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THE NATIONAL DRUG CONTROL STRATEGY FOR 2008, THE FISCAL YEAR 2009 NATIONAL DRUG CONTROL BUDGET, AND COMPLIANCE WITH THE ONDCP REAUTHORIZATION ACT OF 2006: PRIORITIES AND ACCOUNTABILITY AT ONDCP

HEARING

BEFORE THE

SUBCOMMITTEE ON DOMESTIC POLICY

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

MARCH 12, 2008

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THE NATIONAL DRUG CONTROL STRATEGY FOR 2008, THE FISCAL YEAR 2009 NATIONAL DRUG CONTROL BUDGET, AND COMPLIANCE WITH THE ONDCP REAUTHORIZATION ACT OF 2006: PRIORITIES AND ACCOUNTABILITY AT ONDCP

WEDNESDAY, MARCH 12, 2008

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON DOMESTIC POLICY,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:22 p.m., in room 2154, Rayburn House Office Building, Hon. Dennis J. Kucinich (chairman of the subcommittee) presiding.

Present: Representatives Kucinich, Cummings, Tierney, Souder, Cannon, and Issa.

Staff present: Jaron R. Bourke, staff director; Charles Honig, counsel; Jean Gosa, clerk; Emily Jagger, intern; Leneal Scott, information systems manager; and Jill Schmaltz and Alex Cooper, minority professional staff members.

Mr. KUCINICH. The committee will come to order. Sorry for the delay. Some of the Members know that our procedural votes have kind of made hash of the schedule, but we are going to proceed right now with the hearing.

I want to welcome the presence of the ranking member, Mr. Issa, and a person who has been long involved on national drug issues and for whom I have a great respect for his efforts, Mr. Souder. And my colleague, Mr. Tierney, joins us from our side of the aisle here.

We are here today to address the Office of National Drug Control Policy's stewardship over the national drug control programs. First the good news. There are some successes that we can all celebrate: notable declines in youth drug usage, the proliferation of pragmatic evidence-based programs such as drug treatment courts, and ONDCP's focus on the more recent threats posed by prescription drug abuse and methamphetamine. I am confident that the Director will elaborate on these and other successes in his testimony. However, the larger picture of ONDCP's accountability and overall effectiveness is less heartening.

First, I want to again commend Mr. Souder and Mr. Cummings for their work as Chair and ranking minority member of our predecessor Subcommittee on Criminal Justice, Drug Policy, and Human

Resources, ensuring that ONDCP consistently exercised its statutory responsibilities in setting our Nation's drug control priorities. While there were issues of disagreement, the members of the Criminal Justice Subcommittee exhibited an admiral bipartisan commitment to working with ONDCP to make it accountable, transparent, and effective.

The culmination of the subcommittee's work was Congress's passage of the ONDCP Reauthorization Act of 2006, which bore the stamp of this committee more than any other. The Reauthorization Act set levels for and conditions on spending for ONDCP's three largest programs: HIDTA, the National Youth Anti-Drug Media Campaign, and the Drug-Free Communities Support Program. Perhaps more importantly, the Reauthorization Act mandated reforms to ONDCP's organizational structure and processes and its interactions with Congress. These reforms were crucial because of the complexity of ONDCP's responsibility in coordinating a multi-billion dollar national drug control budget spread across many Federal agencies.

Put simply, Congress wanted to ensure that ONDCP upholds its statutory responsibility to identify, develop, and advocate for drug control policies that are effective in reducing drug abuse. Lack of transparency and accountability at ONDCP impairs ONDCP's and Congress's ability to determine which of the Federal drug controls are effective in combating drug abuse. To that end, the Reauthorization Act focused on ONDCP developing and implementing improved performance measures. It also mandated numerous reports to Congress to ensure that ONDCP was addressing important issues and sharing what it learned with Congress.

Importantly, the Reauthorization Act also required that the National Drug Control Budget that ONDCP certifies include all funding requests for any drug control activity, including costs attributable to drug law enforcement activities such as prosecuting and incarcerating Federal drug law offenders. This requirement was necessary because ONDCP had, in 2002, dropped many of these costs from the budget.

The removal effectively reduced the budget's size by one-third, exaggerated the proportion of the budget slated for drug treatment and prevention, and obscured important components of this Nation's drug control programs. In passing the Reauthorization Act, Congress explicitly rejected ONDCP's new methodology and mandated ONDCP prepare and certify a unified, comprehensive budget including all these costs to inform Congress and the broader public of the full scope of drug control program expenditures.

Unfortunately, the fiscal year 2008 National Drug Control Budget completely omitted the activities that Congress ordered reinstated, and the fiscal year 2009 budget relegates these activities to a skeletal, one-page table in the appendix.

Does Congress require a detailed reporting from ONDCP? Yes, we do. A sober assessment of the quantity and breadth of congressional reporting mandates—involving such varying subjects as improved performance measures for the Media Campaign, updates on drug price and purity data, plans for using unexpended funds in the Counterdrug Technology Assessment Center, specifics of ONDCP staffing levels, plans for using policy research funds, and

close accounting of ONDCP's travel budget—reveals an agency in need of aggressive congressional oversight.

ONDCP seems unwilling to comply with the standards of accountability that Congress has imposed. The Deputy Director of ONDCP has informed this subcommittee that ONDCP believes the Reauthorization Act did not require ONDCP to revert to its previous budgeting methodology. Frankly, ONDCP's obstinacy in the face of unambiguous statutory language and clear legislative history is troubling. Even if ONDCP's noncompliance with the act were confined to the budgetary issue, it would be a serious issue. However, the lack of accountability is more widespread.

Maybe not surprisingly, given the burden imposed on it, ONDCP has also been deficient in providing the reports mandated by the Reauthorization Act. Some of the completed reports are only minimally compliant with what was requested by the act, and a good portion of these reports submitted were 3 or 4 months late. Finally, other reports are long overdue and are not yet submitted, including reports on best practices in reducing use of illicit drugs by hard drug users, drug testing in schools, and the impact of Federal drug reduction strategies.

In its interactions with this subcommittee leading up to this hearing, ONDCP has continued to demonstrate a lack of accountability. Even well after their February 1st statutory due date, ONDCP would not provide the subcommittee with a firm date for the release of the National Drug Control Strategy and its budget. Ultimately, they were released on February 29th, still dated February, but a month late.

While I am pleased that Director Walter is testifying here today, his written testimony—due Monday morning—was not submitted to the subcommittee until yesterday evening. More troubling still is this testimony entirely omits discussion of ONDCP's compliance with the Reauthorization Act despite repeated clear requests that these issues be addressed. Viewed in isolation, an incomplete budget, an insufficient or incomplete report, or a delayed or partially deficient testimony may or may not be excusable; viewed together, these practices form a pattern of noncompliance that frustrates policy formation and congressional overview alike.

Perhaps most troubling is the prospect that ONDCP's lack of accountability encompasses and extends to the internal metrics it uses to guide its own policy formulation. Because it doesn't employ consistent or useful performance measures and frequently shifts its policy goals, it is difficult to determine if our Nation has actually made progress in combating drug abuse. Our second panel is going to examine the deficiencies in ONDCP's budget process and policy evaluation process, and the evaluation process may lead to ONDCP to advocate for programs that are not cost-effective in reducing drug use.

In conclusion, while some of the initiatives that Director Walters will highlight today are doubtlessly worthy products of ONDCP's and other agencies' hard work, without proper accountability, it is difficult to determine which programs work and which don't. The lack of accountability at ONDCP may go a long way to explaining why, over the last 7 years, funding for interdiction efforts have doubled and funding for every international programs has risen

faster than funding for treatment, domestic law enforcement, prevention efforts, despite research that demonstrates that demand-side approaches are generally more cost-effective than supply side approaches.

This assessment of ONDCP may seem critical, and it is. We now have the advantages of reflecting on nearly 20 years of ONDCP's operation. We have also begun to see whether reforms initiated in the Reauthorization Act have born fruit. This hearing is meant to look at the issues broadly. I hope that when we get down to the many details of funding and policy decisions, this subcommittee can continue the bipartisan approach of its predecessor and work cooperatively with ONDCP to strengthen our Nation's drug policy.

[The prepared statement of Hon. Dennis J. Kucinich follows:]

Opening Statement
Dennis J. Kucinich, Chairman
Domestic Policy Subcommittee
Oversight and Government Reform Committee

"The National Drug Control Strategy for 2008, the Fiscal Year 2009 National Drug Control Budget, and Compliance with the ONDCP Reauthorization Act of 2006: Priorities and Accountability at ONDCP."

March 12, 2008
2154 Rayburn HOB
2:00 P.M.

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policies that are effective in reducing drug abuse. Lack of transparency and accountability at ONDCP impairs ONDCP's and Congress' ability to determine which of the federal drug control are effective in combating drug abuse. To that end, the Reauthorization Act focused on ONDCP developing and implementing improved performance measures. It also mandated numerous reports to Congress to ensure that ONDCP was addressing important issues and sharing what it learned with Congress.

Importantly, the Reauthorization Act also required that the National Drug Control Budget that ONDCP certifies include all funding requests for any drug control activity, including costs attributable to drug law enforcement activities such as prosecuting and incarcerating federal drug law offenders. This requirement was necessary because ONDCP had in 2002 dropped many of these costs from the budget. The removal effectively reduced the budget's size by one-third, exaggerated the proportion of the budget slated for drug treatment and prevention, and obscured important components of this nation's drug control programs. In passing the Reauthorization Act, Congress explicitly rejected ONDCP's new methodology and mandated ONDCP prepare and certify a unified, comprehensive budget including all these costs to inform Congress and the broader public of the full scope of drug control program expenditures.

Unfortunately, the Fiscal Year 2008 National Drug Control Budget completely omitted the activities that Congress ordered reinstated, and the Fiscal Year 2009 budget relegates these activities to a skeletal, one-page table in the appendix.

Does Congress require a lot of detailed reporting from ONDCP? Yes, we do. A sober assessment of the quantity and breadth of Congressional reporting mandates—involving such varying subjects as improved performance measures for the Media Campaign, updates on drug price and purity data, plans for using unexpended funds in the Counterdrug Technology Assessment Center (CTAC), specifics of ONDCP staffing levels, plans for using policy research funds, and close accounting of ONDCP's travel budget—reveaks an agency in need of aggressive Congressional oversight.

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In its interactions with this Subcommittee leading up to this hearing, ONDCP has continued to demonstrate a lack of accountability. Even well after their February 1 statutory due date, ONDCP would not provide the Subcommittee with a firm date for the release of the National Drug Control Strategy and its Budget. Ultimately, they were released on February 29; still dated "February" but a month late. And, while I am pleased that Director Walters is testifying here today, his written testimony—due Monday morning—was not submitted to the Subcommittee until yesterday evening. More troubling still is that this testimony entirely omits discussion of

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enforcement, and prevention efforts, despite research that demonstrates that demand-side approaches are generally more cost-effective than supply-side approaches.

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Mr. KUCINICH. At this time, the Chair recognizes the ranking member, Mr. Issa.

Mr. ISSA. Thank you, Mr. Chairman, and thank you for holding this hearing today. Judging from our audience here, the number of cameras, the spectacle that we are all going through, we are not going to focus on steroids or human growth hormones today. [Laughter.]

Thank you for that laughter.

A few weeks ago, Director Walters and I met to discuss the current sentencing guidelines for offenses involving crack cocaine versus powder cocaine. The impetus for this meeting was the U.S. Sentencing Commission recently significantly restructured the guidelines for sentencing crack offenses. The result, although in the long run perhaps fair reshuffling, could cause and will likely cause early release of some of the most dangerous criminals presently incarcerated. The prospect worried many Members of Congress. I, for one, have wanted to harmonize to the actual dosage the real effective rate of these two drugs.

Having said that, it is clear one of the challenges facing this committee and others is to ensure that, regardless of the type of illicit drug, that the worst offenders in trafficking and production serve long sentences. Additionally, because so many of these offenses involve serious acts of violence—I wasn't talking that long—incarcerated for the safety of our community.

I know there are many other issues that the Director deals with every day, and the oversight of this committee certainly has every right to focus on the reporting requirement. I am equally, though, concerned and interested to hear about the successes that have occurred under Plan Colombia, the threats that face us from other emerging drug trafficking areas such as Mexico to our south and the Dominican Republic.

Last but not least, thanks to the majority, I think we have a chart in front of us today that is particularly instructive, with the recent reduction in the rates of people having in their systems cocaine and methamphetamine, two of the greatest threats to our safety and our community.

So, Mr. Chairman, I look forward to both parts of this. I am actually quite happy that this is dull, but important, work being done in a bipartisan fashion, and look forward to the testimony of the Director and yield back.

Mr. KUCINICH. I thank Mr. Issa.

I have just been informed that we have a series of four votes, and they are about no more than 5 minutes left before they vote, so we will be back. Thank you for your presence here, and we will recess until the votes are over; I am guessing probably about 40 minutes.

[Recess.]

Mr. KUCINICH. The committee will come to order.

This is a hearing of the Domestic Policy Subcommittee of the Oversight and Government Reform Committee, and the hearing today is the National Drug Control Strategy for 2008, Fiscal Year 2009 National Drug Control Budget, and Compliance with the ONDCP Reauthorization Act of 2006: Priorities and Accountability at ONDCP.

I am Dennis Kucinich, Chair of the committee. I have given an opening statement, as has the ranking member. Members of the committee will have 5 days to give an opening statement.

All Members have 5 legislative days to give an opening statement to the committee. Also, Members and witnesses may have 5 legislative days to submit a written statement or extraneous materials for the record.

There are no additional opening statements, so the subcommittee is now going to receive testimony from the witnesses before us.

I want to introduce our first panel. Mr. John Walters is the Director of the Office of National Drug Control Policy. As the Nation's drug czar, Mr. Walters coordinates all aspects of Federal drug programs and spending. From 1989 to 1991, Mr. Walters was Chief of Staff for William Bennett, and Deputy Secretary for Supply Reduction from 1991 until leaving the Office in 1993.

During his service at ONDCP, he was responsible for helping guide the development and implementation of anti-drug programs in all areas. From 1996 until 2001, Mr. Walters served as president of the Philanthropy Roundtable. During the Reagan administration, he served as Assistant to the Secretary at the U.S. Department of Education and was responsible for leading the development of anti-drug programs. He has previously taught political science at Michigan State University's James Madison College and at Boston College.

Mr. Walters, welcome, and we are pleased that you are here today. You may know that it is the policy of the Committee on Oversight and Government Reform to swear in all witnesses before they testify. I would ask, if you would, please, rise and raise your right hand.

[Witness sworn.]

Mr. KUCINICH. Thank you, sir.

Let the record reflect that the witness answered in the affirmative.

I would ask, Mr. Walters, if you would give a brief summary of your testimony and to try to keep the summary under 5 minutes in duration. If you go a little bit longer, that is fine. You have been very patient and you have a right to expect the courtesy. Your whole written statement, however, will be included in the hearing record. So if you would proceed with your testimony, we would be very grateful to hear it. Thank you, sir.

And let's make sure that mic is close by so we can all hear what Mr. Walters has to say. Maybe staff could maybe help with that too.

STATEMENT OF JOHN P. WALTERS, DIRECTOR, OFFICE OF NATIONAL DRUG CONTROL POLICY

Mr. WALTERS. Thank you, Mr. Chairman, Mr. Tierney. I recognize the comments of Mr. Issa and, of course, Mr. Souder has been working on this issue for a long time, as you noted. Thank you for including my written statement. I will summarize briefly, tell you where we are. I won't cover all the issues that you want to touch on, and I will be guided by your questions thereafter.

Briefly, when President Bush released the first National Drug Control Strategy of his administration in 2002, America had wit-

nessed a steep increase in illegal drug use. Between 1992 and 1996, current teen use doubled, virtually, and remained stubbornly higher through 2001.

With bipartisan congressional support, we have now implemented a balanced drug control strategy focused on preventing Americans from ever starting to use, helping more who suffer from substance abuse get treatment, and reducing the market for illegal drugs. I think the evidence before us shows that the Nation has made progress on all three of these areas, in some cases remarkable progress.

Since 2001, overall youth drug use has decline 24 percent. Youth amphetamine use is down 64 percent, LSD use 60 percent, ecstacy by 54 percent among teens, and steroid use down 33 percent. Marijuana alone is down 25 percent. In 2007, approximately 860,000 fewer young people are using drugs than in 2001. That is obviously good for all of us.

Workplace drug testing also shows welcome reductions for adults. As was alluded to in some of the opening comments, workers testing positive for marijuana have declined 29 percent from 2000 to 2007; methamphetamine drug test positives among workers are declining after a significant increase during the first half of this decade, falling by more than 50 percent between 2005 and 2007; cocaine drug test positives among the general work force declined 19 percent between 2006 and 2007 alone, to the lowest level since 1997, when cocaine positives were first measured by Quest Diagnostics nationwide.

Overall, drug test positives, as measured by Quest Diagnostics Drug Testing Index, show the lowest levels in the adult worker force since 1988. Our new goal is to continue these reductions and for youth to reduce by another 10 percent, youth drug use between 2006 as a baseline and the end of this year.

Let me talk about the three areas we focused on briefly.

In prevention, for fiscal year 2009, the President has requested $1.5 billion. The most powerful prevention program used by many of our largest corporations in the work force, by the military, and by our transportation industry is random drug testing. In the 2004 State of the Union, as you know, the President proposed adding Federal support for random drug testing in schools. He did this following Supreme Court action that settled the issue that random testing could be done in schools, provided that the results were held in confidence between students and parents and, most importantly, that testing could not be used to punish, but had to be used to help young people get the help they need. Since this ruling, to the best of my knowledge, no random student drug testing program has been successfully challenged in court.

Today, CDC estimates there are over 4,100 schools now involved in random testing, and the numbers are growing rapidly. The administration has requested $11.8 million for random drug testing to fund an estimated 61 additional grants. I should point out the majority of these schools that have added it have also done this on their own. We have provided some support, but that has been something that is started at the grassroots.

Our Media Campaign, we believe, has been an important factor. We designed this to focus on messages to young people and to par-

ents. The 2009 budget request includes a substantial increase for this award-winning campaign, from $60 million that was appropriated in 2008 to $100 million in 2009. We believe the available evidence shows the campaign is a contributor to changing-for-the-better attitudes regarding drug use and has been a critical contributor to the declines we have seen in drug use among teens.

Drug-Free Communities, as you may know, is a program lodged in ONDCP itself. The administration has requested $80 million to support Drug-Free Communities program in 2009. This level would fund nearly 650 coalitions. Since the beginning of this administration, the program has doubled in dollar amount.

I know an issue that we all are concerned about is treatment and intervention. The 2009 budget request of the President includes $3.4 billion for drug treatment and intervention programs. In 2002, as you know, the President directed us to create a proposal to close the treatment gap: the difference between those people who suffer from drug addiction and seek treatment and those who receive it. For the first time, as a result of additions to national surveys, we were able to approximate that about 100,000 people were seeking treatment nationwide and not getting it because of inadequate services or funding.

The President launched his Access to Recovery program in the 2003 State of the Union address. At that time, HHS estimated the average cost of a treatment episode in the United States of all types was $2,000, with a gap of $100,000. The President asked for $200 million to unilaterally close the treatment gap with Federal money. Starting in 2004, Congress appropriated half the President's request, $98 million, which we have had over 3 years. These initial grants went to 14 States and one tribal organization targeted on unmet needs and included meth treatment, adolescent treatment, treatment in the criminal justice system, and other identified gaps.

ATR expands substance abuse treatment, promotes choices in both recovery paths and services, increases the numbers and types a providers, uses vouchers to allow clients to pay for significant additions to treatment support and recovery, and links to the clinical treatment with improved recovery support services such as child care, transportation, and mentoring.

As of September 30th of last year, more than 190,000 people with substance abuse disorders have received clinical treatment under the program. In 2009 we requested another $98 million. We hope the resources will support 24 grantees providing services to 65,000 individuals in fiscal year 2009 and another 160,000 over 3 years. In addition, the Public Health Services provided $1.7 million to evaluate fully the program now that it has been established.

In addition, drug courts I know is something that you, Mr. Chairman, and others that we have worked with on the committee have been particularly concerned about. The 2009 budget request includes $40 million to improve and expand treatment services to adult, juvenile, and family drug courts, which is an increase of $30 million over fiscal year 2008, or a threefold increase. The administration will award 82 new grants under this proposal.

In candor, it has been difficult to secure Federal funding for drug courts at levels the administration has sought. We would welcome

additional assistance from members of this committee in helping us get those appropriated funds. The good news is that drug courts have grown rapidly and doubled in number during this administration, to over 2,000 nationwide. Still, we need more of them. They save lives and they save public resources by breaking the cycle of crime, driven in many cases by addiction.

We also make progress when we build on the central facts about addiction into the way we heal the addicted. Most families know from personal experience that one of the worst aspects of the disease of addiction is that those suffering are usually blinded to the fact they are victims of the disease. Tell a loved one who has a problem that you think they need help, and the common response is angry denial. That is why, for many, drug courts have been a critical step in facing their disease and finally getting help. But we can and we are reaching more people in earlier stages of the disease, before they get to the criminal justice system.

Our fiscal year 2009 budget request includes $56.2 million for screening, brief interventions, and referrals to treatment, a program that engages the health care community in diagnosing and intervening in the substance abuse problems before they progress to dependence and addiction. This request represents an increase of $27 million over fiscal year 2008. Our goal is to make screening for substance abuse as common as checking for blood pressure.

Screening and brief intervention reimbursement has also been a feature of the initiatives we have tried to launch. The administration has created two new health common procedure coding system codes for alcohol and drug screening and brief interventions, which became effective in January of this year. These codes can be adopted by States and used by health care providers. They expand the range of medical settings and will enable clinicians to screen more patients for substance abuse disorders, prevent use, treat individuals, and ultimately reduce the burden of addictive disorders.

The Federal Medicaid outlays are estimated to be $265 million in fiscal year 2009. I believe the initiatives the administration has proposed, and Congress has supported, in prevention, intervention, and treatment, have our Nation on the path to increasing dramatically our power to reduce illegal drug use, and we need to follow through.

Now, I see my time has expired. I have some comments about supply reduction programs. If you would rather take those in questions, I would be happy to take them.

[The prepared statement of Mr. Walters follows:]

Statement
John P. Walters,
Director of National Drug Control Policy
Dennis Kucinich, Chairman
Domestic Policy Subcommittee
Oversight and Government Reform Committee
March 12, 2008
2154 Rayburn HOB
2:00 P.M.

I. INTRODUCTION

Chairman Kucinich, Ranking Member Issa, Members of the Subcommittee, I very much appreciate your interest in the Office of National Drug Control Policy, and I welcome this opportunity to discuss both the Administration's 2008 National Drug Control Strategy, and the progress we've made as a nation toward stemming what once was a growing tide of illegal drug use and abuse in America.

As this Committee is well aware, my office recently issued the 2008 National Drug Control Strategy. Because this represents the last National Drug Control Strategy to be released by this Administration, this hearing provides an excellent opportunity to look back to 2002, take stock of the progress we've made, and put the intervening years in perspective.

When President Bush released his first national Drug Control Strategy in 2002, America was experiencing rates of drug use by youth that had increased sharply since the early 1990's. Of particular concern were troubling rates of drug use by our nation's youth. Between 1991 and 2001, the percentage of 8th graders who used marijuana in the past year doubled from approximately one in ten to one in five (2007 *Monitoring the Future Survey*). In 2001, about two-thirds (67%) of new marijuana users were under the age of 18. This proportion has generally increased since the 1960s, when less than half of initiates were under 18 (2002 *National Survey on Drug Use and Health*). In 2002, more than 50 percent of our high school seniors said they had used illegal drugs at least once prior to graduation, and a full 25 percent of high school seniors reported using illegal drugs in the past month.

With the help of Congress, President Bush implemented a well-rounded, comprehensive package of anti-drug policies designed to accomplish three important things: 1) To prevent young Americans from ever initiating illegal drug use; 2) To help those in the grips of addiction get the help and treatment they need; and 3) To disrupt the market for illegal drugs through domestic and international action.

When the Strategy was first designed and implemented some six years ago, the President set ambitious goals for progress – benchmarks that some found unrealistic at the time. The Strategy would pursue a 10 percent reduction in youth drug use in 2 years, and a 25 percent reduction in youth drug use over 5 years.

Distinguished Members, I am extremely fortunate to come before you today to tell you that this approach is working. Though the Strategy tells this story in great detail, I want to take a moment to consider the profound impacts of the President's policies. Since 2001, overall youth drug use has declined 24 percent, with many specific drugs showing even more stunning declines. Methamphetamine use is down by 64 percent, LSD is down by 60 percent, Ecstasy is down by 54 percent, steroids are down by 33 percent, and marijuana is down by 25 percent. These reductions mean that, today, approximately 860,000 fewer young people are using drugs than in 2001.

