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THE STRUGGLE

There is no magic bullet to eradicate drug abuse. Drugs purport to provide an instant answer to boredom, anxiety or pain. But the solution to the drug problem for the individual and the country is anything but instant. Treating drug addiction requires patience, compassion, and a will to carry on.

Barry McCaffrey
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Drug Control Policy

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NOTE ON INTERNET SITES: The Narcotics and Substance Abuse page on the USIS homepage provides an extensive amount of additional information, including documents and articles, as well as many other internet sites from both the public and private sectors. Readers may visit the narcotics page on the USIS home page at "http://www.usia.gov/topical/global/drugs/subab.htm" under Global Issues/Communications.

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FOCUS

Dealing With Addiction

By Barry McCaffrey
Director of the Office of National Drug Control Policy

As a nation we have made enormous progress in our efforts to reduce drug use and its consequences. Our diverse drug prevention and education campaigns have been successful. While America's illegal drug problem remains serious, it does not approach the emergency situation of the late 1970s, when drug abuse skyrocketed, or the cocaine epidemic of the 1980s.

In the past 15 years, we have reduced the number of illicit drug users by 50 percent. Just 6 percent of our household population age 12 and over was using drugs in 1995, down from 14.1 percent in 1979. Cocaine use has also plunged, dropping 30 percent in the past four years. More than 1.5 million Americans were current cocaine users in 1995, a 74 percent decline from 5.7 million a decade earlier. Cocaine is on its way out as a major threat in America. In addition, drug-related homicides are down by 25 percent. Most of our largest companies have effective drug-free workplace programs. And our towns and cities have formed more than 3,500 community anti-drug coalitions — the one in Miami reducing drug use by 50 percent. It is clear that when we focus on the drug problem, drug use and its consequences can be driven down.

But the consequences of illegal drug use remain unacceptably high. Currently we have 3.6 million Americans who are addicted to illegal drugs. Of those, 2.7 million are hard-core addicts who consume 80 percent of the illegal drugs in America. There is no doubt that substance abuse is our biggest national health problem. During the decade of the 1990s, illegal drugs have killed more than 100,000 people and cost more than $300,000 million in health care, prison incarceration, accidents, and litigation. Tobacco kills another 400,000 a year. Alcohol kills more than 100,000. Between 13 and 24 percent of Americans suffer from substance-abuse disorders sometime in their lives, making this the most prevalent of all psychiatric disorders in the United States.

The most alarming drug trend is the increasing use of illegal drugs, tobacco, and alcohol among youth. According to a study conducted by Columbia University's Center on Addiction and Substance Abuse (CASA), children who smoke marijuana are 85 times more likely to use cocaine than peers who never tried marijuana. The use of illicit drugs among eighth graders is up 150 percent over the past five years. While alarmingly high, the prevalence of drug use among today's young people has not returned to the near-epidemic levels of the late 1970s. Still, we cannot stand idly by and allow drug use by our children to continue to rise.

We are not content with the current domestic demand for illegal drugs, and our government will

not tolerate its continuation. We are absolutely committed to reducing drug use and its disastrous consequences. Each year our federal, state, and local governments spend more than a combined $30,000 million on counterdrug programs, and treatment is the centerpiece of our counterdrug strategy.

No Magic Bullet

There is no question that effective treatment programs can put people in a position where they no longer suffer from addiction, where they are not involved in street crime, where they are less likely to be a victim of AIDS. We can intervene successfully in these situations. And that's the kind of thing we're trying to organize for those who are suffering from addiction to cocaine, heroin, methamphetamines, and other drugs.

No magic bullet can eradicate drug abuse overnight, but treatment does bring sustained reduction in drug use. Drugs purport to be an "instant" answer — whether to boredom, anxiety, frustration, thrill-seeking, or pain. By contrast, the solution to the drug problem for the individual and the country is anything but instant. We can make headway against this difficult problem by adopting a long-range approach that demands patience and perseverance.

The metaphor of a "war on drugs" is misleading. It implies a lightning, overwhelming attack. We defeat an enemy. But who's the enemy in this case? It's our own children. It's fellow employees. The metaphor starts to break down. The United States does not wage war on its citizens. The chronically addicted must be helped, not defeated.

A more appropriate conceptual framework for the drug problem is the metaphor of cancer. Dealing with cancer is a long-term proposition. It requires the mobilization of support mechanisms — human, medical, educational, and societal, among others. To confront cancer, we must check its spread, deal with its consequences, and improve the prognosis. Resistance to the spread of both cancer and drug addiction is necessary, but so is patience, compassion, and the will to carry on. Pain must be managed while the root cause is attacked. The road to recovery is long and complex.

For women and men of all ages, regardless of the drugs, we have found that treatment works when it is structured, flexible, sufficiently long, and integrated with other forms of rehabilitation. Drug addiction was once viewed exclusively as a moral problem or character defect. Today we understand it to be a chronic, recurring illness with personal and social underpinnings. Drug addiction produces changes in brain chemistry, but treatment can help restore chemical balance and give patients a chance to regain control of their lives. In conjunction with treatment, addicts need job training, relapse prevention, supervision, psychological support, and medication where indicated. Equally important are aftercare transitional treatment, self-help groups, and community support.

All of these treatment approaches contribute to recovery and long-term abstinence. The National Treatment Improvement Evaluation Study (NTIES), a five-year study conducted by the National Opinion Research Center at the University of Chicago, found that the percentage of patients reporting use of illicit drugs dropped by approximately 50 percent during the year after treatment compared to the year before treatment. The study also documented that violent behavior was reduced from 49.3 percent to 11 percent, and that reports of arrests went down by almost two-thirds. These results held for methadone and non-methadone outpatient treatment, and short- and long-term residential and correctional treatment.

We have found that drug treatment lowers medical costs, reduces accidents and worker absenteeism, diminishes criminal behavior, and cuts down on child abuse and neglect. Following treatment, recovering users require less public assistance, are less likely to be homeless, contract fewer illnesses (including sexually transmitted diseases), and are more productive.
A 1994 study by the Rand Corporation demonstrated a cost-benefit ratio of seven-to-one for drug prevention and treatment compared to supply reduction. In other words, for every dollar not spent on drug prevention and treatment, we would have to spend $7 on reducing the supply of drugs. The question is not whether we can afford to pay for treatment. Rather, how can we afford not to? The message of treatment is

clear: people whose lives have been ravaged by drugs can become productive citizens once again, restoring their dignity, reuniting their families, and strengthening society as a whole.

Drug Control Strategy Provides Direction

The National Drug Control Strategy is America's main guide in the struggle to decrease illegal drug use. The strategy provides a compass for the nation to reach this critical objective. Developed in consultation with public and private organizations, it sets a course for the nation's collective effort against drugs. The 1997 strategy proposes a 10-year commitment supported by five-year budgets so that continuity of effort can help insure success.

The strategy addresses the two sides of the challenge: limiting availability of illegal drugs and reducing demand. Our first priority is to set our own house in order. To that end, one-third of the U.S. federal counterdrug budget — $5,000 million — has been dedicated to demand reduction programs. Fifty-five percent — $8,000 million — goes for domestic law enforcement. The first three goals of the 1997 strategy call for educating America's youth to reject illegal drugs as well as alcohol and tobacco; increasing the safety of citizens by substantially reducing drug-related crime and violence; and reducing the health and social costs of illegal drug use.

Under the last initiative, reducing health and social problems, the strategy focuses on helping the 3.6 million chronic drug users in America overcome addiction. Chronic drug users are at the heart of America's drug problem. They comprise about 20 percent of the drug-using population yet consume over 80 percent of the supply of drugs. Chronic users maintain drug markets and keep drug traffickers in business.

The willingness of chronic drug users to undergo treatment is influenced by the availability of treatment programs, affordability of services, access to publicly funded programs, family and employer support, and the potential consequences of admitting a dependency problem. The strategy seeks to reduce these barriers so that increasing numbers of chronic users can begin treatment. Programs capitalize on individual motivation to end drug dependency.

We are also increasing research efforts to treat those addicted to cocaine. While methadone exists for the treatment of opiate addiction, pharmacotherapies for cocaine dependency do not exist.

Since addiction is particularly devastating for the poor, who lack economic and family safety nets, we encourage treatment programs that address the special needs of these populations. States, communities, and health-care professionals are encouraged to integrate drug prevention and assessment programs in prenatal, pediatric, and adolescent medical clinics.

Drug testing and employee assistance programs also reduce drug use. The McDonnell-Douglas Corporation found that such programs returned $3 for every dollar invested through reduced absenteeism and medical claims. The share of major U.S. firms that test for drugs rose to 81 percent in January 1996. Our challenge is to expand these programs to the small business community that employs 87 percent of all workers.

Drug Courts Offer Alternative to Prison

Also of particular concern is the relationship between drugs and crime. In major American cities up to one half of all homicides are drug-related. As many as two-thirds of individuals arrested for serious crimes test positive for illicit drugs. Unless treatment programs are readily available in federal justice and state prison systems, we are doomed to a cycle of arresting people, incarcerating them, and eventually sending them back out into the streets and back into a life of crime.

So we are encouraging drug treatment and education for prisoners, expanded use of "drug courts" that offer incentives for drug rehabilitation in lieu of incarceration, and integrated efforts to rid criminals of drug habits. The coercive power of the criminal justice system can be used to test and treat drug addicts arrested for committing crimes. And alternative judicial processes such as the drug courts, have demonstrated

that they can motivate non-violent offenders to abandon drug-related activities and lower recidivism rates by sentences that do not involve incarceration. More than 200 drug courts around the country and community programs like Treatment Accountability for Safer Communities are already helping non-violent offenders break the cycle of drugs and crime. There's no question that if major cities like New York, Miami, and San Diego can reduce the impact of drug addiction on street crime, which they have, then there is hope for all of us.

But Americans are especially concerned about the increased use of drugs by young people. Today, dangerous drugs like cocaine, heroine, and methamphetamines are cheaper and more potent than they were at the height of our domestic drug problem 15 or 20 years ago. Our children also dropped their guard when drugs faded as a pressing problem in the late 1980s and early 1990s, and first-hand knowledge of dangerous substances became scarce. According to the Partnership for a Drug-Free America, there has been a 20 percent reduction in the number of public service announcements carried by television, radio, and the print media since 1991. Consequently, disapproval of drugs and the perception of risk on the part of young people has declined throughout the decade. As a result, since 1992, more youth have been using alcohol, tobacco, and illegal drugs.

A disturbing study prepared by CASA also suggests that adults have become resigned to teen drug use. In fact, nearly half the parents from the "baby-boomer" generation expect their teenagers to try illegal drugs. Forty percent believe they have little influence over their teenagers' decisions about whether to smoke, drink, or use illegal drugs. But this assumption is incorrect. Parents have enormous influence over the decisions young people make.

In fact, the first priority in the prevention effort must include parents, teachers, coaches, ministers, and youth counselors. Youngsters and adolescents listen most to those they know, love, and respect. The 50 million Americans who used drugs in their youth but have now rejected illegal drugs must also participate in this national prevention effort.

We know statistically that if we can keep a young person between the ages of 10- and 21-years-old from smoking, abusing alcohol, or using illegal drugs, then the chances of that person becoming one of the 3.6 million people currently addicted to drugs approach zero. You normally don't start using cocaine in your last year of law school, or start using methamphetamines in your first job. And we know that when we get organized at the community level, when we get involved with educators, and when we give children positive options in their lives — less of them, by enormous numbers, become involved in addictive behavior, even when their family circumstances are dysfunctional.

Drug education and prevention are the centerpiece of the national drug strategy. Key strategy initiatives being undertaken to decrease drug use among young people include keeping drugs out of areas where children and adolescents study, play, and spend leisure time; having schools offer both formal and informal opportunities for changing the attitudes of students and parents regarding illicit use of alcohol, tobacco, and drugs; and increasing the number of drug-related public service announcements carried by the media.

Communities and community anti-drug coalitions are also part of the prevention effort. The community-based anti-drug movement in this country is strong, with more than 3,500 coalitions already organized. These coalitions involve partnerships between local groups and state and federal agencies to reduce drug use, especially among young people. Such groups have the ability to mobilize community resources; inspire collective action; synchronize complementary prevention, treatment, and enforcement; and engender community pride.

I'll conclude by saying that we must also continue to oppose efforts to legalize marijuana if we want to reduce the rate of teenage drug use and prevent American youth from using more dangerous drugs like cocaine. According to research conducted by CASA, marijuana is a gateway drug. Children who smoke it are 85 times more likely to use cocaine. Marijuana is listed under the provisions of the Controlled Substances Act because of its high potential for abuse and because there is no

currently accepted medical use in the United States. In response to anecdotal claims about marijuana's medicinal effectiveness for things like glaucoma, wasting illness, and the management of pain, we are funding a comprehensive review of the drug by the National Academy of Science's Institute of Medicine.

