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ABSTRACT

president Bush's new National Drug Control Strategy for 2003 focuses on three core priorities: stopping drug use before it starts, healing America's drug users and disrupting the market. The 2003 strategy reports progress toward meeting the President's goals of reducing drug use by 10 percent over 2 years, and 25 percent over 5 years. With regard to Priority I of the Strategy, "Stopping Drug Use Before It Starts," this document recognizes that it is critical to teach young people how to avoid drug use because of the damage drugs can inflict on their health and on their future. Where parents and educators deem appropriate, it is recommended that programs such as student drug testing be used. Priority II of the Strategy, "Healing America's Drug Users," emphasizes the crucial need for family, friends, and people with shared experiences to intercede with and support those fighting to overcome substance abuse. Priority III of the Strategy, "Disrupting the Market," addresses the drug trade as a business, one that faces numerous and often overlooked obstacles that may be used as pressure points. The report argues that the drug trade is not an unstoppable force of nature, but is rather a profit-making enterprise where costs and rewards exist in an equilibrium that can be disrupted. The 2003 strategy also highlights a new treatment initiative funded with $600 million over 3 years to help addicted Americans find needed treatment and support services from the most effective programs, including faith-based and community-based organizations. (GCP)

National Drug Control Strategy

The White House
February 2003

National Drug Control Strategy

UPDATE

The White House
February 2003

TO THE CONGRESS OF THE UNITED STATES:

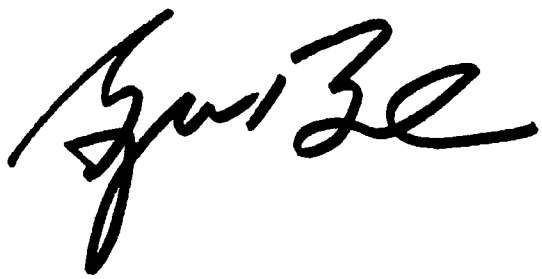
I am pleased to transmit the 2003 National Drug Control Strategy, consistent with the Office of National Drug Control Policy Reauthorization Act of 1998 (21 U.S.C. 1705).

A critical component of our Strategy is to teach young people how to avoid illegal drugs because of the damage drugs can do to their health and future. Our children must learn early that they have a lifelong responsibility to reject illegal drug use and to stay sober. Our young people who avoid drugs will grow up best able to participate in the promise of America.

Yet far too many Americans already use illegal drugs, and most of those whose drug use has progressed -- more than five million Americans -- do not even realize they need help. While those who suffer from addiction must help themselves, family, friends, and people with drug experiences must do their part to help to heal and to make whole men and women who have been broken by addiction.

We know the drug trade is a business. Drug traffickers are in that business to make money, and this Strategy outlines how we intend to deny them revenue. In short, we intend to make the drug trade unprofitable wherever we can.

Our Strategy is performance-based, and its success will be measured by its results. Those results are our moral obligation to our children. I ask for your continued support in this critical endeavor.



THE WHITE HOUSE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CONTENTS

INTRODUCTION

Last year's National Drug Control Strategy opened on an unsettling note. Just-released data from the 2000–2001 school year had confirmed the continuation of a trend, begun in the early 1990s, of near-record levels of drug use among young people. More than half of American high school seniors had tried illegal drugs at least once by graduation, while a quarter of seniors were regular users. An unacceptably high percentage were regular users of drugs such as marijuana, Ecstasy, and hallucinogens such as LSD. As was the case in the 1960s and 1970s, drug use had once again become all too accepted by our young people.

In this year's Strategy, by contrast, we are pleased to report that after a long upward trajectory, teen drug use is once again headed in the right direction—down. In fact, data from the University of Michigan's most recent *Monitoring the Future* survey show the first significant downturn in youth drug use in nearly a decade, with reductions in drug use noted among 8th, 10th, and 12th graders, and levels of use for some drugs that are lower than they have been in almost three decades. Such comprehensive declines are remarkably rare; they carry the hopeful suggestion that America has, again, begun to work effectively to reduce the drug problem.

Among the survey's findings:

- The percentages of 8th and 10th graders using "any illicit drug" were at their lowest levels since 1993 and 1995, respectively.

- Among 10th graders, marijuana use in the past year and past month decreased, as did daily use in the past month. Past-year marijuana use among 8th graders has dropped to 14.6 percent—its lowest level since 1994.

- With a single exception (past-month, or "current," use by 12th graders), the use of illegal drugs other than marijuana fell for all three grades surveyed and for all three prevalence periods (lifetime, annual, and past month), although not all changes reached statistical significance.

- Ecstasy use was down in all three grades. Ecstasy use in the past year and past month decreased significantly among 10th graders from 2001 to 2002. Past-year and lifetime rates were below those for 2000 in all three grades.

- Lifetime and past-year LSD use decreased significantly among 8th, 10th, and 12th graders, and past-month use declined among 10th and 12th graders. Past-year and past-month LSD use by 12th graders reached its lowest point in the 28-year history of the survey.

Nor are these hopeful trends confined to a single survey. The *Monitoring the Future* data is reinforced by other studies, including the annual survey of the Parents' Resource Institute for Drug Education (PRIDE), which measures drug use among junior high and high school students. The simultaneous decline of teen drinking and smoking (another finding of the *Monitoring the Future* survey) shows that students are not substituting one substance for another, as some had predicted, but rather avoiding (and in some cases having difficulty obtaining) intoxicants of all types.

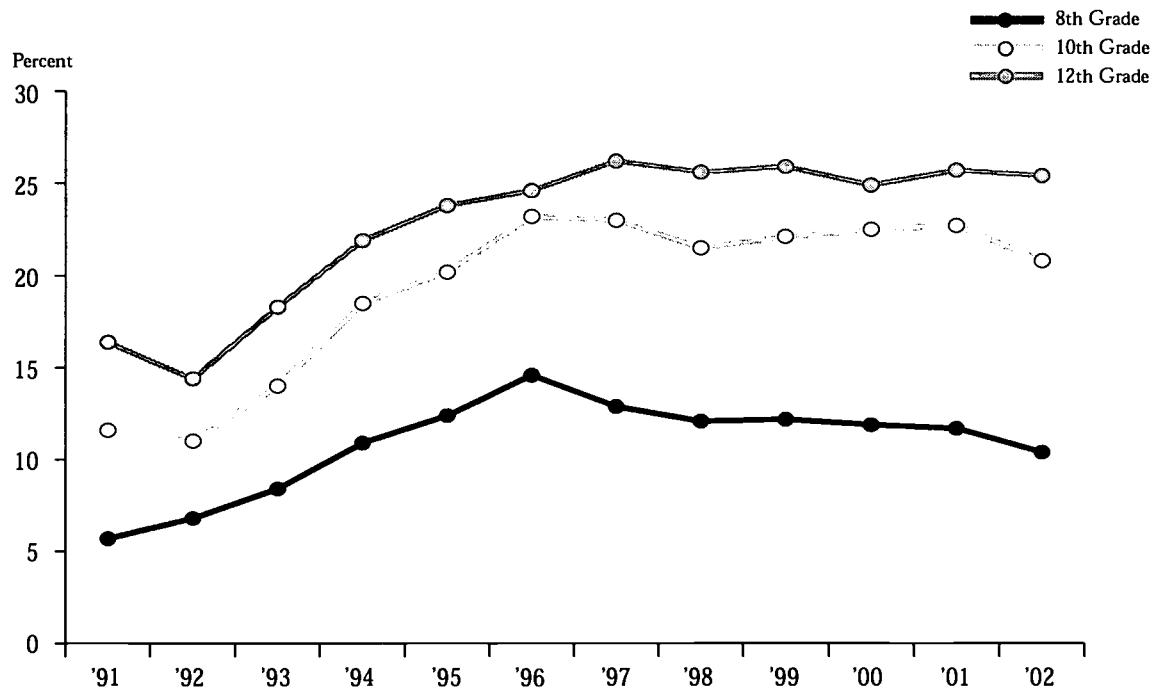
A Balanced Strategy

We have achieved the important goal of getting drug use by our young people moving downward. We now must secure the equally important objective of sustaining, accelerating, and broadening that downward movement. This time we intend to make the problem much smaller and build the structures that will keep it from growing larger in the future. Maintaining our momentum will require a sustained focus on all aspects of drug control, as well as a balanced strategy for approaching the problem. With its three priorities and clarity of purpose, this document offers both.

With regard to Priority I of the Strategy, Stopping Drug Use Before It Starts, this document recognizes that it is critical to teach young people how to avoid drug use because of the damage drugs can inflict on their health and on their future. Our children must learn from an early age that avoiding drug use is a lifelong responsibility. Where parents and educators deem appropriate, we should use programs such as student drug testing. Testing programs work because they reflect an understanding of teen motivations, giving students an easy way to say "no" at an age when peer pressure is at its peak.

Despite our substantial drug prevention efforts, some 16 million Americans still use drugs on a current basis, and roughly six million meet the

Figure 1: Past-Month Use of Any Illicit Drug by Eighth, Tenth, and Twelfth Graders

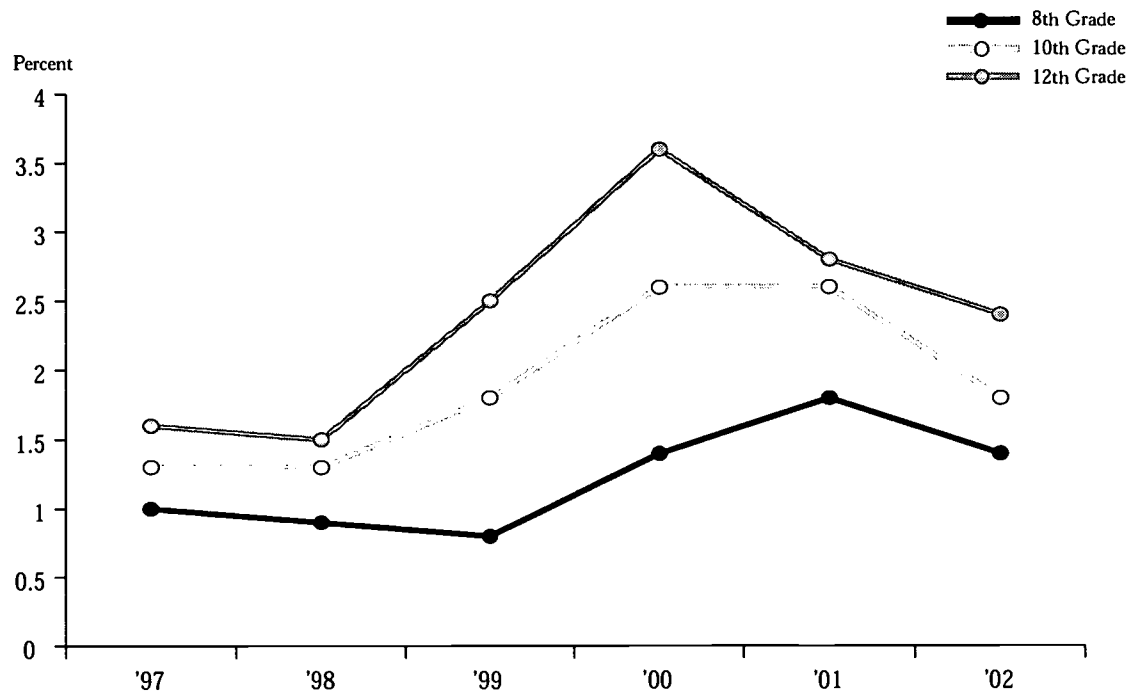


Source: Monitoring the Future (2002)

clinical criteria for needing drug treatment. Yet the overwhelming majority of users in need of drug treatment fail to recognize it—a fact that would not come as a surprise to those with a loved one who has battled drug dependency. Priority II of the Strategy, Healing America's Drug Users, emphasizes the crucial need for family, friends, and people with shared experiences to intercede with and support those fighting to overcome substance abuse. Drug users also need the support of institutions and the people who run them—employers, law enforcement agencies, faith communities, and health care providers, among others—to help identify them as drug users and direct those who need it into drug treatment. To expand access to substance abuse treatment, this Strategy proposes a new voucher program, funded with $600 million over three years, that will encourage accountability in the treatment system while making funds available on a non-discriminatory basis to all providers—including programs run by faith-based organizations.

Priority III of the Strategy, Disrupting the Market, addresses the drug trade as a business—one that faces numerous and often overlooked obstacles that may be used as pressure points. The drug trade is not an unstoppable force of nature but rather a profit-making enterprise where costs and rewards exist in an equilibrium that can be disrupted. Every action that makes the drug trade more costly and less profitable is a step toward "breaking" the market. As the Strategy explains, drug traffickers are in business to make money. We intend to deny them that revenue.

Figure 2: Past-Month Use of MDMA (Ecstasy) by Eighth, Tenth, and Twelfth Graders



Source: Monitoring the Future (2002)

Progress Toward Two- and Five-Year Goals

The President's National Drug Control Strategy, transmitted to Congress in February 2002, had as its goal reducing past-month, or current, use of illegal drugs in the 12- to 17-year-old age group by 10 percent over 2 years and 25 percent over 5 years. Similarly, the Strategy set the goal of reducing current drug use among adults (age 18 and up) by 10 percent over 2 years and 25 percent over 5 years.

Progress toward youth goals was to have been measured entirely from the baseline of the *National Household Survey on Drug Abuse*, but recent improvements to that survey have created a discontinuity between the 2002 survey and previous years' data. Although changes to the survey will permit more reliable estimates of drug use in future years, they prevent comparisons with use rates from the baseline year (2000). Fortunately, there is another survey that measures drug use among young people while preserving continuity over time. As a result, the Strategy will measure progress toward the two- and five-year goals as follows: drug use by young people will be measured at the 8th, 10th, and 12th grade levels using the *Monitoring the Future* survey, with the 2000–2001 school year as a baseline.

Although only the first year of the two-year goal period has elapsed, the goal of reducing current use by 10 percent among 8th, 10th, and 12th graders, as measured by *Monitoring the Future*, is well on the way to being met (with reductions of 11.1, 8.4, and 1.2 percent, respectively). These findings are comparable to those of the PRIDE survey, which, using a different methodology and measuring slightly different age groups, found

NATIONAL DRUG CONTROL STRATEGY GOALS

Two-Year Goals:	A 10-percent reduction in current use of illegal drugs by 8th, 10th, and 12th graders.
	A 10-percent reduction in current use of illegal drugs by adults age 18 and older.
Five-Year Goals:	A 25-percent reduction in current use of illegal drugs by 8th, 10th, and 12th graders.
	A 25-percent reduction in current use of illegal drugs by adults age 18 and older.

Progress toward youth goals will be measured from the baseline established by the *Monitoring the Future* survey for the 2000–2001 school year. Progress toward adult goals will be measured from the baseline of the 2002 *National Household Survey on Drug Abuse*. All Strategy goals seek to reduce "current" use of "any illicit drug." Use of alcohol and tobacco products, although illegal for youths, is not measured in these estimates.

