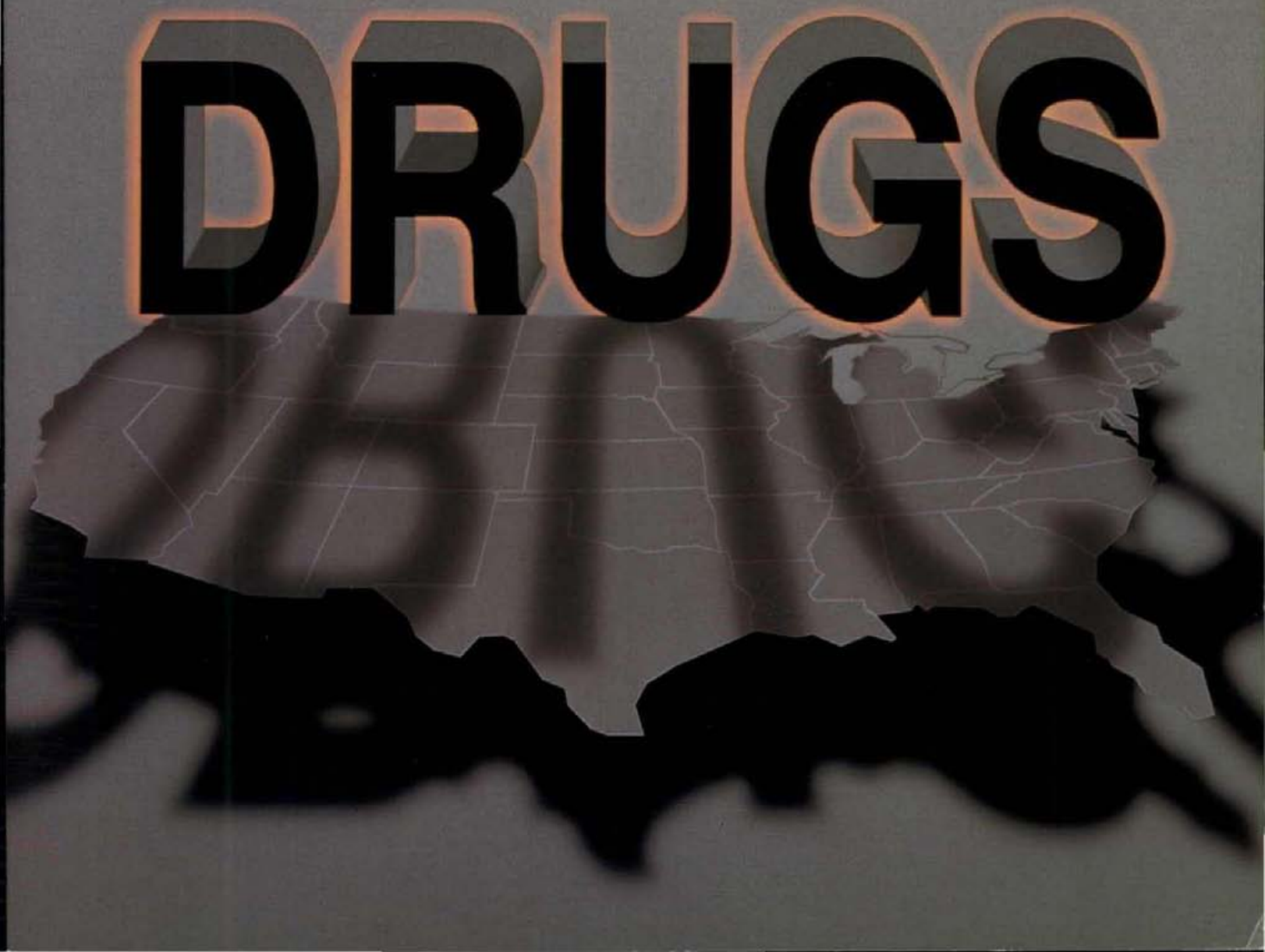
GAO

Special Report From The
Comptroller General Of The United States

Controlling Drug Abuse: A Status Report



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GAO/GGD-88-39

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Message From The Comptroller General Of The United States

Throughout the 1980s, the nation witnessed a great increase in federal drug control efforts. Congress passed two major pieces of legislation, the Comprehensive Crime Control Act of 1984 and the Anti-Drug Abuse Act of 1986, to strengthen existing drug statutes and provide new tools for greater drug control effectiveness. The 1986 act significantly increased the amount of federal money and resources available for drug abuse control. The federal budget for drug abuse control climbed from $1.2 billion in 1981 to nearly $4 billion in 1987. In an era of budget deficits and budget-cutting, this large increase reflects the heightened national concern over drug abuse and drug trafficking.

This report is designed to provide an overview of the drug problem and federal response, particularly for those Members of Congress, the executive branch, and the public who are concerned about the problem but who have not participated in key policy decisions. Our goal is to help these groups better understand the nature and dimensions of the drug problem and federal anti-drug efforts. In this regard, the report should be particularly useful to participants at the White House Conference for a Drug Free America, mandated by the Anti-Drug Abuse Act of 1986, as they assess our drug problems and work to develop more effective national strategies.

The report describes the drug problem in the 1980s nationally and in six major cities (Washington, D.C., New York, Miami, Chicago, Los Angeles, and San Francisco) whose drug problems are among the worst in the nation. It contains indicators of the prevalence of illegal drug use, drug-related hospital emergencies and deaths, and the availability of illegal drugs. We also present information on trafficking and production and the extent and cost of federal drug abuse control efforts.

We plan to periodically update these data in future reports, so Congress can use this information as a baseline and judge whether the funds it provides to the executive branch are having the desired effect.

We collected nationwide data from federal organizations involved in drug control. We also sought local views on the drug problem from law enforcement and health officials in six U.S. cities. Appendix I—Objectives, Scope, and Methodology—describes our data sources and the limitations of the data presented in the report.

This report shows that the supply of and demand for illegal drugs persist nationwide and continue to adversely affect American society, despite significant increases in federal anti-drug efforts. The report also shows that the six cities we visited reflected national trends regarding the availability of major drugs, but problems in each city involving particular drugs, drug forms, and methods of drug ingestion were often unique and localized to that city.

Opinions vary about what the federal government should do to control drug abuse. Experts disagree about which anti-drug programs work best, the proper mix of anti-drug programs, and the level of resources needed to make anti-drug efforts successful. Some experts believe that devoting more resources—money, personnel, and equipment—to law enforcement will reduce the supply of drugs available for use. Others say we must increase our efforts to eradicate drug production in foreign countries and shut off supplies at their source. An increasing number of experts believe that a higher priority and more resources must be assigned to reducing the demand for drugs through programs aimed at preventing drug abuse, treating drug abusers, and conducting research on the causes and cures of drug abuse. Some experts believe that substantial reductions in drug abuse will not occur unless there are fundamental changes in cultural attitudes and values which decrease society's demand for illegal drugs.

During the 1980s, GAO has issued to Congress over 40 reports and has presented numerous testimonies on various aspects of the government's efforts to combat the drug problem. The results of our work do not provide clear-cut answers as to the appropriate mix of anti-drug programs or the priority and level of resources which the federal government should devote to drug abuse control. Such decisions are exceedingly difficult to make and require a broad focus and synthesis of the government's efforts. Unfortunately, the ability of Congress and the executive branch to effectively address the overall issue is greatly hampered by the absence of factual information about which anti-drug programs work best. Existing data systems portray general drug trends and help gauge the overall impact of the federal drug strategy but do not adequately measure the effectiveness of specific federal drug control efforts. Moreover, despite numerous organizational changes, fragmented and uncoordinated anti-drug policies and programs remain obstacles to the success of federal drug abuse control efforts.

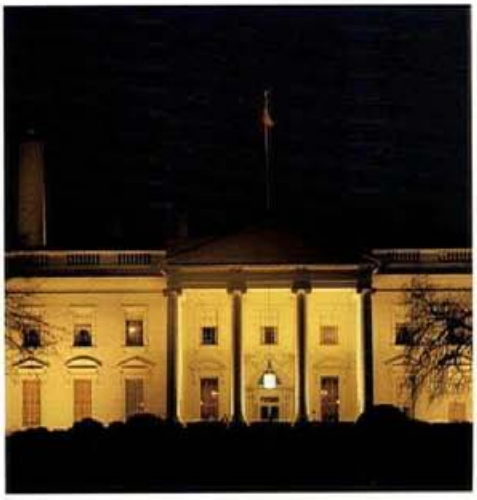
We have repeatedly pointed out problems caused by the fragmentation of federal anti-drug efforts among several cabinet departments and agencies and the resulting lack of coordination of federal drug abuse control policies and programs. Differing agency priorities, interagency rivalries, conflicts, and jurisdictional disputes have impeded drug abuse control efforts in the past, and continue to present obstacles to the success of the government's anti-drug programs. Congress and the executive branch have made several organizational changes over the past 20 years aimed at reducing fragmentation. But those changes have not succeeded in resolving conflicts among federal anti-drug policies and programs.

Additional organizational changes, such as the proposed establishment of a Director of National Drug Control Policy, may help. Organizational changes by themselves, however, are insufficient to accomplish the goal of stronger leadership and more centralized oversight and coordination of federal anti-drug policy. Such changes can succeed only if they are accompanied by a firm and continuing commitment by the President and Congress to resolve conflicts in the government's anti-drug programs.

GAO has conducted numerous reviews of specific federal anti-drug programs since the early 1970s. In our future work, we propose to broaden our focus and concentrate on evaluating the overall effectiveness of drug abuse control efforts. In particular, we will attempt to identify ways to improve Congress' ability to make decisions about which anti-drug programs work best and where limited federal resources should be concentrated.

Charles A. Bowsher

Comptroller General of the United States



U.S. Drug Problem Persists

Drug abuse in the United States has persisted at a very high level throughout the 1980s. Drug abuse is a serious national problem that adversely affects all parts of our society.

The U.S. drug problem has undergone several changes since 1980. Cocaine has emerged as the widely abused drug of greatest concern, and the potent and dangerous "crack" cocaine has become popular in some cities. In the heroin market, Mexican "black tar," a new and crude form of heroin that is high in purity but low in price, has become more widely available. Marijuana use has been declining, according to the National Institute on Drug Abuse (NIDA), but domestic production has increased as has the potency of marijuana available on the market. Various clandestinely produced synthetic substances, known as "designer drugs," have emerged as a significant phenomenon during the 1980s. On the other hand, methaqualone (Quaalude) availability and abuse, a serious problem in the late 1970s, has sharply decreased each year since 1980.

The adverse consequences of drug abuse are serious, not only to the individual user but to society as a whole. Individuals may suffer such adverse effects as death, mental illness, loss of employment, and family disruption. Society suffers the burden of increased crime, violence, public corruption, reduced economic productivity, and various other social ills. A Research Triangle Institute study, *Economic Costs to Society of Alcohol and Drug Abuse and Mental Illness*, estimated that the economic cost of drug abuse to the United States during 1983 was $59.7 billion. This study, prepared for the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), estimated the costs of drug abuse to society for crime (which included lost employment of crime victims and criminal justice and incarceration expenses), reduced productivity, treatment, and other items. The estimate did not include items such as social costs (e.g., family conflict, suicide) and the value of the illicit drugs consumed.

The connection between intravenous (IV) drug use and Acquired Immune Deficiency Syndrome (AIDS) has become a major national and local concern. The Director of NIDA told us in October 1987 that 25 percent of AIDS victims have acquired this disease because of IV drug abuse.

Opposite page, top lft.: Dealing drugs on the street. Opposite page, top rt.: Local police making drug arrest. Opposite page, bottom: Teenagers smoking "crack." Below: Shooting heroin.

Mario Ruiz—Picture Group

Mario Ruiz—Picture Group

Mario Ruiz—Picture Group

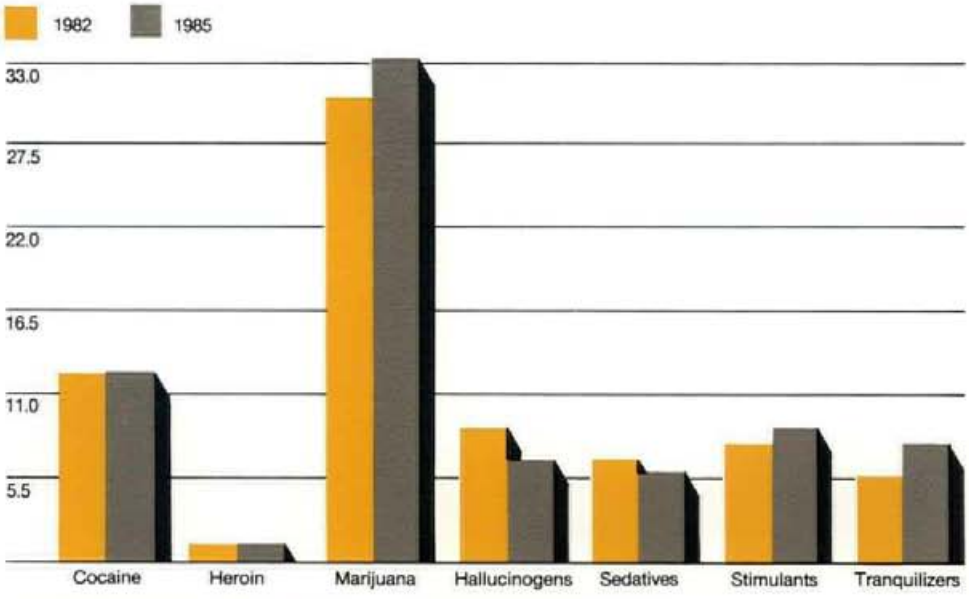
National Indicators Of The Drug Problem

In preparing this report, we reviewed statistical indicators of the national drug abuse situation prepared by federal drug abuse control agencies. The indicators describe the prevalence of drug abuse (the National Survey on Drug Abuse and the High School Senior Survey), the health effects of drug abuse (data on drug-related hospital emergencies and deaths), and the availability of illegal drugs (as reflected, for example, by retail drug prices and purity). Although the indicators have recognized statistical limitations, the agencies that prepare them and the experts who use them believe they reliably portray general trends. Appendix I contains a description of the indicators and their limitations.

Prevalence Of Illegal Drug Abuse In The 1980s

Two key indicators—the National Survey on Drug Abuse and the High School Senior Survey, both funded by NIDA and conducted periodically—describe the levels of drug abuse reported by certain segments of the population. The National Survey on Drug Abuse (also referred to as the National Household Survey) shows that, despite decreased use of some drugs, the overall level of illicit drug use reported by households has remained high. Based on the latest survey in 1985, NIDA projected that 70.4 million people (37 percent of the population over 12 years of age) had used an illegal drug at least once in their lifetime and that 23 million people (12 percent) were current users.[1]

Estimated Percentages Of The Household Population Who Reported Ever Having Used Drugs, 1982 And 1985 (Percent of Population)



Note: For 1982, N=182,481,000. For 1985, N=190,790,000.

Source: NIDA, National Household Surveys, 1982 and 1985.

Estimated Percentages Of High School Seniors Who Reported Ever Having Used Drugs, 1980-1987

	1980	1981	1982	1983	1984	1985	1986	1987
Cocaine	15.7	16.5	16.0	16.2	16.1	17.3	16.9	15.2
Heroin	1.1	1.1	1.2	1.2	1.3	1.2	1.1	1.2
Marijuana and Hashish	60.3	59.5	58.7	57.0	54.9	54.2	50.9	50.2
Hallucinogens[a]	15.6	15.3	14.3	13.6	12.3	12.1	11.9	10.6
Sedatives[b]	14.9	16.0	15.2	14.4	13.3	11.8	10.4	8.7
Stimulants[b,c]	[d]	[d]	27.9	26.9	27.9	26.2	23.4	21.6
Tranquilizers[b]	15.2	14.7	14.0	13.3	12.4	11.9	10.9	10.9

[a] Figures adjusted for underreporting of PCP.

[b] Only non-medical use is reported here.

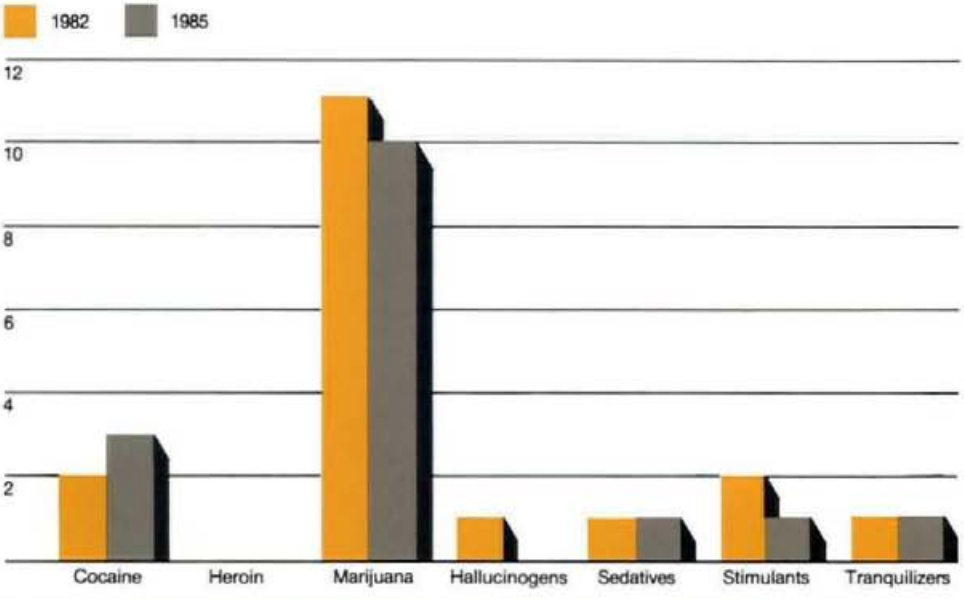
[c] Figures adjusted for the inappropriate reporting of nonprescription stimulants.

