National Drug Control Strategy

1999

Office of National Drug Control Policy

The National Drug Control Strategy: 1999

The President's Message

TO THE CONGRESS OF THE UNITED STATES:

On behalf of the American people, I am pleased to transmit the *1999 National Drug Control Strategy* to the Congress. This *Strategy* renews and advances our efforts to counter the threat of drugs — a threat that continues to cost our Nation over 14,000 lives and billions of dollars each year.

There is some encouraging progress in the struggle against drugs. The *1998 Monitoring the Future* study found that youth drug use has leveled off and in many instances is on the decline — the second straight year of progress after years of steady increases. The study also found a significant strengthening of youth attitudes toward drugs: young people increasingly perceive drug use as a risky and unacceptable behavior. The rate of drug-related murders continues to decline, down from 1,302 in 1992 to 786 in 1997. Overseas, we have witnessed a decline in cocaine production by 325 metric tons in Bolivia and Peru over the last 4 years. Coca cultivation in Peru plunged 56 percent since 1995.

Nevertheless, drugs still exact a tremendous toll on this Nation. In a 10-year period, over 100,000 Americans will die from drug use. The social costs of drug use continue to climb, reaching $110 billion in 1995, a 64 percent increase since 1990. Much of the economic burden of drug abuse falls on those who do not abuse drugs — American families and their communities. Although we have made progress, much remains to be done.

The *1999 National Drug Control Strategy* provides a comprehensive balanced approach to move us closer to a drug-free America. This *Strategy* presents a long-term plan to change American attitudes and behavior with regard to illegal drugs. Among the efforts this *Strategy* focuses on are:

- Educating children: studies demonstrate that when our children understand the dangers of drugs, their rates of drug use drop. Through the National Youth Anti-Drug Media Campaign, the Safe and Drug Free Schools Program and other efforts, we will continue to focus on helping our youth reject drugs.
- Decreasing the addicted population: the addicted make up roughly a quarter of all drug users, but consume two-thirds of all drugs in America. Our strategy for reducing the number of addicts focuses on closing the "treatment gap."
- Breaking the cycle of drugs and crime: numerous studies confirm that the vast majority of prisoners commit their crimes to buy drugs or while under the influence of drugs. To help break this link between crime and drugs, we must promote the Zero Tolerance Drug Supervision initiative to better keep offenders drug- and crime-free. We can do this by helping States and localities to implement tough new systems to drug test, treat, and punish prisoners, parolees, and probationers.
- Securing our borders: the vast majority of drugs consumed in the United States enter this Nation through the Southwest border, Florida, the Gulf States, and other border areas and air and sea ports of entry. The flow of drugs into this Nation violates our sovereignty and brings crime and suffering to our streets and communities. We remain committed to, and will expand, efforts to safeguard our borders from drugs.
- Reducing the supply of drugs: we must reduce the availability of drugs and the ease with which they can be obtained. Our efforts to reduce the supply of drugs must target both domestic and overseas production of these deadly substances.

Our ability to attain these objectives is dependent upon the collective will of the American people and the strength of our leadership. The progress we have made to date is a credit to Americans of all walks of life — State and local leaders, parents, teachers, coaches, doctors, police officers, and clergy. Many have taken a stand against drugs. These gains also result from the leadership and hard work of many, including Attorney General Reno, Secretary of Health and Human Services Shalala, Secretary of Education Riley, Treasury Secretary Rubin, and Drug Policy Director McCaffrey. I also thank the Congress for their past and future support. If we are to make further progress, we must maintain a bipartisan commitment to the goals of the *Strategy.*

As we enter the new millennium, we are reminded of our common obligation to build and leave for coming generations a stronger Nation. Our *National Drug Control Strategy* will help create a safer, healthier future for all Americans.

William J. Clinton

THE WHITE HOUSE

Foreword

The *1999 National Drug Control Strategy* updates the effort to reduce the abuse, availability, and consequences of illegal drugs throughout our country. The *Strategy* focuses on shrinking America's demand for drugs, through prevention and treatment, and attacking the supply of drugs through law enforcement and international cooperation.

Drug use is preventable. If children reach adulthood without using illegal drugs, alcohol, or tobacco, they are unlikely to develop a chemical-dependency problem. To this end, the Strategy seeks to involve parents, coaches, mentors, teachers, clergy, and other role models in a broad prevention campaign.

Drug dependence is a chronic, relapsing disorder that exacts an enormous cost on individuals, families, businesses, communities, and nations. Addicted individuals frequently engage in self-destructive and criminal behavior. Treatment can help them end dependence on addictive drugs. Treatment programs also reduce the consequences of addictive drug use on the rest of society. Providing treatment for America's chronic drug users is both compassionate public policy and a sound investment.

Along with prevention and treatment, law enforcement is essential to reducing drug use in the United States. Illegal drug trafficking inflicts violence and corruption on our communities. Law enforcement is the first line of defense against such unacceptable activity.

The federal government alone bears responsibility for securing our national borders. Better organization along our land borders and at air and seaports will reduce the volume of illegal drugs reaching our communities. In 1998, 145 metric tons of cocaine were seized enroute to the United States from South America.