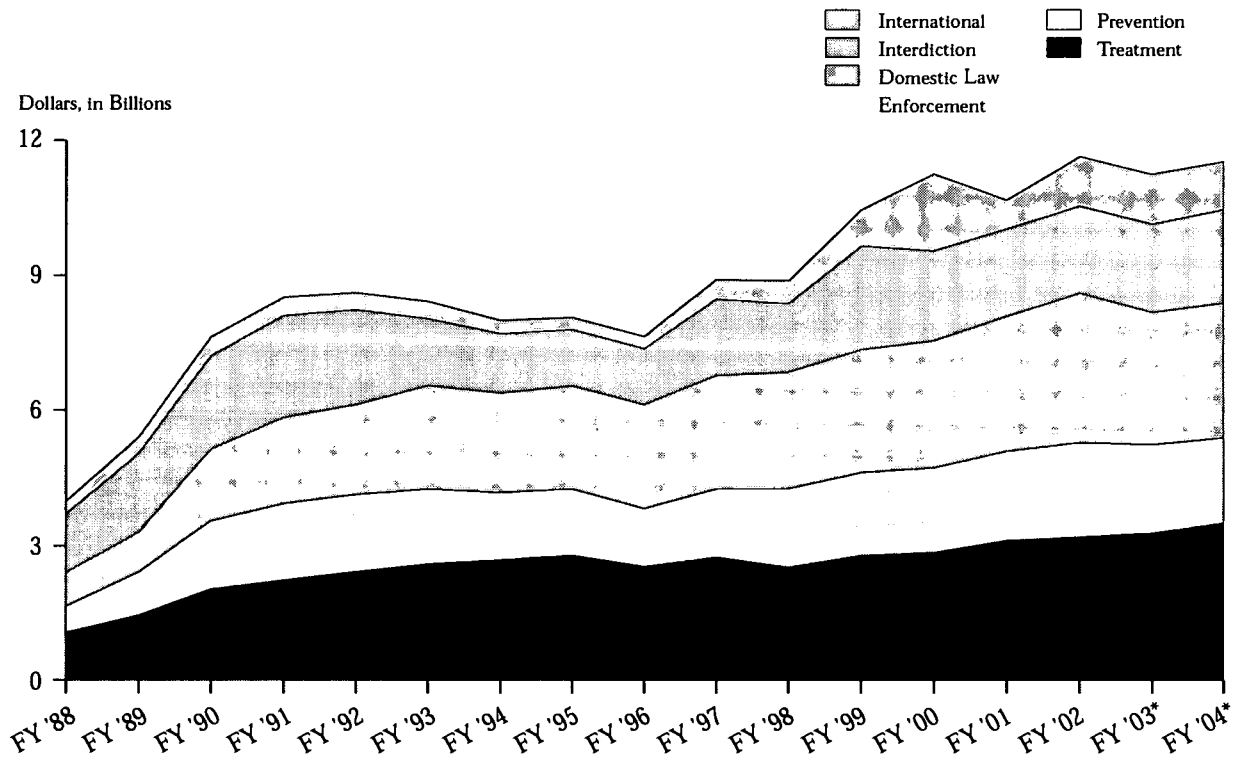
reductions of 14.3 percent for past-month drug use by junior high school students and an 11.1 percent drop among high school students—over the same one-year period. Either way, the observed reductions are on track for meeting the Strategy's goal of a 10 percent reduction over two years.

Given the discontinuity problem, and with no available substitute for measuring adult use (*Monitoring the Future* focuses on teen use), measuring the two- and five-year goals for adults poses a different challenge. This Strategy meets the challenge by measuring adult use from the baseline of the improved and redesigned 2002 *Household Survey.*

The President's Management Agenda: Integrating Budget and Performance

Over the past year, the Administration has continued to apply the principles of the President's management agenda to the National Drug Control Program. Working with the Office of Management and Budget (OMB), the Office of National Drug Control Policy (ONDCP)

Figure 3: The Federal Drug Control Budget 1988-2004—Constant Dollars



* President's Request

has implemented the budget restructuring proposal outlined last year in the National Drug Control Strategy. Additionally, all national drug control agencies have worked to enhance information on program performance and integrate this information into budget decisions. The Administration is committed to continuing this effort and integrating performance data more closely with the new drug budget.

As a result, the drug budget presented for fiscal year 2004 reflects for the first time actual resources committed to anti-drug efforts. (See Figure 3 for a brief history of the drug budget.) Rather than being based on estimates derived after decisions were made, as was the case in previous years, with few exceptions this budget reflects actual dollars identified in the congressional presentations of drug control agencies that accompany the annual submission of the President's budget. Additionally, the budget reflects only those expenditures aimed at reducing drug use rather than, as in the past, those associated with the consequences of drug use. (The latter are reported periodically in *The Economic Costs of Drug Abuse in the United States.*)

Now that the drug control budget has been narrowed in scope and presented in terms of actual expenditures, it will serve as a more useful tool for policymakers. Resource allocation will become part of the decision-making process rather than information reported after decisions are made.

Making wise allocation decisions requires that policymakers have better performance data about the programs supported by the budget. To that end, in preparation for the development of the President's budget, ONDCP worked closely with OMB to assess the results of selected drug control programs that collectively comprise 32 percent of the drug budget. The results of those assessments are presented in the President's budget.

As we work together to expand the coverage of these assessments across the drug control budget, we will develop a new framework for integrating program results with the Strategy's principal goal—reducing drug use.

Progress toward reducing overall U.S. drug use will be measured by monitoring key indicators and targets that are tied to the Strategy's three priorities—Stopping Use Before it Starts, Healing America's Drug Users, and Disrupting the Market. Each of these priority indicators in turn will be supported by the goals of the individual drug control programs.

Under the Government Performance and Results Act, each drug control agency already presents a strategic plan and annual performance plans and reports. Over the coming year, ONDCP will work with the agencies responsible for drug control programs to ensure that measures of effectiveness are in place and appropriate targets are set.

From the central goal of reducing drug use, all planning will proceed to the priorities, and from there to individual program plans. Program results will be tracked in reverse order: as each program accomplishes its objective, progress will be reflected in the priorities and, ultimately, in the central goal of reducing drug use. Where progress is lacking, we will adjust the array of programs to get back on track. Allocation decisions will be made to support programs that work and those that effectively support the Strategy.

The new drug budget and the results framework that supports it will enhance accountability in government by integrating budget and performance across the Federal Government.

National Drug Control Strategy:

NATIONAL PRIORITIES

BUDGET HIGHLIGHTS

- **ONDCP—National Youth Anti-Drug Media Campaign: $170 million.** The fiscal year 2004 President's Budget continues funding for ONDCP's Media Campaign, which uses paid advertising and grassroots public outreach to educate the Nation's families, parents, and youth about drug use and its consequences. Targeted, high-impact media messages—at both the national and local levels—seek to reduce drug use through changes in adolescents' perceptions of the danger and social disapproval of drugs. In a continuing effort to reach the Nation's youth, the Media Campaign has recently undergone a significant revision and instituted a new strategy. This new strategy requires testing of all television advertising for effectiveness before airing; a shift of the youth target audience to focus on ages 14–16, the years during which youth appear to be at greater risk for initiating drug use; reduction in the number of youth-strategic message platforms from three to two, for a more focused approach; modification of the Media Campaign to focus primarily on the prevention of marijuana use by youth; more oversight by ONDCP in the creative/ad development process; and a harder-hitting ad style.

- **ONDCP—Drug-Free Communities Program: $70 million.** This program assists community groups in forming and sustaining effective community and anti-drug coalitions that fight the use of illegal drugs. These coalitions work toward reducing substance abuse among youth and strengthening collaboration among organizations and agencies in both the private and public sectors, and serve as catalysts for increased citizen participation in strategic planning to reduce drug use over time. In addition, Drug-Free Community coalitions are expected to synthesize data from all available sources to better document the nature and extent of local drug problems, including the underage use of alcohol and tobacco and any use of illicit drugs and inhalants. To further the efforts of these important coalitions, the Administration proposes an increase of $10 million over the fiscal year 2003 requested level.

- **Education—Safe and Drug-Free Schools and Communities (SDFSC) Program: $694 million** ($584 million drug related). The fiscal year 2004 President's Budget determined that this program is ineffective, and recommends the investigation of new strategies for measuring program performance and distributing funds. The Budget makes a modest reduction in funding for this school-based drug prevention program, which reaches young people in most of the Nation's school districts, until the program can demonstrate results. SDFSC funds are appropriated directly for State Grants and National Programs. State Grants provide funding to all 50 governors and state education agencies. As part of the National Programs budget in fiscal year 2004, $8 million is requested for a competitive grant program that will provide for drug testing, assessment, referral, and intervention. Drug testing has been shown to be effective at reducing drug use in schools and businesses across the country. This funding will expand drug testing efforts initiated by the Department of Education in fiscal year 2003.

- **Corporation for National and Community Service—Parents Drug Corps Initiative: $5 million.** This initiative will establish a program to support and encourage parents to help children stay drug free. This program will provide matching funds to national parents' organizations to train thousands of parents nationwide in how to reduce drug abuse and form parent drug prevention groups.

Stopping Use Before It Starts: Education and Community Action

Prevention efforts are our first line of defense against illegal drug use. Such efforts hold out the promise of preventing drug use before it starts and sparing families the anguish of watching a loved one slip into the grasp of addiction. Although we face a major challenge in driving down drug use—with 16 million past-month (current) users and six million in need of drug treatment—our Nation's strategy for preventing the use of illegal drugs has much to recommend it. The fact is that although 7 percent of Americans use an illegal drug on a current basis, 93 percent do not. Legal substances such as alcohol are inherently more difficult to control, and the numbers show it, with 109 million current users, 13 million of whom need help. Similarly, alcohol use among young people is more prevalent than use of illegal drugs.

Drug prevention programs—particularly those programs that are research-based and involve the community—are invaluable in educating young people about the dangers of drug use and reinforcing a climate of social disapproval of drug use. The Federal Government supports such programs both with funding and by supplying the best available evidence, technology, and tools.

But drug prevention makes for a difficult public policy discussion because prevention activities are not, for the most part, discrete, government-funded programs. In fact, they can best be understood as the sum of the efforts parents and communities make in bringing up young people.

Unfortunately, for too many years, the popular culture has not supported parents seeking to educate their children about the dangers of drug use and to empower them to make good decisions. In music, film, and television, drug use has too often been portrayed as glamorous and exciting, drug users and even drug dealers as free-spirited nonconformists.

Worse, well-funded legalization groups have spread misinformation about the effects of drugs. They have even insinuated to young people that drug use is an adolescent rite of passage and that adults who tell them otherwise are seeking to limit opportunities for personal growth that are rightfully theirs.

Such misinformation has taken on the force of law in states where legalization groups have pushed through a series of state referenda to legalize "medical" marijuana. Legalization lobbyists have portrayed their agenda as a representation of popular will, as though parents and communities were seeking to bring more drugs into their schools and homes. Operating with the benefit of slick ad campaigns, with virtually no opposition, and making outlandish claims that deceive well-meaning citizens, campaign proponents have tallied up an impressive string of victories.

That is, until now: in 2002, the movement lost key referenda and similar efforts in four states (Nevada, Arizona, Ohio, and South Dakota), and otherwise failed to proceed with efforts in Florida and Michigan.

The sheer comprehensiveness of the failure is impressive: losses ranged from a Nevada effort to legalize possession and use of marijuana, to an Ohio proposal that would have gutted that state's ability to incarcerate drug dealers and provide drug treatment to prisoners, to a greatly expanded medical marijuana initiative in Arizona.

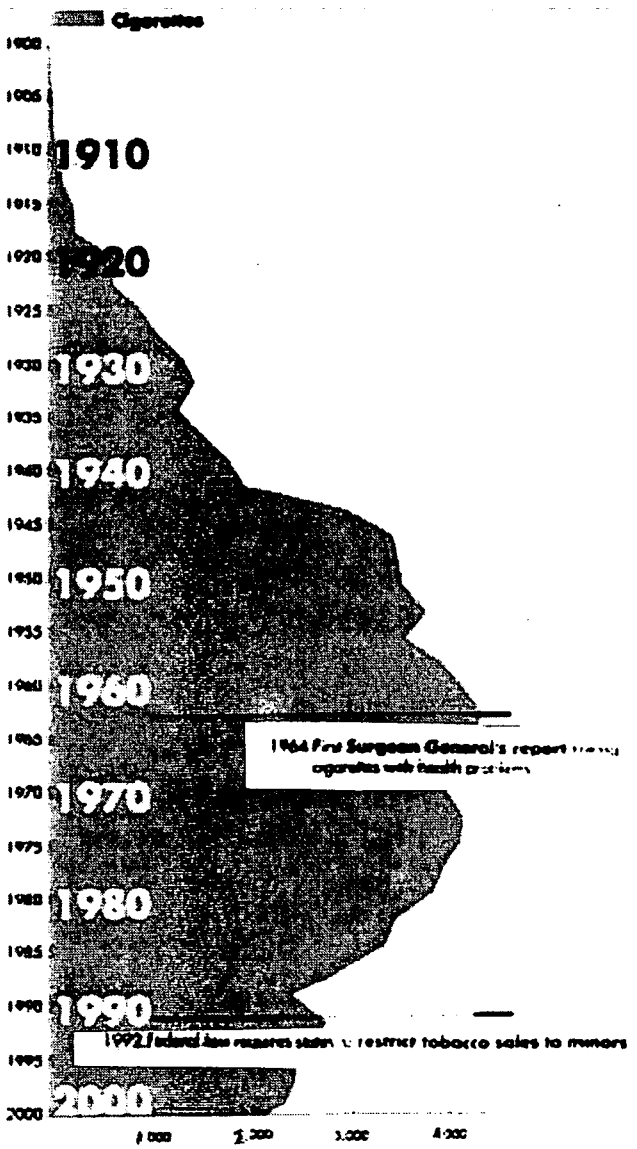
A small band of wealthy backers spent millions of dollars on various campaigns last year; their across-the-board defeat suggests something of what citizens in targeted states actually think of the deceptions they were offered. The record of 2002 also suggests that the mood of national seriousness following the September 11 attacks is less open to self-indulgent social engineering than some had hoped.

The ultimate direction of that mood is significant, and probably critical, to the success of our Nation's drug control efforts, which, like efforts to regulate smoking and alcohol use, owe much to public awareness and an engaged citizenry. As examples, the charts on these pages illustrate the major reductions in smoking that followed the 1964 Surgeon General's report linking cigarettes with health problems, and the imposition of federal restrictions on tobacco sales to minors in 1992.

Similarly, the data on the prevalence of drug use shows the steep reductions in use that followed the national mobilization started in 1985 by Nancy Reagan's "Just Say No" campaign. Like smoking and other social pathologies, drug use is a problem that responds to societal pressure; when we push against this problem, it gets smaller.

Trends in Cigarette Use, 1900–2000

Annual per Capita Consumption of Cigarettes for Those 18 Years and Over

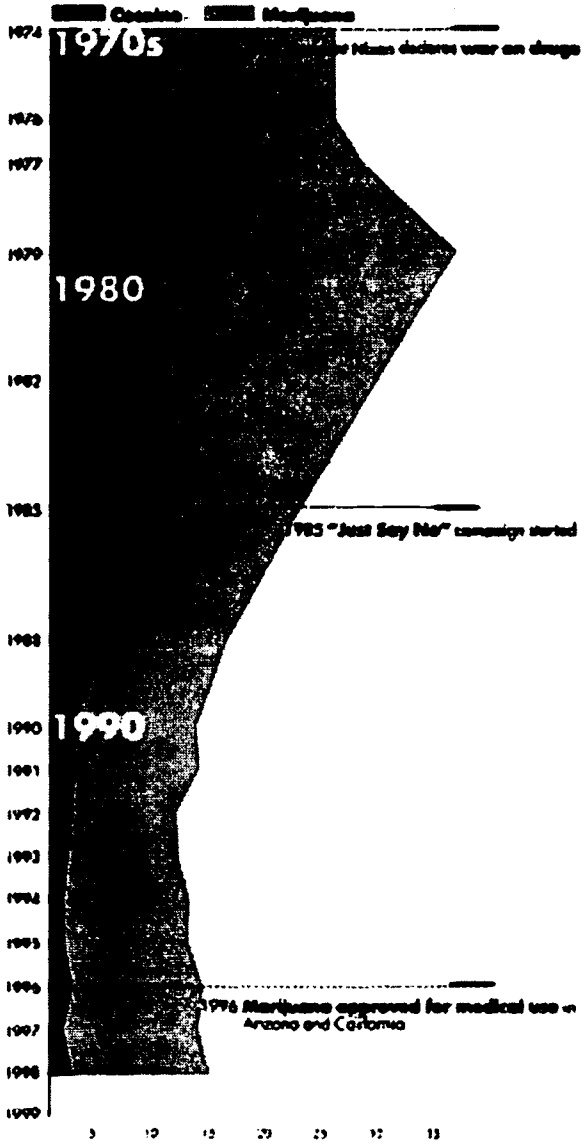


Note: Data for 2000 are preliminary.