[d] Data are not available for these years.

Note: Sample size ranged from 15,200 to 17,700.

Source: NIDA, Monitoring the Future, 1987.

Estimated Percentages Of The Household Population Who Reported Using Drugs In Prior 30 days, 1982 And 1985 (Percent of Population)



Note 1: For 1982, N=182,481,000. For 1985, N=190,790,000.

Note 2: Amounts of less than .5% are not shown.

Source: NIDA, National Household Surveys, 1982 and 1985.

Estimated Percentages Of High School Students Who Reported Drug Use In Prior 30 Days, 1980-1987

	1980	1981	1982	1983	1984	1985	1986	1987
Cocaine	5.2	5.8	5.0	4.9	5.8	6.7	6.2	4.3
Heroin	.2	.2	.2	.2	.3	.3	.2	.2
Marijuana and Hashish	33.7	31.6	28.5	27.0	25.2	25.7	23.4	21.0
Hallucinogens[a]	4.4	4.5	4.1	3.5	3.2	3.8	3.5	2.5
Sedatives[b]	4.8	4.6	3.4	3.0	2.3	2.4	2.2	1.7
Stimulants[b,c]	[d]	[d]	10.7	8.9	8.3	6.8	5.5	5.2
Tranquilizers[b]	3.1	2.7	2.4	2.5	2.1	2.1	2.1	2.0

[a] Figures adjusted for underreporting of PCP.

[b] Only non-medical use is reported here.

[c] Figures adjusted for the inappropriate reporting of nonprescription stimulants.

[d] Data are not available for these years.

Note: Sample size ranged from 15,200 to 17,700.

Source: NIDA, Monitoring the Future, 1987.

On a positive note, the 1985 National Household Survey showed a downward trend from 1982 in the use of most drugs among youth (ages 12 to 17) and young adults (ages 18 to 25). Similarly, the annual High School Senior Survey found a decline in the use of most drugs, except cocaine and heroin, during the 1980 through 1986 period. Declines in cocaine use among high school seniors were noted for the first time in 1987.

The following sections of this report describe the nationwide drug problem and trends in the 1980s for cocaine, heroin, marijuana, and other substances which are categorized as "dangerous drugs."[2] The information comes from overall federal summaries, which are based on a variety of data including the above national surveys and other key drug indicators as well as information on drug trafficking trends. Discussion of the various drugs is followed by a section presenting the views of local officials along with other information from the six major cities we visited (Washington, D.C., New York, Miami, Chicago, Los Angeles, and San Francisco).

[1] NIDA defines a "current user" as an individual who has reported using a drug or substance of abuse at least once within the thirty-day period prior to being surveyed.

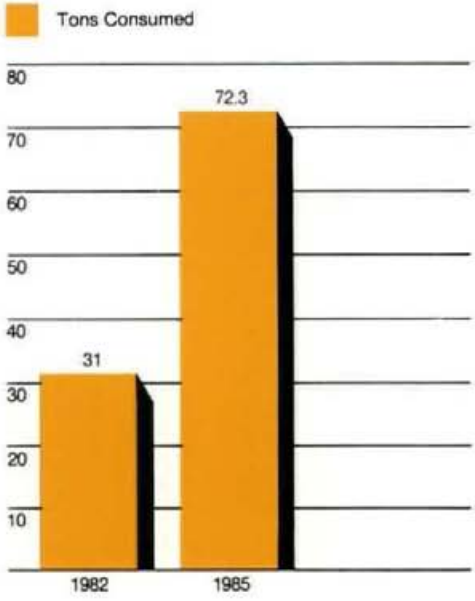
[2] According to the Drug Enforcement Administration (DEA), the term "dangerous drugs" refers to all drugs of abuse except heroin and opium, cannabis products (marijuana and hashish), and cocaine. Dangerous drugs are manufactured legally and illegally, and include tranquilizers, barbiturates, amphetamines, and PCP.

Cocaine

Cocaine is widely acknowledged by drug experts to be the most serious problem drug of the 1980s. According to the Drug Enforcement Administration (DEA), average street-level purity more than doubled from 1981 through 1986, while prices for the drug declined, indicating increased availability. The National Survey on Drug Abuse found that the number of people who had ever used cocaine remained about the same from 1982 to 1985 (from 21.6 million to 22.2 million). However, the number of Americans over age 12 who were current cocaine users increased 38 percent (from 4.2 million to 5.8 million).

The High School Senior Survey found a decrease in reported cocaine use in 1987. The percentage of seniors who had ever used cocaine dropped from 16.9 percent in 1986 to 15.2 percent in 1987, while the percentage of those who had used cocaine in the 30 days prior to the survey fell from 6.2 to 4.3 percent.

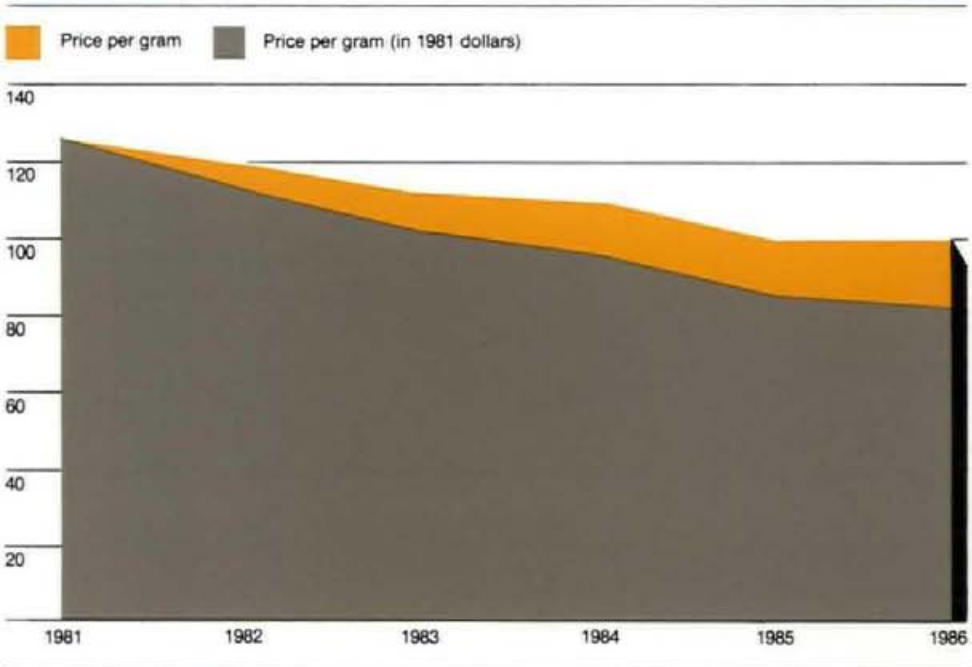
Estimated U.S. Cocaine Consumption, 1982 And 1985 (In Metric Tons)



Note: Metric ton=2,205 pounds.

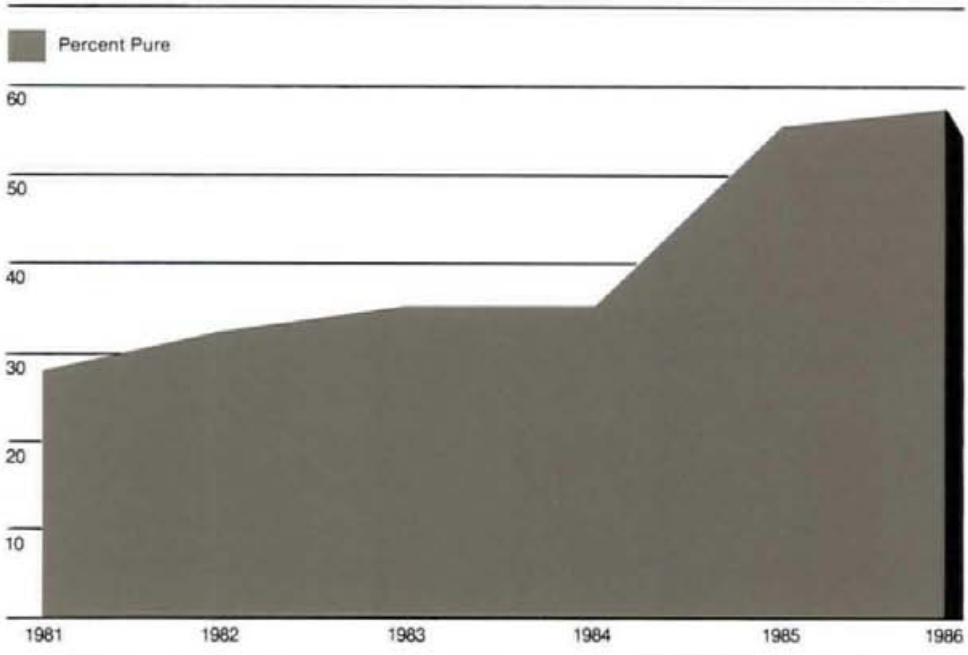
Source: *The NNICC Report 1985-1986.*

Retail Cocaine Prices, 1981-1986 (Dollars per Gram)



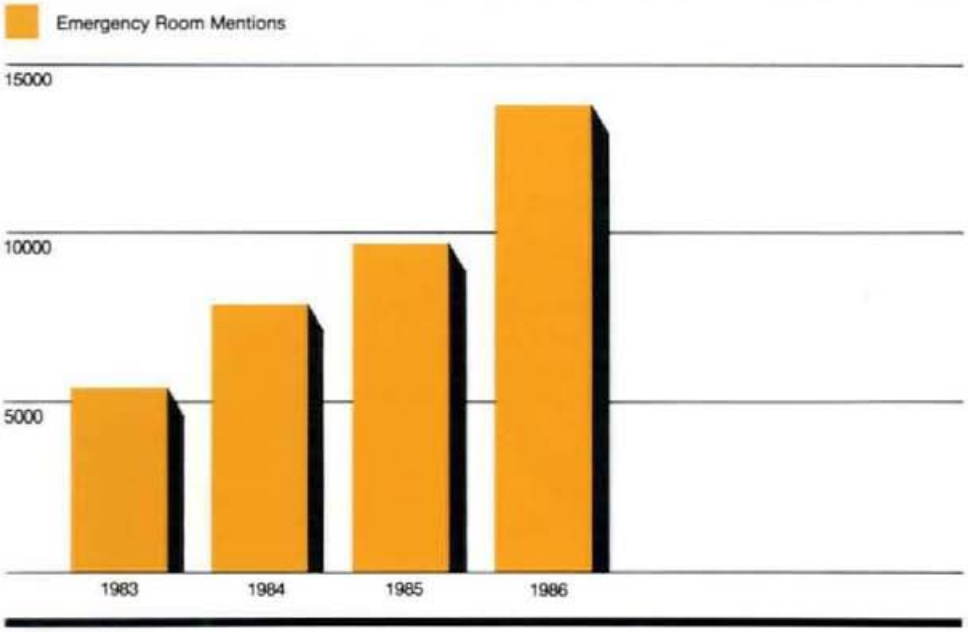
Source: DEA.

Retail Cocaine Purity, 1981-1986



Source: DEA.

Trends In Cocaine-Related Hospital Emergencies Reported Through DAWN, 1983-1986



Note: The figure for 1986 was projected based on data for the first six months of that year.

Source: *The NNICC Report 1985-1986.*

"Crack," a potent and highly addictive form of cocaine, first appeared on the illicit drug market in the early eighties and became widely available in some cities in 1985 and 1986. "Crack" is cocaine hydrochloride powder converted to a base state which is suitable for smoking. It is made by mixing powdered cocaine with baking soda (or ammonia) and water. The mixture is dried, broken into smaller chunks or "rocks," and packaged for sale, often in small plastic vials which sell for as little as $10. "Crack's" low price, according to local law enforcement officials, has made it popular, especially among younger drug users. "Crack" is smoked, is extremely addictive, and can lead the user into more expensive consumption patterns.

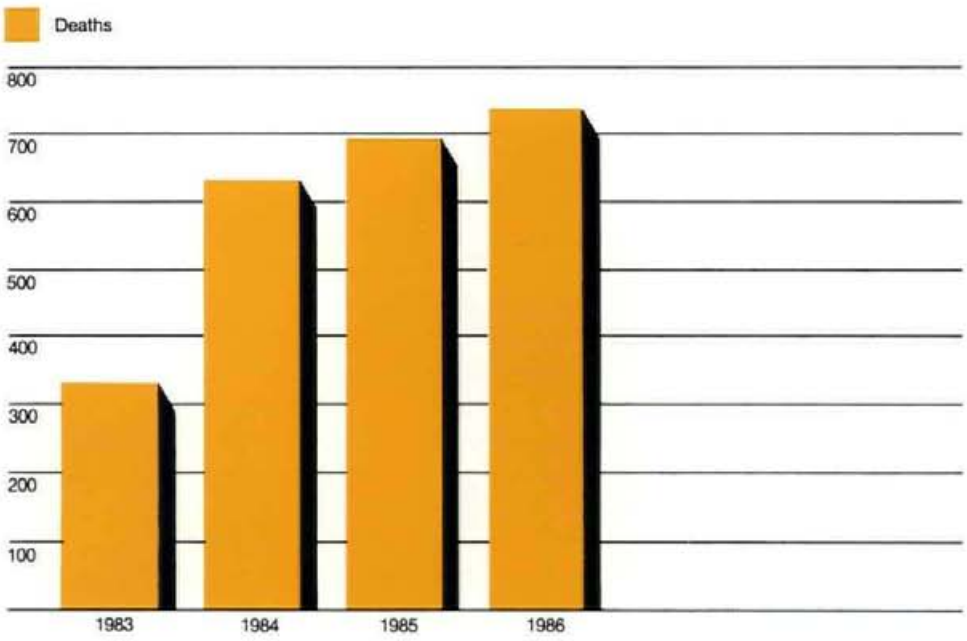
According to NIDA officials, the trend for "crack" use among high school seniors is uncertain because data were not comparable before 1987. However, "crack" may not be following the decline for general cocaine use. In 1987, 5.6 percent of seniors reported ever having used "crack" while 4 percent reported using it in the 12 months prior to the survey.

The survey figures may underrepresent "crack" use among people in this age group—NIDA officials pointed out that dropouts are much more likely to use drugs such as "crack" than are those who stay in school. (See app. I.)

Reported cocaine-related deaths and hospital emergencies increased significantly from 1983 to 1986. The number of cocaine-related emergencies reported by hospitals participating in the Drug Abuse Warning Network (DAWN)[3] rose 167 percent, from 5,223 to a projected 13,938. The number of cocaine-related deaths reported by medical examiners participating in the DAWN system increased 124 percent, from 328 to a projected 734. According to NIDA officials, the trend of increasing cocaine-related hospital emergencies and deaths continued through the first 6 months of 1987.

Cocaine is derived from the coca plant, which is grown mainly in the highlands of Peru and Bolivia. Colombia is the primary location for laboratories that convert coca base and paste into cocaine hydrochloride powder. However, cocaine-processing laboratories are spreading in other South American countries, and they are also being found in the United States; 23 labs were seized in the United States in 1986.

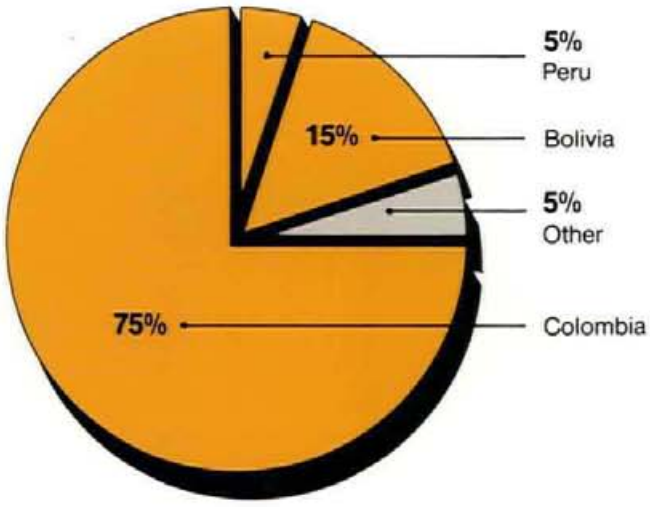
Trends In Cocaine-Related Deaths Reported Through DAWN, 1983-1986



Note: The figure for 1986 was projected based on data for the first six months of that year.