Workplace testing also shows similar reductions: the percentage of workers testing positive for marijuana declined by 34 percent from January 2000 to December 2006, and methamphetamine use among workers is declining after a significant increase during the first half of the decade, falling by 45 percent between 2004 and 2006. Perhaps most remarkably, overall drug test positives, as measured by Quest Diagnostics' Drug Testing Index, show the lowest levels of drug use in the adult workforce since 1988.

But however stark these improvements may be, I'm sure we can all agree that this represents only a beginning. Research addressing the myriad factors that can influence the development and progression of drug abuse and addiction is critical to advancing the development of effective tailored prevention strategies as well as informing and improving treatment approaches to facilitate abstinence and prevent relapse. By promoting the use of evidence-based tools, we will seek to achieve a further 10 percent reduction in youth illegal drug use in 2008, using 2006 as the baseline.

II. Stopping Drug Use Before It Starts – Deterring Drug Use by Changing Attitudes

The goal of prevention is to stop substance use before it ever begins. Believing not only in this mission but in our ability to achieve it, this Administration outlined a strategy 6 years ago that called upon multiple sectors of society—parents, schools, employers, communities, and the media—to help Americans, and youth in particular, take a stand against drugs

Focusing on youth is effective and will yield results for decades to come. Prevention efforts involve many players and are most successful when messages from parents, schools, the community, and State and Federal partners are consistent: young people should not use drugs. In an age when most young people get their information and influences from friends, the media, or the Internet, scientifically accurate and credible information can help keep youth away from these dangerous substances and avoid the lasting consequences that drugs can have on their lives.

Random Student Drug Testing

One of the most important aspects of preventing America's youth from using illegal drugs is providing them a safe atmosphere where a culture of abstinence is pre-eminent. We believe we have found a tool which greatly assists us in establishing this social environment: Random Student Drug Testing.

The spread of drug use throughout a school often closely mirrors the way a disease is spread—from student-to-student contact, multiplying rapidly as more and more students are affected. Random testing can provide young people with a reason never to start using drugs, protecting them during a time when they are the most vulnerable to peer influence and the adverse health effects of drug use.

Moreover, random student drug testing isn't punitive. Though its deterrent effect is important, random student drug testing was primarily designed to identify kids in trouble so that responsible adults can make a meaningful intervention in their lives. The testing is random and not for-cause, and students who test positive are discreetly referred for professional counseling and treatment.

Across America, hundreds of schools have implemented random testing programs. The Centers for Disease Control and Prevention's 2006 School Health Policies and Programs Study (SHPPS) found that nationwide, of the 25.5 percent of districts containing middle or high schools that had adopted a student drug testing policy, over half conducted random drug testing. The same survey reported that 72.2 percent of middle and high schools provided alcohol- or other drug-use treatment at school through health services or mental health and social services staff, and 34.9 percent made arrangements for treatment through organizations or professionals outside the school.

The United States Military's Experience With Drug Testing

In June 1971, responding to a report that approximately 42 percent of U.S. Military personnel in Vietnam had used illegal drugs at least once, the Department of Defense (DoD) began testing all service members for drug use. A DoD survey of behavior among military personnel about a decade later showed that nearly 28 percent of service members had used an illegal drug in the past 30 days and that the rate was greater than 38 percent in some units. The DoD drug testing program was revised and expanded in 1983, following an investigation that revealed illegal drug use might have been a contributing factor in a 1981 aircraft carrier accident that resulted in 14 fatalities and the damage or destruction of 18 planes.

In the more than 25 years since the military began random testing of service members for drug use, positive use rates have dropped from nearly 30 percent to less than 2 percent. Despite the recent demands of combat deployment, the Armed Services have maintained a high rate of drug testing in the combat theaters. Data from the DoD Defense Manpower Database Center shows that the drug positive rate in deployed military members is now below 0.5 percent

Community Partnerships to Protect Youth

While random testing programs protect people of all ages by discouraging illicit drug use and identifying those with substance abuse problems, community-based prevention activities such as the work of anti-drug coalitions complement the testing framework.

The Drug Free Communities Support Program

Recognizing that local problems require local solutions, ONDCP, in partnership with The Substance Abuse and Mental Health Services Administration (SAMHSA), administers the Drug Free Communities Support Program (DFC), an innovative grant program to reduce youth substance abuse. Unique in its ability to provide Federal funding directly to local community organizations, DFC currently supports 736 grassroots community coalitions in 49 States, the District of Columbia, Puerto Rico, and the United States Virgin Islands with grants up to $100,000 per year for up to 5 years. Since 1997, an estimated $450 million has been awarded to prevent youth drug use. The DFC program involves more than 10,000 community volunteers, all working together to save young lives.

The Administration works with parents, youth, community leaders, clergy, educators, law enforcement, employers, and others to plan and implement an appropriate and sustainable response to local drug challenges, whether that's methamphetamine or prescription drug abuse. Because this isn't a "one-size-fits-all" approach, DFC promotes creative community solutions, and the dollar-for-dollar match requirement ensures that the community will be invested in the performance and success of the partnerships. Successful coalitions may qualify to "mentor" new and emerging community groups, allowing leaders in mentor communities to network with their counterparts in the target or "mentee" community, in order to create a new drug-free community coalition capable of effectively competing for a DFC grant award.

Among the 2007 DFC grantees, 38 percent represent communities in economically disadvantaged areas, 23 percent represent urban areas, 41 percent represent suburban areas, and 34 percent represent rural areas. In 2007, special outreach to Native American communities was conducted to assist Native American coalitions in combating substance abuse in their communities – nearly a doubling of grantees serving Native American communities. Now constituting 8 percent of the total grants, coalitions focusing on Native American communities represented the largest demographic increase in program participation in 2007.

Educating Youth About the Dangers of Drug Use

The National Youth Anti-Drug Media Campaign

Another feature integral to grassroots education and awareness is the work of the National Youth Anti-Drug Media Campaign (Media Campaign). The Media Campaign is a social marketing effort designed to prevent and reduce youth illicit drug use by increasing awareness of the consequences of drugs, changing youth attitudes and intentions toward drug use, and motivating adults to employ effective anti-drug strategies.

The Campaign targets the audience in the most danger of initiating drug use (12 – 17 year-olds [the key audience being tenth-graders]) by increasing their perception of risk and peer disapproval of drug use, while encouraging parental involvement and monitoring. Approximately 74 percent of the Campaign's funding is allocated to purchase advertising time and space in youth, adult, and ethnic media outlets, including national and cable TV, radio, newspapers and other publications, out-of-home media (such as movies), and the Internet.

The teen brand "Above the Influence" inspires teens to reject negative influences, specifically drug use, by appealing to their sense of individuality, independence, and aspirations. All television advertisements are subject to a rigorous process of qualitative and quantitative testing, ensuring, before they are broadcast, that the advertisements are clear and credible and have the intended effect on awareness, attitudes, and behaviors. Then once the ads are on the air, monthly tracking surveys monitor their performance to help assure the right blend of messages and media outlets.

Since 2002, the Campaign's primary focus has been on marijuana—a policy decision driven by a public health goal: delay onset of use of the first drugs of abuse (marijuana, tobacco, and alcohol) to reduce drug problems of any kind during teen years and into adulthood. Marijuana continues to be the most prevalent and widely used illicit drug among youth, representing 88 percent of all lifetime teen illicit drug use. By focusing on marijuana and on the negative social consequences of drug use, the Campaign has significantly contributed to the overall reduction of teen marijuana use by 25 percent since 2001.

Still, young people are vulnerable to other drug challenges. Against the overall backdrop of declining drug use, there is new evidence of a troubling trend regarding the abuse of prescription and over-the-counter medicines among young people. More teens are now using these products than methamphetamine, heroin, cocaine and ecstasy combined. In 2008, the Campaign is addressing this emerging drug threat by implementing a national campaign to inform parents about the risky and growing abuse of prescription drugs by young people. Because the most common reported source of abused prescription drugs is friends and family, the Media Campaign focuses on educating parents and making them aware of the threat in the home medicine cabinet. The Campaign is also reaching out to health care professionals including doctors, dentists, and pharmacists about what they can do to help stem the problem, and many of these professional associations have endorsed the Campaign's message to parents, adding further credibility and reach to the advertising.

The Media Campaign is also continuing its efforts to reduce the demand for methamphetamine, in response to the ONDCP Reauthorization, in at-risk regions of the country, with special focus on those populations at highest risk – rural communities and American Indians.

Fighting Pharmaceutical Diversion and Preventing Addiction

As was previously noted, prescription drug abuse has emerged as the fastest growing drug threat, requiring a concerted response from every sector of our society. In 2006, the latest year for which data are available, past-year initiation of prescription drugs exceeded that of marijuana. Abuse of prescription drugs among 12 and 13 year-olds now exceeds marijuana use, and among 18 to 25 year-olds, it has increased 17 percent over the past 3 years.

Admissions to treatment facilities for addiction to prescription drugs have risen steeply since the mid-1990s and now rank third among youth, behind marijuana and alcohol. Admissions to emergency departments for overdoses have also escalated in a similar timeframe. Abuse of opioid painkillers such as Vicodin, Percocet, and Oxycontin is of particular concern, because of

the large number of users, the high addictive potential, and the potential to induce overdose or death. These substances pose particular risks because many mistakenly believe that prescription drugs are safer to abuse than illicit street drugs; prescription drugs are relatively easy to obtain from friends and family; and many people are not aware of the potentially serious consequences of using prescription drugs nonmedically. And parents are talking to their teens about the risk of these products much less than about illegal drugs.

Existing prevention programs such as the National Youth Anti-Drug Media Campaign and random student drug testing are enhancing awareness of the dangers of abusing prescription drugs and helping to identify young abusers who need help. And other Federal partners are active in this area. SAMHSA has begun point-of-purchase messaging targeted to prescription drugs that have high abuse potentials. Information about a drug's potential for diversion and abuse is listed on the reverse side of the information patients receive when picking up their prescription. During fall 2007, this pilot program was tested through 6,300 pharmacies nationwide.

Internet Pharmacy Legislation

The Internet is another source of prescription drug diversion. Rogue online pharmacies provide controlled substances to individuals who either abuse the drugs themselves or sell them to others.

The Administration has worked closely with Members of the Senate on legislation to stem the flow of controlled substances without a proper prescription and advocates a commonsense approach for the sale of controlled substances online. Under the Fenstein/Sessions Substitute Amendment, unless certain exceptions apply, a face-to-face meeting is required in order for a licensed medical professional to dispense a controlled substance. The substitute bill defines a "valid prescription" as one that is issued: i) for a legitimate medical purpose; ii) in the usual course of professional practice; and iii) by either a practitioner who has conducted at least one in-person medical evaluation of the patient or a covering practitioner. Pharmacies are prohibited from filling unlawful prescriptions, online pharmacies will be subject to special registration and reporting requirements, and will have to provide detailed information on their Internet sites such as the location, identity, and licensure of the pharmacy, pharmacists and doctors with whom they are associated.

The substitute bill enhances penalties for unlawfully dispensing controlled substances in schedules III through V (applying equally to all unlawful distributors and dispensers of controlled substances -- not just those who do so by means of the Internet), and sets forth proper advertising of the sale of a controlled substance by means of the Internet. Finally, the substitute bill protects Americans in remote areas or other difficult circumstances by exempting certain qualifying Telemedicine providers.

I know that many Members of the House share our interest in this legislation, and I look forward to working with you as we move the Feinstein/Sessions substitute amendment forward through both the House and the Senate.

Prescription Drug Monitoring Programs (PDMPs)

Another important way to track the diversion and illegal use of controlled substances is through Prescription Drug Monitoring Programs (PDMPs). PDMPs track controlled substances through a variety of means and are implemented at the State level. At the end of 2007, 35 States had enacted enabling legislation to create or had already created PDMPs. Federal assistance for PDMPs is also available. States may apply to the Department of Justice for Federal grant funding to set up PDMPs. In many cases, members of both the law enforcement and medical communities may access a State's database, providing important safeguards to pharmacists at the point of sale to prevent prescription fraud and doctor-shopping.

III. INTERVENING AND HEALING AMERICA'S DRUG USERS FROM SCREENING TO RECOVERY SUPPORT: A CONTINUUM OF CARE

Despite recent reductions in drug use, Americans continue to drink to excess, abuse prescription drugs, and use illegal drugs. Many Americans have some experience with substance abuse and its devastating effects on the individual, the family, and the community.

Recognizing that addiction to substances is a treatable disease and that recovery is possible, the Administration has supported innovative and effective programs designed to help expand treatment options, enhance treatment delivery, and improve treatment outcomes.

Today, there are approximately 23 million Americans who were classified with abuse or dependence on alcohol or illicit drugs. This means nearly 10 percent of the U.S. population over age 12 was dependent on or abused alcohol or illicit drugs. Of the 23 million, 21 million did not receive treatment from a specialty treatment facility. Yet the vast majority of these 21 million people— more than 95.5 percent—do not realize they need help and have not sought treatment or other professional care (2006 National Survey on Drug Use and Health). Most users fall into a much broader category of people whose use has not yet progressed to addiction. For many of these users, an accident or serious trauma may be just around the corner.

Screening and Brief Intervention

Approximately 180 million Americans age 18 or older see a healthcare provider at least once a year, providing a unique opportunity for drug and alcohol screening to increase awareness of substance abuse issues, and bring help to millions of Americans with drug and alcohol problems. With a few carefully worded questions using an evidence-based questionnaire, health-care providers can learn a great deal about whether a patient is at risk for problems related to substance abuse.

In 2003, the Federal Government began providing funding to support screening and brief intervention programs in States and tribal communities through Screening, Brief Intervention, and Referral to Treatment (SBIRT) cooperative agreements. Screening is a simple diagnostic questionnaire administered through personal interviews or self-reporting, which can be incorporated into routine practice in medical settings.

If the score on the screen test exceeds a certain value, suggesting a likely substance abuse problem, the provider decides the level of intensity for follow-up assistance. For a score showing

moderate risk, a "brief intervention" may be the most appropriate response. Brief interventions are nonjudgmental motivational conversations between providers and patients. The purpose is to increase patients' insight into their substance abuse and its consequences, and to provide patients with a workable strategy for reducing or stopping their drug use. Sometimes a meaningful discussion with a healthcare provider is all it takes to convince a patient to stop using drugs.

Other times, a brief intervention is the first in as many as six follow-up sessions aimed at modifying the patient's risky behavior. If a score falls in the range consistent with addiction, the patient is referred to specialty treatment for a more extensive and longer period of care.

As of December 2007, more than 577,436 clients in 11 States had been screened. Approximately 23 percent received a score that triggered the need for further assistance. Of this number, 15.9 percent received a brief intervention, 3.1 percent received brief drug treatment, and only 3.6 percent required referral to specialized drug treatment programs.

Screening and brief interventions can reduce emergency room and trauma center visits and deaths, increase the percentage of people who enter specialized treatment, and positively enhance other facets of overall health, including general and mental health, employment, housing, and a reduction in arrests. Federal program outcomes indicate that these results persist even 6 months after a brief intervention, and cost-benefit analyses of Federal programs have demonstrated net healthcare cost savings from screening and brief interventions (an analysis of SBIRT Grantee Government Performance and Results Act [GPRA] Measures, compiled by the Office of National Drug Control Policy, the National Institute on Drug Abuse [NIDA] and the Substance Abuse and Mental Health Services Administration [SAMHSA]).

Medical Education on Substance Abuse

Since 2004, ONDCP has hosted three separate Leadership Conferences on Medical Education in Substance Abuse, bringing together leaders of private sector organizations, Federal agencies, organized medicine, and licensure and certification bodies to discuss ways to enhance physician training in the prevention, diagnosis, and management of alcohol and drug use disorders. The conferences addressed such topics as how to increase the limited training physicians receive in the diagnosis, management, and underlying science of addiction; how to overcome physicians' attitudes about substance use disorders and the patients who have them; and the effectiveness of treatment protocols. Conference participants identified several evidence-based strategies to address these issues, including the development of educational programs and clinical protocols and guidelines.

The 2006 Conference reviewed progress made in reaching the objectives of the first Conference and focused attention on two key priorities: 1) engaging the medical community in screening and brief interventions; and 2) the prevalence of prescription drug abuse. This highly successful conference gave rise to a series of recommendations on the medical response needed to adopt screening and brief intervention as preventive medicine and to address prescription drug abuse.

The Third Conference in 2008 followed up on the 2007 recommendations, and addressed sustainability and institutionalization of screening and brief interventions and the promotion and adoption of new healthcare codes for these procedures.

In January 2007, the Centers for Medicare & Medicaid Services (CMS) adopted new Healthcare Common Procedure Coding System (HCPCS) procedural codes for screening and brief intervention (SBI) within Medicaid. These codes make it possible for State Medicaid plans to reimburse medical claims for these services if States choose to make SBI a covered benefit. ONDCP continues to work closely with the CMS, States, and medical societies to evaluate State participation, as well as educate States and clinicians about the SBI approach.
Increasing support for screening and brief intervention within the medical community reflects a growing awareness of the importance of addressing substance use. In 2007, the Accreditation Council for Continuing Medical Education, the organization that accredits providers of continuing medical education (CME) courses in the United States, used the concept of screening and brief intervention to illustrate their new CME requirements. The Federation of State Medical Boards and the American Medical Association have also adopted policies aimed at educating medical professionals on screening and brief interventions and on prescription drug abuse. Finally, in January 2008, the American Medical Association Board adopted codes for screening and brief intervention

Screening is also an integral component of some Federal health care programs, including the U.S. Department of Veterans Affairs (VA) Health Administration and the Indian Health Service, which have initiated programs to instruct all its healthcare centers on screening and brief interventions.

Breaking the Cycle of Addiction: Maintaining Recovery

Individuals come to treatment through a variety of channels, including screening, involvement with the criminal justice system, or their own initiative, and the Administration has engaged in targeted efforts to provide a variety of services to underserved populations and to increase the number of treatment slots, providers, and modalities.

Concerned about treatment for Americans whose "fight against drugs is a fight for their own lives," the President launched Access to Recovery (ATR) in his 2003 State of the Union address. Starting in 2004, Congress appropriated approximately $98 million per year over 3 years for the first ATR grants in 14 States and 1 tribal organization.

ATR expands substance abuse treatment capacity, promotes choices in both recovery paths and services, increases the number and types of providers, uses voucher systems to allow clients to play a more significant role in the development of their treatment plans, and links clinical treatment with important recovery support services such as childcare, transportation, and mentoring.

As of late September 2007, more than 190,000 people with substance use disorders received clinical treatment and/or recovery support services through ATR, exceeding the 3-year target of 125,000. Approximately 65 percent of the clients for whom status and discharge data are

available have received recovery support services, which, though critical for recovery, are not typically funded through the Substance Abuse Prevention and Treatment (SAPT) block grant.

The SAMHSA-administered grant program allows States and tribal organizations to tailor programs to meet their primary treatment needs. In Texas, ATR has been used to target the State's criminal justice population, which generally has been underserved in the area of drug treatment services. Tennessee targeted ATR funds on those whose primary addiction is methamphetamine. The voucher component of the program, which affords individuals an unprecedented degree of flexibility to choose among eligible clinical treatment and recovery support providers, empowers Americans to be active in their recovery and may contribute to higher treatment retention and completion rates.

As a result of ATR, States and tribal organizations have expanded the number of providers of treatment and recovery support services. Faith-based organizations, which generally do not receive funding from State governments for substance abuse treatment, have received approximately 32 percent of the ATR dollars. These organizations offer a unique and compassionate approach to people in need.

A Chance to Heal: Treating Substance Abusing Offenders

For many Americans, substance abuse can lead to involvement in the criminal justice system. With 32 percent of State prisoners and 26 percent of Federal prisoners reporting in 2004 that they had committed their crimes while under the influence of drugs, connecting offenders with substance abuse treatment through drug courts, during incarceration, or after release back into the community is an important component of the Nation's strategy to heal drug users.

For nonviolent drug offenders whose underlying problem is substance use, drug treatment courts combine the power of the justice system with effective treatment services to break the cycle of criminal behavior, alcohol and drug use, child abuse and neglect, and incarceration. A decade of drug court research indicates that drug courts reduce crime by lowering re-arrest and conviction rates, improving substance abuse treatment outcomes, and reuniting families, while also producing measurable cost benefits. A recent study in Suffolk County, Massachusetts, found that drug court participants were 13 percent less likely to be rearrested, 34 percent less likely to be re-convicted, and 24 percent less likely to be re-incarcerated compared to probationers. Concurrently, drug courts have proven cost-effective. One analysis in Washington State concluded that drug courts cost an average of $4,333 per client, but save $4,705 for taxpayers and $4,395 for potential crime victims, thus yielding a net cost-benefit of $4,767 per client. An analysis in California concluded that drug courts cost an average of about $3,000 per client but save an average of $11,000 per client.

Since 1995, the Office of Justice Programs at the U.S. Department of Justice has provided grants to fund the planning, implementation, and enhancement of juvenile, adult, family and tribal drug treatment courts across the country. There are currently more than 2,000 such courts in operation, with more in development. With the number of treatment drug courts sometimes outpacing treatment capacity, Federal resources provided through SAMHSA/CSAT Family, Adult and Juvenile Treatment Drug Courts grants help close the treatment gap by supporting the

efforts of treatment drug courts to expand and/or enhance treatment services. The Family, Adult, and Juvenile Treatment Drug Courts program began in FY02 and continues today.

Recognizing the success of drug treatment courts in addressing the chronic, acute, and long-term effects of drug abuse, the Administration requested resources in FY08 for drug courts within overall funding for SAMHSA's criminal justice activities. The FY09 request for SAMHSA drug courts program funding is $40 million, an increase of $30 million over the 2008 enacted level. This funding would increase treatment capacity by supporting treatment and wrap-around services, case management, drug testing, and program coordination, which are vital for the recovering drug user.

The drug treatment court approach is being adopted by nations around the world. To date, 10 other countries have instituted drug courts, and several more plan to establish them. Every year, the number of international participants who attend the NADCP's Annual Training Conference increases. In 2006, the June meeting, held in Washington, D.C., included representatives from England, Ireland, Scotland, Chile, the British Virgin Islands, Canada, the Organization of American States/Inter-American Drug Abuse Control Commission (CICAD), and the United Nations Office on Drugs and Crime. ONDCP is working with partners around the world to further broaden international participation in 2008.

IV. The National Security Strategy: Tackling Transnational Threats

For more than 20 years, the United States has viewed the global drug trade as a serious threat to our national security because of its capacity to destabilize democratic and friendly governments, undermine U.S. foreign policy objectives, and generate violence and human suffering on a scale that constitutes a public security threat.

Over the years, the drug trade has grown more sophisticated and complex. It has evolved in such a way that its infrastructure—including its profits, alliances, organizations, and criminal methods—help facilitate and reinforce other systemic transnational threats, such as arms and human trafficking, money laundering and illicit financial flows, and gangs. The drug trade also serves as a critical source of revenue for some terrorist groups and insurgencies. Further, the drug trade plays a critical destabilizing role in a number of regions of strategic importance to the United States.

In Colombia, all fronts of the Revolutionary Armed Forces of Colombia (FARC) are involved in the drug trade at some level, including controlling cocaine production, securing labs and airstrips, and at times cooperating with other organizations to transport multi-ton quantities of cocaine from Colombia through transit countries such as Venezuela to the United States and Europe.

In Afghanistan, the Taliban continues to leverage its role in that nation's $3 billion opium trade in order to finance insurgent and terrorist activities. And in West Africa, weak governance and enforcement structures have permitted an explosion of drug trafficking, particularly in Guinea-Bissau, which could fuel wide regional instability.

Venezuela—due to government ineffectiveness, inattention, and corruption—has evolved into a major hub for cocaine trafficking, and also provides a dangerously permissive environment for narcotic, criminal, and terrorist activities by the FARC and the National Liberation Army.

Our international drug control efforts have evolved into a multi-pronged strategy focusing on: reducing the flow of illicit drugs into the United States; disrupting and dismantling major drug trafficking organizations; strengthening the democratic and law enforcement institutions of partner nations threatened by illegal drugs; and reducing the underlying financial and other support that drug trafficking provides to international terrorist organizations. In 2008, the United States will embark on a historic security partnership with Mexico and Central America seeking a safer and more secure hemisphere, breaking the power and impunity of the drug organizations and gangs that threaten the region, and preventing the spread of illicit drugs and transnational and terrorist threats toward the United States. The United States also maintains close partnerships with international organizations such as the UN Office on Drugs and Crime and the Inter-American Drug Abuse Control Commission of the Organization of American States (OAS/CICAD), which focus on capacity building among member states to combat drug trafficking through legislation and enforcement. These organizations also foster an important concept of shared responsibility among friendly government in the fight against drugs.

The National Drug Control Strategy will complement and support the National Security Strategy of the United States by focusing on several key priorities, including: focusing on areas where the illicit drug trade has converged or may converge with other transnational threats; denying drug traffickers, narco-terrorists, and their criminal associates their illicit profits and access to the U.S. and international banking systems; strengthening U.S. capabilities to target links between drug trafficking and other national security threats; and disrupting the flow of drugs to the United States and other strategic areas by building new and stronger bilateral and multilateral partnerships.

