDIES.....		<u>(43)</u>
*DISCLOSURE NOT AUTHORIZED		

20 February 1980
 John A. Scigliano, Ph.D.
 FDA/(301) 443-3504

DRUG THEFTS
By Number and Volume

Attachment IX



ALL FIRMS IN ALL STATES
 FROM 1/1/78 THROUGH 3/31/79

	NIGHT BRK-IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
OF THEFTS	1492	369	210	73	378	387	2909
DRUGS UNITS STOLEN							
COCAINE	33637	4965	186	351	2803	3096	45038
HEROINE	68137	16733	1009	104	2098	7073	95154
MARIJUANA	619002	75485	6259	2591	260437	42980	1006754
BARBITURATES	160433	103780	31239	2375	8504	46831	353162
ETHADONE	19031	2216	83	0	200	6071	28401
ETHADINE	282224	57399	4553	2135	5534	8721	360566
LYCONE	455459	107183	18080	4981	7183	20202	613088
CLALDI	139120	75101	3634	2114	4602	3972	228623
ALL DRUGS	125227	19639	893	400	3313	6503	155975
TOTAL NARCOTICS	1903070	462501	65936	15051	294754	145449	2886761
AMPHETAMINES	896834	149409	36033	540	221763	49194	1353773
BARBITURATES	1568683	273529	20704	5202	65988	69520	2003626
STIMULANTS	1152291	115652	16194	4808	432084	18976	1740005
DEPRESSANTS	2954242	224088	211125	56721	559317	167805	4173298
TOTAL STOLEN	8475120	1225179	349992	82322	1573906	450944	12157463

ALL STATES
FOR THE PERIOD FROM 1/78 THROUGH 3/78

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	1356	355	122	63	26	159	2081
DOSAGE UNITS STOLEN							
OPIUM	32410	4955	174	351	135	527	38552
MORPHINE	59782	16542	647	84	0	5058	82113
CODEINE	585817	74065	3407	2591	1898	18988	686767
COCAINE	117803	103205	19658	2375	2835	28846	274722
METHADONE	9423	2116	83	0	0	447	12069
PETHEDINE	275431	56685	2748	1714	405	4906	341889
OXYCODONE	442623	103737	14429	3981	2074	16087	582931
DILAUDID	131370	78721	3592	2114	132	3707	214636
MISC. NARC.	121321	19631	833	400	431	3458	146074
TOTAL NARCOTICS	1775980	454658	45571	13610	7913	82024	2379753
AMPHETAMINES	856494	147507	34332	540	1484	17079	1057426
BARBITURATES	1406197	256060	18897	4954	3015	32766	1721889
STIMULANTS	772113	93716	15094	4808	856	13920	900507
DEPRESSANTS	2844887	214999	52279	45321	7945	64483	3229914
TOTAL STOLEN	7655661	1166940	166173	69233	21210	210272	9289489

THEFTS FROM PRACTITIONERS IN ALL STATES
FOR THE PERIOD FROM 1/78 THROUGH 3/78

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	68	7	4	3	3	15	100
DOSAGE UNITS STOLEN							
OPIUM	625	10	0	0	0	0	635
MORPHINE	935	0	15	20	0	55	1025
CODEINE	16908	1141	0	0	0	70	18119
COCAINE	1684	575	0	0	0	2478	4737
METHADONE	267	0	0	0	0	9	276
PETHEDINE	2058	229	74	21	0	454	2836
OXYCODONE	2077	2696	0	0	0	6	4779
DILAUDID	31	568	10	0	0	0	609
MISC. NARC.	581	8	0	0	100	8	697
TOTAL NARCOTICS	25166	5227	99	41	100	3080	33713
AMPHETAMINES	29480	1895	0	0	0	450	31825
BARBITURATES	92872	13324	0	0	0	473	106669
STIMULANTS	364199	21936	0	0	1000	460	387595
DEPRESSANTS	38038	5444	4000	0	5000	5025	57507
TOTAL STOLEN	549755	47826	4099	41	6100	9488	617309

ALL STATES
FROM 1/78 THROUGH 3/78

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	16	3	12	5	338	110	484
DOSAGE UNITS STOLEN							
OPIMUM	0	0	0	0	2668	2544	5212
MORPHINE	120	0	0	0	2025	0	2145
CODEINE	12655	0	1100	0	258339	16906	289000
COCAINE	0	0	5670	0	5669	354	11693
METHADONE	10100	0	0	0	200	287	10587
PETHEDINE	1622	46	910	400	5079	1558	9615
OXYCODONE	7515	0	1400	1000	5109	4042	19066
DILAUID	5300	794	0	0	3350	22	9466
MISC. NARC.	784	0	0	0	2732	446	3962
TOTAL NARCOTICS	38096	840	9080	1400	285171	26159	360746
AMPHETAMINES	6360	0	1300	0	220179	20389	248228
BARBITURATES	36302	37	1400	202	62618	22764	123323
STIMULANTS	14715	0	1100	0	419642	3846	439303
DEPRESSANTS	49065	0	127850	11300	544642	37640	770497
TOTAL STOLEN	144538	877	140730	12902	1532252	110798	1942097

THEFTS FROM OTHER FIRMS IN ALL STATES
FOR THE PERIOD FROM 1/78 THROUGH 3/78

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	52	4	72	2	11	103	244
DOSAGE UNITS STOLEN							
OPIMUM	602	0	12	0	0	25	639
MORPHINE	7300	191	347	0	73	1960	9871
CODEINE	3622	278	1752	0	200	7016	12868
COCAINE	40946	0	5911	0	0	15153	62010
METHADONE	41	100	0	0	0	5328	5469
PETHEDINE	3113	439	821	0	50	1803	6226
OXYCODONE	3244	750	2251	0	0	67	6312
DILAUID	2419	18	32	0	1200	243	3912
MISC. NARC.	2541	0	60	0	50	2591	5242
TOTAL NARCOTICS	63828	1776	11186	0	1573	34186	112549
AMPHETAMINES	4510	7	401	0	100	11276	16294
BARBITURATES	33312	4108	407	46	355	13517	51745
STIMULANTS	1264	0	0	0	10586	750	12600
DEPRESSANTS	22252	3645	26996	100	1730	60657	115380
TOTAL STOLEN	125166	9536	38990	146	14344	120386	308568

THEFTS FROM ALL FIRMS IN ALL STATES .
FOR THE PERIOD FROM 4/ 78 THROUGH 6/ 78

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	1464	388	230	74	493	432	3081
DOSAGE UNITS STOLEN							
OPIUM	43333	7571	42651	34	824	482	94815
MORPHINE	107726	24614	1584	808	1480	8471	144683
CODEINE	687963	124980	27899	8210	222647	28751	1100458
COCAINE	177663	36626	16543	1196	13458	40448	285926
METHADONE	12201	1327	1900	3	2460	6247	24138
PETHEDINE	287476	66844	7116	1175	3027	17657	383295
OMYCODONE	494139	89643	30037	5200	2832	33715	655566
DILAUDID	542056	54448	14203	1841	5384	4250	622182
MISC. NARC.	75482	25429	2274	419	19169	3162	125935
TOTAL NARCOTICS	2428039	431482	144207	18886	271281	143095	3436990
AMPHETAMINES	1019834	179182	52975	2632	71249	33824	1359696
BARBITURATES	1704002	216378	80507	4568	35177	68541	2109173
STIMULANTS	848469	106596	60019	2467	404988	230988	1653527
DEPRESSANTS	3246793	365072	111124	34922	305532	102497	4165940
TOTAL STOLEN	9247137	1298710	448832	63475	1088227	578945	12725326

THEFTS FROM PHARMACIES IN ALL STATES
FOR THE PERIOD FROM 4/ 78 THROUGH 6/ 78

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	1347	376	153	62	20	176	2134
DOSAGE UNITS STOLEN							
OPIUM	43185	7563	42628	34	200	264	93874
MORPHINE	106205	23241	1330	808	0	7969	139553
CODEINE	670818	120469	24383	7434	580	10369	834053
COCAINE	142337	36626	10790	1146	1418	24535	216852
METHADONE	11280	1323	1800	3	0	1792	16198
PETHEDINE	280424	65124	6782	1130	100	14153	367713
OXYCODONE	488832	88584	28067	4800	632	33090	644805
DILAUDID	540483	54218	14074	1841	1219	3177	615012
MISC. NARC.	72601	25429	1497	319	0	1234	101080
TOTAL NARCOTICS	2356165	422577	131351	17515	4149	96583	3028340
AMPHETAMINES	957086	157432	52130	2632	1055	16290	1186625
BARBITURATES	1395110	213066	75326	4568	2584	31605	1722259
STIMULANTS	616985	105857	26427	1467	1667	10006	762409
DEPRESSANTS	3055389	356544	88418	34822	3777	61614	3600564
TOTAL STOLEN	8380735	1255476	373652	61004	13232	216098	10300197

THEFTS FROM PRACTITIONERS IN ALL STATES
FOR THE PERIOD FROM 4/ 78 THROUGH 6/ 78

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	81	4	9	3	4	28	129
DOSAGE UNITS STOLEN							
OPIUM	18	0	0	0	0	0	18
MORPHINE	1172	70	70	0	0	144	1456
CODEINE	15184	1615	0	0	0	1812	18611
COCAINE	20584	0	0	50	0	0	20634
METHADONE	0	0	0	0	0	26	26
PETHEDINE	4203	703	2	45	5	614	5572
OXYCODONE	3073	1020	1221	0	0	10	5324
DILAUDID	510	40	0	0	0	0	550
MISC. NARC.	1632	0	60	0	0	13	1705
TOTAL NARCOTICS	46376	3448	1353	95	5	2619	53896
AMPHETAMINES	59243	21200	237	0	94	107	80881
BARBITURATES	47720	0	696	0	44	2099	50559
STIMULANTS	44658	0	32137	0	10000	965	87760
DEPRESSANTS	70261	1500	0	0	49	1043	72853
TOTAL STOLEN	268258	26148	34423	95	10192	6833	345949

THEFTS FROM MANUFAC/DISTRIB IN ALL STATES
FOR THE PERIOD FROM 4/ 78 THROUGH 6/ 78

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	6	2	12	7	456	151	634
DOSAGE UNITS STOLEN							
OPIUM	0	0	0	0	624	108	732
MORPHINE	64	0	20	0	1340	300	1724
CODEINE	231	100	0	776	222051	15664	238822
COCAINE	0	0	2843	0	11340	39	14222
METHADONE	137	4	0	0	2400	1389	3930
PETHEDINE	0	0	0	0	2312	1082	3394
OXYCODONE	831	0	10	200	2100	200	3341
DILAUDID	475	0	0	0	4165	310	4950
MISC. NARC.	485	0	600	100	19169	250	20604
TOTAL NARCOTICS	2223	104	3473	1076	265501	19342	291719
AMPHETAMINES	1240	0	0	0	70100	15945	87285
BARBITURATES	257649	100	4002	0	31574	32403	325728
STIMULANTS	175288	0	489	1000	393321	218411	788509
DEPRESSANTS	102057	2500	21901	100	301656	26093	454307
TOTAL STOLEN	538457	2704	29865	2176	1062152	312194	1947548

THEFTS FROM OTHER FIRMS IN ALL STATES
FOR THE PERIOD FROM 4/ 78 THROUGH 6/ 78

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	30	6	56	2	13	77	184
DOSAGE UNITS STOLEN							
OPIUM	130	8	23	0	0	30	191
MORPHINE	285	1303	164	0	140	58	1950
CODEINE	1730	2796	3516	0	16	906	8964
COCAINE	14742	0	2910	0	700	15866	34218
METHADONE	784	0	100	0	60	3040	3984
PETHEDINE	2849	1017	332	0	610	1808	6616
OXYCODONE	1403	39	739	200	100	415	2896
DILAUDID	588	190	129	0	0	763	1670
MISC. NARC.	764	0	117	0	0	1665	2546
TOTAL NARCOTICS	23275	5353	8030	200	1626	24551	63035
AMPHETAMINES	2265	550	608	0	0	1482	4905
BARBITURATES	3523	3212	483	0	975	2434	10627
STIMULANTS	11538	739	966	0	0	1606	14849
DEPRESSANTS	19086	4528	805	0	50	13747	38216
TOTAL STOLEN	59687	14382	10892	200	2651	43820	131632

THEFTS FROM ALL FIRMS IN ALL STATES
FOR THE PERIOD FROM 7/ 78 THROUGH 9/ 78

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	1246	343	218	71	479	313	2670
DOSAGE UNITS STOLEN							
OPIMUM	26319	5287	495	3	4584	382	37070
MORPHINE	55762	13483	3745	670	430	3916	78006
CODEINE	540973	77812	5981	6955	167932	44124	843777
COCAINE	115958	49629	45638	0	14704	42358	268287
METHADONE	39659	5820	460	40	1422	17761	65162
PETHEDINE	251609	70115	8140	3405	10596	20310	364175
ORXYCODONE	457504	94358	12972	81290	166767	9918	822809
WILAUDID	129573	51679	13015	1690	1530	7681	205168
MISC. NARC.	94091	17129	1378	1291	4685	1707	120281
TOTAL NARCOTICS	1711448	385312	91824	95344	372650	148157	2804735
AMPHETAMINES	789489	171681	45115	5626	158788	19862	1190561
BARBITURATES	1326601	169205	39795	6283	22355	35005	1599244
STIMULANTS	587107	87858	19778	4141	815345	24257	1538486
DEPRESSANTS	2466343	229314	71581	26999	585433	375408	3755078
TOTAL STOLEN	6880988	1043370	268093	138393	1954571	602689	10888104

THEFTS FROM PHARMACIES IN ALL STATES
FOR THE PERIOD FROM 7/ 78 THROUGH 9/ 78

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	1103	335	124	63	27	136	1788
DOSAGE UNITS STOLEN							
OPIUM	24626	5287	495	0	296	215	30919
MORPHINE	51826	13396	1120	670	0	2243	69255
CODEINE	480082	76264	3027	6955	416	13110	579854
COCAINE	103541	46794	23770	0	0	15995	190100
METHADONE	8254	5374	353	40	0	10832	24853
PETHEDINE	207395	69844	7011	3234	2801	5592	295877
OXYCODONE	355299	93865	11485	80952	3800	5987	551388
DILAUDID	110820	51621	5870	1662	0	3537	173510
MISC. NARC.	87320	17073	1069	1291	300	224	107277
TOTAL NARCOTICS	1429163	379518	54200	94804	7613	57735	2023033
AMPHETAMINES	617109	147813	24759	5567	951	15627	811826
BARBITURATES	1158120	162485	30826	6283	4000	21941	1383655
STIMULANTS	462302	85386	14285	2131	100	6457	570661
DEPRESSANTS	2358524	228581	26350	26448	33287	68726	2741916
TOTAL STOLEN	6025218	1003783	150420	135233	45951	170486	7531091

THEFTS FROM PRACTITIONERS IN ALL STATES
FOR THE PERIOD FROM 7/ 78 THROUGH 9/ 78

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	69	2	10	3	2	27	113
DOSAGE UNITS STOLEN							
OPIUM	0	0	0	0	0	0	0
MORPHINE	734	0	278	0	0	230	1242
CODEINE	8192	1300	730	0	0	210	10432
COCAINE	2845	2835	0	0	0	3015	8695
METHADONE	0	0	0	0	0	46	46
PETHEDINE	2379	100	197	14	0	11230	13920
OXYCODONE	0	400	0	288	0	40	728
DILAUDID	0	0	0	0	0	701	701
MISC. NARC.	2558	0	0	0	0	10	2568
TOTAL NARCOTICS	16708	4635	1205	302	0	15482	38332
AMPHETAMINES	117361	23859	0	40	0	710	141970
BARBITURATES	40630	6500	700	0	2510	1076	51416
STIMULANTS	114256	2451	4993	0	0	2050	123750
DEPRESSANTS	42529	260	2851	550	210	1479	47879
TOTAL STOLEN	331484	37705	9749	892	2720	20797	403347

THEFTS FROM MANUFAC/DISTRIB IN ALL STATES
FOR THE PERIOD FROM 7/ 78 THROUGH 9/ 78

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	19	2	22	3	437	69	552
DOSAGE UNITS STOLEN							
OPIUM	50	0	0	3	4288	120	4461
MORPHINE	381	0	20	0	330	1085	1736
CODEINE	24042	52	2100	0	167270	30438	223902
COCAINE	2655	0	200	0	11469	6780	21104
METHADONE	4302	340	100	0	1422	622	6786
PETHEDINE	16747	0	200	27	6165	1560	24699
OXYCODONE	1400	0	1112	50	161930	2858	167350
DILAUDID	487	0	0	28	1530	3393	5438
MISC. NARC.	190	0	279	0	4380	1200	6049
TOTAL NARCOTICS	50254	392	4011	108	358784	47976	461525
AMPHETAMINES	1069	0	12150	19	157487	2032	172757
BARBITURATES	2558	0	1240	0	15771	8855	28424
STIMULANTS	2047	0	500	2010	814845	14328	833730
DEPRESSANTS	5705	300	26690	1	529355	235499	797550
TOTAL STOLEN	61633	692	44591	2138	1876242	308690	2293986

THEFTS FROM OTHER FIRMS IN ALL STATES
FOR THE PERIOD FROM 7/ 78 THROUGH 9/ 78

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	55	4	62	2	13	81	217
DOSAGE UNITS STOLEN							
OPIUM	1643	0	0	0	0	47	1690
MORPHINE	2821	87	2327	0	100	438	5773
CODEINE	28657	196	124	0	246	366	29589
COCAINE	6917	0	21668	0	3235	16568	48388
METHADONE	27103	106	7	0	0	6261	33477
PETHEDINE	25088	171	732	130	1630	1928	29679
OXYCODONE	100805	93	375	0	1037	1033	103343
DILAUDID	18266	58	7145	0	0	50	25519
MISC. NARC.	4023	56	30	0	5	273	4387
TOTAL NARCOTICS	215323	767	32408	130	6253	26964	281845
AMPHETAMINES	53950	9	8206	0	350	1493	64008
BARBITURATES	125293	220	7029	0	74	3133	135749
STIMULANTS	8502	21	0	0	400	1422	10345
DEPRESSANTS	59585	173	15690	0	22581	69704	167733
TOTAL STOLEN	462653	1190	63333	130	29658	102716	659680

THEFTS FROM ALL FIRMS IN ALL STATES
 FOR THE PERIOD FROM 10/ 78 THROUGH 12/ 78

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	1109	318	197	68	373	345	2410
DOSAGE UNITS STOLEN							
OPIUM	27700	5516	251	353	94	383	34297
MORPHINE	67116	15127	3325	1824	2656	102055	192103
CODEINE	479336	84779	19570	2061	281216	31199	898161
COCAINE	139443	37311	63412	9	2111	34311	276597
METHADONE	22208	21596	151	76	5	1683	45719
PETHIDINE	190638	55228	10842	2820	28257	8131	303906
ORXYCODONE	385099	118950	19292	15240	13137	8215	559933
DILAUDID	99020	53771	6420	3433	3104	6188	171936
MISC. NARC.	63891	25293	2055	5200	7887	5900	110226
TOTAL NARCOTICS	1482441	417571	125318	31016	338467	198065	2592878
AMPHETAMINES	711146	432026	35734	6149	78203	18144	1281402
BARBITURATES	1117147	170099	27815	2175	80249	27992	1425477
STIMULANTS	476976	126618	123257	3168	738971	23684	1492674
DEPRESSANTS	2628579	279379	83676	23432	973804	79269	4068139
TOTAL STOLEN	6416289	1425693	395800	65940	2209694	347154	10860570

ALL PHARMACIES IN ALL STATES
FOR THE PERIOD FROM 10/ 78 THROUGH 12/ 78

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	1003	299	129	57	33	120	1641
DOSAGE UNITS STOLEN							
OPIUM	19639	5233	0	353	0	16	25241
MORPHINE	52020	14823	2841	1672	296	414	72066
CODEINE	452368	72676	11341	1861	1180	8025	547451
COCAINE	126388	27336	36457	0	0	12756	202937
METHADONE	12434	2213	4	76	5	384	15116
PETHEDINE	176152	53376	8319	2817	612	4136	245412
OXYCODONE	328138	114465	17820	9240	600	8002	478265
DILAUDID	77102	52961	4206	3416	304	5084	143073
MISC. NARC.	61142	24323	1106	1200	0	1291	89062
TOTAL NARCOTICS	1305383	367406	82094	20635	2997	40108	1818623
AMPHETAMINES	618897	121168	28484	4149	1170	14498	788366
BARBITURATES	970453	160124	25042	2175	5176	18495	1181465
STIMULANTS	391154	96078	18812	3168	465	12748	522425
DEPRESSANTS	2393007	237166	78321	22725	4300	43490	2779009
TOTAL STOLEN	5678894	981942	232753	52852	14108	129339	7089888