Source: *The NNICC Report 1985-1986.*

Probable Sources Of Cocaine Available In The United States, 1985-1986



Note: Other countries include Argentina, Brazil, and Ecuador.

Source: *The NNICC Report 1985-1986.*

[3]DAWN is a nationwide program that gathers data on drug abuse emergencies and deaths from hospitals and medical examiners in selected locations throughout the United States, according to NIDA. In each reported drug abuse "episode," a patient may "mention" more than one drug. DAWN records and analyzes the number of drug *mentions*. DAWN data reflect *trends* in drug abuse-related hospital emergencies and deaths, but do *not* represent the *total* number of drug abuse-related hospital emergencies and deaths nationwide. As explained in appendix I, the hospital emergency room data in this report are from the DAWN Consistent Panel and the death data are from the total DAWN system.

Major Cocaine Smuggling Routes Into The United States

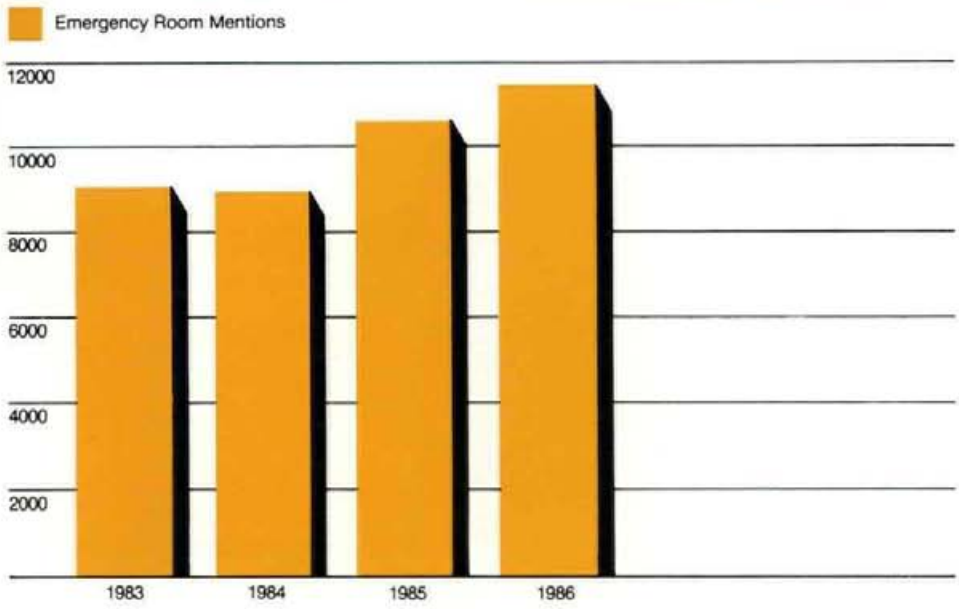
Source: *DEA Quarterly Intelligence Trends, Vol. 13, No. 1, 1986.*

An estimated 75 percent of the cocaine available in the United States is exported from Colombia, according to the National Narcotics Intelligence Consumers Committee (NNICC)—*The NNICC Report 1985 - 1986.* The report also says that the drug is generally transported by aircraft and most of it enters through the southeastern United States. Cocaine smuggling, however, is becoming more dispersed, with increased activity in the Gulf Coast and southwestern states. Air transport from Colombia through Mexico to the United States also appears to be increasing.

Heroin

Heroin appears to be readily available in most parts of the country. Estimates of the heroin addict population remained relatively stable since the 1970s, with the last estimate in 1981 showing approximately 500,000. According to *The NNICC Report 1985 - 1986*, the average age of heroin users has continued to increase and this population consists mostly of long-term users. DAWN data, however, show that the number of heroin/morphine-related emergencies in participating hospitals increased approximately 24 percent between 1983 and 1986 (from 9,178 to a projected 11,416) and deaths reported by participating medical examiners almost doubled from 771 in 1983 to 1,420 in 1986, as projected in the NNICC report.

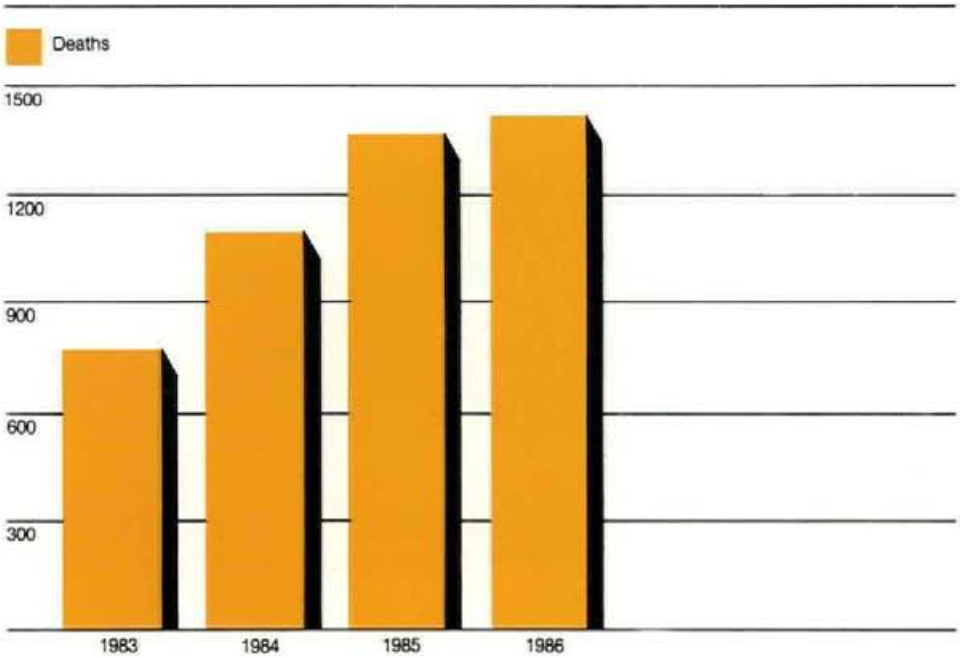
Trends In Heroin-Related Hospital Emergencies Reported Through DAWN, 1983-1986



Note: The figure for 1986 was projected based on data for the first six months of that year.

Source: *The NNICC Report 1985-1986.*

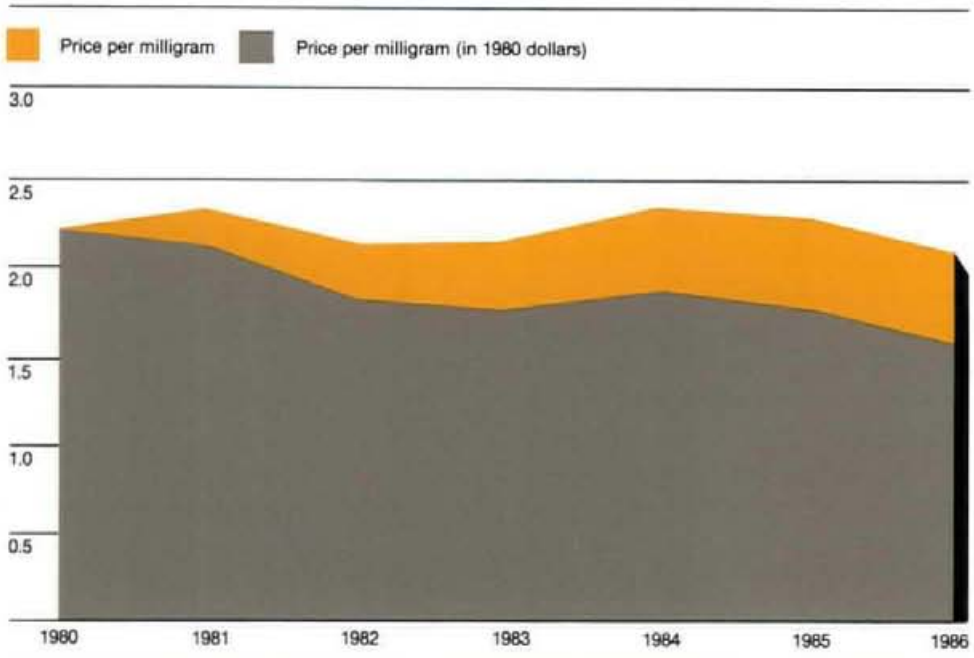
Trends In Heroin-Related Deaths Reported Through DAWN, 1983-1986



Note: The figure for 1986 was projected based on data for the first six months of that year.

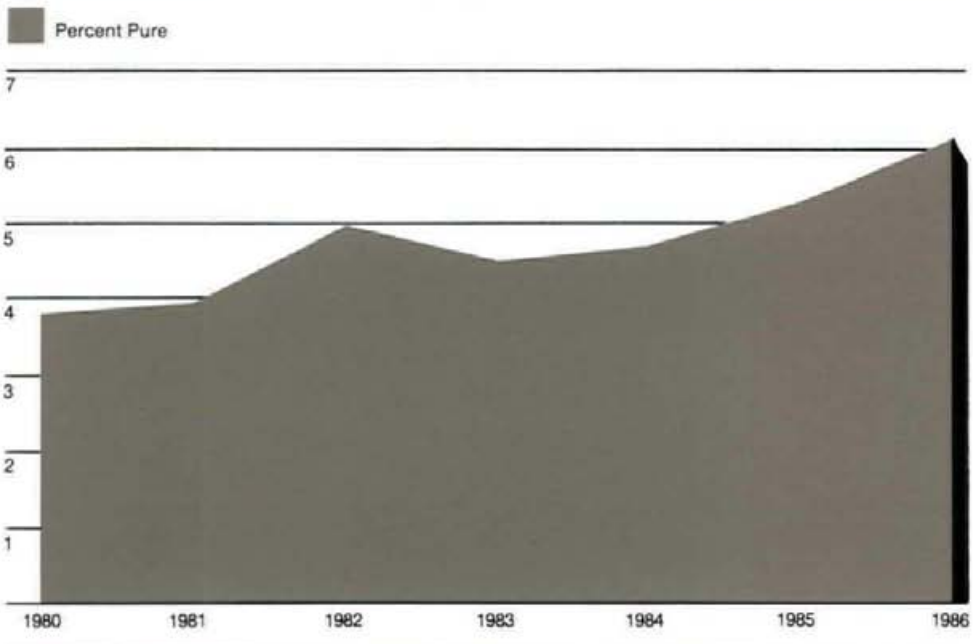
Source: *The NNICC Report 1985-1986.*

Retail Heroin Prices, 1980-1986 (Dollars per Milligram)



Source: DEA.

Retail Heroin Purity, 1980-1986



Note: The purity level for 1986 is for January through June of that year.

Source: DEA.

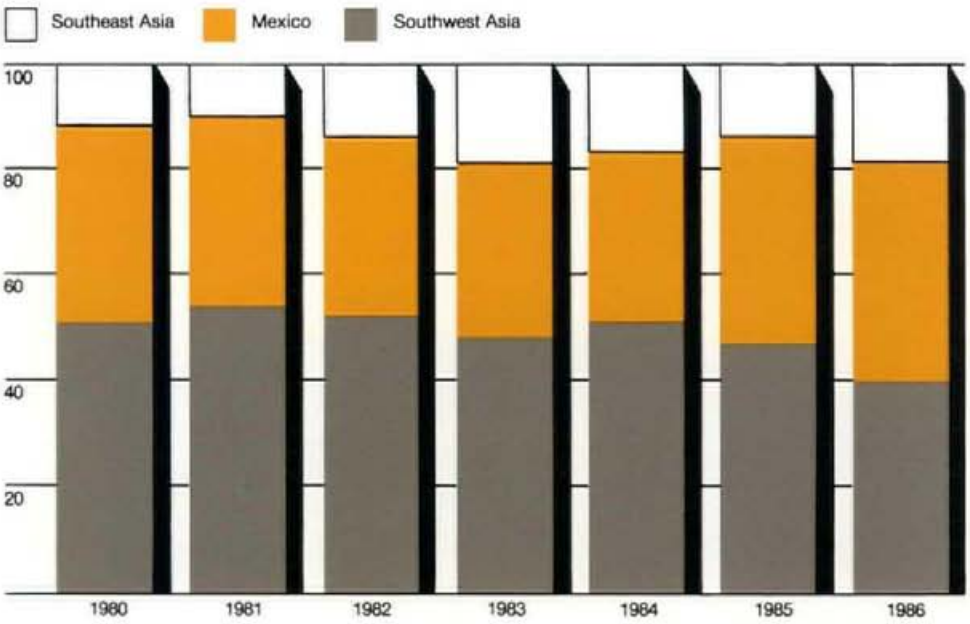
One of the most significant trends in the heroin market during the 1980s has been the emergence of Mexican "black tar," a crudely processed, highly potent form of heroin. While the purity of most heroin on the street ranged from nearly 4 to more than 6 percent over the 1980 to 1986 period, purities of 60 to 70 percent for "black tar" were common. The demand for the drug is due to its low price as well as its high purity. "Black tar" is growing in availability and has been especially common in the western United States. Drug experts believe the drug may be a significant factor in the increased number of heroin-related hospital emergencies.

Drug experts believe that the use of heroin in combination with other drugs is another significant contributor to both emergency room episodes and deaths reported to DAWN. Heroin users have combined heroin with other drugs for years. The combination of heroin and cocaine, called a "speedball," is particularly hazardous. The number of deaths involving this combination reported by medical examiners participating in DAWN rose 754 percent between 1981 and 1985 (26 deaths in 1981 and 222 in 1985).

Injection is the most common method of administering heroin, and the connection between AIDS and IV drug use has become a serious national health concern. As discussed earlier, heroin addicts can contract and spread AIDS through needle-sharing.

The heroin consumed in the United States comes from the opium poppy, cultivated primarily in Mexico, Southeast Asia (Burma, Laos, and Thailand), and Southwest Asia (primarily Afghanistan, Iran, and Pakistan). These three areas yielded approximately 1,500 metric tons of opium in 1985. Of this amount, about 60 metric tons were used to produce the nearly 6 metric tons of heroin available in the United States that year. In 1986, total estimated opium production was increased for these three areas, with estimates ranging from 1,680 to 2,815 metric tons. Most Asian heroin is smuggled into the United States by commercial air passengers and air cargo. Mexican heroin is typically smuggled across the U.S.-Mexico border in vehicles or by pedestrians.

Sources Of Heroin Available In The United States, 1980-1986 (Percent)

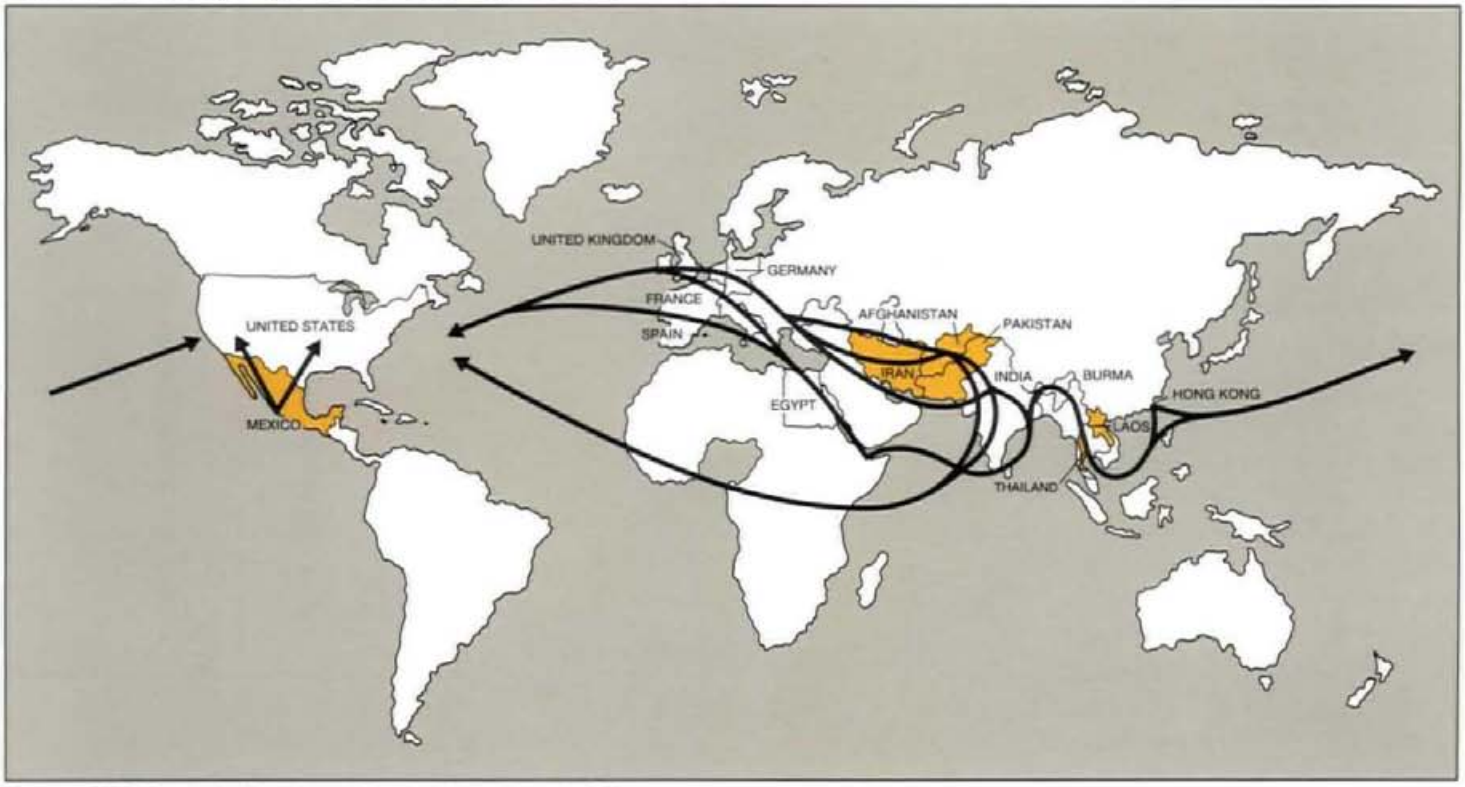


Note: The percentages for 1986 are for January through June of that year.

