STRATEGY RESEARCH PROJECT



# THE 1999 NATIONAL DRUG CONTROL STRATEGY: TIME TO REDUCE THE DEMAND FOR ILLEGAL DRUGS

BY

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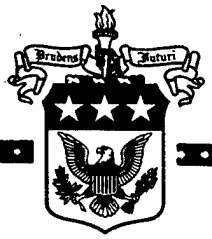
USAWC CLASS OF 2000

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# The 1999 National Drug Control Strategy: Time to Reduce the Demand for Illegal Drugs

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# ABSTRACT

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This research project reviews the drug program over the previous century and evaluates the current strategy into the new millennium. It recommends better and more efficient ways to spend tax payer dollars to counter the ill effects of illegal drugs on the well-being and economy of the United States. The study will uses analyses of history and personal experience in evaluating what will and can work to fix the drug problem in America. It finally recommends that treatment for drug abusers between the ages of 18-32 should receive top priority and that drug treatment facilities such as the "Phoenix House" exemplify programs the U.S. government should consider providing dollars to for treatment of young drug abusers. The costs associated with incarcerating drug users, indicate that effective treatment is cheaper. Finally, if demands for illegal drugs are reduced then less money would be needed to defend the borders and more dollars would be available for effective treatment. The study concludes with recommendations for better methods to deal with addicts.

## TABLE OF CONTENTS

# THE 1999 NATIONAL DRUG CONTROL STRATEGY: TIME TO REDUCE THE DEMAND FOR ILLEGAL DRUGS

## INTRODUCTION

This Strategic Research Project analyzes the national drug control strategy. It describes the current strategy and assesses its effectiveness, predicting its relevance into the new millennium. It concludes with recommendations for an improved national strategy.

The 1999 National Drug Control Strategy takes a long term, holistic view of the nation's drug problem and recognizes the significant effect drug abuse has on the nation's public health and safety.[1] The strategy maintains that no single solution or entity can effectively deal with the multifaceted challenge that drug abuse represents; that several solutions must be applied simultaneously; and that by focusing on outcomes-measured in declining drug use, reduced supply, and a lessening of attendant social consequences we can achieve our goals.[2] The current drug control strategy describes drug abuse as a national problem; it states that considerable national assets should be allocated to decrease and eventually eliminate the damage illegal drugs have inflicted on this country.

The current drug problem crosses all boundaries, affecting Americans of all races, incomes, educational levels, and social status. The strategy cities several drug-related problems, such as increases in property crime and domestic violence, noting the increasing numbers of crack addicted infants. The drug control strategy also identifies the need to combat the drug problems of young adults, the 18- to 28-year - old group that constitutes the majority of drug users in this country.

## A LOOK AT THE PREVIOUS CENTURY

The Constitution of the United States as interpreted over 208 years articulates the obligation of the federal government to uphold the public good and to provide a bulwark against all threats, foreign and domestic. Illegal drugs constitutes one such threat, as in the National Drug Control Strategy,1997. Though there were laws on the books during colonial times that prohibited public intoxication, the national attitude toward controlling alcohol and other psychoactive drugs was fairly lax until the nineteenth century.[3]

The first recorded anti-drug law was a municipal ordinance passed in San Francisco in 1875. This law prohibited Opium dens. The first actions taken at the federal level prohibited the importation of opium by Chinese nationals in 1887 (supply side strategy). In 1906, the Pure Food and Drug Act required accurate labeling of patent medicines. Heroin, cocaine, and other drugs had to be listed on the label. This Act also banned interstate shipment of cocaine and placed a limit on the import of coca leaves (supply side strategy). By 1912 nearly every state had laws controlling the distribution of certain drugs. Prior to the 1930s' most of the federal anti-narcotics legislation was oriented toward the reduction of international drug traffic (International Opium Convention of 1913 committed the United States to enact legislation to suppress the abuse of opium, morphine and cocaine and helped ensure passage of the Harrison Act in 1914). The Eighteen Amendment to the U.S. Constitution (1918) prohibiting alcohol is further evidence of

American reliance on supply-side strategies. The U.S. Treasury Department shifted focus from controlling heroin to controlling marijuana a result of the hysteria created by the press over atrocities committed against Mexican farm workers by parties under the influence of marijuana. This policy shift resulted in the creation of the Marijuana Act of 1937 (modeled after the Harrison Act). During the 1950s two new laws increased federal sanctions for drug violations. The Boggs Act of 1951 and the Narcotics Control Act of 1956 significantly increased the severity of criminal penalties for violations of the import/export and internal revenue laws related to narcotics and marijuana (supply side strategy).