THEFTS FROM PRACTITIONERS IN ALL STATES
FOR THE PERIOD FROM 10/ 78 THROUGH 12/ 78

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	63	5	5	1	1	17	92
DOSAGE UNITS STOLEN							
OPIUM	8027	200	100	0	0	0	8327
MORPHINE	1361	20	129	2	0	31	1543
CODEINE	5925	9941	0	0	0	3189	19055
COCAINE	6350	0	0	0	0	709	7059
METHADONE	80	7	0	0	0	0	87
PETHEDINE	2836	760	342	3	20	1566	5527
OXYCODONE	3505	2350	0	0	0	51	5906
DILAUDID	592	320	0	0	0	30	942
MISC. NARC.	525	870	0	0	0	923	2318
TOTAL NARCOTICS	29201	14468	571	5	20	6499	50764
AMPHETAMINES	43999	16876	23	0	0	0	60898
BARBITURATES	37399	8136	495	0	0	4129	50159
STIMULANTS	27796	29010	0	0	0	0	56806
DEPRESSANTS	40461	36904	0	8	0	10751	88124
TOTAL STOLEN	178856	105394	1089	13	20	21379	306751

IN ALL STATES
FOR THE PERIOD FROM 10/ 78 THROUGH 12/ 78

	NIGHT BRK-IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	9	4	14	6	327	104	464
DOSAGE UNITS STOLEN							
OPIMUM	0	0	0	0	94	364	458
MORPHINE	4818	0	200	0	2360	100210	107588
CODEINE	0	300	800	200	279936	16849	298085
COCAINE	3582	0	0	0	2111	0	5693
METHADONE	8700	0	0	0	0	398	9098
PETHEDINE	7780	200	0	0	27425	1356	36761
OXYCODONE	24000	0	400	6000	11537	100	42037
DILAUDID	17020	0	0	17	2800	673	20510
MISC. NARC.	48	0	0	4000	7787	2600	14435
TOTAL NARCOTICS	65942	500	1400	10217	334050	122550	534665
AMPHETAMINES	32800	293700	6615	2000	77033	806	412954
BARBITURATES	75112	200	2008	0	51069	1460	129849
STIMULANTS	37100	1500	104400	0	738506	10689	892195
DEPRESSANTS	83512	1400	3900	0	704484	16647	809943
TOTAL STOLEN	294472	297300	118323	12217	1905142	152152	2779606

THEFTS FROM OTHER FIRMS IN ALL STATES
FOR THE PERIOD FROM 10/ 78 THROUGH 12/ 78

	NIGHT BRK-IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	34	10	49	4	12	104	213
DOSAGE UNITS STOLEN							
OPIMUM	34	83	151	0	0	3	271
MORPHINE	8917	284	155	150	0	1400	10906
CODEINE	21043	1862	7429	0	100	3136	33570
COCAINE	3123	9975	26955	9	0	20846	60908
METHADONE	994	19376	147	0	0	901	21418
PETHEDINE	11860	892	2181	0	200	1073	16206
OXYCODONE	29456	2135	1072	0	1000	62	33725
DILAUDID	4306	490	2214	0	0	401	7411
MISC. NARC.	2176	100	949	0	100	1086	4411
TOTAL NARCOTICS	81909	35197	41253	159	1400	28908	188826
AMPHETAMINES	15450	282	612	0	0	2840	19184
BARBITURATES	34183	1639	270	0	24004	3908	64004
STIMULANTS	20926	30	45	0	0	247	21248
DEPRESSANTS	111599	3909	1455	699	265020	8381	391063
TOTAL STOLEN	264067	41057	43635	858	290424	44284	684325

REPORT FROM ALL FIRMS IN ALL STATES
FOR THE PERIOD FROM 1/ 79 THROUGH 3/ 79

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	1487	577	253	63	415	380	3095
DOSAGE UNITS STOLEN							
OPIUM	41986	19310	534	15	35954	6682	104481
MORPHINE	64158	39137	4561	556	8435	7994	124841
CODEINE	719351	131485	9993	4708	228756	47542	1141835
COCAINE	149170	91595	48099	3000	31250	51037	374161
METHADONE	18404	39413	367	8	805	6996	65993
PETHIDINE	241522	110659	12106	2445	10773	13388	390893
PROPOXONE	424943	205399	49946	8684	32071	49463	770506
DIALUDIL	178247	114372	4134	2974	1464	9971	311162
MISC. NARC.	167543	30400	1963	0	4755	6067	210728
TOTAL NARCOTICS	2005324	781770	131703	22390	354273	199140	3494600
AMPHETAMINES	707705	341412	31936	1608	66269	82910	1231840
BARBITURATES	1123954	290304	17993	7050	80380	414176	1933857
STIMULANTS	509299	358004	38290	1310	299210	30346	1236459
DEPRESSANTS	2685042	431085	73044	20913	569521	1034166	4813771
TOTAL STOLEN	7031324	2202575	292966	53271	1369653	1760738	12710527

IN ALL STATES
FOR THE PERIOD FROM 1/ 79 THROUGH 3/79

	NIGHT BRK-IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	1295	559	148	55	27	194	2278
DOSAGE UNITS STOLEN							
OPIUM	41585	19310	506	15	170	4428	66814
MORPHINE	53264	38543	1248	554	3572	2384	99565
CODEINE	680969	131289	7796	3951	2135	20931	847071
COCAINE	135341	91595	31773	0	1816	40262	300787
METHADONE	17816	3532	167	0	205	2001	23721
PETHEDINE	225989	109642	6758	2266	336	10824	355815
OXYCODONE	408709	199842	43040	8684	4579	42599	707453
DILAUDID	144532	113887	2743	2974	344	7537	272017
MISC. NARC.	86236	30400	1913	0	900	3367	122816
TOTAL NARCOTICS	1794441	738040	95944	18444	14057	134333	2795259
AMPHETAMINES	643436	254756	30298	1608	4869	16654	951621
BARBITURATES	1002373	283935	16434	7050	2171	35916	1347879
STIMULANTS	463334	284017	34545	1310	1754	16769	801729
DEPRESSANTS	2558443	424966	62068	20713	3925	60754	3130069
TOTAL STOLEN	6462027	1985714	239289	49125	26776	264426	9027357

THEFTS FROM PRACTITIONERS IN ALL STATES
FOR THE PERIOD FROM 1/ 79 THROUGH 3/ 79

	NIGHT BRK-IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	70	6	7	4	0	16	103
DOSAGE UNITS STOLEN							
OPIUM	126	0	28	0	0	0	154
MORPHINE	3255	0	399	0	0	2044	5698
CODEINE	17487	50	1293	0	0	111	18941
COCAINE	4950	0	1342	3000	0	5751	15043
METHADONE	0	0	0	0	0	443	443
PETHEDINE	8243	310	2822	175	0	283	11833
OXYCODONE	7245	3338	1770	0	0	0	12353
DILAUDID	537	50	450	0	0	0	1037
MISC. NARC.	6242	0	0	0	0	0	6242
TOTAL NARCOTICS	48085	3748	8104	3175	0	8632	71744
AMPHETAMINES	41994	85456	1335	0	0	0	128785
BARBITURATES	88139	3000	100	0	0	1431	92670
STIMULANTS	29134	73455	2142	0	0	2	104733
DEPRESSANTS	54537	3050	200	100	0	294	58181
TOTAL STOLEN	261889	168709	11881	3275	0	10359	456113

THEFTS FROM OTHER FIRMS IN ALL STATES
FOR THE PERIOD FROM 1/ 79 THROUGH 3/ 79

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	7	2	13	2	376	86	486
DOSAGE UNITS STOLEN							
OPIMUM	0	0	0	0	35784	2054	37838
MORPHINE	4377	100	0	0	4863	0	9340
CODEINE	17379	0	310	757	226221	25514	270181
COCAINE	2700	0	0	0	29444	0	32144
METHADONE	200	2412	0	0	600	1198	4410
PETHEDINE	5920	200	700	0	10262	802	17884
OXYCODONE	7524	2000	1700	0	24792	6700	42716
DILAUDID	33110	0	100	0	1120	2200	36530
MISC. NARC.	3204	0	0	0	3855	2000	9059
TOTAL NARCOTICS	74414	4712	2810	757	336941	40468	460102
AMPHETAMINES	18150	1200	100	0	61150	65840	146440
BARBITURATES	22700	1800	577	0	76425	11800	113302
STIMULANTS	16204	0	1500	0	296256	12175	326135
DEPRESSANTS	46018	500	4300	100	565496	964920	1581334
TOTAL STOLEN	177486	8212	9287	857	1336268	1095203	2627313

THEFTS FROM OTHER FIRMS IN ALL STATES
FOR THE PERIOD FROM 1/ 79 THROUGH 3/ 79

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	35	10	85	2	12	84	228
DOSAGE UNITS STOLEN							
OPIMUM	275	0	0	0	0	200	475
MORPHINE	3262	494	2914	2	0	3566	10238
CODEINE	3516	146	594	0	400	986	5642
COCAINE	6179	0	14984	0	0	5024	26187
METHADONE	388	33469	200	0	0	3354	37419
PETHEDINE	1370	507	1826	4	175	1479	5361
OXYCODONE	1465	219	3436	0	2700	164	7984
DILAUDID	68	435	841	0	0	234	1578
MISC. NARC.	71861	0	50	0	0	700	72611
TOTAL NARCOTICS	88384	35270	24845	14	3275	15707	167495
AMPHETAMINES	4125	0	203	0	250	416	4994
BARBITURATES	10742	1569	882	0	1784	365029	380006
STIMULANTS	627	532	103	0	1200	1400	3862
DEPRESSANTS	26044	2569	6476	0	100	8198	43387
TOTAL STOLEN	129922	39940	32509	14	6609	390750	599744

REPORT FROM ALL FIRMS IN ALL STATES
FOR THE PERIOD FROM 4/ 79 THROUGH 6/ 79

	NIGHT BRK-IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	1112	436	214	70	347	377	2556
DOSAGE UNITS STOLEN							
OPIUM	22648	10526	639	15	52990	311	87129
MORPHINE	34433	28871	3121	100	9041	2917	78483
CODEINE	587929	148702	12434	10187	73080	40656	872988
COCAINE	108001	66558	155433	6599	3548	40058	380197
METHAONE	11259	11922	413	6	100	10739	34439
PETHEDINE	182033	80430	8247	1439	9920	23225	305294
OXYCODONE	387532	148827	52440	13253	47401	21863	671326
DILAUDID	97602	65421	7493	1435	1300	8829	182080
MISC. NARC.	67162	19732	156	136	3961	1656	92803
TOTAL NARCOTICS	1498599	580989	240376	33180	201341	150254	2704739
AMPHETAMINES	558116	3365663	18656	4524	36461	34093	4017513
BARBITURATES	914476	197542	10992	3064	95418	43653	1265145
STIMULANTS	682069	142331	35296	1964	65842	530416	1457918
DEPRESSANTS	2311584	371520	137045	16071	565344	136727	3538291
TOTAL STOLEN	5964844	4658045	442365	58803	964406	895143	12983606

FOR THE PERIOD FROM 4/ 79 THROUGH 6/ 79

# OF THEFTS	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
1023	419	135	62	34	200	1873	
DOSAGE UNITS STOLEN							
OPIUM	20876	10526	166	15	0	197	31780
MORPHINE	32692	28417	2328	100	21	1541	65899
CODEINE	569271	146303	10907	10187	464	23087	760219
COCAINE	106791	54691	127791	6599	0	21708	317580
METHADONE	10946	7441	313	6	100	1143	19949
PETHEDINE	178122	79746	6189	1438	830	17541	283866
OXYCODONE	381390	148171	51893	13263	2600	18423	615740
DILAUDID	96517	62277	6020	1435	0	7899	174148
MISC. NARC.	65044	19732	156	136	500	1264	86832
TOTAL NARCOTICS	1461649	557304	205763	33179	4515	92803	2355213
AMPHETAMINES	532228	186463	16722	3740	550	18238	757941
BARBITURATES	883206	172642	9554	2257	1341	33301	1102301
STIMULANTS	636408	127431	14817	1356	2060	16216	798288
DEPRESSANTS	2238647	366034	64353	14571	10385	91659	2785649
TOTAL STOLEN	5752138	1409874	311209	55103	18851	252217	7799392

THEFTS FROM PRACTITIONERS IN ALL STATES
FOR THE PERIOD FROM 4/ 79 THROUGH 6/ 79

# OF THEFTS	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
54	6	5	2	2	19	88	
DOSAGE UNITS STOLEN							
OPIUM	1772	0	473	0	0	0	2245
MORPHINE	1366	0	31	0	0	50	1447
CODEINE	7010	575	0	0	0	38	7623
COCAINE	2	0	0	0	0	29	31
METHADONE	26	740	0	0	0	1054	1820
PETHEDINE	2315	532	503	1	0	183	3534
OXYCODONE	154	400	400	0	0	12	966
DILAUDID	204	445	200	0	0	100	949
MISC. NARC.	1979	0	0	0	0	10	1989
TOTAL NARCOTICS	14828	2692	1607	1	0	1476	20604
AMPHETAMINES	7982	24000	350	784	210	8290	41616
BARBITURATES	27900	400	673	0	0	5861	34834
STIMULANTS	44753	0	0	0	0	50	44803
DEPRESSANTS	47610	781	0	0	0	714	49105
TOTAL STOLEN	143073	27873	2630	785	210	16391	190962

PERIOD FROM 4/79 THROUGH 6/79

	NIGHT BRK-IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	2	2	5	3	296	91	399
DOSAGE UNITS STOLEN							
OPIUM	0	0	0	0	52990	20	53010
MORPHINE	0	0	0	0	9020	610	9630
CODEINE	600	1824	0	0	72415	8306	83145
COCAINE	0	400	0	0	3548	2	3950
METHADONE	0	0	0	0	0	6	6
PETHEDINE	196	0	0	0	9090	4130	13416
OXYCODONE	5310	0	0	0	40300	3200	48810
DILAUDID	0	2000	0	0	1300	48	3348
MISC. NARC.	100	0	0	0	2961	306	3361
TOTAL NARCOTICS	6206	4224	0	0	191624	16622	218676
AMPHETAMINES	1875	3155200	350	0	35700	7105	3200230
BARBITURATES	220	24500	0	800	93862	3302	122684
STIMULANTS	57	14900	20400	0	63782	513603	612742
DEPRESSANTS	57	4500	17800	1500	549424	39837	613118
TOTAL STOLEN	8415	3203324	38550	2300	934392	580469	4767450

THEFTS FROM OTHER FIRMS IN ALL STATES
FOR THE PERIOD FROM 4/79 THROUGH 6/79

	NIGHT BRK-IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	33	9	69	3	15	67	196
DOSAGE UNITS STOLEN							
OPIUM	0	0	0	0	0	94	94
MORPHINE	375	454	762	0	0	716	2307
CODEINE	11048	0	1527	0	201	9225	22001
COCAINE	1208	11467	27642	0	0	18319	58636
METHADONE	287	3741	100	0	0	8536	12664
PETHEDINE	1400	152	1555	0	0	1371	4478
OXYCODONE	678	256	147	0	4501	228	5810
DILAUDID	881	699	1273	0	0	782	3635
MISC. NARC.	39	0	0	0	500	82	621
TOTAL NARCOTICS	15916	16769	33006	0	5202	39353	110246
AMPHETAMINES	16031	0	1234	0	1	460	17726
BARBITURATES	3150	0	765	7	215	1189	5326
STIMULANTS	851	0	79	608	0	547	2085
DEPRESSANTS	25270	205	54892	0	5535	4517	90419
TOTAL STOLEN	61218	16974	89976	615	10953	46066	225802

FROM ALL FIRMS IN ALL STATES
PERIOD FROM 7/1/78 THROUGH 9/78

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	1227	367	201	71	394	436	2696
DOSAGE UNITS STOLEN							
OPIUM	40143	6292	191	0	369	57113	104108
MORPHINE	57406	20359	1040	933	1367	3071	84176
CODEINE	609431	82940	30630	3254	54677	33938	814870
COCAINE	144454	79490	40560	290	50460	56755	371999
METHADONE	21445	78145	2851	26	440	1692	104599
METHEDINE	221286	72504	5849	1158	12814	12539	326150
XYCODONE	392734	116817	56646	7319	35550	36307	645373
LAUDID	124557	76822	7792	2635	3112	11913	226831
MISC. NARC.	66220	16589	3596	278	15861	4082	106626
TOTAL NARCOTICS	1677676	549958	149155	15883	174650	217410	2784732
AMPHETAMINES	531209	134033	38685	3312	14110	42321	763670
BARBITURATES	928431	120989	22169	3197	52520	50743	1178049
STIMULANTS	574889	108510	5337	962	167334	142522	999554
DEPRESSANTS	2298416	250403	115107	30024	692928	128017	3714895
TOTAL STOLEN	6010621	1163893	330453	53378	101542	581013	9440900

THEFTS FROM PRACTITIONERS IN ALL STATES
FOR THE PERIOD FROM 7/ 79 THROUGH 9/ 79

	NIGHT BRK/IN	ARMED EMPLOYEE ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	1125	352	131	61	24	200	1893
DOSAGE UNITS STOLEN							
OPIUM	88715	6268	179	0	16	290	45468
MORPHINE	51810	17718	940	930	210	2137	73745
CODEINE	602427	80421	27730	3154	323	13285	727340
COCAINE	123806	68700	24877	280	2800	29079	249542
METHADONE	15120	5740	2840	0	240	83	24023
PETHEDINE	199888	70420	4733	1095	640	8796	285572
OXYCODONE	387986	115619	55721	7319	200	26468	593313
DILAUDID	115552	73262	7071	2635	700	8449	207669
MISC. NARC.	65246	16239	114	278	0	1666	83543
TOTAL NARCOTICS	1600550	454387	124205	15691	5129	90253	2290215
AMPHETAMINES	525311	133690	37145	2966	400	20209	719721
BARBITURATES	903348	119132	21576	2728	313	44578	1091675
STIMULANTS	533952	107488	4087	814	4000	18026	668367
DEPRESSANTS	2153943	245203	98180	25022	5518	95252	2623118
TOTAL STOLEN	5717104	1059900	285193	47221	15360	268318	7393096

THEFTS FROM PRACTITIONERS IN ALL STATES
FOR THE PERIOD FROM 7/ 79 THROUGH 9/ 79

	NIGHT BRK/IN	ARMED EMPLOYEE ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	64	3	5	2	3	29	106
DOSAGE UNITS STOLEN							
OPIUM	1070	0	0	0	0	56	1126
MORPHINE	774	20	10	3	40	382	1229
CODEINE	3752	0	0	0	30	128	3910
COCAINE	4142	2835	6	0	0	90	7073
METHADONE	0	175	0	0	0	139	314
PETHEDINE	2289	0	29	32	540	510	3400
OXYCODONE	938	0	10	0	600	500	2048
DILAUDID	172	0	0	0	0	20	192
MISC. NARC.	261	0	0	0	40	63	364
TOTAL NARCOTICS	13398	3030	55	35	1250	1888	19656
AMPHETAMINES	1350	0	0	0	10	4044	5404
BARBITURATES	12085	0	42	0	20	1033	13180
STIMULANTS	36615	0	0	0	0	26	36641
DEPRESSANTS	41462	1265	0	0	700	346	43773
TOTAL STOLEN	104910	4295	97	35	1980	7337	118654