Source: DEA Heroin Signature Analysis Program.

DEA's chemical analysis of heroin revealed that of the samples analyzed in the first 6 months of 1986, Mexican heroin accounted for 41 percent, Southwest Asian heroin for 40 percent, and Southeast Asian heroin for 19 percent. Comparing these figures with earlier years shows the proportion of heroin supplied by Mexico was higher than at any other time during the 1980s.

Major Heroin Smuggling Routes Into The United States



Source: *DEA Quarterly Intelligence Trends, Vol. 13, No. 1, 1986.*

Marijuana

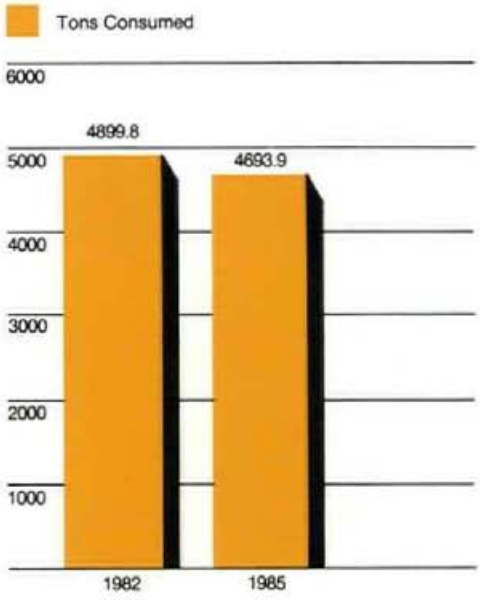
Marijuana use declined in the 1980s, but it remains the most widely used illegal drug in the country. Based on NIDA's 1985 National Survey on Drug Abuse, an estimated 61.9 million people over age 12 had used marijuana at least once in their lifetime and 18.2 million people were current users. This level of use compares to the 1982 estimates of 56.3 million people who had used marijuana at least once and 20 million who were current users. The High School Senior Survey also showed a decline in current users of marijuana[4] (from 33.7 percent in 1980 compared to 21 percent in 1987) and in the percentage of students who had ever used the drug (from 60.3 percent in 1980 to 50.2 percent in 1987).

Marijuana-related DAWN emergencies as reported by participating hospitals increased approximately 25 percent from 1983 to 1986.[5] There were 3,360 emergencies in 1983 and 4,201 emergencies projected for 1986.

[4]Includes hashish, another cannabis product.

[5]In approximately 80 percent of all marijuana-related hospital emergencies reported to DAWN, marijuana was used in combination with other drugs.

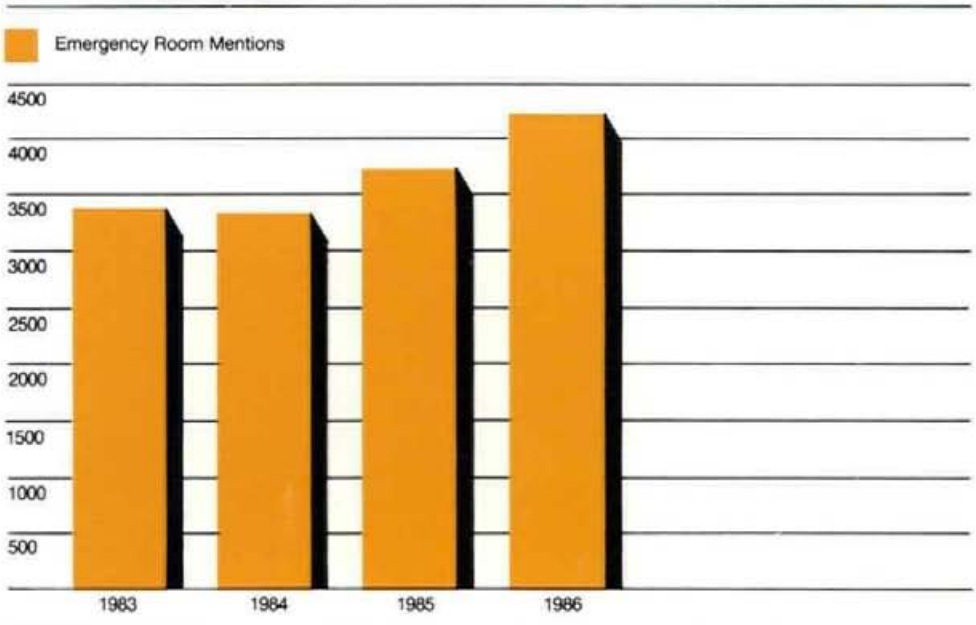
Estimated U.S. Marijuana Consumption, 1982 And 1985 (In Metric Tons)



Note: Metric ton=2,205 pounds.

Source: *The NNICC Report 1985-1986.*

Trends In Marijuana-Related Hospital Emergencies Reported Through DAWN, 1983-1986



Note: The figure for 1986 was projected based on data for the first six months of that year.

Source: *The NNICC Report 1985-1986.*

Probable Sources Of Marijuana Available In The United States, 1986

Country	Quantity (in metric tons)	Percentage of Total Supply[a]
Mexico	3,000 — 4,000	30
Colombia	2,200 — 3,900	26[b]
Jamaica	1,100 — 1,700	12
Belize	500 — 500[c]	4
Domestic	2,100 — 2,100[c]	18
Other	800 — 1,200	9[b]
Gross marijuana available	9,700 — 13,400	100[d]
Less U.S. Seizures, Seizures in Transit and Losses[e]	3,000 — 4,000	
Net marijuana available	6,700 — 9,400	

[a] The percentages reflect the midpoints of the quantity ranges.

[b] NNICC inaccurately reported these percentages as 27 and 8 percent, respectively.

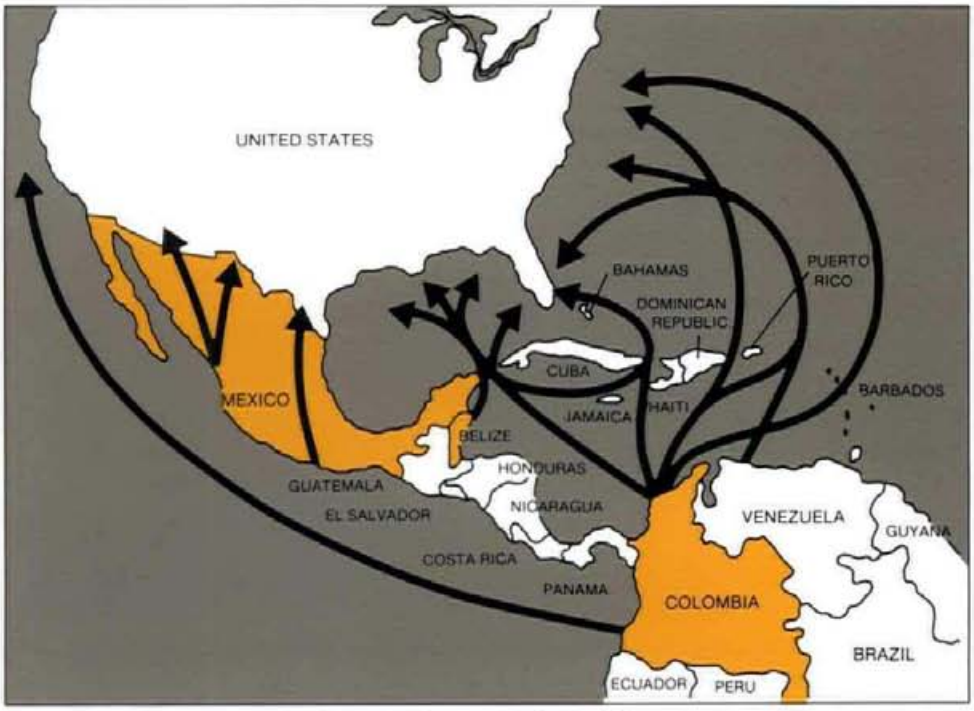
[c] No range was given for these amounts.

[d] Does not add to 100 percent because of rounding.

[e] U.S. seizures include coastal, border, and internal (not domestic eradicated sites); seizures in transit include those on the high seas, in transit countries, from aircraft, etc. The loss factor includes marijuana lost because of abandoned shipments, undistributed stockpiles, and inefficient handling and transport, etc.

Source: *The NNICC Report 1985-1986.*

Major Marijuana Smuggling Routes Into The United States



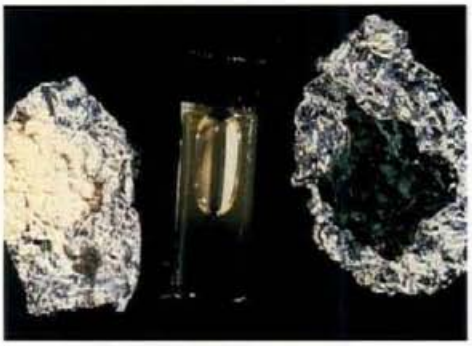
Source: *DEA Quarterly Intelligence Trends, Vol. 13, No. 1, 1986.*

Marijuana continues to be readily available in most areas of the country, with a trend towards increased potency levels. According to the NNICC report, in 1986 approximately 82 percent of the marijuana was smuggled in from foreign countries, with Mexico (30 percent) and Colombia (26 percent) the principal sources.[6] In 1982, 6 percent of the U.S. supply came from Mexico and 57 percent from Colombia.

Federal law enforcement agencies report that traffickers often smuggle marijuana in multiton quantities, and they very frequently use noncommercial marine vessels. Mexican marijuana, however, typically enters the United States in overland vehicles, with smaller loads than marine vessels.

Cultivation within the United States accounted for an estimated 18 percent of the marijuana available in 1986. Despite DEA's assisting the states with eradicating marijuana, domestic supplies still increased between 1980 and 1986. Cultivation takes place in all 50 states. To avoid detection, marijuana growers are moving their operations indoors and are growing smaller and more scattered plots outdoors.

[6] The Department of State provides different estimates of production for Mexico and Colombia (37 and 23 percent respectively, of the total estimated supply).



Dangerous Drugs

The dangerous drugs category includes drugs that are produced illegally, drugs legally produced but diverted to illicit use (e.g., pharmacy thefts, forged prescriptions, illegal sales), as well as legally produced drugs obtained from legitimate channels (e.g., legally and properly prescribed). Some of the most common drugs in this category are lysergic acid diethylamide (LSD), phencyclidine (PCP), methamphetamine, diazepam (Valium), and clandestinely produced substances ("designer drugs") that are chemically similar to drugs covered under federal drug control law.

During the 1980s, dangerous drugs were widely abused. Trends in the use of the various drugs were mixed, with few major changes in the use of most dangerous drugs. However, Methaqualone (a synthetic marketed under the brand name Quaalude) availability and abuse has decreased sharply each year since 1981. This is the result of stringent international controls on bulk methaqualone powder and action taken by the federal government in 1984 to make methaqualone an illegal substance. Manufacture, distribution, or possession of this drug is now illegal in the United States except for research.

Many of the dangerous drugs abused in the United States are manufactured domestically in clandestine laboratories. During 1986, 522 clandestine laboratories were seized in the United States, a 193 percent increase over the 178 laboratories seized in 1981. During the 1980s, most seizures involved methamphetamine, amphetamine, and PCP. Amphetamines and methamphetamines are stimulants produced both legally for medical purposes and illegally as drugs of abuse. PCP was produced legally for use as an animal tranquilizer, but is now only produced clandestinely as a drug of abuse for its hallucinogenic properties. Outlaw motorcycle gangs have traditionally been associated with methamphetamine production, but many different types of groups are involved in the clandestine manufacture of other dangerous drugs.

Trends In Numbers Of Dangerous Drug-Related Hospital Emergencies And Deaths Reported Through DAWN, 1983-1986

	1983	1984	1985	1986[a]
Hospital Emergencies				
Amphetamine	1,537	1,378	1,231	1,280
Methamphetamine	1,371	1,804	1,689	1,649
Methaqualone	1,544	848	384	241
PCP	5,067	4,820	4,259	4,695
LSD	715	666	805	691
Drug-related Deaths				
Amphetamine	47	60	79	48
Methamphetamine	65	79	66	98
Methaqualone	49	11	11	2
PCP	238	230	197	206
LSD	4	1	2	2

[a]Figures for 1986 were projected based on data for the first six months of that year.

Source: *The NNICC Report 1985-1986.*

The "designer drugs" phenomenon emerged during the 1980s. Designer drugs are potent, clandestinely produced synthetic substances that resemble other drugs of abuse. The intent of the clandestine chemists is to manufacture drugs that have the same effects as narcotics, stimulants, depressants, or hallucinogens. Designer drugs have primarily been chemically similar to (analogues of) synthetic narcotics and have substantial health risks. For example, some analogues are estimated to be 1,000 times more powerful than morphine, thus creating a great risk of fatal overdoses. Designer drugs are slightly different in chemical structure, and they were not covered under federal law until the Anti-Drug Abuse Act of 1986. It is too early to tell what effect the new law will have on the threat that designer drugs pose.

Many abused dangerous drugs are obtained legally and properly from doctors and pharmacists. For example, Valium, a tranquilizer used for treating anxiety disorders and other medical conditions, is one of the most widely abused drugs in the country. Valium is frequently prescribed by physicians. Another source of abused drugs falls within a gray area—where the physician misprescribes drugs through carelessness and is unaware that the drugs will be misused. Opinions differ and little information exists on the extent to which abused legal drugs are obtained legitimately or are illegally diverted from legitimate channels.

Dangerous Drug Clandestine Laboratory Seizures In The United States, 1981-1986

	1981	1982	1983	1984	1985	1986
PCP	35	47	39	30	20	8
Methamphetamine	89	133	119	185	266	412
Amphetamine	14	18	25	40	69	63
Methaqualone	13	7	10	4	4	4
Other Drugs	27	14	22	32	33	35
Total	**178**	**219**	**215**	**291**	**392**	**522**

Sources: *Narcotics Intelligence Estimate, 1984* (for years 1981 and 1982). *The NNICC Report 1985-1986* (for years 1983-1986).

Drug Problems — Local Perspectives In Six Major Cities

While drug abuse is a serious national problem, it is not the same throughout the country. Accordingly, we visited Washington, D.C., New York, Miami, Chicago, Los Angeles, and San Francisco to obtain information on the extent of the problem and how each city has been affected. In each city, we contacted local DEA, police, health, and drug-research officials to discuss their views concerning the drug abuse and trafficking situation and the future outlook of the drug problem in their cities.

The cities had both similarities and differences in their drug problems. Generally, the cities reflected national trends regarding the availability of major drugs, but problems in each city involving particular drugs, drug forms, and methods of ingestion were often unique and localized. For example, use of "black tar" heroin was predominant in San Francisco but relatively unknown in New York; "crack" cocaine was rampant in New York, but had not shown any significant impact in Chicago; and although PCP usage was widespread in Los Angeles and Washington, D.C., PCP had not become nearly as popular in the other cities.

Local officials reported that the availability of cocaine has increased tremendously since 1980, with dramatic price decreases and increased purity levels. Heroin remains readily available with increases in purity levels. Marijuana availability has decreased somewhat, but it still remains the most widely used illegal drug in the cities we visited and its potency has been increasing. The availability of other drugs varies in the different cities.

Local officials in most of the cities described numerous examples of how drug abuse contributes to violence, crime, hospital emergency room episodes, and health problems. Some of the cities had undertaken what local officials termed "sweep" and "pressure point" law enforcement operations aimed at ridding neighborhoods of street drug buyers and sellers. Although numerous drug arrests and seizures resulted from these special operations, local law enforcement officials questioned the lasting impact of such operations.

They said that their cities' courts, prosecutors, jails, and treatment centers were already overloaded and unable to handle the increased number of arrests resulting from the special operations. As a result, they told us that arrested drug violators often serve little or no jail time and typically return to the drug trafficking business when they are released. In some instances, the main effect of the special operations is to shift the location of street trafficking from one neighborhood to another.

Some Significant Drug Problems Cited By Local Officials

Washington, D.C.