The rule of law and human rights are both threatened by drug trafficking. Our international supply-reduction programs attack international criminal organizations, strengthen democratic institutions, and honor our international drug-control commitments.

We are confident that a balanced strategy that relies on prevention, treatment, law enforcement, supply reduction, and international coordination can dramatically reduce the prevalence and social consequences of drug abuse.

Barry R. McCaffrey
Director
Office of National Drug Control Policy

The National Drug Control Strategy: 1999

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I. Drug-Control Strategy: An Overview

INTRODUCTION

Throughout history, the American people have demonstrated a resolve to strengthen the nation's democratic structures and improve the opportunities for all citizens to realize their full potential. In the face of wide and divergent threats to the nation's well-being, successive generations have not wavered in their determination to build a stronger, healthier country. That essential wisdom and perseverance remains with us today, especially with regard to the problem of drug abuse. The vast majority of our citizens have repeatedly asserted their desire to be rid of the threat posed by illegal drugs. The American people have consistently reaffirmed their commitment to reduce illegal drug use and its destructive consequences.

Drug abuse inflicts considerable damage on our country. The pages that follow detail the extent to which the nation suffers from drug abuse and describe what we plan to do about it. As the title of the *Strategy* implies, drug abuse is a national problem that demands a national solution that includes not only federal efforts, but efforts by states, counties, cities, communities, families, civic groups, anti-drug coalitions, and other committed organizations.

Illegal drug use and its consequences, including crime, permeate every corner of our society, afflicting inner cities, affluent suburbs, and rural communities. Drug use affects the rich and poor, educated and uneducated, professional and blue collar workers. Seventy-three percent of drug users in America are employed. Addict populations include the elderly and those — were it not for their drug habit — considered to be in the prime of their lives. Drug use is prevalent among the young (although not as widespread as many youth think). In recent years, we have seen the age for first use of drugs decline. Innocent infants are suffering in great numbers from the chemical dependencies passed on to them by mothers who are addicted to drugs. In short, illegal drugs harm all society.

The history of drug use in America over the last hundred years indicates this blight is cyclic in nature. When the nation fails to pay attention and guard against it, drug use tends to spread. The introduction of cocaine to an unsuspecting America in the late nineteenth century is a prime example of how perception and attitude affect the incidence of drug abuse. Since the psycho-pharmacological effects of cocaine were unknown and its alleged benefits were touted by some of the leading health authorities of the age (whose claims were repeated in commercial advertising), cocaine use sky-rocketed. Actions followed attitudes until the negative consequences of addiction to the drug were so apparent and widespread that the resulting alteration in perception produced a social rejection of drug abuse. Laws were promulgated, medical processes implemented, and values adopted that led to decreased drug abuse and a healthier, less crime-ridden nation.

When we relaxed our vigilance again, extensive drug abuse reappeared. New drugs came on the scene, often more potent and destructive than those that had come before. They brought with them subcultures that offered special appeal to different segments of society, too often the young and impressionable. Once again drug abuse spread, and with it deleterious consequences. Three times in a century we have seen drug use rise and fall. Illegal drug use has never disappeared entirely, although it is clear that we have brought the percentages of Americans who choose to use drugs way down.

Today, 6.4 percent of Americans use illegal drugs, down more than 50 percent from 17.5 percent of the population in 1979. But if we are not careful, the numbers could go the other way. Drug use is a reflection of attitudes. In that regard, we are concerned for children. Beginning around 1990, youth attitudes towards substance abuse became more permissive. Soon thereafter actions followed perceptions and youth use of illegal drugs increased. That trend continued for the better part of the decade. If we do not reverse it, a generation of our youth will come of age having established a pattern of drug abuse. The nation will be a long time recovering from such a tragedy.

Drug use and its consequences can be reduced. By historical standards, present rates of drug use are relatively low. With the concerted efforts outlined in this *Strategy*, we can lower them further. Indeed, the will and commitment of the American people are such that we aim to slash rates of drug use by half over the next several years.

An American View

"The care of human life and happiness, and not their destruction, is the first and only legitimate object of good government." — Thomas Jefferson

The first duty of government is to provide security for citizens. The Constitution of the United States articulates the obligation of the federal government to uphold the public good, providing a bulwark against all threats, foreign and domestic. Drug abuse, and the illicit use of alcohol and tobacco by those under the legal age, constitute such a threat. Toxic, addictive substances are a hazard to our safety and freedom, producing devastating crime and health problems. Drug abuse diminishes the potential of citizens for growth and development. Not surprisingly, 56 percent of respondents to a survey conducted by the Harvard School of Public Health in 1997 identified drugs as the most serious problem facing children in the United States.[1]

The traditions of American democracy affirm our commitment to both the rule of law and individual freedom. Although government must minimize interference in the private lives of citizens, it cannot deny people the security on which peace of mind depends. Drug abuse impairs rational thinking and the potential for a full, productive life. Drug abuse, drug trafficking, and their consequences destroy personal liberty and the well-being of communities. Drugs drain the physical, intellectual, spiritual, and moral strength of America. Crime, violence, workplace accidents, family misery, drug-exposed children, and addiction are only part of the price imposed on society. Drug abuse spawns global criminal syndicates and bankrolls those who sell drugs to young people. Illegal drugs indiscriminately destroy old and young, men and women from all racial and ethnic groups and every walk of life. No person or group is immune.