Disrupting the Market for Illegal Drugs

In the 2002 National Drug Control Strategy, this Administration articulated a clear plan to reduce the supply of illegal drugs in America, based on the insight that "the drug trade is in fact a vast market, one that faces numerous and often overlooked obstacles that may be used as pressure points." These pressure points exist all along the illegal drug supply chain, where traffickers undertake such challenging tasks as overseeing extensive drug crop cultivation operations, importing thousands of tons of essential and precursor chemicals, moving finished drugs over thousands of miles and numerous national borders, distributing the product in a foreign country, and covertly repatriating billions of dollars in illegal profit. This Administration has aggressively attacked these pressure points, and as a result we have seen that drug trafficking does indeed operate like a business, with traffickers and users alike clearly responding to market forces such as changes in price and purity, risk and reward.

For example, when domestic law enforcement efforts dismantled the world's largest LSD production organization in 2000, LSD use by young people plummeted by nearly two-thirds from 2001 to 2006 (unpublished estimates from the 2007 *Monitoring the Future Survey*). Similarly, dedicated efforts to tighten controls on methamphetamine's key ingredients

contributed to a 70 percent decline in lab incidents, and a 59 percent decrease in past-year methamphetamine use among the Nation's youth (unpublished estimates from the 2007 *Monitoring the Future Survey*).

Internationally, the disruption of several major MDMA (Ecstasy) trafficking organizations in Europe led to an 80 percent decline in U.S. seizures of MDMA tablets from abroad between 2001 and 2004, and a nearly 50 percent drop in use among young people between 2002 and 2006. Aggressive eradication reduced Colombian opium poppy cultivation by 68 percent from 2001 to 2004 and combined with increased seizures to yield a 22 percent decrease in the retail purity of Colombian heroin and a 33 percent increase in the retail price from 2003 to 2004. This progress continues, with eradication teams in Colombia now reporting difficulty in locating any significant concentrations of opium poppy and with poppy cultivation falling to the lowest levels since surveys began in 1996.

Most recently, domestic and international law enforcement efforts have combined to yield a historic cocaine shortage on U.S. streets. Law enforcement reporting and interagency analysis coordinated by the National Drug Intelligence Center (NDIC) indicate that 38 cities with large cocaine markets experienced sustained cocaine shortages between January and September 2007, a period in which Drug Enforcement Administration (DEA) reports indicated a 44 percent climb in the price per pure gram of cocaine. This cocaine shortage affected more areas of the United States for a longer period of time than any previously recorded disruption of the U.S. cocaine market.

Other data points reflect this same progress. Workplace drug test positives for cocaine were 21 percent lower during the second quarter of 2007 than the comparable period of 2006. Among the 30 cities for which more focused workplace drug testing data is available, 26 experienced significant decreases in the rates of positive workplace from 2006. SAMHSA's Drug Abuse Warning Network (DAWN) (which provides emergency room admissions data related to drugs), demonstrated that drug-related emergency department (ED) visits involving cocaine were declining.

The Vital Role of State and Local Law Enforcement

The success of the market disruption efforts described previously is due in large part to the tireless work of the 732,000 sworn State and local law enforcement officers throughout our Nation. However, with almost 18,000 distinct State and local law enforcement agencies operating throughout the country, effective coordination is often a challenge. Federally-supported task forces, such as those funded through the Office of National Drug Control Policy's (ONDCP's) High Intensity Drug Trafficking Areas (HIDTA) program and the Department of Justice's Organized Crime Drug Enforcement Task Force (OCDETF) Program have helped to close these gaps by facilitating cooperation among all law enforcement agencies. The Drug Enforcement Agency's (DEA) State and Local Task Forces have also helped facilitate cooperation and information sharing with State and local law enforcement agencies across the U.S.

The HIDTA program provides additional Federal resources to State and local law enforcement agencies in those areas of the country designated as exhibiting serious drug trafficking problems. Participating agencies, as a condition to joining the program, must agree to work together in multi-agency initiatives, share intelligence and information, and provide data to measure their performance. Law enforcement organizations that participate in HIDTAs assess drug trafficking problems and design specific initiatives to combat drug crime and disrupt money laundering activities.

In total, there are 28 HIDTAs and five Southwest Border Regions. In 2006, the HIDTA program provided over $224 million in support to law enforcement in 43 States, Puerto Rico, the U.S. Virgin Islands, and the District of Columbia. The HIDTA program has recently been expanding its engagement with law enforcement on Native American lands. Over $1 million has been provided to law enforcement agencies to use within tribal areas.

The OCDETF program, which is the centerpiece of the Department of Justice's long-term drug control strategy, plays a critical role in bringing Federal, State, and local law enforcement agencies together to conduct coordinated nationwide investigations and prosecutions, targeting the infrastructures of the most significant drug trafficking organizations and money laundering networks. Participation is broad, with a membership that includes DEA, U.S. Immigration and Customs Enforcement (ICE), the Federal Bureau of Investigation (FBI), the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF), the U.S. Marshals Service (USMS), the Internal Revenue Service (IRS), and the U.S. Coast Guard—working in cooperation with the Department of Justice's Criminal Division, the Tax Division, the 93 U.S. Attorney's Offices, as well as with State and local law enforcement.

In addition to increasing investigative resources through multi-agency taskforces, the Federal Government supports State and local law enforcement by expanding access to law enforcement information and intelligence. NDIC, in support of the HIDTA and OCDETF programs, produces detailed regional and market-based reports highlighting significant drug trafficking trends and challenges for use by Federal, State, and local law enforcement officials and policymakers. DEA, in cooperation with its Federal partners, is working to make the El Paso Intelligence Center (EPIC) more useful to State, local, and tribal police counterparts.

Targeting Marijuana Cultivation in the United States

Due to its high rate of use and low cost of production relative to other drugs, marijuana remains one of the most profitable products for drug trafficking organizations. While the bulk of the marijuana consumed in the United States is produced in Mexico, Mexican criminal organizations have recognized the increased profit potential of moving their production operations to the United States, reducing the expense of transportation and the threat of seizure during risky border crossings.

Outdoor marijuana cultivation in the United States is generally concentrated in the remote national parks and forests of seven states—California, Kentucky, Hawaii, Washington, Oregon, Tennessee, and West Virginia. Of the over 6.8 million marijuana plants eradicated in the United States in 2007, close to 4.7 million of them were eradicated outdoors in California, including 2.6

million plants eradicated from California's Federal lands. Ongoing criminal investigations indicate that drug trafficking organizations headquartered in Mexico continue to supply workers, many of whom are illegal aliens, to tend marijuana fields in California. Overall, in the past 3 years more than 80 percent of the marijuana eradicated from Federal and state lands has come from California and Kentucky.

Marijuana cultivation on public lands has created a litany of problems. An increasing number of unsuspecting campers, fishermen, hikers, hunters, and forest and park officials have been intimidated, threatened, or even physically harmed when they neared marijuana cultivation sites. To establish and maintain a marijuana field, traffickers must clear cut native plants and trees; poach and hunt wildlife; devastate the soil with insecticides, herbicides, pesticides, and fertilizers; and divert natural waterways like springs, streams, and creeks. According to the National Park Service, 10 acres of forest are damaged for every acre planted with marijuana, with an estimated cost of $11,000 per acre to repair and restore land that has been contaminated with the toxic chemicals, fertilizers, irrigation tubing, and pipes associated with marijuana cultivation.

Federal, State, and local law enforcement agencies are adjusting strategies to disrupt these large-scale, outdoor marijuana cultivation operations. The Department of Justice is now working with ONDCP and Federal land management agencies to target the Mexican drug trafficking organizations that have grown to dominate marijuana cultivation on America's public lands. Based on the success in 2007 of Operation Alesia, led by the Shasta County Sherriff's Office in conjunction with the California National Guard's Counterdrug Task Force, and Operation Green Acres, led by DEA, the primary focus of enforcement operations is no longer just the number of plants eradicated. The new approach uses multi-agency task forces to identify areas of operations and then eradicate plants and arrest and prosecute those involved in the illicit business. Reclaiming and restoring marijuana cultivation sites is also part of the mission, with the ultimate goal being the elimination of this harmful illegal practice from America's private and public lands.

In response to interagency efforts targeting marijuana grown outdoors, law enforcement reporting indicates that many traffickers are shifting their cultivation efforts indoors, where the risk of detection is lower and the quality and quantity of harvests are higher. Several Asian drug trafficking organizations are setting up indoor marijuana grow operations in states near the Northern border, including Washington, Oregon, California, and New Hampshire, and in other states such as Colorado, Pennsylvania, and Texas. Cuban drug trafficking organizations also appear to be extending their indoor grow operations from Florida to Georgia and North Carolina. This surge in indoor marijuana cultivation is reflected in a 70 percent increase in indoor plant eradication between 2005 and 2006.

Methamphetamine and Synthetic Drugs

The disruption of the cocaine market discussed above is not the only indication that the drug supply chain has come under increasing pressure. According to DEA analysis, the price per pure gram of methamphetamine also increased during the first three quarters of 2007, rising from $141 to $244, or an increase of 73 percent. At the same time the average purity of

methamphetamine in the U.S. market dropped by 31 percent, from 56.9 percent to 39.1 percent. These price and purity trends, along with consistent declines in methamphetamine lab seizure incidents, indicate that a significant disruption is occurring in the U.S. methamphetamine market.

The Synthetic Drug Control Strategy, released by the Administration in 2006, established the goal of reducing methamphetamine abuse by 15 percent, reducing prescription drug abuse by 15 percent, and reducing domestic methamphetamine laboratory incidents (seizures of methamphetamine labs, lab equipment, or lab waste) by 25 percent, all by the end of 2008 using 2005 data as a baseline. Thanks to the enactment of chemical control laws at the State, then Federal, levels; the outstanding efforts of State, local, and tribal law enforcement; and initiatives in chemical source, transit, and producing countries, methamphetamine laboratory incidents recorded in EPIC's database declined by 48 percent by the end of 2006—almost twice the established goal and 2 years ahead of schedule.

The Combat Methamphetamine Epidemic Act (CMEA) of 2006 established stricter national controls for the sale of products containing ephedrine and pseudoephedrine. The Act's retail sales restrictions, stronger criminal penalties, and provisions for enhanced international enforcement have directly contributed to the sharp reduction in domestic methamphetamine production. The number of both small toxic labs (STLs) and domestic superlabs (defined as capable of producing 10 or more pounds of methamphetamine per production cycle) are now far less common.

Law enforcement efforts, the CMEA, and tightened precursor chemical restrictions in Canada contributed to a significant decline in methamphetamine production in the United States. However, this progress has caused production to shift to Mexico. Mexico has responded to this threat, however, by taking stringent steps to counter chemical precursor diversion. The Government of Mexico recently announced that as of January 2008, the importation of pseudoephedrine and ephedrine would be banned completely. Sellers of pseudoephedrine products must deplete their remaining supplies by 2009, after which use of these products will be illegal in Mexico. Until then, consumers will need a doctor's prescription to obtain these drug products. These new policies represent bold moves that promise to significantly disrupt the methamphetamine trade in the years ahead.

Taking the Fight Against Methamphetamine Global

The battle against methamphetamine includes a global campaign to prevent the diversion of precursor chemicals by all producing, transit, and consumer nations. Two international entities have played a crucial role in this effort: the United Nations (U.N.) Commission on Narcotic Drugs (CND) and the International Narcotics Control Board (INCB). The CND is the central policymaking body within the U.N. system dealing with drug-related matters. The INCB is a quasi-judicial independent body that monitors the implementation of the three U.N. international drug control conventions.

Building on the passage of a United States-sponsored 2006 CND resolution that requested governments to provide an annual estimate of licit precursor requirements and to track the export

and import of such precursors, the United States in 2007 supported a resolution drafted by the European Union that asks countries to take measures to strengthen oversight over pseudoephedrine derivatives and other precursor alternatives. The INCB Secretariat's program to monitor licit shipments of precursor chemicals through its Pre-Export Notification (PEN) online system allows the use of such estimates to evaluate whether a chemical shipment appears to exceed legitimate commercial needs, allowing the INCB can work with the relevant countries to block shipments of chemicals before diversion for meth production.

Additionally, the INCB Project Prism Task Force assists countries in developing and implementing operating procedures to more effectively control trade in precursors. In 2007, Project Prism initiated Operation Crystal Flow, which focused on the Americas, Africa, and West Asia, and identified 35 suspicious shipments, ultimately stopping the diversion of 53 tons of precursor chemicals. Current intelligence suggests that drug trafficking organizations are trying to establish contacts in Africa, the Middle East, and Asia to evade law enforcement.

Joint Interagency Task Force (JIATF) West, which supports counternarcotics efforts in the Pacific, is cooperatively addressing these challenges through a multifaceted campaign against transnational crime in the region. This campaign includes working with host nations to conduct operations to detect and disrupt criminal networks, developing host nation law enforcement capabilities to conduct organizational attacks, and enhancing regional cooperation.

Stemming the Flow of Drugs Across the Southwest Border

Over the years increasing pressure in western hemisphere coca and opium growing regions and on the high seas has made direct transportation of drugs from their source to the U.S. mainland far more difficult. As a result, traffickers have resorted to abbreviated transit zone movements, with drug loads making landfall in Central America or Mexico for subsequent overland entry to the United States via the Southwest Border. Today, the vast majority of the cocaine, heroin, methamphetamine, and marijuana available in the United States enters the country through the border with Mexico.

To respond to this threat, and to contribute to broader homeland security efforts, the Administration is continuing to pursue a coordinated National Southwest Border Counternarcotics Strategy. This Southwest Border Strategy aims to improve Federal counterdrug efforts in the following areas: intelligence collection and information sharing, interdiction at and between ports of entry, aerial surveillance and interdiction of smuggling aircraft, investigations and prosecutions, countering financial crime, and cooperation with Mexico. Significant progress has already been made in the implementation of the Strategy, including enhancements in information sharing, advanced targeting at ports of entry, interdiction between ports of entry, air capabilities, financial investigations, and continued support for Mexico's counternarcotics programs and policies.

Indeed, the declines in drug availability being reported by cities across the United States are likely attributable to the combined impact of the courageous actions taken by the Mexican Government, the pressure applied in the source and transit zones, and stronger border enforcement.

The Southwest Border Strategy is moving forward in coordination with broader homeland security initiatives that promise to reduce the availability of drugs in the United States. The Department of Homeland Security's Secure Border Initiative is a comprehensive multiyear plan to secure America's borders. The enhancements to border security personnel, infrastructure, and surveillance technology being implemented under SBI are already yielding results. In FY07, the Border Patrol seized over 1.2 million pounds of marijuana in Arizona, where many of the first enhancements under the Secure Border Initiative are concentrated. This constitutes an increase of over 38 percent compared to FY06.

To improve our understanding of the organizations that facilitate trafficking across the border, The El Paso Intelligence Center (EPIC) has developed "Gatekeeper" assessments based on intelligence and debriefings from confidential sources. Gatekeepers are individuals who control geographically specific corridors, or "plazas," along the U.S.-Mexico border and utilize political, social, and family connections to facilitate smuggling of all kinds. The EPIC assessments provide a consolidated publication detailing the Gatekeepers and their organizations and provide a tactical tool for law enforcement entities involved in the investigation of cross-border smuggling activities along the entire border. OCDETF's Gatekeeper Strategic Initiative combines the statutory expertise and authorities of DEA, FBI, USMS, IRS, ICE, ATF and the Border Patrol in a coordinated, multi-agency attack on these facilitators, led by OCDETF's co-located Houston Strike Force and its satellite offices located in key cities along the Southwest Border. Over the past 2 years several major Gatekeepers have been arrested, significantly disrupting drug trafficking operations at key ports of entry. With this combination of enhanced border security and smart law enforcement, we can expect to see continued progress in the fight against drug trafficking and other threats to our border with Mexico.

Working With Mexico and Central America

Mexico is taking bold action against the drug threat. Mexican President Felipe Calderón made his intentions clear shortly after taking office in December 2006 with the unprecedented extradition of more than a dozen major drug traffickers and other criminals, including Consolidated Priority Organization Target (CPOT) Osiel Cárdenas Guillén, the notorious leader of the violent Gulf Cartel. This breakthrough in bilateral judicial cooperation continued throughout 2007, with a record 83 extraditions by year's end, far surpassing the previous record of 63 for the entire calendar year of 2006.

President Calderón's battle against drug trafficking has employed forces from seven government agencies, spending in excess of $2.5 billion in 2007 (a 24 percent increase over spending levels in 2006) to improve security and reduce drug-related violence. Mexico has deployed more than 12,000 military troops to over a dozen Mexican States. Anticorruption initiatives and institutional reforms by the Mexican Government have enhanced the U.S. Law Enforcement's ability to share sensitive information and conduct joint investigations, including DEA, FBI, ATF, and ICE, contributing to an impressive string of law enforcement achievements, such as the arrest of leading figures in the Tijuana, Gulf, and Sinaloa Cartels.

The Merida Initiative, a multiyear security cooperation program, is designed to enhance U.S., Mexican, and Central American enforcement capabilities while also expanding regional cooperation. All countries in the region, including the United States, have a shared responsibility for combating the common problem of crime and violence.

The Merida Initiative is truly a regional effort, with support going to Mexico and its Central American neighbors in the form of hardware, inspection equipment, information technology, training, capacity building, institutional reform, and drug demand reduction initiatives. This support will complement ongoing efforts by entities such as the Organization of American States Inter-American Drug Abuse Control Commission (OAS/CICAD) to help countries in the hemisphere build their counterdrug capabilities and institutions. The Central America portion of the package seeks to address citizen insecurity by more effectively addressing criminal gangs, modernizing and professionalizing police forces, and reforming the judicial sector.

To address the proliferation of gangs and gang violence, the Central American portion of the Merida Initiative will employ all five elements of the U.S. Strategy to Combat Criminal Gangs from Central America and Mexico: diplomacy, repatriation, law enforcement, capacity enhancement, and prevention.

It is essential that the United States does all that it can to partner with Mexico as it aggressively counters the drug trafficking threat, including the role that weapons purchased in the United States often play in the narcoviolence that has been plaguing Mexico. In an effort to stem the flow of weapons being smuggled illegally to Mexico and used by drug trafficking organizations, ICE implemented Operation Lower Receiver. This initiative will utilize the investigative strengths of the Border Enforcement Security Task Forces (BESTs) and Mexican representatives to identify and prosecute those who attempt to illegally export weapons to Mexico. The ATF is working with Mexican authorities to enhance the use of ATF's eTrace program in Mexico, allowing investigators to electronically trace firearms recovered at crime scenes. Cooperation through eTrace greatly facilitates the interdiction of arms smuggled into Mexico and will strengthen investigations into the sources of illegal weapons.

Transit Zone Interdiction

Last year's National Drug Control Strategy set an aggressive 40 percent interdiction goal for calendar year 2007, as measured against the Consolidated Counterdrug Database (CCDB) estimate of all cocaine movement through the transit zone toward the United States during the prior fiscal year (October 1, 2005 through September 30, 2006). The FY06 CCDB total documented movement was 912 metric tons, making the 2007 interdiction target 365 metric tons. In aggregate, U.S. and allied interdictors removed a total of 299 metric tons of cocaine (preliminary data as of January 2008), or 82 percent of the 2007 calendar year target.

Going forward, to better align the annual transit zone interdiction goal with the Federal budget process, the goal will apply to the current fiscal year rather than the calendar year. Since the FY07 CCDB total documented movement through the transit zone to secondary transshipment countries (such as Mexico, Central American countries, and the Caribbean) was 1,265 metric tons, the 2008 fiscal year 40 percent interdiction goal would be 506 metric tons. However,

acknowledging the 2-year gap between establishment of the national goal and any opportunity to request needed increases in capability and capacity through the federal budget process, the Administration is pursuing an incremental approach to the accomplishment of the goal. Therefore, the national interdiction target for FY08 is 25 percent of the total movement documented in FY07: 316 metric tons.

In 2007, U.S. and allied counterdrug forces leveraged lessons-learned and continued to optimize the use of existing resources against an ever-evolving threat. U.S. Customs and Border Protection's P-3 fleet continued to provide yeoman service despite the demands of its service life extension program. Moreover, the Coast Guard realized yet another successive year of record removals, over 161 metric tons of cocaine, while also breaking its own all time single-event record by seizing 15.2 metric tons of cocaine from the Panamanian Motor Vessel GATUN in the Eastern Pacific in March 2007.

DEA also continued to work with its interagency and international partners to implement Operation All Inclusive, a series of maritime and land-based interdiction operations in the Caribbean, Eastern Pacific, Central America, and Mexico. Part of DEA's large-scale Drug Flow Attack Strategy, Operation All Inclusive utilizes intensive intelligence-based planning. In 2007 wire intercepts and other sources confirmed that the operation was vastly complicating trafficker operations. As smuggling routes and times changed, Operation All Inclusive partners adjusted accordingly, resulting in a significant increase in arrests and seizures compared to the two previous phases of the operation (2005 and 2006).

Due to the continued effectiveness of U.S. and allied interdiction efforts in the transit zone, drug traffickers are attempting to use new and innovative methods to transport drugs to the United States, including constantly changing trafficking routes; suspending cocaine in liquids such as diesel fuel; and the development and enhancement of low-profile and self-propelled semi-submersible vessels. The production quality and operational capabilities of these vessels steadily improved, allowing traffickers to move more product with greater stealth, and traffickers continue to move cocaine to the United States and to the growing markets in Europe. By pursuing the ultimate goal of a 40 percent removal rate, beginning with an incremental goal for 2008 of 25 percent (316 metric tons), U.S. forces in the transit zone will do their part to ensure that this disruption continues.

Attacking Trafficker Finances

U.S. efforts to seize or freeze the assets and proceeds of illicit drug traffickers directly target the core motive of their criminal activity. Revenues from drug transactions in the United States primarily depart the country through the smuggling of large sums of cash across our borders, with an estimated $15–20 billion in bulk cash smuggled annually across the border with Mexico.

DEA has partnered with other Federal agencies on successful bulk seizure programs—including ICE, U.S. Customs and Border Protection (CBP), FBI, and the IRS Criminal Investigation Division. The United States also assists other governments in developing their capabilities to interdict cash couriers through training and technical assistance programs funded by the Department of State and implemented by international organizations such as OAS/CICAD.

Bulk cash discoveries often lead to fruitful follow-on investigations targeting associated drug trafficking organizations and their wider financial networks. One notable example is DEA's Money Trail Initiative, which in addition to yielding more than $157 million in currency and $23 million in other assets since its inception in 2005, has also resulted in the seizure of over 15 metric tons of cocaine, 550 kilograms of methamphetamine, and 35 kilograms of heroin.

To combat the increasing use of bulk currency smuggling by criminal organizations, ICE and CBP developed a joint strategic initiative called Operation Firewall that began in August 2005. In FY07, Operation Firewall resulted in the seizure of over $49 million in bulk currency. Since its inception Operation Firewall has led to the seizure of over $106 million, of which over $45 million were seized outside of the United States.

U.S. efforts to deny drug traffickers their illicit proceeds extend to domestic efforts by ICE and the Treasury Department's Office of Foreign Assets Control (OFAC) to block illicit access to the U.S. financial system and the financial services industry. In 2006, ICE launched an initiative to put unlicensed money services businesses out of business, which to date has resulted in the identification of over 420 unlicensed money services businesses and in the seizure of nearly $1 million in currency and other assets.

Progress and Challenges in the Andean Ridge

Since Plan Colombia began in 2000, the United States has pursued a comprehensive strategy to attack the production and distribution of cocaine and heroin from Colombia. Eradication, interdiction, and organizational attack have facilitated progress in alternative development, judicial reform, and the establishment of democratic institutions, effectively expanding the State's authority into areas previously controlled by criminal narcoterrorist groups.

Aerial eradication remains central to the strategy for destroying coca before it can be turned into cocaine and marketed by traffickers or terrorists such as the Revolutionary Armed Forces of Colombia (Fuerzas Armadas Revolucionarias de Colombia, or FARC). As aerial eradication increased from 2001 to 2003, drug growers were placed on the defensive, shrinking the size of their plots, dispersing them, pruning and replanting seedlings, and, finally, moving further into the eastern regions of Colombia.

The Government of Colombia maintained pressure on the cultivators, adapting to their changing tactics, improving intelligence, protecting spray platforms, and staying in key cultivation areas for longer periods of time. Over this same period, the Government of Colombia also increased its capacity for manual eradication, from 1,700 hectares of coca in 2001 to over 65,000 hectares in 2007, with an announced goal of 100,000 hectares in 2008 in order to supplement reduced U.S. funding for aerial eradication in 2008. Colombia's ability to expand their manual eradication operations depends greatly on capacity to transport police and security forces to protect eradication teams in terrorist regions of high coca production. Air transport capacity is extensively financed by the United States, and may be reduced in coming years.