- Heavy PCP use
- Cocaine availability has sharply increased
- Officials report high per capita overdose rate

New York

- "Crack" use rapidly swept city
- Cocaine readily available
- Heroin importation center
- Largest heroin addict population
- Chinese organized crime now dominates heroin trade
- AIDS spreading through IV drug use

Miami

- Cocaine importation center of the United States
- "Crack" increasingly prevalent
- Many homicides believed drug-related
- IV drug use contributes to spread of AIDS

Chicago

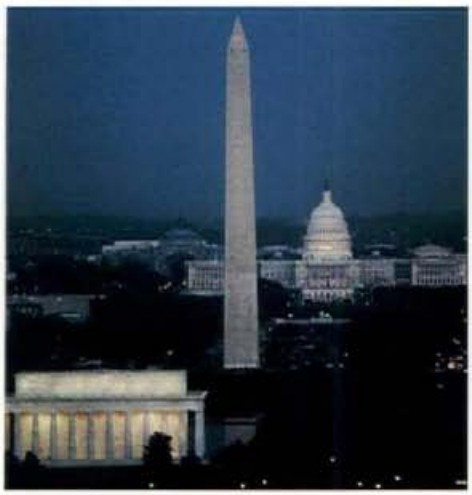
- Increased cocaine availability
- "Crack" epidemic feared
- Use of "T's and Blues," a heroin substitute, decreased

Los Angeles

- Cocaine consumption capital
- Record drug seizures in 1986
- PCP and heroin still epidemic
- Transshipment point for Mexican heroin

San Francisco

- Methamphetamine a major problem
- Primary source for LSD
- Heroin addiction increasing
- Influx of "black tar" heroin
- Cocaine problem increasing



Washington, D.C.

Washington, D.C., along with Los Angeles, has a heavy concentration of PCP users. According to local police officials, PCP availability has increased every year for the last 5 years, and has recently skyrocketed with larger shipments coming into the city. The vast majority of the PCP used in Washington comes from Los Angeles.

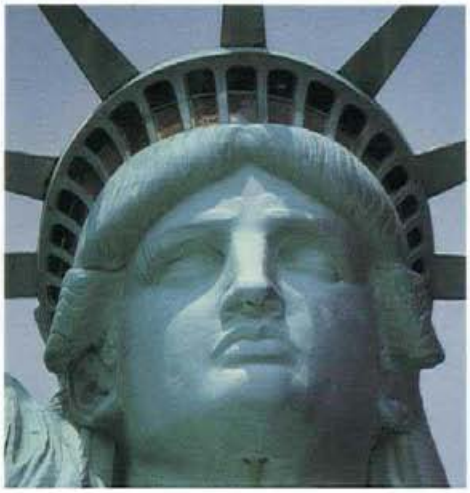
Cocaine availability and abuse is at an all time high. Cocaine use has more than tripled in the last 2 years. Sales of multikilogram quantities are more common than a year ago. Some trafficking in "crack" occurs, but the phenomenon of "crack houses," where "crack" is sold and smoked, has not developed as law enforcement officials expected.

Marijuana continues to be the most commonly used drug in the District and is increasingly used in combination with other drugs, particularly PCP and cocaine. Local officials differed in their opinions as to whether heroin availability had increased, but there was general agreement that purity levels have risen in recent years.

Drug control officials in Washington, D.C., said that some of the worst social effects of the District's drug problem are execution-style killings and other forms of violence, bizarre behavior by drug users, drug dealers exercising control over neighborhoods, and the potential for corruption of public officials. Drug-related AIDS cases are increasing in the District. A study of 27 downtown prostitutes conducted between October 1986 and March 1987, found that over 50 percent tested positive for the AIDS virus, and that all who tested positive were IV drug users. It is also believed by local health officials that Washington, D.C., has the highest per capita narcotics overdose rate of any U.S. city and the second highest rate of infant mortality related to drug abuse.

In 1986, the D.C. Government spent a record $28 million for services related to drug and alcohol abuse, reportedly more per capita than any other city in the country, according to a local health official. In March 1984, the city established a drug testing program for all arrestees (73 percent of those arrested for major offenses in June 1987 tested positive for drugs). A reported 6 percent of the Washington, D.C., police force is involved in drug law enforcement — the highest percentage of any city we visited.

Washington, D.C., police implemented Operation Clean Sweep in 1986. This round-up of drug users and sellers accounted for 13,000 drug arrests in a 5-month period. However, the operation overloaded the courts, prosecutors, jails, and drug treatment programs, and some cases were dropped. A local health official told us that the operation did little, and dealers were merely pushed from one neighborhood to another. Local police officials were also pessimistic — they said that the solution to the drug problem lies in social awareness rather than law enforcement.



New York

The most significant drug abuse problems in New York City involve cocaine and heroin. "Crack" cocaine is the number one drug, and "crack" use has spread throughout the city in a 6-month period, according to a local DEA official. "Crack" trafficking patterns are changing from distribution by small-time operators to the involvement of major trafficking organizations and networks. For example, one recently disbanded organization reportedly distributed over 25,000 vials of "crack" per day at $10 to $20 per vial. Overall cocaine availability in 1986 was at a very high level, with prices dropping and purity rising. Multihundred kilogram loads are imported into the city regularly and lower-level traffickers are buying and selling larger quantities than ever before, according to DEA officials.

According to a local health official, drug experts believe that New York City has more heroin addicts than any other city in the country. Heroin is readily available throughout the city, according to local police. Recently, purity levels on the street have increased to as high as 46 percent in some neighborhoods, while purity levels in other areas of the city remain in the 3 to 4 percent range. "Black tar" heroin has not shown up in any significant quantities. New York continues to be a major importation center for heroin, and traditional organized crime groups have been involved in this traffic for years. A local DEA official reported that members of Chinese organized crime groups have recently taken over the dominant role in the city's heroin industry, flooding the marketplace with huge shipments of very pure heroin.

The New York Police Department (NYPD) reported tens of thousands of drug arrests from 1984 to 1986 in "pressure point" operations designed to clear dealers out of targeted areas. NYPD officials said, however, that only a fraction of those arrested (a newspaper reported fewer than 500) actually received jail terms. While such operations may successfully deter street-dealing in the short term, their long-term success has been questioned by some local officials who believe that such operations are little more than harassment techniques which simply move the drug dealers around town. Police officials acknowledged that both police and the public get demoralized when drug violators arrested in such operations spend only an average of 18 hours in the court system, and fewer than 5 percent spend more than 30 days in jail. One police official, summing up his frustration, said that "it is not hard to catch the criminals, just hard to put them away." He also said it is not unusual to arrest the same person 30 to 40 times for selling drugs on the street, and he cited the case of one drug dealer who had been arrested 68 times. (We did not determine the reasons that arrests in such cases did not necessarily result in convictions.)

Local officials told us that the increased crime and violence resulting from the prevalence of illegal drug use in New York City substantially lowers the quality of life for the city's residents. A local drug abuse researcher cited a variety of social problems, such as crime, violence, disease, public corruption, and family disruption that result from New York's drug problem. She also said that a large number of babies born in the city's hospital system inherit drug addiction from their mothers. She further believes that the AIDS epidemic is likely to make the overall situation worse. Local health officials reported in 1986 that about 35 percent of the more than 8,000 AIDS cases in New York City were drug-related, and that deaths due to AIDS had increased over 800 percent (from 88 in 1983 to 800 in 1986). The rate of increase in AIDS cases for IV drug users was higher than the rate for homosexuals, according to local health officials.

The future outlook for the drug situation in New York City is not optimistic unless the demand for drugs can be reduced, police officials told us. A DEA official said that we are at a crossroad, and that in retrospect, "crack" in 1986 either may look like the "good old days" or may be the drug that caused people finally to say "enough is enough."

Miami

The notably high availability of cocaine is the most significant drug problem in Miami. Over 80 percent of all cocaine seizures in the United States occur in the Miami - South Florida area. In 1986 there were large seizures of 3,900 and 6,000 pounds, and in 1987, there was a record seizure of 8,000 pounds. However, the price of cocaine (an indicator of availability) has dropped dramatically in the last 2 years from approximately $30,000 to $15,000 per kilo. As of October 1987, this trend has continued, with kilogram prices falling to between $9,000 and $11,000.

Local law enforcement officials estimated that at least 1,000 to 1,500 kilos of cocaine move through Miami each week. Regarding a reported shift of cocaine smuggling from the Miami area to Southern California, local enforcement officials pointed out that there has been increased smuggling and availability of cocaine in both areas.

"Crack" cocaine has become increasingly prevalent in Miami. "Crack" has exploded in epidemic proportions in inner-city areas not previously involved with cocaine, according to local drug researchers. Local police said "crack" now accounts for an estimated 60 to 65 percent of all drug arrests in the city.

Local officials described a whole range of social ills resulting from the drug situation in Miami. For example, local police estimated that at least 30 to 35 percent of Miami's homicides are drug-related. Also, scandals have been reported involving public corruption, including allegations of drug trafficking and murder by Miami police officers. Another problem is IV drug use, which health officials said accounts for approximately 20 percent of the AIDS cases in Florida. Miami is among those cities nationally with the highest number of known AIDS cases.

Intensive police "reverse sting" operations targeting drug buyers in Dade County (in which the city of Miami is located) resulted in over 3,000 arrests in 1986. These operations placed a heavy burden on Miami's criminal justice and drug treatment systems, local officials told us. A local health official said as many as 60 percent of those arrested who were referred to treatment had to be dropped because criminal proceedings against them had been halted. Local police told us that many of those arrested did not serve any time in jail.

Law enforcement officials we met with said the future outlook favors the drug traffickers. They said the situation requires a balanced and coordinated attack on drugs involving police, prosecutors, judges, and prison officials. A local drug researcher, on the other hand, said he believes that law enforcement may solve 10 percent of the drug problem, but demand reduction through prevention and treatment is needed to solve the remaining 90 percent of the problem.

Chicago

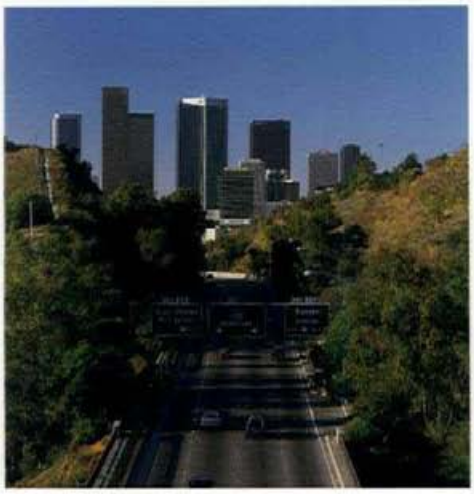
Cocaine use is the primary drug problem in Chicago. It is the only drug to have significantly increased in availability during the last several years. Cocaine kilogram prices have decreased by over one-half, while street purity levels have increased. Seizures of cocaine by the Chicago Police Department Narcotics Section increased from a total of 92 pounds in 1980 to 510 pounds in 1986, an increase of over 450 percent. Seizures of 40 to 55 pounds are now made 2 to 3 times a year.

Low quality Mexican brown heroin dominates Chicago's heroin market. This heroin remains readily available. "T's and Blues" (a combination of synthetic substances) have long been used as a heroin substitute in Chicago, but use of these drugs appears to have declined in the past few years, according to officials.

Hispanic drug traffickers bring in the majority of heroin distributed in Chicago, frequently by automobile from Mexico. Large cocaine trafficking organizations have also been identified, but no single group dominates. A unique development in the trafficking of cocaine has been the use of elderly persons as couriers traveling on trains from South Florida, because such persons do not fit the usual profile of drug traffickers.

Local officials said that some drug-related problems that have become epidemic in cities such as Los Angeles and New York are still in a relatively early stage in Chicago. For example, "crack" cocaine has not yet become a significant problem; however, officials believe that increased use of "crack" is only a matter of time. Another concern is the potential increase in the number of AIDS cases related to IV drug use.

Local law enforcement and health officials are skeptical of any immediate improvements in Chicago's drug situation. They believe that the future outlook holds more of the same drug problems. One health official said that after the current widespread cocaine problem has run its course, another drug will come along to replace it. Local officials cited the need for increased drug supply and demand reduction efforts.



Los Angeles

Los Angeles is a major drug importation and transshipment center for the United States, with a massive amount of drugs flowing into the city. The Los Angeles Police Department (LAPD) reported drug seizures in 1985 with a street value of over $1 billion. This exceeds the total amount of drugs seized in the previous 4 years combined. In 1986, the LAPD seized over $2.8 billion in drugs, with cocaine accounting for well over half of this amount.

Due to the widespread popularity of cocaine and "crack," local DEA officials have labeled Los Angeles the "cocaine consumption capital of the country." Cocaine has become the "drug of choice" and this is reflected in the increased emergency room episodes, deaths, treatment admissions, arrests, and drug seizures involving cocaine. From 1980 to 1986, LAPD cocaine seizures increased 7,000 percent, from 183 pounds to 13,184 pounds. DEA officials told us that the price of a kilo of cocaine has decreased, while purity levels are over 90 percent in many cases. There are also indications, according to local officials, that Los Angeles' role as a cocaine distribution center is expanding.

Los Angeles officials report that heroin and PCP are also abused in epidemic proportions, and said that there is much trafficking in these drugs. Los Angeles serves as a major transshipment area for Mexican heroin to other parts of the country. A large portion of the PCP abused in the United States is manufactured in the Los Angeles area and shipped to other cities.

Local health officials are concerned with the increasing number of babies born drug-addicted. They estimated that approximately 45 to 50 drug-addicted babies are born each month in Los Angeles County.

Considering the trends since 1980, Los Angeles faces a bleak future with respect to drug abuse, according to a local law enforcement official. He noted that law enforcement is already doing all it can. A local health official expressed concern that budgetary restrictions in the 1980s have reduced drug treatment services despite increased demand for treatment. Both officials agreed that the only hope for the future lies in a reduction in the demand for drugs by users.

San Francisco

Heroin, cocaine, and methamphetamine are the main drug problems in San Francisco. During 1984 to 1986, there was a large influx of Mexican "black tar" heroin. The purity level of "black tar" has ranged from 60 to 70 percent, compared with 1 to 3 percent for Mexican heroin in the late 1970s. Since 1980, the number of heroin addicts in treatment has doubled (4,000 to 8,000).

Cocaine's price per kilo decreased 50 percent during 1985 and 1986, while the average purity level of street cocaine nearly doubled. The quantity of cocaine involved in individual seizures on the street has increased from a few grams to kilograms. Wholesale cocaine shipments have also increased in size, from 10 to 15 kilos in the early 1980s to shipments of 200 to 250 kilos, which are not uncommon today. Local police said that "crack" presents their biggest street problem and accounts for most public drug complaints. In particular, there is concern about "crack" dealers controlling neighborhoods and about "crack's" addictiveness.

Methamphetamine abuse is also widespread. It is a major health problem because the sharing of needles used to inject the drug has contributed to the transmission of AIDS. Also noteworthy is the increasing popularity of LSD, according to local police officials. Federal law enforcement officials, however, told us that dosage units are less potent today than in the 1960s. They said that most of the LSD in the country is manufactured in the San Francisco area.

Drug addiction, overdoses, and deaths have all increased recently, according to San Francisco officials. The police have reported violent clashes between groups vying for control of drug distribution, especially in public housing projects. Local officials also have noted that San Francisco appears to have become the home for a large number of illegal aliens who earn their living selling drugs.

The courts, jails, and treatment programs are all overcrowded, according to local law enforcement officials. They further said that although they conduct massive "sweep" operations to clear the neighborhoods of drug dealers, many dealers are either not prosecuted or serve minimal time in jail. One police official said the department is dealing with the symptoms and not the disease, and that with the current limited commitment of resources, the drug problem is getting worse.