President Kennedy opened the decade of the 60s with a strong commitment to mental health and treatment of addicts. The Prettyman Commission (1963 President's Commission on Narcotics and Drug Abuse) called for a larger federal role in treatment of drug addicts. The Community Mental Health Centers Acts of 1963 provided the first federal assistance to non-federal entities for treatment.

President Johnson's Administration opted for a few additional demand side initiatives. Under the Narcotics Addict Rehabilitation Act of 1966, Congress specified that "Narcotics addition" was now a mental illness, thus paving the way for federal support of local drug dependence treatment. The Mental Health Act amendments of 1968 provided funds for local drug dependence treatment. However, the primary response under the Johnson administration continued to focus on at the supply of drugs. The 1965 Drug Control Amendments brought the manufacture and distribution of amphetamines and barbiturates under federal control. Criminal penalties were also imposed for illegally manufacturing these drugs. Finally in 1968, President Johnson's Commission on Law Enforcement and the Administration of Justice (Katzenbach Commission) urged increased spending to regulate the supply of drugs.[4]

This unbalanced attack on the supply side continued through the Nixon Administration. New laws in the 1970s focused on the leaders of illegal drug enterprises and added forfeiture of the profits to international sanctions. The Controlled Substance Act of 1970 created a federal standard for drug control (schedule one and two listings of drugs). The Controlled Substance Act, Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, provided the legal foundation of the government's fight against abuse of drugs and other substances. Alarmed by the continued rise in drug use, Congress then adopted a demand strategy resulting in the passage of the Drug Abuse Office and Treatment Act of 1972. This Act created the National Institute on Drug Abuse (NIDA) and the Special Action Office for Drug Abuse Prevention. The Nixon Administration provided a $3 billion budget toward this demand strategy, a substantial allocation. The Nixon administration implemented several landmark supply strategies: The Drug Enforcement Agency (DEA) was created in 1973, along with the slogan "War On Drugs" and commencement of Operation Intercept.

Operation Intercept was the first organized and deliberate attempt to interdict the flow of drugs (mainly marijuana) at the U.S.- Mexican border by U.S. Customs Agents. Indeed Operation Intercept represented the first major U.S. attack on Latin American drugs. But it was called off after less than 30 days. It was an economic disaster for Mexico. Tourism dropped by an estimated 70%. U.S. merchants along the boarder also suffered from this poorly conceived policy. U.S. interdiction of the Mexican drug

traffic led directly to the evolution of the Columbian drug flow. In 1971 President Nixon declared a "War on drugs." The Presidential Cabinet Committee for International Narcotic Control was formed to check the illegal flow of narcotics into the U.S. The Foreign Assistance Act of 1971 provided the means to assist countries to control drug trafficking via foreign aid. It also provided the economic sanctions against and suspension of military assistance to countries not supporting the U.S. drug control strategy.[5] Nixon's foreign strategy produced some tactical successes. However, his administration failed to implement a more holistic approach to the drug problem. As the supply of heroin on American streets dwindled, the price of heroin rose sharply, making the drug even more lucrative for suppliers, thus giving rise to international Cartels in Iran, Afghanistan, Pakistan (the golden Crescent) and Southeast Asia (the Golden Triangle). Noting reduced availability of heroin on American streets, Nixon declared victory in the "War On Drugs". Overall, the Nixon administration had perhaps the most balanced demand/supply strategy up to this time in terms of budget, Infact, federal expenditures for prevention and treatment efforts actually exceeded those for trafficking control until 1975.