Interdiction efforts also continued to put pressure on the illicit drug industry in Colombia in 2007, with the seizure of near record amounts of cocaine and the dismantling of an increasing number of cocaine hydrochloride (HCl) laboratories (more than 240 compared to 205 in 2006, according to the Government of Colombia). Increased cooperation with Colombia and Ecuador is improving the interdiction of illicit drugs moving via fishing vessels that venture far out into the Pacific Ocean before turning north toward Mexico. The increased cooperation has resulted in increased seizures inside Colombia and within its territorial waters—over 170 metric tons of coca base and cocaine HCl in 2007, according to the Government of Colombia's Directorate of Dangerous Drugs (DNE).

Initiatives targeting Colombian drug trafficking organizations proved exceptionally successful in 2007. Results included the extradition of over 164 traffickers from Colombia to the United States, including several CPOTs from the North Valley Cartel, such as Luis Hernando Gomez-Bustamante, a.k.a. Rasguño. Colombian authorities captured notorious drug trafficker and CPOT Diego León Montoya Sánchez (a.k.a. Don Diego), one of the FBI's 10 most wanted people in the world.

Significant gains were also made against the FARC in 2007 and early 2008. The most damaging blow stuck against the FARC was the death March 1 of Secretariat member and strategist Luis Edgar Devia Silva (a.k.a. Raul Reyes) in a Colombian raid on a FARC camp just inside Ecuador. The FARC's 37th Front Commander, Gustavo Rueda Diaz (a.k.a. Martin Caballero) was killed in 2007, and Colombian security forces killed CPOT and FARC commander Tomás Molina Caracas (a.k.a. Negro Acacio) during a military raid near the border with Venezuela. Molina was one of 50 FARC commanders indicted by the U.S. Government in March 2006 for allegedly running Colombia's largest cocaine smuggling organization. A former high-level leader of the FARC, Juvenal Ovidio Ricardo Palmera Pineda (a.k.a. Simón Trinidad), was convicted in United States Federal court of a hostage-taking conspiracy and was sentenced to 60 years. Also, a former narcotics trafficker and finance officer of the FARC, Anayibe Royas-Valderrama (a.k.a. Sonia) was convicted of cocaine trafficking and sentenced to more than 16 years imprisonment. Desertions from the FARC are also up, with almost 2,500 deserting in 2007 compared to 1,558 in 2006.

The Government of Colombia increased its capacity to control national territory by standing up additional rural police forces (up to 65 companies of Carabineros), 2 more mobile brigades, and by purchasing more Blackhawk helicopters to provide additional mobility to its forces. The expanded government presence throughout the country has been instrumental in reclaiming key illicit cultivation areas from the FARC and other drug trafficking organizations. By moving into the Department of Meta, the historical birthplace of the FARC and the center of the old demilitarized zone, the Government of Colombia has made it more difficult to produce illegal drugs in a once highly productive coca cultivation zone. Additionally, once security was established, alternative development projects were able to operate to help the local population grow licit crops and allow the Colombian Government to provide basic social services.

Venezuela, on the other hand, is failing to take effective action against the increased flow of illicit drugs from eastern Colombia into Venezuela and then onward to Hispaniola, the United States, Africa, and Europe. Drug flights from Venezuela to Hispaniola increased from 27 in the

first three quarters of 2004 to 82 during the same period of 2006, and numbered 81 during the first three quarters of 2007. The flow of drugs through Venezuela has increased almost fivefold, from 57 metric tons in 2004, to around 250 metric tons of cocaine in 2007. This flow of drugs is increasing corruption and putting enormous pressure on the democratic institutions of Haiti and the Dominican Republic.

There also have been setbacks in Bolivia. The effects of the coca cultivation policies of Bolivian President Evo Morales are yet to be fully seen. The influence of coca growers over the government has contributed to falling eradication rates. The United States continues to seek ways to cooperate with the Bolivian Government in areas such as arresting drug traffickers, disrupting cocaine production, seizing illicit drugs and precursors, supporting alternative development, reducing demand, and training law enforcement and judicial officials.

Afghanistan: Counternarcotics and Counterinsurgency

Combating the production and trafficking of narcotics in Afghanistan is essential to defeating narcoterrorism and to fostering the development of a budding democracy. The drug trade undermines every aspect of the Government of Afghanistan's drive to build political stability, economic growth, and establish security and the rule of law.

The resolute efforts of the Afghan people, combined with international assistance, have produced substantial counternarcotics progress in vast areas of Afghanistan, but significant challenges remain. In 2007, the number of poppy-free provinces increased from 12 to 15, and opium poppy cultivation decreased significantly in another 8 provinces. However, progress in these areas was more than offset by increased opium poppy cultivation in the southwest region, resulting in the production of 8,000 tons of opium in 2007, 42 percent more than in 2006. Approximately 86 percent of Afghanistan's opium poppy cultivation occurred in just 6 provinces with approximately half taking place in a single province, Helmand.

In August 2007, the U.S. Government released the 2007 U.S. Counternarcotics Strategy for Afghanistan to enhance the multinational strategy adopted in 2004, focusing on the five pillars of public information, alternative development, poppy elimination and eradication, interdiction, and justice reform.

The revised strategy—developed in coordination with the Governments of Afghanistan and the United Kingdom—involves three main elements: (1) Dramatically increasing development assistance to incentivize cultivation of legitimate agricultural crops while simultaneously amplifying the scope and intensity of interdiction and eradication operations; (2) Coordinating counternarcotics and counterinsurgency planning and operations more fully, with an emphasis on integrating drug interdiction into the counterinsurgency mission; and (3) Encouraging consistent, sustained support for the counternarcotics effort among the Afghan Government, our allies, and international civilian and military organizations.

Improvements are also being implemented to dramatically expand the impact of eradication and interdiction efforts in Afghanistan. Eradication efforts led by the Government of Afghanistan will target the fields of the wealthiest and most powerful poppy-growers. Interdiction operations in Afghanistan that target the highest-level traffickers will be increasingly integrated into the

counterinsurgency campaign, with the direct support of DEA agents embedded in U.S. and coalition forces. In addition, DEA has expanded its Foreign-deployed Advisory Support Team (FAST) initiatives, continued its support for the Afghan Counter-Narcotics Police and is developing and mentoring several newly formed Afghan counternarcotics investigative units.

Despite the significant increases in opium production in Afghanistan, the availability of Afghan heroin in the United States remains low. However, Afghanistan is by far the largest producer of illegal opiates, and proceeds from narcotrafficking are fueling the insurgency while drug-related corruption undercuts international reconstruction efforts. Attacking the nexus between terrorism and the drug trade in Afghanistan remains vital to U.S. national security.

Conclusion

As with other serious societal problems—crime, disease, hunger—we must continue to directly confront all aspects of the drug problem. We know that traffickers will react and respond to our successes, and that there is always another generation of American youth that must be educated about the terrible risks of drug abuse and addiction. It is with them in mind that we have set the new goals described in the introduction to this Strategy: an additional 10 percent reduction in youth drug use, the continuation of random student drug testing as a prevention tool, greater access to screening and brief intervention services, the reduced diversion of prescription drugs and methamphetamine precursors, declines in Andean cocaine production and Afghan opium poppy cultivation, an aggressive interdiction goal in the maritime transit zone, a reduction in the flow of illegal drugs across the Southwest Border, and declines in the domestic production and use of marijuana.

Achieving these goals will require a continuing partnership with all those throughout the Nation whose hard work has produced such meaningful progress for the American people over the past six years.

We greatly appreciate the Committee's interest in drug policy, and we look forward to working with Congress to accelerate and make permanent the hard-fought gains we've made over the last six years.

Mr. KUCINICH. Thank you, Mr. Walters, for your testimony. Your whole statement will be included in the record. I am sure we will be able to get some of the information forward in the question period.

I have been troubled that ONDCP's national drug control budget for the last two fiscal years is not a comprehensive and integrated account of all national drug control activities as explicitly mandated by the Reauthorization Act. The fiscal year 2009 budget omits at least $5 billion, representing in large part the cost of prosecuting and incarcerating Federal drug offenders, costs that ONDCP unilaterally decided to exclude beginning with its fiscal year 2003 budget. A rough one-page accounting of these costs is relegated to the appendix. Nowhere in the strategy or budget are the costs otherwise broken down, subject to performance reviews, or analyzed.

Now, Deputy Director Burns expressed a view that ONDCP does not agree that the Reauthorization Act mandated that ONDCP revert to the old budget methodology and, this omission really invites critical inquiry by this committee. Given the clear and unambiguous statute and legislative history, could you tell this committee why aren't these costs included and analyzed in the main portion of this year's national drug control budget summary?

Mr. WALTERS. Let me go back and maybe correct what may be a misunderstanding about how this got started.

When I came back to the drug office in this administration—as you pointed out, I served in the President's father's administration as Chief of Staff and Deputy for Supply Reduction when the Office was being created—what we had accumulated was a budget that, as I think even there has been talk, I think, of the Rand Report—some of the people testifying after me are going to talk about—even that report says old budgets grossly inflated the expenditures for drug control; it pretended the Government was doing things that it wasn't doing, it wasn't controlling, it wasn't managing.

I agreed with that from my own experience and I asked that the budget reduce the amount of estimated costs in peripheral programs where drug control is a secondary issue. At one time in the past, for example, Head Start was scored a portion of it as a drug control expenditure because some parts of Head Start programs sometimes referred people who had a problem for treatment to treatment. It wasn't managed; it was a good faith estimate. But because Head Start is a big program, it inflated the drug control program.

Now, what is wrong with that? What is wrong with that is when I deal with OMB in the past—I will say this OMB has been good; I am not criticizing my colleagues now—but when I deal with OMB in the past and I have to fight for resources, as you have to fight for resources with appropriators, when the budget includes a lot of stuff that is estimated or is modeled and everything else, they can cut primary things in treatment or prevention and say, well, this other big part hides the fact that we are making a reduction here that may be central.

What we did is focus on the budget that was central and managed. All the agencies in the current drug control budget that we represented are 100 percent drug control programs, or, if they

aren't—there are, I think, six of them—we now have a spending plan from that agency—the Coast Guard, the CBP, ICE, Veterans Affairs, Bureau of Indian Affairs, Indian Health Service—showing how they are going to expend the moneys we present in a direct drug control manner and their IGs verify they did that. So when you see the budget, that budget is verified to the extent to which we currently have the ability to do that.

Mr. KUCINICH. OK, now, let me just follow this. It seems like this was decided to handle it this way as a matter of policy and that, as a matter of policy, it made no sense to include these costs because these expenditures represented mixed drug, non-drug costs. I am going back on the work of this subcommittee. This sounds exactly like the policy reasons that ONDCP gave to justify its decision to change the budget methodology for fiscal year 2003.

But Congress considered this and rejected these justifications. Whether or not this subcommittee agrees with ONDCP's policy views and its issues is really not relevant here. Congress has spoken and in effect said we don't agree with your take on policy. To me, it is becoming clear that ONDCP doesn't want to implement the change in policy, which it always opposed, and is intent on defying this congressional mandate, or at least ignoring it.

So I still want to go back to the point where you got costs included and the costs that should be included and analyzed in the main portion of the budget summary. Are you still at the point of insisting that this just doesn't have to be done because that is where you are at? And do you not believe that Congress's intent in any way needs to be regarded here?

Mr. WALTERS. No, it is never my opinion the Congress's intent doesn't need to be regarded, but it is our view that, to have credibility in the process and to read the statute as it was written, we have complied with the current budget. This is also the last budget this administration is going to be submitting, so I will pass on, and I am sure the successors in my position will pass on.

But I would also say just one thing about how we relate, because I think that is not trivial, in my experience, working in the executive branch and Congress. We proposed this in, you are right, the 2002 submission of the 2003 budget. We said we think we would like to do this. We didn't ram this in; we said this is an alternative proposal.

And we then did it because we had no serious objections. No objections from the Hill. We did it in the subsequent year and we also presented the budget in the old way in the subsequent year. There was no objection. Our process here is being presented as we defied this, but this is kind of like talking to somebody who is two light years away. We submitted this and several years later people said we don't like this. OK, we tried to adjust it. We explained it; we followed through.

Mr. KUCINICH. How did you get into at least some of the costs, though? You had DOJ expenditures for prosecuting and incarcerating drug offenders in a one-page appendix to this year's budget. What specific statutory provision obligates ONDCP to include these costs in an appendix but not in its integrated budget analysis? Or were you just hedging your bets?

Mr. WALTERS. No, we understand the authority of the Reauthorization to allow us to designate drug control programs as a part of the authority of the Office, and we have done that and we have complied with the other programs here.

Again, look, let me just ask you one other thing as you look at this for the future, because this is going to be something passed on to our successors, obviously, in my job, not your job.

Mr. KUCINICH. That is an interesting admission.

Mr. WALTERS. Well, I understand how the executive branch works.

But the fact of the matter is you are always going to have to focus on the things that work. We are focusing on the programs that make a difference with a lot of agencies and with the help of Congress. I think you can't get there if you put a lot of stuff in there that we don't manage. A large part of this discussion has been over the prison costs. We don't manage the prison costs; we take an estimate of what people think is going to happen. The number of people incarcerated in State and local large category has been going down for drugs.

But we don't manage those costs. And we can't move those costs. Something is going to happen and someone is going to have to provide a slot. A lot of this has increased because of immigration enforcement.

But the fact of the matter is what we have done is said you need money for treatment, you need money for intervention, you need money for prevention, you need money for supply control in these agencies, and that will make a difference. I think it helps us work together to focus on what is making a difference.

I know there has been discussion and your opening remarks talked about for the first time we have a management system that links performance to the budget. You can see performance measures tied to the budget. I inherited one that didn't. There was a lot of bureaucratic back and forth; it didn't work. It occupied the space of what had to work. We tore it down and we created something that I think works.

Mr. KUCINICH. I want to go to Mr. Tierney.

Mr. TIERNEY. Thank you, Mr. Walters for your testimony today, for coming and joining us.

Thank you, Mr. Chairman, for having this hearing. It is important on a number of different levels.

But I want to talk about things that I think we all agree work, if I listened to your testimony and prior administration statements, and that would be the drug courts on that. I have had great response from district attorneys nationwide, as well as in my State and district, and from judges themselves, from participants.

But when the staff analyzes your budget proposal, it looks as though you have ramped up the money for treatment services to try and get people away from the courts before they need to get there—and I think that is certainly admirable—but it seems to reflect an elimination of over $15 million for new drug courts and over $1 million taken out for training and technical advice or starting of new facilities. It would seem to me that might be a move in the wrong direction, given their success and given, at least what

I am hearing, the success and favorable reviews on that. Would you explain to me what the rationale is behind that?

Mr. WALTERS. Yes. There is a shift here. We had sought, in the past, up to $70 million for drug courts. We have been unable to get those appropriations through Congress in the old program structure. We have made two shifts based on where we think drug courts are now. There may be differences of views; I understand that about this. Drug courts seem to be being established now quite rapidly and with the existing infrastructure being able to handle new drug courts.

When we talk to people out there in the field that are running these or setting them up, what they need is treatment services. So we shifted some of our request from the setup cost to providing money even in HHS—where we think we may have a better chance of receiving the money we request—to support the treatment need of the drug courts, because that is a big expense.

If it was an ideal environment, we would do all these things. The problem is we have simply had resistance in getting the amounts that we wanted in the competitive appropriations process in the Justice Department, so we have now moved. Some of it is in Justice in a competitive process; some of it is in HHS. And we think we have a better chance of actually providing Federal support to this rapidly growing area that needs to grow and continue to grow.

Mr. TIERNEY. Do you have documentation or some evidence that would verify what you are hearing about the courts being able to use the existing structure and set things up in that respect? It would seem to be contradictory to what I am hearing, at least in my district, on that. And would you share that with the committee?

Mr. WALTERS. Sure. I am not quite sure whether we have a kind of comprehensive survey of all drug courts, but, again——

Mr. TIERNEY. If it is anecdotal, then I think it depends on who is listening to who, and that gets me to——

Mr. WALTERS. No, I agree.

Mr. TIERNEY. And I would rather fight for $15 million and $70 million if I had good indications—and I don't have any statistical information either, just anecdotal, and I was wondering if I would match anecdote to anecdote or if there is hard evidence against what I am hearing locally or whatever, because I think we all want the same thing, we want to put it where it works and make sure we have the structures there to deal with it on that basis. So whatever you can get for me, I would appreciate.

The other area I want to question, again, is what I hear, at least in my district—I assume other Members might as well—and that is the use of naloxone, which I guess the trade name is, what, Narcan, something on that basis? I am told by physicians, people in emergency rooms, by district attorneys and others that this is a good tool; it is saving a lot of young people that are having problems with OxyContin, heroin, things of that nature, whatever. Your department seems to have a contrary view of that. Would you discuss that a little bit?

Mr. WALTERS. No, we have no contrary view that Narcan is a very important medication for people suffering overdose. I think the difference here has been whether this can be effectively distributed to non-medical professionals or that it is a sensible policy to

tell people who are addicted, kind of carry this around and then when somebody gets an overdose, if you feel it, you are going to inject yourself or whether friends with you who are also engaged in narcotic or opiate addiction are going to be competent and able to properly administer this medication.

Again, all these things cost money and a lot of people can differ.

Mr. TIERNEY. No, no, I——

Mr. WALTERS. Our view is put the money into treatment; put the money into outreach.

Mr. TIERNEY. Dr. Madrasas' comments shouldn't be construed as wanting to take the money out of emergency rooms and things of that nature and encouraging them to use it.

Mr. WALTERS. No.

Mr. TIERNEY. Only that she does not prefer it to be distributed to the field.

Mr. WALTERS. Yes.

Mr. TIERNEY. But it would be to EMTs and others——

Mr. WALTERS. Absolutely.

Mr. TIERNEY [continuing]. Who may respond on that basis.

Mr. WALTERS. Absolutely.

Mr. TIERNEY. All right, thank you very much.

Thank you, Mr. Chairman.

Mr. KUCINICH. I want to go back to this issue of the Reauthorization Act. Precisely what ONDCP's position with respect to compliance with the Reauthorization Act? Are you saying you have complied with it?

Mr. WALTERS. With regard to the budget, yes. And I think the other aspects I am aware of, but there may be others that you have questions about.

Mr. KUCINICH. So you have complied with all reporting requirements?

Mr. WALTERS. Just so that I am clear and we are together, let me just state my understanding of where we are on reporting requirements. There are three categories of reporting requirements. There were one-time reports required by the Reauthorization Act. Our count is there were 20 reports required under that category; 19 have been completed; 1 is past due, and that is a report on drug testing in schools that we were waiting which has just arrived, and we expect to get that here quickly.

There are a series of reports required by the fiscal year 2008 appropriations. Our count is there were 12 reports required. One of those is completed; the number of them that are coming due but not yet due is 10; one report is past due, and that is a report on meth and its implications for society——

Mr. KUCINICH. We would like you to transmit that information to the subcommittee.

Mr. WALTERS. OK.

Mr. KUCINICH. I look at the 2009 budget and these reports may reflect on this because you are making choices. Budgets are always a matter of choices. I am seeing a trend that prioritizes growth in funding for supply reduction strategies, such as interdiction and source country eradication, over growth and demand reduction strategies, such as prevention and treatment. Now, we have a witness on the next panel who is saying that such a choice is not sup-

ported by the social science. Would you be able to provide this subcommittee the specific scientific basis, the evidence on which you base your choice to increase funding for interdiction and source country eradication over prevention and treatment? Would you do that?

Mr. WALTERS. I don't think it works that way, Mr. Chairman. And, again, I don't think you think it——

Mr. KUCINICH. What do you mean?

Mr. WALTERS. I don't think you think it works that way because you know how Congress works. We are not making choices against different categories of appropriations. Some of the——

Mr. KUCINICH. No, no, but you are making specific choices that produce specific policies.

Mr. WALTERS. Yes, but when we increase prevention money or treatment money, that is going against things in the Education Department, in HHS, in SAMHSA; that is not going against things in the Defense Department.

Mr. KUCINICH. OK, absolutely. We are talking about things within your own budget. Now, for example——

Mr. WALTERS. But that means we are not making a choice to say the Media Campaign is better or worse than the Coast Guard. We are making a question about whether the Media Campaign is better or worse than the four programs in my office, which are HIDTA, which are the Media Campaign, the Drug-Free Communities, and CTAC.

Mr. KUCINICH. I want to understand your thinking here about the budgeting, because what you have is, you know, according to one report, since fiscal year 2002, Federal spending on supply side efforts—interdiction, law enforcement, overseas activities—has grown 57 percent; whereas, spending on treatment and prevention grew 2.7 percent. You take the choices that are being made on the budget, you match them to where you put your inflection with your policies, and, Congress had an intent here to kind of balance this out in a bipartisan way, and I am not getting yet that is where you are coming from.

Mr. WALTERS. OK, if we can, I think we need to get——

Mr. KUCINICH. I don't want to run your department, but I need to know how you are running your department.

Mr. WALTERS. Yes. No, you do and I think, again, you also know that there is kind of a cartoon version of this, that one is being judged against the other and, as we just talked about, that is not the case. They are competing against real priorities in the domestic realm and in the foreign realm. Let me talk about supply control.

There have been some decisions to increase spending for specific drug control mission-oriented programs in the supply area, but one of the things that has contributed to the growth of supply control, as you know, is the decisions by the Executive and Congress to increase border security; some for drug control reasons, some for homeland security reasons, some for issues of getting control of the border.

We have had increases, for example, in drug control programs in Afghanistan. Virtually none of the heroin in the United States comes from Afghanistan or West Asia. It would be prudent to be aware that it could, but the fact of the matter is the efforts that

we are making in that country are driven not simply by drug control reasons, but because we know the opium crop in Afghanistan is corrosive to counter-terror efforts, stability of Afghanistan, stability of huge parts of the country.

Now, we have properly scored those programs in the budget, but we didn't make a decision that we are going to spend money either on the community coalitions program or Afghanistan. Afghanistan came from a decision which there is debate over, I understand, but that decision had to do with a series of national security issues, which we have properly represented in the budget, but we didn't take any money from the demand side.

Mr. KUCINICH. So when the administration decreases, or will try to decrease, the share of the National Drug Control budget reserve for prevention by $250 million, 14 percent, while increasing interdiction by $616 million, or 19 percent, we look at from fiscal year 2002 to fiscal year 2009, funding for interdiction efforts doubled; funding for international programs such as the crop eradication efforts in Plan Colombia, the Andean Drug initiative have risen faster than funding for treatment, domestic law enforcement, and prevention efforts.

Are these numbers correctly stating the proportion of funding for treatment and prevention? Because I don't see the data in your upfront budget report. It seems to me, the first thing that comes to me is maybe you are omitting some information here that makes it difficult for Congress to be able to make an assessment of where we are actually at with these policy choices.

Mr. WALTERS. We should be able to explain to you the specific choices, because we have made those with some care in each of these cases. We may have disagreements where reasonable people differ, but I don't believe we have an unreasonable position. To disaggregate this, let me take the example of the prevention dollars you talked about.

Almost all the debate over those prevention dollars has been over the proposal of the administration—which has not been accepted over the last several years—to reduce the amount of money in the State grants of the Safe and Drug-Free Schools program in the Department of Education. How, why did we make that decision? There had been repeated evaluations—including some by the same Rand Corp. that is going to have some authority in the next panel, as I understand it—saying the program is spread too thin over too many areas with too small amount of money; it can't show it makes results.

So in this case we have chosen to protect moneys for programs that we think can work. We put money, as I say, into a new program to help support random student drug testing; into part of our effort to reach screening includes screening in health clinics in schools, not in Education, but in HHS; we have sought to expand and support our Youth Anti-drug Media Campaign. We have made decisions here. It is at a reduced amount of money, but to put more money in programs that don't work we don't think makes sense.

Now, on the international side, yes, we have spent money on the Andean Counter Drug Initiative. We think that is working; it is saving lives here; it is producing some of the lack of availability of cocaine that you see driving the declines that we are seeing; it is

helping to stabilize an important ally in the face of these threats; and it is also, frankly, a bipartisan program that, as you know, started with the Clinton administration, and we are proud to be the people who are continuing to carry that on.

We have proposed additional money, as you know, for the merit initiative for Mexico. That is reflected in our budget. It is a substantial amount of money. The first tranche is in the supplemental pending before you; the second is in the 2009 budget. It is a total of $1.4 billion. Again, why did we do this? Because we think there is a unique opportunity with the leadership of President Calderon to change the face of destruction of institutions in Mexico that we can help them with their own money and resources accelerate for the good of both countries. We think already the efforts by the Mexican government have helped, again, to reduce the availability of cocaine that we see reflected in declines in use and the availability of methamphetamine has dropped dramatically.

Again, these are programs that we are already seeing results on, that supply control, for the first time, is doing something that supply control talked about doing in the past and couldn't do: changing the availability of drugs and changing the most important thing, which is the number of users.

Mr. KUCINICH. OK, we raised the question about the compliance with the Reauthorization Act; you have made your response. We talked about drug control strategy and budget priorities and balance. I want to talk a little bit about the supply side initiative and cocaine price and purity data.