Federal Drug Control Efforts Aimed At Reducing Supply And Demand

To combat drug abuse and drug trafficking, the federal government employs a dual strategy aimed at simultaneously reducing both (1) the supply of illicit drugs through drug law enforcement efforts and (2) the demand for these drugs through drug abuse prevention and treatment activities. The strategy is both national and international in scope.[1]

Supply Reduction (Law Enforcement) Components

- International Drug Control
- Interdiction and Border Control
- Investigation and Prosecution
- Intelligence Activities
- Diversion Control

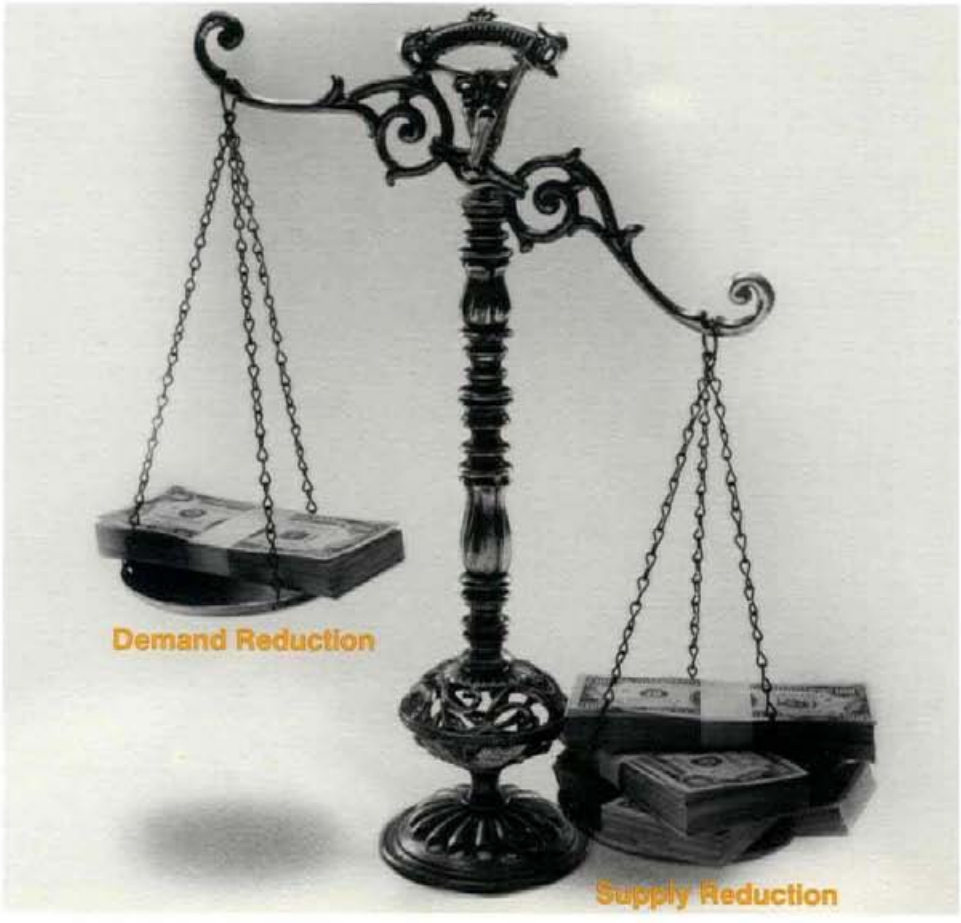
Demand Reduction Components

- Drug Abuse Prevention
- Drug Abuse Treatment

The federal anti-drug strategy consists of various components with programs and activities carried out by several federal agencies. GAO has issued numerous reports and testified on various programs and activities relating to both the supply and demand reduction objectives of the federal strategy. (See appendix II for a selected list of our reports and testimonies issued since fiscal year 1980.)

Throughout the 1980s, there were large increases in resources for the federal drug effort, most of which were aimed at reducing the supply of drugs through law enforcement efforts. Before the Anti-Drug Abuse Act of 1986, monies (budget authority) devoted to the total federal drug abuse control effort climbed from $1.2 billion in 1981 to $2.3 billion in 1986, according to the National Drug Enforcement Policy Board. In 1982, approximately 78 percent of the total federal drug control budget was allocated for supply reduction (law enforcement) efforts.[2] Supply reduction money increased by 73 percent from $1.1 billion in 1982 to $1.9 billion in 1986. Of the total increase in federal drug control money from 1982 to 1986, about 90 percent was for supply reduction.

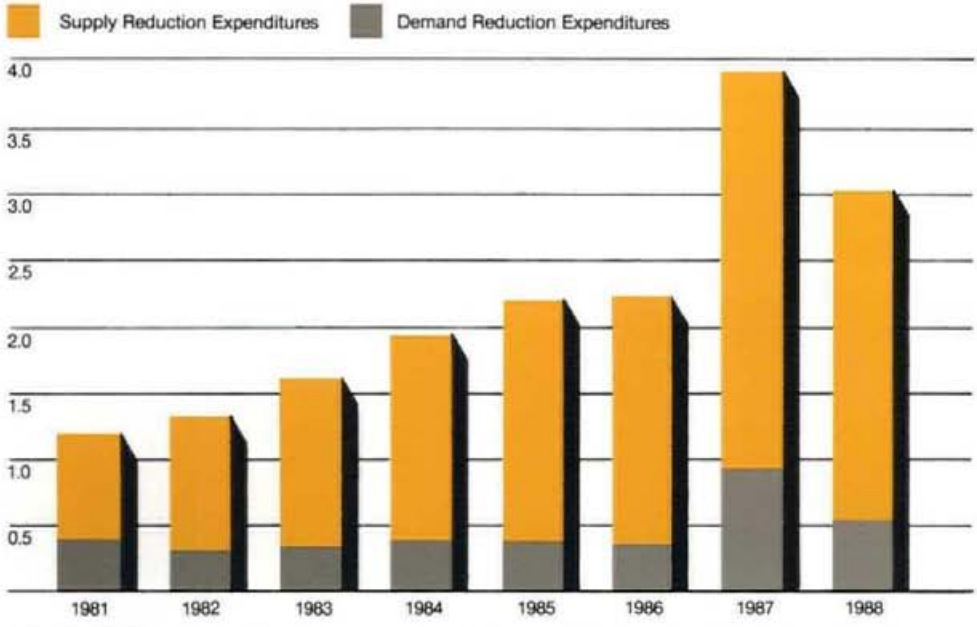
Federal resources for demand reduction efforts also increased but at a slower pace. Demand reduction resources in current dollars (see app. I) increased by 28.4 percent from $305.1 million in 1982 to $391.8 million in 1986. After adjusting for inflation, money for demand reduction increased by 14.8 percent from 1982 to 1986, while money for supply reduction increased by 55.4 percent.



[1]Our discussion of the federal drug strategy is based on the President's *1984 Strategy for Prevention of Drug Abuse and Drug Trafficking* and the *National and International Drug Law Enforcement Strategy* (National Drug Enforcement Policy Board, January 1987).

[2]We did not include 1981 in our analysis of the changes in drug supply and demand reduction resources. Federal drug abuse prevention and treatment outlays decreased with the implementation of the Alcohol, Drug Abuse and Mental Health Block Grant in 1982. NIDA's categorical grants to state governments were consolidated into this block grant program and funding was reduced to reflect savings in federal overhead expenditures.

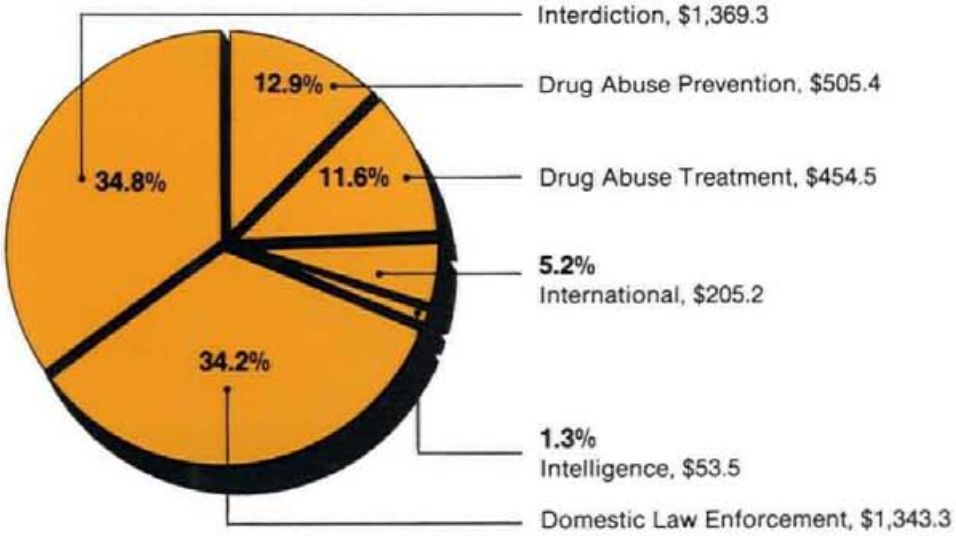
Federal Drug Control Budget Authority, Fiscal Years 1981-1988 (In Billions of Dollars)



Note: 1987 and 1988 figures are as estimated in the President's 1988 Budget.

Source: National Drug Enforcement Policy Board.

Federal Drug Control Budget, Fiscal Year 1987 (In Millions of Dollars)



Note 1: Domestic Law Enforcement includes investigation, prosecution, and diversion control.

Note 2: Total Budget Authority is $3.9 billion.

Source: National Drug Enforcement Policy Board.

With the passage of the Anti-Drug Abuse Act of 1986, authorized funding for the federal effort was greatly increased for both demand and supply reduction efforts. Authorized resources for the total federal drug effort climbed to nearly $4 billion in fiscal year 1987 (as shown in the President's fiscal year 1988 budget).

Budget information on resources devoted to drug abuse control is shown in the Federal Drug Abuse Budget Summary, prepared periodically by the White House Drug Abuse Policy Office with the assistance of the Office of Management and Budget. In a 1985 report, we discussed the Federal Drug Abuse Budget Summary including information on how it is developed.[3] We commented that the budget summary is not the result of any planning process that deals with agencies' drug abuse mission requirements. Rather, it is an informal document that describes the level of federal budget authority and outlays for federal agencies and drug abuse control programs. The budget summary included as part of the *National and International Drug Law Enforcement Strategy* issued in January 1987, reports only budget authority, not federal outlays. In a report issued in February 1988, we concluded that the National Drug Policy Board could play a more active role in setting budget priorities for drug abuse control programs.[4]

[3]*Reported Federal Drug Abuse Expenditures—Fiscal Years 1981 to 1985* (GAO/GGD-85-61, June 3, 1985).

[4]*National Drug Policy Board: Leadership Evolving, Greater Role in Developing Budgets Possible* (GAO/GGD-88-24, Feb. 12, 1988).

Drug Supply Reduction

Drug supply reduction efforts are aimed at reducing the availability of drugs along the entire distribution chain from field and laboratory to consumer.

The long-term objective is to reduce the availability of drugs to such a degree that drug abuse is inhibited. In the short term, objectives are to: deter drug trafficking and use through enforcement actions; disrupt trafficking networks; and displace established production sources, trafficking routes, and trafficking methods. Successful drug law enforcement actions along these lines increase the costs and risks for drug traffickers.

Major supply reduction initiatives undertaken during the 1980s include:

- expanding the role of the military and the U.S. intelligence community in drug enforcement;
- assigning the FBI authority to conduct drug investigations along with DEA;
- establishing 13 Organized Crime Drug Enforcement Task Forces around the country to attack high-level drug traffickers in a multi-agency approach;
- creating the National Narcotics Border Interdiction System (NNBIS) to coordinate multiagency drug interdiction activity;
- increasing significantly DEA's resources as well as the commitment of Internal Revenue Service's resources;
- placing increased emphasis on sophisticated investigative techniques, such as electronic surveillance, and on financial investigations aimed at seizing the assets of drug traffickers;
- expanding the State Department's assistance for crop eradication and enforcement activities in foreign countries; and
- issuing, in 1986, a Presidential National Security Directive stating that the international drug trade is a national security concern of the United States.

As a result of the increased resources and new initiatives, federal agencies responsible for reducing the

supply of illicit drugs in the United States significantly increased their accomplishments.

Combined arrests of drug violators by DEA, FBI, the United States Customs Service (Customs) and the U.S. Coast Guard increased from 30,446 in 1982 to 48,061 in 1986, an increase of 58 percent. DEA arrests of reported high-level drug traffickers, such as heads of trafficking organizations and drug financiers, increased from 2,124 in 1982 to 6,002 in 1986.[5]

Increased arrests of high-level drug traffickers is an important accomplishment in the federal effort to combat drug abuse and disrupt drug trafficking in the United States. However, the enormous profits that can be made in the illicit drug trade provide an incentive for new traffickers to fill the ranks of those immobilizied by federal law enforcement agencies. In a 1984 report, we discussed DEA's efforts and progress to immobilize major drug traffickers. The report assessed DEA's system for classifying drug violators, described targeting methods and investigative techniques against major drug violators and their organizations, and discussed the need for a better system to measure effects.[6]

In the 1980s, both the Department of Justice and the Department of the Treasury placed increasing emphasis on efforts to seize and obtain forfeiture of drug traffickers' assets. The purpose of asset seizure and forfeiture efforts is to deny drug traffickers the fruits of their labor as well as the means for continuing their illicit activities. Forfeitures of drug traffickers' assets as reported by DEA, FBI, and Customs increased from $69.9 million in 1984 to $112 million in 1986. Many more millions have been seized and await forfeiture. For example, the three agencies reported asset seizures totaling $479.2 million in 1986.

GAO has played a role in bringing about greater use of asset seizure and forfeiture as enforcement tools to combat drug trafficking. In a 1981 report, we identified lack of leadership by the Department of Justice and the need to clarify legislation as barriers to wider use of asset seizure and forfeiture.[7] Subsequently, Congress strengthened the criminal forfeiture statutes and the Attorney General improved forfeiture program management. In September 1987, we testified on the need for greater congressional oversight of the rapidly increasing revenues in the Department of Justice's and Customs' Asset Forfeiture Funds. We recommended various corrective actions including a limit (preferably in the $10 to $20 million range) on the amount of funds that could be carried forward in Justice's fund from one year to the next.[8] As of August 31, 1987, an $88 million balance remained in the fund.

Along with increases in the arrests of drug violators and forfeitures of their assets, seizures of drugs increased significantly during the 1980s. Customs, for example, increased its cocaine seizures by 362 percent from 1982 to 1986 (5.2 metric tons to 24 metric tons).

Like arrests of major drug traffickers, increased seizures of drugs is an important accomplishment in the war on drugs. However, illegal drugs are still readily available in the United States. In a June 1987 report, we discussed the capabilities of the federal government to interdict illegal drug smuggling. We concluded that even though drug seizures have greatly increased, relatively small portions of cocaine, marijuana, and other illegal drugs smuggled into the United States are seized by drug interdiction agencies. We commented that the increased resources for drug interdiction authorized by the Anti-Drug Abuse Act of 1986 should fill some gaps in the present interdiction system with more equipment and additional staff. However, smugglers succeeded in thwarting past changes in the interdiction system and may continue to do so.[9]

[5]Accomplishments of the various federal agencies responsible for supply reduction activities are detailed in the *National Drug Policy Board's Federal Drug Enforcement Progress Report 1986*, April 1987. The accomplishments we discuss are shown in that report.

[6]*Investigations of Major Drug Trafficking Organizations* (GAO/GGD-84-36, Mar. 5, 1984).

[7]*Asset Forfeiture—A Seldom Used Tool in Combating Drug Trafficking* (GAO/GGD-81-51, Apr. 10, 1981).

[8]"Asset Forfeiture Funds: Changes Needed to Enhance Congressional Oversight," Testimony before the Senate Committee on Governmental Affairs: Federal Spending, Budget, and Accounting Subcommittee (GAO/T-87-27, Sept. 25, 1987).

[9]*Drug Smuggling: Large Amounts of Illegal Drugs Not Seized by Federal Authorities* (GAO/GGD-87-91, June 12, 1987).

Opposite page, top: Operator uses radar equipment to identify drug smugglers in South Florida. Opposite page, bottom: Radar equipped military planes assist civilian law enforcement agencies by detecting drug smuggling flights.

Drug Demand Reduction

Reducing the demand for drugs has been increasingly recognized by Congress and the executive branch as a crucial element in the federal government's effort to reduce drug abuse. Many law enforcement and health officials agree that efforts to reduce the supply of illegal drugs cannot succeed as long as the demand for drugs in our society is so great. There are two major components to the current federal demand reduction strategy—drug abuse prevention and treatment. Drug abuse research efforts supplement these components as new knowledge directed at the causes and consequences of drug abuse is developed and applied.

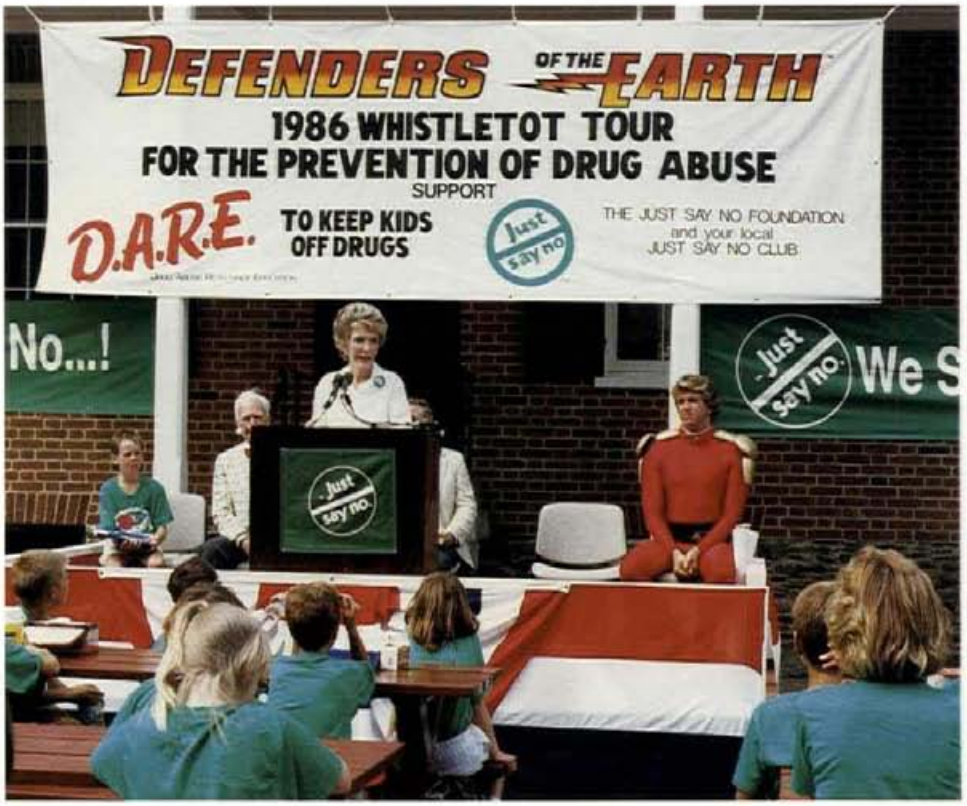
The federal role in drug abuse prevention and treatment changed in 1982, when through the introduction of block grants, Congress provided that funds for drug abuse prevention and treatment services be given directly to the states. States were given greater responsibility for establishing program requirements and monitoring program activities. The current federal strategy defines the federal role as one of providing national leadership and pursuing functions beyond state capabilities.