A Comprehensive, Long-Term Plan

Strategy determines the relationship between goals and available resources. Strategy guides the development of programs to achieve goals efficiently. Strategy sets timetables that can adjust as conditions change. Finally, strategy embodies and expresses will. The *National Drug Control Strategy* proposes a multi-year conceptual framework to reduce illegal drug use and availability by 50 percent. If this goal is achieved, just 3 percent of the household population aged twelve and over would use illegal drugs. This level would be the lowest recorded drug-use rate in American history. Drug-related health, economic, social, and criminal costs would also be reduced commensurately. The *Strategy* focuses on prevention, treatment, research, law enforcement, protection of our borders, and international cooperation. It provides general guidance while identifying specific initiatives. This document expresses the collective wisdom and optimism of the American people with regard to illegal drugs.

Mandate for a National Drug Control Strategy

The ways in which the federal government responds to drug abuse and trafficking are outlined in the following laws and executive orders:

- **The Controlled Substances Act, Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970** provided an effective approach to the regulation, manufacture, and

distribution of narcotics, stimulants, depressants, hallucinogens, anabolic steroids, and chemicals used in the production of controlled substances.

- **Executive Order No. 12564 (1986)** made refraining from drug use a condition of employment for all federal employees. This order required every federal agency to develop a comprehensive drug-free workplace program.
- **The Anti-Drug Abuse Act of 1988** established as a policy goal the creation of a drug-free America. A key provision of that Act was the establishment of the Office of National Drug Control Policy (ONDCP) to set priorities, implement a national strategy, and certify federal drug-control budgets. The law specifies that the strategy must be comprehensive and research-based, contain long-range goals and measurable objectives, and seek to reduce drug abuse, trafficking, and their consequences. Specifically, drug abuse is to be curbed by preventing youth from using illegal drugs, reducing the number of users, and decreasing drug availability.
- **The Violent Crime Control and Law Enforcement Act of 1994** extended ONDCP's mission to assessing budgets and resources related to the *National Drug Control Strategy.* It also established specific reporting requirements in the areas of drug use, availability, consequences, and treatment.
- **Executive Order No. 12880 (1993) and Executive Orders Nos. 12992 and 13023 (1996)** assigned ONDCP responsibility within the executive branch for leading drug-control policy and developing an outcome-measurement system. The executive orders also chartered the President's Drug Policy Council and established the ONDCP Director as the President's chief spokesman for drug control.
- **The Office of National Drug Control Policy Reauthorization Act of 1998** expanded ONDCP's mandate and authorities and set forth additional reporting requirements and expectations, including:
  1) Development of a long-term national drug strategy.
  2) Implementation of a robust performance-measurement system.
  3) Commitment to a five-year national drug-control program budget.
  4) Permanent authority granted to the High Intensity Drug Trafficking Areas (HIDTA) Program, along with improvements in HIDTA management.
  5) Greater demand-reduction responsibilities given to the Counter-Drug Technology Assessment Center (CTAC).
  6) Statutory authority for the President's Council on Counter-Narcotics.
  7) Increased reporting to Congress on drug-control activities.
  8) Reorganization of ONDCP to allow more effective national leadership.
  9) Improved coordination among National Drug Control Program agencies.
  10) Establishment of a Parents Advisory Council on Drug Abuse.

It was the sense of the Congress in this Act that substantial progress could be made toward achieving specific reductions in drug supply and demand by the year 2003 as well as during the intervening years.* This *Strategy* sets in motion policies and programs designed to make progress toward these targets. It contains careful analysis of what is achievable by when. It also presents a detailed performance measurement system that links goals, objectives, and mid- and long-term targets. As we succeed in reaching our targets, we will continue to achieve even further reductions insofar as resources and other developments allow.

Evolution of the *National Drug Control Strategy*

National drug control strategies have been produced annually since 1989. Each defined demand reduction as a priority. In addition, the strategies increasingly recognized the importance of preventing drug use by youth. The various documents affirmed that no single approach could rescue the nation from the cycle of drug abuse. A consensus was reached that drug prevention, education, treatment, and research must be complemented by supply reduction actions abroad, on our borders, and within the United States. Each strategy also shared the commitment to maintain and enforce anti-drug laws. All the strategies, with growing

* These exact targets are listed in Chapter III of this *Strategy.*

success, tied policy to a scientific body of knowledge about the nation's drug problems. The *1996 Strategy* established five goals and thirty-two supporting objectives as the basis for a coherent, long-term national effort. These goals remain the heart of the *1999 Strategy* and will guide federal drug-control agencies over the next five years. In addition, the goals will be useful for state and local governments and the private sector. They are discussed in detail in Chapter III.

Overview of the *1999 National Drug Control Strategy*

The *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. The *Strategy* maintains that no single solution or entity can suffice to 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.

The two major areas that the *Strategy's* five goals are designed to limit are the demand for drugs and the supply of drugs. It is only through a balanced array of demand reduction and supply reduction programs that we will be able to achieve a 50 percent reduction in drug use and availability and at least a 25 percent reduction in their consequences.