Sources: For 1900–1974: Tobacco Yearbook. 1981. Col. Clem Cockrel. Bowling Green, KY. p. 53. For 1975–1981: U.S. Department of Agriculture. Tobacco Situation and Outlook Report. Rockville, MD: Commodity Economics Division, Economic Research Service, 1985. Table 2, p. 6. For 1982–1989: U.S. Department of Agriculture. Tobacco Situation and Outlook Report. Rockville, MD: Commodity Economics Division, Economic Research Service, 1992. Table 2, p. 4. For 1990–2000: U.S. Department of Agriculture. Tobacco Situation and Outlook Report. Washington, DC: Market and Trade Economics Division, Economic Research Service, 2000. Table 2.

Trends in Illicit Drug Use, 1974–1998

Percent Past Month Marijuana and Cocaine Users among Those Ages 18–25

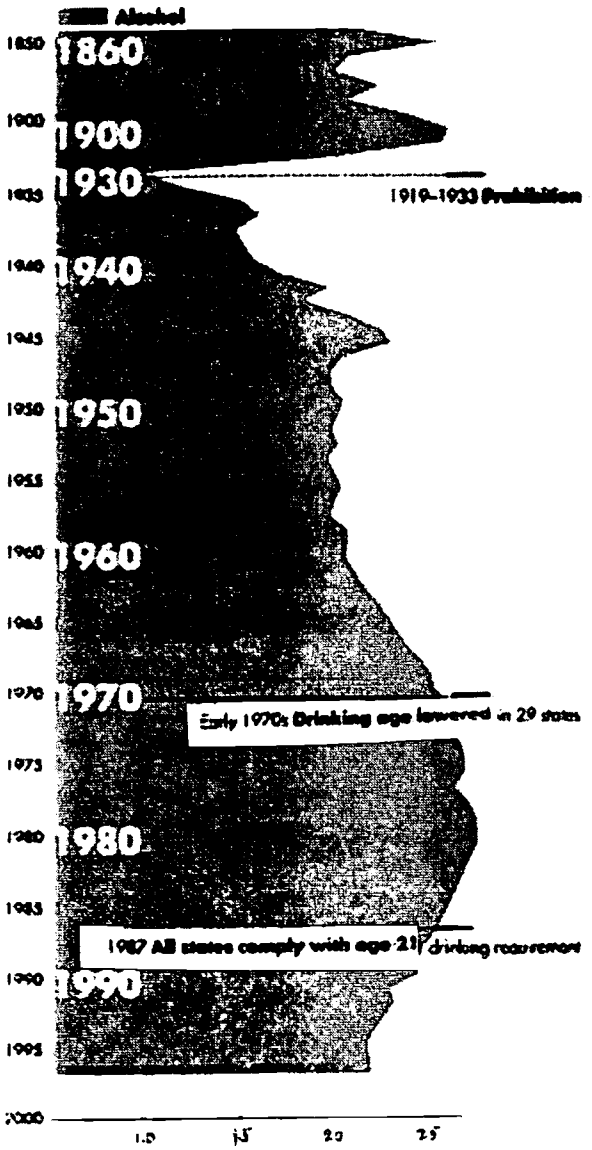


Sources: For 1974–1978: U.S. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. National Household Survey on Drug Abuse: Highlights 1991. Rockville, MD. 1993. Table A.10. p. 78. For 1979–1998 data: U.S. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Summary of Findings from the 1998 National Household Survey on Drug Abuse. Rockville, MD. 1999. Table 12. p. 74; Table 13. p. 75.

Adapted from charts originally published in "Substance Abuse: The Nation's Number One Health Problem." Reprinted with permission from Robert Woods Johnson Foundation.

Trends in Alcohol Use, 1850–1997

Annual per Capita Consumption in Gallons of Ethanol



Notes: Alcohol consumption is measured by converting the gallons of sold or shipped wine, beer and spirits into gallons of ethanol (pure alcohol), using estimates of average ethanol content for each beverage type. Per capita estimates are then calculated per person age 15 and older prior to 1970 and per person age 14 and older thereafter.

Source: National Institute on Alcohol Abuse and Alcoholism. Division of Biometry and Epidemiology. Apparent Per Capita Alcohol Consumption: National, State, and Regional Trends, 1977–1997. Surveillance Report No. 51. December 1999. Table 1. p. 16.

A Boost for Student Drug Testing Programs

For young people in middle and high school, drug testing programs are an effective means of identifying those in need of drug treatment or counseling—and discouraging others from ever starting. But until recently, the legal future of school drug testing programs was unclear.

In a landmark decision last summer, the U.S. Supreme Court gave a boost to schools struggling to combat illegal drugs. By upholding an Oklahoma school district's drug testing policy, the Court cleared the way for schools everywhere to perform random drug tests on a broad segment of the student population. The decision marks the beginning of a hopeful new phase in the effort to keep our children drug free.

Previous Court rulings were restricted to the testing of student athletes. The new ruling expands the scope of drug testing to include not only boys and girls who play sports, but those who participate in any competitive extracurricular activity, from cheerleading to the debate team. Now, public middle and high schools everywhere can more effectively gauge their drug problem and direct students in trouble to the treatment they need.

The purpose of school-based drug testing is not to punish students who use drugs. If drug-using students are suspended or expelled without any attempt to intervene in their drug use, the community will be faced with a surge in the number of drug-using dropouts—a more serious problem in the long run. Of course, any effective testing program should include clear-cut consequences for students who use illegal drugs—suspension from an athletic activity, for example. But above all else, the goal is to keep students from using drugs and to guide users into counseling or drug treatment.

Student drug testing programs also function as a prevention tool, ideally as part of a comprehensive prevention strategy. Testing programs work because they reflect an understanding of teen motivations, giving students an easy way to say "no" at an age when peer pressure is at its peak. For many young people, simply knowing they may suddenly be called in to take a drug test provides a convenient

REDUCING DRUG USE THROUGH STUDENT DRUG TESTING

- According to the *Journal of Adolescent Health*, a school in Oregon that drug tested student athletes had a rate of drug use that was one-quarter that of a comparable school with no drug testing policy.
- After two years of a drug testing program, Hunterdon Central Regional High School in New Jersey saw significant reductions in 20 of 28 key drug use categories. For instance, use of cocaine by seniors dropped from 13 to 4 percent.

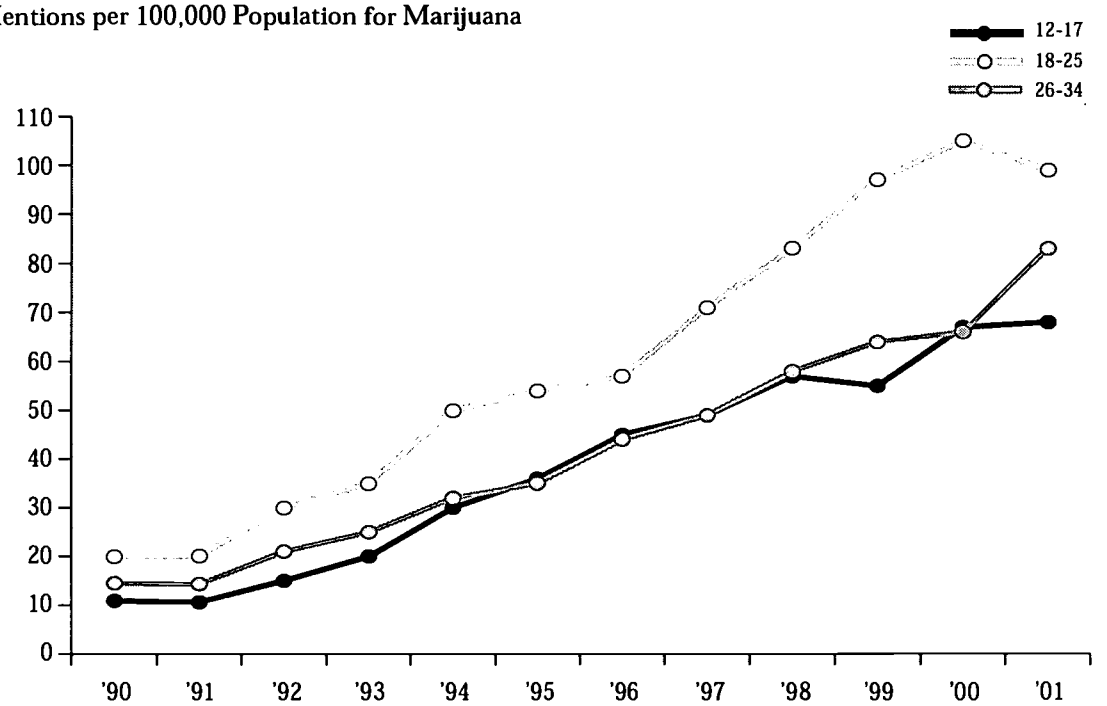
"out," which is often enough to make a student stop taking drugs or never start in the first place.

This Administration is committed to providing families and schools with the tools they need to keep children focused on learning, undistracted by drug use. To that end, it will devote a portion of the Safe and Drug-Free Schools and Communities program's national activities funds to provide grants to schools that choose to implement effective drug testing programs that include provision of treatment services for students who test positive. In fiscal year 2004, $8 million is requested for student drug testing, which will expand efforts initiated by the Department of Education in 2003.

Seeing through the Haze: Marijuana Use and the Debate over Dependency

No analysis of drug prevention would be complete without a discussion of marijuana, the drug so widespread in today's schools that nearly half of all high school seniors report having tried it by graduation. After years of giggling at quaintly outdated marijuana scare stories like the 1936 movie "Reefer Madness," many Americans have been conditioned to think that any warnings about the true dangers

Figure 7: Among Youth and Young Adults, a Steep Increase in Emergency Department Mentions for Marijuana



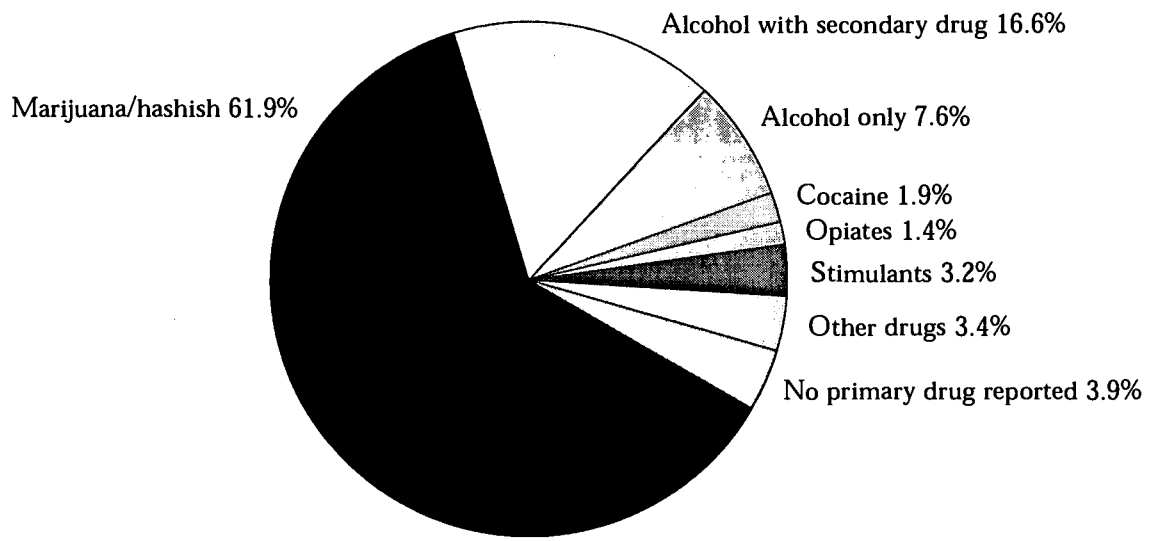
Source: Drug Abuse Warning Network (2001)

of marijuana are overblown. But marijuana produces withdrawal symptoms and is associated with learning and memory disturbances. Among youth, frequent users of marijuana are four times more likely than non-users to have physically attacked someone during the past six months. Daily marijuana smoking was recently implicated in a five-fold increase of risk for depression and anxiety among females, according to an article in the *British Medical Journal.*

And the harm is not just to the user. Marijuana is the illicit drug most used by pregnant women and women of reproductive age; yet recent research has shown motor, behavioral, and cognitive disturbances in offspring who were exposed to cannabis in the womb. Such disturbances include findings indicative of reduced activity in portions of the brain that regulate emotion and attentiveness. In some communities, as many as 20 percent of infants are prenatally exposed to a mother's marijuana intake.

Moreover, research has now conclusively established that marijuana is addictive. Of the 5.6 million Americans who meet the diagnostic criteria for needing drug treatment (criteria developed by the American Psychiatric Association, not police departments or prosecutors), 62 percent were found to abuse or be dependent on marijuana, according to data compiled by the Department of Health and Human Services. These are not occasional pot smokers. These are people with real problems directly traceable to their use of marijuana, including significant health problems, emotional problems, and difficulty in cutting down on use.

Figure 8: Treatment Admissions by Primary Substance of Abuse (Ages 12–17)



Source: Treatment Episode Data Set (2000)

Parents are often unaware that today's marijuana, with its blend of sophisticated cultivation and plant breeding techniques, is different from that of a generation ago. In 1974, according to data compiled by the Drug Enforcement Administration (DEA), the average THC content of marijuana was less than 1 percent. Twenty-five years later, potency was averaging around 7 percent, with some samples in the 30 percent range. Recent research published in the *British Journal of Psychiatry* suggests a 15-fold increase in THC content and concludes that "the modern cannabis smoker may be exposed to doses of THC many times greater than his or her counterpart in the 1960s and 1970s." The *Journal* concludes that this "single fact has made obsolete much of what we once knew about the risks and consequences of marijuana use."

The topic of drug treatment is handled in greater detail in the following chapter, but the implications are obvious. More than 60 percent of young people in drug treatment are there for problems associated with marijuana, and there has been a nearly four-fold increase in the number of adolescent marijuana admissions between 1992 and 2000.

BUDGET HIGHLIGHTS

- **Substance Abuse and Mental Health Services Administration (SAMHSA)—President's Treatment Initiative: +$600 million over three years.** The President has committed to add $1.6 billion to the drug treatment system over five years. As part of this effort, the fiscal year 2004 Budget includes new funding of $200 million in indirect aid for substance abuse treatment and other supportive services. People in need of treatment, no matter where they are—emergency rooms, health clinics, the criminal justice system, schools, or the faith community—will receive an evidence-based assessment of their treatment need and will be issued vouchers for the cost of providing that treatment.

- **Office of Justice Programs—Drug Courts Program: $68 million.** The Administration proposes an increase in the Drug Courts program of $16 million above the fiscal year 2003 requested level. This enhancement will expand the number of drug courts; increase retention in, and successful completion of, drug court programs by expanding the scope and improving the quality of drug court services; and generate drug court program outcome data. Successful drug courts provide alternatives to incarceration by using the coercive power of the court to force abstinence and alter behavior with a combination of escalating sanctions, mandatory drug testing, treatment, and strong aftercare programs.