Drug Abuse Prevention

Many law enforcement and health officials agree that preventing drug abuse before it starts is a key to long-term success in resolving the drug problem. Prevention involves public awareness and drug education.

Although many agencies are involved, the Departments of Education and Health and Human Services, and ACTION (which administers and coordinates federally sponsored domestic volunteer programs) have primary responsibility for administering federal drug abuse prevention programs. In the 1980s, prevention activities included awarding grants, providing information and technical assistance, and using volunteers.

Most recently, the First Lady's "Just Say No" campaign has provided drug abuse prevention with increased visibility. "Just Say No" clubs (primarily aimed at youths age 7 to 14) have been formed in schools, community organizations, and churches to deter



drug use through posters, booklets, t-shirts, and various club rallies and other activities.

The current federal strategy also encourages the private sector to take part in the anti-drug effort. A wide variety of groups and organizations have responded, often in highly creative ways. A large corporation, for example, has provided information on drug abuse in specially designed comic books aimed at young people.

Because of the importance of drug abuse prevention as the potential long-term solution to our drug problem, it is vital that resources for this area be directed at those programs that work best. In a December 1987 report, we pointed out that evaluations of the effectiveness of drug abuse prevention and education activities by public and private organizations have been limited. Considerable uncertainty exists about what really works to prevent drug abuse. We commented that the Anti-Drug Abuse Act of 1986 significantly increased funding for drug abuse prevention and education and also added a number of requirements for evaluations of programs and activities. These are in various stages of implementation, but most will not be completed for some time and thus are of little help to states and localities in deciding how best to use initial funding available under the act. We have recommended to Congress that it increase the accountability of state and local drug prevention and education programs including a recommendation to tie funding at the local level to program success.[10]

Drug Abuse Treatment

Treatment for drug abusers is another element of the federal strategy and helps in reducing the demand for drugs. Treatment programs have been directed at overcoming the physical problems of drug addiction and providing psychological and social counseling to help the individual drug abuser live without drugs.

Funds are allocated by the federal government to states through a formula based on population as well as need. The states then disburse funds to local treatment entities. The Alcohol, Drug Abuse and Mental Health Administration is primarily responsible for administering federal treatment funds through the block grant mechanism.

In treatment research, the federal government also plays a leading role. NIDA, the major agency involved, focuses its research on how best to treat persons with different kinds of drug abuse problems.

Other federal agencies responsible for drug abuse treatment programs include the Department of Defense, the Bureau of Indian Affairs, and the Veterans Administration.

Opposite page, top: Comic books communicating drug abuse prevention message. Opposite page, bottom: First Lady Nancy Reagan speaking at "Just Say No" rally. Above: Dispensing methadone at a Washington, D.C. clinic.

[10] *Drug Abuse Prevention: Further Efforts Needed to Identify Programs That Work* (GAO/HRD-88-26, Dec. 4, 1987).

Managing Federal Drug Control Efforts

Despite enhanced federal anti-drug efforts—increased funding, new supply and demand reduction initiatives, and increased drug seizures and arrests—the nation's drug problem persists. Opinions vary about what the federal government should do to control drug abuse. Experts disagree about which anti-drug programs work best, the proper mix of anti-drug programs, and the level of resources needed to make anti-drug efforts successful. While we cannot quantify the impact of federal efforts on drug abuse and trafficking, it seems likely that the problem would be more serious had anti-drug efforts not increased.

Some experts believe that devoting more resources—money, personnel, and equipment—to anti-smuggling efforts will reduce the supply of drugs available for use. Others say we must increase our efforts to eradicate drug production in foreign countries and shut off supplies at their source. An increasing number of experts believe that a higher priority and increased resources must be assigned to reducing the demand for drugs through programs aimed at preventing drug abuse, treating drug abusers, and conducting research on the causes and cures of drug abuse. Regardless of their views on the appropriate strategy and level of resources for anti-drug efforts, some experts believe that substantial reductions in drug abuse will not occur unless there are fundamental changes in cultural attitudes and values which decrease society's demand for illegal drugs.

Over the past 15 years, we have made numerous evaluations of the nation's drug problem and federal anti-drug efforts (see app. II). The results of our work do not provide clear-cut answers as to the appropriate mix of anti-drug programs or the priority and level of resources which the federal government should devote to drug abuse control. To begin to seek the answers, Congress and the executive branch need factual information about which anti-drug programs work best. Unfortunately, there is little such information available.

Moreover, despite numerous organizational changes over the past 20 years, fragmented and uncoordinated anti-drug policies and programs remain obstacles to the success of federal drug abuse control efforts.

Measures Of Program Effectiveness Are Needed

One of the most important decisions that Congress and the executive branch must make about government programs is resource allocation. In the area of drug abuse control, as in other areas of government, Congress and the executive branch must agree on the total amount of resources which the government should allocate to the area, as well as how those resources should be divided among specific programs. We believe that making good decisions about the allocation of resources to federal drug control efforts requires soundly based measures of program effectiveness. Existing data systems portray general drug trends and help gauge the overall impact of the federal drug strategy, but do not adequately measure the effectiveness of specific federal drug control efforts.

We recognize that measuring effectiveness is difficult. First, drug abuse control efforts are mutually supportive; it is difficult to isolate the full impact and effectiveness of a single program such as drug interdiction. Second, the clandestine nature of drug production, trafficking, and use limits the quality and quantity of data that can be collected to measure program success. Third, the data that are collected—for example, the data used to prepare estimates of drug availability and consumption—are generally not designed to measure program effectiveness.

Despite these difficulties, the government can and should do more to develop measures of program effectiveness. The development of reliable effectiveness measures for drug abuse control programs should be assigned a high priority by Congress in its oversight and legislative functions, and by the President and his cabinet members in administering anti-drug programs. Such action would significantly improve the ability of Congress and the executive branch to make decisions about the allocation of budget resources to drug abuse control programs.

Organizational Changes Have Not Resolved Interagency Conflicts

In reports and testimonies dating back to the early 1970s, we have repeatedly pointed out problems caused by the fragmentation of federal anti-drug efforts among several cabinet departments and agencies,[1] and the resulting lack of coordination of federal drug abuse control policies and programs. Differing agency priorities and interagency rivalries, conflicts, and jurisdictional disputes have impeded drug abuse control efforts in the past and continue to present obstacles to the success of the government's anti-drug programs.

Over the past 20 years, numerous organizational changes have been made to reduce the fragmentation of federal anti-drug efforts. These changes have had the aim of improving coordination and strengthening leadership and oversight. For example:

- In 1966, the Bureau of Drug Abuse Control (BDAC) was established within the Department of Health, Education and Welfare to enforce federal laws over the manufacture, distribution, and sale of dangerous drugs such as stimulants and depressants.

- In 1968, President Johnson established the Bureau of Narcotics and Dangerous Drugs (BNDD) in the Justice Department, consolidating functions previously performed by the Federal Bureau of Narcotics (FBN) in the Treasury Department and BDAC in the Department of Health, Education and Welfare.

- In 1971, President Nixon created the Cabinet Committee on International Narcotics Control, charged with setting a strategy to check the flow of illegal drugs into the United States and coordinating federal efforts abroad.

- In 1971, President Nixon also established the Special Action Office for Drug Abuse Prevention (SAODAP) by executive order, and charged the Office with coordinating all federal demand reduction efforts.

- In 1972, President Nixon established the Office for Drug Abuse Law Enforcement (ODALE) and the Office of National Narcotics Intelligence (ONNI) in the Department of Justice. The ODALE Director was designated by the President as a Special Assistant Attorney General. The Director also served as a Special Consultant to the President for Drug Abuse Law Enforcement to advise him on all matters relating to more effective enforcement by all federal agencies. ONNI was responsible for developing and maintaining a national narcotics intelligence system.

- In 1972, Congress enacted the Drug Abuse Office and Treatment Act which statutorily authorized SAODAP for 3 years. The act also established NIDA within the Department of Health, Education and Welfare to administer federal demand reduction programs. In addition, the act created the Strategy Council on Drug Abuse, whose primary responsibility was to develop a comprehensive federal drug abuse control strategy.

[1]GAO identified at least 10 cabinet departments, 29 agencies, and various multiagency organizations involved in carrying out the federal drug strategy.

• In 1973, President Nixon, through Reorganization Plan Number 2, created the Drug Enforcement Administration in the Justice Department and assigned the new agency responsibility for all federal drug investigations. BNDD, ODALE, and ONNI were abolished. Their functions and resources along with Customs' drug investigative and intelligence-gathering functions were transferred to DEA. Customs' anti-drug role was limited to interdiction of illegal drugs at U.S. borders and ports-of-entry.

• In 1976, Congress established the Office of Drug Abuse Policy to oversee and coordinate federal anti-drug policies and programs. President Carter nominated a director of the Office in 1977, then took steps to abolish it later that year. The Office's functions were absorbed by a drug policy office within the Domestic Policy Staff of the Executive Office of the President. In June 1982, President Reagan issued an executive order officially designating the Office as the Drug Abuse Policy Office.

In a 1979 report to Congress, we assessed the federal government's efforts to reduce the supply of illegal drugs in this country during the previous 10 years.[2] In that report, we said that one of the main reasons the government had not been more effective was the long-standing problem of fragmented federal drug supply reduction activities.

The same report concluded that the federal government had failed to provide a central mechanism with the responsibility and authority to plan and coordinate all federal drug supply reduction efforts and to be accountable for effective implementation of a consistent federal drug policy. We proposed that the executive and legislative branches of government reach agreement on a national drug abuse policy, enact necessary legislation, and provide the requisite oversight to ensure that the agreed-upon policy was vigorously carried out. We also said that the authority to direct and coordinate drug supply reduction policy and programs should be clearly delegated to someone acting on behalf of the President.

The need for strong leadership and central oversight was also the theme of our 1983 report to Congress.[3] In this report, we focused on federal efforts to interdict illegal drugs being smuggled into the country. We concluded that the fragmentation of these activities limited their effectiveness.

We noted that authority and responsiblity for federal interdiction efforts were divided among three agencies—Customs, the Coast Guard, and DEA—in three separate departments—Treasury, Transportation, and Justice. We also noted that each agency had different programs, goals, and priorities, and that this led to inefficiency and interagency conflict. Our report pointed out that these problems with interdiction programs were only one manifestation of a broader problem: the need for centralized direction and greater coordination of all federal drug supply reduction activities.

To promote cohesive and centralized oversight of federal drug law enforcement efforts, we recommended that the President (1) direct the development of a more definitive federal drug strategy that stipulates the roles of the various agencies with drug enforcement responsibilities and (2) make a clear delegation of responsibility to one individual to oversee federal drug enforcement programs. We recommended that the responsibilities of this individual include:

• developing and reviewing U.S. government policy with respect to illegal drugs;

• providing for effective coordination of federal efforts to control the production, halt the flow into the United States, and stop the sale and use of illegal drugs;

[2]*Gains Made in Controlling Illegal Drugs, Yet the Drug Trade Flourishes* (GAO/GGD-80-4, Oct. 25, 1979).

[3]*Federal Drug Interdiction Efforts Need Strong Central Oversight* (GAO/GGD-83-52, June 13, 1983).

- developing a unified budget that would present (1) a composite picture of all federal resources being devoted to the drug war and (2) recommendations for rationalizing these efforts in terms of budgetary priorities; and
- collecting and disseminating information necessary to implement and evaluate U.S. policy with respect to illegal drugs.

Recent Efforts To Strengthen Leadership And Central Oversight

Congress and the Administration, through the National Narcotics Act of 1984 (Public Law 98-473), established the National Drug Enforcement Policy Board to provide stronger leadership and more centralized direction to federal drug supply reduction efforts. The Attorney General was designated as Chairman of the Board. Other members, as originally constituted, included the Secretaries of State, the Treasury, Defense, Transportation, and Health and Human Services; and the Directors of the Office of Management and Budget and the Central Intelligence Agency, with a provision for additional members as appointed by the President.

On March 26, 1987, the President signed Executive Order 12590 creating the National Drug Policy Board to oversee all federal drug control programs, including demand reduction efforts. The new Board, which absorbed the functions of the statutorily mandated National Drug Enforcement Policy Board, is now in charge of all anti-drug policy for the federal government. The Attorney General is Chairman, and the Secretary of the Department of Health and Human Services is Vice-Chairman. We think this is a positive step, but believe it is too early to say whether the new Board eventually will be successful in achieving a balanced, effective, and well-coordinated federal anti-drug policy. In a report issued in February 1988, we concluded that the Board could play a more active role in setting budget priorities for drug abuse control programs.[4]

Prior to, and since the establishment of the Policy Board, there has been a continuing debate in Congress over the merits of designating a single individual, rather than a board, to oversee federal drug abuse control policy and programs. Whether there should be one individual or a board to coordinate policy is debatable and needs careful consideration. This consideration should recognize that organizational changes by themselves are insufficient to accomplish the goal of stronger leadership and more centralized oversight and coordination of federal anti-drug policy.

Although past organizational changes sometimes have had positive results, our evaluations of federal anti-drug efforts indicate that none has significantly altered the fragmentation and lack of coordination that still exists in federal drug abuse control policy and programs. Additional organizational changes, such as the proposed establishment of a Director of National Drug Control Policy, may be desirable and needed. However, solving the nation's drug abuse problem will be a long-term process that will require a strong and enduring commitment by the President and Congress to anti-drug efforts and to resolving policy and program conflicts.

[4] *National Drug Policy Board: Leadership Evolving, Greater Role in Developing Budgets Possible* (GAO/GGD-88-24, Feb. 12, 1988).

Appendix I Objectives, Scope, And Methodology

This report is designed to provide an overview of the nation's drug problem and the federal response. It also summarizes some of our key conclusions and recommendations from our past work. The report contains information that we plan to update periodically in future reports. Congress can use the information as a baseline to determine whether the funds it provides for controlling drug abuse are having the desired effect.

We obtained information on the current drug situation and significant trends since 1980 on (1) drug abuse, availability, trafficking, and production; (2) federal drug supply and demand reduction efforts; and (3) the costs of the federal efforts. We collected nationwide information from federal organizations in Washington, D.C., including DEA, NIDA, the Department of State, the White House Drug Abuse Policy Office, and the National Drug Policy Board. At DEA and NIDA, we collected information on the methodology and limitations of key drug indicators and estimates of the drug problem. We also obtained views on drug problems and related information from local police departments, health officials, drug abuse researchers, and DEA field offices in Los Angeles, San Francisco, Chicago, New York, Miami, and Washington, D.C. We did not independently verify the validity or reliability of the information we obtained. (The illegal nature of activities such as drug use, trafficking, and production makes independent verification of many of these data difficult.) In some instances, figures were either not available or not comparable for all the years since 1980.

Nationwide Estimates Of The Drug Problem

Information in this report describing the nationwide drug problem comes primarily from overall federal summaries and estimates, which are described below. The estimates are based on a variety of information, including certain data systems regarded by drug abuse control agencies as the key indicators of drug abuse. Each indicator provides a different perspective on the problem, and they complement one another. Although the indicators have recognized limitations and deficiencies that affect the quality of information and make specific estimates uncertain, the agencies that prepare them believe that the data can reliably portray general trends.

NNICC Narcotics Intelligence Estimates

The National Narcotics Intelligence Consumers Committee (NNICC) is a federal interagency mechanism for coordinating drug intelligence collection requirements and producing joint intelligence estimates. NNICC issues periodic reports on the worldwide illicit drug situation, which are considered by drug abuse control agencies to be the most authoritative and comprehensive assessments prepared for the federal government. The latest report, called *The NNICC Report 1985–1986*, was published in June 1987.

The NNICC report contains estimates of illegal drug production, availability, and consumption, and it discusses the four major drug categories (marijuana, cocaine, opiates, and dangerous drugs). The report also contains information on drug trafficking routes and methods and on the flow of drug-related money.

NNICC obtains drug production data for individual countries from information sources such as host country records, local contacts, informants, and sophisticated intelligence-gathering techniques. NNICC derives drug availability and consumption estimates from sample surveys, drug seizures, drug price and purity data, drug-related hospital emergencies, and other data.

NNICC estimates result from an elaborate process of analysis, discussion, and review. Federal agencies involved in drug control submit information on their various functions which is then compiled by NNICC. The Committee attempts to reach a consensus on the estimates before a final report draft is sent to all member agencies for comment and final figures are printed.