While both demand and supply reduction efforts must be advanced simultaneously, demand must be the priority. People's desire for drugs is what sets the drug abuse cycle in motion. Drugs are supplied by traffickers only because a profit can be made. Thus demand fuels supply. In a perfect world, if we could bring demand to zero, the economic incentive to traffic drugs would evaporate and supply would disappear. This *Strategy* recognizes, however, that in the real world some demand for illegal drugs will always be present in any given population. Drug traffickers, seeking profit, will attempt to supply that demand. They must be countered.

In a solid, well-defined strategy, demand and supply reduction efforts complement and support one another. We know that cheap and readily available drugs can undercut the effectiveness of otherwise successful demand reduction programs. We know that restricted availability and high prices can help to hold down the number of first-time users, prevent aggressive marketing of illegal drugs to the most at-risk populations by criminal drug organizations, and reduce the human, social, and economic costs of drug abuse. Only through a comprehensive, coordinated approach of both demand and supply programs can we achieve success.

If demand reduction is the primary effort, prevention is the key. Clearly, preventing drug use in the first place is preferable to waiting to address the problem later with law enforcement and treatment. The *Strategy* focuses on our young, seeking to educate them about the dangers of drugs, alcohol, and tobacco during their formative years. If we can bring the almost seventy million American children to adulthood free of substance abuse, the vast majority will avoid drug dependency for the rest of their lives. Accordingly, our primary goal is to educate and enable our youth to reject substance abuse.

During the decade of the 90s, with the exception of the past two years, the rate of substance abuse by children has risen dramatically. This increase is in contrast to the overall declining rates of drug abuse which have come down significantly from where they were in the 1970s and 1980s. Today's problem is rooted in youth perceptions, which began in 1990 and 1991 to reflect less concern for the risk of drug use and a belief that substance abuse was not all that harmful for them. Indeed, today many young people believe that most of their peers are using tobacco, alcohol, and drugs, either singularly or in combination. But this belief does not bear out in fact. Most youth do not use drugs. However, it is true that among youth, there is a strong correlation between smoking, drinking, and taking drugs, and that the more frequently each behavior is practiced, the more likely the others are to occur. The *National Drug Control Strategy* sets as its priority the prevention of our youth from using any of these substances.

Nevertheless, focusing on youth is not enough. We must develop appropriate prevention, early identification and intervention programs for vulnerable young adults as they leave their homes and families to go to college, enter the military, or come into the workplace as full-time employees. We need to treat a

large, mostly adult population of more than four million chronic users who constitute a major portion of domestic demand. Without help, these adults will suffer from poor health, unstable family relations, and other negative consequences of substance abuse. In addition, since parental alcohol and other drug abuse is a significant predictor of youth drug use, and is often the cause of serious child abuse and neglect, treatment for parents is key to breaking the inter-generational cycle of addiction. Accordingly, the *Strategy* will focus on treating those in need through a variety of means that heighten the chances of successful recovery. Although this is often a long and difficult process, research clearly demonstrates that treatment can and does work. The Strategy will take advantage of all opportunities — in the workplace, the criminal justice system, the community, and on athletic fields — to encourage drug abusers to become drug free. Indeed, there must be a synergy among the anti-drug programs offered by the nation's health care, educational, criminal justice, welfare, and job-training systems.

We must also address substance abuse by offenders. A third of state prisoners and one in five federal prisoners said they had committed their current offense while under the influence of drugs.[2] Drug offenders account for 25 percent of the growth in the state prison population and 72 percent of the growth in the federal prison population since 1990.[3] Many nonviolent, drug-related offenders will respond to a zero tolerance drug supervision program that includes treatment for substance abuse as required in lieu of incarceration. Experience shows that drug courts, testing and sanctions programs, and treatment within the criminal justice system reduce drug consumption and recidivism. Over time, expansion of alternatives to incarceration promises to decrease the overall addicted population and reduce both crime and the number of incarcerated Americans. However, the ultimate success of any of these programs will be measured by whether or not those with various combinations of substance-abuse problems, welfare dependency, and/or criminal backgrounds succeed in entering the workforce and becoming productive, self-sufficient, tax-paying members of society. Education and job-training programs must include a continuum of prevention, early identification, intervention and supportive services which effectively address the needs of the addicted, and abet recovery in training programs and in the workplace.

Along with prevention and treatment, law enforcement is essential to reducing drug use in the United States. The supply of drugs to our citizens is a criminal enterprise harmful to them and injurious to our society. Illegal drug trafficking inflicts violence and corruption on our communities. It violates the rule of law and cannot be tolerated. Law enforcement is the first line of defense against such unacceptable activity. Moreover, the criminal activity that comes with drug trafficking has both a domestic and international component. Domestic traffickers are often linked with international organizations. Our law enforcement efforts must include investigations and prosecutions to address both components of this criminal enterprise. Both domestic investigation and prosecution of drug trafficking organizations are important components of the *National Drug Control Strategy*.