IN ALL STATES
 FROM 7/ 79 THROUGH 9/ 79

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	9	4	10	2	358	135	518
DOSAGE UNITS STOLEN							
OPIUM	152	0	0	0	353	560	1065
MORPHINE	722	0	0	0	1091	303	2116
CODEINE	766	25	2100	0	54166	13386	70443
COCAINE	307	2870	0	0	47660	2800	53637
METHADONE	2936	72000	0	24	200	201	75361
PETHEDINE	15674	0	100	0	11424	2131	29329
OXYCODONE	2719	0	0	0	34750	8771	46240
DILAUDID	5902	2400	500	0	2412	2048	13262
MISC. NARC.	487	0	100	0	15802	1294	17683
TOTAL NARCOTICS	29665	77295	2800	24	167858	31494	309136
AMPHETAMINES	4034	300	1300	0	13700	16822	36156
BARBITURATES	7187	0	317	0	52154	1502	61160
STIMULANTS	4030	1000	100	0	161234	124164	290528
DEPRESSANTS	55375	1500	12370	300	680561	26487	978593
TOTAL STOLEN	100291	80095	16887	324	1275507	202469	1675573

IN ALL STATES
 FOR THE PERIOD FROM 7/ 79 THROUGH 9/ 79

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	29	8	55	6	9	72	179
DOSAGE UNITS STOLEN							
OPIUM	206	24	12	0	0	56207	56449
MORPHINE	4100	2621	90	0	26	249	7086
CODEINE	2486	2494	800	100	158	7139	13177
COCAINE	16199	5085	15677	0	0	24786	61747
METHADONE	3389	230	11	2	0	1269	4901
PETHEDINE	3435	2084	987	31	210	1102	7849
OXYCODONE	1091	1198	915	0	0	568	3772
DILAUDID	2931	1160	221	0	0	1396	5708
MISC. NARC.	226	350	3382	0	19	1059	5036
TOTAL NARCOTICS	34063	15246	22095	133	413	93775	165725
AMPHETAMINES	514	43	240	346	0	1246	2389
BARBITURATES	5811	1857	234	469	33	3630	12034
STIMULANTS	292	22	1150	148	2100	306	4018
DEPRESSANTS	47636	2435	4557	4702	6149	3932	69411
TOTAL STOLEN	88316	19603	28276	5798	8695	102889	253577

FROM ALL FIRMS IN ALL STATES
PERIOD FROM 12/ 78 THROUGH 12/ 79

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	1167	512	280	89	523	486	3057
DOSAGE UNITS STOLEN							
OPIUM	133935	11454	98	128	251	1785	147651
MORPHINE	52831	22354	1999	132	3767	8601	90684
CODEINE	631898	155014	9137	4061	122291	27470	949871
COCAINE	176168	83117	97863	0	26930	61996	446075
METHADONE	60225	8779	530	0	1247	6012	76793
NETHEDINE	194443	88532	9649	1602	15800	13652	323678
DAYCODONE	414150	187446	15058	11268	150903	33634	812510
BILAUDID	125387	78224	22011	3287	15078	11754	255741
MISC. NARC.	80564	25134	415	696	10885	4668	122362
TOTAL NARCOTICS	1869602	661054	156760	21175	347152	169622	3225365
AMPHETAMINES	494849	160104	11326	3439	52255	24813	746786
BARBITURATES	968161	178100	14163	2848	63679	39808	1266759
STIMULANTS	370555	113140	10820	1321	211848	108871	816555
DEPRESSANTS	2308681	291928	96411	40429	836341	150707	3724497
TOTAL STOLEN	6011848	1404326	289480	69212	1511275	493821	9779962

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	1075	494	105	79	26	240	2099
DOSAGE UNITS STOLEN							
OPIUM	132799	11440	98	128	0	1663	146128
MORPHINE	43396	23354	1651	130	337	3326	72194
CODEINE	609674	152389	7848	4061	1500	22906	798378
COCAINE	156947	72927	94767	0	0	38074	362715
METHADONE	57982	6555	130	0	0	2534	67201
PETHEDINE	184209	87814	7041	1533	2172	9615	292384
OXYCODONE	406050	186851	10952	11269	2200	26528	643850
DILAUDID	102877	72752	20886	3287	0	8731	208533
MISC. NARC.	80150	25106	355	696	0	2262	108569
TOTAL NARCOTICS	1774084	639188	143728	21104	6209	115639	2699952
AMPHETAMINES	419860	157741	9592	3439	1763	22580	614975
BARBITURATES	902381	175367	7658	2834	800	19971	1109011
STIMULANTS	359862	110872	7246	1221	3600	17644	500445
DEPRESSANTS	2235869	289569	75208	39785	3100	81564	2725095
TOTAL STOLEN	5692056	1372737	243432	68383	15472	257398	7649478

THEFTS FROM PRACTITIONERS IN ALL STATES
FOR THE PERIOD FROM 10/ 79 THROUGH 12/ 79

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	50	5	2	2	0	29	88
DOSAGE UNITS STOLEN							
OPIUM	0	0	0	0	0	0	0
MORPHINE	1848	0	0	0	0	4476	6324
CODEINE	14254	0	0	0	0	120	14374
COCAINE	2481	10	0	0	0	668	3159
METHADONE	0	0	0	0	0	4	4
PETHEDINE	4606	0	5	47	0	1647	6305
OXYCODONE	610	0	0	0	0	1000	1610
DILAUDID	3501	1245	0	0	0	85	4831
MISC. NARC.	207	0	0	0	0	670	877
TOTAL NARCOTICS	27507	1255	5	47	0	8670	37484
AMPHETAMINES	57429	1090	0	0	0	0	58519
BARBITURATES	39514	0	2	0	0	3019	42535
STIMULANTS	4385	582	0	0	0	210	5177
DEPRESSANTS	27637	1623	0	0	0	2121	31381
TOTAL STOLEN	156472	4550	7	47	0	14020	175096

CALIFORNIA FROM 10/79 THROUGH 12/79

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	7	4	17	5	488	118	639
DOSAGE UNITS STOLEN							
OPIUM	754	0	0	0	251	108	1113
MORPHINE	1393	0	0	0	1230	352	2975
CODEINE	577	1600	300	0	120691	4355	127523
COCAINE	5501	0	0	0	26930	2835	35266
METHADONE	267	0	400	0	940	2955	4562
PETHEDINE	1648	0	1125	20	13578	562	16933
OXYCODONE	3257	16	4000	0	148503	5650	161426
DILAUDID	7961	3300	395	0	15078	2544	29278
MISC. NARC.	0	4	0	0	10885	1458	12347
TOTAL NARCOTICS	21358	4920	6220	20	338086	20819	391423
AMPHETAMINES	13323	0	1574	0	48692	1674	65263
BARBITURATES	16587	2000	2000	0	62579	11319	94485
STIMULANTS	2100	1200	3243	100	206748	90468	303859
DEPRESSANTS	13100	100	14350	600	740265	46906	815321
TOTAL STOLEN	66468	8220	27387	720	1396370	171186	1670351

THEFTS FROM OTHER FIRMS IN ALL STATES
FOR THE PERIOD FROM 10/79 THROUGH 12/79

	NIGHT BRK/IN	ARMED ROBBERY	EMPLOYEE PILFERGE	CUSTOMER THEFT	LOST IN TRANSIT	OTHER THEFTS	TOTAL THEFTS
# OF THEFTS	35	9	76	3	9	99	231
DOSAGE UNITS STOLEN							
OPIUM	382	14	0	0	0	14	410
MORPHINE	6194	0	348	2	2200	447	9191
CODEINE	7393	1025	989	0	100	89	9596
COCAINE	11240	10180	3096	0	0	20419	44935
METHADONE	1976	2224	0	0	307	519	5026
PETHEDINE	3980	718	1478	2	50	1828	8856
OXYCODONE	4233	579	106	0	200	506	5624
DILAUDID	11048	927	730	0	0	394	13099
MISC. NARC.	207	24	60	0	0	278	569
TOTAL NARCOTICS	46653	15691	6807	4	2857	24494	96506
AMPHETAMINES	4237	1273	160	0	1800	559	8029
BARBITURATES	9679	733	4503	14	300	5499	20728
STIMULANTS	4208	486	331	0	1500	549	7074
DEPRESSANTS	32075	636	6853	44	92976	20116	152700
TOTAL STOLEN	96852	18819	18654	62	99433	51217	285037

Mr. WAXMAN. Thank you. Our next group of witnesses will testify as a panel. Each witness represents an innovative statewide program designed to identify, prevent, and control the diversion of licit drugs from the retail level.

We know retail diversion is a serious problem and one in which the Federal Government has determined to be a State responsibility. I am hopeful our witnesses will provide the subcommittee with an assessment of ways the Federal Government can be of greater assistance to State diversion control activities.

Our witnesses are Mr. Fred Brinkley, the executive director of the Texas State Board of Pharmacy; Mr. David Joranson of the Wisconsin Bureau of Alcohol and Other Drug Abuse Controlled Substances Board, and Ms. Patricia Larsen, assistant to the director of the Illinois Dangerous Drugs Commission.

I want to welcome each of you to this hearing. We have your prepared statements and will without objection include them in the record in their entirety. We would like to ask you to proceed in any way you wish in a summarization of your remarks so we will have an opportunity for questions.

Mr. Brinkley?

STATEMENTS OF FRED S. BRINKLEY, JR., R. PH., EXECUTIVE DIRECTOR/SECRETARY, TEXAS STATE BOARD OF PHARMACY; DAVID E. JORANSON, MSSW, CHIEF, PLANNING AND EXECUTIVE STAFFING SUPPORT SECTION, BUREAU OF ALCOHOL AND OTHER DRUG ABUSE/CONTROLLED SUBSTANCES BOARD, STATE OF WISCONSIN; AND PATRICIA J. LARSEN, ASSISTANT TO THE DIRECTOR, ILLINOIS DANGEROUS DRUGS COMMISSION

Mr. BRINKLEY. Thank you, Mr. Chairman.

Mr. Chairman and members of the subcommittee, my name is Fred Brinkley. I am here representing the Texas State Board of Pharmacy in my capacity as executive director and secretary of the board.

I am also a member of the State Drug Abuse Advisory Council to the single State agency for drug abuse prevention in the State of Texas and previously served as the director of the Iowa Drug Abuse Authority the single State agency in the State of Iowa.

I am here today to present testimony to this subcommittee regarding the problems of drug abuse and misuse and the diversion of highly abused prescription drugs from legitimate medical and pharmaceutical channels. Additionally I hope to present to the subcommittee some alternative approaches that the Federal Government could consider in controlling and addressing the problem we have in this particular area.

The problem as I see it really consists of two major areas. First the legal misuse and abuse of drugs involving physicians, pharmacists, and their patients. We have heard a lot about this. I will not attempt to go into that in detail except to recognize it is a problem.

Today my comments will focus on what we consider a more insidious problem that being the diversion of controlled substances at the retail level by physicians and pharmacists.

Since the Board of Pharmacy's responsibility in the State of Texas is in the regulation of the practice of pharmacy, my primary

focus will be directed at this particular area although I think there is no doubt physicians are equally problematic in this particular area.

What I do want to emphasize before I review some of the examples of problems in the State of Texas is the fact that I think it is fairly well established that most pharmacists in Texas and throughout the United States practice in a legal and ethical manner.

I think Mr. Bensinger quoted that he thought that probably 98 percent of the pharmacists and physicians practiced in a way that is ethical and legal and do not become involved in serious diversion of dangerous drugs and controlled substances.

Even though 1 to 2 percent is not a large percentage overall, it does represent a significant number of individuals from a regulatory, law enforcement point of view and, to reemphasize what has already been said, the potential damage these individuals can do with respect to the public health and welfare is substantial because they purchase and they maintain large quantities of prescription drugs.

I would like to give you some examples of diversion activities that have occurred in the past several years in Texas. For instance a pharmacist-owner of three pharmacies in the Dallas area was responsible for shortages of a total of 126,472 schedule II capsules during a 17-month period. The pharmacist pled guilty in State district court and was placed on probation but this judgment was later set aside. The Board of Pharmacy revoked her license to practice pharmacy.

A pharmacist-owner of a pharmacy in the Dallas area was responsible for shortages of a total of 4,139 schedule II capsules and 24,178 ounces or 188 gallons of schedule V codeine-containing cough syrups during an 8-month period. He was not tried criminally. The board of pharmacy revoked his license.

A pharmacist-owner of pharmacy in Humble, Tex., delivered without a prescription a total of 930 schedule II capsules on various dates. An audit of his pharmacy revealed shortages of 1,748 schedule II tablets and 116,759 schedule III-IV tablets. He received concurrent 10-year probated sentences in district court. His license was revoked by the board of pharmacy.

Another example to show this problem does not exist just in major metropolitan areas, a pharmacist-owner of a pharmacy in Hemphill, Tex., with a population of 1,424 was responsible for shortages of 3,053 schedule II capsules and 16,486 schedule IV tablets during a 9-month period. There was no criminal prosecution. The board revoked his license.

I will give you an example of probably the most significant and most dramatic case of diversion I am aware that has ever occurred in Texas.

Two pharmacist-owners of two pharmacies in the Houston, Tex., area were responsible for shortages in their two pharmacies of 51,925 schedule II tablets during a 2-year period. Both received probated sentences in district court. Both pharmacist's licenses were revoked by the board of pharmacy.

A Houston, Tex., hospital pharmacist delivered quantities of schedule II narcotics to a county narcotics agent. He received a

probated sentence in district court. His license was revoked by the board of pharmacy.

A pharmacist-owner of a pharmacy located in a medical complex in Houston was convicted of conspiracy to dispense and distribute schedule II substances. This conspiracy involved a physician who received a probated sentence in Federal court. The pharmacist was sentenced to 5 years imprisonment to be followed by 5 years special probation and is in Segoville at this time which is a minimum security Federal prison outside the city of Dallas.

This was the largest diversion case to date in Texas.

During a 23-month period this pharmacist distributed 495,620 tablets of various schedule II substances. At least half of the tablets dispensed were dilaudid tablets which is a synthetic narcotic that is used many times by addicts to replace heroin if they are not able to obtain heroin.

A DEA analyst estimated that during this period this pharmacy accounted for approximately 2 percent of the total national sales of dilaudid. Because of the amount of dilaudid on the illicit market in Houston during this period of time the demand for heroin became almost nonexistent.

Controlled substances may be diverted from legitimate channels by physicians and pharmacists to the illicit market in the following manner:

Pharmacists may: distribute controlled substance without a prescription; fill forged prescriptions (knowingly or unknowingly); dispense less than the amount prescribed on legitimate prescriptions, then divert the difference.

Order controlled substances from out-of-State suppliers, destroys all receiving records concerning these orders. If the out-of-State suppliers are not known, it is difficult to obtain shipping information.

Alter prescriptions: increases the amount prescribed and diverts the difference.

Physicians may: dispense controlled substances for nontherapeutic purposes; issue prescriptions for nontherapeutic purposes; issue prescriptions for nonexistent patients.

Pharmacists-physicians may: report nonexistent theft of controlled substances to cover the diversion which could occur before or after the reported theft; enter into a conspiracy to distribute and divert controlled substances.

I will not attempt to go into different ways pharmacists and physicians can divert the controlled substances. I think you have been told about that before. It is very easy to do and it is very hard to apprehend these individuals.

The current approach to the problem in Texas with regard to enforcement involves formal and informal cooperative arrangements between the Texas Department of Public Safety, the Texas State Board of Pharmacy and the regional Drug Enforcement Administration Office in Dallas and in the case of large metropolitan areas such as Houston, Dallas, and San Antonio we work with local law enforcement agencies very closely.

Cooperation between the respective agencies has been excellent and has resulted in coordinated enforcement activities throughout the State. The board of pharmacy has taken a lead role in coordi-

nating enforcement activities between these agencies to avoid duplication of efforts and to help assure efficient and effective investigation and adjudication of cases. I am talking primarily about the area of pharmacy investigations.

Presently we are attacking the problem of diversion utilizing really two different but interrelated approaches. The first approach is what we consider a voluntary compliance program and could be considered a preventative law enforcement program. We term it a voluntary compliance program because its emphasis assumes that the large majority of pharmacists will voluntarily abide by the laws if they are educated and informed of their responsibility under the law.

Our program initiated approximately 2 years ago involves the education of pharmacists through a quarterly newsletter which outlines State and Federal law and regulation changes and interpretations in addition to the fact that we publish the names of pharmacists that have been subject to disciplinary action by the board.

The other component of this voluntary compliance program involves the onsite inspection of pharmacies by overt compliance officers who review records and procedures of pharmacies to determine if they are complying with the requirements of the State and Federal law including the Federal Controlled Substances Act.

The board of pharmacy is the only agency either State or Federal that routinely conducts this type of onsite compliance review of pharmacies. Even though we believe our program is efficient and effective and has shown some degree of success, our overall effectiveness may be questionable if you consider we employ two compliance officers to review 4,100 pharmacies over a land area of approximately 270,000 square miles.

At our present rate of inspection it would take our compliance officers approximately 11 years to review every pharmacy in Texas and I repeat we are the only agency either State or Federal involved with this type of prevention-enforcement activity on a regular basis.

If this program is expanded we believe it could impact heavily upon the pharmacist that may be inclined to divert controlled substances and prevent much of this activity from occurring in the first place.

We recognize this type of approach is not going to work with everyone. There are going to be certain people that are going to continue to violate the law no matter what type of prevention activities a board involves itself with.

As a result of this fact the board has continued to increase its covert investigative efforts in the area of diversion of controlled substances. The No. 1 priority for the board of pharmacy investigations for the past 3 years is the diversion of controlled substances by pharmacists.

Currently the board employs a small number of covert investigators who work closely with agents of the Department of Public Safety; Drug Enforcement Administration and local law enforcement officials to investigate these types of cases.

Most of the previously mentioned examples of diversion cases were joint efforts between agencies during either the investigative or adjudicative stages of the case.

These cases involve direct undercover purchases of controlled substances or in many cases an accountability audit of the pharmacy's records to determine if shortages exist. In some cases both procedures were used depending upon the particular circumstances.

With reference to solutions regarding the diversion of controlled substances we firmly believe that the majority of current DEA efforts are appropriate and consistent with the agency's legislative mandate. Additionally with specific reference to regional DEA offices the Dallas regional office has been very cooperative and helpful to our efforts in Texas. DEA enforcement efforts need to be continued at the current level within an additional area of emphasis. This additional area of emphasis that needs to be addressed is DEA's assistance to States in preventing the problem of retail diversion before it occurs.

As you have heard, DEA's efforts in assisting States with regard to retail diversion have been largely directed at dealing with problems after the act has already occurred. Although this activity is absolutely necessary, it accomplishes little in terms of preventing the problem from occurring in the first place.

We would suggest a new and expanded emphasis at the Federal level be directed at what I would call drug abuse prevention-enforcement efforts. Such an effort would focus on physicians and pharmacists and would explore innovative approaches directed at preventing retail diversion before it occurs.

This effort should allow DEA to allocate financial resources to States through a demonstration or discretionary grant program to carry out innovative programs directed at preventing the diversion of controlled substances by physicians and pharmacists.

In my opinion these programs should be involved with activities not totally educational in scope. For instance an example of such a program would be conducting regular onsite inspections of pharmacies to include but not be limited to spot auditing of certain highly abused controlled substances; thorough review of records of pharmacies and the recordkeeping procedures they have and also in cases where serious problems exist, provision of onsite technical assistance for specific problem areas and correction of those problems.

This approach would be especially effective in those cases where inadvertent diversion might be present; in other words theft by an employee. For those pharmacists who may be involved in diversion on a limited basis the knowledge that such inspections were occurring would be a powerful deterrent.

In terms of cost to Federal and State governments direct enforcement activities such as investigation and indepth audits of controlled substances records are expensive and time consuming. Moreover subsequent adjudicative efforts often result in staggering costs to both Federal and State governments. On the other hand preventative programs such as the one previously mentioned are relatively inexpensive and may be very cost effective.

In summary, drug misuse and abuse is prevalent throughout the Nation. There is no doubt that the retail diversion of controlled substances is contributing to the problem of drug abuse in the United States. Although only a small percentage of pharmacists and physicians are involved in the retail diversion of controlled substances the actual numbers of these individuals are significant because of their direct and legal access to these drugs.

DEA's current responsibility and the corresponding State responsibility under Federal and State controlled substance acts are appropriate. Additionally current drug enforcement activities of the Federal Government should not be reduced.

The Congress through DEA should provide for a mechanism that would allow DEA to seek out innovative approaches directed at the prevention of retail diversion of controlled substances. This could be accomplished by providing financial and technical assistance to States for demonstration projects directed at drug enforcement-related prevention activities.