Estimates of illegal drug quantities are very difficult to make. Since the drugs are illegal, little reliable data exist. NNICC has continually worked to review and update estimation methodologies, resulting in a number of revisions to previous estimates.

National Survey On Drug Abuse

The National Survey on Drug Abuse (commonly referred to as the Household Survey) is funded by NIDA and conducted under contract every 2 or 3 years. The survey provides data on incidence, prevalence, and trends of drug use for persons age 12 and older living in households. Results are based on personal interviews with individuals randomly selected from the household population who record their responses on self-administered answer sheets. Household Survey data are used in conjunction with High School Senior Survey data (see below) to describe levels of drug abuse in specific segments of the population. These data may also be used in conjunction with DAWN data to describe long-term trends in drug abuse.

Survey limitations include the fact that the homeless and persons living in military installations, dormitories, and institutions, such as jails and hospitals, are not covered. Since the survey is voluntary and the questionnaires are self-administered, the results may be biased. The National Drug Enforcement Policy Board considered the abuse estimates from the survey to be conservative.

High School Senior Survey

The High School Senior Survey is sponsored by NIDA. Also known as *Monitoring the Future: A Continuing Study of the Lifestyles and Values of Youth*, it is an annual survey of drug use among high school seniors. Information is collected from nearly 17,000 respondents in approximately 130 public and private high schools. Primary uses of the data include (1) assessing the prevalence and trends of drug use among high school seniors and (2) gaining a better understanding of the lifestyles and value orientations associated with patterns of drug use, and monitoring how these orientations are shifting over time. The survey is considered important by NNICC in describing the shape and dimension of the U.S. drug problem because young people are often the leading edge of social change.

However, several problems and limitations in the survey data have been identified. Dropouts, who are associated with higher rates of drug use, are not part of the sampled universe. Chronic absentees, who may also have high rates of drug abuse, are less likely to be surveyed. Conscious or unconscious distortions by students in self-reporting the information can also bias results. In addition, new trends in drug abuse may not be initially detected because the survey is designed to measure only those drugs abused at a significant level. The National Drug Enforcement Policy Board considered the abuse estimates from the survey to be conservative.

Drug Abuse Warning Network (DAWN)

The Drug Abuse Warning Network (DAWN), funded by NIDA, is a large-scale drug abuse data collection system designed as an early warning indicator of the nation's drug abuse problem. An episode report is submitted for each drug abuse patient who visits the emergency room of a hospital participating in DAWN, and for each drug abuse death encountered by a participating medical examiner or coroner. In a single hospital emergency room "episode," a patient may "mention" having ingested more than one drug. DAWN records each drug a patient reports having used within 4 days prior to the hospital visit, according to DEA.

Data are collected from a nonrandom sample in selected metropolitan areas throughout the country representing approximately one-third of the U.S. population. While there are standard definitions and data collection procedures, variations among individual reporters may occur. Incomplete reporting, turnover of reporting facilities and personnel, and reporting delays of up to 1 year (primarily for medical examiner data) are some of the system's limitations.

For hospital emergencies, NNICC, in its last two publications, has used data from the DAWN Consistent Panel rather than from the Total Panel. The Consistent Panel includes only those hospitals reporting on a consistent basis (i.e., 90 percent of the time or more during each year). Data representing the total DAWN system were not used for trend analysis by NNICC because of reporting fluctuations. Although the Consistent Panel numbers are lower because fewer facilities report, they are considered more accurate indicators of trends.

NNICC used data from the total DAWN system for drug-related deaths. The DAWN Consistent Panel database for medical examiner reports is so small compared to the total DAWN system that it is not considered a valid trend indicator. According to NNICC, DAWN medical examiner data are not subject to the same reporting inconsistencies as DAWN emergency room data. Medical examiner data for New York City are considered incomplete and are not included.

Retail Price/Purity

The price and purity of illegal drugs at the retail level are key values in the NNICC estimating process. DEA gathers these data, which are used as an indicator of drug availability. Drug prices are developed from a computerized database and derived primarily from reports on purchases of, and negotiations to purchase, illegal drugs by undercover federal, state, and local law enforcement officers. Purity levels for heroin and cocaine are determined through laboratory analysis, but are not applicable to marijuana and most dangerous drugs. A limited number of reports and lack of randomness are problems that have plagued these indicators in the past.

Local Perspectives On The Drug Situation In Six U.S. Cities

In addition to gathering nationwide information, we visited six cities (Los Angeles, San Francisco, Chicago, New York, Miami, and Washington, D.C.) with drug abuse and trafficking problems considered among the worst in the country. In each city, we contacted local DEA, police, health, and drug research officials. We obtained the views of the officials concerning (1) the most significant trends in drug abuse and trafficking since 1980, (2) adverse social and economic impacts of the local drug situation, and (3) the future outlook for the drug situation in each city.

We also gathered information from the Community Epidemiology Work Group (CEWG) and met with its representatives in each of the six cities. Established by NIDA in 1976, CEWG comprises researchers, mostly city and state drug treatment and research officials, who provide analyses of drug abuse patterns in their respective cities. The group convenes twice a year to report on drug trends and to discuss prevention strategies and medical and law enforcement issues.

Price And Budget Data Adjusted For Inflation

To determine real changes over time in the retail prices of heroin and cocaine, we adjusted the nominal (current dollar) retail prices using the "all items" expenditures class of the Consumer Price Index.[1]

We calculated real increases in budget authority by adjusting nominal (current dollar) budget figures using the GNP implicit price deflator for federal purchases of goods and services (total). The deflator series covered calendar years while the budget data were available for fiscal years. We therefore used quarterly deflators to construct a fiscal year deflator series, which was then based in fiscal year 1982 dollars.

[1]The Bureau of the Census defines "current dollars" as "the dollar amounts that reflect the value of the dollar at the time of its use."

Appendix II

Selected GAO Reports And Testimonies Since Fiscal Year 1980 Related To Federal Drug Control Efforts

Coordination, Oversight, And Policy

National Drug Policy Board: Leadership Evolving, Greater Role in Developing Budgets Possible. GAO/GGD-88-24, 2/12/88.

Interagency Agreements: Customs-Coast Guard Agreement for U.S.-Bahamas Drug Task Force Was Proper. GAO/AFMD-87-69, 8/31/87.

The Need for Strong Central Oversight of the Federal Government's War on Drugs. Testimony before the House Select Committee on Narcotics Abuse and Control, Senate Committee on the Judiciary. GAO/T-GGD-87-17, 5/14/87.

Reported Federal Drug Abuse Expenditures—Fiscal Years 1981 to 1985. GAO/GGD-85-61, 6/3/85.

The Need to Control Prescription Drug Abuse. Testimony before the House Committee on the Judiciary: Crime Subcommittee. 6/29/83.

Interdepartmental Cooperation of Drug Enforcement Programs. Testimony before the House Committee on Government Operations: Government Information, Justice and Agriculture Subcommittee. 2/25/83.

Drug Enforcement Coordination. Testimony before the House Committee on the Judiciary: Crime Subcommittee. 2/17/83.

Comprehensive Approach Needed to Help Control Prescription Drug Abuse. GAO/GGD-83-2, 10/29/82.

FBI-DEA Task Forces: An Unsuccessful Attempt at Joint Operations. GAO/GGD-82-50, 3/26/82.

Narcotics Enforcement Policy. Testimony before the House Committee on the Judiciary: Crime Subcommittee. 12/10/81.

Changes Needed to Strengthen Federal Efforts to Combat Narcotics Trafficking. Testimony before the Senate Committee on Appropriations: Treasury, Postal Service and General Government Subcommittee. 4/22/80.

Drug Abuse Problem in the Southwest. Testimony before the Senate Committee on Appropriations: Commerce, Justice, State, the Judiciary and Related Agencies Subcommittee. 4/14/80.

Federal Drug Enforcement and Supply Control Efforts. Testimony before the House Committee on Energy and Commerce: Commerce, Transportation and Tourism Subcommittee. 3/10/80.

Gains Made in Controlling Illegal Drugs, Yet the Drug Trade Flourishes. GAO/GGD-80-4, 10/25/79.

Domestic Marijuana

Additional Actions Taken to Control Marijuana Cultivation and Other Crimes on Federal Lands. GAO/RCED-85-18, 11/28/84.

Law Enforcement Efforts to Control Domestically Grown Marijuana. GAO/GGD-84-77, 5/25/84.

Financial Tools And Asset Forfeitures

Asset Forfeiture Funds: Changes Needed to Enhance Congressional Oversight. Testimony before the Senate Committee on Governmental Affairs: Federal Spending, Budget and Accounting Subcommittee. GAO/T-GGD-87-27, 9/25/87.

Millions of Dollars in Seized Cash Can Be Deposited Faster. Testimony before the Senate Committee on Governmental Affairs: Federal Spending, Budget and Accounting Subcommittee. GAO/T-GGD-87-7, 3/13/87.

Internal Controls: Drug Enforcement Administration's Use of Forfeited Personal Property. GAO/GGD-87-20, 12/10/86.

Bank Secrecy Act: Treasury Can Improve Implementation of the Act. GAO/GGD-86-95, 6/11/86.

Better Care and Disposal of Seized Cars, Boats and Planes Should Save Money and Benefit Law Enforcement. GAO/PLRD-83-94, 7/15/83.

Consideration of Whether the Existing Tax Disclosure Statute Strikes a Proper Balance Between Privacy Rights and Law Enforcement Needs. Testimony before the House Committee on Ways and Means: Oversight Subcommittee. 12/14/81.

Improving the Effectiveness of Criminal Forfeitures of Assets. Testimony before the House Committee on the Judiciary: Crime Subcommittee. 9/16/81.

Asset Forfeiture—A Seldom Used Tool in Combating Drug Trafficking. GAO/GGD-81-51, 4/10/81.

Implementation of Bank Secrecy Act's Reporting Requirements. Testimony before the House Committee on Banking, Finance and Urban Affairs: General Oversight and Investigations Subcommittee. 10/1/80.

Taking the Profit Out of Crime. Testimony before the Senate Committee on the Judiciary: Criminal Justice Subcommittee. 7/23/80.

Interdiction

Drug Smuggling: Large Amounts of Illegal Drugs Not Seized by Federal Authorities. GAO/GGD-87-91, 6/12/87.

The U.S. Customs Service's Command, Control, Communications and Intelligence Center Program. Testimony before the Senate Committee on Governmental Affairs: Permanent Subcommittee on Investigations. GAO/T-GGD-87-8, 3/18/87.

Federal Drug Interdiction Efforts. Testimony before the House Committee on Government Operations: Government Information, Justice and Agriculture Subcommittee, 9/9/86.

Coordination of Federal Drug Interdiction Efforts. GAO/GGD-85-67, 7/15/85.

Installation of an Air Force F-15 Aircraft Radar in a Navy P-3A Aircraft for Use by the Customs Service. GAO/NSIAD-85-31, 2/14/85.

The Role of the National Narcotics Border Interdiction System in Coordinating Federal Drug Interdiction Efforts. Testimony before the House Committee on Government Operations: Government Information, Justice and Agriculture Subcommittee. 3/21/84.

The Need for Improved Intelligence Capabilities to Support Drug Interdiction Programs. Testimony before the House Committee on Government Operations: Government Information, Justice and Agriculture Subcommittee. 7/7/83.

Federal Drug Interdiction Efforts Need Strong Central Oversight. GAO/GGD-83-52, 6/13/83.

Coast Guard Drug Interdiction on the Texas Coast. GAO/CED-81-104, 5/19/81.

International Drug Control

Drug Control: River Patrol Craft for the Government of Bolivia. GAO/NSIAD-88-101FS, 2/2/88.

Drug Control: U.S.-Mexico Opium Poppy and Marijuana Aerial Eradication Program. GAO/NSIAD-88-73, 1/11/88.

U.S.-Mexico Opium Poppy and Marijuana Aerial Eradication Program. Testimony before the House Select Committee on Narcotics Abuse and Control. GAO/T-NSIAD-87-42, 8/5/87.

Status Report on GAO Review of the U.S. International Narcotics Control Program. Testimony before the House Committee on Foreign Affairs: Special International Narcotics Control Subcommittee. GAO/T-NSIAD-87-40, 7/29/87.

Drug Control: International Narcotics Control Activities of the United States. GAO/NSIAD-87-72BR, 1/30/87.

Suggested Improvements in Management of International Narcotics Control Program. GAO/ID-81-13, 11/13/80.

Investigations

Drug Investigations: Organized Crime Drug Enforcement Task Force Program's Accomplishments. GAO/GGD-87-64BR, 5/6/87.

Drug Investigations: Organized Crime Drug Enforcement Task Force Program: A Coordinating Mechanism. GAO/GGD-86-73BR, 7/17/86.

Customs Service's Participation in Follow-Up Investigations of Drug Smuggling Interdictions in South Florida. GAO/GGD-84-37, 7/18/84.

Investigations of Major Drug Trafficking Organizations. GAO/GGD-84-36, 3/5/84.

Organized Crime Drug Enforcement Task Forces: Status and Observation. GAO/GGD-84-35, 12/9/83.

Stronger Crackdown Needed on Clandestine Laboratories Manufacturing Dangerous Drugs. GAO/GGD-82-6, 11/6/81.

The Drug Enforcement Administration's CENTAC Program—An Effective Approach to Investigating Major Traffickers That Needs to be Expanded. GAO/GGD-80-52, 3/27/80.

Military Role

Drug Law Enforcement: Military Assistance for Anti-Drug Agencies. GAO/GGD-88-27, 12/23/87.

Coordination of Requests for Military Assistance to Civilian Law Enforcement Agencies. GAO/GGD-84-27, 11/2/83.

Military Cooperation with Civilian Law Enforcement Agencies. Testimony before the House Committee on the Judiciary: Crime Subcommittee. 7/28/83.

Sentences And Fines

Criminal Penalties Resulting from the Organized Crime Drug Enforcement Task Forces. GAO/GGD-87-29BR, 12/22/86.

Criminal Fines: Imposed and Collected as a Result of Investigations of the Organized Crime Drug Enforcement Task Force Program. GAO/GGD-86-101FS, 6/27/86.

Organized Crime Figures and Major Drug Traffickers: Parole Decisions and Sentences Served. GAO/GGD-85-29, 4/4/85.

Sentences and Fines for Organized Crime Figures and Major Drug Traffickers. GAO/GGD-85-19, 4/4/85.

Treatment And Prevention

Drug Abuse Prevention: Further Efforts Needed to Identify Programs That Work. GAO/HRD-88-26, 12/4/87.

Block Grants: Federal Set-Asides for Substance Abuse and Mental Health Services. GAO/HRD-88-17, 10/14/87.

Substance Abuse: Description of Proposed State Allotment Grant Formulas. GAO/HRD-86-140FS, 9/10/86.

Improvements in the Alcohol, Drug Abuse and Mental Health Block Grant Distribution Formula Can be Made Both Now and in the Future. GAO/GGD-84-88, 6/21/84.

States Have Made Few Changes in Implementing the Alcohol, Drug Abuse and Mental Health Services Block Grant. GAO/HRD-84-52, 6/6/84.

Drug Suppression/Habitual Offender Program Awards Were Proper. GAO/GGD-84-44, 4/3/84.

State Implementation of the Alcohol, Drug Abuse and Mental Health Block Grant. Testimony before the Senate Committee on Labor and Human Resources. 3/7/84.

Action Needed to Improve Management and Effectiveness of Drug Abuse Treatment. GAO/HRD-80-32, 4/14/80.

Other Topics

Federal Employee Drug Testing. Testimony before the House Committee on Post Office and Civil Service: Human Resources Subcommittee. GAO/T-GGD-87-18, 5/20/87.

Comments on Mandatory Drug Testing for Federal Employees. Testimony before the House Committee on Post Office and Civil Service: Human Resources Subcommittee. 9/25/86.

National Parks: Allegations Concerning Yosemite National Park Drug Investigation. GAO/RCED-86-67FS, 12/20/85.

Heroin Statistics Can be Made More Reliable. GAO/GGD-80-84, 7/30/80.

Abbreviations

ADAMHA	Alcohol, Drug Abuse and Mental Health Administration
AIDS	Acquired Immune Deficiency Syndrome
BDAC	Bureau of Drug Abuse Control
BNDD	Bureau of Narcotics and Dangerous Drugs
CEWG	Community Epidemiology Work Group
Customs	United States Customs Service
DAWN	Drug Abuse Warning Network
DEA	Drug Enforcement Administration
FBI	Federal Bureau of Investigation
FBN	Federal Bureau of Narcotics
GAO	General Accounting Office
IV	Intravenous
LAPD	Los Angeles Police Department
LSD	Lysergic Acid Diethylamide
NIDA	National Institute on Drug Abuse
NNBIS	National Narcotics Border Interdiction System
NNICC	National Narcotics Intelligence Consumers Committee
NYPD	New York Police Department
ODALE	Office for Drug Abuse Law Enforcement
ONNI	Office of National Narcotics Intelligence
PCP	Phencyclidine
SAODAP	Special Action Office for Drug Abuse Prevention

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