The *Strategy* also stresses the need to protect borders from drug incursion and to cut drug supply more effectively in domestic communities. We have developed initiatives to share information and intelligence,[4] make use of technology, and coordinate efforts to stop the flow of drugs. Since the Southwest border is a major gateway for the entry of illegal drugs into the United States, the *Strategy* focuses on this area to synchronize technology, intelligence, and operations, and work cooperatively with Mexico to decrease drug trafficking. The *Strategy* anticipates that as we gain success at the U.S.-Mexican border, drug dealers will redouble their efforts there and elsewhere. Therefore, resources have been allocated simultaneously to close other avenues into the United States including the Virgin Islands, Puerto Rico, maritime approaches to the United States, the Canadian border, and all air and sea ports of entry.

The *Strategy* also seeks to curtail illegal drug trafficking in the transit zone between the source countries and the United States. Multinational efforts in the Caribbean, Central American, European, Far Eastern, and trans-oceanic regions will be coordinated to exert maximum pressure on drug traffickers as they seek to bring drugs in and get money out. The *Strategy* supports a number of international efforts aimed at curbing trafficking within and across international borders. Such initiatives are being coordinated with the United Nations (UN), the European Union (EU), and the Organization of American States (OAS).

The most efficient supply-reduction operations can be mounted at the source: the Andean Ridge for cocaine as well as some of the heroin supply; Mexico for a significant share of methamphetamine, heroin, and marijuana; and Southeast Asia and South Central Asia for much of the heroin. The *Strategy* describes a number of efforts to eliminate cultivation, processing, and manufacturing of illegal drugs at the source. Where our access to source regions is limited because of political or security reasons, the *Strategy* supports international efforts to curtail drug production and trafficking.

Overall, the *National Drug Control Strategy* is based on the best available research and well-designed technological, information, and intelligence systems. The *Strategy* is linked to a budget through on-going feedback from ONDCP's performance measures of effectiveness system in order to apply increasingly more effective approaches to the nation's drug problem. In that conditions are fluid, the *Strategy* will change as new drug trends develop. We will measure — target by target — how successful we are in achieving the goals and objectives. Yet we recognize that the federal government cannot meet these goals by itself. Only a truly national effort that is buttressed by international cooperation can achieve them. Constant reassessment will allow the *Strategy* to adapt continually in the face of new realities. The *Strategy* is informed by — and therefore seeks — input and feedback from all governmental and non-governmental agencies, organizations, and individuals committed to the lessening of drug abuse.

In the end, we have only one overriding objective. We seek to keep Americans safe from the threats posed by illegal drugs. We want to see a healthier, more secure, less violent, and more stable nation unfettered by illegal drugs and those who traffic in them.

Elements of the *1999 National Drug Control Strategy*

Democratic: Our nation's domestic challenge is to reduce illegal drug use and its criminal, health, and economic consequences while protecting individual liberty and the rule of law. Our international challenge is to develop effective, cooperative programs that respect national sovereignty and reduce the cultivation, production, trafficking, distribution, and use of illegal drugs while supporting democratic governance and human rights.

Outcome-oriented: To translate words into deeds, the *Strategy* must ensure accountability. *Performance Measures of Effectiveness: Implementation and Findings*[5] details long- and mid-term targets that gauge progress toward each of the *Strategy's* goals and objectives.

Comprehensive: Successfully addressing the devastating drug problem in America requires a multi-faceted, balanced program that attacks both supply and demand. Prevention, education, treatment, workplace programs, research, law enforcement, interdiction, and drug-crop reduction must all be components of the response. The *1999 Strategy* continues to adhere to a principle that appeared originally ten years ago, that no single tactic, pursued alone or to the detriment of other possible and valuable initiatives, can work to contain or reduce drug use. We can expect no panacea, no "silver bullet," to solve the nation's drug-abuse problem. We will have to move forward simultaneously on several paths at once if we are to be successful.

Long-term: No short-term solution is possible to a national drug problem that requires the education of each new generation and resolute opposition to criminal drug traffickers. We must adhere to our principles over the long term. Only with a consistent approach that is internally coherent can we hope to turn back the threat of rising drug abuse.

Wide-ranging: Our response to the drug problem must support the needs of families, schools, and communities. It also must address international aspects of drug control through bilateral, regional, and global accords.

Realistic: Some people believe drug use is so deeply embedded in society that we can never decrease it. Others feel that draconian measures are required. The *1999 Strategy* rejects both these views. Although we cannot eliminate illegal drug use, history demonstrates that we can control this cancer without compromising American ideals.

Science-based: Facts, rather than ideology or anecdote, must provide the foundation for rational drug policy. The informational basis of this *Strategy* is grounded in research. Its effectiveness is gauged over time by objective performance measurements. Over the years it will be adjusted in accordance with the findings of the research and performance measurement efforts.

Goals of the *1999 Strategy*

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.

The five goals and thirty-one objectives* reflect the need for prevention and education to protect all Americans, especially children, from the perils of drugs; treatment to help the chemically dependent; law enforcement to bring traffickers and other drug offenders to justice; interdiction to reduce the flow of drugs into our nation; international cooperation to confront drug cultivation, production, trafficking, and use; and research to provide a foundation based on science.