The Carter Administration continued to support the increase in supply side strategy with continued budget increases 1976-1979. This administration also opted to relax laws on possession of marijuana. In 1977 the administration endorsed the decriminalization of marijuana. During this time period cocaine use rapidly increased. A U.S. interagency group reported that U.S. cocaine consumption climbed to between 19 and 25 tons by 1978. But by 1984 it had grown to between 71 and 137 tons.

During his first press conference March 1981, President Reagan pledged he would refocus U.S. anti-drug policy on the demand side. "It's far more effective if you take the customers away than if you try to take the drugs away from those who want to be customers."[6] Unfortunately Reagan's subsequent actions did not reflect this early rhetoric. The Reagan administration in fact shifted to a radical supply side strategy. His administration poured huge amounts of human and financial resources into an effort to suppress drug supplies while cutting the funds aimed at reducing drug demand. Federal drug control spending on supply side programs had averaged $437 million annually for the preceding five years before Reagan took office. But during the first five years of his administration (1981-1986), spending on the supply side programs reached an annual average of $1.4 billion. In these same years, funding for demand side programs fell from an average of $386 million annually to $362.8 million annually.[7] It is easier to preach demand reduction, but time and again the facts indicate expenditure of more money for supply reduction.

The U.S. military formally entered the drug interdiction business during the Bush administration. Under increasing pressure from the public, President Bush acquiesced to Secretary of Defense Chaney and Congress and agreed to U.S. military involvement in the "War on Drugs". However, the origins of military involvement can be traced to the Nixon administration, when military equipment was loaned to the Coast Guard and U.S. Customs Agency. The translation of the Defense Appropriations Act of 1981 into Public Law 97-86 amended the Posse Comitatus Act and allowed the Department of Defense (DOD) to give limited support to federal agencies. The amendment permitted the active military to:provide

information collected during the normal course of military operations, to share military equipment and facilities, to allow military personnel to operate and maintain the equipment it had provided, and finally to train and advise civilian law enforcement.[8] The amendment had two major stipulations: "assistance could not interfere with military readiness or preparedness; and there will be no direct participation by military forces in interdiction."[9] The federal Anti-Drug Abuse Act of 1988 established as a policy goal the creation of a drug-free America. This Act established the Office of National Drug Policy to set priorities and objectives for national drug control to promulgate the National Drug Control Strategy on an annual basis, and to oversee the strategy's implementation. The 1989 Defense Authorization Act tasked DOD as the lead agency for detecting and monitoring the drug flow. President Bush issued a three-phased concept to fight the war on drugs in 1989: Phase I Attack drugs at their source through nation- building assistance. Phase II Interdict drugs from the source country. Phase III Attack drugs domestically. President Bush policy was directed primarily at the cocaine industry.

The Clinton Administration initially tried to avoid making the politically explosive choice between demand and supply strategies. The President rejected the premise that the two strategies had to compete against one another. The administration countered that demand reduction programs cannot succeed if drugs are readily available and that drug enforcement cannot succeed if the nation's appetite for illegal drugs is not curbed. The bulk of the Administration's requested increase in total drug control resources was for demand reduction programs. Clinton wanted demand reduction programs to increase by 18%, but supply reduction programs would increase by only 3%. However, the FY 95 budget, approved by Congress, under-funded many of the demand side budget initiatives sought by the Clinton administration. Supply side reduction programs decreased only from 63.7% in FY 94 to 62.8% in FY 95. The current National strategy contains all of the elements to support a balanced attack in the nation's War on Drugs. However, Congressional funding still gives primacy to the supply side.

**CURRENT STRATEGY**

The Administration's current strategy seeks to reduce the demand for drugs while curtailing the supply of illegal drugs. This strategy assumes that if the demand and supply for drugs are cut substantially, then the country could anticipate a 50% reduction in drug use. This may be true. But the strategy provides no evidence to support this auspicious prediction. So assertion seems flawed, especially since no evidence is provided to support this prediction. The current drug strategy cities five goals and thirty-one supporting objectives:

Goal #1: Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco.

Goal #2: Increase the safety of America's citizens by substantially reducing drug-related crime and violence.

Goal #3: Reduce health and social costs to the public of illegal drug use.

Goal #4: Shield America's air, land, and sea frontiers from the drug threat.