These projects could be reviewed and evaluated over a period of 2 or 3 years to determine the effectiveness of such prevention efforts. This financial and technical assistance to States should be made available to State health regulatory agencies in addition to appropriate law enforcement agencies.

Health regulatory agencies such as boards of pharmacy have the interest, expertise, commitment, and rapport with health professionals necessary to make such projects successful. They also have the responsibility of regulation of the respective professions and are mandated to protect the health, safety, and welfare of the citizens of their respective States.

It has been an honor and pleasure to speak before you today. I will be happy to clarify any of my testimony or provide the subcommittee with additional information if necessary.

Mr. LELAND [presiding]. Mr. Brinkley, we certainly thank you for your testimony. Dr. Carter, would you like to question Mr. Brinkley before we move on to the other members of the panel?

Mr. CARTER. Mr. Chairman, in the interest of saving time I think it would be more appropriate if we wait until the rest of the panel have testified.

Mr. LELAND. Mr. Brinkley, let me thank you personally for coming on behalf of your favorite Congressman from Texas. We certainly appreciate your participation.

Mr. Joranson? We will insert your prepared statement into the record.

STATEMENT OF DAVID E. JORANSON

Mr. JORANSON. Thank you.

My name is David Joranson. I am chief of the Planning and Executive Staffing Support Section in the Bureau of Alcohol and other Drug Abuse in Wisconsin. That is the single State agency for drug abuse and alcohol in our State.

I have staffed the State controlled substances board for about 5 years and in that respect Wisconsin is somewhat unique in that we have that additional bridge over into the drug enforcement aspect of compliance in retail diversion which many States do not.

I appreciate the opportunity to describe very briefly our model for reducing retail diversion at the State level and will be presenting several recommendations for strengthening DEA's role in this as well as the State's role, which parallel Mr. Brinkley's remarks.

I will not go any further into the problems of retail diversion. You have heard those already. They are serious and I would just like to echo that.

I would also like to echo a theme that emerges of the need for a multifaceted response at the State level which include health officials and enforcement and regulatory approaches as well as education and compliance.

I would like to emphasize one point that at least I think is very important and that is the source of retail diversion and thus very much drug abuse in this country lies within the health care system. I think that is a terrible affront to the health care system itself. I think it needs to be moved on rapidly and solved. I am quite optimistic as to the possibility of doing that.

I would like to show you some charts which describe what happened in Wisconsin. This is a computer map of the State of Wisconsin. The lower right-hand corner is where we join the northern border of Illinois and the lower left hand area is where we join the State of Minnesota to the west.

This is a three-dimensional computer map that describes all of the retail level purchases of amphetamines in schedule II for calendar year 1975. We simply aggregated all of the physician and pharmacy purchases of all amphetamines in schedule II and plotted them over the center of each three digit Zip zone. There are 18 data points on that map. It shows an incredible peak over the Milwaukee area.

This happened to coincide with reports the controlled substances board had gotten that there was a widespread illicit availability of legally manufactured prescription amphetamines on the streets in Milwaukee selling at a brisk pace. These drugs were the subject of a considerable drain on law enforcement resources inasmuch as there were numerous arrests for persons who were illegally in possession or possession with intent to sell of these prescription drugs.

These facts led us to be suspicious that the source of amphetamines was actually physicians and pharmacists in the Milwaukee area.

Following our interagency study effort Wisconsin enacted several controls, some of which have been alluded to in Mr. Bensinger's testimony. The first one was an education program for practitioners. The second one was a restriction on title XIX reimbursements in the medical assistance program for amphetamines, so that tax dollars were no longer going to pay for amphetamine prescriptions.

Following that the medical examining board—which is the State licensing authority for physicians—concluded that amphetamines had at best a trivial advantage over placebo therapy in the treatment of obesity. While there was very little benefit for the patient who had a serious health problem of obesity, it was even worse for the patient in that there was such a dependence liability in taking amphetamines.

The medical examining board concluded as a matter of policy that treating obesity with amphetamines in Wisconsin was a matter of unprofessional conduct. The third restriction was an administrative rule pursuant to their authority under the Medical Practice Act. Late in 1977 the rule went into effect and after November of 1977 a physician would run the risk of losing his license to practice medicine if he were to prescribe amphetamines for obesity.

I should mention there were six or seven other indications that were permitted specifically. Amphetamines have not been banned in Wisconsin but they have been heavily restricted by the removal of the anorectic indication.

I would like to show you the impact on prescribing on the next chart. This is the same base map. This is 1978 purchases, the first complete year following the enactment of the restrictions in 1977.

Mr. DANMEYER. People slimmed down a lot.

Mr. JORANSON. Considerably, yes, sir.

I believe this is the kind of a topography that you would expect to see when amphetamines are being used for legitimate medical purposes and this is all the need for amphetamines there was in Wisconsin after taking away the obesity indication.

It is a reduction of in excess of 90 percent and it is closer to 95 percent.

The next chart simply details the specifics as to how those retail purchases declined beginning in 1975 with purchases of over 40,000 grams down to approximately 3,500 grams in 1978.

We were very interested to see whether these particular policy actions would have any effect on local law enforcement arrests in the Milwaukee area. They did. In 1976 there were over 100 local law enforcement arrests of people in possession of amphetamines illegally. By 1978 after the restrictions had an effect of substantial or drastic supply reduction, amphetamine arrests dropped off. I think we reduced substantially the drain on local law enforcement resources.

Other data is available from other police departments around the State of Wisconsin. This is most notable. Arrests declined throughout the State by approximately 80 percent.

We have a supply reduction of about 90 percent and an arrest reduction of about 80 percent.

We could not have defined our problem without DEA's assistance and I want to call your attention to the ARCOS system. ARCOS stands for the automation of reports of consumated orders. It is a report that is available to States which chronicles every retail level purchase of every drug in schedule II.

Besides the fact that ARCOS is not timely and besides the fact that the reports come out in very raw form requiring hours and hours of analysis, and besides the fact that it is only limited to the drugs in schedule II—which are not all the primary drugs of abuse in this country by any means—ARCOS can aid States in targeting drug abuse problems. It is extremely valuable to us in helping to focus public attention in our own State to these problems.

It can assist us in reallocating our own governmental resources in dealing with the problems and in selling the need for additional resources.

I believe the actions that have been taken subsequent to this analysis have upgraded the overall level of medical and pharmacy practice in Wisconsin. Physicians and pharmacists are proud of what happened in Wisconsin. The only people that came in to oppose the medical examining board rule was the amphetamine manufacturing industry.

I believe this information appropriately used can also help the Federal Government in targeting its efforts and in setting its priorities. For instance on page 15 in the testimony there is a map that describes the distribution of methaqualone or quaaludes in the United States for 1977. There are four States whose purchases when totaled, the ones circled, add up to 50 percent of the total U.S. distribution of methaqualone. It happens to be Texas, Florida, California, and Ohio.

I believe for instance effective use of this tool would be to make a map like that which I showed you earlier of those particular States and you can come up with a perfect picture of the distribution patterns and decide where to target your resources and your efforts.

When we run out of the drugs in schedule II then we will have to decide how we are going to get that kind of information on drugs like darvon and valium.

I do believe that the way these drugs are distributed can tell very quickly the type of effort that is required whether it be education; regulation; fiscal restrictions such as title XIX; enforcement and so forth.

To move on to my recommendations, to begin with, for 1981, we would support upgrading the ARCOS to give it the capability of providing this kind of reporting on an annual basis to States. It is going to require some resources. It is going to require some manpower. It is going to require some more computer time in DEA.

We believe that is the place to start because that is what helps us define the problem and without that we cannot get to the second step.

The second step we feel equally strongly about and this also reflects Mr. Brinkley's testimony and his support for a State assistance program of technical assistance, information and resources. I would like to echo his recommendation that there be an authorization for a grant assistance program to States to help upgrade the capacity of State regulatory boards to investigate and monitor and prevent these kind of retail diversion problems.

The third recommendation for DEA is to review the Controlled Substances Act. I think it is time. The original CSA was passed in 1970 and it was based on the problems that were perceived in the 1960's when wholesale diversion was rampant and that is not the case now. That has been contained. We now have a problem with retail diversion and there is a need to relook at the Controlled Substances Act with respect to DEA's role in retail diversion and also the possibility that we could draft up some model amendments to the uniform acts passed by the States which would help clarify and focus resources at the State level.

In addition, while I understand this is a hearing specifically directed to DEA, I would like to make reference to what I think is a very good idea that has been mentioned and I believe originally

surfaced at the White House meeting on this topic on September 12 of last year: that there be a national working conference of retail diversion interests on the whole question of appropriate prescribing of drugs so we can start to pool our resources and our information and talent and get this thing going.

I think that is in HEW's ballpark right now. I would recommend that such a conference be actualized.

I would strongly urge FDA to proceed with removing the anorectic indication from amphetamines. But I would also urge them to include phenmetrazine when they do so. It is a drug that is used for the same purpose. The brand name is Preludin. We have evidence in Wisconsin that just as the amphetamines were going down, Preludin came up in response. If you do not remove the anorectic indication from phenmetrazine as well, you will simply cause a substitution phenomenon to occur.

I appreciate the opportunity to make a presentation.

[Testimony resumes on p. 197.]

[Mr. Joranson's prepared statement follows:]

STATEMENT OF DAVID E. JORANSON, MSSW, CHIEF, PLANNING AND EXECUTIVE
STAFFING SUPPORT SECTION, BUREAU OF ALCOHOL AND OTHER DRUG ABUSE/
CONTROLLED SUBSTANCES BOARD, STATE OF WISCONSIN

ABSTRACT

A model state interagency approach for identification and control of retail diversion is presented. Wisconsin concern began with Milwaukee law enforcement reports of illicit availability and high physician purchases of a Schedule II amphetamine product, Biphedamine 20. Computerized information on all physician and pharmacy purchases of amphetamines was obtained from DEA. Computer mapping techniques and pharmacy audits revealed extraordinary prescribing and dispensing patterns. Numerous physicians were investigated, several were arrested, controls were applied to Title XIX (Medical Assistance) and restrictions were placed on the medical uses for amphetamines. As a result, retail purchases (supply) fell in excess of 90 percent, and local law enforcement reported sharp drops in illicit availability of prescription amphetamines and amphetamine-related arrests.

Recommendations are made, including the establishment within DEA of a new retail diversion state assistance program and advisory group.

Mr. Chairman, members of the Subcommittee on Health and the Environment, on behalf of the State of Wisconsin we appreciate the opportunity to present information to you on a successful diversion control program in Wisconsin, along with recommendations for strengthening the Drug Enforcement Administration compliance program.

I am Chief of the Planning and Executive Staffing Support Section of the Bureau of Alcohol and Other Drug Abuse, of which Larry W. Monson is the Director. I have provided staff services to the Wisconsin Controlled Substances Board (CSB) since June 1975. Darold A. Treffert, M.D., is the Chairman. He is serving his third three-year appointment by the Governor. Dr. Treffert is a noted psychiatrist and is president of the State Medical Society.

The Controlled Substances Board is a six member* statutory authority for placing drugs in the schedules of the Wisconsin Uniform Controlled Substances Act. We use scheduling criteria similar to those in the federal Controlled Substances Act (CSA). The Board, in conjunction with the Drug Enforcement Administration (DEA) registers researchers for possession of controlled substances. The Board approves and the Bureau of Alcohol and Other Drug Abuse

*The other statutory members of the Board are the Attorney General, represented by John W. Calhoun, Robert Maile, Chairman of the Pharmacy Examining Board, the Secretary of the Department of Health and Social Services represented by Theodore Collins, the Secretary of the Department of Agriculture, Trade and Consumer Protection represented by Donald Willett and June Dahl, Ph.D., a pharmacologist of the University of Wisconsin. The Medical Examining Board representative is ex officio, pending introduction of legislation to provide statutory membership.

monitors methadone detoxification and maintenance programs in conjunction with the Food and Drug Administration (FDA) and DEA. As a result of the activities described here, the Board is seeking additional statutory authority for its interagency program to monitor diversion of controlled substances. The Board has met monthly for ten years and has been active in providing leadership and expertise to the drug abuse field in Wisconsin.

State alcohol and drug abuse agencies like our own usually have their primary federal level relationships with the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA). Wisconsin has an additional primary relationship to controlled substances policy, and thus a link to the CSA and DEA's compliance functions, the ultimate focus of this presentation.

First, I will describe the Controlled Substances Board's amphetamine project and its results. Then those experiences will be related to the CSA and the DEA compliance program.

The Amphetamine Problem in Wisconsin

Prior to 1976 there was limited concern about amphetamine problems in the state. The State Medical Society had conducted an educational program among its members urging an end to the use of amphetamines unless related to medically indicated conditions. But the actual dimensions of amphetamine distribution and abuse were unknown.

In early 1976 the CSB received reports from DEA's Milwaukee Compliance Office that several physicians in the Milwaukee area

had made large purchases of Biphedamine 20. Other law enforcement personnel reported widespread illicit availability of the same product, particularly in Milwaukee, leading the Board to suspect diversion from physicians or pharmacies.

Biphedamine 20 (street name "Black Cadillac", "Black Beauty") contains a combination of amphetamine and dextro amphetamine, which have a high potential for abuse and are therefore subject to the strictest regulatory controls of Schedule II of the Controlled Substances Act, including production and import quotas, secure storage, separate record keeping, written prescriptions with no refills, and completion of a consecutively numbered triplicate order form for each purchase or transaction. The manufacturer's product information calls for Biphedamine to be prescribed or dispensed sparingly for exogenous obesity for a few weeks in a program of reduced caloric intake, for patients with conditions that are refractory to other weight loss therapies.

Upon further investigation we learned that DEA manages an information system which was capable of providing us with data that described annual physician and pharmacy purchases of all controlled substances in Schedule II and the narcotics in Schedule III. The system is called ARCOS (Automation of Reports of Consolidated Orders System) and is a computerized record of manufacturers' and distributors' reports of all retail purchases made using the triplicate order form. Because ARCOS was not oriented or programmed to assist states and because we were inexperienced in using ARCOS, our first request was for 1975 purchase data on only one product, Biphedamine 20. The ARCOS report that formed

the foundation of Wisconsin's monitoring program arrived late in 1976.

Analysis of 1975 purchase information on Biphentamine 20 showed that 922,700 dosage units (capsules) had been purchased by state practitioners, hospitals, and pharmacies. 118,300 dosage units were purchased by 26 practitioners, representing less than 1 percent of the state's physicians. Of the 26 practitioners, 20 were physicians, 3 were osteopaths, 2 were dentists, and 1 was a podiatrist. Purchases ranged from 100 to 34,000 dosage units. The top five practitioners purchased 71 percent of practitioner purchases. Ten of the 26 dispensing practitioners were from urban Milwaukee (population 629,162). They purchased 50,000 dosage units. Rural Dodge County with less than a tenth the population of Milwaukee, had six practitioners who purchased 52,000 dosage units.

798,200 dosage units were purchased by 465 pharmacies, representing approximately 44 percent of state pharmacies. Purchases ranged from 100 to 62,400 dosage units. The highest purchases were tightly concentrated in the Milwaukee area, although several pharmacies in Appleton (population 61,416) and Green Bay (population 89,289) purchased in excess of 10,000 dosage units.

6,200 dosage units were purchased by 13 hospitals.

The CSB was concerned about such high concentrations of amphetamines and forwarded the purchase data to the pharmacy and medical licensing boards with the request they determine the legitimacy of the dispensing or prescribing of their licensees. Specifically, the CSB asked the Pharmacy Examining Board (PEB)

to examine the physician prescribing patterns that lay behind the very large pharmacy purchases in the Milwaukee area. Was this the prescribing activity of many physicians, or a few?

At the direction of the PEB, state pharmacy inspectors conducted a unique prescription audit in the Milwaukee area at 10 of the state's pharmacies that purchased the most Biphedamine 20. Inspectors tallied and organized all Biphedamine 20 prescriptions for 1975, by prescribing physician. Their results, which were forwarded to the Medical Examining Board (MEB), showed that of the total 10,202 prescriptions filled (approximately one-third million dosages), 82.7 percent (8,432 prescriptions) were written by only eight physicians.

Later, DEA arrested two of the physicians responsible for generating the 10,202 prescriptions. They were convicted in federal court for unlawful distribution of a controlled substance without a legitimate medical purpose.

The CSB subsequently requested and received complete 1975 and 1976 ARCOS data on Biphedamine 20 and on the other stimulants in Schedule II. These reports showed that, while there was an overall 29 percent drop in Wisconsin retail amphetamine sales from 1975 to 1976, there continued to be approximately 2 million dosages of amphetamine and methamphetamine sold to a concentrated pattern of a small number of pharmacies and physicians. High concentration patterns also existed for other amphetamine products, such as Dexedrine. Because a new report included amphetamine-like substances as well as amphetamines, the CSB learned that while amphetamine purchases were decreasing, phenmetrazine purchases had increased during the same period.

Figure 1 shows the distribution of amphetamine purchases in 1975 by zip zones (reduced to fit the page). Total purchases of all registrants within each of 18 three-digit zip zone areas are plotted at the center of the zip zone. Computer mapping techniques aided in visualizing complex information and were particularly useful for decision-makers.

Responding to new concerns about amphetamines, the Department of Health and Social Services' (DHSS) Bureau of Health Care Financing conducted an investigation of the high volume of Title XIX (Medical Assistance) claims for reimbursement for amphetamine prescriptions. In February 1977 the first of two state restrictions on amphetamines was implemented. Based on its findings, DHSS stopped reimbursement of Title XIX claims for all Schedule II, III, and IV amphetamine and anorectic products unless a prior authorization had been approved.

In June 1977 the CSB conducted its annual symposium. Titled "Diversion of Licit Controlled Substances", participants included state leadership of the medical, dental, nursing, and pharmacy professions and licensing authorities, representatives of state and federal health and law enforcement agencies and members of the press. The CSB presented the analysis of amphetamine purchases, and the PEB presented the results of its amphetamine prescription audit. The Medical Examining Board (MEB) representative announced their concern about amphetamines and reported they had recently initiated 60 investigations of licensees.

The MEB later states that they found a pattern of improper prescribing of amphetamines. In testimony at the Food and Drug

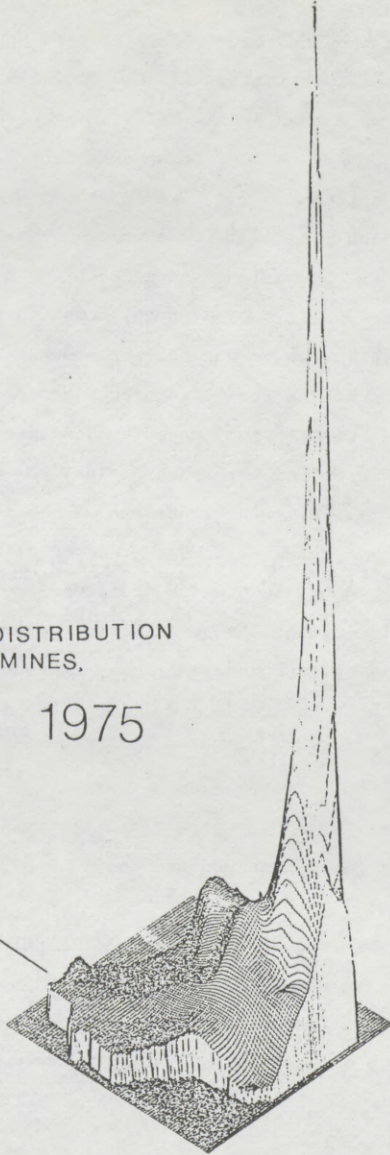
FIGURE 1

WISCONSIN DISTRIBUTION
OF AMPHETAMINES,

1975

NORTH
↖

Source:
ARCOS



Administration public hearing on amphetamines December 2, 1977, the MEB said that they had been unable to find any credible evidence that was statistically reliable or valid to show that amphetamines had more than a trivial advantage over placebo therapy in either the short or long term management of obesity. They concluded that the treatment of a serious disorder with a substance having a high potential for abuse and little likelihood of significant gain to the patient was a danger to the health, safety, and welfare of the public and, as such, constituted unprofessional conduct. In addition, there was serious concern that such conduct was the source of much of the illicit amphetamine market.