Addressing drug abuse is a continuous challenge; the moment we believe ourselves to be victorious and free to relax our resolve, drug abuse will rise again. We must continue to do all in our power to prevent that from happening.

The U.S. Effort to Fight Drug Use

By Senator Charles E. Grassley
Chairman of the U.S. Senate Caucus on
International Narcotics Control

The Congress of the United States is in the process of considering the budget for 1998 to combat the production, transit, and use of illegal drugs. President Clinton has asked for almost $16,000 million to fund a variety of programs designed to deal with the drug problem in all its aspects. Last year, the United States, at the federal level alone, allocated over $15,000 million. In the last 10 years, the United States has spent, again only at the federal level, $110,000 million to fight drugs. In addition to these sums, state and local governments in the United States have spent a comparable amount. On top of this, one must also include out-of-pocket efforts by businesses, communities, schools, and private individuals to deal with the range of problems associated with drug use. The conservative total from all these efforts adds up to close to $500,000 million. This figure does not count the indirect costs of drug use measured in human suffering, increased violence, and lost lives. What these numbers indicate is the terrible price the United States pays for its drug problem. It also indicates an abiding willingness on the part of the government and the people to fight back.

The government and the American public are committed to this effort for one simple reason: kids. It is an unfortunate fact that the most vulnerable population for drug use — whether in the United States or in other countries — is children. The original drug epidemic in the United States occurred among teenagers and young adults, many as young as 15 and 16. Today, the target for drug pushers are kids as young as 11 and 12. No country can sit by passively and watch as its future is consumed by a plague that destroys lives and creates problems for future generations. No responsible government can passively accept such a situation. That is why the United States devotes resources, time, and effort to the war on drugs, at home and abroad.

U.S. Efforts

The U.S. effort at home consumes the overwhelming majority of federal funds and, of course, all the monies spent by state, local, and private groups. This totals more than $30,000 million annually. Federal counter-drug resources are spent in four main areas: treatment,

prevention, law enforcement, and international programs. Considerable sums are also allocated to research in these same areas. The totals, in thousands of millions of dollars for 1997 and 1998 are as follows:

Drug Function	FY97	FY98
Law Enforcement	$7,835	$8,126
Treatment	$2,808	$3,003
Prevention	$1,648	$1,916
International	$450	$487
Interdiction	$1,638	$1,609
Research and Intelligence	$723	$831

In 1988, Congress created the Office of National Drug Control Policy, the "Drug Czar", to coordinate all federal drug control programs. Congress requires the administration to present each year a national drug control strategy. As part of that strategy, the law requires the administration to submit a consolidated budget based on the strategy. The $16,000 million request now before Congress is in response to these requirements. This budget represents a national commitment to deal with the drug problem in all its aspects.

Law enforcement resources in the budget cover a number of activities, including investigations, court proceedings, incarceration costs, and small sums for drug treatment programs in prisons. This request also includes some $10 million, for example, to the National Forest Service to combat illegal marijuana production in several parks. It includes support to state governments for marijuana crop eradication.

Treatment assistance goes to support treatment programs for addicts across the country. The majority of these funds are provided in bloc grants to states to administer. This money supports a variety of treatment efforts, from long-term residential programs to various forms of intervention programs designed to help addicts. Unfortunately, there is no cure for drug addiction, and treatment is often a lifelong undertaking. This is why we also support prevention efforts. The goal is to persuade potential users to never start. The majority of the prevention funds are allocated to individual states to promote education in schools and to support community coalition efforts to keep kids off drugs. In addition to these efforts, I am also working in Congress to pass legislation that would provide resources to communities for drug prevention.

It is our experience that when parents, community leaders, schools, businesses, religious leaders, and students commit to drug prevention, we see the best results. Community efforts in Miami and in Cincinnati today serve as clear models and success stories. Our experiences during the 1980s and early 1990s also serve as an example. During those years, major efforts among the nation's young people dramatically reduced experimentation with drugs. Teenage drug use dropped by more than 50 percent, cocaine use by more than 70 percent between 1980 and 1990. Moreover, attitudes about the dangers of drug use similarly changed, the growing perception among young people being that drugs were dangerous and wrong. We achieved these declines despite the fact that drugs remained available.

In addition to the resources that the United States devotes to control the domestic problems of drug use, we also spend considerable sums to interdict drugs at and beyond our borders. We support international efforts to stop the illegal production and transit of drugs overseas. Virtually all the drugs consumed in the United States are produced illegally in Asia and Latin America and smuggled into this country by major criminal organizations based outside the United States. In the past five years, the United States has spent over $500 million in Colombia, Bolivia, and Peru alone to support law enforcement, interdiction, alternative development, treatment and prevention, and military support. This money has gone to assist in local efforts to combat not only illegal drug production but also to deal with the threats posed by major criminal organizations that use violence, intimidation, and corruption to undermine the integrity of the courts, businesses, and political leaders.

U.S. efforts to combat drugs have not stopped at spending money on the problem. The United States, particularly Congress, has pioneered legislation to create the appropriate legal framework to combat drug production and money

laundering. In this regard, the United States created some of the first major anti-money laundering and criminal enterprise legislation. These include reporting requirements on bank deposits on sums over $10,000 as a means to prevent large cash and non-cash transactions to disguise the sources of the money. These laws also include confiscation provisions that permit the seizure of assets directly and indirectly acquired as a result of drug smuggling and selling. These laws have been aggressively employed against individuals involved in the drug trade, in the United States and abroad.

As part of the effort to control drug production, the United States also pioneered legislation to control the sale and transit of the precursor chemicals used in the production of illegal drugs. This law gave U.S. law enforcement agencies a powerful tool to prevent the diversion of key chemical components in drug production. The United States has encouraged other countries to adopt similar laws and has worked with individual companies to develop self-regulating mechanisms. Unfortunately, many countries have yet to adopt rigorous standards to actively enforce existing laws.

As part of its overall efforts to promote comprehensive drug control, the United States has also worked with the international community. The United States has worked with the G-7 countries to promote international standards for appropriate financial controls through the Financial Action Task Force. The Congress has also put great emphasis on international compliance with the 1988 U.N. Convention on Psychotropic Drugs. In addition, the United States has supplied money to the United Nations Drug Control Program to promote treatment, prevention, crop eradication, and alternative development projects in many different countries. All of these efforts, along with domestic programs, are part of on-going progress to deal with the range of problems created by international drug production, trafficking, and use.

Misconceptions

There are a variety of misconceptions about the drug problem in general and what the United States is doing about it. The biggest misconception involves oversimplified distinctions made between supply and demand. The most common argument is that if Americans did not consume drugs — no demand — there would be no incentive to produce and smuggle drugs — no supply. While this seems plausible, it does not reflect the complexity of the relationship between supply and demand generally or with drugs more specifically.

In many cases, it is supply that drives or creates demand. No new product, for example, for which there is no current market, begins with demand. The creator and manufacturer of the product must create the demand through marketing, pricing, and advertising. Similarly, when a business wants to break into a market, it will often try to flood the market with large quantities of its goods at low prices. This is true whether we are talking about computer chips or cocaine. The criminal organizations involved in drug production are big businesses and many of their practices and activities mirror those of legitimate business. Like many legal enterprises before them, they recognized that the United States was the world's largest market. For drug traffickers, breaking into the American market was tapping into the opportunity for huge profits. As part of a business strategy, these groups targeted the American market and aggressively worked to create a demand for their product.

The evolution of these activities is easy to trace. The United States in the early 1970s had no serious cocaine problem. Use was confined to the cultural elite with the money to pay the high prices for the drugs. Carlos Lehder, an enterprising smuggler, realized the possibilities for creating a new market. Using his connections in Colombia and his smuggling networks, he began to increase the supply of cocaine in the United States. He targeted middle class users. By dramatically increasing the supply and lowering the price, he made cocaine more available, helping to create a demand. Once the demand began to grow, supply and demand began to complement one another. While he was doing this, U.S. law enforcement and policy makers missed the significance of what was happening. It was not until there was an explosion of violence and spreading addiction problems that authorities

realized what was going on. By then, cocaine had established itself across the country as a major drug of choice.

A similar story can be told about the rapid expansion of methamphetamine use in the United States. The drug organizations are also expanding their user networks in Latin America, the Caribbean, and Mexico. They are paying local traffickers in drugs. They are offering drugs at very low costs or, in some cases, giving it away, in order to build a base of users. Unfortunately, one of the characteristics of drug supply and demand is that large supplies at affordable prices drives demand. No country is immune to this pattern.

In discussing this aspect of the drug problem, I am not arguing that the United States has no responsibility to deal with drug use. Quite the contrary. We have a responsibility and an obligation, not only as responsible members of the international community but also as parents trying to protect our children, who are the primary victims of drug use. My point in discussing the issue of supply and demand is to make clear that the problem is not a simple one. There is a further issue to consider in addressing this misconception. It is a moral question. The question is simply put: who is more responsible for the drug problem, the person who chooses to use illegal drugs, or the person who produces, transits, and sells them? There are no simple answers, but the point is that neither producing countries nor consumers can afford to ignore the problems created by illegal drugs. Serious efforts to fight back are not the result of simplistic distinctions between supply and demand, especially if they are an attempt to shift responsibility in order to do nothing.

A second misconception involves the certification process in the United States. Many seem to believe that this is an unfair process that singles out other countries arbitrarily for blame while the United States does nothing to combat drug use at home. As I noted above, the United States devotes considerable resources to the drug problem. We do this because we are fighting for the lives and futures of our children. We take the drug problem very seriously at home and we expect others to do the same. The certification process is the mechanism that we use to determine that seriousness of purpose.

Many critics of certification argue that the United States has no right to judge the efforts of other countries on drugs. This is not a very tenable position. Few countries around the world, in fact, fail to judge the behavior of other countries on a whole range of issues. And they are prepared to take action if they believe that important interests are involved. This is true whether we are talking about environmental concerns, trade issues, intellectual property rights, international terrorism, or human rights. As members of the international community, we expect countries to adhere to certain standards of conduct and we are prepared, individually and collectively, to respond when those standards are violated. In addition, every country reserves the right to take necessary steps to protect its sovereignty and the well-being of its citizens.

The certification process is essentially a domestic concern. Congress instituted the certification requirement some 10 years ago to force U.S. administrations to make drugs a key element in our foreign policy. What certification requires is that the U.S. president must identify those countries that are major producing or transit countries for illegal drugs. This is not some arbitrary determination, but based on actual estimates of crop size in individual countries or on specific information on smuggling activities. Congress further requires the president to certify each year which countries on this list are taking realistic and credible steps to deal with drug production or transit. Again, this is not an arbitrary decision but is based on an assessment of specific actions and efforts. These are covered in a comprehensive report, the International Narcotics Control Strategy Report, that Congress also requires the administration to submit every year.

The requirement for certification is not an absolute success. The expectation in the law is not that country X will have eliminated drug production or transit in order to be certified, but that it has taken meaningful steps leading to the suppression of these activities, either in conformity with the 1988 U.N. Convention or in bilateral agreements with the United States or others. Certification recognizes the difficulties involved in dealing with

drug production and the criminal gangs that engage in it, but it also takes into consideration whether a country is doing what it can and should under international law. Moreover, drug production is illegal under the laws of most of the countries affected by certification and many of these countries have signed agreements with the United States committing them to specific action in exchange for assistance of various kinds. The expectation is that these countries will take adequate steps to enforce their own laws and to meet the requirements of bilateral and international agreements.

If the president determines, based on an evaluation of a number of factors, that a country is not meeting its obligations, then the president must report this to Congress and must take steps to withhold U.S. assistance to that country. That the United States has a right to determine whether or not a country is qualified to receive U.S. assistance should not be a matter of debate. U.S. assistance is not an entitlement. The fact that the United States, as a democratic country, discusses its decisions in public as a matter of public business, likewise, should not be a surprise. Nor should it be surprising that the United States is prepared to take steps designed to protect its sovereignty and its citizens when deemed necessary.

Drugs are produced overseas and smuggled into the United States by organizations operating from foreign soil in violation of local, international, and U.S. laws. The substances that they produce and smuggle cause incalculable damage to American citizens daily. Indeed, drug smugglers cause more deaths and more harm in this country annually than have international terrorists in the past 10 years. To ignore these activities is not possible, nor is it responsible. To expect other countries to cooperate in the effort to control these illegal activities is neither unrealistic or unprecedented. To be prepared to take unilateral steps in order to protect the nation's interests is also not extravagant.

The third misconception that percolates through the debate on drugs is that the United States does nothing to deal with its own problem. I hope that my earlier remarks address that misconception.