- **National Institute on Drug Abuse (NIDA): +$35.6 million.** This proposed increase would enable NIDA to fund ongoing commitments, undertake research collaborations with other National Institutes of Health organizations, and embark on new initiatives to advance treatment and prevention. NIDA projects that are instrumental in helping to meet the drug use reduction goals outlined by the President include the National Prevention Research Initiative, National Drug Abuse Treatment Clinical Trials Network, and Research-Based Treatment Approaches for Drug Abusing Criminal Offenders.

Healing America's Drug Users: Getting Treatment Resources Where They Are Needed

In 1854, Dr. John Snow revolutionized the field of public health when he discovered how a plague of cholera was spreading through London. In one neighborhood, the number of deaths reached more than 500 in ten days. Snow mapped the cases and found they radiated out from the Broad Street pump, where infected people had drawn their water. Snow had the pump handle removed. The epidemic ceased.

Medicine was transformed by Dr. Snow's strategy, which was to block the vectors that spread contagion. The same logic can help us fight a modern epidemic—the spread of drug use and addiction.

Medical research has established a clear fact about drug use: once started, it can develop into a devastating disease of the brain, with consequences that are anything but enticing. No young person watching an addict stumbling on the street looks at the loss of human potential and decides to seek the same end.

And yet the disease spreads. It spreads because the vectors of contagion are not addicts in the streets but users who do not yet show the consequences of their drug habit. Last year, some 16 million Americans used an illegal drug on at least a monthly basis, while 6.1 million Americans were in need of treatment. The rest, still in the "honeymoon" phase of their drug-using careers, are "carriers" who transmit the disease to others who see only the surface of the fraud. Treatment practitioners report that new users in particular are prone to encouraging their peers to join them in their new behavior.

Applying Principles of Public Health

The public health model offers three key lessons for drug policy.

First, as discussed in the previous chapter, young people must be educated about the lie that drug use represents. Drug use promises one thing but delivers something else—something sad and debilitating for users, their families, and their communities. The deception can be masked for some time, and it is during this time that the habit is "carried" by users to other vulnerable young people.

A second, key lesson of the public health model applies to those still in the honeymoon phase. It is a lesson with important implications for the field of drug treatment, where a large and growing collection of providers have been hampered by an imperfect intake mechanism for directing individuals in need of help to the most appropriate form, or modality, of drug treatment. Simply put, for many users—including the large majority in the 18-25 age group—the optimal response to their drug use is not an extended stay at a treatment center but screening to determine if help is needed. This screening can be followed, if necessary, by a brief period of drug treatment.

The third lesson involves those whose use has progressed to the point where they need drug treatment but who are not actively seeking help, because even the best treatment program cannot

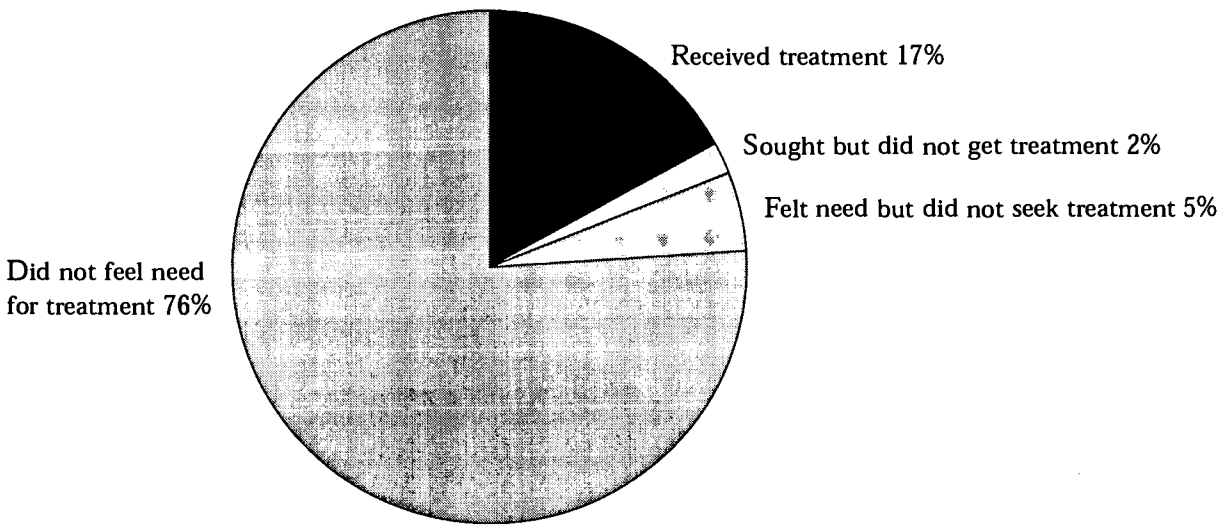
help a drug user who does not seek its assistance. According to a survey by the Department of Health and Human Services, the overwhelming majority of drug users who need treatment fail to recognize it (see Figure 9), a fact that would not come as a surprise to those with a loved one who has battled drug dependency. Of the estimated five million individuals who needed but did not receive treatment in 2001, fewer than 8 percent felt they actually needed help.

The conventional wisdom about drug treatment—that the hardest to help are the down-and-out cases—turns out to be less than accurate, because the hardest cases are actually those who are never seen. The third lesson of the public health model thus involves the crucial need to get people into treatment—no small matter when dealing with an illness whose core characteristic is denial.

Closing this "denial gap" requires us as a Nation to create a climate in which Americans confront drug use honestly and directly, encouraging those in need to enter and remain in drug treatment. Compassionate coercion of this type begins with family, friends, and the community, including colleagues in the workplace. It also requires the support of institutions and the people who run them—law enforcement, faith communities, and health care providers, among others—to identify and direct individuals in need into drug treatment. And it requires the use of innovative techniques for fighting addiction, such as specialized pharmaceuticals. (The approval in October 2002 of buprenorphine, a drug used for fighting opiate dependence, marks the first narcotic drug available for the treatment of opiate dependence that can be prescribed in a doctor's office.)

Figure 9: Most of Those in Need of Drug Treatment Did Not Seek It

Total in need of treatment = 6.1 million



Source: National Household Survey on Drug Abuse (2001)

While most of those who are dependent on illegal drugs are in denial, the good news is that more than one million Americans receive treatment each year and have started down the road to recovery. They deserve our respect for having the courage to come forward and seek help. Unfortunately, it is estimated that as many as 101,000 of those who seek treatment each year are not able to receive it. They have an immediate need, and when that need goes unfilled, many revert to their old ways and may not seek help.

To address this critical need, this year we will launch a new program, funded with $600 million over three years, that will expand access to substance abuse treatment while encouraging accountability in the treatment system. For those without private treatment coverage, we will make sure that medical professionals in emergency rooms, health clinics, the criminal justice system, schools, and private practice will be able to evaluate their treatment need and at the same time issue a voucher good for

LIFECHANGE: HARNESSING THE POWER OF FAITH

At the Union Gospel Mission in Portland, Oregon, homeless men and women can get food, clothing, and blankets. The people who walk through the doors of this faith-based center may also find an opportunity to change their lives for better through LifeChange—a drug treatment program with a difference.

LifeChange was founded in 1995 by Bill Russell, a former prosecutor, and has since graduated 62 people. Although drug treatment programs typically last 90 days, LifeChange's much longer duration limits it to 32 people at any given time, although expansion to a total of 80 recovery beds is in the works. Close to one-third of those in the program were ordered to LifeChange by judges and parole officers.

Although members of LifeChange do not have direct access to money while in the program, they do earn a living of sorts, working full-time at the Union Gospel Mission thrift store, where two-thirds of the program's budget is raised. Residents also help area homeless. A staff member puts it this way: "When you're in the program, you're supposed to give something back. You have to make up for all the bad things you did to your family and community when you were an addict." In addition to the work they do, residents attend academic classes, go to Bible study, and tackle the issues that led to their life of addiction.

Residents gradually attain increasing levels of responsibility, in preparation for the world after LifeChange. Coupled with education, the program arms graduates with job skills, a GED, and, frequently, vocational training. Assistance and mentoring are provided as residents make the transition to full employment and independent living. LifeChange is a faith-based program that works.

the cost of providing that treatment. Treatment vouchers will be redeemable on a sliding scale that rewards the provider for treatment effectiveness. Services can range from interventions designed for young substance abusers before they progress deeper into dependency, to outpatient services, to intensive residential treatment. For the first time, we will provide a consumer-driven path to treatment.

The path to help will be direct, appropriate, and open on a non-discriminatory basis to all treatment programs that save lives, including programs run by faith-based organizations. For many Americans, the transforming powers of faith are resources in overcoming dependency. Through this new program, we will ensure that treatment vouchers are available to those individuals who choose to turn to faith-based treatment organizations for help. Our goal is to make recovery the future for all those struggling with substance abuse.

Ending the Honeymoon: A New Focus on Brief Treatments

The nearly 12 million current drug users whose use has not progressed to dependence face an uncertain future. Their likelihood of eventually crossing over into addiction ranges from one in three to roughly one in ten, depending on the drug—high enough to be unacceptable but low enough to encourage many to persist in their drug use. More urgent, from the public health perspective, is the need to head off the destructive message non-dependent users send to others. A developing trend toward "brief treatments" offers promise in this area.

A drug addicted individual typically comes into contact with the health care and criminal justice systems repeatedly and in a variety of ways. Not so for the relatively asymptomatic casual drug user, whose use is not obvious and may go for months or years before a triggering event such as an automobile accident, an overdose, or an arrest.

One promising way to reach out to people in this latter category is to use the existing medical infrastructure, which already has extensive experience in identifying problem drinkers, to screen for drug use during some of the millions of emergency room and primary care visits that occur each year.

The majority of those identified as drug users will have an incipient problem (see box), one that has not progressed to the point of requiring admission to a treatment facility. These individuals are likely to respond to a brief intervention, ranging from a highly structured, five-minute talk to half a dozen counseling sessions. The degree of professional training needed to conduct these interventions increases with their length and intensity, but most can be accomplished in a doctor's office or within a hospital's social services department.

While a referral for thorough assessment and treatment is in order for some, even brief interventions can be quite effective when delivered to a nonaddicted drug user by an authority figure. Recent research supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) through the Cannabis Youth Treatment Study found that brief treatments are very successful, especially with low-severity clients. As can be imagined, cost savings are substantial when compared with the alternative of detoxification followed by an extended treatment stay.

Of course, many drug users have more serious problems, which not uncommonly include mental and other medical disorders. Such disorders interact in unfortunate ways: drug users are more likely to develop mental problems, while individuals with mental disorders are more likely to use illegal drugs than the population at large. These "co-occurring disorders" take a terrible toll on individuals and complicate the task of helping them through drug treatment. As a result, some state treatment systems are moving toward routinely screening individuals for both types of disorders.

PROGRAMS THAT WORK: SCREENING, BRIEF INTERVENTION, AND REFERRAL

John Doe, age 45, is admitted to the emergency room after a car accident. What the doctors do not know at the time of his arrival is that he uses cocaine and marijuana. At many hospitals, the doctors would not pursue John's health care needs beyond his injuries, thereby missing an opportunity to intervene early and derail behavior that could lead to greater harm.

Not so at Scripps Mercy Hospital in San Diego, where a Screening and Brief Intervention and Referral (SBIR) program has been implemented in various settings, including the emergency room, primary care unit, and trauma service. At Scripps Mercy, John Doe is interviewed by a specially trained peer health educator while still in the emergency room. This interview, which principally seeks to determine John's drug and alcohol use, does not interfere with traditional medical care. It does, however, determine whether Mr. Doe has a problem with drinking or drug use.

On determining that Mr. Doe has a problem, a five-minute "brief intervention" will be delivered by a physician attached to the emergency room. If Mr. Doe is found to need a more extensive intervention, he will be referred to appropriate treatment services.

John Doe, like most drug users in America, was determined in this instance not to be dependent or an abuser. (As defined by the American Psychiatric Association, drug dependence—characterized by significant health problems, emotional problems, difficulty in cutting down on use, drug tolerance, withdrawal, and other symptoms—is more severe than drug abuse.) The brief intervention Mr. Doe received was reinforced by the doctors who treated his injuries and may be enough to get him to stop using drugs.

Unfortunately, despite growing evidence of the effectiveness of this modest form of intervention, most primary care settings, emergency rooms, and trauma centers around the country do not integrate the SBIR program with medical care. In other words, John Doe would have been treated for his injuries and sent home, with his developing substance abuse problem overlooked.

Targeting Drugged Driving

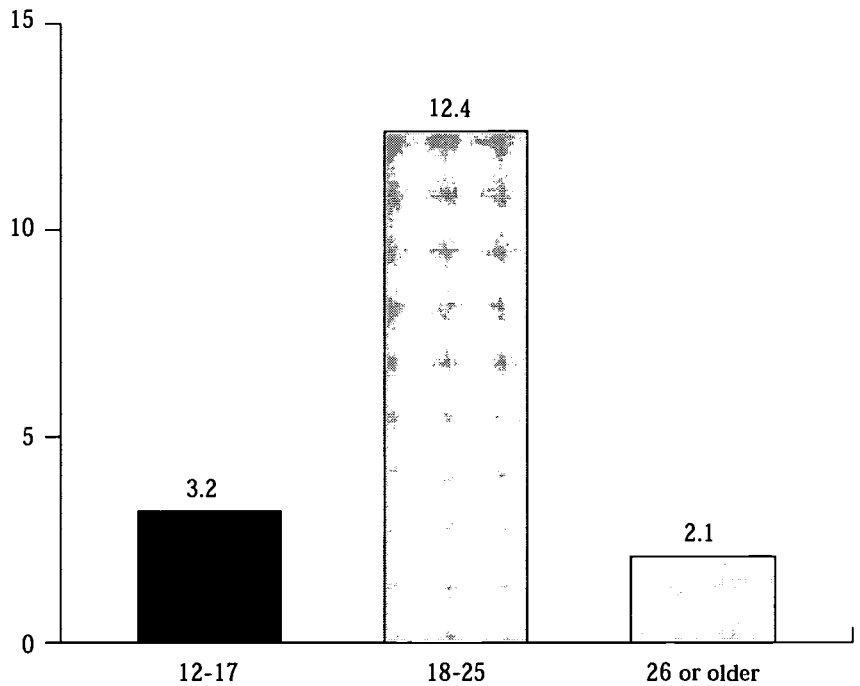
Over time, brief treatments should allow treatment professionals to reach non-dependent drug users through other institutions with which they have regular contact, notably workplace and school settings, and provide appropriate assistance. Drug users who trigger such interventions are among the most fortunate; many injure themselves or others on our Nation's roads before coming to the attention of the drug treatment system.

Drug legalization advocates who suggest that drug use is "victimless" are brought up short when confronted with the grief of a family that has lost a parent or child to a driver who was high on marijuana. The problem is real: research indicates that in 2001, some eight million drivers got behind the wheel of a car after using drugs, and the problem is particularly acute among younger drivers (see Figure 10).

More than two decades ago, a group of brokenhearted mothers formed what came to be known as Mothers Against Drunk Driving (MADD), whose tireless efforts—along with those of the National Highway Traffic Safety

Figure 10: Drugged Driving Is Highest Among Young Adults

Percent Reporting Driving Under the Influence of an Illicit Drug



Source: National Household Survey on Drug Abuse (2001)

Administration—have contributed to a 43 percent decline in alcohol-related highway fatalities. Groups like MADD have expanded to focus on drug-impaired driving, but there exists at present no reliable system that identifies drugged drivers and directs them into drug treatment before innocent lives are lost. Because slightly more than half of all contacts between law enforcement and the public occur during traffic stops, giving police officers tools to better recognize drug use is a tremendous opportunity to make our roadways safer and get users into treatment.