* The goals and objectives are displayed at the center of the *Strategy.*

Drug Control is a Continuous Challenge

The metaphor of a "war on drugs" is misleading. Although wars are expected to end, drug control is a continuous challenge. The moment we believe ourselves victorious and drop our guard, the drug problem will resurface with the next generation. In order to reduce demand for drugs, prevention efforts must be ongoing. The chronically addicted should be held accountable for negative behavior and offered treatment to help change destructive patterns. Addicts must be helped, not defeated. While we seek to reduce demand, we also must target supply.

Cancer is a more appropriate metaphor for the nation's drug problem. Dealing with cancer is a long-term proposition. It requires the mobilization of support mechanisms — medical, educational, and societal — to check the spread of the disease and improve the prognosis. The symptoms of the illness must be managed while the root cause is attacked. The key to reducing both drug abuse and cancer is research-driven prevention coupled with cutting-edge treatment.

Endnotes

1 Harvard University/University of Maryland, *American Attitudes Toward Children's Health Issues* (Princeton, N.J.: Robert Wood Johnson Foundation, 1997).

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I. Drug-Control Strategy: An Overview

INTRODUCTION

Throughout history, the American people have demonstrated a resolve to strengthen the nation's democratic structures and improve the opportunities for all citizens to realize their full potential. In the face of wide and divergent threats to the nation's well-being, successive generations have not wavered in their determination to build a stronger, healthier country. That essential wisdom and perseverance remains with us today, especially with regard to the problem of drug abuse. The vast majority of our citizens have repeatedly asserted their desire to be rid of the threat posed by illegal drugs. The American people have consistently reaffirmed their commitment to reduce illegal drug use and its destructive consequences.

Drug abuse inflicts considerable damage on our country. The pages that follow detail the extent to which the nation suffers from drug abuse and describe what we plan to do about it. As the title of the *Strategy* implies, drug abuse is a national problem that demands a national solution that includes not only federal efforts, but efforts by states, counties, cities, communities, families, civic groups, anti-drug coalitions, and other committed organizations.

Illegal drug use and its consequences, including crime, permeate every corner of our society, afflicting inner cities, affluent suburbs, and rural communities. Drug use affects the rich and poor, educated and uneducated, professional and blue collar workers. Seventy-three percent of drug users in America are employed. Addict populations include the elderly and those — were it not for their drug habit — considered to be in the prime of their lives. Drug use is prevalent among the young (although not as widespread as many youth think). In recent years, we have seen the age for first use of drugs decline. Innocent infants are suffering in great numbers from the chemical dependencies passed on to them by mothers who are addicted to drugs. In short, illegal drugs harm all society.

The history of drug use in America over the last hundred years indicates this blight is cyclic in nature. When the nation fails to pay attention and guard against it, drug use tends to spread. The introduction of cocaine to an unsuspecting America in the late nineteenth century is a prime example of how perception and attitude affect the incidence of drug abuse. Since the psycho-pharmacological effects of cocaine were unknown and its alleged benefits were touted by some of the leading health authorities of the age (whose claims were repeated in commercial advertising), cocaine use sky-rocketed. Actions followed attitudes until the negative consequences of addiction to the drug were so apparent and widespread that the resulting alteration in perception produced a social rejection of drug abuse. Laws were promulgated, medical processes implemented, and values adopted that led to decreased drug abuse and a healthier, less crime-ridden nation.

When we relaxed our vigilance again, extensive drug abuse reappeared. New drugs came on the scene, often more potent and destructive than those that had come before. They brought with them subcultures that offered special appeal to different segments of society, too often the young and impressionable. Once again drug abuse spread, and with it deleterious consequences. Three times in a century we have seen drug use rise and fall. Illegal drug use has never disappeared entirely, although it is clear that we have brought the percentages of Americans who choose to use drugs way down.

Today, 6.4 percent of Americans use illegal drugs, down more than 50 percent from 17.5 percent of the population in 1979. But if we are not careful, the numbers could go the other way. Drug use is a reflection of attitudes. In that regard, we are concerned for children. Beginning around 1990, youth attitudes towards substance abuse became more permissive. Soon thereafter actions followed perceptions and youth use of illegal drugs increased. That trend continued for the better part of the decade. If we do not reverse it, a generation of our youth will come of age having established a pattern of drug abuse. The nation will be a long time recovering from such a tragedy.

Drug use and its consequences can be reduced. By historical standards, present rates of drug use are relatively low. With the concerted efforts outlined in this *Strategy*, we can lower them further. Indeed, the will and commitment of the American people are such that we aim to slash rates of drug use by half over the next several years.