There is one further issue in this vein that I wish to address, and that is the notion that legalizing drug use would solve all the problems. In this view, simply legalizing dangerous drugs for personal use would end criminal activities, would reduce the harm of punitive legal steps against consenting users, and would do away with the need for the whole, expensive architecture of enforcement. None of these views is accurate. Indeed, as a formula for public policy they court disaster. At a minimum, they would dramatically increase the number of current users of dangerous drugs. Rather than reduce the harm currently caused by drugs, they would redistribute the harm to a large number of individuals and foist the costs for this onto the public purse.

There is no royal road to a solution of our drug problem, either supply or demand. What is required is determination to deal with the problem, a willingness to act, and stamina to stay the course. The consequences of failure mean losing more kids and giving free reign to the criminal thugs that push the drugs.

COMMENTARY

Addiction Is a Brain Disease

An interview with Dr. Alan Leshner, director of the National Institute of Drug Abuse.

One of America's foremost experts on drug abuse discusses some of the latest knowledge about use, addiction, and treatment. Addictive drugs change the brain in fundamental ways, he says, producing compulsive, uncontrollable drug seeking and use. Leshner was interviewed by Contributing Editor Jerry Stilkind.

Question: Are there particular personality types or socioeconomic conditions that predominate among those who try a drug in the first place?

Leshner: There are different ways to approach this question. One is to recognize that there are 72 risk factors for drug abuse and addiction that have been identified. They're not equally important. They operate either at the level of the individual, the level of the family or the level of the community. These are, by the way, the same risk factors for everything else bad that can happen — poverty, racism, weak parenting, peer-group pressure, and getting involved with the wrong bunch of kids, for example. What these risk factors do is increase the probability that people with certain characteristics will, in fact, take drugs.

But you cannot generalize because the majority of people who have a lot of risk factors never do use drugs. In spite of the importance of these risk factors, they are not determinants.

So, what determines whether, say, Harry will use drugs, and whether Harry will become addicted to drugs? They're not the same question. Whether or not Harry will use drugs has to do with his personal situation — is he under stress, are his peers using drugs, are drugs readily available, what kind of pressure is there to use drugs, and does Harry have a life situation that, in effect, he wants to medicate? That is, does Harry feel that if he changed his mood he would feel better, he would have a happier life? People, at first, take drugs to modify their mood, their perception, or their emotional state. They don't use drugs to counteract racism or poverty. They use drugs to make them feel good. And we, by the way, know a tremendous amount about how drugs make you feel good, why they make you feel good, the brain mechanisms that are involved.

Now, there are individual differences, not only in whether or not someone will take drugs, but in how they will respond to drugs once they take them. A Harvard University study published a few weeks ago demonstrated that there is a genetic component to how much you like marijuana. That's very interesting because the prediction, of course, is that the more you like it the more you would be prone to take it again, and the greater the probability you would become addicted. And so there's a genetic component to your initial response to it — whether you like it or not — and also to your vulnerability to becoming addicted

once you have begun taking it. We know far more about this for alcohol than we do about other drugs.

Q: Do you mean that the genetic make-up of one person may be such that he gets more of a kick from taking cocaine than another individual? Is that what you mean by vulnerability?

Leshner: There's no question that there are individual differences in the experience of drug-taking — not everybody becomes addicted equally easily. There's a myth that I was taught when I was a kid, and that was if you take heroin once, you're instantly addicted for the rest of your life. It's not true. Some people get addicted very quickly, and other people become addicted much less quickly. Why is that? Well, it's probably determined by your genes, and by other unknown factors like your environment, social context, and who you are.

Q: Is this true for people around the world — in the United States, Western Europe, India, Colombia?

Leshner: The fundamental phenomenon of getting addicted is a biological event and, therefore, it's the same everywhere, and the underlying principles that describe the vulnerability, or the propensity to become addicted, are universal.

Q: What is addiction? How is it created in the body?

Leshner: There has long been a discussion about the difference between physical addiction, or physical dependence, and psychological dependence, behavioral forms of addiction. That is a useless and unimportant distinction. First of all, not all drugs that are highly addicting lead to dramatic physical withdrawal symptoms when you stop taking them. Those that do — alcohol and heroin, for example — produce a physical dependence, which means that when you stop taking them you have withdrawal symptoms — gastrointestinal problems, shaking, cramps, difficulty breathing in some people and difficulty with temperature control.

Drugs that don't have those withdrawal symptoms include some of the most addicting substances ever known — crack cocaine and methamphetamine are the two most dramatic examples. These are phenomenally addicting substances, and when you stop taking them you get depressed, you get sad, you crave the drug, but you don't have dramatic — what we call "florid" — withdrawal symptoms.

Second, when you do have those dramatic withdrawal symptoms with alcohol and heroin, we have medicines that pretty well control those symptoms. So, the important issue is not of detoxifying people. What is important is what we call clinical addiction, or the clinical manifestation of addiction, and that is compulsive, uncontrollable drug seeking and use. That's what matters. People have trouble understanding that uncontrollable, compulsive drug seeking — and the words "compulsive" and "uncontrollable" are very important — is the result of drugs changing your brain in fundamental ways.

Q: How do drugs change the brain? What is it that makes you feel good and wants you to have more?

Leshner: Let's, again, separate initial drug use from addiction. Although addiction is the result of voluntary drug use, addiction is no longer voluntary behavior, it's uncontrollable behavior. So, drug use and addiction are not a part of a single continuum. One comes from the other, but you really move into a qualitatively different state. Now, we know more about drugs and the brain than we know about anything else and the brain. We have identified the receptors in the brain for every major drug of abuse. We know the natural compounds that normally bind to those receptors in the brain. We know the mechanisms, by and large, by which every major drug of abuse produces its euphoric effects.

Q: Including tobacco, alcohol, marijuana?

Leshner: Tobacco, alcohol, marijuana, cocaine, heroin, barbiturates, inhalants — every abusable substance. We know a phenomenal amount. What we also know is that each of these drugs has its own receptor system — its own mechanism of action. But in addition to having idiosyncratic mechanisms of action, each also has common mechanisms of action. That common mechanism of action is to cause the release of dopamine, a

substance in the base of the brain, in what is actually a circuit called the mesolimbic reward pathway. That circuit has a neurochemical neurotransmitter, which is dopamine.

We believe that the positive experience of drugs comes through the mesolimbic-dopamine pathway. We know that because if you block activation of that dopamine pathway, animals who had been giving themselves drugs no longer give themselves drugs. In addition to that, about a week ago, Nature Magazine (a British science and medicine journal) published a study showing that the greater the activation of the dopamine system following the administration of cocaine the greater the experience of the high. So we know that this is a critical element, and we know that every addicting substance modifies dopamine levels in that part of the brain. That is to say, alcohol, nicotine, amphetamines, heroin, cocaine, marijuana — all produce dopamine changes in the nucleus accumbens, in the mesolimbic pathway in the base of the brain.

We also know that in the connection between the ventral tegmentum and the nucleus accumbens — in the mesolimbic circuit — that at least cocaine, heroin, and alcohol produce quite similar changes at the biochemical level. That is, not only in terms of how much dopamine is produced but also in the similar effects these substances have long after you stop using the drug. So the point here is that we are close to understanding the common essence of addiction in the brain and we care about this because it tells us how to develop medications for drug addiction. That is the goal — how to treat drug addiction.

Q: But over time, doesn't the brain of an addict release less and less dopamine? So how does he continue to feel good? How does he get his high if dopamine levels are reduced, rather than increased?

Leshner: Here is another indication of the difference between drug use and addiction. Initially, taking drugs increases dopamine levels, but over time, it actually has the reverse effect. That is, dopamine levels go down. And one of the reasons that we believe that most addicts have trouble experiencing pleasure is that dopamine is important to the experience of pleasure, and when the levels are low you don't feel so good. But once addicted, an individual actually does not take the drug to produce the high.

It is the case in heroin addiction that, initially, they take the drug for the high, but ultimately they take the drug to avoid being sick. The same is true, to some degree, in crack cocaine addiction. That is, we find that people coming off crack cocaine get depressed very badly, and so they are, in effect, medicating themselves, giving themselves crack cocaine to avoid the low. What they're trying to do is pump their dopamine levels up, which doesn't happen, but they keep trying to do it.

Q: Perhaps we should assure people that a certain level of dopamine is normally produced in the brain by pleasurable foods, or activities, and is necessary for human life. Is that correct?

Leshner: Dopamine is a very important substance in many different ways. It is, for example, involved in motor function. In order to maintain motor function, you must have a minimal amount of dopamine. Parkinson's disease is a deficit in dopamine levels, which results in motor problems. Both schizophrenia and depression have dopamine components to them, mostly schizophrenia. In fact, anti-psychotic drugs work on dopamine levels. And so, what you need to be doing is balancing your dopamine, not raising it or lowering it. You're trying to maintain dopamine at a normal level. And again, we think that people who are addicted have trouble experiencing pleasure because their dopamine systems are altered.

Q: If the working of the brain changes during addiction, is this alteration permanent, or can other drugs administered by physicians, or behavioral changes in various programs, bring the brain back to an unaddicted, unaffected state?

Leshner: Drugs of abuse have at least two categories of effects. One is what I will call "brain damage." That is, they literally destroy cells or functions in the brain. For example, if you use inhalants, you literally destroy brain tissue. If you use large doses of methamphetamine, we believe you literally destroy both dopamine and serotonin

neurons. In most cases, however, we believe changes in the brain associated with addiction are reversible in one way or another, or they can be compensated for. We know that the brain of an addicted individual is substantially different from the brain of a non-addicted individual, and we have many markers of those differences — changes in dopamine levels, changes in various structures and in various functions at the biochemical level. We know some of those changes, like the ability to produce dopamine, recover over time. What we don't know is if they recover to fully normal.

Secondly, we know that some medications can compensate, or can reverse some effects. If the change is reversible, your goal is to reverse. If it's not reversible, but you still need to get that person back to normal functioning, you need a mechanism to compensate for the change.

Q: That moves us into the question of prevention and treatment programs. First, what kinds of prevention programs are known to work?

Leshner: One problem in the prevention of drug abuse is that people think in terms of programs, rather than in terms of principles. But the truth is, like anything else that you study scientifically, stock programs that you apply anywhere around the world in exactly the same way do not work. Rather what you want are guiding principles. And we have now supported over 10 years of research into prevention, and have actually been able to derive a series of principles of what works in prevention, and have just issued the first ever science-based guide to drug-abuse prevention. And some of those principles are fairly obvious once you state them, but if you don't say them you don't do them. For example, prevention programs need to be culturally appropriate. Well, people say that all the time, and then they look at a prevention program and they say, "Oh good, I'm going to just take that one and put it in my country." Then they're shocked when it doesn't work. Well, you need to have the cultural context to whatever you do.

Another obvious principle is that programs need to be age appropriate. Everyone knows that youngsters early in adolescence are a different species from those late in adolescence. So, you need to deal with them differently. The messages have to be different. The advertisement industry has done a very good job with that.
In addition, people frequently like "one-shot" prevention programs. Go in, do something, and then the problem's solved. Well, they never work. You need to have sustained efforts with what we call "boosters." You make your first intervention, then you go back and give another intervention, and then another, and finally you successfully inoculate the individual. There are a whole series of principles outlined in a pamphlet we recently published — "Preventing Drug Use Among Children and Adolescents: A Research Based Guide" — and a checklist against which you could rate programs.

Q: Is this booklet on your web site?

Leshner: Yes. You can find this prevention booklet by going to — www.nida.nih.gov — and looking under publications. You can download the whole thing.

Q: Which have been found more effective in treating addicts — behavioral or medical programs? Or do they need to complement each other?

Leshner: I believe that addiction is a brain disease, but a special kind of brain disease — a brain disease that has behavioral and social aspects. Therefore, the best treatments are going to deal with the biological, the behavioral, and the social-context aspects. Now that's difficult for people to understand, I think, but it's a very important principle. We have studies that show that although behavioral treatment can be very effective, and biological treatment can be very effective, combining the two makes them more effective. In addition to that, remember that people who are addicted typically have been addicted for many, many years, and, therefore, they have to almost relearn how to live in society. And that's a part of treatment.

Q: Such a comprehensive approach sounds pretty expensive. Is it more expensive than a prevention program?

Leshner: The question boils down to whether

you're going to try to compare treating an individual once addicted, which involves doing a cost-benefit analysis of what that individual's habit is costing society, versus a massive prevention program that might cost only three cents per person but which only affects the one or two people who would have used the drug in the first place. So, it's not a comparison that you can actually make. However, I can tell you that even the most expensive treatments — inpatient, therapeutic communities that cost, depending on the particular kind of program, between $13,000 and $20,000 a year per person, are a lot less than imprisoning people. Incarceration costs $40,000 a year per person. So the cost-benefit ratio always is in favor of the treatment approach.

Q: How many drug addicts are there in the United States and around the world?