Goal #5: Break foreign and domestic drug sources of supply.[10]

These goals indeed strike a balance between supply and demand. But the dollar trail indicates that more money is spent on supply reduction rather than demand reduction. For example, a contributing author to the American Journal of Public Health, Hortensia Amaro, points out that the federal government's continued policy of spending nearly double the amount on supply reduction (interdiction) as on demand reduction (prevention) is perplexing. Treatment has been convincingly demonstrated to be more effective than law enforcement and incarceration in reducing the demand for illicit drugs. Yet in 1998 66.6% of the 16.18 billion federal drug control budget was allocated for supply reduction activities, while only 33.4% was allocated for demand reduction activities. Demand reduction dollars for FY 2000 have been increased slightly, but still fall short of dollars allocated to the supply reduction efforts.[11]

Consider this is a summary of the FY99 budget for drug control: In total, drug control funding recommended for FY 1999 is $ 17.1 billion, an increase of $1.1 billion (+6.8%) over the FY 1998 level. FY 1999 funding includes an increase of 491 million for treatment and prevention programs and an increase of $602 million for supply reduction efforts. The largest percentage increase in FY 1999 is for Goal 1 activities, which target youth: Goal 1 funding increased by 602 million (+15%). In FY 1999, new resources are included for a School Counselor Initiative, prevention research, and prevention of youth tobacco use.

Certainly both demand and supply are critical. But the administration cites demand as the primary problem. Clearly, demand is the only reason suppliers exist: They satisfy the need of drug addicts as well as more casual users. The administration realizes that this is not a perfect world and agrees that traffickers must be punished with long jail and prison terms. To ensure this occurs, the Clinton administration has hired additional policeman and prosecutors under such initiatives as "Taking back our Neighborhoods One Block at a Time."

In order to carry out its drug enforcement strategy, the Clinton administration strongly believes it must bring the nation's more than seventy million young people to adulthood free of illegal drugs. According to the Clinton administration, the only possible way to do this is to educate the youth and teach them how to reject these drugs. Current anti-drug educational programs stress the ill effects of drug abuse to communities. Also, law enforcement officers work with young people and educate them during their formative years. The administration believes these programs will prevent later drug use. Indeed recent research reveals that if young people don't use illegal drugs during their formative years, chances are good that they will never use illegal drugs. This demand-reduction strategy encourages youth not to use alcohol products or tobacco products so they will be less likely to abuse illegal drugs later inlife. In short, the National Drug Control Strategy has set a priority on preventing our youth from using drugs.

The national strategy then calls for providing treatment for the more than four million chronic abusers across the country. This group poses a major problem, since they are of childbearing age. Most of them suffer from most of the negative effects of drug addiction, such as lack of self-esteem, high unemployment, and failure to provide a supportive environment for their offspring. In short, the current strategy does not sufficiently address the need to effectively treat the young adult population of addicts.

The strategy likewise stresses the need to severely punish the suppliers of illegal drugs. Domestic criminal activity must be prosecuted aggressively. Accordingly, the administration has supported hiring an additional 100,000 policeman and additional prosecutors throughout the country.

The strategy further directs that we guard our borders against drug traffic, especially Texas, New Mexico, Arizona, and California. This effort began before the current administration; it is maintained as a carry-over from the strategy of previous administrations. Current drug control strategy acknowledges guarding the border as a federal requirement. Accordingly, we have consistently added more border patrol agents over the past eight years.

The strategy also supports a counterdrug agency operation within the Department of Defense, which uses military assets to assist in guarding our borders. This program was reduced somewhat after a young Marine patrolling the Texas border shot and killed a goat farmer. The incidents in Waco have also played a part in the reduction of the use of active forces in the drug war.

**STRATEGY INTO THE NEW MILLENNIUM**

The current strategy is sound. It should serve the nation well into the new millennium. Current data indicates that today, 6.4 percent of Americans use illegal drugs - down more than 50 percent from the 17.5 percent of the population using drugs in 1979.[12] Yet the current strategy's failure to emphasize treatment of addicts presents a real problem. The current strategy acknowledges that young adults are the major users of illegal drugs. But while it emphasizes both demand reduction and supply reduction, more money is used to reduce supply than to reduce demand. If young adult addicts remain untreated, the country risks raising another generation that will follow in the footsteps of their addicted parents. Young adult abusers are generally single parents from the lower socioeconomic level of our society.