In November, the ONDCP announced the average price of domestic cocaine increased 44 percent in the first part of the year. At the time, you characterized it as the deepest and longest cocaine shortage that we have ever had. But outside observers have pointed to four such cocaine price effects since 1981. After each of these increases, the price of cocaine substantially fell back to historical trend lines. In addition, despite increasing amounts of money devoted to supply side strategy such as eradication, interdiction, and law enforcement, cocaine and heroin have become less expensive and more potent over the last 25 years.

In the 2008 strategy, you suggest that the cocaine price strike and associated decline in positive cocaine tests and hospitalizations were more than transitory, but the most recent national drug threat assessment released in November by DOJ noted that cocaine prices had already declined in some markets and predicted that the best cocaine production in South America appears to be stable or increasing cocaine availability could return to normal levels during late 2007 and early 2008. That is a quote.

Do you expect this to be anything more than a temporary blip? And if so, on what basis do you expect it to be? Also, does ONDCP employ any performance measures to its eradication/interdiction policies that are tied to trends in a domestic price and purity trends of heroin and cocaine or that link these supply initiatives to reductions in drug use and abuse? What are they?

Mr. WALTERS. This has been a challenge for decades, of course: what difference does supply make? Do we ever do more than chase this around? And I think the difference that we saw here is not only the old method of looking at price and purity—and these are

the data that have just been released that show up through the end of 2007 the changes in price and purity for cocaine and even more starkly for methamphetamine—but we also have the underlying data from workplace drug testing now that has over 8 million tests a year, many of the data go down to three-digit zip codes and show us what the use is.

Again, what is price and purity? It is an intersection of supply and demand. It shows us what the cost and what the efforts to meet the demand through dilution or concentration are in the marketplace. What we have seen for the first time, and what my comments before—and I think they are still true together, and I gather that is part of your question—is the availability of cocaine seems to be a critical factor in driving down, as the availability of meth is, the number of users. The number of users at a much smaller number—and, again, cocaine users are now at the lowest level we have ever measured—at a much smaller number means that the demand has been diminished. That is a good thing. That will allow some recovery if we don't continue to reduce supply on the price side, and there has been some adjustment.

But, again, I started working on this during the Reagan administration. We haven't had some of these data sets before. We are glad to have the insight they give us and they give you, we hope. There has never been a demonstrable, sustained reduction in the availability of cocaine reflected in use over as long a period. This happened—initially the reports were—in the beginning of last year. You see the workplace data that shows the changes and the continued decline.

Yes, month-to-month, there is a little bit of up and down in some of these phenomenon because they are not machines, they are people underneath this data, but what we have had is a sustained decline. In the past, the only declines we could detect were declines that we thought were demand-driven. That is why the argument you heard about it is demand investments that make a difference. I think what we have in this new environment is that for the first time substantial and sustained declines that are reinforced, certainly, by what we do in treatment and prevention, but are driven by supply control.

Mr. KUCINICH. OK, you are making a case that your position is the best way to reduce harms associated with substance abuse is to reduce substance abuse, to stop people from using drugs. We all agree, absolutely agree on this goal, but I am worried that a fixation on drug use reduction obscures other important problems associated with drug use.

For instance, I applaud the fact that fewer Americans use illegal drugs than 10 years ago, but the number of Americans dying from drug use has substantially increased. And isn't this relevant measuring our progress on the war on drugs? And if drug rate use declines, let's say, by 10 percent but the number of people dying from drug overdose increases by 60 percent, the more people who contract HIV/AIDS from sharing needles, how do you address that conundrum?

Mr. WALTERS. Well, I think we both agree the most powerful way to stop all the consequences of drug use—death, destruction of your life, your family, your health—is to, first and foremost, try to re-

duce the number of people that start. We know that starts in adolescence in the United States. We are encouraged that these numbers are down.

I mean, your and my generation now has the highest rates in our 50's and 60's of alcoholism and substance abuse because we had the highest rates of exposure as teens. We didn't know that at the time. We got a bum rap; this is not going to be a problem. We now know that we increase the risk of young people when we expose their brains to these substances in adolescents because their brains are still developing. So these kids today, this 24 percent reduction, they are likely to be safe for the rest of their lives and won't suffer that death. We need to, first and foremost, reduce that onset. Second, we need to treat the phenomena. The best way to stop the crime, the family destruction, the blood-borne disease is to get people into treatment and recovery. Every dollar we can spend there, we are trying to drive in that direction through the health care system, through the criminal justice system.

Mr. KUCINICH. Fine, Mr. Walters, but what about laying out specific goals, targeted goals to reduce the number of hard-core drug addicts? Because I haven't seen you really lay that out in your——

Mr. WALTERS. Again, what we try to do is have goals that we can actually measure. As you know, there is a lot of cynicism in this field because people have promised things they couldn't deliver——

Mr. KUCINICH. So this is a thing you can't measure, if you add additional measurement criteria and performance goals relating to, let's say, drug overdose deaths, HIV transmission rates, number of hard-core addicts, that this would be something that you couldn't measure?

Mr. WALTERS. No, I think some of them are easier than others and I think there is more data. For hard-core drug users, there have been estimates—my office has produced and tried to use estimates. And I have looked at the models; I have worked at this a long time. Those models have confidence rates—actually measuring the number of hard-core, you know how hard that is. You have looked at this a long time. People on the street, people who hide this behavior because of shame, people who are functioning but are falling out of the system or falling back into the system at various times, we can create numbers that let us think we are measuring hard-core users. I am not sure they are measuring hard-core users. So then, to say you are going to take that many—what I can tell you is what these programs are treating——

Mr. KUCINICH. If you can create those numbers, even if you have to qualify them, I think it would be helpful for this committee to look at specific targeted goals that you have for reducing hard-core addicts.

Mr. WALTERS. We have some of those. If I can ask——

Mr. KUCINICH. And also measuring——

Mr. WALTERS. Tell me if this is the kind of number you want. If you put up chart No. 5.

[Slide.]

Mr. WALTERS. This is from the National Survey on Drug Abusive Health, people in households. It measures the number of people who report using drugs on the left-hand side and it measures the 7 million estimated people that are dependent or abuse drugs such

as they need treatment intervention on the right. Red is the users; the purple is the addicted. So we can measure that. Now, again, that is self-reported data. We built in essentially intake data at treatment, try to determine whether their use is at the level of abuse or dependency and they need treatment. We can measure that.

Now, again, we produce that data annually, it is an annual report. We have not given you a goal to reduce the number of those people because I don't know that there is a credible way of identifying our program dollars as they are mixed with State and local program dollars or with private dollars to actually close that gap.

And I will say one other thing about this, which is why we are doing screening, and I talked about it and we talked about it, I think, when I met with you. The difference between this problem and a regular health care problem like breast cancer—maybe some of these like breast cancer or like something that would be more visible like appendicitis—is you know people hide this; that this phenomenon is one that people deny to themselves and they hide themselves.

Most people who suffer from this, 90 percent of them don't believe they have a problem and don't seek help. We need to bring them in; that is why the emphasis on screening, on drug courts, on work in schools and with families. So we can look at that, but, again, I think that is where we need to pull more people, because I think the ability to have people raise their hand and say I am somebody who needs drug treatment and, therefore, get a census is extremely limited and more misleading in some cases than not.

Mr. KUCINICH. In your 2006 strategy and your testimony you pointed to random student drug testing as a key component to your prevention program. Have you done any research on that indicates its effectiveness?

Mr. WALTERS. Yes, we have had a couple of different studies that we have looked at, some from the schools that have done random testing over a period of time. Some of them have had either surveys of what the rates of use were before they implemented—we recommend they do that when they implement the program now—but, second, some of that had been done even before the program and the reason why we recommended it was visiting De La Salle School in New Orleans before Katrina. They are one of the longtime testing programs that had problems with all the things you see from drugs: dropouts, fighting, truancy. They instituted a program that changed the environment of the school.

After Katrina, De La Salle was the first high school in New Orleans to open. Even though it is a parochial school, it accepted everybody that was there because there was a desperate need. It stopped the testing program under those circumstances; it couldn't operate it. As the school got up and running, they began to have some of the old problems they had before. They re-instituted the drug testing program and those problems subsided.

We have had other schools in New Jersey and other places that have had not only surveys, but have had periods where the programs for reasons outside the school cause had been turned on or turned off, and they show you the difference between the program on and program off.

We are looking at additional research about this nationwide, but, again, testing has been an enormously powerful force for adults in the workplace, in the military, as you know, in the transportation and safety industry. I don't think there is much debate in the formal structure. I recognize there is——

Mr. KUCINICH. What about compulsory testing for all students?

Mr. WALTERS. Well, for private schools, many of them do test all students. For public schools, as you know, what the Supreme Court has reviewed is testing for those in extracurricular activities. That usually means schools can allow parents to opt kids in that are not in extracurricular activities. Some do. It is a bigger pool——

Mr. KUCINICH. So you are mindful of the civil liberty issues here with respect to the children.

Mr. WALTERS. Absolutely. But why does this work? This, I think, is something important and I really hope you, because of the positions that you have taken and the kind of leadership you can offer here that I can't, frankly, in certain areas. If we understand substance abuse as a disease, we have to understand that testing is like screening, as a public health matter, for other diseases, as we have done for tuberculosis. It is not a source of shame, it is a source of bringing the resources of society to those who are suffering from that disease and help keep them from the consequences of destruction and death.

Mr. KUCINICH. But even if you have some kind of a chronic disease, you have the right to be tested or not. I mean, you can go and submit to a test; no one can tell you you have to be tested. That is the difference.

Mr. WALTERS. Well, as an adult. But take my example of tuberculosis. There are many States that require a child to have a tuberculosis test before they can come to school. It is required. Now, why do they do that? Because children are not adults and we are responsible for their health and, second, because we know how to treat that disease and we know if we don't treat someone who is infected, they will get sicker and can die; and, second, they will infect every other child and adult, potentially, they come in contact with.

I think what we are understanding with the disease of addiction is it happens the same way, although not by a bacillus or a virus; by behavior. A child who starts using, tries to get their friends to use them. We can break that cycle. We can break the cycle of intergenerational substance abuse by using the tools on the table.

That is what I meant in my oral statement about I think we are on the verge of revolution. We are removing the shame, treating this as a disease and using what we know about epidemiology to really change the face of this, so that when you get a physical, when you bring your child to the pediatrician, they ask about substance abuse and drinking, and they can make a medical intervention. It is not in the juvenile justice system, it is not when the disease has progressed.

We need help in making this a kind of social revolution so we expect our communities to stand together and say if you have a problem, we are going to help you. We are not going to throw you away; we are not going to wait until you drop out of school or go into the criminal justice system.

We have an obligation as a society, since we can treat this disease. Every single person who suffers from it and is untreated needs to be seen as an obligation of society to treat; in the public system, in the private system, in community organizations, as well as in government. We have to be together; we can't just turn this over to government. This has to be done at the local level. But if we do that, that is when we really change the future of substance abuse in the country in a permanent way. That is what I think this revolution is about.

Mr. KUCINICH. Well, I certainly appreciate your own passion and, of course, the concerns that some of us have as you talk about prevention, is that those programs are funded. Now, our next panel we are going to get some analysis of that. I want to say, Mr. Walters, the committee will have some questions that we will submit as a followup to this meeting, and we will have more hearings on drug policy, which will be an opportunity to go into some more specific areas. I want to thank you for the comprehensive answers that you have given.

Before Mr. Walters leaves, Mr. Cannon, do you want to ask him any questions?

Mr. CANNON. Thank you, Mr. Chairman. I am just here to sort of fill a seat.

Mr. KUCINICH. Oh, OK. The Republican conference is well represented by your presence.

But anyhow, Mr. Walters, thank you very much——

Mr. WALTERS. Thank you.

Mr. KUCINICH [continuing]. For the comprehensive answers that you have given. And I would also say to keep in mind with respect to the bipartisan concerns that we have here, is that the Reauthorization Act imposed some metrics and we are still waiting, and I don't want to diminish the efforts that you are making, but——

Mr. WALTERS. And I would appreciate the opportunity. We have had staff come up to me, your staff, I think, for quite some time in preparation for this hearing. I will meet with you, I will meet with other Members. We want to make this work. We have trends that have never happened before. They won't continue if we don't follow through. It is a critical time with changes of administrations.

Mr. KUCINICH. Well, let's work together on this, though, OK?

Mr. WALTERS. I would be happy to.

Mr. KUCINICH. Thank you, Mr. Walters.

Mr. CANNON. May I just say thank you also, Mr. Walters? We appreciate your being here.

Mr. KUCINICH. Thank you, Mr. Cannon.

We are going to go to the next panel and thank the next panel for its patience, forbearance. You have been here a few hours waiting to come forward.

OK, our next panel, we have Mr. John Carnevale and Ms. Rosalie Liccardo Pacula.

Mr. Carnevale is the president of the Carnevale Associates LLC, a strategy public policy firm. He served three administrations and four directors within the executive branch of the U.S. Government. At the White House Office of National Drug Control Policy he directed the formulation of the President's National Drug Control Strategy, as well as the Federal Drug Control budget. Mr.

Carnevale is recognized as the key architect of the Performance Measures of Effectiveness [PME], system, which ONDCP used to determine progress toward national goals and objectives. He is also credited with directing policy research that shifted the primary focus of the Nation's drug control strategy from supply to demand reduction. Mr. Carnevale has also worked as a researcher at the Office of Management and Budget and in the U.S. Department of Treasury in the Office of State and Local Affairs.

Ms. Rosalie Liccardo Pacula earned her Ph.D. from Duke University in 1995. She is a senior economist and co-director of the Drug Policy Research Center at RAND, as well as a faculty research fellow at the National Bureau of Economic Research. Ms. Pacula's research has largely focused on evaluating the effectiveness and cost-effectiveness of State and local public policies that diminish use and abuse, as well as their costs. Previous and ongoing research areas include analyses evaluating the impact of marijuana decriminalization and medicalization of youth marijuana use and marijuana markets; the impact of enforcement and policy on drug markets; the cost benefit of drug treatment and school-based prevention programs; social costs associated with marijuana use; the impact of funding volatility on substance abuse treatment and outcomes; and changes in the global drug market over the past 10 years.

As part of this larger research agenda, she has done in-depth policy analysis of State level parity legislation, medical marijuana laws, and impact of State funding volatility on treatment availability and quality in California. She is currently the principal investigator at a 4-year grant from National Institute of Drug Abuse to update and improve previous estimates of the social cost of drug abuse in America.

Thank you to both witnesses for being here. You are certainly well qualified to be able to make statements on these issues. It is the policy of our Committee on Oversight and Government Reform to swear in all the witnesses before they testify. I would ask that our witnesses please rise and raise your right hands.

[Witnesses sworn.]

Mr. KUCINICH. Thank you. Let the record show that the witnesses have answered in the affirmative.

As with the first panel, I would ask that you give an oral summary of your testimony. Try to keep the summary 5 minutes in duration. Please don't go too much beyond that. I want you to know that any written testimony that you have, the entire of it will be included in the record.

I also want Mr. Cannon to know that if he has any statement or questions for the record, that we will be happy to receive them.

So why don't we begin with Mr. Carnevale? Thank you.

STATEMENTS OF JOHN CARNEVALE, PH.D., PRESIDENT, CARNEVALE ASSOCIATES, LLC; AND ROSALIE LICCARDO PACULA, PH.D., CO-DIRECTOR, RAND DRUG POLICY RESEARCH CENTER

STATEMENT OF JOHN CARNEVALE, PH.D.

Mr. CARNEVALE. Good afternoon, Mr. Chairman and Congressman Cannon. I want to thank you for the opportunity to present my views on this Nation's progress in the so-called war on drugs. By way of my background, as you mentioned, I have been involved in the National Drug Control Policy for well over 20 years as a Federal employee and have served under three administrations and four drug czars. While at ONDCP, I was in charge of formulating the National Drug Control Strategy in the Federal budget to implement it. Another responsibility was to design a performance measurement system that Congress and GAO found quite acceptable in meeting ONDCP statutory requirement to develop such a system. I left ONDCP in 2000 and remain active today in drug policy work at all levels of government.

My purpose here today is twofold. One is to quickly review ONDCP's claim that we are turning the tide in the drug war. In my opinion, the tide has not yet turned. My second objective is to talk about ONDCP's future. In less than a year, a new administration will assume office, and we must be ready to assist it in making ONDCP more effective.

Let me start with the issue of whether we have reached a turning point in the drug war. Figure 1 of the 2008 Strategy Report shows youth drug use since 2001 has declined after a decade of increase. This is used to make the point that we have reached a turning point in the drug war. However, as this figure clearly shows, youth drug use actually started its decline after the 1996–1997 time period. This means that the so-called turning point actually occurred in the last decade. Second, the claim that we are turning the tide overlooks the fact that the current strategy also has a similar goal to reduce drug use among adults. For the record, there has been no change in adult illicit drug use since 2002.

This now brings me to the topic of performance measurement. I developed a performance measurement system in the 1990's that linked the budget to key outcome measures. It was one that was endorsed by, as I said earlier, the GAO and the Congress. The system focused on performance measures in three basic areas: one had to do with drug use; the second area had to do with drug availability; and the third had to do with drug use consequences, essentially health and crime consequences.

Current law requires that ONDCP develop performance measures in exactly these three areas. It has not. Instead, it has limited performance measurement to just one area: drug use—and mostly youth drug use.

So what about progress in other performance areas? It is fair to say, in my mind, that progress is lacking. Consider the following. The overall rate of illicit drug use has not changed since 2002. And this is as measured by our National Survey on Drug Use and Health. This rate was 8.3 percent in both 2002 and in 2006. Adult

drug use, for those over 18 years of age, has not changed since 2002.

Almost 20 percent of those 18 to 25 years of age and 6 percent of those over 25 continue to use illicit drugs on a regular basis. About 7 million individuals remain addicted or abuse illicit drugs. This is unchanged since 2002. And, by the way, cocaine flow toward the United States, according to the 2008 Strategy, increased from 912 metric tons in fiscal year 2006 to 1,265 metric tons in fiscal year 2007, an increase of almost 40 percent.

I would like now to turn to the topic of challenges facing ONDCP. Right now, ONDCP is not meeting many of its most important statutory obligations. Some highlights. It is not providing the Nation with a comprehensive accounting of Federal drug control spending; it is ignoring billions of dollars in Federal drug control spending that policymakers need to know about to make more informed decisions.

It has not implemented a performance measurement system that attributes the relative contributions of treatment, prevention, law enforcement, interdiction, and source country programs to outcomes across the three outcome areas I spoke to you about a minute ago; it is not coordinating Federal drug control policy across the multitude of Federal agencies that a role in shaping national drug control policy. There used to be committees on supply reduction, demand reduction, and science and technology. They no longer exist.

So what about ONDCP's future? I believe ONDCP has a future role, but only if certain changes occur. The statutorily mandated organizational structure that reflected the 1980's cocaine drug war that was designed originally by the 1988 Drug Control Act must be reconsidered. We are now fighting a modern day drug war with old bureaucratic technology.

Second, ONDCP must rediscover its roots by again becoming a leader in policy formulation to develop a drug policy that is evidence-based and includes a performance measurement system to hold it accountable for results. ONDCP must fix the drug budget, as we talked about earlier. It must re-establish a performance measurement system. As far as I can tell, it does not have one. It must jettison to other agencies, perhaps, some of the programs that are distracting it from its core policy formulation mission, such as Drug-Free Communities.

It must rebuild and promote data surveillance systems to track emerging drug use problems. Let's face it, it missed the ball on prescription drugs and methamphetamine because it lacked such systems. It took this Congress and the previous one to get involved and make ONDCP pay attention to these particular issues. And, finally, it must become part of the movement toward electronic health records. The entire health care industry is currently being transformed by the introduction of electronic health care records. This will help move drug treatment into the mainstream with all of health care.

In summary, it is my view that ONDCP is not now serving the Nation's interest in addressing the drug problem; it has ignored many of its legal responsibilities; and, most seriously, it is now not informing the Nation about the totality of the drug problem.

This concludes my comments, and I thank you for your time and attention.

[The prepared statement of Mr. Carnevale follows:]

Testimony of John Carnevale, Ph.D.

Before The Domestic Policy Subcommittee
Of the Oversight and Government Reform Committee

ONDCP's Progress in the War on Drugs and
Its Ability to Serve the National Interest

Wednesday, March 12, 2008

Rayburn House Office Building.

Good afternoon Mr. Chairman and members of the Committee. I want to thank you for this opportunity to present my views on our nation's progress in achieving measurable outcomes in reducing drug use and its damaging consequences and on the efficacy of the Office of National Drug Control Policy (ONDCP).

Background: I have been involved in shaping federal national drug control policy as a federal employee since 1986 and have served under three administrations and four "Drug Czars" within the Executive Branch of the U.S. Government. At ONDCP, I was responsible for first assembling the required data and information on which to base the development of the Administration's National Drug Control Strategy and then managing the preparation process to formulate that Strategy. In addition, I was responsible for proposing priorities in the drug control arena and for formulation of the national drug control budget to implement both those priorities and the overall Strategy. Key to these tasks was the development of a policy and research agenda to inform national drug control policy as well as designing and implementing a performance management system to measure the impact and effectiveness of any given policy toward reducing drug use, drug availability, and the health and crime consequences of drug use.

I left ONDCP in 2000 and started a firm that offers guidance to all levels of government, organizations, and communities to help them confront the drug public policy and program challenges of the 21st century. My firm is organized into three practice groups to provide value and insight to our clients—Strategic Planning, Performance Measurement, and Policy Research and Data Analysis. My firm also produces information and policy bulletins on the topic of drug policy and the federal drug control budget that is distributed free to over 7,000 individuals with an interest in this policy issue. For example, our latest policy brief looks at the drug budget since FY 2002 and compares it to what 30 years of research says should otherwise constitute a sound, evidence-based and balanced federal drug policy. A copy of that bulletin is attached to this testimony and elements of it are incorporated into this statement.

My purpose here today is twofold: one is to quickly review ONDCP's claim that we are turning the tide in the drug war. In my opinion, supported by a substantial body of data and research, the tide has not yet turned. My second objective is to talk about ONDCP's future role. In less than a year a new Administration will assume office, which will give this nation the much-needed opportunity to breathe new life into our national drug control policy–that is to validate and refine approaches, redefine goals and objectives, and institute proper and much needed measures of performance outcome effectiveness. In my view, ONDCP can make a meaningful contribution to our nation's effort to reduce drug use and its damaging consequences, but some organizational restructuring must occur to better address the current and evolving drug situation, both domestically and internationally. This requires that ONDCP and the federal drug control agencies to be held accountable for achieving performance results.

Ingredients of a National Drug Control Policy: Let me begin by offering my understanding about what goes into a comprehensive national drug control policy. A federal national drug control policy must include at least five essential ingredients:

prevention, treatment, domestic law enforcement, international or source country programs, and interdiction (targeting drugs flowing to the United States). These ingredients tend to be clustered into two broad categories: demand reduction (treatment and prevention programs that seek to discourage individuals from trying illicit substances or to help existing drug users to stop) and supply reduction (programs that attempt to eliminate the cultivation or production of illicit drugs, stop the flow of drugs from entering the country, or disrupt domestic drug markets). In terms of these five main ingredients, the national policy debate has always been about how best to combine them to most effectively and efficiently reduce drug use and its damaging consequences. It is the case that some ingredients have been emphasized more than others over time as our knowledge of effective programs has evolved and as the drug threat has changed. For example: Dr. Jerome Jaffe, who served as our first drug czar from 1971 to 1973, released this nation's first formal comprehensive drug control strategy in 1972—it emphasized drug treatment to reduce illicit drug use among returning Vietnam veterans.

During the 1980's we focused on supply reduction, largely in response to a cocaine epidemic, and with the belief that source and transit zone interdiction was the most effective means of reducing drug use in the United States. By the 1990's we had learned that interdiction was a relatively ineffective way of reducing drug use—and expensive besides. So we focused our efforts on demand reduction. Now, at the beginning of the new millennium we have—inexplicably—come to believe again that source and transit zone interdiction is an effective way to reduce drug use in America. There is no evidence to support this belief. And it is all the more surprising that we have refocused our efforts in this way at a time when many of the major drugs of abuse – including marijuana, methamphetamine, and controlled pharmaceuticals, are produced or cultivated domestically.

In short, we seem to have reverted to fighting the 1980s drug war at a time when it is clear from the data and most recent scientific findings that demand reduction needs to be the first priority response.

Have We Reached a Turning Point in the Drug War? According to the 2008 National Drug Control Strategy, our nation has reached a turning point in the war on drugs. Figure 1 of that 2008 Strategy reports that youth drug use since 2001 has declined after a decade of increase. The problem with this figure is that it misleads the reader in a number of ways. First, as the figure clearly shows, youth drug use actually started its decline after the 1996-1997 period. This means that the origin of this good news has its roots not necessarily in our current drug policy, but instead in another time well before 2001. Moreover, the survey says that the percentage of youth reporting having tried an illicit drug by the time they graduate from high school has changed little since 1995. Regardless of when they first begin drug use, about 50 percent of youth report having tried an illegal substance by the time they complete high school. In other words, while initiation into drug use seems to be somehow delayed, our nation has achieved no progress in reducing illicit drug use by the time youth graduate from high school.