Leshner: We believe that there are about 3.6 million individuals in the United States who are addicted to heroin, crack cocaine, amphetamine, marijuana — the illegal drugs. So, at least that many are in need of treatment. Then heavy users add to that number. It's impossible to know exactly the total number who are in need of treatment, but it's probably between four and six million people. I don't know what the comparable figures are internationally.

Jerry Stilkind writes on drugs, environment and other subjects for the Global Issues team of the U.S. Information Agency.

Drug Prevention Makes a Difference

By Mathea Falco

Americans are deeply concerned about drugs. Two-thirds of the public think that drug abuse is worse today than five years ago. Half say that they know someone who has been addicted to an illegal drug.

Over the years, Americans have spent substantial amounts of money to combat drug problems. Since 1980, we have spent $290,000 million on federal, state, and local anti-drug efforts. This amount — some $20,000 million a year — is twice as much as the federal government spends annually for all biomedical research, including research on heart disease, cancer, and AIDS.

Federal policy has been consistent for years: we have spent most of the money trying to reduce the supply of drugs in this country through enforcement, interdiction, and overseas programs to eliminate drug production. Unfortunately, this effort has failed. Despite a fivefold increase in federal expenditures for supply reduction efforts since 1986, cocaine is cheaper today than it was a decade ago. Heroin is sold on the streets for $10 a bag at purities exceeding 60 percent compared to less than 30 percent in 1990. The nation's chief drug enforcement official, Thomas Constantine, administrator of the Drug Enforcement Administration (DEA), told Congress in March 1995 that "availability and purity of cocaine and heroin are at an all-time high." And for the first time, arrests for drug possession reached the one million mark in 1994 — a 30 percent increase over the previous three years.

Faced with these statistics, many have come to question whether supply can ever be reduced enough to affect drug abuse. Despite America's overseas efforts, worldwide opium and cocaine production has doubled in the last 10 years. The number of countries producing drugs has doubled as well, making drugs a truly global business. Pressure on one country only leads to increased production elsewhere. Since a single 25-square mile plot is enough to grow all the opium consumed in the United States, the likelihood that we can stop drug production becomes small. Nor are our borders easily sealed when a single DC-3A flight can bring a year's supply of heroin into the United States and 12 trailer trucks can bring in a year's supply of cocaine. It is doubtful whether any policy to cut off the supply of drugs to America can ever succeed.

But if supply cannot be curtailed, perhaps demand can be reduced. Such considerations have led to new interest in drug prevention, treatment, and community efforts to organize citizens against drugs. Drug use among young teenagers is climbing rapidly: marijuana smoking among eighth

graders has more than doubled since 1991. Yet most children do not get effective drug prevention teaching, even though such programs can cut new drug use by half. In addition, one million prison inmates in this country have serious drug habits, regardless of the crimes for which they were convicted. Treatment for drug abuse is not readily available inside the criminal justice system or in many communities. Yet extensive research confirms that treatment is the most cost-effective way to combat addiction and drug-related crime.

Polls show Americans strongly favor a balanced approach, which includes law enforcement, treatment, and prevention, and focuses anti-drug spending in their communities rather than overseas.

Increasing Drug Use

Illegal drug use cuts across all economic and ethnic groups. Of the 12 million Americans who admit they use drugs at least once a month, three-quarters are white and employed. Since 1992, adult drug use has gone up 12 percent, the first sustained increase since the 1970s. Among young adults ages 18 to 21, one in seven now reports using illicit drugs at least once a month.

Marijuana remains the most widely used illegal drug, among both adults and teenagers. Because of more intensive cultivation and hybridization of potent strains, today's marijuana is much stronger than its 1960s counterpart. Heroin use is increasing, particularly among young professionals and those in the entertainment world. Because of its higher purity, the drug can be snorted or smoked, increasing its appeal to those reluctant to inject drugs.

Methamphetamine abuse is also increasing. A synthetic stimulant that produces euphoria, high energy, and self-confidence, the drug may induce violent, paranoid behavior as well as stroke, seizure, and death. Methamphetamine-related emergency room episodes more than tripled between 1991 and 1994 nationwide, according to the Drug Abuse Warning Network (DAWN).

Among medical professionals, the legal narcotic fentanyl — 10 times more powerful than heroin — is frequently abused. The overdose death in November 1995 of a young medical student in New York drew national attention to the usually hidden problem of drug addiction among doctors, nurses, and other health providers. In 1990, fentanyl sold on the streets as heroin was blamed for 17 deaths in the New York area.

Teen Drug, Alcohol and Tobacco Use

Drug use is rising dramatically among the nation's youth after a decade of decline. From 1993 to 1994, marijuana use among young people aged 12 to 17 jumped 50 percent. One in five high school seniors smokes marijuana daily. Monitoring the Future, which surveys student drug use annually, reports that negative attitudes about drugs have declined for the fourth year in a row. Fewer young people see great risk in using drugs.

Mood-altering pharmaceutical drugs are gaining new popularity among young people. Ritalin, prescribed as a diet pill in the 1970s and now used to treat hyperactive children, has become a recreational drug on college campuses. A central nervous system stimulant, Ritalin can cause strokes, hypertension, and seizures. Rohypnol, produced in Europe as a legal tranquilizer, lowers inhibitions and suppresses short-term memory, which has led to some women being raped by men they are going out with. When taken with alcohol, its effects are greatly magnified. Rock singer Kurt Cobain collapsed from an overdose of Rohypnol and champagne a month before he committed suicide in 1994. In Florida and Texas, Rohypnol, known as "roofies" and "rope," has become widely abused among teens, who see the drug as a less expensive substitute for marijuana and LSD.

Glue, aerosol sprays, lighter fluid, and paint thinner are inhaled by growing numbers of children to get a quick but potentially lethal high. These volatile solvents and gases can cause brain damage, paralysis, and even death. Both adults and youngsters are generally unaware of the terrible risks posed by inhalants; many parents do not know which of these household products can be misused in this way. In 1995, one in five 13-year-olds reported using inhalants, an increase of 30 percent since 1991. Inhalants kill as many as 1,000 people each year, most of them still in their teens.

Alcohol and tobacco use is increasing among teenagers, particularly younger adolescents. Each year, more than one million teens become regular smokers, even though they cannot legally purchase tobacco. By 12th grade, one in three students smokes. In 1995, one in five 14-year-olds reported smoking regularly, a 33 percent jump since 1991. Drinking among 14-year-olds climbed 50 percent from 1992 to 1994, and all teens reported substantial increases in heavy drinking. In 1995, one in five 10th graders reported having been drunk in the past 30 days. Two-thirds of high school seniors say they know a peer with a drinking problem.

Preventing Drug Use

Extensive studies have documented that drug prevention programs work. Life Skills Training, a program for junior high students, can reduce new tobacco and marijuana use by half and drinking by one-third. With booster sessions in 9th and 10th grade, these results are sustained through high school.

Effective prevention programs are not expensive, compared to the costs of prison construction, high-tech interdiction equipment, and health care for diseases related to tobacco, alcohol, and illegal drugs. Life Skills Training, for example, costs about $7 per pupil per year, including classroom materials and teacher training.

Successful prevention efforts reach beyond the classroom to include the larger world that shapes attitudes toward drugs — families, neighborhoods, businesses, and the media. The Carnegie Council on Adolescent Development, which recently completed a landmark study of children aged 10 to 14, concluded that a comprehensive approach is needed during these critical years when drug use and other problem behaviors begin. The essential "protective factors" that help children move successfully through adolescence include educational achievement, social skills, strong bonds with family members, teachers, and other adults as well as clear rules for behavior.

Parental disapproval of substance abuse is also an important protective factor. The 1995 PRIDE survey found that parental involvement can significantly deter drug use, even among older teenagers. Positive options that create optimism about the future also reduce children's vulnerability to drugs. The Carnegie Council recommended the creation of middle schools small enough to respond to children's developmental needs, "family friendly" workplaces that encourage greater parental involvement, education in health and decision-making, and strong community support as steps to help raise resilient, productive teenagers.

The influences on a child's decisions to smoke, drink, and use illegal drugs are complex, including anxiety, stress, peer values, and the desire to fit in socially. Advertising is a particularly powerful influence. A recent California study found that children were twice as likely to be influenced to smoke by cigarette advertising than by peer pressure. In 1993, the tobacco industry spent $6,000 million for advertising and promotions. Preventing teen smoking is critically important: 90 percent of all adult smokers began smoking before the age of 19.

Programs That Work

Helping Children at Risk. Project HighRoad brings together parents, schools, community organizations, housing authorities, local police, and clergy to create comprehensive substance abuse prevention programs in three New York inner city schools and related housing projects: in the South Bronx, on Manhattan's Lower East Side, and in the Astoria section of Queens. Project HighRoad provides continuous support — family group sessions, school health clinics, tutoring programs, after school and weekend enrichment programs, youth leadership training, and crisis intervention — for almost 2,500 primarily black and Hispanic young people.

At one school drug use among eighth graders declined 25 percent, while eighth grade drug use rose nationally between 1993 and 1995. Smoking declined by half; binge drinking declined at all grade levels.

Building Bridges to the Future. Started in San Francisco in 1978, and recently expanded to 30 cities in the United States and Hong Kong, Summerbridge serves more than 2,000 students recruited each year from inner city schools. The program provides tuition-free intensive summer sessions

after sixth and seventh grades, as well as year-round tutorials, counseling, and family advocacy that continue through high school. Rigorous academic classes, sports, field trips, art, theater, and photography classes are taught by outstanding high school and college students, many of whom attended Summerbridge themselves. Eighty-four percent of recent Summerbridge graduates have gone on to college preparatory high schools and 64 percent of its summer teachers have continued into the teaching profession. More than half of the Summerbridge teachers are from ethnic minorities, compared to 10 percent nationally. Summerbridge costs $1,330 per student annually.

Options for Portland Youth. "Life Has Options" is the motto of Self Enhancement, Inc. (SEI), a program in Portland, Oregon, that has served more than 12,000 inner city school students since 1981. SEI offers classroom instruction, extracurricular activities, cultural enrichment, career counseling, and summer outreach for 450 high-risk children every year. Paid SEI staff work with participants in their schools, tutoring, encouraging, and handling crises. They provide after-school supervision and guidance with homework. They also work with families and help parents obtain counseling or find jobs when needed.

A 1994 study found that school attendance improved and disciplinary referrals dropped dramatically among participants. Students in elementary school raised their grades by 47 percent; middle school students by 70 percent. SEI costs $1,800 a year per child. Oregon residents pay $21,375 a year in taxes to lock up one juvenile.

Volunteers Fight Against Drugs. Since 1990, the American Bar Association (ABA) has found ways to engage lawyers, judges, and local bar associations in anti-drug efforts across the country. With close ties to many segments of the community — business, professional, and government — lawyers are in a unique position to pull together local and national support to combat drugs. Volunteer programs involve lawyers in teaching legal rights and responsibilities to first-time offenders and their families; in working as mentors for juveniles arrested for drug abuse or drug-related crime; and in helping communities fight street drug markets.

Through the active participation of judges and lawyers, the ABA Standing Committee on Substance Abuse has also led to reform of the justice system, including the development of local drug courts.

Communities Drive Out Street Drug Dealers. Through strong partnerships with police, government agencies, businesses, and non-profit institutions, citizens in Baltimore, Maryland, are dismantling the drug trade one city block at a time. Baltimore's Comprehensive Communities Program aims to retake public spaces from dealers and to replace drug markets with youth activities. Baltimore received a Bureau of Justice Assistance grant of $1.9 million to combine community policing, alternatives to incarceration, drug courts, and anti-gang initiatives as part of a national pilot program to create coordinated strategies against drugs.

The Boyd Booth community of West Baltimore is once again a livable neighborhood. Citizens boarded up vacant houses, fenced off drug dealers' get-away alleys, pursued nuisance abatement against drug houses, and prevented apartment rentals by out-of-state dealers. Cleaning up trash, replacing street lights, removing public telephones from drug routes, and planning community social gatherings on drug corners have dramatically decreased open drug dealing on street corners.

Since the program began in 1993, violent crime in Boyd Booth has dropped 52 percent and overall crime 40 percent. At the same time, fewer police resources are consumed by crime in the neighborhood, with calls to police dropping to one-fifth their 1993 rate.

Mathea Falco, president of Drug Strategies, a non profit policy institute in Washington, D.C., was assistant secretary of state for international narcotics matters from 1977 to 1981.

REPORTS AND DOCUMENTS

Drug Courts: a Personalized Form of Justice

It's hard to argue with the success of drug courts, where judges maintain personal contact with drug offenders and use the threat of jail to prod addicts into programs that include treatment, educational opportunities, and job training.

Following are excerpts of a February 1994 article by Jeffrey Tauber in Corrections Today.

Interest in drug courts is sweeping the nation as a number of innovative courts have reported success in reducing the levels of drug abuse, incarceration, and criminal recidivism among drug-using offenders. That interest is heightened by the realization that these same offenders clog court calendars, strain treasuries, and flood the jails and prisons. According to a recent American Bar Association report, imprisonment of drug offenders alone increased by 327 percent between 1986 and 1991.