Late in 1977 the MEB promulgated an administrative rule under the state Medical Practice Act which defined the use of amphetamines and phenmetrazine in the treatment of obesity as unprofessional conduct. The rule, which was prepared using a list of indications prepared by the State Medical Society, lists seven legitimate uses including: treatment of narcolepsy; hyperkinesia; drug induced brain dysfunction; epilepsy; depression shown to be refractory to other therapeutic modalities; the differential diagnostic psychiatric evaluation of depression; or the clinical investigation of the effects of such drugs. The initial administrative rule restricted all anorectic drugs in Schedules II, III, and IV. The final rule was amended to apply only to Schedule II stimulant drugs.

At a public hearing the MEB amphetamine rule received the support of the State Medical Society and was opposed by amphetamine manufacturers. The MEB amphetamine rule, the second restrictive policy on stimulants, took effect on November 1, 1977.

Since the primary usage of amphetamines is in treatment of obesity, restriction of that use should affect retail sales. ARCOS information on amphetamine purchases over a three year period was obtained. The period includes 1976, the year preceding the policy restrictions, 1977, the year when both the Title XIX and the MEB rule took effect, and 1978, the first full year that both policies were in effect. 1976 amphetamine purchases totaled 72,870 grams. Purchases dropped to 35,693 grams in 1977. In 1978, purchases fell to 3,583 grams. From 1976 to 1978 purchases decreased by 95 percent. In addition, the sales of Biphphetamine 20 were monitored at a large Milwaukee distributor. Figure 2 shows how month-to-month sales were affected.

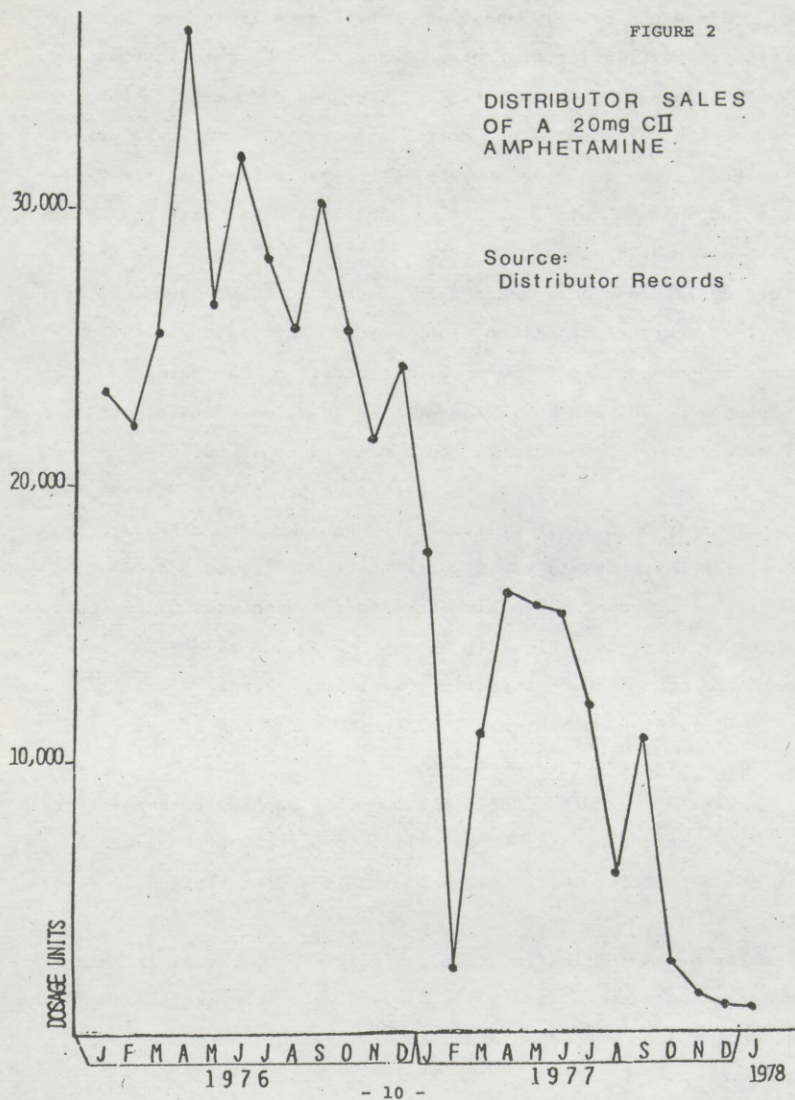
In order to determine the effect of sharply reduced amphetamine supply on illicit availability, we asked the Milwaukee Police Department via the Department of Justice to provide the number of amphetamine-related arrests for each year of the same three year period. Figure 3 shows the decline of arrests during the same period the restrictions went into effect.

Statistical tests show that the purchase and arrest data have a near-perfect correlation.

Finally, Figure 4 shows the computer mapping technique for the 1978 purchase data. The rolling topography of 1978 stands in sharp contrast to the peaks of the 1975 distribution in Figure 1.

As one might imagine, the participating agencies in this cooperative venture were quite pleased with the results and so a second project was begun using ARCOS to study the patterns of

FIGURE 2

DISTRIBUTOR SALES
OF A 20mg CII
AMPHETAMINESource:
Distributor Records

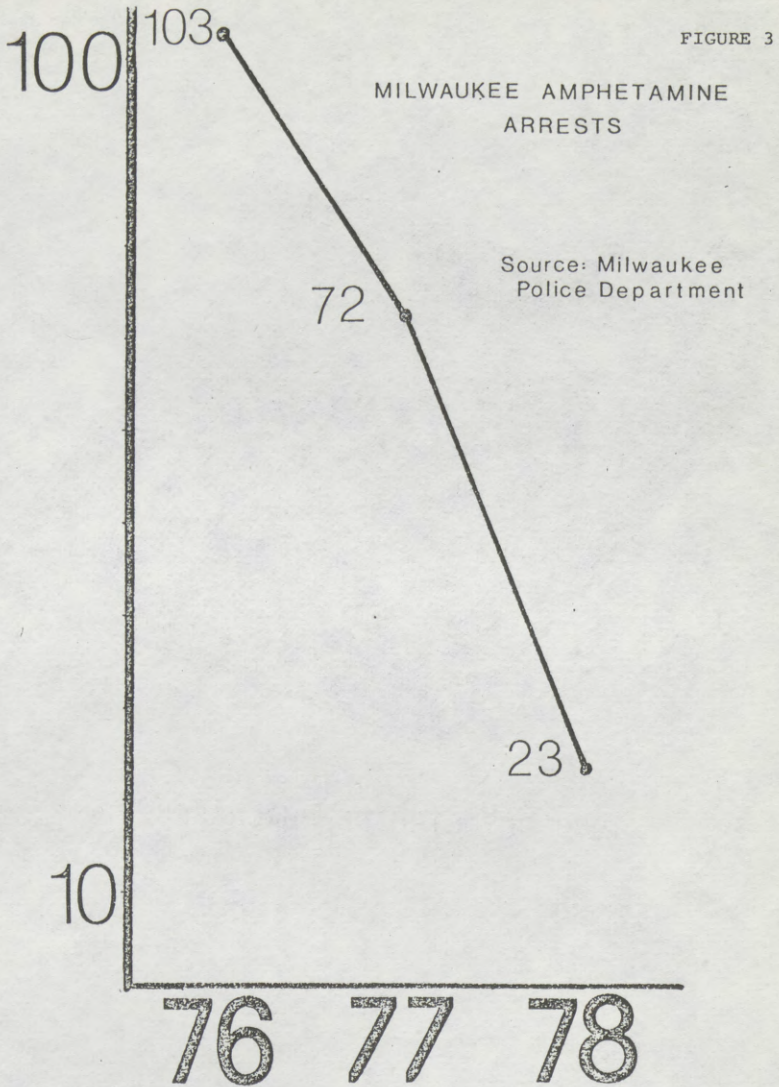
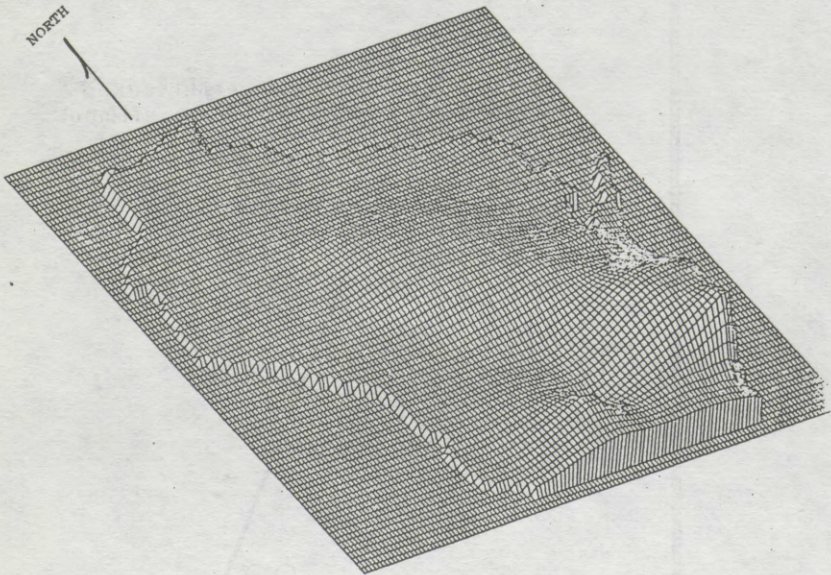


FIGURE 4



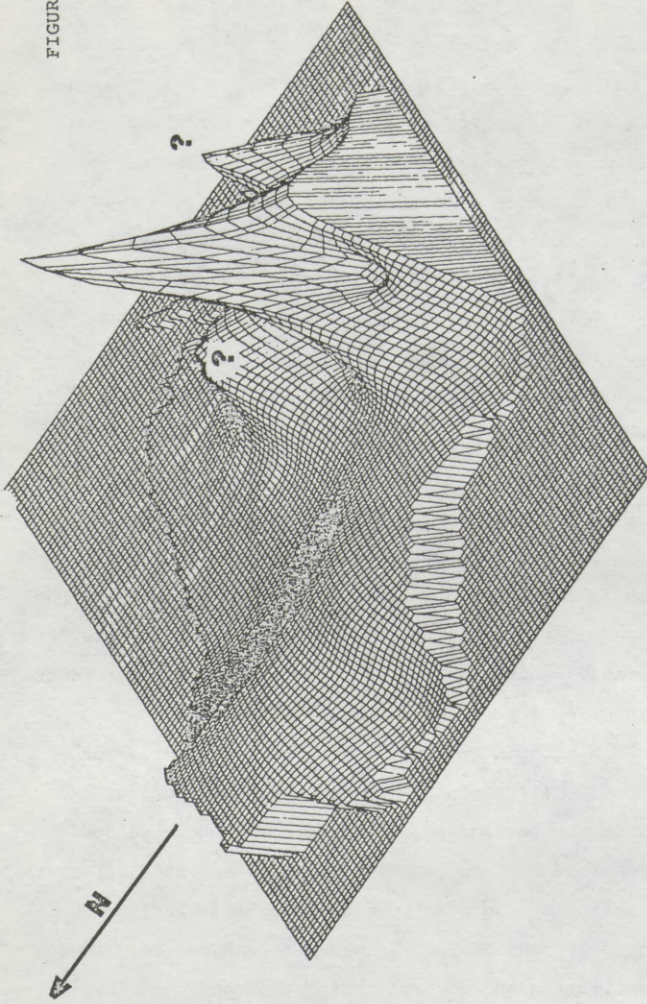
1978 AMPHETAMINE PURCHASES

prescribing and dispensing of the sedative-hypnotic drugs in Schedule II (fast acting barbiturates and methaqualone). Figure 5 describes the 1977 distribution of methaqualone (Quaalude, Sopor, Parest) in Wisconsin. The only restrictive policy deemed necessary was a prior authorization policy on Title XIX reimbursement of methaqualone. Instead, the primary activities have included public disclosure of distribution patterns and several investigations of high prescribers and will include education, development of prescribing guidelines, and a "state of the art" piece on medical management of sleep disorders. In this regard, the sedative hypnotic initiatives at the federal level have been very useful to us. No evaluative studies on outcome are available at this time.

Because ARCOS data are available for the entire United States, we prepared a U.S. map showing the distribution of methaqualone, by population density (Figure 6). The highest ten states are ranked, and the four states whose total purchases of methaqualone contribute over 50 percent of the total U.S. distribution are circled. Naturally, we would be most supportive of further investigation of prescribing patterns in those states.

Because the Wisconsin Controlled Substances Act does not specifically provide for a program of diversion monitoring, the Board, along with the participating agencies and DEA, are now developing a Memorandum of Cooperation to guide and solidify state agency and DEA efforts. We plan to add appropriate language to the Act to provide a mandate and resources for an ongoing program of diversion monitoring and control. Without such authority, our

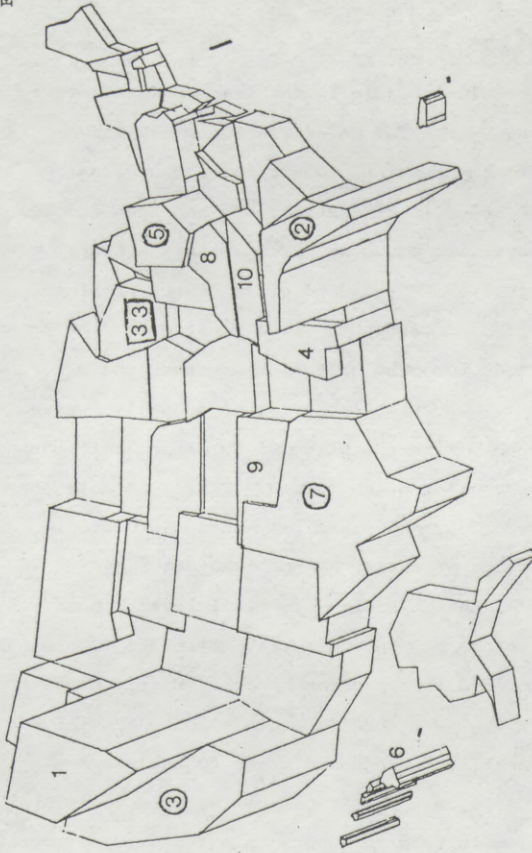
FIGURE 5



WISCONSIN DISTRIBUTION OF
METHAQUALONE, 1977

Source: ARCOS

FIGURE 6



US. DISTRIBUTION OF METHAQUALONE
BY POPULATION DENSITY, 1977

Source: ARCOS

program could falter, particularly when we come to the drugs that are not in Schedule II and therefore are not in ARCOS.

Relation to the Federal CSA and DEA

Amphetamines had been in Schedule II for years. Total state purchases were decreasing except for phenmetrazine which was rising rapidly. National amphetamine production quotas were coming down. All of the Schedule II restrictions had been invoked. There had even been a physician education program in the state. With all of these restrictions, why did we still have a problem? Partly because the obesity indication provided a carte blanche medical justification to doctors who write scripts for good money or don't know any better. Schedule II provisions actually insured that patients return monthly with the price of an office call, or a Title XIX card, to get another prescription. Partly because controlled substances restrictions, especially those in Schedule II, operate and are enforced primarily at the manufacturing and distribution level, not at the physician or retail level. But mainly because state government posed no threat to retail diversion.

Why hadn't we discovered this problem before? Partly because we didn't know about ARCOS. We literally stumbled onto the information system. And then it took weeks and weeks to analyze the data and prepare useful reports. Partly because we tend to relate to the amphetamine problem in terms of users' problems and concepts of consumer-focused education, prevention, treatment, rehabilitation. Partly because no state agency had the specific responsibility to relate to retail diversion. State and local enforcement

agencies tend to avoid "doctor cases", and licensing boards tend to respond only to consumer complaints, and there are precious few consumers who will complain.

Why hadn't scheduling eliminated the problem? Scheduling alone can't eliminate the problem, but it can provide a good beginning. The most important aspect of Schedule II from my perspective is that those products become ARCOS reportable, thereby providing the capability of analyzing distribution trends.

The value of ARCOS to Wisconsin has been tremendous. It has given us information with which to access a drug abuse problem whose roots are in the health care delivery system. It has allowed health care, law enforcement, and health regulatory personnel to work together to solve a drug abuse/medical practice/health care cost problem. Very few states use ARCOS. Very few of DEA's Diversion Investigation Units (DIU) use ARCOS this way. But the information is there waiting to be programmed and packaged.

Scheduling is not a substitute for enforcement, regulatory actions, professional education, peer review, and consumer education. It only takes a relatively small number of unprofessional doctors or pharmacists to circumvent and frustrate controlled substances restrictions and standards of medical or pharmacy practice. And when that occurs, no degree of scheduling, education, or peer review will solve the problem. The hard core of unprofessional practitioners who knowingly divert controlled substances only respond to the suspension or revocation of the license to practice, or to the threat of criminal prosecution. It is this latter group that are now responsible for most of the

80 to 90 percent of controlled substances diversion, which in turn contributed heavily to the Nation's drug abuse problem.

The CSA was enacted to confront a special set of problems that existed in the sixties. There was wholesale diversion at the manufacturing and wholesale distribution levels. Truckloads of drugs were diverted long before they reached pharmacies and physicians. Now DEA has effectively confronted that problem. Now DEA must reorient itself to meet the challenge of retail diversion, without losing ground at the wholesale and manufacturing level. Only a small percentage of diversion occurs at the upper levels of distribution, and very few of those registrants have problems any more. The bulk of DEA compliance investigators concentrate most of their efforts on routine audits of "B level" registrants. DEA compliance functions are still operating under the objectives established ten years ago. While compliance investigators are instructed to assist states in combating retail diversion, there is no reward system or objectives or work plan toward that end. Compliance is one of the lowest priorities in DEA, and there is only a soft commitment to assisting states.

Conclusions

Because diversion patterns have substantially shifted since 1970, bringing into focus the primary responsibility of state regulatory agencies and professional associations to reduce prescription drug abuse problems, there is a need to review the CSA with respect to its capacity to direct federal assistance to states to monitor and control retail diversion. DEA should

maintain a strong federal capability to curtail criminal large scale retail diversion. But I would not recommend a substantial expansion of DEA's authority to regulate physicians' and pharmacists' use of controlled substances. It would be an unnecessary intrusion into the practice of medicine and the states' authority to regulate. I would urge the Subcommittee to support The White House initiatives which include: a national conference to initiate a broader attack on the problem; encouraging states to develop Prescription Drug Abuse Task Forces; an expansion of the National Drug Abuse Strategy; and the HEW initiatives to remove the obesity indication from amphetamines and to educate health care providers on the state of the art in treating sleep disorders and anxiety. I would recommend to you the very helpful analyses and conclusions of the GAO reports on retail diversion. I would strongly encourage you to inquire after the retail diversion efforts in your own states, because there are developing programs that could benefit from your support.

Recommendations

The following recommendations are submitted for the Subcommittee's consideration. They are based on the conclusion that continuation of the existing federal and state programs will not materially affect retail diversion problems and abuse of prescription drugs.

I. The Controlled Substances Act

- A. Because the CSA was drafted to respond to the problems of the late 1960s when wholesale level

diversion was rampant, a review of the Act with respect to the existing problem would be timely.

- B. ARCOS information is available only for drugs in Schedule II and narcotics in Schedule III. Other drugs with high abuse profiles like diazepam (Valium) and propoxyphene (Darvon) are not now ARCOS reportable. The alternative to making these drugs ARCOS reportable would be for DEA in conjunction with several states to conduct audits on prescribing patterns of Valium and Darvon in areas that have both high and low problem rates. The purpose would be to compare actual prescribing patterns to recommended or accepted standards to evaluate sources of diversion and to ascertain need for more restrictive scheduling.
- C. Because the Uniform Controlled Substances Acts passed in many states do not provide specific organizational structures, mandates or resources to monitor and control diversion, the Subcommittee may wish to consider the drafting of model amendments to the state Acts.

II. DEA

The DEA Office of Compliance and Regulatory Affairs should be provided with the mandate and resources to significantly upgrade the compliance program with respect to the problem of retail diversion.

- A. The ARCOS unit should be given the mandate and resources to prepare annual reports to states

evaluating drug distribution patterns and using such analytic and display techniques so as to make the information readily useable.