One means of accomplishing these two goals is support of the Drug Recognition Expert (DRE) program, which trains police officers to recognize and readily identify the signs of drug use. Such training is crucial in avoiding the common scenario where a driver who has used drugs is stopped for suspicion of driving under the influence but released after failing to register evidence of drinking. DRE training, in contrast, relies on behavioral cues to better recognize the signs of drug use and gets dangerous drivers off the road and into treatment or an appropriate correctional setting.

The chief limitation with current DRE-trained officers is simple: there are too few of them, and a drugged driver's chances of encountering a DRE-trained officer at a traffic stop are slim. (If there is an encounter, however, the odds shift; DRE training is rigorous, and toxicology tests confirm the assessments of DRE-trained officers more than 90 percent of the time.)

Research into new detection technologies promises to lead to a version of the familiar alcohol breath-testing devices to supplement officers' expertise in confirming drug use and presence. ONDCP's Counterdrug Technology Assessment Center (CTAC) is sponsoring research into saliva tests that can quickly, cleanly, and accurately help an officer tell if a driver has used illegal drugs. CTAC will fund this research at a level of $1.5 million over the next three years.

Reducing Recidivism through Drug Courts

In addition, the Administration proposes a $16 million increase in federal support for the Drug Courts program in fiscal year 2004. Drug courts use the coercive authority of a judge to require abstinence and alter behavior through a combination of graduated sanctions, mandatory drug testing, case management, supervised treatment, and aftercare programs. Intrusive and carefully modulated programs like drug courts are often the only way to free a drug user from the grip of addiction. Such programs represent one of the most promising innovations in recent memory.

New research findings suggest that drug courts are effective in reducing criminal recidivism. A preliminary report from the National Institute of Justice, "Estimate of Drug Court Recidivism Rates," followed more than 2,000 graduates from 100 drug courts and determined that the recidivism rate (defined as being arrested and charged for an offense that, on conviction, would result in a sentence of at least one year) was just 16.4 percent one year after graduation and 27.5 percent at the two-year mark. Figures for individuals who were imprisoned for drug offenses, instead of entering drug court, are 43.5 and 58.6 percent, respectively. (Because violent drug offenders are typically ineligible to be admitted to drug court, the drug court and prison populations are not strictly comparable.)

Results like these explain why the drug court movement has progressed from the novel status it enjoyed when the concept was first highlighted in the President's National Drug Control Strategy in 1991, when there were fewer than half a dozen drug courts. Now, more than 940 drug courts

GETTING PEOPLE BACK ON TRACK AT CINCINNATI'S DRUG COURT

Dan Smith, a 32-year-old drifter, is arrested on charges of possession of cocaine and methamphetamine. Numerous prior arrests of a similar nature have been documented throughout his life, but this is the first time Dan has been detained in Cincinnati. In the Hamilton County Drug Court, he will be given the tools he needs to get on track to a law-abiding, drug-free life.

After his arrest, a public defender identifies Dan as a potential candidate for the drug court. For two weeks he undergoes an inpatient assessment period conducted by substance abuse professionals at Talbert House Treatment Center. Four probation officers are assigned to the site to foster coordination between the criminal justice system and the treatment providers.

After the center's clinical experts determine that Dan is dependent on illicit drugs, he goes before the Honorable Kim W. Burke. Dan is placed on probation and ordered to complete a treatment regimen that typically includes 90 days of residential treatment, followed by six weeks of intensive outpatient care, and a minimum of 12 months of continuing care.

Judge Burke keeps a close eye on the drug court's clients, meeting with all 400 of them at least once a month and some as often as weekly. Key to the drug court's success is creating an environment that is supportive but firm. Says Judge Burke, "At our evening status reports, I have the probation officer there, I have the treatment counselor there, and I have the attorney there. That avoids a lot of people saying 'My probation officer told me I could do this,' or 'My counselor told me I could do that'."

As long as Dan remains drug- and alcohol-free for the duration of this sentence, he will serve no jail time for the original charge. The program relies on Dan's knowledge that he will receive weekly drug tests; if he is found to have used illegal drugs, he can expect immediate consequences.

Judge Burke puts it this way: "If a person tests positive, I find out about it pretty quickly—usually the next day. Relapse is part of what we deal with, but when they come in with a dirty drug screen, they know that they're going to spend a couple of days in jail. The point of it is for them to have immediate consequences for their actions."

operate in 49 states, with an additional 441 courts in the planning stages. Key goals for the program in coming years include expanding the number of drug courts, improving retention rates, and generating credible post-program outcome data.

BUDGET HIGHLIGHTS

- **DEA—Priority Targeting Initiative: +$39 million.** This proposal includes 329 positions to implement DEA's plan for addressing the Nation's illegal drug threats. This initiative will target Priority Drug Trafficking Organizations involved in the manufacture and distribution of illegal drugs, as well as those involved in the diversion of precursor chemicals used to manufacture these products.

- **Organized Crime Drug Enforcement Task Forces (OCDETF) Program.** The fiscal year 2004 Budget restructures the OCDETF program by consolidating funding within the Department of Justice. In addition, the budget includes resources for the following initiatives to strengthen these critical interagency investigations:

  - **Consolidated Priority Organization Target List (CPOT) Initiative: +$26 million.** This proposal includes 192 positions to generate and advance investigations of command and control targets linked to the Attorney General's CPOT list. The requested funds will provide agents, analysts, and Assistant U.S. Attorneys dedicated to CPOT-linked investigations.

  - **Automated Tracking Initiative: +$22 million.** This proposal will establish the automated capacity, using existing Foreign Terrorist Tracking Task Force technology, to rapidly scan, analyze, and disseminate the voluminous drug investigative information of participating OCDETF agencies. This capacity is especially important in identifying components of those organizations on the Attorney General's CPOT list.

  - **Financial and Money Laundering Initiative: +$10 million.** This enhancement includes 83 positions to expand OCDETF financial and money laundering investigations. This improvement will fund financial investigative efforts, including intelligence gathering, document exploitation, and undercover operations.

- **Department of State—Andean Counterdrug Initiative: $731 million.** The fiscal year 2004 request maintains funding to support various programs in Colombia, Bolivia, Peru, and the Andean region. This initiative includes resources for critical drug law enforcement programs, as well as other efforts associated with security in drug-producing areas, illicit crop reduction, alternative development, institution building, the administration of justice, and human rights programs. For Colombia, funding includes several broad categories to include operations and maintenance of air assets, Colombian National Police and Army Counterdrug Mobile Brigade operational support, and crop eradication programs. This request also supports humanitarian, social, economic, and alternative development programs implemented by the U.S. Agency for International Development (USAID).

- **Department of Defense—Expanded Support to Colombia: +$25 million.** This initiative adds $25 million to current funding of close to $116 million in support of counterdrug activities in Colombia. The expanded support will be used to fund various programs to conduct a unified campaign against both terrorism and drugs. These programs include counternarcotics training for Colombian ground and aviation units, riverine and coastal interdiction support activities and training, and improvements to intelligence, surveillance, and reconnaissance capabilities.

Disrupting the Market: Attacking the Economic Basis of the Drug Trade

The National Drug Control Strategy recognizes the inherent link between drug supply and drug demand, a link that is particularly visible in the behavior of the addicted drug user. Even dependent drug users are quite conscious of the price (and purity) of the drugs they consume and can adjust their use of drugs to market conditions. This should not come as a surprise: addicts must spend almost all their disposable income on illegal drugs, and a disrupted market with unreliable quality and rising prices for drugs such as cocaine and heroin does not magically enable them to earn, beg, borrow, or steal more.

Drug users respond to market forces because the drug trade itself is just that, a market—a profitable one, to be sure (though less profitable than often assumed), but nonetheless a market that faces numerous and often overlooked obstacles that may be used as pressure points. To view the drug trade as a market is to recognize both the challenges involved and the hopeful lessons of our recent experience: that the drug trade is not an unstoppable force of nature but a profit-making enterprise where costs and rewards exist in an equilibrium that can be disrupted. Every action that makes the drug trade more costly and less profitable is a step toward "breaking" the market.

Once the drug trade is seen as a type—admittedly, a special type—of business enterprise, the next step is to examine the way the business operates and locate vulnerabilities in specific market sectors and activities that can then be attacked, both abroad and here at home. Such sectors and activities include the drug trade's agricultural sources, management structure, processing and transportation systems, financing, and organizational decisionmaking. Each represents an activity that must be performed for the market to function.

Reduced to the simplest possible terms, locating market vulnerabilities means identifying the business activities in which traffickers have invested the most in time and money and received the least back in profits. Once identified, these vulnerabilities can be exploited, the efficiency of the business suffers, and the traffickers' investment is diminished or lost.

Business costs of the drug trade include those borne by any large agroindustrial enterprise (such as labor force, cultivation and processing, transportation, communication, warehousing, and wholesale and retail distribution), as well as costs that occur because the enterprise is illegal (such as the need to consolidate and launder proceeds, pay bribes, and accommodate the risks of intertrade betrayal and violence, as well as incorporating "risk premiums" that are charged by those who face possible arrest, incarceration, or death).

Disrupting the Market at Home

As a government, faced with the obvious and urgent challenges of punishing the guilty and taking drugs off the street, our focus on targeting the drug trade as a business—with a view to

increasing its costs—has been episodic. We need to do a more consistent job of ratcheting up trafficker costs at a tempo that does not allow the drug trade to reestablish itself or adapt.

Domestically, the market approach is leading to a new focus on extracting the drug trade's ill-gotten gains; traffickers are, after all, in business to make money. The Department of Justice's Organized Crime Drug Enforcement Task Force (OCDETF) program has been a major force in driving these financial investigations. The OCDETF program was created in 1982 to concentrate federal resources on dismantling and disrupting major drug-trafficking organizations and their money laundering operations. The program also provides a framework for federal, state, and local law enforcement agencies to work together to target well-established and complex organizations that direct, finance, or engage in illegal narcotics trafficking and related crimes.

In the past year, in keeping with the strategy of attacking trafficker vulnerabilities such as money laundering, the Department of Justice has moved to refocus the OCDETF program and its nine member agencies on financial investigations and on multijurisdictional investigations directed at the most significant drug-trafficking organizations responsible for distributing most of the drugs in the United States.

For fiscal year 2004, the Administration proposes an increase of $72 million over the previous fiscal year's requested level for the OCDETF program. This request proposes to consolidate within the Department of Justice what had been three separate OCDETF appropriations, one each for the departments of Justice, Treasury, and Transportation, with the goal of improving the program's accountability, coordination, and focus. More important, it proposes to earmark $73 million of the OCDETF appropriation specifically for the Internal Revenue Service's Criminal Investigation Division—an increase of $7 million over the fiscal year 2003 level—to support that agency's special focus on complex money laundering investigations.

Achieving Unity of Effort

Tales of rival agencies' narcotics agents investigating and ultimately trying to arrest one another are a staple of crime novels, but such lapses in coordination are in fact remarkably rare. A much fairer and less often articulated criticism has been law enforcement agencies' lack of collaboration or across-the-board agreement on a set of trafficker targets.

In order to adopt a market disruption perspective and attack specific market segments, we need such a focus, along with a clear understanding of the scope and character of the drug market. We now have both, thanks largely to a unique collaboration between the DEA, the Federal Bureau of Investigation, the multiagency Special Operations Division, and the Department of Justice, which has, for the first time, resulted in a consolidated list of top trafficker targets. The Consolidated Priority Organization Target (CPOT) list makes unity of effort possible among those federal agencies.

The CPOT list will drive more than the activities of the agencies that produced it. The High Intensity Drug Trafficking Areas (HIDTA) program, administered by ONDCP in 28 HIDTA regions around the country, has already begun using the CPOT list as part of a priority targeting initiative piloted with fiscal year 2002 funds with a budget of $5.7 million.

The HIDTA program was created in 1990 to focus law enforcement efforts on the Nation's most serious drug trafficking threats, but reviews conducted as part of the President's fiscal year 2004 Budget found that the program had not demonstrated adequate results and that over time the initial focus of the program has been diluted. Over the past year, as evidenced by the pilot CPOT initiative, the HIDTA program has begun a shift back to that initial focus on the highest priority trafficking organizations—the wholesale distributors and command-and-control targets.

The HIDTA program has also increased its emphasis on money laundering and financial crimes investigations related to trafficking organizations, providing training for key law enforcement personnel in financial investigative techniques. In 2003, the HIDTA program will continue to increase its focus on investigations, such as those against organizations on the CPOT list, that target the top of the trafficking pyramid. This will entail continuing expansion and refinement of the program's intelligence network—an area that can pay dividends for federal as well as state and local law enforcement.

The goal of unity of effort is being pursued in other areas, including border security. The establishment of the Department of Homeland Security (DHS), by combining into one agency the separate activities and assets of agencies such as the Customs Service, Coast Guard, and Border Patrol, will improve our ability to identify and interdict suspect personnel and illegal contraband entering the United States. Effective DHS counterterrorism systems at and between our ports of entry are also critical in improving our ability to stem the flow of illegal drugs.

A New Focus on Revenue Denial

Americans spend more than $63 billion on illegal drugs—money that must be laundered to be usable by traffickers. It does little good to attack trafficking organizations and leave the proceeds of their crimes untouched. Indeed, money laundering investigations are often key to identifying such organizations in the first place. Anti-money laundering efforts are thus critical to destabilizing trafficking organizations and limiting their power. Enforcement experts divide the process of money laundering into three stages:

- Placement of the illicit funds into the financial system. In the case of paper currency paid for illegal narcotics, the need is obvious. Currency is anonymous, but it is hard to hide, takes time to move, and attracts attention.

- Layering of funds involves moving funds to hide their origin and suggest a legitimate source. Launderers can move funds between nations or financial institutions in a matter of seconds.

- Integration of funds means simply that the funds are put to use by the criminals who "earned" them, either to enjoy as fruits of the crime or to reinvest in their illegal enterprise.

The money launderer is most vulnerable during the placement stage. The strategy of the U.S. Government, both on the regulatory and enforcement sides, is therefore to attack the placement of funds into the financial system. (Valuable new authorities created under the USA PATRIOT Act will increase the government's ability to attack transactions, jurisdictions, and money laundering systems during the layering and integration phases as well.)

Money transmitters, broker-dealers, check cashers, and money order providers are particularly vulnerable to exploitation by organized drug money launderers seeking funds placement. New regulations and strengthened criminal laws provide law enforcement and regulatory agencies with new tools to stop money laundering, for example, subjecting money service businesses to requirements for registration and reporting of suspicious activities, and providing clearer criminal penalties for violations. The departments of Justice, Treasury, and Homeland Security, in consultation with other responsible law enforcement agencies, will develop a long-term comprehensive plan to attack money laundering groups who exploit the money remission system.