Some have criticized drug courts as a radical and unwarranted departure for the courts. However, there is nothing radical or even particularly new about how a drug court works. Drug courts, in fact, mark a turning back to a time when judges ran their own calendars and were responsible for their court's operations, defendants had to answer directly and immediately to the judge for their conduct, and cases moved slowly and purposefully through the judicial system rather than relying on sentencing guidelines, mandatory minimums, and negotiated pleas to speed up the court process.

This article describes how drug courts work and what the underlying principles are that make them successful.

The Drug Court in Action

There is a persistent belief in the judicial community that a drug-using offender's failures while under court supervision are willful and deliberate and consequently ought to be dealt with severely. Unfortunately, this belief fails to recognize the compulsive, addictive nature of drug abuse and the court's limited ability to coerce abstinence.

Drug court judges recognize the limitations of coercion as a drug rehabilitation tool and reject the notion that failure of the program is necessarily the result of willful defiance of judicial authority and therefore something to be punished as a kind of contempt of court. Rather than using coercion, drug court judges use a pragmatic judicial intervention strategy based on the development of an ongoing, working relationship between the judge and the offender and the use of both positive and negative incentives to encourage compliance. In a drug court, communications between judge and offender are crucial. By increasing the frequency of court hearings as well as the intensity and length of judge-offender contacts, the drug court judge becomes a powerful motivator for the offender's rehabilitation.

A successful drug court requires the judge and staff to work together as a team. The defense attorney takes a step back — both literally and figuratively — to allow the judge to have direct contact with the offender. The prosecuting attorney adopts a conciliatory position. All staff see their job as facilitating the offender's rehabilitation.

Drug court judges hold hearings before an audience full of offenders. As appropriate, the judge assumes the role of confessor, task master, cheerleader, and mentor, in turn exhorting, threatening, encouraging, and congratulating the participant for his or her progress or lack thereof. The court hearing is used to educate the audience as well as the individual offender on the potential consequences of the program. Offenders who have failed the program are seen early in the hearing before a full audience of participants, while successful graduates are often handed diplomas by the judge, accompanied by the applause and congratulations of staff.

Principles of a Drug Court

Court-ordered drug rehabilitation programs suffer from the generally held belief that "nothing works" in treating drug offenders. Unfortunately, that perception, although untrue, becomes a self-fulfilling prophecy when financially strapped communities inadequately fund court-ordered treatment programs and skeptical judges halfheartedly implement those programs, often terminating participants at the first sign of drug relapse.

It takes more than increased funding and full judicial support to create an effective drug court program. Such programs are based on an understanding of the physiological, psychological, and behavioral realities of drug abuse and are implemented with those realities in mind.

Successful programs recognize that:

- drug abuse is a serious debilitating disorder;
- relapse and intermittent progress are part of most successful drug rehabilitation;
- a drug addiction is not created overnight and cannot be cured overnight;
- drug users are most vulnerable to successful intervention when they are in crisis, such as immediately after initial arrest and incarceration; and
- drug users are in denial and will do everything possible to avoid responsibility, make excuses for program failure, and evade the court and its programs.

Several jurisdictions have developed successful drug courts and court-ordered drug rehabilitation programs that recognize and work with the realities of drug abuse. Although these programs often have substantially different program characteristics, what is crucial is that they share the same underlying reality-based principles. The most important principles are immediate and up-front intervention; coordinated, comprehensive supervision; long-term treatment and aftercare; and progressive sanctions and incentive programs.

Immediate, up-front intervention. A drug addict is most vulnerable to successful intervention when he or she is in crisis. Therefore, intervention should be immediate and used up front.

Even the best-designed court-ordered drug rehabilitation program will be less than effective when intervention is delayed. Recognizing this, drug courts order participants to begin treatment

immediately after their court hearing. In Miami, Florida, participants are transported by van; in Oakland, California, they are ordered to appear within 15 minutes of the court hearing.

For the same reason, supervision and treatment should engage the offender early and often, giving the program and treatment the opportunity to take root. In Miami, offender contact with the program is required five times a week for the first three weeks; in Oakland, an average of three contacts per week is required for the first 10 weeks.

Coordinated, comprehensive supervision. If there are gaps in program supervision, the offender will find and exploit them. Therefore, supervision must be comprehensive and well-coordinated to ensure accountability. Few offenders enter a court's program with rehabilitation on their minds. They are in denial and are in a program mostly to beat the system and avoid incarceration. The challenge is to keep them in the program until sobriety and attitudinal changes can occur. This may be difficult to accomplish because drug offenders are often experts at avoiding responsibility, making excuses for their failures, and evading the court and its programs.

Drug offenders must be held accountable for their conduct if rehabilitation is to be successful. A drug court program builds a "chain-link fence" around drug offenders. The links of that fence consist of frequent supervision contacts and drug testing, direct access to full information on the offenders' progress, immediate responses to program failures, and frequent progress report hearings before a single drug court judge and staff. Oakland allows a maximum of 90 days, Miami no more than 60 days, between hearings.

Long-term treatment and aftercare. A drug addict is not created overnight and cannot be cured overnight. Therefore, the drug-using offender needs intensive long-term treatment and aftercare. Drug addiction is a serious, debilitating disorder that demands intensive long-term treatment. Miami and Oakland participants average approximately one year to graduation. Preferably, this treatment begins in a medically supervised jail drug detoxification unit. For most offenders, however, a community-based non-residential treatment program is the initial treatment experience. More costly residential treatment spaces are generally reserved for those who have not responded well to non-residential treatment.

Without adequate aftercare, sobriety may be short-lived when offenders face the same problems that contributed to their drug use in the first place. A drug court rehabilitation program should include ongoing treatment and counseling, educational opportunities, job training and placement, and health and housing assistance.

Progressive sanctions and incentives programs. Relapse and intermittent progress are part of successful drug rehabilitation. Therefore, the drug court must apply a patient, flexible approach in monitoring compliance.

In most cases, progress toward rehabilitation will be slow-starting and fitful, with sobriety taking hold only over a period of months. The judge must apply progressive sanctions and incentives in response to an offender's failure or success in moving toward sobriety.

Smart Punishment

The judge who uses extended incarceration as the only response to drug use is like a carpenter who shows up at a job site with only a hammer. The drug court judge has a variety of tools he or she should use — intensive supervision, counseling, educational services, residential treatment, acupuncture, medical intervention, drug testing and program incentives, as well as incarceration.

The problem is not in using incarceration, but in overusing it. Incarceration can work for drug offenders by providing them with the opportunity to detox from drugs. It can work as a deterrent by subjecting them to the stressful, anxiety-producing experience of incarceration. And it can work by coercing them to enter and complete rehabilitation.

The use of extended periods of incarceration, however, does not appear to increase the value of incarceration and may in fact be counterproductive to sentencing goals. Extended incarceration may disrupt whatever stability exists in a drug-user's life,

initiate him or her into a criminal lifestyle, and reduce the deterrent effect of incarceration, thus limiting the effectiveness of court-ordered rehabilitation.

"Smart punishment" is the imposition of the minimum amount of punishment needed to achieve the twin sentencing goals of reduced criminality and reduced drug use. It relies on the use of progressive sanctions — the measured application of a spectrum of sanctions whose intensity increases incrementally with the number and seriousness of program failures — and a set of incentives aimed at encouraging and motivating offenders toward program success.

Progressive Sanctions. In a drug court, there are immediate and direct consequences for all conduct. Sanctions follow violations and are applied as close to the time of failure as possible. This calls for frequent court hearings to monitor the offender and mete out sanctions.

In many drug courts, less serious violations, such as inadequate participation in a court-ordered program, call for sanctions that start with the intensification of supervision, treatment, or a day's incarceration. Those sanctions increase incrementally — one day, two days, four days — with continued violations. At the other end of the spectrum, complete program failure may call for a substantial period of incarceration — at least a week — to detox the offender and deter him or her from future program failure or drug use.

Diversion and other Incentives. Drug rehabilitation is at best a difficult, demanding, and lengthy process. To motivate offenders to complete the process, drug courts offer them substantial positive incentives to do so. Encouragement, appreciation, and real incentives are given to participants for positive behaviors.

A diversion program (that includes treatment as well as learning social, educational, and vocational skills) provides a powerful motivational tool for drug rehabilitation, offering the defendant the opportunity to work toward a complete dismissal of a felony drug charge.

Hybrid diversion programs that do not offer a complete dismissal, such as those offering to reduce felony convictions to misdemeanors, are common but provide less incentive for participants to succeed. Even where a diversion program is not available at all, significant incentives often are offered to offenders through the innovative application of probation terms, such as offering participants reductions in the length, intensity, or cost of probation supervision.

Contingency Contracting: A Program Example

A contingency contract sets out the standards of and consequences for offender conduct during the program. Developed by the drug court judge, the supervision and treatment staff, and other participating agencies, it ensures that positive and negative behaviors are rewarded or penalized according to the number of rehabilitative tasks completed.

In Oakland's diversion program called FIRST (fast, intensive, report, supervision, and treatment), the number of points achieved under the contract reflects the number of rehabilitative tasks completed. Over the life of the program, an offender's point total translates into rewards or sanctions. For example, an offender who achieves a high point total may have diversion reduced from 24 months to as few as six months and the diversion fee reduced from $220 to as little as $20. On the other hand, for an offender whose point total is low, the court may increase the intensity of supervision and treatment or impose a period of incarceration.

The contract makes offenders accountable for their behavior and gives them control over their own rehabilitation, ultimately making them participants rather than self-described victims of the rehabilitation program. In addition, the court, supervision staff, and all participating agencies, having committed to the contingency contract, also are accountable to the offender and to each other for the contract's consequences.

Oakland's FIRST diversion program (initiated in January 1991) has achieved a 50 percent graduation rate, about twice the number of successful diversions of the previous program. In addition, its felony recidivism rate is about half the

old rate. Significantly, younger offenders placed in the program within three days of arraignment show nearly three times the success of younger offenders in the previous program. For the first time, Alameda County has been able to rent empty jail cells to neighboring counties, as FIRST diversion participants spent approximately 35,000 fewer days in custody over a two-year period. This represents a 45 percent reduction in incarceration time and a savings of more than $2 million for the county.

The development of drug courts has been described as a golden opportunity to treat drug-using offenders in their communities with minimal incarceration, recidivism risk, and cost. In particular, U.S. Attorney General Janet Reno's support for drug courts and other alternative sanctions programs has drawn attention to the idea that we can do better than simply warehousing drug offenders in jails and prisons.

However, with this opportunity comes a challenge: We must carefully and intelligently design and implement these programs or risk fulfilling the prophecy of the naysayers who say that nothing works.

While local communities should be encouraged to create their own drug court programs, the federal government can play an important role by providing the technical assistance and funding incentives necessary to promote the adoption of proven design strategies.

Drug Use: A U.S. Concern for Over a Century

Federal drug control efforts have been a public policy concern since the late 19th century when the use of opiates and cocaine spread to the United States from Europe. Today the use of illicit drugs is still a major concern following recent surveys that show a sharp increase in teenage use of marijuana and hashish, and a National Drug Control Strategy that gives top priority to the prevention of drug use by young people.

Following are excerpts of a May 1997 report on "Drug Supply Control" prepared by the Congressional Research Service (CRS) of the Library of Congress.

Illicit Drugs in the United States

The use of illicit drugs has been a public policy concern in the United States since the late 19th century. Policymakers by law and custom usually define the word narcotics as products of the poppy plant or opiates (heroin, morphine), as well as products derived from the coca leaf (cocaine, crack) and the cannabis plant (marijuana).

Illicit drug use patterns tend to change over time; some suggest that there are cycles in popular drug use. The history of opium use for medicinal purposes dates back to ancient times. Morphine, the chief active ingredient of opium, was isolated in 1803 and began to be used as a painkiller and calming agent by U.S. physicians about 1832. Opiate use increased in the mid-19th century with the rise in the opium trade with China, the advent of the hypodermic needle, and the liberal use of opiates by physicians during the Civil War. Heroin, a semi-synthetic narcotic derived from morphine, was first synthesized in 1874 and was offered as a medical remedy for coughs and chest pains around 1900.
The history of the use of coca leaf for medicinal purposes dates back at least to the mid-19th century, when European chemists derived cocaine from it. From 1870 to 1920, use and abuse of opiates and cocaine spread in the United States, due in part to a lack of knowledge about the negative effects of these drugs. Statistics on the number of U.S. narcotics addicts in 1920, though generally unreliable, ranged from 300,000 to 1.5 million.