By way of background, these data on youth drug use are from the University of Michigan Study (MTF). It is worth noting that the MTF, with its focus on certain youth, measures essentially marijuana use and is not the best measure of the use of other drugs, such as cocaine, heroin, and methamphetamine. The prevalence of use of these drugs among youth has always been very low.

Second, the claim that we are turning the tide in the war on drugs overlooks the fact that the current drug control strategy also has a similar goal to reduce drug use among adults. The current 2008 drug strategy is silent on whether progress has occurred in achieving reduced drug use among this population. For the record, and as is highlighted below, a review of the federal government's National Survey on Drug Use and Health (NSDUH) shows that there has been no significant movement in achieving reductions in adult drug use since 2002.

A review of drug strategies since the first comprehensive one was issued in 1972 shows that measuring the success of any drug strategy requires performance measurement in three fundamental areas: drug use, both youth and adult drug use that includes regular drug use and addiction; drug access, which can get at the issue of drug availability, the robustness of the market, and/or supply; and drug use consequences, which tends to measure the serious health and drug-related crime consequences. Our current national drug control strategy is limited to measuring performance by setting performance goals that just reflect drug use, rather than all three performance areas.

Even though ONDCP should have measures in these three key areas that can be linked back to the key ingredients of a drug strategy (prevention, treatment, law enforcement; international, and interdiction), recent drug control strategies simply ignore these areas. ONDCP seems to pick progress or performance outcomes based on only one area where there is good news: reductions in youth drug use.

What about the other performance outcome areas that should be measured? Let's review the facts based on nationally recognized data that have been used for decades to monitor performance: Consider the following changes in drug use and consequences since FY 2002:

- The overall current rate of illicit drug use as measured by past month use among <u>all users</u> 12 years of age and older has not changed since 2002: this rate was 8.3 percent in both 2002 and 2006.

- The rate of current illicit drug use among <u>youth aged 12 to 17</u> has declined, but much less than reported by ONDCP, based on findings from the University of Michigan's study of 8th,10th, and 12th graders. According to the NSDUH, the rate has declined 15.5 percent, from 11.6 percent in 2002 to 9.8 percent in 2006—good news, but well below ONDCP's goal of reducing youth drug use by 25 percent in five years.

- Adult drug use for those over 18 years of age has not changed since 2002. Almost 20 percent of those 18-25 years of age and 6 percent of those over 25 continue to use illicit drugs on a regular basis.

- The most prevalent drugs of abuse among Americans 12 and older are marijuana, illicitly obtained prescription drugs, and cocaine.

- Cocaine is showing signs of a quiet comeback. An estimated 2.4 million Americans aged 12 and older used cocaine on a current basis in 2006. This level of use represents a 20 percent statistically significant increase since 2002.

- The number of persons classified with abuse or dependence who could benefit from treatment remains unchanged.

- While youth perceptions of the risk of drug abuse—specifically smoking marijuana once a month or once or twice a week—have improved since 2002, their perceptions of the risk of using cocaine, heroin, and LSD have worsened since 2002 and 2003. These negative trends are particularly disturbing since research indicates that weakened perceptions often precede increases in use.

The price of cocaine continues to decline when adjusted for purity. ONDCP claims that many cities are experiencing shortages of cocaine, but press interviews of chiefs of police in most of these cities have found that they are not seeing changes in supply, prices, or purities. And they are certainly not seeing any changes in the demand for treatment, which one would expect to see if drug access were truly being reduced or even limited. In fact, data now reported by ONDCP directly contradicts claims of widespread cocaine shortages in the United States. The 2008 National Drug Control Strategy noted that cocaine flow toward the United States increased from 912 metric tons in FY 2006 to 1,265 metric tons in FY 2007, an increase of almost 40 percent in just one year.

When one looks at these trends and then considers the drug budget proposed by ONDCP since 2002, it can be argued that exactly the wrong policy ingredients are being promoted to confront today's drug problem:

- The drug control budget since FY02 has emphasized supply reduction programs over demand reduction programs.

- Resources for supply reduction (interdiction of drugs, source country programs, and law enforcement), grew by almost 57 percent from the FY 02 baseline level to the FY 09 request now before Congress.

- By comparison, demand reduction resources (prevention and treatment, including resources for research for agencies like the National Institute on Drug Abuse) grew by only 2.7 percent—prevention has actually been reduced by 25 percent.

- The nation's current drug strategy emphasizes reducing demand among youth and adults, but does so by mostly targeting source country and interdiction programs—focusing on the source and flow of drugs rather than this nation's underlying demand for illicit drugs.

- The FY 02-09 budget trend runs counter to what research has found: that efforts to reduce demand are better addressed through treatment and prevention rather than supply reduction

I do not enjoy being a naysayer about this nation's progress or lack thereof in addressing the drug problem. I am pleased to say that we have indeed made substantial progress in reducing the overall impact of the drug problem over the last few decades. Since 1979, the NSDUH shows that past month use of illicit drugs has fallen by about half. Most of this decline represents reductions in marijuana use, but abuse of other illicit drugs has declined as well. Almost 6 million individuals used cocaine in the mid-1980s, for example. Today, we are down to about 2 million users (but up from about 1 million users by the end of the last decade).

As for illicit drug availability, research has taught us that intelligence-cued supply reduction efforts can improve seizures of drugs, but we have also witnessed the fact that interruptions in supply are transitory. Smugglers can adapt faster that we can respond to their changing tactics. This has proven true again and again.

As for claims of success in the war against cocaine, while overall use is down, the evidence of the past two decades shows that any increases in drug prices (adjusted for drug purity) have been temporary and have not resulted in any reduction in consumption. Nor has the nation ever witnessed these temporary market shortages causing drug users to increase their demand for treatment. In short, what we now know is that as long as there is a demand for illicit drugs, supply will follow.

Looking Forward: The bigger issue facing this Committee and the next Administration is ONDCP' S role in defining this nation's drug problem and establishing a national drug control strategy to more effectively address it. ONDCP's original authorizing legislation—the Anti-Drug Abuse Act of 1988—established it within the Executive Office of the President for a five-year period, with the express purpose of formulating and implementing a National Drug Control Strategy. This legislation also recognized the importance of the Federal drug control budget. ONDCP was granted the authority to instruct what was then more than 50 federal drug control departments and agencies to prepare estimates of drug control spending that would allow the Federal Government to undertake better resource planning and more cost-effective implementation.

In addition, ONDCP was granted the authority to "certify" the individual agency budgets as to their adequacy in achieving the goals, priorities, and objectives of the President as stated in the National Drug Control Strategy. With the creation of ONDCP and its new budget certification powers, the federal drug control budget was to take front seat in the discussion about the nature and direction of the nation's drug policy.

The Anti-Drug Abuse Act of 1988 further declared the overall mission of ONDCP to be the creation of a drug-free America. Congress no longer wanted a drug policy that was budget-driven, but instead one that was research driven and performance based. In other words, Congress intended ONDCP to be truly non-partisan and to formulate policy based on evidence and to measure the progress of that policy using a performance measurement system, one designed to both inform policy makers and clearly illuminate the attribution of the key policy ingredients discussed earlier to overall performance findings and outcomes. A performance system designed to achieve this result did once exist, but in this decade the current administration abandoned it after attempts to modify the methodology for estimating federal drug control spending.

Sadly, today ONDCP is not meeting all of its statutory obligations. Some of its most significant shortcomings include the following:

- Not providing the nation with a comprehensive accounting of federal drug control spending. This is an enormous failing of the Office with regard to meeting its statutory obligation to provide a comprehensive accounting of all federal drug control spending. A "drug budget" aims to provide exact and comprehensive estimates of drug control spending. It should support a strategic decision-making process that includes articulation of goals, specification of measurable outcomes to be attained, and identification of programs that help achieve those goals and outcomes. Policy should drive the budget process. ONDCP's current drug budget grossly underestimates federal drug control spending, which means that policy makers are much less able to evaluate program decisions to support the Strategy's strategic goals and objectives.

- Not implementing a performance measurement system that attributes the relative contributions of the ingredients of a balanced, comprehensive drug policy in addressing drug use and its damaging consequences. This is yet another major failing of the Office. ONDCP should measure the performance of its overall policy with regards to achieving success. Right now, we are unable to understand, for example, the reason for the reduction in youth drug use. Nor are we able to understand why we have not achieved success in reducing adult drug use, rates of addiction, drug use availability, and the health and crime consequences of drug use.

- Not coordinating federal drug control policy across the multitude of federal agencies that have a role in shaping national drug control policy. ONDCP once had coordinating bodies—a demand reduction group, a supply reduction group, and a science and technology group—that met regularly to discuss coordination efforts and both existing and emerging problems and to support ONDCP with its mission to coordinate policy on behalf of the administration. These committees no longer exist and their valuable functions are simply not being done by anyone.

- Not developing long term goals and measurable objectives in the areas of drug use, availability of drugs, and drug use (health and crime) consequences. The current strategy addresses just drug use, particularly youth drug use, and does not have measurable goals and objectives for reducing drug use availability or drug use consequences.

- Not promoting knowledge development and data systems to inform the nation about existing and emerging drug problems. Under this Administration, the Arrestee Drug Abuse Monitoring system (ADAM), which provided a leading indicator to identify emerging drug use trends, was cut back significantly to be rendered practically useless.

As a result of these failures, ONDCP is no longer seen as a serious player in the drug issue. It has become just another federal agency involved in some aspects of drug policy, but its vital leadership role has been misplaced. As evidence of this, we merely need to look at the actions of this and prior oversight Congressional Committees that have been forced to step in and direct ONDCP to take action in areas related, for example, to methamphetamine and prescription drug abuse, federal drug budget accounting, and performance measurement. Again and again questions are asked, but answers do not seem to be forthcoming.

In my view, ONDCP is not serving the nation's interest in addressing the drug problem. It has ignored many of its legal responsibilities to address the drug control problem and, most seriously, it is now misinforming the nation about its overall progress in reducing drug use.

So, this now leads to the future of ONDCP. Should ONDCP continue to exist? Can it have a meaningful role in shaping drug policy in the next Administration? The answer is yes, but only if certain changes occur:

- The statutorily mandated organizational structure that reflected the1980's cocaine drug war must be reconsidered. Perhaps it should be updated in favor of one that addresses today's multifaceted and rapidly evolving drug threat. Having an organization with Offices of Supply Reduction and Demand Reduction made sense at a time when the nation sought to stop drugs from entering the United States while at the same time trying to curb demand. Today, this structure pits supply against demand—it's time we recognize that drug use occurs in drug markets and those drugs coming from outside our borders are not necessarily the most serious component of the overall drug situation. According to the NSDUH, the drugs that enter the United States illegally (mostly cocaine and heroin) are relatively less of a problem today than drugs that can be produced or cultivated in the United States, such as illicitly obtained and diverted prescription drugs, methamphetamine, and marijuana.

- ONDCP must rediscover its roots. By this statement, I mean that ONDCP should again focus on becoming a leader in policy formulation on behalf of the President

to allow the Administration to develop a drug policy that is evidence-based and includes performance measurement to hold it accountable for results.

- The office must jettison some of the programs that are distracting it from its core mission. I strongly support and would expand, for example, the Drug Free Communities program—after all, the national drug problem is essentially the culmination of local drug problems—but question why funds for it are appropriated to a policy-making organization in the Executive Office of the President: in this case, ONDCP. Because it is a prevention program, funds for it should be put it in an agency responsible with knowledge of effectively administering prevention programs. And what about the media campaign? A recent scientific evaluation of that program found it to be ineffective, which strongly suggests that its funding should probably be ended. However, if Congress desires to continue to fund the program, then I recommend that it should be placed in an agency that programmatically understands demand reduction—SAMHSA would be a logical candidate.

- ONDCP must rebuild and promote data surveillance systems to track emerging drug use problems. ONDCP has let die such systems in the past few years to the detriment of informing the future of an effective national drug control policy. An informed drug policy is one that does not look backward at previous trends, but instead relies on leading drug use indicators to promote new policies, programs, and practices. For example, systems like the Department of Justice's ADAM should be greatly expanded.

- ONDCP must become part of the movement towards electronic health records. The entire health care industry is currently being transformed by the introduction of electronic health records. Drug treatment providers must be part of this movement so that drug treatment is properly located in the mainstream with all of health care, with real time data available to inform policy and program development. But of course this must be done in a way that continues to protect the patient's right to confidentiality and privacy as established by 42 CFR Part 2.

- ONDCP should promote more understanding about the drug problem as being one that is related to behavioral health. This would enable drug policy to better address co-occurring problems as well as to use the coercive powers of the criminal justice system to help those with serious drug problems achieve abstinence and move towards living productive lives.

- ONDCP must also re-establish its role in developing priorities, setting policy, and in developing and promoting a budget adequate to implement it. This will require that the next Administration commit to letting ONDCP fully exercise its authority to coordinate drug policy and work with the Office of Management and Budget to formulate a federal budget that reflects our nation's need to address drug use and its damaging consequences.

- ONDCP must be held more accountable by Congress for reporting accurately and completely on performance. In addition to reinstating a transparent and open performance measurement system, the office must be taken to task whenever it fails to meet a congressional mandate to report on a particular topic in a particular time frame.

- ONDCP must take the lead in developing a policy research agenda to inform the national strategy about what does and what does not work.

- ONDCP must work more effectively with other nations to establish a stronger leadership role in coordinating international drug control policy. All nations, not just the United States, face problems with illicit drugs and consequences. This especially includes promoting demand reduction programs like those funded by the State Department and the United Nations, but it also should include efforts to learn what is working in other countries.

In summary, ONDCP must return to being a policy office, one that administers few programs that could interfere with its original policy mission. It must develop policies based on what research tells us is effective in reducing demand and its damaging consequences. It must coordinate and propose to Congress on behalf of the administration a budget that logically implements the evidence-based policy. Right now, we have a budget that undercounts federal resources and is directly at odds with what research tells us needs to be done. We must never let our own opinions about what works or what needs to be done overcome what competent research and supportable findings tell us must be done. The drug issue is one that many confront, but few really understand. Much of what we think about drug abuse comes not from research, but from our hearts and our personal experiences. We can clearly see the pain drug abuse brings, especially for our families and friends, and we want to believe that we, as a nation, can overcome it. We can, and we must. But the answer lies not in our hearts but rather in properly informed and focused policy supported by adequate and stable funding, with the required checks and balances provided by performance evaluation and strong, open-handed leadership and management. This nation deserves no less.

Mr. KUCINICH. Thank you. We will be interested in questions.
Ms. Pacula, please proceed.

STATEMENT OF ROSALIE LICCARDO PACULA, PH.D.

Ms. PACULA. Thank you, Mr. Chairman and Mr. Cannon. It is my pleasure to be here today, and thank you for inviting me. As was stated before, I am a senior economist at RAND and co-director of RAND's Drug Policy Research Center. So, as an economist, I tend to examine policies in terms of their impact on markets and behaviors, as well as their cost-effectiveness vis-a-vis other strategies with the same objectives. My testimony today reflects that perspective applied to the Nation's drug problem.

In my view, the 2008 National Drug Control Strategy has three general shortcomings that need to be examined by Congress when you are considering appropriations in the 2009 budget. First, as has already been noticed and discussed, the strategy does not provide the appropriate balance between enforcement, prevention, and treatment to tackle the current U.S. drug problem. Second, it fails to make adequate use of scientific research regarding the effective and ineffective policies that we are pursuing today. And, third, it presents a very narrow representation, as was mentioned already by Mr. Carnevale, of the drug situation by ignoring the important indicators of chronic use.

To provide a little more background on each of these, first with respect to the current balance of enforcement, prevention, and treatment strategies, as has been mentioned already, there is RAND research that talks about the cost-effectiveness of alternative strategies in this regard, and it has demonstrated that we have far surpassed the point of diminishing marginal returns with respect to our supply side interventions for cocaine.

A far more effective and cost-effective way of dealing with the problem in the United States would be to allocate more resources to treatment, instead of to supply side strategies. Treatment, according to RAND research, is at least five times more effective at diminishing consumption than either source country control or interdiction. It also generates substantially greater reductions in serious crime than conventional enforcement or mandatory minimum sentences.

The treatment's larger cost-effectiveness has to do with the fact that we are dealing with a mature drug market. An immature drug market is heavy in chronic users, represent the much larger fraction of total users, and the vast majority of consumption. Thus, policies targeting these chronic users will have the greater impact in terms of reduction in total consumption.

Second, the strategy's failure to make adequate use of scientific findings. ONDCP continues to advocate funding for particular strategies that have weak or no scientific evidence. Examples of these include the $85 million to Colombia to fund rule of law, human rights, and judicial programs that have no scientific basis for impacting the price or purity of cocaine here in the United States. Second, there is the spending of $336 million drug control in Afghanistan that isn't likely to affect the U.S. heroin markets because, as Mr. Walters explained, the United States doesn't get our heroin from Afghanistan. While these policies may serve other

national interests, justifying this part of the drug control budget is difficult at best.

As I am sure this committee is aware, although ONDCP has been advocating the National Youth Anti-Media Campaign, three different evaluations of the campaign have shown that the campaign has had absolutely no effect on drug use among youth. At the same time, they are ignoring significant research showing that expansion of the pharmacotherapies—in particular, methadone maintenance and buphenorphine—and evidence-based school curriculum could have a very significant effect on the prevention strategies. Instead, it chooses to emphasize policies, such as random drug testing, for which the research is relatively thin.

The final point is that it narrowly represents the current U.S. drug problem. As Mr. Carnevale has already explained, the drug problem in the current strategy is largely expressed in terms of youth drug use and in workplace drug testing. Nowhere does it discuss the important indicators of chronic drug use, such as race or dependence, overdose, and HIV, which are common measures used in other western countries for describing the drug problem. This is not something that we are advocating because it is a silly idea; this is what other countries do to help measure their drug problem, and it should be considered as part of our drug problem, at least measures of performance in tackling the problem.

The current strategy does make three important contributions that I would like to highlight. First, the focus on brief interventions and screening in the medical profession is a great idea and should be encouraged, and I am pleased to see the strategy does so. Second, it appropriately considers policies on a drug-by-drug basis. Given that the supply and demand for each of these substances differs so substantially, the mix of policies really depends on the drug you are considering. And, finally, the strategy gives serious consideration to the relevance of data collection by pouring more funding back into the collection of information through the National Survey of Drug Use and Health and ADAM. All of these I view as very important steps in a positive direction to help us improve our understanding of the drug problem here in the United States.

[The prepared statement of Ms. Pacula follows:]

TESTIMONY

What Research Tells Us About the Reasonableness of the Current Priorities of National Drug Control

ROSALIE LICCARDO PACULA

CT-302

March 2008

Testimony presented before the House Oversight and Government Reform Committee, Subcommittee on Domestic Policy on March 12, 2008

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Rosalie Liccardo Pacula[1]
The RAND Corporation

What Research Tells Us About the Reasonableness of the Current Priorities of National Drug Control [2]

Before the Committee on Oversight and Government Reform
Subcommittee on Domestic Policy
United States House of Representatives

March 12, 2008

Chairman Kucinich, Ranking Member Issa, and distinguished Members of the Subcommittee, thank you for inviting me here today. I am honored to appear before you to discuss the reasonableness of the national drug control priorities set forth in the 2008 National Drug Control Strategy and the Fiscal Year 2009 National Drug Control Budget. To clarify my perspective, I am a Senior Economist and Co-Director of RAND's Drug Policy Research Center. RAND is an independent, non-profit, non-partisan policy research organization.

As an economist, I tend to examine policy in terms of its impact on markets and behavior and in terms of the policy's cost-effectiveness vis-à-vis other strategies with similar objectives. My testimony today reflects this perspective, but it represents only my own opinion and not that of RAND.

On its surface the 2008 National Drug Control Strategy proposes a balanced approach to reducing drug use within the United States by emphasizing the three primary objectives this Administration has set forth since it took office in 2002: stopping use before it starts, healing America's drug users, and disrupting illicit drug markets. In practice the budget and implementation of the Strategy are far from balanced. As in previous years, the budget allocation supporting each of these objectives reflects the continuation of a supply-reduction strategy that began decades ago. Domestic law enforcement, interdiction, and international programs represent 65.2% of the requested budget for FY2009, growing at a rate of 6.1% over the enacted amounts in FY 2008, while treatment and prevention programs represent only 34.8% of the total budget, declining by1.5% over enacted spending last fiscal year (ONDCP, 2008). Moreover, the ONDCP budget continues to omit large items from the enforcement side of the budget, namely the costs of prosecuting and incarcerating

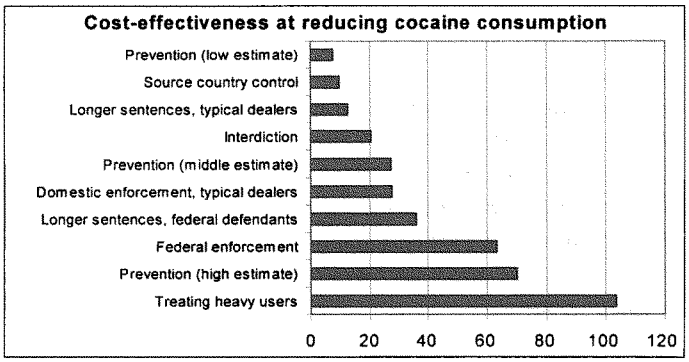
[1] The opinions and conclusions expressed in this testimony are the author's alone and should not be interpreted as representing those of RAND or any of the sponsors of its research. This product is part of the RAND Corporation testimony series. RAND testimonies record testimony presented by RAND associates to federal, state, or local legislative committees; government-appointed commissions and panels; and private review and oversight bodies. The RAND Corporation is a nonprofit research organization providing objective analysis and effective solutions that address the challenges facing the public and private sectors around the world. RAND's publications do not necessarily reflect the opinions of its research clients and sponsors.
[2] This testimony is available for free download at http://www.rand.org/pubs/testimonies/CT302/.

drug offenders in the federal system, which may well add as much as $5 billion to total expenditures. Thus, the actual budget being allocated to enforcement is under-represented.

The problem with this unbalanced approach becomes clear if you understand the epidemic nature of drug problems and the current stage of the expected epidemic for each major drug of abuse in the United States today (Caulkins, 2007; Behrens et al., 2000; Behrens et al., 1999). The current mix of enforcement, prevention and treatment strategies is not the optimal for managing the drug situation we have today. But the problem is not just one of balance in the budget, which implies that simply re-allocating monies across the three primary objectives would fix the problem. The problem is also one of waste. In several areas, the 2008 National Drug Control Strategy advocates continuing or new support for programs that have either (a) never been scientifically proven to be effective and which on analytic grounds seem unlikely to be successful or (b) have already been shown to be completely ineffective. I will draw on the scientific literature to support my point regarding waste as I discuss each of the major sections of the Strategy below.

(1) Enforcement and Supply-Side Strategies

While disrupting markets through supply-side strategies may be effective, RAND research published nearly a decade ago demonstrated that we have far surpassed the point of diminishing marginal returns on our supply-side investments in the cocaine market (Rydell and Everingham, 1994; Caulkins et al., 1997; Caulkins et al., 1999). A more effective and cost-effective way of influencing the U.S. cocaine market involves shifting new investment in drug policy toward effective treatment of hard core users (see Figure 1 below from Caulkins et al., 1999). Work examining the dynamics of drug markets conducted by Jonathan Caulkins and several of his colleagues explains why this is the case. The cocaine market in the U.S. today is a mature drug market, late in the episodic cycle. Although initiation rates are no longer growing and have actually declined, consumption remains high because of heavy and dependent users, who now represent a relatively large fraction of total users due to lower initiation rates (Behrens et al., 2000). The heroin and marijuana are in similar episodic stages, as evidence regarding new initiates is low, but data from treatment facilities and ER mentions shows that dependent use is still a problem.



Source: Caulkins et al., 1999. Numbers on the x-axis reflect kilograms of cocaine averted per million program dollars spent.

According to mathematical models capturing the dynamics of drug epidemics, the gains from prevention and conventional enforcement are much greater in emerging drug markets, when the size of the market is small, there are relatively few dependent users, and these policies can easily target the segment of the population driving growth in use (Caulkins, 2007; Behrens, et al., 2000; Behrens et al., 1999). However, as the size of the market grows and the epidemic becomes mature, treatment becomes a more cost- effective way of reducing use. In addition, it has the additional benefit of reducing the collateral harms associated with dependent use (crime, spread of HIV, etc).

Given that drug markets for our three primary drugs of abuse (marijuana, cocaine and heroin) are all in mature stages, the continued emphasis on supply-side strategies is inappropriate. This is a point that has been made for quite a while by prominent drug policy experts, including Jonathan Caulkins, Mark Kleiman, and Peter Reuter. Nonetheless, since FY 2002, investment in domestic law enforcement, interdiction and international policies have grown at significantly higher rates (31.3 percent, 100.2 percent and 48.4 percent, respectively) than investment in treatment (22.2%) (Carnevale Associates, 2008).