- B. A State Assistance Program should be created and given the mandate and resources to: administer a grants program for selected states to increase their health regulatory capacity to monitor and control diversion; provide a proactive technical assistance and training program to all states' regulatory staff; establish state-federal liaison coverage to each state.
- C. Communication devices should be developed to enhance dialogue, sharing and learning among retail diversion interests, including conferences, training programs, and newsletters.
- D. A Retail Diversion Advisory Group should be appointed by the Attorney General from a cross-section of affected parties with particular attention to state personnel, to advise the program.
- E. DEA should prepare and disseminate to states a "state of the law" summary of case law, both criminal and with respect to state licensing actions.

III. FDA

FDA should proceed with removal of the anorectic indication from amphetamines, but only if the removal applies to phenmetrazine (Preludin) and only if the ruling is followed by a program of production quota reduction and

monitoring of "resistant" distribution patterns through ARCOS.

IV. Health Care Financing Administration (HCFA)

HCFA should prepare and disseminate a summary of state reimbursement restrictions on controlled substances in the Title XIX program, along with recommendations.

V. Department of Justice

State Medicaid Fraud units should be alerted to high prescribers or dispensers as potential targets of investigation.

VI. Internal Revenue Service (IRS)

IRS should be alerted to physicians who purchase and then dispense large amounts of controlled substances directly from their offices. Record keeping is often minimal and because of the elimination of the pharmacy as middleman, the likelihood of unreported income is increased.

Congressman Waxman, members of the Subcommittee, this concludes the written presentation. Please do not hesitate to contact me if I or others from Wisconsin can be of any assistance to you.

Mr. WAXMAN. Thank you very much.

Ms. Larsen?

We welcome you and will insert a copy of Mr. Kirkpatrick's prepared statement into the record.

STATEMENT OF PATRICIA J. LARSEN

Ms. LARSEN. Thank you, Mr. Chairman and members of the committee. I am here representing Thomas B. Kirkpatrick, Jr. who is the executive director of the Illinois Dangerous Drugs Commission. He is sorry he cannot be with you today as originally scheduled.

I think most of my comments will reinforce those of Mr. Brinkley and Mr. Joranson.

Those of us in the States with the direct responsibility for providing treatment and rehabilitation to the victims of drug dependence have long been concerned with the viewpoint and the scope of drug abuse being too narrowly defined.

Historically the efforts have been directed at illegally produced and distributed narcotics, and while we certainly do not intend to minimize the importance of heroin and opium abuse, we are beginning to realize now that the dimensions of the dependency and addiction problem are much greater.

The number of persons dependent on legitimate pharmaceutical drugs far exceeds the number addicted to the purely illegal substances. It is a more hidden population. The cost to the individual and to society for this widespread use of legitimate pharmaceuticals is tremendous. Again, that is not to say that heroin has ceased to be a problem. It is appearing as Mr. Bensinger indicated in new concentrations and new amounts and new locations.

Those of us who have accepted the responsibility for dealing with the impact of drug abuse on our society have been working desperately to come to grips with the greater problem and have been frustrated in our efforts by the sheer enormity of scale and the lack of any cohesive approach to the widespread problem.

We are only now just beginning to get accurate information about the population groups affected by the abuse of prescription drugs and we have discovered groups particularly susceptible to whom little attention has been paid in the past and for whom few resources have been made available.

For example, it has been estimated that up to 80 percent of all prescribed psychoactive substances are used by women, and these are legitimately prescribed pharmaceutical drugs. In the State of Illinois the number of women admitted to drug abuse treatment programs for prescription drug abuse has increased tremendously and we must bear in mind that the majority of women affected by this problem are not going to be seeking admission to the kinds of drug abuse treatment programs that we operate.

Even though persons seeking treatment and rehabilitation for dependence on illegal narcotics often show an equally problematic involvement with prescription drugs; when you find someone who has entered into a treatment program for treatment of heroin addiction, you will find while that may be their primary drug problem, the majority of them are also using other prescription

drugs at the same time and once they are not using heroin, they continue to use those other prescription drugs.

More than half of the drug related deaths reported by the Cook County Medical Examiner involved prescription drugs. I do not think there is any doubt that the problem is a life-threatening one.

We at the Illinois Dangerous Drugs Commission have been in a unique position to initiate some successful efforts in this area. Not only are we the single State agency for drug abuse treatment and prevention but we are also the scheduling authority under the State Controlled Substances Act.

The membership of the commission is comprised of the heads of all other State agencies which impact in the area of drug abuse such as children and family services; public health, mental health, law enforcement, et cetera.

Our advisory council consists of 30 members from the State legislature; the professional societies, the law enforcement and criminal justice communities. I think the inclusion of the professional organizations, the State medical society and the State pharmaceutical association and other prescribing organizations is a key factor when talking about prescription drugs. Without the participation and involvement of the professional organizations it is very difficult to come to grips with the prescription drug problem.

As a result of our organizational structure it became obvious to us that in addition to traditional criminal prosecution approaches, we had a wide array of regulatory tools available to us to deal with the spectrum of the problem.

In Illinois we sponsored several pieces of legislation which had some immediate impact, two of which were to place talwin and preludin on schedule II in the State of Illinois.

We tightened the recordkeeping requirements of practitioners who dispense drugs in their own offices so they are now subject to the same scrutiny and dispensing requirements as a pharmacy is. We have prohibited the use of preprinted prescriptions for controlled substances, a marketing tool of pharmaceutical manufacturers which is no longer useable in the State of Illinois.

We have also expanded the statutory definitions of "addiction" to encompass the problem of dependency upon legitimate substances.

Our best available tool is the triplicate prescription system which exists in Illinois which enables the State to monitor the distribution of pharmaceuticals.

I do have a flow chart which will indicate the way the triplicate prescription system works.

Basically the Dangerous Drugs Commission designates a schedule II controlled substance by rule as requiring a triplicate prescription. In order to prescribe or dispense such a drug, the physician must use an official State prescription form, which are serially numbered on special paper. They are like a book of sales checks which the physician must order from the State department of registration and education, which then records the number of that particular physician's prescription form.

When he or she prescribes a schedule II designated product, the physician retains one copy; the pharmacist retains one and the third copy is filed with the State department of registration and education which enters the data into its computerized monitoring

system which can then analyze the prescribing patterns of individuals as well as general patterns regarding particular drugs.

The department can use the data as a base for initiating disciplinary proceedings as well as criminal proceedings against physicians or pharmacists and it provides us with vital information concerning drug use patterns throughout the State.

Even with the procedures and legislative changes that I have outlined, the Dangerous Drugs Commission realized that much more needed to be done in the area of prescription drug abuse. Consequently the Commission and its Advisory Council created the Prescription Drug Task Force which brought together approximately 60 individuals representing the public and private interests to analyze the current situation and make recommendations for the future.

The final report of the task force is appended to the testimony and I think you will find it is an interesting and challenging document.

As a result of our efforts we have learned the key to success in dealing with the prescription drug problem lies in two areas both of which are areas, that the Federal Government generally and DEA specifically can be helpful in.

One is recognizing that the problem can only be met with a comprehensive approach that involves using the regulation of controlled substances and the regulation of the practice of medically related professions as resources for drug abuse prevention.

The second is developing the necessary cooperation between traditional law enforcement agencies; treatment and rehabilitation agencies; regulatory bodies and professional organizations and societies.

The individual States are in great need of assistance from the Federal Government and from DEA in some more specific ways. The greatest one is for accurate and timely information. DEA has available to it both the DAWN system which monitors emergency room episodes and the ARCOS system which Mr. Joranson referred to.

The problems with using this data at the State level are that it comes to us much too late to be useful in clamping down on prescription mills before. An unscrupulous physician can flood the streets with hundreds of thousands of dosage units of controlled substances within a matter of a few weeks, and in the absence of timely distribution information, those dosage units are out there before anyone is aware of the fact that these prescription mills are in business.

The DAWN system does not cover all emergency rooms in any of the States and the ARCOS system does not cover all controlled substances. They are good systems as far as they go and to the extent they are timely, but there are some serious problems with the usefulness of the information.

While we have investigated the possibility of implementing similar programs on a State level basis we have found the costs are prohibitive.

Of equal importance is the need for DEA to take the lead in initiating cooperative efforts at the State and local level which it can only do if it allocates more resources to this area. DEA could

be of tremendous help in assisting States in developing and analyzing necessary data and suggesting ways in which it can be used effectively.

The Federal Government unfortunately is no model of cooperation in this area either. DEA, FDA, and the National Institute on Drug Abuse have yet to come together in any meaningful way so that their own resources may be effectively directed. One hopeful sign was the recent White House meeting convened with representatives of State and Federal agencies as well as representatives from the private sector. At that time an interagency conference on appropriate prescribing was suggested although we have not seen any progress in that area. We hope the White House Conference is an indication that we can look forward to a better focused effort in the future.

I would like to summarize by saying that if we accept as our goal the reduction of the harmful effects of drug abuse and dependency on our population, then we must necessarily be ready to accept the fact that prescription drugs are our most important concern and begin at once to utilize all the resources at our disposal in an organized and cohesive way.

Thank you very much.

[Testimony resumes on p. 215.]

[Mr. Kirkpatrick's prepared statement and attachment follow:]

TESTIMONY OF THOMAS B. KIRKPATRICK, JR.
EXECUTIVE DIRECTOR, ILLINOIS DANGEROUS DRUGS COMMISSION

Mr. Chairman and Members of the Committee:

I appreciate the opportunity to appear before you today on behalf of both the State of Illinois and the membership of the Association.

Those of us responsible for providing treatment and rehabilitation for persons and families whose lives have been disrupted by dependency on drugs, and for developing programs to prevent the further spread of drug dependency and addiction, have long been concerned that the traditional view of the extent of the drug abuse problem has been much too narrowly defined. Historically, our efforts have been directed at illegally produced and distributed narcotics which were available only through an underground black market system and which had no claims of respectability among the population. These targets of our early efforts were easily identifiable and were appropriately dealt with by a traditional law enforcement response. In the last few years, however, it has become quite obvious even to the public, who in the end are the victims, that the true dimensions of drug dependency and addiction are much greater and its scope more pervasive. The number of persons dependent on legitimate pharmaceutical drugs far exceeds the number addicted to the purely illegal substances. The cost to the individual and to society for this wide spread use of legitimate drugs is tremendous. That is not to say that heroin has ceased to be a problem. Quite the contrary, it is appearing today in our

cities in greater amounts and in higher concentrations than ever before. Nevertheless, those of us who have accepted the responsibility for dealing with the impact of drug abuse on our society have been working desperately to come to grips with the greater problem, and have been frustrated in our efforts by the sheer enormity of scale and the lack of any cohesive approach. We are only now just beginning to get accurate information about the population groups affected by the abuse of prescription drugs and have discovered groups particularly susceptible, to whom little attention has been paid in the past and for whom little resources have been made available. For example, it has been estimated that up to 80% of all prescribed psychoactive substances are used by women. In Illinois, the number of women admitted to drug abuse treatment programs for prescription drug abuse has increased by 186% for sedatives, 164% for tranquilizers and 148% for amphetamines. The number of emergency room drug episodes involving women has increased by 25%. Clearly, prescription drug abuse is an especially important health issue for today's women.

Even those persons seeking treatment and rehabilitation for dependency on illegal narcotics often show an equally problematic involvement with prescription drugs. Our toxicology laboratory conducts 50,000 urinalysis tests a month for persons receiving treatment in our programs, and of those persons who show evidence of drug taking, 41% of the time the drug detected is a prescription drug, not an illegal drug. Our street drug analysis centers which monitor the types and content of drugs available on the street report that 46% of street drug sales are of prescription drugs, and more than half of the drug related deaths reported by the Cook County Medical Examiner involved prescription drugs.

The Illinois Dangerous Drugs Commission has been in a unique position to initiate some successful efforts in this area. Not only is the Commission the single state agency for drug abuse treatment and prevention, but it is also the scheduling authority under the State Controlled Substances Act. Its membership is comprised of the heads of all other State agencies whose programs might interface with drug abuse problems, such as the Department of Children and Family Services, Department of Public Health, Department of Mental Health/Developmental Disabilities, Department of Law Enforcement, Department of Corrections, and Department of Rehabilitation Services. We have a 29 member Advisory Council which includes representatives of public and private organizations such as the State Medical Society, the pharmacists association, the nurses association and the hospital association, as well as eight legislative members. It became obvious to us that in addition to traditional criminal prosecution, a wide array of regulatory tools was available to us to deal with the whole spectrum of prescription drug abuse. We sponsored several pieces of legislation which had some immediate impact. We rescheduled Talwin and Preludin. We tightened the recordkeeping requirements of practitioners who dispense drugs in their own offices so that they would be subject to the same scrutiny as a dispensing pharmacy, and we prohibited the use of pre-printed prescriptions for controlled substances. We also expanded the statutory definitions of addiction to encompass the problem of dependency upon legitimate substances.

Our best available tool, however, is the triplicate prescription system which enables the State to monitor the distribution of pharmaceuticals. Simply stated, the system works as described below.

The Commission designates a controlled substance by rule as requiring the triplicate prescription. In order to prescribe or dispense such a drug, the physician must use the official state prescription forms which are serially numbered on special paper. The physician maintains one copy, the pharmacist retains one copy, and the third copy is filed with the State Department of Registration and Education, which enters the data into its computerized monitoring system which then can analyze the prescribing patterns of individuals as well as general patterns regarding particular drugs. That Department can use the data as a base for initiating disciplinary proceedings as well as criminal proceedings, and it provides us with vital information concerning drug use throughout the State. Even with these procedures and legislative changes the Commission realized that much more needed to be done. Consequently the Commission and its Advisory Council created the Prescription Drug Task Force, which brought together approximately sixty knowledgeable individuals representing the public and private interests, to analyze our current situation and make recommendations for the future. The final report of the Task Force is appended to this statement, and I think you will find that it is a thoughtful and challenging document.

We have learned that the key to success in dealing with the prescription drug problem lies in two areas:

- 1) Recognizing that the problem can only be met with a comprehensive approach that involves using the regulation of controlled substances and the regulation of the practice of medically related professions as resources for drug abuse prevention.

- 2) Developing the necessary cooperation between traditional law enforcement agencies, treatment and rehabilitation agencies, regulatory bodies and professional organizations and societies.

In Illinois, we have a head start in this area by virtue of our organizational structure and our long history of state-sponsored drug abuse prevention programs which date back to 1968. Many states are more fragmented, and there may not be a central focal point for bringing the divergent interests together and coordinating their efforts. All states, however, are in need of assistance from the Federal government, and specifically from the Drug Enforcement Administration (DEA), in several ways:

- 1) The greatest need is for accurate and timely information. DEA has available to it two systems which could be of great help in dealing with this problem: the DAWN system, which monitors emergency room episodes, and the ARCOS system, which monitors the purchase of certain controlled substances. The problems with using this data at the State level are that it comes to us much too late to be useful in clamping down on prescription mills before millions of dosage units have been put out on the street, and it is not complete insofar as the DAWN system does not cover all emergency rooms, but rather a statistical sample, and the ARCOS system does not cover all controlled substances. In addition, some reliability questions about the method of reporting under the DAWN system have often been raised. In Illinois, we have considered establishing our own statewide systems, but so far

have found the costs prohibitive. Additional nationwide data is available for purchase from private sources regarding the marketing of prescription drugs, but it too is beyond our financial means at the present time.

- 2) Of equal importance is the need for DEA to take the lead in initiating cooperative efforts at the state and local level, which it can only do if it allocates more resources to this area. DEA could be of tremendous help in assisting states in developing and analyzing the necessary data and suggesting ways in which it can be used effectively. The Federal government itself, however, is no model of cooperation in this area. The Drug Enforcement Administration, the Food and Drug Administration and the National Institute on Drug Abuse have yet to come together in any meaningful way so that their own resources may be effectively directed. One hopeful sign was the recent White House meeting convened with representatives of state and federal agencies as well as representatives from the private sector. I hope that this is an indication that we can look forward to a well-focused effort in the future.

I would like to summarize by saying that if we accept as our goal the reduction of the harmful effects of drug abuse and dependency on our population, then we must necessarily be ready to accept the fact that prescription drugs are our most important concern and begin at once to utilize all the resources at our disposal in an organized way.

Thank you for your attention and concern. I would be pleased to answer any questions you may have or provide any further information which might be helpful.

Illinois Prescription Drug Task Force
Final Report

The Illinois Dangerous Drugs Commission, at its regular quarterly meeting on January 8, 1980, adopted the following recommendations of the Prescription Drug Task Force, giving full consideration to the recommendations of the Dangerous Drugs Advisory Council and the Task Force Drafting Committee, and the additional comments of the Illinois State Medical Society and the Illinois Department of Registration and Education:

I. General Recommendations.

- A. The establishment of a permanent Standing Committee on Prescription Drug Abuse, to consist initially of the Executive Director of the Illinois Dangerous Drugs Commission, the Directors of the Departments of Law Enforcement, Public Aid, and Registration and Education, the Superintendent of the Division of Alcoholism of the Illinois Department of Mental Health and Developmental Disabilities and the Presidents of the Illinois State Medical Society and the Illinois Pharmaceutical Association. In addition, the Standing Committee will immediately contact the professional organizations of dentists, veterinarians and other prescribers in the State and invite their participation in the Committee's work. The Standing Committee shall meet on a monthly basis to address the issues referred to it by the Task Force, and bimonthly upon completion of its initial calendar of responsibilities. While each Committee member may appoint a designee to attend meetings for him/her, such appointees should be considered permanent Committee members, and should hold a policymaking position at such a level that the appointee may speak or vote for the member, insofar as is consistent with the internal policies of the respective agencies and organizations.
- B. Implementation of a statewide drug use monitoring system to provide accurate and timely data from throughout the State which is not otherwise available and which can aid in the detection and prevention of drug abuse.
- C. A study of the feasibility of a statewide Illinois ARCOS (Automated Reports of Consummated Orders System) in order to monitor prescription drug activity at the manufacturer/distribution level.

II. Recommendations for Administrative Action.

- A. The Dangerous Drugs Commission shall purchase, from a private legal publisher, a compendium of federal and state laws and regulations concerning dispensation, availability, and use of prescription drugs, which shall be maintained by Commission staff.

- B. The Directors of all relevant state agencies who are the recipients of key drug abuse data, especially the Departments of Public Aid, Public Health, Registration and Education, and Law Enforcement, shall enter into interagency agreements with the Dangerous Drugs Commission by February of 1980, in order to assure fulfillment of the data requirements as determined by the Task Force (see below).
- C. The investigation and prosecution of unlicensed practitioners shall be assigned a high priority within the Department of Registration and Education, the Attorney General's Office, and the appropriate local State's Attorney's Offices.

III. Recommendations Concerning Controlled Substances.

- A. The Standing Committee shall closely monitor the availability and use of specific prescription drugs, including, but not limited to, the following:
 - 1. Amphetamines
 - 2. Amyl Nitrite
 - 3. Dalmane (flurazepam HCl)
 - 4. Darvon (Propoxyphene)
 - 5. Dilaudid (hydromorphone HCl)
 - 6. Librium (chlordiazepoxide HCl)
 - 7. Ritalin (methylphenidate HCl)
 - 8. Sedative-Hypnotics
 - 9. Talwin (Pentazocine)
 - 10. Valium (diazepam)

With respect to amphetamines specifically, a continued monitoring of the Wisconsin experience and Federal action in this area should be considered valuable.

- B. Prescriptions for all Schedule II controlled substances shall be presented to a pharmacy for filling within three (3) days of the date of issuance, inclusive of the date of the prescription order.
- C. The Department of Registration and Education shall monitor the ordering of triplicate prescription blanks as a means of identifying questionable or over-prescribing.
- D. All prescriptions for Schedule II substances shall require both written and numerical notation of quantity on the face of the prescription.