From the mid-1800s until the 1930s, cannabis, from which marijuana is derived, served as an ingredient in paint products, oils, birdseeds, and household medications such as corn plasters, mild tranquilizers, and veterinary medicines. Policymakers expressed growing concern over a perceived rise in marijuana use during the 1930s and acted to restrict it. Reported statistics vary widely and are unreliable. One press account estimated in 1937 that there were 100,000 marijuana addicts, mainly adolescents and college students. Commissioner Harry Anslinger of the Federal Bureau of Narcotics estimated that the states had made 800 arrests of marijuana users in 1936.

Despite stiffer federal penalties for drug offenses enacted during the 1950s, popular use of psychedelic substances, such as LSD, in addition to heroin, marijuana, and cocaine saw a resurgence in the 1960s and early 1970s. The estimated number of heroin users rose from approximately 50,000 in 1960 to about 500,000 by 1970. Methadone, a

synthetic drug created by German scientists during the Second World War due to a shortage in morphine, was introduced in the United States in 1947 and was widely used in the 1960s to treat heroin addicts. In 1971, an estimated 24 million Americans reported use of marijuana at least once, and others reported experimental use of cocaine. At the same time, press accounts noted a growing use of marijuana and heroin by U.S. soldiers in Vietnam.

The use of most illicit drugs has generally declined since the late 1970s, with marijuana remaining the most commonly used illegal drug. In the 1980s, popular use of cocaine, and later the smokeable cocaine base called crack, grew. The National Household Survey's revised estimates of the percentage of those age 12 and older reporting current or past month use of cocaine declined from 3 percent in 1985 (the first year any data on crack were included) to 1 percent in 1990, and has remained at 0.7 percent for each year, 1992-1995.

Other drugs came into greater use during the mid-1970s to late 1980s, including hallucinogens such as PCP (phencyclidine) and MDMA (Ecstasy), designer drugs (analogues chemically and pharmacologically similar to substances regulated under the Controlled Substances Act), and methamphetamines such as Speed and Ice. In the early 1990s, authorities noted the growing use of Cat, an analogue of methamphetamine, in the Great Lakes region of the United States.

Various indicators show that drug use is on the increase. On December 19, 1996, Health and Human Services (HHS) Secretary Donna E. Shalala released the Monitoring the Future Survey, which surveys the use of tobacco, alcohol, and illicit drug use by 8th, 10th, and 12th graders nationwide. (The survey was administered in the spring of 1996.)

According to the HHS press release: The survey showed increases in lifetime, annual, current (use within the past 30 days) and daily use of marijuana by 8th and 10th graders, continuing a trend that began in the early 1990s. Among 12th graders, rates of marijuana use remained high and increased for lifetime use, but for the first time since 1993 showed no significant change in annual, current or daily use.

Surveyors stated that the increase in marijuana use among younger high school students may be contrasted with "mixed or overall unchanged measures for other drugs." Barry McCaffrey (retired army general), director of the White House office on drug policy, who joined Secretary Shalala in releasing the survey results, stated, "Increased use among students in 8th and 10th grades is a wake-up call for America. Because marijuana use by youth is highly correlated with future use of addictive drugs like cocaine and heroin, we must step up our efforts to prevent drug abuse among children of all ages."

Drug use data from the 1995 National Household Survey on Drug Abuse, released August 1996, show that current illicit drug use (in the past month) among those age 12 and older reached an estimated 12.8 million in 1995, an increase over the low of an estimated 12 million in 1992, but lower than the estimated total of 23.3 million in 1985. This estimated total for current drug use nationwide in 1995 includes:

— 9.8 million Americans who use marijuana, the illicit drug with the highest reported use;

— 1.5 million Americans who use cocaine, of which 420,000 use cocaine in the form of crack; and

— 548,000 Americans who use heroin.

The survey reported data showing a continuing rise in teenage use of marijuana nationwide, with the adjusted rate of past month use of marijuana and hashish among 12- to 17-year-olds doubling from 5.3 percent in 1992 to 10.9 percent in 1995. Survey data show a 13.2 percent current drug use rate for this age group in 1985.

Drug Control Legislation

Modern federal drug control legislation may be said to have begun with an 1887 act to keep aspects of the Chinese opium traffic from the United States and prohibit the involvement of U.S. citizens in that traffic. In 1914, Congress enacted the Harrison Narcotics Act to regulate traffic in narcotics and other drugs, require doctors and pharmacists to keep detailed records of drug distribution, and mandate the purchase of tax

stamps to ensure oversight of drug sales. Although the Act was not specifically designed to eliminate drug use except for medicinal purposes, it did provide information on the sale of these drugs and it served as the principal drug control statute until 1970.

Marijuana was not covered under the Harrison Act, though various state and local statutes required a prescription for distribution. Federal efforts to regulate the use of the drug developed during the 1920s and 1930s, culminating in the passage of the Marijuana Tax Act of 1937. The Act required a sizeable transfer tax for all marijuana sales.

Congress enacted the Controlled Substances Act in 1970; its provisions consolidated existing statutory regulations, changed the system of penalties for drug law violations, and increased regulation of pharmaceuticals. The Act provided five schedules for drugs: Schedule 1 includes drugs with a high potential for abuse and no accepted medical use (including heroin and marijuana, though experimental use of the latter has been permitted in certain cases); Schedule 2 includes drugs with a high potential for abuse and an accepted medical use (including cocaine and morphine); and Schedules 3-5 are applied to drugs with a progressively lower potential for abuse. Meanwhile, the establishment of the Drug Enforcement Administration in 1973 combined the drug control efforts of five federal agencies into one.

Congress has enacted five major anti-crime bills including drug-related provisions since 1984: the Crime Control Act of 1984, the Anti-Drug Abuse Act of 1986, the Anti-Drug Abuse Act of 1988, the Crime Control Act of 1990, and the Violent Crime Control and Law Enforcement Act of 1994. Collectively, these Acts enhanced drug-related penalties, provided new funding for drug control initiatives, and sought to improve coordination of federal drug control activities.

National Drug Control Strategy

The Clinton Administration released its FY1998 budget request on February 6 (1997) and the 1997 National Drug Strategy on February 25. Overall, the Strategy proposes $16,000 million in National Drug Control Funding, a 5.4 percent increase ($818 million) over the estimated $15,200 million in budget authority for FY1997.

The National Narcotics Leadership Act of 1988, a component of the Anti-Drug Abuse Act of 1988, created the Office of National Drug Control Policy (ONDCP). The ONDCP director, sometimes known as the "Drug Czar," was charged with coordinating national drug control policy.

The ONDCP Director is also charged with producing a strategy linked to quantifiable goals set annually.... The 1997 Strategy maintains that the metaphor of a "war on drugs" is misleading and that the United States does not wage war on its citizens, among whom are many victims of drug abuse. Instead, it proposes a more appropriate analogy by comparing the drug problem to cancer.

Specifically, the Strategy works to reverse rising drug use among youth nationwide and continuing drug use among older, chronic drug users. ONDCP highlights of the new Strategy include:

(1) Explicit recognition that demand reduction must be the centerpiece of the national anti-drug effort (including the initiation of a new $175 million advertising effort called the National Media Awareness Campaign);

(2) Identification of prevention of drug use by youth as the top priority;

(3) Inclusion of prevention of underage drinking and smoking in the Strategy;

(4) A commitment to robust international drug interdiction programs;

(5) Substantial reinforcement of federal drug interdiction efforts along the Southwest Border and other vulnerable entry points; and

(6) Declaration of the elimination of coca cultivation designed for illicit consumption within the next decade as an objective

Broad Policy Questions

Policymakers are faced with a number of questions regarding drug control: Should the government

attempt to control drug use? If so, is it pursuing the best strategy to achieve this end?

The first question arises from the debate on the pros and cons of drug legalization. Proponents of legalization have had no significant success in influencing Congress on drug control issues. The present Administration opposes drug legalization, as does a majority of the American public. A 1990 Gallup Poll found that 80 percent of respondents felt that legalizing drugs like marijuana, cocaine, and heroin is a bad idea. Only 14 percent favored legalization, 2 percent said some drugs should be legalized but not others, and 4 percent had no opinion. Most of those opposed to drug legalization felt that removing restrictions would result in an increase in drug use in the public schools, higher numbers of drug addicts and drug overdoses, and more drug-related crime.

The case argued by proponents of legalization is that the massive war on drugs has largely failed, resulting in enriching dealers and cartels, and increasing violent crime by gangs fighting turf wars and by users unable to support their habits otherwise. They argue that legalization would reduce drug prices and profits, lower police costs, and lessen corruption of institutions by drug money.

The second question, concerning the best strategy to achieve drug control objectives, focuses on the relative emphasis that should be placed on supply and demand approaches. The Anti-Drug Abuse Act of 1988 requires that the national drug control strategy describe the balance of resources devoted to the two approaches.

Some argue that recent policy places too much emphasis on supply reduction. Although total funding for demand reduction efforts has continued to rise annually at least since 1981, (those arguing for) concentrating greater effort and more money to increase education and other prevention efforts and to provide more and better treatment of those already dependent on drugs urge a 50/50 proportional split. In keeping with the Administration's goals to motivate America's youth to reject illegal drugs and substance abuse; to increase the safety of America's citizens by substantially reducing drug-related crime and violence; and to reduce health, welfare, and crime costs resulting from illegal drug use, the 1997 strategy calls for a split between supply and demand funding of 66/34 (requested) in FY1998.

For a brief discussion of the ONDCP's purpose, organizational structure, and major drug control priorities, see the Office of National Drug Control Policy's Home Page at http://www.whitehouse.gov/WH/EOP/ondcp/html/ondcp.html.

The ONDCP Drugs and Crime Clearinghouse, a component of the National Criminal Justice Reference Service (NCJRS), provides recent ONDCP press releases, provides documents on drug-related subjects, ranging from prevention, treatment, and research efforts to drug testing and drug law enforcement and corrections; and lists various other related websites (at http://www.ncjrs.org/drgshome.htm).

The CRS Issue Brief, "Drug Supply Control: Current Legislation," was prepared by David Teasley, an analyst with CRS's Government Division.

Declaring Illegal Drugs Enemy Number One

The U.S. Conference of Mayors' national action plan to reduce drug use in cities says that equal emphasis must be attached to supply and demand reduction efforts. The mayors, with their associated police chiefs and prosecutors, presented to President Clinton on May 21, 1997 a report emphasizing an urgent need to counter the spread of methamphetamine, a highly addictive drug that can trigger violent behavior. The mayors also say that illegal drugs should be declared one of America's major foreign policy concerns.

The Conference of Mayors is an official nonpartisan organization representing mayors from over 1,000 U.S. cities with populations of 30,000 or more. The conference has assumed a national leadership position in calling for early attention to serious urban problems and pressing for solutions. Its official policy positions are presented to the president and both houses of Congress.

A National Action Plan To Control Drugs

If illegal drugs are to be controlled in this nation, equal importance must be attached to supply reduction and demand reduction efforts. The current level of drug enforcement must be maintained and demand reduction activities must be increased. Prevention, education, treatment sanctions for drug use, and drug testing — all should be viewed as parts of an effective demand reduction strategy.

1. Reaching America's young people and convincing them not to use drugs must be our first priority.

— Parents must be engaged in this effort. They must be helped to understand their responsibility to provide support and guidance that will discourage the use of drugs or alcohol by their children. Parents should also understand that they can be held legally responsible for the actions of their children.

— Children whose parents are not present or are unable to meet their responsibilities pose a special challenge that must be met by other family members or others in the community.

— Parents who develop their own substance abuse problems or are tolerant of drug use in their homes fail in their responsibilities as parents and undermine the efforts of all others in the community to reach children with effective anti-drug messages.

— Businesses should be encouraged to have "family friendly" policies that help, not hinder, the process of child rearing. Examples are the provision of child care on the work site and flexible leave policies.

— Appropriate role models must be employed at both local and national levels to help reach and motivate young people with clear, emphatic drug-free and violence-free messages. Entertainers and sports figures willing to speak out against drugs and violence to counter the pro-drug messages that continue to be carried by the entertainment industry must be more actively recruited. A partnership with the media should be formed in order to eliminate the "glamorization" of the

portrayal of drug use and violence.

— An advertising campaign that shows actual victims, not generalized models of victims, would increase the public's understanding of, and sensitivity to, the consequences of drug abuse. The (Clinton) administration's proposed media campaign designed to help America's youth reject illegal drugs, alcohol, and tobacco should be supported.

— School systems should recognize and stop drug use, drug sales, and violence in and around schools. It is critical that students recognize that their schools do not look the other way and that they do not tolerate drugs. A partnership among schools, the community, and law enforcement should be formed to create drug-free and violence-free schools in which learning is not impeded. Drug and violence prevention campaigns should be incorporated into the curricula of every school. Because of the time young people spend in them, schools provide a valuable vehicle for reaching young people with anti-drug messages.

— If young people are expected to reject drugs, a range of positive options, such as recreational and employment opportunities, must be available to them.