Disrupting Markets Overseas

An effective, balanced drug policy requires an aggressive interdiction program to make drugs scarce, expensive, and of unreliable quality. Yet it is an article of faith among many self-styled drug policy "experts" that drug interdiction is futile, for at least two reasons: with millions of square miles of ocean (or "thousands of miles of border," or "millions of cargo containers"), interdictors must be everywhere to be effective. Not being everywhere, it follows that transit zone interdictors from the departments of Defense and Homeland Security are consigned to seizing

FIVE ILLEGAL DRUG MARKETS

There are five principal illegal drug markets in the United States:

- More than 10,000 metric tons (mt) of domestic marijuana and more than 5,000 mt of marijuana cultivated and harvested in Mexico and Canada—marketed to more than 20 million users.
- More than 250 mt of cocaine, most of it manufactured in Colombia and shipped through Mexico and the Caribbean—marketed to more than five million users.
- More than 13 mt of heroin manufactured in Mexico, Colombia, and Asia and shipped via commercial air and maritime carriers—marketed to more than one million users.
- Between 106 and 144 mt of methamphetamine manufactured in Mexico and in the United States—marketed to 1.3 million users.
- Roughly eight mt of Ecstasy manufactured in the Netherlands and Belgium and shipped via commercial carriers—marketed to more than three million users.

a small and irrelevant portion of the flow of cocaine, to pick the drug that currently generating the most emergency room admissions.

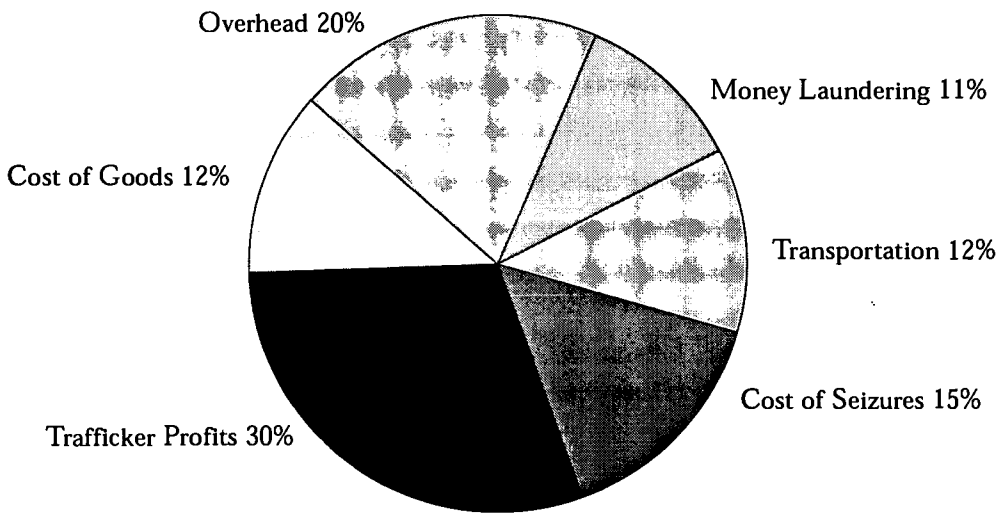
Second, the experts opine that the drug trade is so fabulously lucrative that there will "always be a ready supply" of smugglers (or "kids to deal crack on street corners" or "people willing to grow coca"), and thus seizing even 10 percent (the figure usually cited as folk wisdom) has no effect on the market.

The "experts" are in fact wrong on both counts.

First, although the drug trade is profitable, it is a misunderstanding of the market to assert that every sector and business process in that market has an unlimited capacity to shrug off losses and setbacks.

In 2001, U.S. Government and partner nations seized or otherwise interdicted more than 21 percent of the cocaine shipped to the United States, according to an interagency assessment. When added to the additional 7 percent that is seized at our borders or elsewhere in the United States, current interdiction rates are within reach of the 35 to 50 percent seizure rate that is estimated would prompt a collapse of profitability for smugglers unless they substantially raise their prices or expand their sales to non-U.S. markets. Indeed, according to an interagency assessment of the profitability of the drug trade, traffickers earn just $4,500 for each kilogram of cocaine that is safely

Figure 11: Trafficker Costs and Profits for Cocaine Sold at the U.S. Border



Note: All values are best-point estimates of industry averages. Actual individual organizations' costs can vary. At an average sale price of $15,000/kg at the U.S. border, traffickers earn $4,500/kg. These point estimates average trafficker profits and cost of seizures for two scenarios: 1) Colombian traffickers maintain ownership of the cocaine to the U.S. border, and 2) Colombian traffickers turn over ownership to Mexican counterparts on the high seas.

delivered into the United States—a kilogram that will wholesale for $15,000 (see Figure 11).

Traffickers actually face significant fixed costs for raw materials, money laundering, aircraft and boats, and business overhead such as bribes. Even assuming everything goes according to plan, Colombian groups are typically placed in the unenviable position of handing over an astonishing 40 percent of a given load of cocaine to Mexican traffickers in exchange for the Mexican groups' agreement to smuggle the remaining 60 percent across the border. (Urban ethnographers who looked into the economics of street-level crack dealers in the early 1990s found much the same thing about profitability: many of the kids who supposedly could not be bothered with earning $5 an hour at McDonald's were actually making less than minimum wage dealing crack.)

But, to press the argument, why are the critics necessarily wrong about the impossibility of successful interdiction, especially given the enormous challenge of finding small shipments hidden along extended borders or on vast oceans?

Answering this question requires a closer look at how interdiction is increasingly being focused in ways that cause damage to drug markets. Briefly, interdiction can damage the drug trade precisely because those agencies with responsibility for the interdiction mission—including the Department of Defense and elements of the Department of Homeland Security such as the Coast Guard—do not look for traffickers in millions of square miles of ocean or along thousands of miles of border. Rather, such agencies rely on intelligence to narrow the search and seek out natural chokepoints where they exist.

Interdicting the Flow in Colombia

One such chokepoint is the maritime movement of almost all Colombian cocaine through that nation's coastal waters.

More than 700 metric tons of cocaine is exported annually from South America to the United States and Europe. Roughly 500 mt departs South America in noncommercial maritime conveyances such as elongated "go-fast" boats, each carrying between 0.5 and 2.0 mt of cocaine, and fishing vessels, which typically carry multiton loads of cocaine.

The cocaine threat can thus be described, admittedly in somewhat simplified terms, as 500 maritime shipments heading north annually from the Colombian coast to Mexico and the islands of the Caribbean, in the first stage of multi-leg movements to the U.S. border. According to estimates contained in an interagency assessment of cocaine movement, the 500 shipments are divided roughly evenly between those departing Colombia's north coast (heading both to the Greater Antilles and to Central America) and the west coast (destined for Mexico). In the Pacific, larger cocaine-ferrying fishing vessels are used to consolidate loads far off the Colombian coast, to continue the movement to Mexico.

Go-fast boats are effective because they are small, easily launched from numerous estuaries and small pier locations, and difficult for interdiction forces to locate on the high seas. Colombian traffickers have a significant investment in each shipment as it departs South America—as much as $3 million per go-fast boat. That investment, moreover, is uninsured. Once the cocaine is handed off to

Mexican smugglers for the second leg of its journey, a rudimentary form of insurance takes effect in some cases, with Mexican organizations typically taking as much as 40 percent of the load while agreeing to reimburse Colombian traffickers if the drugs are lost in transport. (This arrangement has had the perverse effect of encouraging local consumption in Mexico, because organizations sell some of their product locally.) While in transit to Mexico, however, cocaine is uninsurable and is owned solely by the Colombian organization.

Attacking go-fast movements in coastal waters thus holds out the promise of rendering unprofitable or minimally profitable a key business sector. The United States will work with the Government of Colombia to direct our air and maritime interdiction resources and assets accordingly, as appropriate, while seeking to create a dedicated sensor infrastructure and establish a robust Colombian capability to interdict drug flows in their coastal waters. The seizures that result will not occur in isolation but will engender investigations into major trafficking organizations and result in better intelligence on future smuggling activities.

About 90 percent of the cocaine entering the United States originates in or passes through Colombia. In addition, the cultivation of opium poppies in Colombia has expanded from almost nothing in 1990 to roughly 6,500 hectares now, producing roughly 4.3 mt of high-purity heroin—enough to supply a sizable portion of the U.S. market. In light of this serious threat, DEA has transferred agent positions from offices in nearby countries to create a heroin task force in Colombia. The Bogota Heroin Group will work with the Colombian National Police on cases involving high-level traffickers servicing U.S. markets.

Colombia's narcotics industry fuels that country's terrorist organizations, which monopolize coca cultivation and are increasingly involved in drug production and trafficking. The Colombian Government estimates that cocaine profits fund more than half of Colombian terror-group purchases of weapons and provide key logistics funding to that nation's illegal armies. Accordingly, U.S. Government policy seeks to support the Government of Colombia in its fight against drug trafficking and terrorism. Those entwined problems are especially evident in parts of Colombia east of the Andes that are underpopulated, and lack a government presence. Most of Colombia's drug crops are grown in such areas, where the rule of law is weak and government access is limited.

In the face of this huge challenge, the past eight months have witnessed a revolution in the way Colombia perceives the link between criminal and political terrorism, drug trafficking, corruption, and weak government institutions. Rather than meekly accepting these as facts of life, Colombia's President Alvaro Uribe is pushing back, both against the drug trade and the terror groups it sustains.

Colombia's rural population, in particular, has been terrorized by Colombia's illegal armies: the FARC, ELN, and AUC. In a single raid last May, FARC rebels incinerated 117 residents of Bojaya, including 45 children, who had taken refuge in the local church. Analysts surmise that the rebels intended to regain control over a smuggling corridor.

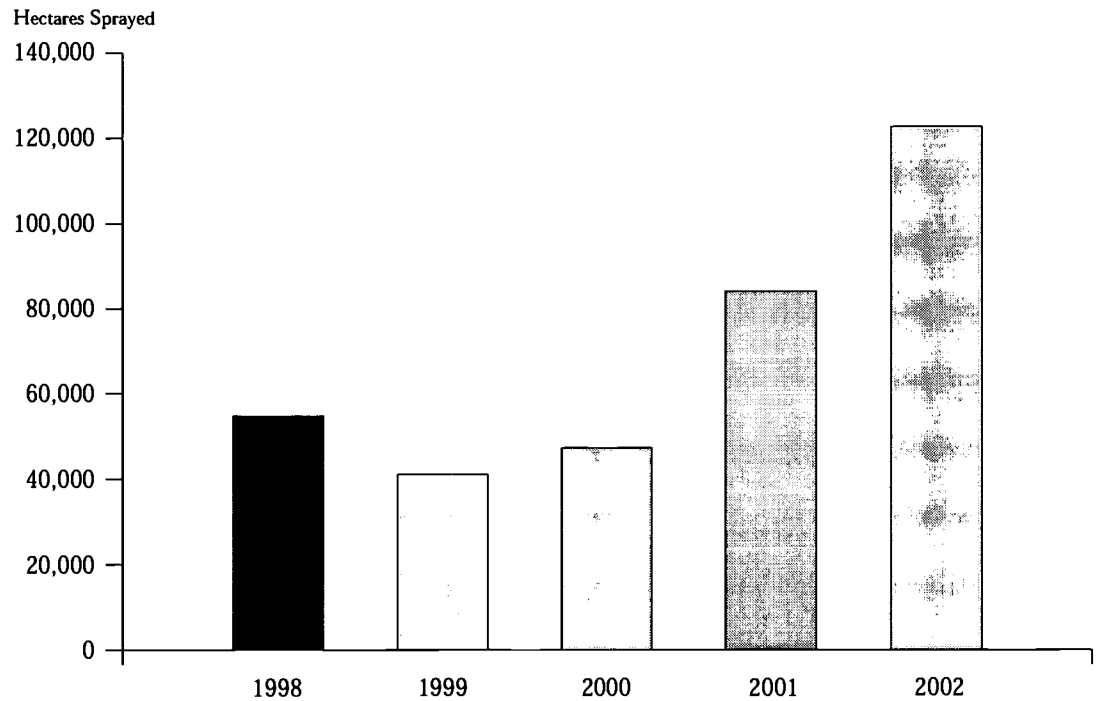
Regrettably, the Bojaya tragedy is not an isolated incident. Terrorist attacks killed more than 3,000 Colombians in 2001. Another 3,041 were kidnapped. The ELN, FARC, and AUC rebels were responsible for more than 2,000 of these victims, including 205 children as young as

three years old. The AUC has killed two Colombia legislators in the past year, and the FARC has kidnapped five legislators, a presidential candidate, and a Catholic archbishop. The three terrorist groups have also assassinated 12 mayors, and the FARC has threatened many others, leaving them with a choice of resigning or being killed.

With the election of President Uribe, Colombia has accelerated implementation of its drug control program, eradicating record levels of coca and moving aggressively in several areas to weaken criminal and terrorist organizations, reestablish the rule of law in war-torn regions, and protect the rights and security of Colombian citizens. Significant drug control gains in Colombia will require—and President Uribe has committed to pursuing—restoration of the rule of law to areas that are currently terrorist-controlled and used to cultivate and produce illegal drugs.

With U.S. assistance, Colombia has established carefully screened, or "vetted," law enforcement task forces comprised of investigators, prosecutors, and support personnel with specialties including asset forfeiture, money laundering, and human rights. Colombian authorities and their U.S. counterparts from the DEA are also working to attack the Black Market Peso Exchange money laundering system, one of the mechanisms that enable Colombian traffickers to repatriate their drug profits.

Figure 12: An Expanding Coca Eradication Program in Colombia



Note: Estimates reflect total ground area covered. Source: U.S. Department of State

Aerial spraying is a major component of Colombia's strategy for fighting the drug trade and is the program with the single greatest potential for disrupting the production of cocaine before it enters the supply train to the United States. Spray operations have the potential to cause collapse of the cocaine industry if the spraying is intensive, effective, and persistent. Replanting coca is expensive for farmers, in terms of both labor inputs and opportunity costs (coca seedlings typically take a year to begin bearing harvestable leaf). According to estimates by the Institute for Defense Analyses, eradicating 200,000 hectares of coca would cost farmers $300 million—costs significant enough to cause growers to conclude cultivation is uneconomical.

The Government of Colombia may have achieved this rate of eradication in the coca-rich parts of Putumayo and Caqueta during parts of 2002, although repeated spraying over the next twelve months will be necessary in most areas to deter replanting. Continued U.S. support will be critical for Colombia to maintain this level of eradication.

Where eradication prompts hoped-for movements of growers out of remote planting areas, alternative development programs managed by the U.S. Agency for International Development will be there to absorb some of the disruptive effect on local economies.

U.S. assistance will focus alternative development aid in areas where projects will be economically viable and self-sustaining and where there is, or soon will be, enough government presence to ensure that the projects will be implemented for the benefit of legitimate production and democratic rule. Implementation should be fully integrated with Colombian government efforts to establish security and implement other anti-drug, economic, and social programs.

The Andean Ridge

Rising demand for cocaine in Europe and Latin America and expanded drug control in Colombia are placing increased stress on Peru and Bolivia, with farmgate prices for coca products at high levels in both countries. New administrations in both these countries face difficult challenges in reducing drug production while confronting economic weakness and political instability.

The economies of Peru and Bolivia have suffered through the sluggish global economy and the economic deterioration of traditional export markets in Brazil and Argentina. This in turn has put a strain on employment and alternative development. In some cases, traffickers are pushing legitimate governments through a combination of lawlessness and radical demands. These actions are undermining democratic institutions, making them vulnerable to increased corruption and violence—the path that Colombia faced many years ago.

In Peru, the Toledo government faces the significant challenge of rebuilding democratic institutions in an atmosphere of reduced public confidence. Coca cultivation is rebounding in regions frequented by Sendero Luminoso terrorists, while Peru has weakened its security presence in some drug cultivation regions and slowed implementation of its overall drug control effort. Peru must act with renewed decisiveness to prevent a resurgence of the volatile combination of Sendero terrorism and expanded cocaine production.

Bolivia is also in the middle of a turbulent period. In the past year, radical groups launched violent protests that have damaged the economy and challenged the government. These groups, including coca growers, indigenous activists,

teachers, and urban consumers, have divergent goals and have not followed a single leader in the past, but more recently they have demonstrated an ability to work together. Opposition and minority political groups have had their legitimate issues hijacked by a vociferous pro-coca movement, and serious reformers may find themselves uncomfortably aligned with a cast of marginal political figures who believe Bolivia's destiny is to supply coca to the world.