The strategy into the new millennium must consider programs that are similar to Narcotic Anonymous or Alcoholics Anonymous such programs enables addicts to connect with people who have been through similar struggles and form a support network to help them through the hard times. This type program should be readily available by going to your local Yellow Pages. Of course, some people will need the additional structure of an inpatient or outpatient substance abuse treatment program, or a halfway house or other such facility. Our local community mental health centers or hospitals should be able to provide a list of resources available in each community.

Spirituality has been an important factor in the recovery of many addicts, and it's a central part of many programs. This should be a focused area for the new millennium: many churches provide volunteers who can assist recovering addicts and make them an integral part of the church family. Of course, we are "thinking out of the box" when we advocate reliance on voluntary support. But it is far better to enlist the help of the church than to continue to spend federal drug dollars in futile efforts to reduce the supply of drugs..

Finally, just as communities started neighborhood watch programs to keep criminals out of their communities, they must do the same to keep illegal drugs out. The strategy into the new millennium should consider starting programs such as "Rational Recovery Meetings." These weekly meetings are

similar to Narcotics Anonymous or Alcoholics Anonymous; feelings are discussed in an open forum. Rational Recovery meetings effectively focus and addictive thought process and behaviors. Behavior and what one think of oneself are key, according to most experts, to recovering from addiction. So Rational Recovery should prove to be a worth while strategy into the new millennium. Until demand is reduced, every mental health office across America should serve as a place where drug addicts can find a drug counselor who is trained in programs like Rational Recovery. They should also serve as the lead agency to pull the resources from the community together. The collective, coordinated efforts of clergy and other community leaders can effectively reduce the demand for drugs in the new millennium.

OPTIONS AND COURSES OF ACTIONS

The National drug control strategy is comprehensive. It includes all the right ingredients. The only part of the strategy that should be changed is the priority accorded to drug treatment. Presently treatment is cited as a means to achieve the third goal of reducing Health and Social Costs to the public of Illegal Drug use. Treatment should be our primary goal, because the majority of drug users are between the ages of 18 and 30, which includes most of the childbearing adults in this country. If treatment for this segment of society is not our highest priority, it doesn't matter what is done in other areas. Left untreated, these addicts will produce another generation of addicts following in the footsteps of their addicted parents. Children do what they see their parents doing. If they grow up in an environment where drugs are prevalent, then a disproportionate number of them will become addicts.

PROPOSED ADJUSTMENT TO THE CURRENT STRATEGY

Recognizing that our current strategy supports placing a higher priority on demand reduction, we should consider three programs for demand reduction. Such programs are less expensive than current supply reduction programs:

(1) Design a program in every major city where young addicted adults with dependent children could enroll in treatment facility for up to 12 months while state and federal funds support the family. Rather than put the parent in jail and the kids in foster care, attempt to salvage the family and restore the parents' health and productivity. This program certainly will have some failure, but so do the majority of other foster care programs for adolescents (under 18) convicted of drug offenses, which put both parents and children on probation and require community service of them.[13]

(2) Community service should focus on selected demand reduction programs: education, speaking at schools, passing out anti-drug literature inpubllic facilities. Some may argue that this is "negative incentive" and violates basic constitutional liberties. Maybe so, but our country's drug problem is significant enough to start experimenting with radical measures. Which is worse, allowing our nation to totally succumb to the effects of drug use, or trying drastic measures to remedy the problem? Realizing the impact on parents if they are caught experimenting with drugs, teenagers may think twice about using and dealing drugs. Realizing the potentially punitive measures, parents would work harder to offset peer influence on their teenagers.