2. *Drug abuse will not be reduced in this country without adequate treatment resources.*

— Treatment works and represents a good investment. The 1996 National Treatment Improvement Evaluation study found that treatment reduces drug use. Clients reported reducing drug use by 50 percent in the year following treatment. The study found all types of treatment can be effective, criminal activity declines after treatment, health improves after treatment, and treatment improves well-being. The Conference has long held that treatment should be expanded so that a continuum of services such as detoxification, stabilization, and after-care that includes job training and education is available on demand to all in need and seeking help. Demand reduction, including prevention and treatment, must be responsive to the emerging trends in drug use patterns and trends. It should also be recognized that when drugs are taken out of someone's life, positive alternative activities must be substituted.

— Cost-effective treatment must become more readily available, especially for uninsured people who are not in the criminal justice system. For those with insurance, policies should cover substance abuse treatment just as they cover other forms of medical treatment, and managed care plans should not decrease coverage of substance abuse treatment. Medicaid reimbursement for drug treatment should be expanded by allowing states the option of (a) covering treatment — including services in hospitals, outpatient clinics, residential facilities, and any other drug treatment facility licensed by the state; and (b) providing drug treatment to financially eligible single individuals as well as pregnant women and families. Modeled after the High Intensity Drug Trafficking Areas, targeted funding should be made available to areas in which there are significant rates of drug addiction and a corresponding insufficiency of treatment programs and facilities.

— While authorities should take full advantage of the fact that the threat of incarceration can motivate an individual to enter into and successfully complete a treatment program, the goal should be to get people into treatment before they are faced with such a threat, and certainly before they come into actual contact with the criminal justice system.

— Authorities should recognize that every contact with the juvenile or criminal justice system is an opportunity to identify substance abusers and to intervene in the form of drug testing and treatment.

— Additional drug courts should be established with funding provided for the necessary continuum of treatment services. Needed are workable, accountable, sufficiently funded treatment programs and immediate consequences for those who fail to remain drug free.

— For young people especially, incarceration should focus on rehabilitation, and the availability of drug treatment is essential to this.

— Research into effective methods of treatment

should be increased, with particular attention to models for cocaine and methamphetamine addiction.

3. Increased prevention and treatment must be accompanied by strong enforcement measures.

— The number of federal agencies involved in drug enforcement and the lack of a protocol for communication among them, as well as between them and local enforcement agencies, is clearly a problem. Cooperation and coordination among the various federal enforcement agencies must improve significantly. There should be improved sharing of intelligence, new technologies, and technical assistance among federal enforcement agencies and between federal enforcement agencies and local police departments.

— Federal-state-local partnerships must continue and expand. A nationwide data system providing all police agencies access to information on gang membership and narcotics traffickers should be instituted. To address the drug problem more aggressively, state and local authorities should be empowered to invoke federal statutes as part of their own enforcement strategies.

— The Internal Revenue Service and other law enforcement agencies should further enhance the use of the tax laws as part of a national anti-drug strategy and should prosecute drug dealers under them.

— Federal prosecutors should target more aggressively the international traffickers and those who reap the profits and launder the money from the drug trade.

— Federal authorities should assume more responsibility for prosecuting major drug offenses and federal courts should take many more major drug cases. Where needed, separate federal drug courts should be established.

— Penalties should be stiffened based on the level of involvement of the individual in drug trafficking and the seriousness of the crime committed. There should be severe and definitive punishment of higher level dealers.

— Federal money-laundering statutes should be strengthened and more aggressively enforced. To deter money laundering, the Customs Service should increase the monitoring of goods and cash leaving the country.

— Funding for the Drug Enforcement Administration (DEA) should be increased, and the administration should improve its coordination with local police departments. DEA should provide local police departments with information concerning seizures and arrests when such activities are planned for their jurisdictions.

— The Immigration and Naturalization Service should continue to expand its efforts to apprehend and deport illegal aliens involved in drug trafficking in non-border areas.

4. Greater attention must be given to the threat of methamphetamine, the use of which is clearly in evidence in western states, with increasing evidence of its spread eastward.

— Methamphetamine is being manufactured in Mexico and the United States using ingredients that are readily available. The facts that methamphetamine is easy to distribute, inexpensive to produce and purchase, is highly addictive, and can trigger violent behavior among users underscore the urgent need to combat this problem.

— There is an immediate need for a national effort to make government and law enforcement officials at all levels, the general public, and young people in particular aware of the threat of methamphetamine. Police, emergency medical staff, and domestic violence counselors should be educated about the dangers methamphetamine presents.

— The administration's initiatives to combat the spread of methamphetamine should be supported.

— Existing laws governing the distribution and regulation of precursor chemicals should be examined and strengthened where possible.

— Enforcement operations targeting methamphetamine traffickers should be supported. Federal, state, and local agencies should work

together to coordinate joint methamphetamine operations and training.

— Scientific research should be conducted to understand the behavior patterns of methamphetamine users and to address public safety and environmental issues connected with the manufacture of the drug.

5. Because all segments of a community must be involved in efforts to combat drug abuse, the private sector role in preventing drug abuse and addressing drugs in the workplace should be greatly expanded.

— Employers in both the public and private sectors should assure that their workplaces are drug free.

— Employers should make employee assistance programs, including drug treatment, available to workers who voluntarily acknowledge a drug problem and request help.

6. Drug control efforts and the intergovernmental system through which they operate should be strengthened and streamlined.

— The Office of National Drug Control Policy should be reauthorized with the role of the director significantly strengthened. The director should have clear authority over the anti-drug activities of the more than 50 federal agencies involved in drug control, and those agencies must improve coordination of their efforts. The visibility of the Office should be increased and the number of staff expanded to the extent necessary for it to fulfill its mission.

— The federal funding sources for state and local anti-drug programs should be restructured to make them more responsive to local needs and provide at least a portion of the funds directly to local governments. The federal COPS (Community Oriented Policing Services) program serves as a model for getting funds directly to the level of government responsible for the activity — to where the need is greatest. Further, all funds provided to local agencies must be directed to the appropriate local government official, the official who must be aware of and responsive to needs throughout the community. The results of the omnibus anti-drug legislation enacted into law 10 years ago have been mixed at best. The impact of these federal programs on cities is not clear, since the funds go to the states as block grants and are used primarily at the discretion of the governor and other state officials.

7. Illegal drugs should be declared one of the nation's major foreign policy concerns, and foreign aid should be denied to any illegal drug source country that fails to cooperate satisfactorily in curbing its illegal exports to our nation.

— Foreign countries should be certified based upon their cooperation with United States counter-narcotics efforts and, where appropriate, foreign aid should be denied to source countries that fail to cooperate satisfactorily.

— Foreign governments should be encouraged to strengthen and more aggressively enforce their laws and policies to reduce money laundering and other financial crimes.

— The interdiction and anti-smuggling efforts of federal agencies should be strengthened to further defend our land, sea, and air borders against penetration by narcotics traffickers.

Treatment Programs Reduce Drug Use

A five-year study conducted by the National Opinion Research Center at the University of Chicago.

A study of drug treatment programs funded by the federal government shows an overall 50 percent decline in drug use and significant declines in alcohol use among participants one year after treatment.

The study, the largest of its kind, also highlights large changes in criminal behavior, a 19 percent increase in employment, and a 42 percent drop in the percentage of respondents who were homeless. The study included interviews with participants before and after treatment.

The National Treatment Improvement Evaluation Study (NTIES), released in September 1996, looked at the impact of drug and alcohol treatment on a sample of 5,388 clients treated in programs supported by the U.S. Center for Substance Abuse Treatment (CSAT). The center is part of the Substance Abuse and Mental Health Services Administration (SAMHSA) of the Department of Health and Human Services (HHS).

SAMHSA Administrator Nelba Chavez has observed that treatment is far less expensive than likely alternatives. For example, one year of methadone maintenance treatment for heroin addiction costs $3,500, while one year of incarceration (jail time) can cost as much as $40,000.

Following is a summary of the findings of the study entitled "The Persistent Effects of Substance Abuse Treatment — One Year Later."

OVERALL FINDINGS:

— Clients served by CSAT-funded treatment programs significantly reduced their alcohol and drug use.
— Treatment resulted in lasting benefits, with significant decreases in drug and alcohol use one year after treatment.
— Clients also reported increases in employment, income, and physical and mental health, and decreases in criminal activity, homelessness, and risk behaviors for HIV/AIDS infection, one year after treatment.

REDUCED DRUG AND ALCOHOL USE:

Typically, significant reductions in substance abuse are found immediately following treatment. More importantly, however, NTIES shows that clients served by federally funded substance abuse treatment programs were able to reduce their drug use by approximately 50 percent as long as one year after leaving treatment. This analysis includes clients who completed an intake interview and may have only returned for one single visit (i.e., they did not really become involved in treatment). Therefore, these results should be viewed as conservative estimates of effectiveness of substance abuse treatment.

NTIES compared respondents' drug use one year before treatment and one year following discharge from that treatment and found that:

— (The number of clients using) their primary drugs (those drugs that led clients to seek treatment) decreased from 72.8 percent before treatment to 37.7 percent one year after treatment.

— Cocaine use significantly decreased from 39.5 percent before treatment to 17.8 percent 12 months after discharge from treatment, a 55 percent drop.

— Heroin use, which most experts believe to be more treatment resistant than use of other drugs, decreased by nearly half, from 23.6 percent of respondents reporting use in the 12 months prior to treatment to only 12.6 percent one year after discharge.

— The use of crack, a drug used by approximately half the NTIES respondents, showed a large and statistically significant post-treatment decline, decreasing from 50.4 percent before treatment to 24.8 percent in the 12 months after treatment.

— As a group, NTIES respondents also demonstrated significant improvement in their assessments of being troubled by alcohol use — 23 percent reported being troubled before treatment and only 7 percent reported being troubled after treatment.

VALIDITY OF SELF-REPORTED DRUG USE:

The data suggest that, in this study, clients were generally candid in reporting drug use. There was some under reporting of recent use (last 30 days) of heroin and cocaine. Among the clients interviewed, 20.4 percent reported cocaine/crack use and 11.3 percent heroin use, while urine tests (sensitive for very recent and recent use) found 28.7 percent positive for cocaine/crack use and 16.2 percent positive for opiate use (e.g. heroin). However, when asked about any use over a longer term (last 12 months), self-reports of marijuana use (27.8 percent) and cocaine/crack use (33.5 percent) were higher than use detected by urine tests (as above). Self-report and urine tests for heroin were about the same (16.5 percent and 16.2 percent, respectively).

REDUCED INVOLVEMENT IN CRIMINAL ACTIVITY:

The linkage between active substance abuse and criminal involvement has been well established. The results from NTIES add to the literature which suggests that substance abuse treatment can play a major role in crime reduction. NTIES respondents reported statistically significant decreases in multiple indicators of criminal involvement.

— Approximately half (49.3 percent) of the NTIES respondents reported "beating someone up" in the year before treatment and only 11 percent reported being involved in this type of behavior one year after treatment.

— Similar substantial decreases (occurred with)...reports of arrest (from 48.2 percent to 17.2 percent) and...of the majority of financial support derived from illegal activities (from 17.4 percent to 9 percent).

IMPROVED EMPLOYMENT, INCOME, AND HOUSING:

In addition to the reduced criminal activity noted above, gains in employment and housing appear to be an ancillary benefit of substance abuse treatment.

— Slightly more than 60 percent of all respondents reported receiving income from a job after treatment, up from 50 percent before treatment. In addition, there was a small but statistically significant decrease in the number of respondents reporting the receipt of general assistance payments.

— Client reports of homelessness dropped from 19 percent before treatment to 11 percent after treatment.

IMPROVED PHYSICAL AND MENTAL HEALTH:

Substance abuse is known to be a major contributor to poor health.

— The number of health visits related to alcohol/drugs...decreased by more than half in the year following treatment, in comparison to the year before.

— NTIES respondents also reported significantly fewer suicide attempts (both those directly related to alcohol and drugs and those not directly related to alcohol and drugs) after treatment, in

comparison to before treatment.
— NTIES also found a smaller but still sizable decline in the proportion of NTIES respondents who received inpatient care for a mental health problem....

REDUCED RISK FOR HIV/AIDS INFECTION:

The sexual behavior of persons who abuse substances is considered to be a major risk pathway for the transmission of HIV, the virus that causes AIDS.

— Compared to their reports before treatment, NTIES respondents successfully reduced behaviors that put them at risk of contracting HIV including relatively large decreases in unprotected heterosexual intercourse, having more than one sexual partner, and having sex for money or drugs.

— Although small in absolute number, male respondents' reports of high-risk homosexual behaviors, including unprotected sex and having more than one sexual partner, (significantly decreased)...in the one year after treatment....