While it is troubling to me that national drug strategy continues to emphasize an approach that does not properly balance prevention, treatment, and enforcement, it is more troubling that some enforcement programs continue to be pursued even though they have no scientific support showing that they impact drug use and there is a good analytic base for skepticism. The cost of producing cocaine (including growing coca and refining it to cocaine hydrochloride) is about one percent of the black market price in the United States. Thus increasing costs in Colombia is very unlikely to have any effect on the retail price in the United States. There is no empirical research showing that payments to the Columbian government to fund Rule of Law, Human Rights, and

Judicial Programs in the amount of $85 million will have any significant impact on the price or purity of cocaine in the United States. Although this might be an effective strategy for achieving other goals, such as increasing stability within the region, this is certainly not a cost-effective drug policy. Similarly, there is no research supporting the notion that paying Afghanistan farmers to divert fields from poppy production (i.e. the Good Performer's Initiative) will influence the price or purity of heroin in the United States. While Afghanistan is by far the world's largest producer of heroin, the fact is that the vast majority of heroin that comes into the United States comes from Colombia, Mexico and Burma (DEA, 2005). So, spending $336 million in Afghanistan is unlikely to influence the heroin market in the U.S., although it may help accomplish other U.S. objectives not specifically part of our National Drug Strategy.

Of course, this is not to say that enforcement has no place in our drug strategy, as we do have two important drugs, methamphetamine and prescription drug abuse, for which enforcement may still be a cost-effective approach. Although methamphetamine use among the household population appears to have remained fairly stable between 2002 and 2007 (0.7% -0.8%), methamphetamine-related admissions to treatment facilities continue to rise (National Drug Intelligence Center, 2007) as have methamphetamine-related hospital admissions (SAMHSA, 2007a; SAMHSA, 2004). The most recent Methamphetamine Threat Assessment reveals that methamphetamine is reported as one of the top two greatest drug threats in 6 out of the 9 regions, demonstrating that the drug is continuing to spread to new parts of the country (National Drug Intelligence Center, 2007). So while some areas in the west struggle with mature methamphetamine markets, there are new and emerging markets in the east where tough local enforcement and prevention can be key to limiting growth of the problem. Prescription drug abuse, on the other hand, is more clearly a broad national concern, with over 10% of high school seniors nationally reporting nonprescription use of Vicodin in the past year and 5% reporting nonprescription use of OxyContin (Johnston et al, 2007).

While enforcement strategies targeting these two drugs are likely to be effective, the bulk of the enforcement activities (and budget supporting it) remains focused on supply-side strategies targeting cocaine, marijuana and heroin, the more mature drug markets. Increasing our spending on interdiction, crop eradication and coordination in Central and South America, is not an effective strategy for influencing either of the methamphetamine or the prescription drug market as neither of these two drugs comes to the U.S. from these regions. Efforts to improve bilateral cooperation with Mexico could be a useful policy to help interrupt the methamphetamine market because Mexico has become a major source of methamphetamine consumed in U.S. markets. But disrupting the black market for prescription drugs requires a whole new set of approaches that are altogether different than those typically used for the other illicit substances and there is minimal research on which to guide this. In the absence of research, those put forth in the Strategy, such as improved domestic intelligence, a crackdown on internet sales of prescription drugs, and assisting

pharmacies with abuse-resistant drugs and capsules, all seem like reasonable approaches to pursue. In the case of methamphetamine, research shows that federal regulation of precursor chemicals used in the production of methamphetamine did in fact influence methamphetamine harms associated with use (Cunningham and Liu, 2003 and 2005). Although the effects of such policies were clearly temporary, the one-year reduction in use and loss of momentum in the spread of the drug market was well-worth achieving.

(2) Prevention Strategies

Prevention is another important element of effectively combating an emerging drug problem, like what we are experiencing with methamphetamine and prescription drugs today (Caulkins, 2007; Behrens, et al. 1999). Here again, however, the 2008 National Drug Control Strategy fails to provide a scientifically supported approach for accomplishing this important goal and instead emphasizes two questionable alternatives: student drug testing and the National Youth Anti-Drug Media Campaign.

Peer-reviewed scientific research evaluating the effectiveness of random drug testing in schools is extremely sparse and far from conclusive (MacCoun, 2007). The two most notable studies draw completely different conclusions and have significant limitations leaving the central question of whether it works unanswered (Yamaguchi et al, 2003; Goldberg et al, 2007). An ambitious follow-up study to the Student Athlete Testing Using Random Notification (SATURN) project which might have provided important insights into this debate was terminated by the Federal Office for Human Research Protection due to human subject concerns. In addition a careful multi-year evaluation of the National Youth Anti-Drug Campaign found that the campaign had absolutely no impact on marijuana use among youth (Hornik et al., 2003a, 2003b). Although a recent study conducted in two southeastern cities suggests that one particular component of the media campaign did influence marijuana use among a small group of high sensation seeking adolescents (Palmgreen et al., 2007), the generalizability of those findings is questionable. A more rigorous study conducted on adolescents throughout a single Midwestern state found that weekly exposure to Campaign media ads had no impact on marijuana use even among high-risk adolescents (Longshore et al., 2006). However, the Longshore et al (2006) study did show that there were synergistic effects of exposure to the Campaign when it was combined with the ALERT Plus classroom-based drug prevention curriculum. They conducted a randomized experiment where youth in some schools received just the ALERT Plus curriculum, some received just exposure to the media Campaign, and some received a combination of the curriculum and the ads (Longshore et al., 2006). The results show that weekly exposure to anti-drug media messages did have a statistically significant deterrent effect on past month marijuana use among all adolescents exposed. This is consistent

with other studies that have evaluated the impact of anti-tobacco and anti-drug media messages (Pentz, 2003; Flay 2000; Flynn et al, 1994, 1997).

So in light of the well-documented failure of the National Youth Anti-Drug Media Campaign, ONDCP's continued promotion of this as a cornerstone of its prevention policy is puzzling. If coupled with the broad adoption of evidence-based drug prevention curricula in the classrooms it would make more sense, but the current National Drug Control Strategy does not propose such a coordinated approach. In fact, there is no discussion about using school-based drug education as part of a comprehensive strategy, and funds supporting school-based programs continue to be fragmented across Federal agencies.

ONDCP has thus missed an opportunity to demonstrate leadership in promoting school-based drug prevention curricula. Research clearly shows school-based drug prevention curricula can be effective, cost-effective, and socially beneficial due to the societal savings generated from reduced consumption of illicit drugs, alcohol and tobacco (Caulkins et al., 2002; Caulkins et al., 1999). Moreover, some studies show that particular programs have demonstrated improvements in general academic performance and school success in addition to diminishing substance abuse among youth (LoSciuto et al., 1996; Eggert et al, 1994).[3] So there are additional benefits to society that can be achieved through these programs. According to a recent ONDCP report, expenditure on prevention activities by Single State Agencies (SSAs) responsible for alcohol and other drug programs within the state was overwhelming supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) Block Grant funds (60-67% of total expenditures) while state funds and other federal funds accounted for relatively smaller shares (18-21% and 14-18%, respectively) (ONDCP, 2006). Given that the Federal government funds the bulk of prevention services delivered within the states, ONDCP as the coordinating agency for all federal agencies and departments is in the most advantageous position to lead the prevention system toward the adoption of scientifically-proven programs that would be effective at combating the initiation of methamphetamine and prescription drugs as well as marijuana and other drugs.

(3) Treatment Strategies

When considered as the late stage of a dynamic cocaine and heroin drug epidemic, the current drug problem in the United States today is best managed through the treatment of heavy and dependent users. Yet, treatment remains a relatively under-funded tool, as indicated by a variety of different measures including its small budget share, its slower growth rate vis-à-vis drug enforcement strategies, and the persistently large number of dependent users who remain in need

[3] See CSAP, 2002 for a summary of those programs and the research supporting them. It can also be accessed on-line at http://modelprograms.samhsa.gov.

of treatment in the United States. Data from the National Survey on Drug Use or Health show that the fraction of the U.S. household population 12 years of age and older meeting DSM-IV criteria for cocaine, heroin and marijuana dependence has remained remarkably stable between 2002 and 2006 (SAMHSA, 2007c), even though overall funding for treatment has increased slightly over the same time period. Further, data from the Treatment Episode Data Set (TEDS) shows that treatment admissions for opiates, stimulants (largely reflecting methamphetamine) have all been on the rise over this time period (SAMHSA, 2007b).

The FY09 Drug Control Budget includes only very modest increases in treatment funds for some key populations. For example, there is a proposed $2 million increase in funds to support inmate treatment programs through the Bureau of Prisons, a $17.9 million increase to improve treatment services within the Department of Veterans Affairs, and a $27.9 million increase for treatment delivered through adult, juvenile and family drug courts. All three of these systems have been studied extensively and research continues to show that treating individuals within these systems is both effective and cost-effective (McCollister et al., 2003; Marlowe, 2003; Belenko, 2001).

The modest increase in treatment resources for these critical populations is a positive step, but I am concerned about cuts in treatment for other vulnerable populations via the $112 million reduction in funds allocated to the Other Treatment Capacity Program. Funding through this program supports capacity building and regulatory activities related to Opioid Treatment Programs as well as the delivery of treatment services to homeless populations and to those suffering from HIV/AIDS. It is the reduced funding to improve our capacity to deliver opioids treatment programs that is most troublesome. There is extensive research demonstrating the effectiveness and cost-effectiveness of methadone maintenance, buprenorphine and other pharmacotherapies as effective strategies for managing addiction to heroin and other substances (Barnett et al., 2001; Barnett 1999; NIH Consensus Statement 1997).

Just increasing funding to make treatment services available to key populations is not sufficient for developing a coherent treatment strategy. Research on the U.S. treatment system clearly shows that significant organizational, structural and regulatory barriers remain that influence the individual's access to, quality of, and cost of substance abuse treatment (Burnam and Watkins, 2006; Weisner et al., 2004; McLellan et al., 2000). For example, the separate public financing and regulation of substance abuse treatment and mental health treatment poses major challenges for people suffering with co-occurring disorders. Furthermore, many people are unable or unwilling to admit they have a need for treatment. While aspects of the 2008 National Drug Control Strategy attempt to address this latter issue related to access, by funding Screening, Brief Intervention, Referral and Treatment (SBIRT) initiatives and drug courts that can help identify people in need of

treatment, the Strategy falls far short in attempting to deal with the organizational, structural and regulatory barriers that remain..

As the designated agency responsible for coordinating initiatives and improving our anti-drug efforts, the Office of National Drug Control Policy (ONDCP) is in the ideal position to take a leadership role in developing strategies that create incentives for agencies and providers to overcome these barriers. ONDCP appears to recognize this role and took a very small step in that direction with the increase in funds in the 2008 Strategy to support the continued adoption and implementation of the screening and brief intervention codes into standard health care coding systems used by the Centers for Medicaid and Medicare, the American Medical Association, and other relevant health care agencies. But the Strategy does not go nearly far enough. There are a number of additional steps ONDCP could take to overcome barriers and ensure that substance abuse services are delivered in a more integrated fashion including support services, aftercare services, and integration with medical care services so that it is dealt with using a more chronic disease model (Parthasarathy et al., 2003; McLellan, Kleber and Carise, 2003; McLellan et al., 2000;. Burnam and Watkins, 2006) For example, ONDCP can challenge state laws that allow insurance companies to deny coverage for emergency room visits that involve alcohol or illicit drugs by encouraging Congress to adopt laws forbidding these exclusions. State laws disallowing coverage for these episodes encourage attending medical personnel to ignore or leave undocumented substance abuse disorders that might otherwise be detected and properly treated because of concerns that the hospital would not be reimbursed for costs incurred (Rivera, et al., 2000). Similarly, ONDCP could work with SAMHSA to make sure that grantees receiving Block Grant funds develop programs that provide continuing care services to those being released from correctional programs, residential programs, or intensive outpatient programs.

Another important step would be to advocate for the expansion of insurance coverage to include substance abuse disorders or to cover these disorder at a level consistent with other medical conditions, a concept known as parity. In 2007, only 14 of the 36 states recognized by the National Alliance for Mental Illness as having enacted and implemented parity legislation include substance use disorders as a covered illness and two of these states only cover substance abuse services for those with a diagnosed mental illness. Thus, patients in need of substance abuse treatment may be deterred from accessing treatment because they have insufficient insurance to help pay for the treatment.

The National Institute for Drug Abuse (NIDA) and SAMHSA have made significant investments in research that strive to better understand the organizational, structural and regulatory barriers that interfere with the delivery of effective substance abuse treatment. By drawing on the science that has already been developed, ONDCP could develop a much more useful treatment strategy that if

successful could have a much larger impact on the market for illicit drugs than its current enforcement strategies.

(4) Some General Issues About the Goals and Indicators Offered in the National Drug Control Strategy

In addition to the concerns raised above regarding the lack of emphasis of effective and cost-effective strategies, I believe a major limitation of the 2008 National Drug Control Strategy is its narrow representation of the U.S. drug problem. In most instances, the Strategy describes the U.S. drug problem in terms of youth prevalence rates and provides only minimal discussion of adult use rates. It is misleading to say that a strategy is working without considering how the strategy influences the whole spectrum of use (initiation, duration, dependence, and harms from use). Indeed, it is standard for other countries to report indicators associated with chronic use as a way of measuring the current drug situation (EMCDDA, 2007; Siggins Miller, 2001). The current National Drug Control Strategy makes no statement regarding trends in important indicators such as rates of dependence, drug overdoses, or the spread of HIV/AIDS and/or Hepatitis C. Without considering these important measures of chronic use, it is inappropriate to claim the success or failure of any strategy.

It should also be noted that a simple examination of trends is insufficient to determine the success or failure of any drug policy. While it is true that youth marijuana prevalence rates have been declining since 2002 as reported in the 2008 Strategy, it is also true that the decline began back in 1998 and the same downward trend in youth prevalence rates for marijuana has been reported in other Western countries in recent years (Johnston et al., 2007; EMCDDA, 2007). The fact that trends in marijuana use in the U.S. rates among youth parallel those observed in other Western countries suggests that the downward trend observed here may not have much to do with U.S. policy.

Finally, I fully support the current request in the 2008 Strategy to fund additional data collection, through the continuation of the NSDUH survey, the resurrection of the ADAM survey in select jurisdictions, and the collection of performance outcome measures for treatment. All of these efforts provide vital information for gauging different elements of the market and are necessary if we hope to ultimately understand the effectiveness of policy. However, I would like to add to these efforts a request made by the 2001 National Research Council (Manski et al., 2001), which suggested that greater effort should be placed on collecting indicators of drug markets, particularly price, purity, and the size of these markets, because only then will we be able to conduct the necessary science that can reasonably guide our policies in the future. While I disagree with the conclusion that the existing STRIDE data are inappropriate for conducting policy analyses and am completing a paper

addressing this issue (Arkes et al., 2008), the STRIDE data are frequently used inappropriately and such inappropriate use of the data can lead to fundamentally different conclusions regarding the impact of policy.

(5) Conclusions

Research at RAND and elsewhere indicates that a greater emphasis placed on treating the chronic users in our mature drug markets and tracking measures of our success with this group would be more effective at addressing this nation's drug problems. Today, too much emphasis is placed on supply-side strategies that offer too little of a return given the stage of the epidemic we are in with cocaine, heroin and marijuana. Enforcement strategies targeting methamphetamine and prescription drugs are likely to provide high returns, given that these markets are less endemic, but the mix of strategies needs to be thoughtfully considered in light of the nuances of these markets.

The National Strategy needs to do a better job of reflecting the current wisdom that has come from scientific evaluation of drug markets. Although data have been weak in some areas, careful evaluations have been done in others, and the Strategy fails to reflect the knowledge gained from these analyses (e.g. the effectiveness of treatment and prevention, the failure of the National Media Campaign). In some cases evaluation of a policy is not entirely possible, but strong analytic arguments can be made for why a particular policy will or will not work.

The Strategy in its current form is neither balanced nor cost-effective, and as such, suggests a need for Congress to carefully scrutinize the structure of the budget request. By cutting the budget for programs lacking scientific support or strong analytic arguments and reallocating those funds to program areas that are known to be effective, the nation will have a much better chance of successfully reducing substance abuse and its many costs on society. This would produce a Strategy that more closely addresses the drug situation that exists here in the United States. I would be happy to answer any questions you may have at this time.

References

Arkes A, RL Pacula, S Paddock, J Caulkins, and P Reuter (2008). "Why the DEAs STRIDE Data are Still Useful for Understanding Drug Markets." RAND, Santa Monica, CA.

Barnett PG (1999). "The Cost-Effectiveness of Methadone Maintenance as Health Care Intervention." *Addiction* 94(4): 479-499.

Barnett PG, GS Zaric, and ML Brandeau (2001). "The Cost-Effectiveness of Buprenorphine Maintenance Therapy for Opiate Addiction in the United States." *Addiction* 96(9): 1276-1278.

Behrens DA, J Caulkins, G Tragler, and G Feichtinger (2002). "Why present-Oriented Societies Undergo Cycles of Drug Epidemics." *Journal of Economic Dynamics and Control* 26(6): 919-936.

Behrens DA, J Caulkins, G Tragler, and G Feichtinger (2000). "Optimal Control of Drug Epidemics: Prevent and Treat – But Not at the Same Time." *Management Science* 46(3): 333-347.

Behrens DA, J Caulkins, G Tragler, J Haunschmied, and G Feichtinger (1999). "A Dynamic Model of Drug Initiation: Implications for Treatment and Drug Control." *Mathematical Biosciences* 159: 1-20.

Belenko S (2001). *Research on drug courts: A critical review 2001 update*. New York: National Center on Addiction and Substance Abuse.

Burnam A and K Watkins (2006). "Substance Abuse with Mental Disorders: Specialized Public Systems and Integrated Care." *Health Affairs* 25(3): 6-48.

Carnevale Associates (2008). "FY02-09 Budget Emphasizes Least Effective Ingredients of Drug Policy." Carnevale Associates LLC Policy Brief.

Caulkins J (2007). "The Need for Dynamic Drug Policy." *Addiction* 102(1): 4-7.

Caulkins J, CP Rydell, WL Schwabe, and J. Chiesa (1997). *Mandatory Minimum Drug Sentences: Throwing Away the Key or the Taxpayers' Money?* MR-827-DPRC, RAND, Santa Monica, CA.

Caulkins J, CP Rydell, S Everingham, J Chiesa, and S Bushway (1999). *An Ounce of Prevention, a Pound of Uncertainty: The Cost-Effectiveness of School-Based Drug Prevention Programs*. MR-923-RWJ, RAND, Santa Monica, CA.

Caulkins J, RL Pacula, S Paddock, and J Chiesa (2004). "What Can We – And Can't We – Expect from School-Based Drug Prevention?" *Drug and Alcohol Review* 23(1): 79-87.

Caulkins J, RL Pacula, S Paddock, and J Chiesa (2002). *School-Based Drug Prevention: What kind of drug use does it prevent?* MR-1459-RWJ, RAND, Santa Monica, CA.

Center for Substance Abuse Prevention (CSAP) (2002). *SAMHSA Model Programs: Model Prevention Programs Supporting Academic Achievement*. Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Cunningham JK and L Liu (2003). "Impacts of Federal Ephedrine and Pseudoephedrine Regulations on Methamphetamine-related Hospital Admissions: A Reply to Reuter and Caulkins." *Addiction* 98(10).

Cunningham JK and L Liu (2005). "Impacts of Federal Precursor Chemical Regulations on Methamphetamine Arrests." *Addiction* 100(4).

Drug Enforcement Agency (DEA) (2005). *Drugs of Abuse*. U.S. Department of Justice, Government Printing Office: Washington, DC.

Eggert LL, EA Thompson, JR Herting, LJ Nicholas, and BG Dicker (1994). "Preventing adolescent drug abuse and high school dropout through an intensive school-based social network development program." *American Journal of Health Promotion* 8(3): 202-215.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2007). *Annual Report 2007: The State of the Drug Problem in Europe*. Luxembourg: Office of Official Publications of the European Communities.

Flay BR (2000). "Approaches to substance use prevention utilizing school curriculum plus social environment change." *Addictive Behaviors* 25(6): 861-885.

Flynn BS, JK Worden, RH Secker-Walker, PL Pirie, GJ Badger, and JH Carpenter (1997). "Long-term responses of higher and lower risk youths to smoking prevention interventions." *Preventive Medicine* 26: 389-394.

Flynn BS, JK Worden, RH Secker-Walker, PL Pirie, GJ Badger, and JH Carpenter, et al. (1994). "Mass media and school interventions for cigarette smoking prevention: Effects 2 years after completion." *American Journal of Public Health* 84(7): 1148-1150.

Goldberg L, DL Elliot, DP MacKinnon, EL Moe, KS Kuehl, et al. (2007). "Outcomes of a prospective trial of student-athlete drug testing: the Student Athlete Testing Using Random Notification (SATURN) study." *Journal of Adolescent Health* 41(5):421-9.

Hornik R, D Maklan, D Cadell, CH Barmada, L Jacobsohn, V Hendersen, et al. (2003a). *Evaluation of the National Youth Anti-Drug Media Campaign: 2003 Report of Findings Executive Summary*. Rockville, MD: Westat.

Hornik R, D Maklan, D Cadell, CH Barmada, L Jacobsohn, V Hendersen, et al. (2003b). *Evaluation of the National Youth Anti-Drug Media Campaign: Fifth semi-annual report of findings*. Rockville, MD: Westat.

Johnston LD, PM O'Malley, JG Bachman, and JE Schulenberg (2007). "Overall, illicit drug use by American teens continues gradual decline in 2007." University of Michigan News Service: Ann Arbor, MI. [Online]. Available: www.monitoringthefuture.org; accessed 03/09/08.

Longshore D, B Ghosh-Dastidar, and PL Ellickson (2006). "National Youth Anti-Drug Media Campaign and school drug prevention: Evidence for a synergistic effect in ALERT Plus." *Addictive Behaviors* 31: 496-508.

LoSciuto L, AK Rajala, TN Townsend, and AS Taylor (1996). "An Outcome Evaluation of Across Ages." *Journal of Adolescent Research* 11(1): 116-129.

MacCoun RJ (2007). "Testing drugs vs. testing users: Private risk management in the shadow of the criminal law." *DePaul Law Review* 56: 507-538.

National Drug Intelligence Center (2007). *National Drug Threat Assessment 2008*. U.S. Department of Justice, Product Number 2007-Q0317-006.

Marlowe DB (2003). "Integrating substance abuse treatment and criminal justice supervision." *Science and Practice Perspectives* 2(1): 4-17.

McCollister KE, MT French, JA Inciardi, CA Butzin, SS Martin, and RM Hopper (2003). "Post-Release Substance Abuse Treatment for criminal Offenders: A Cost-Effectiveness Analysis." *Journal of Quantitative Criminology* 19: 389-407.

McLellan AT, HD Kleber, and D Carise (2003). "The National Addiction Treatment Infrastructure: Can it Support the Public's Demand for Quality Care?" *Journal of Substance Abuse Treatment* 25: 117-121.

McLellan AT, D Lewis, CP O'Brien, HG Hoffmann, HD Kleber (2000). "Drug Addiction as Chronic Medical Illness: Implications for Treatment, Insurance and Evaluation." *Journal of the American Medical Association* 284: 1689-1695.

National Research Council (NRC) (2001). *Informing America's Policy on Illegal Drugs: What We Don't Know Keeps Hurting Us*. Eds. CF Manski, JV Pepper, and CV Petrie. Washington DC: National Academy Press.

NIH Consensus Statement (1997). *Effective Medical Treatment of Opiate Addiction* 15(6):1-38.

Office of National Drug Control Policy (ONDCP) (2008). *National Drug Control Strategy FY 2009 Budget Summary*. Executive Office of the President, the White House. Washington DC: U.S. Government Printing Office.

Office of National Drug Control Policy (2006). *Inventory of State Substance Abuse Prevention and Treatment Activities and Expenditures.* Executive Office of the President, the White House. Washington, DC: U.S. Government Printing Office, NCJ 216918.

Palmgreen P, EP Lorch, MT Stephenson, RH Hoyle, and L Donohew (2007). "Effects of the Office of National Drug Control Policy's Marijuana Initiative Campaign on High-Sensation-Seeking Adolescents." *American Journal of Public Health* 97: 1644-1649.

Parthasarathy S, J Mertens, C Moore, and C Weisner (2003). "Utilization and cost impact of integrating substance abuse treatment and primary care." *Medical Care* 41: 357-367.

Pentz, MA (2003). "Evidence-based prevention: Characteristics, impact, and future direction." *Journal of Psychoactive Drugs*: 143-152.

Rivera FP, S Tollefson, E Tesh, and LM Gentilello (2000). "Screening Trauma Patients for Alcohol Problems: Are Insurance Companies Barriers?" *The Journal of Trauma, Injury, Infection and Critical Care* 48(1): 115-118.

Rydell P and S Everingham (1994). *Controlling Cocaine: Supply Versus Demand Programs*. MR-331-ONDCP/A/DPRC, RAND, Santa Monica, CA.