IV. Recommendations for Administrative Action.

- A. The Medical Practice Act (IRS, Ch. III, Sec. 4401, et seq.) shall be amended as follows:

1. Section 4408, concerning labelling requirements for dispensation, should include a requirement for the inclusion of the name of the drug or medicine on the label, and a provision for an exception to this requirement where authorized by Department of Registration and Education regulation, which regulation would need to be drafted by the Department of Registration and Education to specify the circumstances under which an exception might be granted. This recommendation should apply to all other prescribers under other Professional Practices Act, and, if a similar labelling provision is included in the Controlled Substances Act, then an exception provision ought also to be included.
 2. The definition of the term "dangerous drugs" as contained in the Dangerous Drugs Abuse Act should be included within the Medical Practice Act and other Professional Practice Acts.
 3. Section 4435 concerning the Illinois State Medical Disciplinary Board should be reviewed by the Board and by the Department of Registration and Education to determine whether amendment is indicated with respect to qualifications of investigators (Subsection f), as well as to specify the type of training required for investigators. Training should also be reviewed by the Board to insure competency by means of on-the-job training in all investigations of professions where controlled substances violations may occur.
 4. Section 4471 concerning penalties for violations of certain sections of the Act should be amended to include violations of Section 4408 concerning labeling, and any such amendment should clearly include labeling violations with respect to any drug.
 5. The definition of "good faith" included in the Controlled Substances Act should be included in the Medical Practice Act with respect to the dispensing of drugs.
 6. The Department of Registration and Education should promulgate a regulation establishing minimum information requirements for a patient record.
- B. The Pharmacy Practice Act (IRS, Ch. III, Sec. 4001, et seq.) shall be amended to provide that the Department of Registration and Education promulgate a regulation under Section 4030, concerning the book or file of prescriptions, which would identify or establish mechanisms whereby individuals could report suspected illegal activities (i.e., unethical prescription writing) of physicians to the Departments of Registration and Education, and Law Enforcement, and that furthermore, this mechanism should be widely publicized in order to encourage reporting.

- C. The Illinois Criminal Code (IRS, Ch. 38, Sec. 1005-5-5(d)) should be amended to exclude the provision for restoration of professional license where the crime relates to the licensed practice or is an infamous crime, provided, however, that all Professional Practice Acts included in the exception are (a) standardized, and (b) contain restoration provisions.
- D. The Controlled Substances Act (IRS, Ch. 56½, Sec. 1507) should be amended to include a provision similar to that under the Medical Practice Act (IRS, Ch. III, Sec. 4447) stating that during the pendency of any and all judicial proceedings under the Administrative Review Act incident to disciplinary action, the sanctions imposed upon the accused by the Department of Registration and Education shall remain in full force and effect, thus eliminating the obtaining of a Stay by a licensee or registrant pending judicial review. This action was conditionally recommended by a 4-3 vote of the Professional Practices Committee of the Prescription Drug Task Force.

V. Recommendations Concerning Data and Information.

- A. The Dangerous Drugs Commission shall be charged with the accumulation and analysis of all possible sources of drug use pattern data, and with the responsibility for providing the Standing Committee with reports on both emerging drug problems and effectiveness measures of public policy (e.g., scheduling). Such reports should be produced twice a year by Commission staff, and sufficient staff support and resources must be made available to meet this requirement.
- B. All necessary efforts shall be made to secure ARCOS data from the Drug Enforcement Administration, as well as any other relevant data regarding the manufacture and distribution of prescription drugs within the state, on a timely and more frequent basis.

VI. Other Recommendations for the Standing Committee.

The Standing Committee shall establish a meeting schedule and begin consideration of the following additional issues as early as possible:

- A. The regulation of the practice of providing manufacturers' samples of controlled substances.
- B. The exploration of the feasibility of a requirement that prescribers of controlled substances obtain positive identification from patients for whom such controlled substances are prescribed or dispensed.
- C. The study and development of a provision to permit disclosure of

patient records for the purpose of determining compliance with applicable Professional Practice Acts and the Controlled Substances Act or any rules promulgated thereunder, as well as for purposes of conducting investigations and hearings in connection with licensure actions, while at the same time assuring maximum protection against unauthorized disclosure.

- D. The exploration of the feasibility of a time/dosage limitation for Schedule II substance prescriptions.
- E. The review of the propriety and feasibility of the Dangerous Drugs Commission acting as the responsible agency for furnishing notice of controlled substances scheduling changes to practitioners registered under the Controlled Substances Act, law enforcement associations, county sheriffs, prosecutors, and public defenders.
- F. The amendment of Section 4433 concerning the grounds for revocation of the license to practice as follows:
 - 1. Subsection 6 should be changed to read, "Habitual intemperance in the use of ardent spirits, narcotics or other dangerous drugs to such an extent as to incapacitate for performance of professional duties;"
 - 2. Subsection 19 should be changed to read, "Administering, dispensing or prescribing narcotics or any other controlled substances in any way other than for therapeutic purposes." To the extent that new terminology requires definition under the Medical Practice Act, the definitions contained in the Controlled Substances Act should be included or cross-referenced under the Medical Practice Act.
 - 3. A new ground for revocation should be added to Section 4433 immediately following Subsection 24, which should be numbered Subsection 25, and should read, "Refusal to furnish or allow inspection of records required to be maintained." Existing Subsections 25, 26, 27 and 28 should be re-numbered.
 - 4. Existing Subsection 27 (new Subsection 28) should be changed to read, "Professional incompetence as manifested by substantiated charges of poor standards of care upheld by the Illinois State Medical Disciplinary Board, or mental incompetence as declared by a court of competent jurisdiction." (In the event that this Subsection is so amended, DRE regulations will require change reflecting regulations formulated by the Medical Disciplinary Board concerning standards of care with respect to the dispensing of drugs.)

- G. The review of Sections 4459 through 4470 inclusive of the Medical Practice Act with respect to consistency and propriety of penalties imposed for violations of the Act; furthermore, any disparity in penalty between the Medical Practice Act and the Pharmacy Practice Act or other related Acts which lacks a sound basis or other justification should be rectified. Additionally, there should be a section on disciplinary action, dispensing, labeling requirements, and penalties imposed for non-compliance in other Professional Practice Act.
- H. An examination of the possible expansion of Section 4403 of the Medical Practice Act requiring a license as a prerequisite to practice to apply to corporations registered under the Medical Corporation Act by requiring all shareholders, officers, and directors of such corporations to be licensed physicians. The definition of the term "person" under the Medical Practice Act may be amended to include "shareholders, directors or officers of medical corporations incorporated under the Medical Corporation Act".
- I. An examination of the issue of revocation of a practitioner's license to practice or to prescribe upon conviction of a drug-related misdemeanor.
- J. An exploration of the feasibility of notification of Controlled Substances Act registrants of information received concerning problems with a particular controlled substance; solicitation on a voluntary basis of the aid of the respective professional associations in disseminating this information (feasibility exploration to include financial costs).
- K. A review with the Illinois State Medical Society of the possibility of an informational and "peer pressure" program, similar to Utah's PSRO project, which includes a review of prescribing practices as reflected in Department of Public Aid payment records.
- L. A review of medical school and allied professional curricula and CEU programs with a view toward increasing and improving attention to substance abuse and dependency.
- M. An investigation by the Department of Registration and Education of the possibility of limiting eligibility to order triplicate prescription forms as a regulatory tool to deal with questionable or over-prescribing.

APPENDIX

The Prescription Drug Task Force Membership

Illinois Dangerous Drugs Commission

Chairman: Robert A. deVito, M.D. - Director, Illinois Department of Mental Health and Developmental Disabilities

Gregory L. Coler - Director, Illinois Department of Children and Family Services

. James Gottreich - Chief, Investigations

Joseph M. Cronin, Ed.D. - Superintendent, Illinois State Board of Education

. Thomas M. Janeway - Educational Consultant, Program Planning and Development

Gayle Franzen - Director, Illinois Department of Corrections

. Philip G. Shayne - Labor Relations Administrator

James S. Jeffers - Director, Department of Rehabilitative Services

. Cleo Anderson - Interagency Coordinator

William L. Kempiners - Acting Director, Illinois Department of Public Health

. Gary Swinger, DVM

Jeffrey C. Miller - Acting Director, Illinois Department of Public Aid

. Jane M. Snowden - Special Assistant to the Director

. Jay Wavering

Robin Morgenstern, PA-C, MHA - Public Member

Honorable R. Eugene Pincham - Judge of the Circuit Court of Cook County and Public Member

Joseph H. Skom, M.D. - Public Member

Daniel Webb - Director, Illinois Department of Law Enforcement

. Richard S. Kozak - Statewide Metropolitan Enforcement Group Coordinator

. Ben Haynes - Special Agent

. Robert Cutright - Special Agent

Illinois Dangerous Drugs Advisory Council

Chairman: Honorable L. Michael Getty - Illinois State Representative

Roalda J. Alderman - Superintendent, Division of Alcoholism, Illinois Department of Mental Health and Developmental Disabilities

. Michael Rainey - Special Assistant to the Assistant Director for Alcoholism

APPENDIX - Continued

- Joan Anderson - Director, Illinois Department of Registration and Education
- . Billie J. Paige - Coordinator of Program Development
 - . Larry Slotnik - Pharmacy Coordinator
 - . Veva Meyer - Coordinator of Operations
 - . Charles McHugh, M.D. - Medical Coordinator
- David B. Bingaman - Public Member
- David Blumenfeld, Esq. - Public Member
- Emanuel M. Cannonito, Esq. - Public Member
- Bernard Carey, Esq. - Cook County State's Attorney
- . Edward Hansen - Assistant State's Attorney
- Honorable John D'Arco - Illinois State Senator
- Honorable John A. Davidson - Illinois State Senator
- Joseph diLeonardi - Acting Superintendent, Chicago Police Department
- . Philip Cline, Sgt. - Narcotics Division
- Edward E. Duffy, R.Ph. - President, Illinois Pharmacists Association
- . Alan Granat - Executive Director, Illinois Pharmacists Association
 - . Leonard Sherman - Director of Governmental Affairs, Illinois Pharmacists Association
- Joan Elbow, R.N. - Illinois Nurses Association
- Norman Garfinkel, R.Ph. - Public Member
- Charles A. Gruber - Chief, City of Quincy Police Department
- Honorable George Hudson - Illinois State Representative
- Honorable Benjamin S. Mackoff - Judge of the Circuit Court of Cook County
- Michael M. Mihm, Esq. - Peoria County State's Attorney
- Hugo Muriel, M.D. - Commissioner of Health, City of Chicago
- . LeRoy Levitt, M.D. - President, Chicago Board of Health
- Honorable Dawn Clark Netsch - Illinois State Senator
- Roger Quick - Illinois Hospital Association
- Donald Paul, Esq., Ph.D. - Assistant Cook County Public Defender
- John Seward, M.D. - President, Illinois State Medical Society
- . Richard Ott - Director, Publications Division, ISMS
 - . Edward Senay, M.D.

APPENDIX - Continued

Harry Sholl - President, Gateway Houses Foundation
 . Michael Darcy - Executive Director, Gateway Houses Foundation

Donna Simonson - Executive Director, Illinois Commission on Children

Honorable Roger C. Stanley - Illinois State Representative

Jay Ulaneck - Executive Director, Illinois State Dental Society

Robert B. Uretz, Ph.D. - Dean of the University of Chicago Pritzker
 School of Medicine

Honorable LeRoy Van Dyne - Illinois State Representative

Task Force Members Not Affiliated with Commission or Advisory Council

Walter Dorus, M.D. - University of Chicago

Eldoris Mason - Executive Director, B.R.A.S.S. Foundation

Ann Uhler - Human Service Center, Peoria

Jerry Weiss, R.Ph.

Mr. WAXMAN. Thank you for your testimony.

Mr. Brinkley, I note that the Texas State Board of Pharmacy publishes the names of pharmacists, who have been convicted of diversion activities, in its newsletters. Why is this done?

Mr. BRINKLEY. We feel it is public information and it is our responsibility to the public to let them know the board is fulfilling its statutory responsibility to the citizens of Texas. We feel it is a significant deterrent to those individuals that may be on the borderline of doing something illegal to know if they are administratively adjudicated by the board in any type of action, diversion or otherwise, that their names will appear in our newsletter.

You find professionals are very sensitive to this issue. Many of these people have very good standing in their communities and they are well respected people in the community and they really lead a dual life, a dual life that on the one hand they may be religiously involved with their particular churches; they may be community leaders. Many times people in the community are not even aware of this type of activity.

We feel it is our responsibility to print those names. I might say just recently the Board of Medical Examiners in the State of Texas has also begun to do the same thing.

Mr. WAXMAN. Do you have any thoughts on the effectiveness of diversion investigative units? Are DIU's as the most effective way for the Federal Government to assist statewide retail diversion control activities?

Mr. BRINKLEY. I believe they are helpful. In some States they brought together the necessary forces to be able to coordinate the efforts of diversion prevention. I think the program is it is a miniscule effort on the part of the Federal Government. In terms of dollars it just did not amount to much. We now operate a same type unit without any Federal assistance. I think it is a good first step especially in those States that do not have active programs.

In our case we know what to do but we just do not have the resources to do it.

Mr. WAXMAN. Mr. Joranson, do you believe it would be helpful to extend ARCOS reporting to other than schedule II drugs?

Mr. JORANSON. Your question points out the fact that there are many drugs that are subject to very high levels of abuse that are not in the ARCOS system. I think that it is very important to recognize that limitation of that system.

If the Controlled Substances Act were sufficiently flexible to apply certain kinds of temporary or selective reporting such as ARCOS on selected products in order to be able to better understand distribution patterns and patterns of abuse, I think that would be worth considering.

I think in addition to that it is possible to conduct specialized audits in those areas that have been determined to have a high level of abuse of a particular product, let's say Darvon or Valium, and then determine what the actual prescribing practices are and compare that to what is acceptable medical practice and then proceed to solve a few problems.

Some drugs might be better shifted into schedule II which then would have ARCOS applied. Other drugs you might want to put in ARCOS in order to gather the information. There are still other ways that can be used to assess abuse patterns.

Mr. WAXMAN. Ms. Larsen, have you made DEA aware of your concerns over the timeliness of receiving ARCOS data and has your triplicate prescription policy replaced the need for ARCOS?

Ms. LARSEN. The answer to your first question is we have made DEA aware of the problems with timeliness. If I might jump in on your question to Mr. Joranson, I think before ARCOS could be extended it should be brought up to a more timely mechanism and then after that perhaps take it beyond schedule II.

In answer to your second question, the triplicate prescription information is a separate tool that is used to locate and identify unscrupulous prescribers and so forth.

Mr. WAXMAN. Do you believe the priorities of DEA should be modified? Should increased Federal resources be placed on retail diversion control activities?

Ms. LARSEN. I think the time has come if not to totally shift the emphasis, to certainly recognize that prescription drugs and legitimately manufactured pharmaceuticals are an equal threat in terms of drug abuse treatment and social cost.

Mr. WAXMAN. Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

I want to commend the panelists for the reports. I think you have a very effective program as shown by your charts and it seems also that both of the other States represented have done quite well.

The testimony was excellent. Texas has participated in the diversion investigative unit program. Could you describe the activities of this program in Texas?

Mr. BRINKLEY. Yes, sir. Most of the cases I mentioned to you as examples and some of the cases in my testimony are representative cases that were a result of that effort, of a DIU being initially established. It since has not been recognized as a formal unit but I believe we are getting better cooperation now between the Department of Public Safety which is responsible for the primary enforcement of the Controlled Substances Act and the Board of Pharmacy who has the responsibility for the practitioner licensing.

I think it is an excellent approach. Depending on the State the program should be tailor made but I think an approach such as this is absolutely necessary. In the case of Texas it was the initiation of that unit really that was responsible for where we are today in terms of our activities.

Mr. CARTER. Do you think you should receive further Federal support?

Mr. BRINKLEY. I think it is something the Federal Government has to consider. It is not mentioned in my testimony. I do think since retail diversion is a problem that cuts across all States; the Federal Government should decide whether or not this area is going to be a priority. If so I would think the most effective approach would be to provide assistance to States much in the same manner as the Federal Government provided to the single State agencies for drug abuse prevention in the 1960's and presently.

That effort I believe was successful. It recognized that drug abuse was a national problem but the solutions to the problem would be most effective if dealt with at the State level. I would think looking at that effort and applying some of the principles of that effort to the enforcement effort might be something you might want to look at.

Mr. CARTER. Has Texas participated in DEA's operation script?

Mr. BRINKLEY. Yes, sir. We are presently involved with it right at this moment. For instance approximately 2 days ago a number of physicians and pharmacists were subpoenaed before a grand jury in San Antonio.

Additionally in another major city we are involved with what may be the largest case of diversion ever uncovered in the United States. The Board of Pharmacy and the Board of Medical Examiners and the Department of Public Safety and DEA are all working very closely together in that operation.

Mr. CARTER. Mr. Joranson, Wisconsin has not participated in the DIU program yet it has had a great deal of success controlling certain substances. How can we best encourage other States to follow your example?

Mr. JORANSON. First of all, Dr. Carter, the reason Wisconsin is not currently participating in a DIU project is because there has been some concern about whether we want to become involved in what tends to be totally an enforcement approach in DIU's.

We want to stress the important nature of the education and regulatory aspects. That is simply our perspective. We may reap-

proach DEA with an idea for participating in an DIU, particularly if it can be modified somewhat to fit our needs.

As far as our own example I think the thing we could best share with others is the acquisition of information and the utilization of that in an interagency approach to help define the problem and decide which problem solving devices are best suited to solve the problems that are uncovered.

Mr. CARTER. Thank you. Ms. Larsen, the scheduling decisions made by the Illinois Dangerous Drugs Commission, do they differ in any way from present Federal scheduling decisions?

Ms. LARSEN. In some cases, yes. An example is Talwin and Preludin are schedule II in Illinois and are either III or IV federally.

Mr. CARTER. Does Illinois receive Federal funding for its diversion investigation unit program?

Ms. LARSEN. I really cannot answer that because the diversion investigation unit is run by the State Department of Law Enforcement and not under the Dangerous Drugs Commission.

Mr. CARTER. Is Mitchell Ware still in any of your drug control programs?

Ms. LARSEN. No, sir, not any longer.

Mr. CARTER. He was a member of the President's Commission on Marihuana and Drug Abuse.

Thank you.

Mr. WAXMAN. Thank you, Dr. Carter. Mr. Dannemeyer?

Mr. DANNEMEYER. I have no questions, Mr. Chairman.

Mr. WAXMAN. Let me thank each member of this panel. Your testimony has been very helpful. We may come back to you for additional information and recommendations. We appreciate your being here with us today.

Our final witnesses represent the General Accounting Office which recently completed a report and major review of Federal drug enforcement activities entitled "Gains Made in Controlling Illegal Drugs—Yet the Drug Trade Flourishes."

It is an excellent report and one which provides useful guidance in plotting the future directions of Federal drug enforcement policy.

I would like to welcome Daniel F. Stanton, Deputy Director of the General Government Division of GAO; Patrick Gormley a management analyst with the Los Angeles Regional Office and Thomas R. Colan, Group Director with the General Government Division.

Your prepared statement will be inserted into the record. Please proceed as you desire.

STATEMENT OF DANIEL F. STANTON, DEPUTY DIRECTOR, GENERAL GOVERNMENT DIVISION, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY THOMAS R. COLAN, GROUP DIRECTOR; AND PATRICK F. GORMLEY, MANAGEMENT ANALYST, LOS ANGELES REGIONAL OFFICE

Mr. STANTON. Our testimony today deals with actions we believe are needed to enable our Nation to make greater inroads in controlling illegal drugs.

As you requested our comments are based on our October 1979 report "Gains Made in Controlling Illegal Drugs, Yet the Drug

Trade Flourishes" and our March 1978 report "Retail Diversion of Legal Drugs—A Major Problem with No Easy Solution."

Our reviews showed that gains made to reduce the adverse impact of illegal drugs are fragile requiring constant vigilance as source countries move quickly to fill temporary drug shortages; trafficking patterns shift, and the types of drugs consumed readily change.

For example the heroin shortage created by the breaking of the French Connection was temporary. Mexico emerged as the next principal supplier of heroin to the United States.

In addition, the use of dangerous drugs is on the increase as heroin users find it difficult to obtain heroin. This is demonstrated by increased burglaries of pharmacies and overdosing as a result of using these drugs.

Federal efforts to reduce drug trafficking by immobilizing major violators have fallen short of expectations. Incarcerating major traffickers for long periods and seizing their financial resources, the key elements to success, have not been accomplished to a sufficient extent.

The use of financial evidence has received much attention recently as an important conspiracy investigation tool.