An American View

"The care of human life and happiness, and not their destruction, is the first and only legitimate object of good government." — Thomas Jefferson

The first duty of government is to provide security for citizens. The Constitution of the United States articulates the obligation of the federal government to uphold the public good, providing a bulwark against all threats, foreign and domestic. Drug abuse, and the illicit use of alcohol and tobacco by those under the legal age, constitute such a threat. Toxic, addictive substances are a hazard to our safety and freedom, producing devastating crime and health problems. Drug abuse diminishes the potential of citizens for growth and development. Not surprisingly, 56 percent of respondents to a survey conducted by the Harvard School of Public Health in 1997 identified drugs as the most serious problem facing children in the United States.[1]

The traditions of American democracy affirm our commitment to both the rule of law and individual freedom. Although government must minimize interference in the private lives of citizens, it cannot deny people the security on which peace of mind depends. Drug abuse impairs rational thinking and the potential for a full, productive life. Drug abuse, drug trafficking, and their consequences destroy personal liberty and the well-being of communities. Drugs drain the physical, intellectual, spiritual, and moral strength of America. Crime, violence, workplace accidents, family misery, drug-exposed children, and addiction are only part of the price imposed on society. Drug abuse spawns global criminal syndicates and bankrolls those who sell drugs to young people. Illegal drugs indiscriminately destroy old and young, men and women from all racial and ethnic groups and every walk of life. No person or group is immune.

A Comprehensive, Long-Term Plan

Strategy determines the relationship between goals and available resources. Strategy guides the development of programs to achieve goals efficiently. Strategy sets timetables that can adjust as conditions change. Finally, strategy embodies and expresses will. The *National Drug Control Strategy* proposes a multi-year conceptual framework to reduce illegal drug use and availability by 50 percent. If this goal is achieved, just 3 percent of the household population aged twelve and over would use illegal drugs. This level would be the lowest recorded drug-use rate in American history. Drug-related health, economic, social, and criminal costs would also be reduced commensurately. The *Strategy* focuses on prevention, treatment, research, law enforcement, protection of our borders, and international cooperation. It provides general guidance while identifying specific initiatives. This document expresses the collective wisdom and optimism of the American people with regard to illegal drugs.

Mandate for a National Drug Control Strategy

The ways in which the federal government responds to drug abuse and trafficking are outlined in the following laws and executive orders:

- **The Controlled Substances Act, Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970** provided an effective approach to the regulation, manufacture, and

distribution of narcotics, stimulants, depressants, hallucinogens, anabolic steroids, and chemicals used in the production of controlled substances.

- **Executive Order No. 12564 (1986)** made refraining from drug use a condition of employment for all federal employees. This order required every federal agency to develop a comprehensive drug-free workplace program.
- **The Anti-Drug Abuse Act of 1988** established as a policy goal the creation of a drug-free America. A key provision of that Act was the establishment of the Office of National Drug Control Policy (ONDCP) to set priorities, implement a national strategy, and certify federal drug-control budgets. The law specifies that the strategy must be comprehensive and research-based, contain long-range goals and measurable objectives, and seek to reduce drug abuse, trafficking, and their consequences. Specifically, drug abuse is to be curbed by preventing youth from using illegal drugs, reducing the number of users, and decreasing drug availability.
- **The Violent Crime Control and Law Enforcement Act of 1994** extended ONDCP's mission to assessing budgets and resources related to the *National Drug Control Strategy.* It also established specific reporting requirements in the areas of drug use, availability, consequences, and treatment.
- **Executive Order No. 12880 (1993) and Executive Orders Nos. 12992 and 13023 (1996)** assigned ONDCP responsibility within the executive branch for leading drug-control policy and developing an outcome-measurement system. The executive orders also chartered the President's Drug Policy Council and established the ONDCP Director as the President's chief spokesman for drug control.
- **The Office of National Drug Control Policy Reauthorization Act of 1998** expanded ONDCP's mandate and authorities and set forth additional reporting requirements and expectations, including:
  1) Development of a long-term national drug strategy.
  2) Implementation of a robust performance-measurement system.
  3) Commitment to a five-year national drug-control program budget.
  4) Permanent authority granted to the High Intensity Drug Trafficking Areas (HIDTA) Program, along with improvements in HIDTA management.
  5) Greater demand-reduction responsibilities given to the Counter-Drug Technology Assessment Center (CTAC).
  6) Statutory authority for the President's Council on Counter-Narcotics.
  7) Increased reporting to Congress on drug-control activities.
  8) Reorganization of ONDCP to allow more effective national leadership.
  9) Improved coordination among National Drug Control Program agencies.
  10) Establishment of a Parents Advisory Council on Drug Abuse.

It was the sense of the Congress in this Act that substantial progress could be made toward achieving specific reductions in drug supply and demand by the year 2003 as well as during the intervening years.* This *Strategy* sets in motion policies and programs designed to make progress toward these targets. It contains careful analysis of what is achievable by when. It also presents a detailed performance measurement system that links goals, objectives, and mid- and long-term targets. As we succeed in reaching our targets, we will continue to achieve even further reductions insofar as resources and other developments allow.

Evolution of the *National Drug Control Strategy*

National drug control strategies have been produced annually since 1989. Each defined demand reduction as a priority. In addition, the strategies increasingly recognized the importance of preventing drug use by youth. The various documents affirmed that no single approach could rescue the nation from the cycle of drug abuse. A consensus was reached that drug prevention, education, treatment, and research must be complemented by supply reduction actions abroad, on our borders, and within the United States. Each strategy also shared the commitment to maintain and enforce anti-drug laws. All the strategies, with growing

* These exact targets are listed in Chapter III of this *Strategy.*

success, tied policy to a scientific body of knowledge about the nation's drug problems. The *1996 Strategy* established five goals and thirty-two supporting objectives as the basis for a coherent, long-term national effort. These goals remain the heart of the *1999 Strategy* and will guide federal drug-control agencies over the next five years. In addition, the goals will be useful for state and local governments and the private sector. They are discussed in detail in Chapter III.