Miller S (2001). *National Action Plan on Illicit Drugs: 2001 to 2002-03*. Commonwealth of Australia: Canberra, Australia.

Substance Abuse and Mental Health Services Administration, Office of Applied Studies (2007a). *Drug Abuse Warning Network, 2005: National Estimates of Drug-Related Emergency Department Visits*. DAWN Series D-29, DHHS Publication No. (SMA) 07-4256. Rockville, MD.

Substance Abuse and Mental Health Services Administration (2007b). *Treatment Episode Data Set (TEDS): 1995-2005. National Admissions to Substance Abuse Treatment Services*. DASIS Series: S-37, DHHS Publication No. (SMA) 07-4234. Rockville, MD.

Substance Abuse and Mental Health Services Administration (2007c). *Results from the 2006 National Survey on Drug Use and Health: National Findings (Office of Applied Studies.* NSDUH Series H-32, DHHS Publication No. SMA 07-4293). Rockville, MD.

Substance Abuse and Mental Health Services Administration (2004). *DAWN, 2003: Interim National Estimates of Drug-related Emergency Department Visits.* DAWN Series D-26, DHHS Publication No. (SMA) 04-3972. Rockville, MD.

Tragler G, J Caulkins, and G Feichtinger (2001). "Optimal Dynamic Allocation of Treatment and Enforcement in Illicit Drug Control." *Operations Research* 49(3): 352-362.

Weisner C, T McLellan, A Barthwell, C Blitz, R Catalan, M Chalk, L Chinnia, RL Collins, W Compton, ML Dennis, R Frank, W Hewitt, JA Inciardi, et al. (2004). *Report of the Blue Ribbon Task Force on Health Services Research at the National Institute on Drug Abuse.* Rockville, MD: National Institute on Drug Abuse.

Yamaguchi R, LD Johnston, PM O'Malley (2003). "Relationship between student illicit drug use and school drug-testing policies" *Journal of School Health* 73(4):159-64.

Mr. KUCINICH. Thank you very much.

We have been joined by Representative Cummings from Maryland.

I would like to start the questioning talking about the supply side initiatives, and I would like both of the witnesses to respond to the questions. How should we regard the success of ONDCP's source country eradication and interdiction initiatives, including Plan Colombia, in terms of reducing drug abuse domestically?

Mr. Carnevale, let's start with you.

Mr. CARNEVALE. Sir, I think, first of all, to do a proper assessment, we need to have some performance indicators related to those programs, and we do not right now. In the past——

Mr. KUCINICH. So you are saying the only way to really make an evaluation is to have performance indicators?

Mr. CARNEVALE. Is to have performance indicators. We used to look at issues related to prices and purity; we used to look at what we called the trafficker's success rate in getting drugs from source countries into the United States; and we would look at the source country, the trend zone and the reliable zone, and we would measure, based on estimates of flow, how much we were seizing. So these measures no longer exist.

Mr. KUCINICH. So if you don't have performance indicators, you can't assess the performance.

Mr. CARNEVALE. Well, yes, exactly.

Mr. KUCINICH. So if you are playing baseball, you don't keep track of the runs, hits, and errors, batting average and stuff, how do you know?

Mr. CARNEVALE. Yes, that is exactly right.

Mr. KUCINICH. Ms. Pacula.

Ms. PACULA. Yes, I would agree. There was a research publication by Jonathan Caulkins talking about the fact that it is very difficult——

Mr. KUCINICH. Closer to the mic, please.

Ms. PACULA. The indicators that we used to use to look at the impact on total consumption, including the ADAM data, which got scrapped, basically, as of 2003, doesn't exist today to be able to do a careful evaluation of what the impact of these policies were.

Mr. KUCINICH. Do you think it is by design that this information just is not available, or is it just overwhelmed with other objectives? Do you want to offer an opinion on that?

Ms. PACULA. I can't offer an opinion on that, I don't know.

Mr. KUCINICH. Let me ask you something else here, and I will start with Ms. Pacula. How do you view the wisdom of using reductions of youth marijuana usage rates as a key measure of success of the Nation's drug control programs?

Ms. PACULA. I think watching youth marijuana use rates is important, but I think it is very improper to consider success or failure of any strategy based off simple correlations in data. There is a lot of different initiatives and strategies going on, and you need to tease out things that are going on generally in markets to be able to identify the true effect of any particular policy in determining that trend.

Mr. KUCINICH. We are going to have a future hearing just on marijuana policy generally, so we won't get into that much more than that.

Mr. Carnevale.

Mr. CARNEVALE. Yes, I would agree, absolutely agree. First of all, youth drug use is just one indicator of success for strategy. There is drug use initiation, then there is adult drug use, and then there is addiction. And then, of course, we shouldn't be limiting our sights, in terms of performance, just on drug use; there is drug availability and then, of course, there is drug use consequences, health and crime consequences that you had raised earlier. All of these are missing. So, at this point, my view is you can't say the National Drug Control Strategy is successful just because youth drug use is declining.

Mr. KUCINICH. Right.

Mr. CARNEVALE. That is very good news, but it is not the only news, and the rest of the news, I think, is quite bad.

Mr. KUCINICH. Mr. Carnevale, how do you view ONDCP's approach to harm reduction programs such as needle exchange and naloxone? And why do you believe that ONDCP has so strenuously attacked harm reduction programs such as needle exchange programs and naloxone? Is it fair to say that in the wider public policy and public health communities these types of initiatives are relatively non-controversial?

Mr. CARNEVALE. It is hard for me to explain their reasoning because I find their position a little confusing. For example, we do support methadone programs in the United States, which, if you step back, is a form of harm reduction. So we still have a mixed view, I think, coming out of this administration on this very topic.

I can't speculate why this current director doesn't like needle exchange, for example. The issues traditionally boil down to whether or not Federal funds should be used out of the substance abuse block grant for that program. But local governments of a lot, including the District of Columbia, are doing very well with these needle exchange programs, using them for outreach to help get people into treatment.

Mr. KUCINICH. Thank you.

Ms. Pacula, would you like to respond to that at all? Can you add anything?

Ms. PACULA. No, I think that Mr. Carnevale summed it up.

Mr. KUCINICH. OK, thank you. We are going to go to questions.

Mr. Cannon has 5 minutes.

Mr. CANNON. Thank you, Mr. Chairman.

Mr. Tom Siebel of Siebel Systems ran a program a couple of years ago in Montana. Ms. Pacula, are either of you familiar with that program?

Ms. PACULA. RAND is currently being funded by the Meth Project Foundation, which is the program you are talking about, to do an assessment of the economic cost of methamphetamine in the United States.

Mr. CANNON. And Mr. Siebel produced a series of ads that he is going to show in Montana and was going to measure the effect in Montana to try and get some data on how effective that program can be. Are you familiar with that?

Ms. PACULA. I am not familiar with the media campaign; we weren't involved in evaluating any of the programs that he put in place, only in terms of measuring the burden of the problem, the meth problem.

Mr. CARNEVALE. I am familiar with the campaign, but I have not yet seen any evaluations of it. But there is a lot of anecdotal information coming out of the State saying that they are seeing progress, but I am an analyst like Rosalie, and I would prefer to see an evaluation of that program.

Mr. CANNON. And I think that his whole point was to do this in a place where you could actually measure and get some progress. So I take it that we have not had enough time here to actually get some data out of that system to see how well that is working.

Mr. CARNEVALE. I am not aware of any study as of right now on the effect of that campaign.

Ms. PACULA. Yes, I am aware that they are collecting data so that an evaluation can be done, but I am not aware that an evaluation has been done.

Mr. CANNON. Anecdotally, are we seeing significant reductions or do we have any sense of the data there at all?

Mr. CARNEVALE. Well, I am one of these people who agreed with the previous director of NIA that the plural of anecdote is not data, so the anecdotal information is just that. People have a tendency to report good news when they are putting a lot of money into programs, and this program is being promoted, I believe, by the Partnership for Drug-Free America, or at least they are working together with them. So I am hopeful that it is working, but I have not seen any real results.

Mr. CANNON. I think your distinction between anecdotes and mini-anecdotes and data is significant. Do you have a sense that they are actually looking at this that will produce scientific data?

Mr. CARNEVALE. I will defer to you, Rosalie, on that one.

Mr. CANNON. I know you are doing it, obviously, at a pretty high level, at least a part of it, and I suspect that shows a commitment by Mr. Siebel to come up with serious data.

Ms. PACULA. I am familiar with what the Meth Project is trying to do both in Montana, as well as Arizona, and spreading to the other States in which they are promoting the program, and there is a concerted effort to collect reasonable information for measuring the problem. Evaluating the effectiveness of the strategy is important to consider in light of the other State and national programs that are going on, and I don't know to the extent that they are collecting that information to do the full evaluation.

Mr. CANNON. Well, there is a world of data. It will be interesting to see. I found the ads compelling and shocking, and hopefully they will be helpful.

Mr. Carnevale, you talked about e-health care records, and I take it what you are talking about there is just a focus on health records so you can distill from that patterns about illicit drug use.

Mr. CARNEVALE. There is a lot to be gained from the adoption of electronic health records. First of all, when you start talking about electronic health records in the area of substance abuse, you are automatically talking about substance abuse as part of a broader

health care issue, which is an improvement, I think, on how we should be thinking about this issue. That is No. 1.

No. 2, electronic health records are going to produce a lot of information and data in terms of the clients who are being served by these programs, and that information will be very valuable in helping us assess effectiveness of treatment.

Mr. CANNON. Are you talking about e-health records on people who have been convicted of crime and therefore have lost, to some degree, their privacy rights, so you are talking about access to those health records to evaluate drug programs in an environment——

Mr. CARNEVALE. One of the issues of electronic health records is actually to protect the confidentiality and the privacy of drug users. Under one law, 42 C.F.R. Part 2, there are very strict restrictions on how information flows from one doctor to another about a patient's health, and that is one of the issues that is being worked out now by the Substance Abuse and Mental Health Services Administration.

Mr. CANNON. But your focus here is very narrowly on people who have been in drug treatment programs.

Mr. CARNEVALE. Yes.

Mr. CANNON. You are not looking at e-health records to say, oh, there is an up-tick on Percocet use and, therefore, we may be seeing a new trend?

Mr. CARNEVALE. No, although there may be that potential to use this, because when people present for treatment, they are going to be filling out on these electronic health records why they are presenting for treatment, which drugs they have been using. So down the road there is that potential.

Mr. CANNON. We care a lot about the effect of that.

Mr. Chairman, would you allow me to ask one more question?

Mr. KUCINICH. Of course.

Mr. CANNON. Do we have enough data to know if you can fix a person who has been addicted to meth? My experience has been very bleak. Not my personal experience, but with people who have had a problem with meth. We have had a large number of people in my area. Is there a path that we know that works for some, for even a few people that have been addicted to meth?

Mr. CARNEVALE. Congressman, yes. In fact, the Substance Abuse and Mental Health Services Administration is promoting what is called its matrix model in terms of treating meth users, and it has been highly effective. So in terms of treatment protocols, you can expect people to be put into residential programs and perhaps intensive outpatient programs and so on.

But these people are treatable; they can be cured. It may take a longer time; they may have more serious problems in terms of not just their own addiction, but what happens to their children. We talk a lot about drug-endangered children and so on. So there are a lot of other social problems associated with their recovery in terms of getting them back in the community, back in their families, but the answer is yes.

Mr. CANNON. Well, that is hopeful. I have not yet seen much hope.

Thank you, Mr. Chairman. I yield back.

Mr. KUCINICH. To Mr. Cannon, this is one of those areas, given the seriousness of it and what is happening in communities across the country, that we are likely, at some time in the future, to come back and go in-depth into the methamphetamine issue. So you, of course, would be very valuable.

Mr. CANNON. Thank you very much. I actually founded the Meth Caucus and have followed this now for most of my career in Congress. I am deeply depressed about my experience with people who have been engaged with meth and hopefully Mr. Siebel's program will work so we can help people avoid it and then come up with a program that will help people actually get off it. It is horrible.

Mr. KUCINICH. I just want staff to be mindful that we have a bipartisan interest in looking at a future hearing on that.

Mr. Cummings, thank you very much for being here. You may proceed with questions.

Mr. CUMMINGS. Ms. Pacula, am I pronouncing that correctly?

Ms. PACULA. Yes, you are.

Mr. CUMMINGS. If I am not mistaken, you were the co-author of the RAND analysis on the ONDCP, is that right?

Ms. PACULA. On the price purity report, yes.

Mr. CUMMINGS. OK. And that was based on the release of its most recent price and purity estimates in 2004, is that right?

Ms. PACULA. The data went through the third quarter of 2003. I was co-author on the previous report. Did the last report come out?

Mr. CARNEVALE. They did their own report.

Ms. PACULA. Yes, but I am not sure——

Mr. CUMMINGS. So you did up to 2003.

Ms. PACULA. Correct.

Mr. CUMMINGS. And tell me what your findings were, what jumped out at you.

Ms. PACULA. Basically saw a continuation of the declines in the price of both cocaine and heroin over time, well into the early 2002, that we had been observing from before, a continuation of the declines with little blips.

Mr. CUMMINGS. A decline in the price?

Ms. PACULA. Price per pure gram, so adjusted for purity.

Mr. CUMMINGS. So that means it was getting cheaper, is that what you are saying?

Ms. PACULA. Yes.

Mr. CUMMINGS. And so that led you to conclude, I guess, that we weren't being very effective.

Ms. PACULA. We draw no conclusions regarding the effectiveness of any process.

Mr. CUMMINGS. Did you think about it while you were going through it?

Ms. PACULA. Yes.

Mr. CUMMINGS. OK. I am not asking you for your conclusions, I am just asking you what you thought.

Ms. PACULA. Actually, the team that contributed to that report had some very different conclusions regarding what we learned from that study.

Mr. CUMMINGS. And what did they say?

Ms. PACULA. The general discussion was that the price has been falling and it could be interpreted as our policy is not working, but it could also be interpreted as a major change in how these drugs are being produced and delivered that we are not accurately capturing or targeting with our current initiatives.

Mr. CUMMINGS. So, when you have a conflict like that, when you have a mixture there—you have some people saying, well, looks like we are not doing too well, then you have another group saying, well, you know, conditions have changed—how do you all reconcile that? Or do you?

Ms. PACULA. Our purpose of that analysis was simply to generate the price trends given the data. We were not asked to comment or evaluate the policies in that report.

Mr. CUMMINGS. Mr. Carnevale, comment?

Mr. CARNEVALE. My background is policy, but a lot of times looking at the drug prices going back 20 years——

Mr. CUMMINGS. So you are the man.

Mr. CARNEVALE. Well, let me pretend to be at least for the next 5 minutes.

Mr. CUMMINGS. All right, well, you will be the man for the day. All right, go ahead.

Mr. CARNEVALE. Just for the day.

In terms of looking at long-term price declines, in terms of what Rosalie said, she is absolutely right, it has been a long-term decline. There have been some temporary increases in prices where we have seen price adjusted for purity go up, but these have always been transitory. And in evaluations that we did out of my old office of research in the Office of National Drug Control Policy, we would look at things about was there an increase in treatment demand associated with alleged shortages in the market, but we never could find any of that.

In terms of what ONDCP is recording now, I worked with the press and they called a lot of cities—because I don't have a big staff anymore—and they did not see—lots of chiefs of police did not report what ONDCP was suggesting in terms of prices and purity.

Mr. CUMMINGS. And ONDCP was saying that the price was going on.

Mr. CARNEVALE. Price was going up and——

Mr. CUMMINGS. And it was getting scarce.

Mr. CARNEVALE. Getting scarce and——

Mr. CUMMINGS. But the police department heads were saying something else.

Mr. CARNEVALE. They were scratching their heads about this, quite frankly. And the treatment programs we looked at locally were not reporting people suddenly running to treatment because they couldn't find any more cocaine. So it was my conclusion, as a policy person, we were just seeing, if there was an increase—and we have had increases in the past 20 years in certain markets—these tend to be temporary. In my mind, as I always said, as long as there is a demand for cocaine, there will be a supply, and profits.

So I agree with Rosalie in terms of, when thinking about maybe traffickers are changing tactics, more is getting in, but I don't see

much hope in what is going on with drug prices right now in terms of winning the drug war.

Mr. CUMMINGS. So——

Ms. PACULA. Can I add something?

Mr. CUMMINGS. Yes.

Ms. PACULA. We did do some specific analysis with respect to methamphetamine precursor chemical levels, and we did find a very significant temporary effect of these national—and even the State—policies relating to the availability of cold medications on the price series, and they are short-lived. But the fact that they have an effect suggests that enforcement is effective in certain markets for short periods of time.

Why is it not a longer effect is the fundamental question. And I think something that we have to keep in mind when looking at price series is that they reflect supply as well as demand, and supply is not a fixed production process; it is a very fluid process and can change dramatically and very quickly, as we saw the crackdown here in the United States cause methamphetamine to grow in terms of our sources in Mexico. So supply is changing and how it is supplied is changing, and we can't always adequately reflect that in these series. We need to keep that in mind.

Mr. CUMMINGS. And I guess we have to look and try to figure out—I mean, as far as prevention is concerned, do you think the programs we have are effective at prevention?

Ms. PACULA. I believe there are definitely some programs that are very effective in prevention. I don't believe that all the prevention programs being proposed and the strategy are effective.

Mr. CUMMINGS. And which ones do you feel are the most ineffective?

Ms. PACULA. The Youth Anti-Drug Media Campaign.

Mr. CUMMINGS. A little bit louder.

Ms. PACULA. The Youth Anti-Drug Media Campaign has been show in three different evaluations to have no impact on use among youth.

Mr. CUMMINGS. I just need 1 more minute.

It is interesting, a few years ago I had the drug czar—this is about 4 years ago—come to my district, and we took the Media Campaign. We actually had, at random, about 100 kids, high schoolers to look at the commercials to kind of rate them, because back then they didn't seem like they were having any effect on African-American kids. So I figured, you know, let them come in and watch them with the drug czar. And the interesting thing, the only two that they felt were most effective was the one where the person says their brains are frying and the other one was Lauryn Hill, because they said that they felt like she could relate to their lives. Other than that, they said you could throw them all in the trash. And I found that very interesting. And I don't know whether the drug czar did anything with that, but it makes no sense for us to be spending a phenomenal amount of money on a media campaign and it not be getting into the kids' heads.

Mr. CARNEVALE. Congressman, in terms of the study that was done, a really large study that was done that spent over $40 million to evaluate this, it also had the strange finding that the kids exposed to the ads, the Media Campaign ads, tended to have high-

er rates of drug use than those who never saw the ads. So that is something, as a researcher, I would like to know more about that, but as a policy person I think the current budget is $60 million. It used to be close to $200 million. In my mind, it is time for this program to go.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

Mr. KUCINICH. Thank you for raising that issue, because that is critical. One of the hearings we are going to have is going to see peer-to-peer efforts to try to lessen drug usage. Instead of media efforts, peer-to-peer.

We are going to just go to a final round of questions here. We have votes coming up soon.

Mr. Carnevale, can you explain your understanding of the budget reporting issue, including the policy reasons behind the ONDCP's decision to eliminate large portions of the National Drug Control budget in 2003, Congress's efforts to mandate that they be reinstated and how this dispute fits in to larger issues of ONDCP's accountability and priorities?

Mr. CARNEVALE. Congressman, let me just start by saying I completely disagree with Mr. Walters with regard to his decision and his rationale in terms of cutting some of the programs that he cut. Throwing out $4.5 billion worth of money that represented Federal drug control agency spending to me just doesn't make sense if you are trying to have an informed policy. Programs like the Bureau of Prisons, as he said, they are at the receiving end of sort of a process that begins at the front end with someone making an arrest and then prosecution, and then someone being incarcerated. In my mind, to have an informed public policy, we need to know sort of the back-end or downstream cost associated with some of these policies that we have in place.

I, for the life of me, don't know why they have put this appendix table in the back of the budget. I have read it, I looked at it, and there are a lot of programs in there, for example, that fund treatment directly that should be part of the budget, and in my mind—and I was around at the origins of this drug budget methodology back in OMB back in 1985, when we started to estimate a comprehensive budget, and I, for the life of me, can't understand why we are now throwing out so much of this money that——

Mr. KUCINICH. What is the practical effect of the direction we are going in right now?

Mr. CARNEVALE. Well, it means, in terms of your job and Congress's job and the administration's job to come up with a rational drug policy and really understand how it is working, you are not going to be looking at a lot of programs that are drug related or have impacts.

As I said before, if we decide to give DEA a lot more money for its mobile enforcement team program, where it goes out into communities and makes arrests, these are Federal arrests, and it is going to affect the Bureau of Prisons. And I think it is important that we think about the downstream costs, and if we don't, the Bureau of Prisons will have no avenue to sort of express itself in terms of the impact of these kinds of——

Mr. KUCINICH. It was interesting hearing your testimony at the beginning, Mr. Cummings. He talked about the fact that there

hasn't been changes in a number of areas since 2002 that drug use has not changed from 2002 to 2006.

Mr. CARNEVALE. That is correct.

Mr. KUCINICH. That cocaine use has increased.

Mr. CARNEVALE. It is increasing. Overall drug use has remained flat; youth drug use has come down; adult drug use is flat or increasing, basically; addiction rates are unchanged.

Mr. KUCINICH. But when you start to look at the amount of money that is being put out here for these programs and then the lack of metrics, which is the whole purpose of this committee hearing, it puts us in a place where the shifting goals that the ONDCP has adopted really raises the question if they have dropped goals that they can't meet or haven't met. There is even a book, as you are probably aware of it, called Lies, Damn Lies and Drug War Statistics, devoted to exposing these kinds of practices.

Mr. CARNEVALE. Right.

Mr. KUCINICH. Now, this kind of criticism, is it overstated or does it have traction? I mean, is this subcommittee looking at something that you think has merit or are we moving in the wrong direction?

Mr. CARNEVALE. I hope this subcommittee continues to press very hard to get ONDCP to correct this budget. One thing I really, in a sense, feel a little concerned about is the fact that the drug czar has made a very clear statement that this is no longer his problem; he is going to hand it off to the next drug czar in the next administration, and my concern is what do we do. My real worry about drug policy——

Mr. KUCINICH. I was wondering about that myself.

Mr. CARNEVALE [continuing]. As you know, the next administration has a chance to make this office more effective by making it comply with the current law by making it put a performance measurement system in it, do a comprehensive accounting of the budget, to really engage in interagency process, in a dialog about policy, to engage the State and local sector like it used to do. It is not doing a lot of things that it used to do and it is hurting us.

Mr. KUCINICH. And, you know, in truth, we are looking at about 11 full months before a new administration would come in, so it is a lot of money being spent; there are a lot of program directions being made. We are flying blind here.

Mr. CARNEVALE. I agree. Based on this budget, you are not getting the full picture of what the Federal Government is doing with regard to drug control.

Mr. KUCINICH. Well, we are not going to let this go. I mean, this is one thing I know Mr. Cummings and I have the same opinion on. We are going to continue to dig into this. Today was kind of an introductory session, but the thinking that you have just shared with us is something that concerns a number of us on the committee.

Let me just see if I have any followup questions before I go to Mr. Cummings. Again, Mr. Carnevale, can you explain the connection, if any, between the accountability issues that we have discussed here, such as the comprehensiveness of ONDCP's budget its lack of timely and sufficient reporting to Congress, its use of statis-

tics, and its overall success in advancing pragmatic and effective national drug control policies?

Mr. CARNEVALE. I couldn't hear the very first part of that question, Mr. Chairman.

Mr. KUCINICH. Can you explain the connection, if any, between accountability issues that we have discussed and their performance?

Mr. CARNEVALE. No. I mean, at this point, ONDCP does not have any accountability system in terms of its strategy. We cannot attribute the role of treatment prevention, law enforcement, source country programs, interdiction to drug use, in this case youth drug use; and I think ONDCP needs to be held accountable for reporting to Congress. There are a number of requirements under the current law that I simply think ONDCP is ignoring, and I think this committee can do a great service to this country by getting them to comply.

Mr. KUCINICH. We are going to persist.

Mr. Cummings, do you have any final questions?

OK, I just want to say this. We will have some followup questions in writing to submit to ask you to answer, and your ability to give us truly an impartial view is going to enable this committee to do not just effective oversight, but to try to make these programs work.

So, with that, I want to thank the witnesses for their participation. We have just made a beginning here.

This has been a hearing of the Domestic Policy Subcommittee on Oversight and Government Reform, a hearing on the National Drug Control Strategy for 2008, Fiscal Year 2009 National Drug Control Policy and Compliance with ONDCP's Reauthorization Act of 2006: Priorities and Accountabilities at ONDCP. I am Congressman Kucinich, the chairman of the subcommittee. I am here with ranking member, Mr. Cannon. I want to thank all the Members who have participated and the staff that have helped us in our hearing that now has spanned almost 3 hours, with some interruptions for votes.

So to everyone in the audience, thank you. I want to assure you that we will stay focused on these issues as a matter of public welfare and the spiritual welfare of this country.

So thank you. This meeting stands adjourned.

[Whereupon, at 4:55 p.m., the subcommittee was adjourned.]

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