The Sanchez de Lozada government has strenuously avoided violent confrontations but is now being pressed to grant concessions that could undo the gains made by the previous administration to substitute legal employment for coca cultivation. In 2002, Bolivian coca cultivation increased by 23 percent over 2001 levels, sufficient to produce roughly 60 mt of cocaine. The United States has been clear in its message that Bolivia must stay the course on eradication or risk losing much U.S. Government assistance and economic support.

Mexico: Building on Success

Mexico lies squarely between Andean Ridge cocaine producers and American consumers. It produces thousands of tons of marijuana, more than seven mt of heroin, and an unknown quantity of methamphetamine yearly. Here the situation is both a great challenge and a great opportunity, offering more hope than at any time in many years. On entering office, President Vicente Fox recognized that his vision for a prosperous Mexico had no place for institutionalized drug cartels and the corruption and lawlessness they foster. He is taking serious action against them, targeting the murderous Arellano Felix Organization, among others. He strengthened law enforcement cooperation with the United States and began the process of reforming dysfunctional and sometimes corrupt institutions.

Such bold action comes at a price. In February 2001, in an incident credited to the drug trade, masked men armed with machine guns herded 15 men and boys into the back of a truck and killed 12. In November of the same year, two Mexican federal judges and the wife of another judge were cut down by AK-47 fire from a passing vehicle; one of the judges had reportedly angered traffickers with a ruling. (President Fox described the latter attack as "a crime against the state as a whole.") More recently, a counterdrug police commander was boxed in on a highway and shot to death, a hit popularly attributed to drug traffickers. Despite all this, Mexican resolve to end international drug trafficking in their territory remains strong.

Since President Fox assumed office in December 2000, 14 major traffickers have been apprehended, and almost 300 of their immediate subordinates have been taken off the streets. Cooperative law enforcement targeting the Tijuana-based Arellano-Felix Organization—responsible for smuggling over one-third of the cocaine consumed in the United States—culminated last March with the arrest of Benjamin Arellano Felix (shortly after the killing of his brother, Ramon Arellano Felix). A month later, the Gulf Cartel's second in command was arrested. The leader of a Juarez-based gang that often coordinated shipments with the Gulf Cartel was arrested last May. In September, Mexican authorities placed in

custody the head of a gang that controlled Mexico City's drug trade.

Key Fox Administration steps toward institutional reform have included compartmentalizing Mexico's anti-organized crime unit to reduce leaks and ensuring that all new members are vetted with polygraph tests and psychological evaluations. A new Agencia Federal de Investigaciones was established by Attorney General Rafael Macedo de la Concha, and Mexico's *National Drug Control Program* was published in November 2002. Finally, the Fox Administration has been unafraid to go after corrupt officials in government and in the military, as evidenced by the sentencing in November 2002 of two general officers accused of aiding the drug trade, and the arrest in October 2002 of two dozen individuals charged with leaking information on the drug control activities of the army, federal police, and the Attorney General.

Other positive signs include a steady stream of internecine trafficker killings, as smugglers vie for market control and command of trafficking routes. Major challenges remain, however, including reducing the backlog of extradition requests from the United States. Meaningfully disrupting the flow of drugs to the United States will also require sustained progress toward strengthening law enforcement and ending impunity to the rule of law.

The United States will continue to support Mexico's drug control efforts through a combination of technical and material assistance that focuses on training and operational support for organizational attack and arrests, disruption of money laundering activities, cocaine and marijuana interdiction initiatives, and enhanced and expanded aid for marijuana and opium poppy eradication.

Afghanistan: Rebuilding Drug Control Capabilities

The state of internal disruption immediately following the fall of the Taliban has brought with it renewed poppy cultivation and a partial rebounding of opium production. Although production levels remain below those of the boom years of 1996–2000, recent increases have returned to Afghanistan the dubious distinction of world's largest opiate producer, with 2002 production estimated to be more than twice that of Burma, the world's other major opium producer (see Figure 13).

For post-Taliban Afghanistan, the stakes could scarcely be higher. By funding local warlords, the Afghan drug trade contributes to local political instability. It also threatens governments worldwide through the financial assistance that drug profits can provide to terrorist organizations such as al Qaeda. For these reasons, the United States strongly supports multilateral efforts to reduce the illegal opium and heroin trade that is returning to Afghanistan.

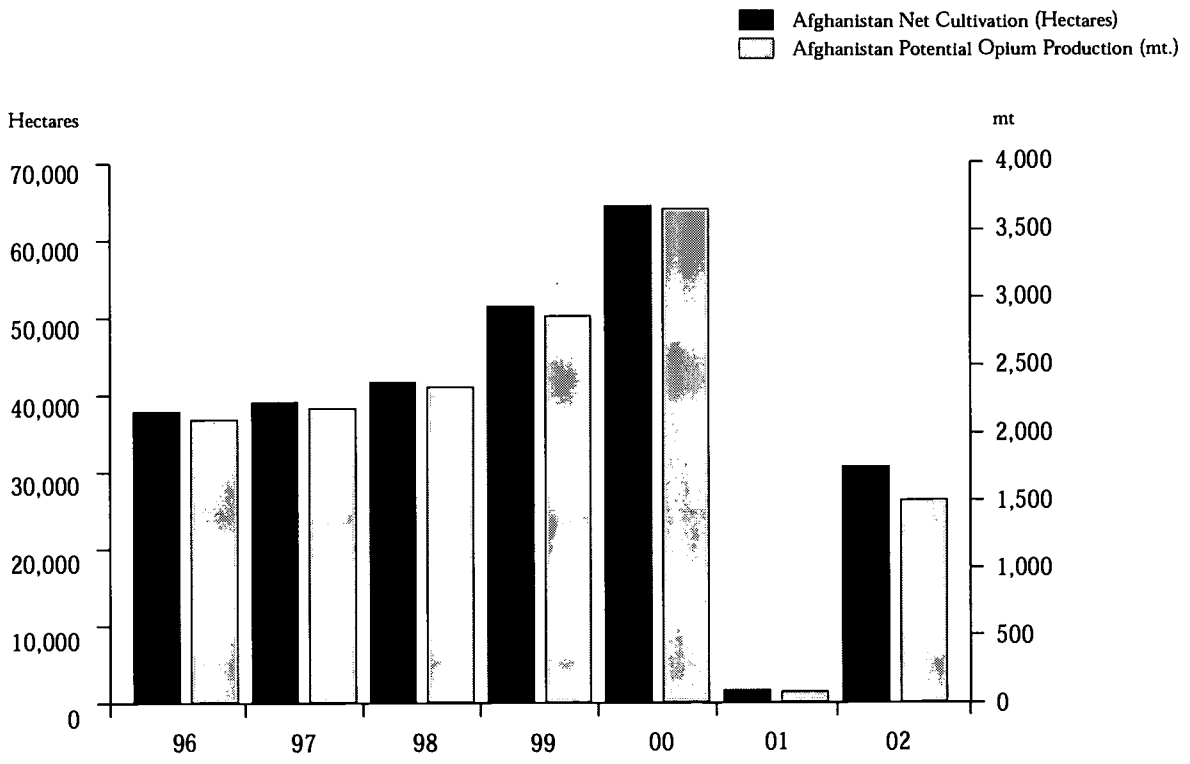
These multinational efforts include as partner nations members of the G-8, particularly the United Kingdom, which is the G-8 lead nation for counternarcotics programs in Afghanistan. The aim of our multilateral efforts is to diminish the destabilizing influence of illegal drugs in Afghanistan and break the links between Afghanistan's drug trade and its terrorist organizations. We intend to achieve these objectives through long-term initiatives that will disrupt Afghanistan's opium trade and provide alternative livelihoods and economic opportunities, a real and effective rule of law, and an environment favorable for an effective representative central government.

The strategy has two key elements. First, it seeks to disrupt the activities of the most significant drug traffickers through interdiction and law enforcement. Through activities such as DEA's Operation Containment, the United States will bolster the counternarcotics capabilities of the countries bordering Afghanistan to choke off the flow of drugs, precursor chemicals, and related supplies into and out of that nation. Second, the strategy seeks to cut opium production through alternative livelihood initiatives for farmers, coupled with comprehensive eradication efforts.

Consistent with this international effort, the United States will support the establishment of a drug policy agency and an anti-drug law enforcement agency and will work to strengthen Afghanistan's judicial institutions to enable the expansion of the rule of law. Afghan military and law enforcement personnel will be trained and equipped to perform the border and regional security functions that are vital to extending government control to areas without the rule of law and permeated by the illegal drug trade. Concurrently, near-term efforts will be started to eliminate drug-related corruption from the central and regional governments and the military.

We will collaborate with the international community and international aid organizations

Figure 13: Afghanistan Net Poppy Cultivation and Potential Opium Production



to create opportunities for legitimate economic livelihoods for Afghan farmers and laborers through initiatives that provide micro-credit alternatives and subsistence loans, legal crop substitution options, and cash-for-work programs for migrant workers. Where possible, programs will be focused on projects to redevelop the education, health, public safety, social services, telecommunications, and transportation infrastructure of Afghanistan.

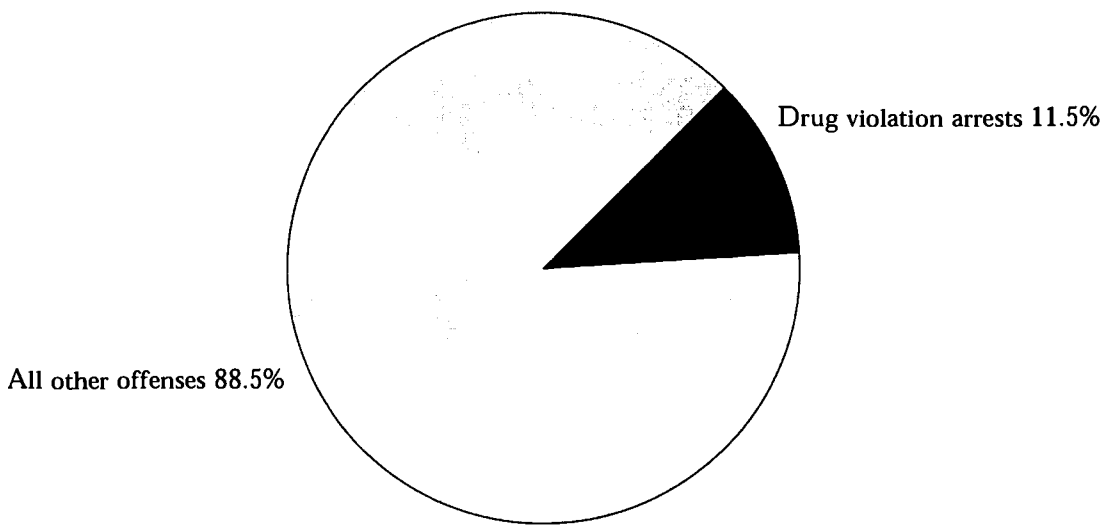
To be successful in Afghanistan, the international community will have to provide a long-term commitment to both the counternarcotics efforts and the broader challenge of nation building. These activities all involve multilateral international efforts, in which the United States is one of many participants.

Developments in Western Europe

The market for illegal drugs is international in scope—the world trade in cocaine now includes significant satellite markets in Europe. Consumption of Asian-produced heroin is also widespread throughout European Union nations. Any market-based understanding of the drug trade must account for the operation of these markets, which, if left unfettered, have the capacity to buffer U.S.-led efforts to disrupt the drug trade in this hemisphere.

The United States is thus watching closely as the debate in several European countries

Figure 14: Drug Violation Arrests Accounted for 11% of All Arrests in 2001



Source: Uniform Crime Reports

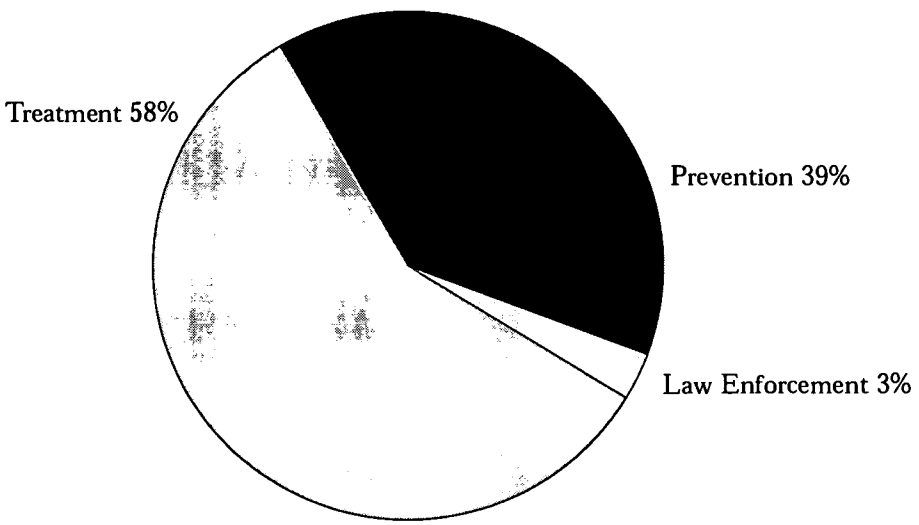
increasingly frames the drug issue as a public health rather than a law enforcement problem. As discussed in detail earlier, a closer look at the drug problem reveals the difficulty of disentangling the two. The fact is, some nations may face an increase in both public health and law enforcement difficulties as a consequence of policies being adopted.

Decriminalization policies are being promoted as precisely what they are not—a public health response to the drug problem. These "tolerant" approaches are contrasted with the supposedly more "punitive" drug policy in the United States. As a recent media report put it, "The trend in Western Europe is to decriminalize all drugs, including heroin and cocaine, and treat drug use as a health problem rather than a crime."

There are two ironies in this characterization. First is the notion that U.S. policy is driven solely by the desire to punish, when, in fact, drug arrests account for a small fraction of total arrests (see Figure 14) and U.S. prevention and treatment programs are the most developed and best funded in the world (President Bush has pledged to increase the drug treatment budget by $1.6 billion over five years.) U.S. medical research on treatment and prevention, led by NIDA, is unsurpassed and heavily outweighs the amounts spent on enforcement- and interdiction-related research (see Figure 15).

The second irony is the posture that such "harm reduction" approaches represent a genuine public health approach. No policy can seriously be considered in the public good if it advances

Figure 15: Federal Research & Development Spending for Treatment and Prevention (FY 2004 Request)



Total Dollars = $1,059 million

the contagion of drug use. Yet that is precisely the effect of harm reduction actions such as marijuana decriminalization: as the drug becomes more available, acceptable, and cheap, it draws in greater numbers of vulnerable youth.

The United States will continue to engage this issue in various multilateral forums, including the U.S.-E.U. Demand Reduction Seminar, which has led to a commitment to exchange ideas and experiences in combating drug use and drug dependence. Other important multilateral fora include the European Monitoring Center for Drugs and Drug Addiction.