We believe that DEA must improve its capabilities in this area to successfully immobilize major trafficking organizations. Therefore we recommended that the DEA Administrator improve his investigative capability against drug traffickers' financial resources by training DEA agents and hiring financial specialists to assist in the investigations.

The Department of Justice agreed that financial specialists are needed and is considering several alternatives but told us these alternatives were too premature to enumerate at this time.

The Federal strategy places reliance on State and local drug enforcement efforts in order to focus Federal activities against leaders of national and international trafficking networks. Although the Federal Government has developed numerous programs to assist and cooperate with State and local agencies the enormous number of jurisdictions coupled with financial problems makes it virtually impossible to mount a unified attack.

Financial resources have not kept pace with drug enforcement needs and the effectiveness of agencies' activities has been hampered by security risks, differing priorities and lack of communication.

In the face of these difficulties we said that the Attorney General should establish a clear realistic policy on what can reasonably be expected from State and local governments and what the Federal Government should do to elicit their support. This policy should include a determination of DEA's role in cooperating with and assisting State and local drug enforcement efforts.

The response of the various levels of government to businesses and individuals promoting the use of drugs through the sale of drug oriented paraphernalia and magazines must also be addressed. In this regard the Justice Department has developed a model law that interested States and localities could use to ban the manufacture, advertisement or sale of a wide range of drug paraphernalia.

International efforts have made some inroads in the long and continuous attempt to limit the availability of illicit drugs. Crop substitution, opium poppy and marihuana eradication, and improved law enforcement have yielded temporary results. When viewed from the perspective of the worldwide dimensions of the drug trade they have not substantially reduced cultivation and trafficking.

To achieve the goals of international narcotics control will require massive expenditures and considerable time. To date most developed countries of the world have been unwilling to fund such ventures as eradication and crop substitution. A continuing enforcement presence is essential to assure that long-range approaches to supply reduction take hold.

Although the abuse of heroin, cocaine, and other illegal drugs has been well documented the use of legal drugs such as barbiturates, tranquilizers, and amphetamines for nonmedical purposes is equally as serious.

Recent DEA data shows that about 20,000 drug products are scheduled under the Controlled Substances Act and over 20 billion dosage units float through the distribution chain to the retail level each year. Its estimates indicate that between 250 and 300 million dosage units of controlled substances were diverted at the retail level in 1978 or about 1 out of every 100 dosage units.

Limited authority and resources, weak regulatory requirements, and the large number of retail outlets restrict DEA's efforts to control retail diversion at the dispensing and practitioner level.

DEA is trying to assess and upgrade State capabilities to evaluate practitioners. Although the largest assistance effort, diversion investigation units composed of Federal agents and State investigators has had some success, most of DEA's other activities have had little effect so far.

In our 1978 report we recommended the Congress strengthen enforcement efforts against the growing diversion of legal drugs by authorizing DEA to either exercise direct regulatory authority over the retail level practitioners or implement grant programs for assisting States in controlling diversion. We continue to support this recommendation.

DEA recently said it was working on a revision of the Controlled Substances Act that would increase its ability to provide necessary resources for State efforts against retail diversion and its authority to act directly against the retail violations when State efforts fail.

Mr. Chairman, this concludes my statement. We would be happy to respond to any questions.

[Testimony resumes on p. 231.]

[Mr. Stanton's prepared statement follows:]

UNITED STATES GENERAL ACCOUNTING OFFICE
Washington, D. C. 20548

FOR RELEASE ON DELIVERY
Monday, March 10, 1980
Expected at 9:30 a.m.

STATEMENT OF
DANIEL F. STANTON, DEPUTY DIRECTOR
OF THE GENERAL GOVERNMENT DIVISION
U. S. GENERAL ACCOUNTING OFFICE
BEFORE THE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE
ON
FEDERAL DRUG ENFORCEMENT AND SUPPLY CONTROL EFFORTS

Mr. Chairman and Members of the Subcommittee:

Our testimony today deals with actions we believe are needed to enable our Nation to make greater inroads in controlling illegal drugs. As you requested, our comments are based on our October 1979 report "Gains Made in Controlling Illegal Drugs, Yet the Drug Trade Flourishes" (GGD-80-4) and our March 1978 report "Retail Diversion of Legal Drugs--A Major Problem with No Easy Solution" (GGD-78-22).

Our reviews showed that gains made to reduce the adverse impact of illegal drugs are fragile, requiring constant vigilance, as

--source countries move quickly to fill temporary drug shortages,

--trafficking patterns shift, and

--the types of drugs consumed readily change.

For example, the heroin shortage created by the breaking of the French Connection was temporary. Mexico emerged as the next principal supplier of heroin to the United States. Today there is evidence that as Mexican heroin availability declines, heroin from Southeast Asia and the Middle East is reaching the United States via Europe. In addition, use of dangerous drugs is on the increase as heroin users find it difficult to obtain heroin. This is demonstrated by increased burglaries of pharmacies and overdosing as a result of using these drugs.

The diversion of legal drugs is a major problem. To illustrate, Drug Enforcement Administration (DEA) data shows a clear relationship between deaths and injuries and the use of licit controlled substances. DEA information indicates that of the 13 most highly abused drugs, 9 were controlled substances. Of the nine, six have a legitimate medical use and are prescribed and dispensed at the retail level.

CONSUMER DEMAND FOR ILLEGAL DRUGS HAS NOT ABATED

The huge supply of and demand for drugs has created a multi-billion dollar worldwide business involving millions of

Americans. The National Institute on Drug Abuse has estimated that there are:

--2.3 million people who have used heroin, with 380,000 daily users.

--13 million people who have abused the use of stimulants such as amphetamines.

--6.9 million people who have used PCP at least once.

--10 million people who have used cocaine.

--43 million people who have tried marijuana at least once and its use has been rising steadily in the past decade.

The enormous profits of drug trafficking attract an ample number of entrepreneurs who see opportunities that far outweigh those offered by legitimate businesses. Payments by users and traffickers for heroin, cocaine, marijuana, hashish and dangerous drugs in the United States are estimated to be on the order of \$45 billion to \$63 billion annually, according to the National Narcotics Intelligence Consumers' Committee. Drug trafficking in the United States today appeals to people from all walks of life, including doctors, lawyers, accountants, businessmen, and entertainers.

DEA SUPPLY REDUCTION EFFORTS NEED IMPROVEMENT

All branches of the Government--executive, legislative, and judicial--need to take actions to strengthen our Nation's

supply reduction efforts. While DEA alone cannot be expected to make the inroads necessary to reduce the availability of illicit drugs, there are measures DEA can take to enhance its contributions to the Nation's efforts.

DEA needs to improve investigative capability
against drug trafficker's financial resources

Federal efforts to reduce drug trafficking by immobilizing major violators have fallen short of expectations. Incarcerating major traffickers for long periods and seizing their financial resources, the key elements to success, have not been accomplished to a sufficient extent. Even in those cases where high-level traffickers are arrested and given stiff prison sentences, their organizations often continue to operate and maintain their distribution capacity because the assets and financial resources of the organizations remain untouched.

The use of financial evidence has received much attention recently as an important conspiracy investigation tool. However, we found that even though DEA had increased its emphasis on conspiracy and financial investigations, it had not attained proficiency in these areas. Many DEA agents simply had not been trained in the latest financial conspiracy techniques.

We believe that DEA must improve its capabilities in this area to successfully immobilize major trafficking organizations. Therefore, we recommended that the DEA Administrator improve investigative capability against drug trafficker's financial resources by training DEA agents and hiring financial specialists to assist in investigations.

In its response to our report, the Department of Justice indicated that DEA will not realize any growth in its overall position strength through fiscal year 1981. Thus, the Department said that DEA would not be able to increase its staff with a significant number of financial specialists to assist in investigations. The Department agrees that financial specialists are needed and is considering several alternatives, but said they were too premature to enumerate.

Firm and clear policy required for Federal,
State, and local drug law enforcement roles

The Federal strategy places reliance on State and local drug enforcement efforts in order to focus Federal activities against leaders of national and international trafficking networks. Although the Federal Government has developed numerous programs to assist and cooperate with State and local agencies, the enormous number of jurisdictions, coupled with financial problems, makes it virtually impossible to mount a unified attack. Financial resources have not kept pace with drug enforcement needs, and the effectiveness of agencies' activities has been hampered by security risks, differing priorities, and lack of communication.

In the face of these difficulties, we said that the Attorney General should establish a clear, realistic policy on what can reasonably be expected from State and local governments and what the Federal Government should do to elicit their

support. This policy should include a determination of DEA's role in cooperating with and assisting State and local drug enforcement efforts. Such a role should provide for such things as training, exchanging intelligence, and furnishing technical equipment, but should discourage Federal involvement in actions against low-level violators. The policy should take into consideration the adverse effects of financial and political realities that have hindered cooperation among agencies.

The response of the various levels of government to businesses and individuals promoting the use of drugs through the sale of drug-oriented paraphernalia and magazines must also be addressed. In this regard, the Justice Department has developed a model law that interested States and localities could use to ban the manufacture, advertisement, or sale of a wide range of drug paraphernalia.

INTERNATIONAL NARCOTICS CONTROL:
SOME PROGRESS BUT TASK IS FORMIDABLE

International efforts have made some inroads in the long and continuous attempt to limit the availability of illicit drugs. Crop substitution, opium poppy and marijuana eradication, and improved law enforcement have yielded temporary results. But, when viewed from the perspective of the worldwide dimensions of the drug trade, they have not substantially reduced cultivation and trafficking.

The United States has been the prime force combatting the illegal drug trade. Because of other countries' priorities and attitudes and the realisms in drug-producing countries, international narcotics control has received only nominal support from international financial institutions and other developed countries in comparison to what is needed.

While international cooperation cannot be fully realized under these circumstances, efforts to obtain greater support must be continual and stressed at the highest levels of government and in international forum. To accomplish more, victim countries must reassess their priorities, develop a unified action plan, and support the plan with the needed resources.

Though drug enforcement and control programs have not overcome the longstanding social, political, and economic conditions in producing countries, they nevertheless have yielded temporary results. These efforts have produced short-term heroin shortages in the United States and helped to motivate foreign agencies in carrying out their drug enforcement missions. For example, the opium poppy and marijuana eradication program in Mexico has significantly reduced the Mexican-produced heroin and marijuana available in the United States. Regardless of the degree of success achieved, these successes are likely to be temporary in nature unless actions are taken to provide growers with an alternative source of income.

To achieve the goals of international narcotics control will require massive expenditures and considerable time. To date, most developed countries of the world have been unwilling to fund such ventures as eradication and crop substitution. A continuing enforcement presence is essential to assure that long-range approaches to supply reduction take hold.

DIVERSION OF LEGAL DRUGS: A FLOURISHING
ACTIVITY WITH LITTLE ENFORCEMENT ATTENTION

Although the abuse of heroin, cocaine, and other illegal drugs has been well-documented, the use of legal drugs, such as barbiturates, tranquilizers, and amphetamines, for non-medical purposes is equally as serious. Diversion of legal drugs, especially at the retail level, has been flourishing for years, yet it has received little attention compared with the efforts spent against drugs like heroin and cocaine.

Recent DEA data shows that about 20,000 drug products are scheduled under the Controlled Substances Act, and over 20 billion dosage units flow through the distribution chain to the retail level each year. Its estimates indicate that between 250 and 300 million dosage units of controlled substances were diverted at the retail level in 1978, or about one out of every 100 dosage units.

Also, DEA estimates that about 80 to 90 percent of domestic diversion occurs at the retail level. The most common methods of retail diversion include pharmacy thefts,

indiscriminate prescribing, forged prescriptions, and the illicit sale of legal drugs by registrants. Individuals who obtain prescriptions and controlled substances by feigning a medical need, or who obtain multiple prescriptions from different physicians, are also responsible for this diversion.

Limited authority and resources, weak regulatory requirements, and the large number of retail outlets restrict DEA's efforts to control retail diversion at the dispensing and practitioner level. The responsibility to control drugs at retail level has been relegated largely to the States, which generally do not have the capability to provide aggressive anti-diversion programs.

Under the Controlled Substances Act, DEA has extensive authority to register and regulate drug manufacturers and distributors. The situation is different, however, at the retail level. Doctors, pharmacists, and other practitioners are generally registered if they are authorized to dispense and prescribe controlled substances by the State in which they are licensed to practice. As with registrations, DEA lacks authority to impose physical security requirements on practitioners.

Limited resources also preclude DEA from pursuing an extensive regulatory program at the retail level. DEA told us that it had greatly reduced diversion at the manufacturing and distribution level, and that redirecting its present resources toward the retail level could compromise these successes.

Most States are incapable of dealing with the retail diversion problem because of inadequate legislation, ineffective organization, and inadequate resources. One study found that State licensing boards, which are primarily responsible for enforcing drug compliance by practitioners, see their primary role as determining fitness to practice and view their responsibilities over controlled substances as only part of their role.

DEA is trying to assess and upgrade State capabilities to evaluate practitioners. Although the largest assistance effort--diversion investigation units composed of Federal agents and State investigators--has had some success, most of DEA's other activities have had little effect so far. DEA stated that its efforts have not had a major impact on retail diversion.

In our 1978 report, we recommended that the Congress strengthen enforcement efforts against the growing diversion of legal drugs by authorizing DEA to either exercise direct regulatory authority over retail-level practitioners or implement grant programs for assisting States in controlling diversion. We continue to support this recommendation.

DEA recently said that it was working on a revision of the Controlled Substances Act that would increase its ability to provide necessary resources for State efforts against retail diversion and its authority to act directly against the retail violations when State efforts fail.

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Mr. Chairman, this concludes my prepared statement. We would be pleased to respond to any questions.

Mr. WAXMAN. I want to thank you for your testimony and commend you and others in GAO for the work you have done and the report you have furnished to us.

Let me ask you under what circumstances can DEA decline to register practitioners to dispense controlled substances and how does this differ from the authority to regulate manufacturing and distribution?

Mr. GORMLEY. We found in our 1978 report that the practitioners are entitled to be registered under the act. They have very stringent requirements as to what would be required before a registrant could be denied. They would have to prove that he falsified the application. They would have to show that the States and local community had taken action where he had violated his ability to prescribe or to fill drugs such as at the pharmaceutical level or at the physician level.

These are very difficult things to prove. In addition most of the States at the time we did our work had not done the types of evidence gathering required for DEA to deny registration. The practical reality was most if not all of the people that were asking to be registered are registered.

Mr. WAXMAN. In your testimony you point out that States are incapable of dealing with retail diversion. Is there any evidence to suggest this situation may improve in the near future?

Mr. STANTON. Yes, sir, there has been improvements over the last couple of years. We feel there will have to be some Federal assistance to have a great improvement. This is why we recommended either a grant program or for DEA to have the authority to regulate.

Mr. WAXMAN. Do you think Congress should take some action in this area such as authorizing DEA to exercise direct regulatory authority over retail level practitioners or develop a demonstration grant project for assistance to States?

Mr. STANTON. Yes. We gave that as an alternative in our report. We fully recognize the problems with the Federal Government getting involved at the State level and the medical practice and certainly DEA does not want that part of it.

Mr. WAXMAN. You think the focus ought to be on the State level?

Mr. STANTON. Yes, sir, with Federal assistance possibly through a grant program.

I think the other alternative is for DEA to have the authority to regulate.

Mr. GORMLEY. I believe this is in agreement with the law enforcement dimension of the problem. It is impossible in most ways for the Federal Government really to replace the initiative and the capability of the State and local law enforcement community in dealing with the problems that are community oriented within the State. The same thing I think is true for retail diversion. There is just simply too many pushers of drugs be they legal prescriptions or the trafficker on the street.

There are too many for the Federal Government to handle. This is something that the States and locals who understand their communities much better than someone at the Federal level could

understand and could deal with. They differ from community to community.

In our work we have always felt the Federal Government can help and lead the way and bring together the experiences of the individual States in dealing with these problems but really the burden lies with the Controlled Substances Act and it places it at the State and local level.

Mr. WAXMAN. Thank you, Dr. Carter?

Mr. CARTER. I believe it was stated that drug traffic involved up to \$45 billion. Is that correct?

Mr. STANTON. That much or even more. I would say it would range from \$45 to \$63 billion.

Mr. CARTER. How much of that is so-called licit drugs?

Mr. STANTON. Dangerous drugs would be approximately \$10 to \$15 billion.

Mr. CARTER. Of the \$45 billion?

Mr. STANTON. Yes, of the \$45 billion.

Mr. CARTER. That is quite an amount.

Mr. STANTON. It is estimated that about 1 percent of the dangerous drugs amount is the value of licit drugs believed to be diverted into the illegal market.

Mr. CARTER. Could you describe the major ways you found 250 to 300 million dosage units of controlled substances subject to diversion at the retail level in 1978? How was this accomplished?

Mr. STANTON. These are figures by NIDA. We have accepted their estimates.

Mr. CARTER. DEA established Operation Script in 1979 to address the diversion problem. Did you study the results of this program?

Mr. STANTON. No, sir. That was started after we had completed our work. We do have another review we plan to start right away to follow up on our 1978 report. We will be looking at that program as well as the more recent developments.

Mr. CARTER. You recommend that in addition to DIU's which will adequately train State groups that they have financial experts. Is that correct?

Mr. STANTON. Yes, sir. We are primarily talking about the illegal drugs where you have the big organizations smuggling it into the country and selling it, the conspiracy type cases.

Mr. CARTER. I agree that is necessary. I have gone over your report and I think it is very good. I commend you. You have done a good job.

Mr. STANTON. Thank you, sir.

Mr. DANNEMEYER. I have no questions, Mr. Chairman.

Mr. CARTER. I will leave the committee to Mr. Dannemeyer since I have an appointment.

Mr. DANNEMEYER [presiding]. I think that concludes our testimony today. It is kind of you to leave me in that posture since the end has come.

Mr. CARTER. No, sir, not until after your questions.

Mr. DANNEMEYER. On page 4 you make mention that long periods of incarceration and seizing of financial resources have not been accomplished to a sufficient extent. What do you think the Federal Government should do in order to modify the law if neces-

sary to increase the success in the area of capturing financial resources?

Mr. STANTON. We believe DEA can improve its capabilities in the area of conspiracy cases by bringing in financial experts, specialists who could go over the records and build up the conspiracy cases. They can call on the FBI experts in this area for assistance.

Mr. DANNEMEYER. Are you talking about civil cases or criminal cases?

Mr. STANTON. Criminal cases. It would get into the financial resources which Mr. Bensinger testified to earlier.

Mr. DANNEMEYER. What would you think of the concept of creating a civil cause of action on behalf of victims of drug abuse and place the responsibility for pursuing the cause of action on the Attorney General and let him bring a civil action against these people involved on the theory great damage has been done to these victims and we need some resources to litigate the damages?

Mr. STANTON. We think that would be very good. We recently issued a report at the request of a Ms. Holtzman of the House Judiciary Committee regarding the Justice Department's effort in the area of recovering civil claims and fraud cases or thefts. I would be happy to send you a copy of that report.

Mr. DANNEMEYER. It is predictable that, if you placed one of these defendants in a civil action under oath for purposes of taking a deposition, the first question would meet with a response of "I decline to answer on the grounds it would intend to incriminate me." The next thing we should perhaps consider is giving the Justice Department the authority to grant immunity for any offense that may be disclosed as a result of the taking of the deposition.

That is a very powerful weapon, the granting of immunity. The thought occurs to me, with respect to the sale of any narcotics that has taken place within the period of the applicable statute of limitations, say 3 years preceding the taking of a deposition, that if the grant of immunity were given for any prosecution that could result from that testimony, it could be a powerful weapon to aid in finding out just what the drug traffickers have been doing and where their resources are.

They would never answer. It would be litigated in Supreme Court because the impact would be devastating.

If we are serious about shutting them down and putting them in jail, I do not think it is enough. I think if, within our system of respecting due process and that is very important we would just go after every last cent they have, we might deter them a little.

Mr. STANTON. Yes, sir. I would agree and certainly much more could be done in that area even under the existing laws and court rules.

Mr. DANNEMEYER. Thank you.

Mr. WAXMAN. Thank you, Mr. Dannemeyer. Thank you, gentlemen, for your testimony.

That concludes the hearing for today. The meeting will stand adjourned.

[Whereupon, the subcommittee was adjourned at 12:25 p.m.]