(3) Offer corporate tax incentives for corporations that volunteer to fund at least 50% of the total costs to operate a long-term drug rehabilitation's facility (using the Phoenix House Model). Organized and legitimate institutions throughout America must "buy into" solving the drug problem. In addition to tax incentives, in-patients assigned to these long-term treatment facilities would work for the sponsoring corporations at a reduced labor rate. The "income delta" would aid in subsidizing their drug treatment. Again the effort is designed to reduce demand. Non-Fortune 500 corporations would be allowed to enter into cooperatives to participate in this program. Currently many of our country's long term treatment facilities are experiencing 85% success rates for drug addicts who complete 18-24 month programs.[14] Programs such as these will put teeth into a demand reduction strategy

**RECOMMENDATION**

The current administration should take a close look at a program structured like the ones at the Phoenix House, which set standards in the drug treatment business. Since its inception in 1967, Phoenix House has treated more than 70,000 people. The organization was among the first to adopt self- help methods that make the individual the focus of treatment and that address the underlying causes of drug abuse. Phoenix House it is one of the largest private non-profit providers of substance abuse treatment, education, and prevention service in the country.

The type of programs provided by the Phoenix House range from long-term residential treatment to day-treatment and outpatient services. These programs are in most cases alternatives to incarceration and they provide an array of options. Through collaborative partnerships with several criminal justice agencies and the courts, they provide programs for adolescents whose substance abuse problems have played a role in their criminal activities. These programs have enabled many patients avoid long-term jail sentences and are reintegrated into the community, even as they are being treated for their addictions.[15]

Continue to fund at current levels the drug control program, but make treatment the primary priority. If addicts are treated successfully, then demand goes down. This reduction in turn frees mores resources for educating the young. The only reason drugs keep flowing into the United States is because of the incredible demand. By successfully treating addicts, we could cut the number of drug users down by at least 50% over the next 10 years. In my view drug abuse is not a major problem in America. My research indicates that the current strategy is working and will continue to work. But it would be more effective if it cited treatment of addicts as its primary objective. More radical efforts must be initiated now if we are to succeed at winning the war on drugs. We must focus on the type programs outlined in this study. Our nation's failure to provide accessible and effective substance abuse treatment costs US taxpayers up to $276 billion per year. Included in these costs are expenditures for medical care, law enforcement, motor vehicle accidents, lost productivity, and incarceration.[16] We can win this war. However, we need to put more money into treatment.

## CONCLUSIONS

The therapeutic community (TC) methodology provides the best approach to substance abuse treatment. The term therapeutic community refers to both a treatment methodology and a highly structured residential treatment facility that employs this methodology. This approach relies greatly on self-help and the group process. It views drug abuse as a disorder affecting the whole person and offers a comprehensive approach to recovery. Programs that adhere to the therapeutic community approach bring a broad array of resources to bear on the needs of clients, enabling them to reformulate their views of themselves, their relationships with others, and their ability to work and to contribute to society.

Therapeutic community treatment has evolved considerably since the first therapeutic community opened in 1958, reflecting the increased professionalism and sophistication of providers and the adoption of fundamental therapeutic community methodology to meet the needs of many different treatment populations. Today the TC can provide effective treatment in a variety of settings and formats, both residential and ambulatory, for almost all substance abusers who require and can benefit from the sustained control and support this potent treatment offers.[17]

Today there are a great many successful applications of therapeutic community methodology. The primary treatment model provides a long-term residential regimen that may last 12 to 18 months. Traditional programs generally consider 12 months the optimal time for completion of this three-stage process of induction, primary treatment, and re-entry. In order to be effective, this treatment during a relatively brief period of a client's life must be capable of overcoming all the influences that will follow. New residents are often challenged with separation from the outside world in a 24 hour a day structured program that separates clients from the context of their drug use, encourages and reinforces positive behavior, and sanctions negative behavior through restrictions, denial of privileges, or additional work assignments.[18]

Traditional therapeutic communities have been able to develop innovative programs for special treatment populations that depart significantly from the basic TC treatment model without altering its essential nature or sacrificing the unique benefits of the modality. Accordingly, short term residential, ambulatory, and intervention programs have been derived from the TC model. Therapeutic communities may operate in settings such as prisons and homeless shelters.

There is little argument that the drug problem in our country has reached crisis proportions. The national strategy seeks to make a marked difference in limiting the supply that enters the country. But this solves only half the problem. If we attack the demand end of the drug epidemic with considerable resources and rigor, we will in time certainly win this war on drugs. We need real balance in our strategy.

Word Count: 4665

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