National Drug Control Strategy:

APPENDIXES

National Drug Control Budget Summary

Drug Control Funding: Agency Summary, FY 2002–FY 2004 (Budget Authority in Millions)

	FY 2002 Final BA	FY 2003 Request	FY 2004 Request
Department of Defense[1]	$852.6	$871.9	$817.4
Department of Education	669.3	634.3	584.3
Department of Health & Human Services			
National Institute on Drug Abuse	885.2	960.0	995.6
Substance Abuse and Mental Health Services Administration	2,304.4	2,372.6	2,575.3
Total HHS	**3,189.6**	**3,332.6**	**3,570.9**
Department of Homeland Security			
Border and Transportation Security	1,183.6	1,271.8	1,372.9
U.S. Coast Guard	609.7	596.1	669.1
Total DHS	**1,793.3**	**1,867.9**	**2,041.9**
Department of Justice			
Bureau of Prisons	39.4	43.5	45.2
Drug Enforcement Administration	1,562.5	1,659.6	1,677.3
Interagency Crime and Drug Enforcement[2]	446.5	470.3	541.8
Office of Justice Programs	893.2	286.7	301.5
Total DOJ	**2,941.5**	**2,460.1**	**2,565.8**
ONDCP			
Operations	25.2	25.5	27.3
High Intensity Drug Trafficking Area Program	221.3	206.4	206.4
Counterdrug Technology Assessment Center	42.3	40.0	40.0
Other Federal Drug Control Programs	239.3	251.3	250.0
Total ONDCP	**528.1**	**523.1**	**523.6**
Department of State			
Bureau of International Narcotics and Law Enforcement Affairs	871.9	877.5	876.9
Department of Veterans Affairs			
Veterans Health Administration	635.7	663.7	690.5
Other Presidential Initiatives[3]	3.0	8.0	8.0
Total Federal Drug Budget	**$11,485**	**$11,239.0**	**$11,679.3**

[1] The FY 2003 funding level for the Department of Defense reflects enacted appropriations.
[2] The FY 2004 Budget proposes the merger of the Treasury ICDE account into Justice's ICDE account. This merger is reflected retrospectively.
[3] This includes $5 million for the Corporation for National Service's Parents Drug Corps beginning in FY 2003 and $3 million for SBA's Drug-Free Workplace programs for all three fiscal years.

Acknowledgments

Consultation

The Office of National Drug Control Policy Reauthorization Act of 1998 requires the ONDCP Director to consult with a variety of experts and officials while developing and implementing the National Drug Control Strategy. Specified consultants include the heads of the National Drug Control Program agencies, Congress, state and local officials, citizens and organizations with expertise in demand and supply reduction, and appropriate representatives of foreign governments. In 2002, ONDCP consulted with both houses of Congress and 28 federal agencies. At the state and local level, 55 Governors were consulted, as well as the National Governors Association, U.S. Conference of Mayors, and National Association of Counties. ONDCP also solicited input from a broad spectrum of nonprofit organizations, community anti-drug coalitions, chambers of commerce, professional associations, research and educational institutions, and religious organizations. The views of the following individuals and organizations were solicited during the development of the National Drug Control Strategy:

Members of the United States Senate

Daniel K. Akaka – HI
Joseph R. Biden – DE
Jeff Bingaman – NM
Christopher Bond – MO
Sam Brownback – KS
Jim Bunning – KY
Ben Nighthorse Campbell – CO
Maria Cantwell – WA
Jean Carnahan – MO
Thomas R. Carper – DE
Hillary Rodham Clinton – NY
Thad Cochran – MS
Susan M. Collins – ME
Mark Dayton – MN
Mike DeWine – OH
Christopher J. Dodd – CT
Byron L. Dorgan – ND
Richard J. Durbin – IL
John Edwards – NC
Michael B. Enzi – WY
Russell D. Feingold – WI
Dianne Feinstein – CA
Bill Frist – TN
Bob Graham – FL
Charles E. Grassley – IA
Judd Gregg – NH
Tom Harkin – IA
Orrin G. Hatch – UT
Tim Hutchinson – AR
James M. Jeffords – VT
Edward M. Kennedy – MA
Herb Kohl – WI
Jon L. Kyl – AZ
Mary L. Landrieu – LA

Patrick J. Leahy – VT
Carl Levin – MI
Joseph P. Lieberman – CT
Mitch McConnell – KY
Barbara A. Mikulski – MD
Patty Murray – WA
Jack Reed – RI
Pat Roberts – KS
Charles E. Schumer – NY
Jeff Sessions – AL
Richard C. Shelby – AL
Arlen Specter – PA
Ted Stevens – AK
Fred D. Thompson – TN
Strom Thurmond – SC
Robert G. Torricelli – NJ
George V. Voinovich – OH
John W. Warner – VA

Members of the United States House of Representatives

Robert B. Aderholt – AL
Thomas H. Allen – ME
Joe Baca – CA
Brian Baird – WA
Cass Ballenger – NC
Bob Barr – GA
Joe Barton – TX
Doug Bereuter – NE
Shelley Berkley – NV
Marion Berry – AR
Judy Biggert – IL
Rod R. Blagojevich – IL
Henry Bonilla – TX
Mary Bono – CA
Leonard Boswell – IA
Dan Burton – IN
Ken Calvert – CA
Chris Cannon – UT
Howard Coble – NC
Christopher Cox – CA
Elijah E. Cummings – MD
Randy "Duke" Cunningham – CA
Danny K. Davis – IL
Jo Ann Davis – VA
Nathan Deal – GA
Norman D. Dicks – WA
Cal Dooley – CA
Jennifer Dunn – WA
Jo Ann Emerson – MO
Lane Evans – IL
Ernie L. Fletcher – KY
Elton Gallegly – CA
Jim Gibbons – NV
Benjamin A. Gilman – NY
Robert W. Goodlatte – VA
Porter J. Goss – FL
Kay Granger – TX
Melissa Hart – PA
J. Dennis Hastert – IL
J.D. Hayworth – AZ
Wally Herger – CA
Van Hilleary – TN
Darlene Hooley – OR
Stephen Horn – CA
John N. Hostettler – IN
Steny H. Hoyer – MD
Duncan L. Hunter – CA
Henry J. Hyde – IL
Jay Inslee – WA
Johnny Isakson – GA
Ernest J. Istook – OK
Jack Kingston – GA
Mark Steven Kirk – IL
Jim Kolbe – AZ
Tom Lantos – CA
Rick Larsen – WA
Tom Latham – IA

Jim Leach – IA
Ron Lewis – KY
Frank LoBiondo – NJ
Frank D. Lucas – OK
Jim Matheson – UT
Robert Matsui – CA
Karen McCarthy – MO
Jim McDermott – WA
Scott McInnis – CO
Buck McKeon – CA
Carrie Meek – FL
John L. Mica – FL
Dan Miller – FL
Jerry Moran – KS
Sue Myrick – NC
George R. Nethercutt – WA
Anne Meagher Northup – KY
Tom Osborne – NE
Doug Ose – CA
Mike Pence – IN
John E. Peterson – PA
Richard Pombo – CA
Rob Portman – OH
David E. Price – NC
George P. Radanovich – CA
Silvestre Reyes – TX
Harold Rogers – KY
Mike Rogers – MI
Ileana Ros-Lehtinen – FL
Mike Ross – AR
Steven B. Rothman – NJ
Loretta Sanchez – CA
Bernard Sanders – VT
Max Sandlin – TX
Bob Schaffer – CO
Janice D. Schakowsky – IL
Pete Sessions – TX
Don Sherwood – PA
Ronnie Shows – MS
Robert R. Simmons – CT
Adam Smith – WA
Chris Smith – NJ
Lamar S. Smith – TX
Mark Souder – IN
John E. Sununu – NH
John E. Sweeney – NY
Ellen Tauscher – CA
W.J. "Billy" Tauzin – LA
Bill Thomas – CA
Todd Tiahrt – KS
Jim Turner – TX
Tom Udall – NM
Peter J. Visclosky – IN
Greg Walden – OR
Zach Wamp – TN
Wes Watkins – OK
J.C. Watts – OK
Dave Weldon – FL
Roger F. Wicker – MS
Heather Wilson – NM
Frank R. Wolf – VA
David Wu – OR

Federal Agencies

Department of Defense
Department of Education
Department of Health and Human Services
Department of the Interior
Department of Justice
Department of Labor
Department of State
Department of Transportation
Department of the Treasury
Department of Veterans Affairs
Corporation for National and Community Service
Small Business Administration
Bureau of Alcohol, Tobacco, and Firearms
Defense Intelligence Agency
Drug Enforcement Administration
Federal Bureau of Investigation

Federal Bureau of Prisons
Immigration and Naturalization Service
National Institute on Drug Abuse
National Institutes of Health
Substance Abuse and Mental Health Services Administration
U.S. Agency for International Development
U.S. Coast Guard
U.S. Forest Service
U.S. Marshals Service
U.S. Secret Service

Foreign Governments and International Organizations

Brazil
Canada
Colombia
Mexico
Peru
International Narcotics Control Board
Organization of American States
United Nations Office on Drugs and Crime

Governors

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John Street – Philadelphia, PA
Wellington Webb – Denver, CO
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Francis Slay – St. Louis, MO

Other Organizations and Individuals

Abt Associates
Addiction Research and Treatment Corporation
AFL-CIO
Alcohol and Drug Problems Association of North America
America Cares
American Association for the Treatment of Opioid Dependence
American Correctional Association
American Enterprise Institute
American Federation of Government Employees
American Federation of Teachers
American Medical Association
American Psychological Association
American Public Health Association
American Public Welfare Association
American Society of Addiction Medicine
Appalachian State University of North Carolina
Arizona Department of Education
Arizona Science Center
Association of Flight Attendants
Auburn University
Boy Scouts of America
Boys & Girls Clubs of America
Brandeis University Institute for Health Policy
Brookhaven National Laboratory
Brookings Institution
Brownsville Police Department
Caliber Associates
California Institute of Technology
California Narcotics Officers' Association
California Regional Primate Center
Californians for Drug-Free Youth
Canada Customs and Revenue Agency
Carnegie Mellon University
Carnevale Associates
Catholic Charities USA
Center for Alcohol and Drug Research and Education
Center for Media Education
Center for Media Literacy
Center for Problem Solving Courts
Centers for Family Life
Century Foundation
Chesterfield County Police Department
Children's Hospital of Philadelphia
Child Welfare League of America
Church of Jesus Christ of Latter-Day Saints

Civitan International
Colorado Department of Human Services
Colorado Justice Information Network
Columbia University
Community Anti-Drug Coalitions of America
Congress of National Black Churches
Harry F. Connick
Cornell University
Council of State Governments
County Executives of America
D.A.R.E. America
Direct Impact
Drug and Alcohol Service Providers Organization of Pennsylvania
Drug Free America Foundation
Drug Free Pennsylvania
Drug Watch International
DuPont Associates, PA
DynMeridian
Employee Assistance Professionals Association
Employee Health Programs
Empower America
Emory University
Entertainment Industries Council
Family Research Council
Federal Law Enforcement Officers Association
Fellowship of Christian Athletes
Florida Chamber of Commerce
Fraternal Order of Police
Gamma Metrics
Georgetown University
Georgia State University Department of Psychology
Girl Scouts of the USA
Harvard University
Heritage Foundation
Hillsborough County Sheriff's Office
Hispanic American Police Command Officers Association
Houston Advanced Research Center
Independent Order of Odd Fellows
Institute of Biological Detection Systems
Institute for Defense Analyses
Institute for a Drug-Free Workplace
Institute on Global Drug Policy
Institute for Social Research
Institute for Youth Development
Integrated Systems Research Corporation
International Association of Chiefs of Police
International Association of Lions Clubs
International Brotherhood of Police Officers
Iowa Board of Parole
Jewish Council for Public Affairs
Johns Hopkins University
Johnson Institute Foundation
Join Together
Joint Center for Political and Economic Studies
Junior Chamber International
Kansas City, Missouri, Police Department
Kiwanis International
Lawrence Livermore National Laboratory
Legal Action Center
Lewin Group
Los Angeles County Sheriff's Department
David M. Luitweiler
Major City Chiefs Association
Massachusetts General Hospital
Massachusetts Institute of Technology
Maximizing Adolescent Potentials
Mayo Clinic
Miami Coalition
Michigan State Police Investigative Services Bureau
Milton S. Eisenhower Foundation
Minneapolis Police Department
Montana State University
Montreal Neurological Institute
Moose International
Mothers Against Drunk Driving
National Alliance of State Drug Enforcement Agencies

National Asian Pacific American Families Against Substance Abuse
National Association of Alcoholism and Drug Abuse Counselors
National Association of Attorneys General
National Association for Children of Alcoholics
National Association of Counties
National Association of County Behavioral Health Directors
National Association of Drug Court Professionals
National Association of Elementary School Principals
National Association of Native American Children of Alcoholics
National Association of Neighborhoods
National Association of Police Organizations
National Association of Secondary School Principals
National Association of State Alcohol and Drug Abuse Directors
National Association of Student Assistance Professionals
National Black Child Development Institute
National Center on Addiction and Substance Abuse at Columbia University
National Center for Missing and Exploited Children
National Center for State Courts
National Center for Tobacco-Free Kids
National Coalition of Hispanic Health and Human Services Organizations
National Conference of State Legislatures
National Council of Juvenile and Family Court Judges
National Council of State Legislatures
National Crime Prevention Council
National Criminal Justice Association
National Development and Research Institutes
National District Attorneys Association
National Exchange Club
National Families in Action
National Family Partnership
National Federation of State High School Associations
National Governors Association
National Hispanic/Latino Community Prevention Network
National Inhalant Prevention Coalition
National Institute of Neurological Disorders and Stroke
National League of Cities
National Legal Aid & Defender Association
National Library of Medicine
National Masonic Foundation for Children
National Mental Health Association
National Narcotic Officers' Associations' Coalition
National Opinion Research Center
National Organization of Black Law Enforcement Executives
National Parents and Teachers Association
National Pharmaceutical Council
National Prevention Network
National Research Council
National School Boards Association
National Sheriffs' Association
National Treatment Consortium
National Troopers Coalition
Naval Research Laboratory
New York State Psychiatric Institute
New York University School of Medicine
Northwestern University
Operation PAR
Oregon Partnership
Oregon Health & Science University
Orthodox Union
Parents' Resource Institute for Drug Education
Partnership for a Drug-Free America
Penn State University
Phoenix House

Physicians for Prevention
Pima County Sheriff's Department
Police Executive Research Forum
Police Foundation
Prevention, Intervention, and Treatment Coalition for Health
Prevention Think Tank
Prevention Through Service Alliance
Quota International
RAND Drug Policy Research Center
Research Triangle Institute
Robert Wood Johnson Foundation
Robert Wood Johnson Medical School
Office of the Rockland County District Attorney
Safe Streets
Sandia National Laboratories
Science Applications International Corporation
Scott Newman Center
Betty Sembler
South Carolina Law Enforcement Division
Southern Christian Leadership Conference
Stanford University School of Medicine
Substance Abuse Program Administrators Association
Support Center for Alcohol and Drug Research and Education
Texas Commission on Alcohol and Drug Abuse
Therapeutic Communities of America
Torrey Mesa Research Institute
Treatment Alternatives for Safe Communities
Treatment Research Institute
Troy Community Coalition for the Prevention of Drug and Alcohol Abuse
Union of American Hebrew Congregations
United Methodist Church, Washington Episcopal Area
U.S. Conference of Mayors
United Synagogue of Conservative Judaism
University Hospitals of Cleveland
University of Arizona
University of California, Los Angeles
University of California, San Diego
University of Chicago
University of Cincinnati
University of Colorado Health Sciences Center
University of Delaware Center for Drug and Alcohol Studies
University of Florida
University of Iowa
University of Kentucky Center for Prevention Research
University of Maryland
University of Miami School of Medicine
University of Minnesota
University of New Mexico
University of North Dakota
University of Pennsylvania
University of Pittsburgh School of Medicine
University of South Florida
University of Texas
Urban Institute Justice Policy Center
U.S. Anti-Doping Agency
Wake Forest University School of Medicine
Walsh Group
Washington Business Group on Health
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White Bison
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