BACKGROUND OF THE STUDY:

— A total of 6,593 NTIES clients were interviewed at treatment intake. Of these, 5,274 clients were also interviewed at discharge from treatment and 5,388 at follow-up, which for the majority of the sample was one year after discharge from treatment.

— An excellent follow-up rate of 83 percent was achieved, yielding a large data base on the treatment outcomes of persons who received publicly supported substance abuse treatment.

— Data were collected across several important outcome areas, including drug and alcohol use, physical and mental health, criminal activity, social functioning, and employment.

— For a random sample of approximately 50 percent of those interviewed, urine specimens were collected at follow-up to corroborate clients' self-report of substance abuse.

— NTIES was originally funded to meet specific Congressional requirements to evaluate the activities of the demonstration programs supported by CSAT (formerly the Office of Treatment Improvement) now part of SAMHSA and HHS.

— The demonstration programs focused on underserved and vulnerable populations whose drug problems tend to be more severe and who have few social supports to help in their recovery (e.g. minority populations, pregnant and parenting women, those living in inner cities or public housing, recipients of public welfare, and those involved with the criminal justice system.)

DEPARTMENTS

Bibliography

BOOKS AND DOCUMENTS

ADDICTION

DeMet, Edward M.
ADDICTIVE BEHAVIOR: MOLECULES TO MANKIND; PERSPECTIVES ON THE NATURE OF ADDICTION.
St. Martin's Press, 1996. 312p.

Fulco, Carolyn E. and others, eds.
THE DEVELOPMENT OF MEDICATIONS FOR THE TREATMENT OF OPIATE AND COCAINE ADDICTIONS: ISSUES FOR THE GOVERNMENT AND PRIVATE SECTOR.
National Academy Press, 1995. 272p.

Kandall, Stephan R.; Petrillo, Jennifer.
SUBSTANCE AND SHADOW: WOMEN AND ADDICTION IN THE UNITED STATES.
Harvard University Press, 1996. 384p.

Knipe, Ed.
CULTURE, SOCIETY, AND DRUGS: THE SOCIAL SCIENCE APPROACH TO DRUG USE.
Waveland Press, 1995. 506p.

Platt, Jerome J.
HEROIN ADDICTION.
Krieger Publishing Company, 1995.
3 vols., 1074p.

U. S. Congress. Office of Technology Assessment.
BIOLOGICAL COMPONENTS OF SUBSTANCE ABUSE AND ADDICTION.
(OTA-BP-BBS-117) U. S. Office of Technology Assessment, 1993. 61p. Available on Internet at http://www.wws.princeton.edu:80/~ota/disk1/1993/9311_n.html

U. S. Institute of Medicine.
PATHWAYS OF ADDICTION: OPPORTUNITIES IN DRUG ABUSE RESEARCH.
National Academy Press, 1996. 290p.

PREVENTION

Council on Foreign Relations.
RETHINKING INTERNATIONAL DRUG CONTROL: NEW DIRECTIONS FOR U. S. POLICY.
Council on Foreign Relations, 1997. 79p.

Delancey, Marci M.; Hannan, Denise M.
INTERNATIONAL GUIDE TO WORKPLACE SUBSTANCE-ABUSE PREVENTION. Washington, DC: Institute for a Drug-Free Workplace, 1994. 246p.

DuPont, Robert L.
THE SELFISH BRAIN: LEARNING FROM ADDICTION.
American Psychiatric Press, 1997. 553p.

Early, Kevin E.
DRUG TREATMENT BEHIND BARS: PRISON-BASED STRATEGIES FOR CHANGE.
Greenwood Publishing Group, 1996. 192p.

Graham, Kathryn and others.
ADDICTIONS TREATMENT FOR OLDER ADULTS: EVALUATION OF AN INNOVATIVE CLIENT-CENTERED APPROACH.
Haworth Press, 1994. 244p.

Kirsch, Henry, ed.
DRUG LESSONS AND EDUCATION PROGRAMS IN DEVELOPING COUNTRIES.
Transaction Publishers, 1995. 345p.

McCoy, Clyde B.; Metsch, Lisa R.; Inciardi, James A.
INTERVENING WITH DRUG-INVOLVED YOUTH.
Sage Publications, 1996. 272p.

Neff, Pauline.
TOUGH LOVE: HOW PARENTS CAN DEAL WITH DRUG ABUSE.
Abington Press, 1996. 160p.

Powell, Richard R. and others.
CLASSROOMS UNDER THE INFLUENCE: ADDICTED FAMILIES-ADDICTED STUDENTS.
Corwin Press, 1995. 168p.

Rhodes, Tim; Hartnoll, Richard.
AIDS, DRUGS AND PREVENTION: PERSPECTIVES ON INDIVIDUAL AND COMMUNITY ACTION.
Routledge, 1996. 240p.

Rotgers, Frederick and others, eds.
TREATING SUBSTANCE ABUSE: THEORY AND TECHNIQUE.
Guilford, 1996. 328p.

U. S. Department of Health and Human Services. Center for Substance Abuse Treatment.
50 STRATEGIES FOR SUBSTANCE ABUSE TREATMENT.
(DHHS Publication No. (SMA) 96-8029) Center for Substance Abuse Treatment, 1997. 148p.

U. S. Department of Health and Human Services. National Cancer Institute.
COMMUNITY-BASED INTERVENTIONS FOR SMOKERS.
(Monograph 6, NIH Publication No. 95-4028) National Cancer Institute, 1995. 252p.

U. S. Department of Health and Human Services. National Institute on Drug Abuse.
PREVENTING DRUG USE AMONG CHILDREN AND ADOLESCENTS; A RESEARCH-BASED GUIDE.
(NIH Publication No. 97-4212) National Institute on Drug Abuse, 1997. 38p.

U. S. Executive Office of the President. Office of National Drug Control Policy.
THE NATIONAL DRUG CONTROL STRATEGY: 1997.
U. S. Government Printing Office, 1997. 70p. Available on Internet at http://www.ncjrs.org/htm/toc.htm

U. S. General Accounting Office.
DRUG AND ALCOHOL ABUSE: BILLIONS SPENT ANNUALLY FOR TREATMENT AND PREVENTION ACTIVITIES.
(GAO/HEHS-97-12) U. S. General Accounting Office, 1996. 69p. Available on Internet at http://www.gao.gov/AIndexFY97/abstracts/he97012.htm

ARTICLES

Bower, Bruce.
ALCOHOLICS SYNONYMOUS
(Science News, Vol. 151, No. 4, January 25, 1997, p. 62)

Breer, Paul; McAuliffe, William E.; Levine, Eliot B.
STATEWIDE SUBSTANCE ABUSE PREVENTION PLANNING
(Evaluation Review, Vol. 20, No. 5, October 1996, pp. 596+)

Califano, Joseph A., Jr.
LEGALIZATION OF NARCOTICS: MYTHS AND REALITY
(USA Today, Vol. 125, No. 2622, March 1997, pp. 46-47)

Dusenbury, Linda; Falco, Mathea.
ELEVEN COMPONENTS OF EFFECTIVE DRUG ABUSE PREVENTION CURRICULA
(Journal of School Health, Vol. 65, No. 10, December 1995, pp. 420-425)

Glass, Stephen.
DON'T YOU D.A.R.E.
(New Republic, Vol. 216, No. 9, March 3, 1997, pp. 18-28)

Inciardi, James A.; Saum, Christine A.
LEGALIZATION MADNESS
(Public Interest, No. 123, Spring 1996, pp. 72-82)

Landry, Donald W.
IMMUNOTHERAPY FOR COCAINE ADDICTION
(Scientific American, Vol. 276, No. 2, February 1997, pp. 42-45)

Lee, Rensselaer W., III.
CUBA'S DRUG TRANSIT TRAFFIC
(Society, Vol. 34, No. 3, March/April 1997, pp. 49-55)

McCaffrey, Barry.
HEMISPHERIC DRUG CONTROL: FIGHTING DRUG PRODUCTION AND TRAFFICKING
(Vital Speeches of the Day, Vol. 63, No. 14, May 1, 1997, pp. 418-421)

Nadelmann, Ethan A.
REEFER MADNESS 1997: THE NEW BAG OF SCARE TACTICS
(Rolling Stone, No. 754, February 20, 1997, pp. 51-53, 77)

Nash, J. Madeleine.
ADDICTED (THE CHEMISTRY OF ADDICTION)
(Time, Vol. 149, No. 18, May 5, 1997, pp. 68-73, 76)

Navarro, Mireya.
EXPERIMENTAL COURTS ARE USING NEW STRATEGIES TO BLUNT THE LURE OF DRUGS
(New York Times, October 17, 1996, p. A25)

Peck, Richard L.
THE ADDICTED BRAIN: AN ERA OF SCIENTIFIC BREAKTHROUGHS
(Behavioral Health Management, Vol. 16, No. 5, September/October 1996, pp. 33+)

Peele, Stanton.
RECOVERING FROM AN ALL-OR-NOTHING APPROACH TO ALCOHOL
(Psychology Today, Vol. 29, No. 5, September/October 1996, pp. 35-43+)

Pentz, Mary Ann; Bonnie, Richard J.; Shopland, Donald R.
INTEGRATING SUPPLY AND DEMAND REDUCTION STRATEGIES FOR DRUG ABUSE PREVENTION
(American Behavioral Scientist, Vol. 39, No. 7, June/July 1996, pp. 897-910)

Prendergast, Michael L.; Anglin, M. Douglas; Wellisch, Jean.
TREATMENT FOR DRUG-ABUSING OFFENDERS UNDER COMMUNITY SUPERVISION
(Federal Probation, Vol. 59, No. 4, December 1995, pp. 66-75)

Tauber, Jeffrey.
DRUG COURTS: TREATING DRUG-USING OFFENDERS THROUGH SANCTIONS, INCENTIVES
(Corrections Today, Vol. 56, No. 1, February 1994, pp. 28-30+)

Terry, W. Clinton, III.
DEDICATED DRUG TREATMENT COURTS: A COLLABORATIVE MODEL OF JUSTICE FOR LOCAL GOVERNMENT
(Spectrum, Vol. 69, No. 3, Summer 1996, pp. 37-47)

Volkow, N. D. and others.
RELATIONSHIP BETWEEN SUBJECTIVE EFFECTS OF COCAINE AND DOPAMINE TRANSPORTER OCCUPANCY
(Nature, Vol. 386, No. 6627, April 24, 1997, pp. 827-830)

Article Alert

Abstracts of a few recent articles on drug addiction.

Bower, Bruce.
ALCOHOLICS SYNONYMOUS
(Science News, vol. 151, no. 4, January 25, 1997, p. 62)

Project Match announced in December 1996 the findings of its eight-year, federally funded investigation into how certain types of alcoholics respond to specific forms of treatment. The study concluded that alcoholics reduce their drinking sharply, and to the same degree, after completing any one of three randomly assigned treatments.

Glass, Stephen.
DON'T YOU D.A.R.E.
(The New Republic, vol. 216, no. 9, March 3, 1997, pp. 18-28)

The anti-drug and anti-alcohol program called D.A.R.E. consists of 17 weekly lessons taught in the fifth or sixth grade. The teachers in the popular and well-financed program are all uniformed policemen trained by D.A.R.E. The author points out that in the last five years studies have appeared criticizing D.A.R.E. and questioning its effectiveness. He discusses the results of the various studies and the reasons why the public may be unaware of the reports.

Landry, Donald W.
IMMUNOTHERAPY FOR COCAINE ADDICTION
(Scientific American, vol. 276, no. 2, February 1997, pp. 42-45)
Landry describes a new approach for combating cocaine addiction by destroying the drug soon after it enters the bloodstream. This strategy, now being studied at Columbia University, would deliver antibodies (molecules of the immune system designed by nature to bind to a variety of target molecules) to the bloodstream where they would trap and break the drug apart before it could reach the brain.

Lee, Rensselaer W., III.
CUBA'S DRUG TRANSIT TRAFFIC
(Society, vol. 34, no. 3, March/April 1997, pp. 49-55)

Cuba's tightly controlled political system probably has acted as a deterrent to drug smugglers (though Cuban officials have proven themselves corruptible on occasion), yet traffickers' use of Cuban territorial waters and airspace to smuggle drug cargoes northward to the Florida coast is well documented.

Nadelmann, Ethan A.
REEFER MADNESS 1997: THE NEW BAG OF SCARE TACTICS
(Rolling Stone, no. 754, February 20, 1997, pp. 51-53, 77)

Nadelmann, director of the Lindesmith Center, a drug-policy research institute, discusses various current claims about marijuana. He acknowledges that there are reasons to be concerned about marijuana which he calls a powerful psychoactive drug. However, he questions some assertions as to its harmful effects. For example, Nadelmann

challenges the claims that marijuana is more potent now and that its use leads to the use of more dangerous drugs.

A more comprehensive Article Alert is offered on the International Home Page of the U. S. Information Agency: http://www.usia.gov/admin/001/wwwhapub.html

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