Overview of the *1999 National Drug Control Strategy*

The *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. The *Strategy* maintains that no single solution or entity can suffice to 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.

The two major areas that the *Strategy's* five goals are designed to limit are the demand for drugs and the supply of drugs. It is only through a balanced array of demand reduction and supply reduction programs that we will be able to achieve a 50 percent reduction in drug use and availability and at least a 25 percent reduction in their consequences.

While both demand and supply reduction efforts must be advanced simultaneously, demand must be the priority. People's desire for drugs is what sets the drug abuse cycle in motion. Drugs are supplied by traffickers only because a profit can be made. Thus demand fuels supply. In a perfect world, if we could bring demand to zero, the economic incentive to traffic drugs would evaporate and supply would disappear. This *Strategy* recognizes, however, that in the real world some demand for illegal drugs will always be present in any given population. Drug traffickers, seeking profit, will attempt to supply that demand. They must be countered.

In a solid, well-defined strategy, demand and supply reduction efforts complement and support one another. We know that cheap and readily available drugs can undercut the effectiveness of otherwise successful demand reduction programs. We know that restricted availability and high prices can help to hold down the number of first-time users, prevent aggressive marketing of illegal drugs to the most at-risk populations by criminal drug organizations, and reduce the human, social, and economic costs of drug abuse. Only through a comprehensive, coordinated approach of both demand and supply programs can we achieve success.

If demand reduction is the primary effort, prevention is the key. Clearly, preventing drug use in the first place is preferable to waiting to address the problem later with law enforcement and treatment. The *Strategy* focuses on our young, seeking to educate them about the dangers of drugs, alcohol, and tobacco during their formative years. If we can bring the almost seventy million American children to adulthood free of substance abuse, the vast majority will avoid drug dependency for the rest of their lives. Accordingly, our primary goal is to educate and enable our youth to reject substance abuse.

During the decade of the 90s, with the exception of the past two years, the rate of substance abuse by children has risen dramatically. This increase is in contrast to the overall declining rates of drug abuse which have come down significantly from where they were in the 1970s and 1980s. Today's problem is rooted in youth perceptions, which began in 1990 and 1991 to reflect less concern for the risk of drug use and a belief that substance abuse was not all that harmful for them. Indeed, today many young people believe that most of their peers are using tobacco, alcohol, and drugs, either singularly or in combination. But this belief does not bear out in fact. Most youth do not use drugs. However, it is true that among youth, there is a strong correlation between smoking, drinking, and taking drugs, and that the more frequently each behavior is practiced, the more likely the others are to occur. The *National Drug Control Strategy* sets as its priority the prevention of our youth from using any of these substances.

Nevertheless, focusing on youth is not enough. We must develop appropriate prevention, early identification and intervention programs for vulnerable young adults as they leave their homes and families to go to college, enter the military, or come into the workplace as full-time employees. We need to treat a

large, mostly adult population of more than four million chronic users who constitute a major portion of domestic demand. Without help, these adults will suffer from poor health, unstable family relations, and other negative consequences of substance abuse. In addition, since parental alcohol and other drug abuse is a significant predictor of youth drug use, and is often the cause of serious child abuse and neglect, treatment for parents is key to breaking the inter-generational cycle of addiction. Accordingly, the *Strategy* will focus on treating those in need through a variety of means that heighten the chances of successful recovery. Although this is often a long and difficult process, research clearly demonstrates that treatment can and does work. The Strategy will take advantage of all opportunities — in the workplace, the criminal justice system, the community, and on athletic fields — to encourage drug abusers to become drug free. Indeed, there must be a synergy among the anti-drug programs offered by the nation's health care, educational, criminal justice, welfare, and job-training systems.

We must also address substance abuse by offenders. A third of state prisoners and one in five federal prisoners said they had committed their current offense while under the influence of drugs.[2] Drug offenders account for 25 percent of the growth in the state prison population and 72 percent of the growth in the federal prison population since 1990.[3] Many nonviolent, drug-related offenders will respond to a zero tolerance drug supervision program that includes treatment for substance abuse as required in lieu of incarceration. Experience shows that drug courts, testing and sanctions programs, and treatment within the criminal justice system reduce drug consumption and recidivism. Over time, expansion of alternatives to incarceration promises to decrease the overall addicted population and reduce both crime and the number of incarcerated Americans. However, the ultimate success of any of these programs will be measured by whether or not those with various combinations of substance-abuse problems, welfare dependency, and/or criminal backgrounds succeed in entering the workforce and becoming productive, self-sufficient, tax-paying members of society. Education and job-training programs must include a continuum of prevention, early identification, intervention and supportive services which effectively address the needs of the addicted, and abet recovery in training programs and in the workplace.

Along with prevention and treatment, law enforcement is essential to reducing drug use in the United States. The supply of drugs to our citizens is a criminal enterprise harmful to them and injurious to our society. Illegal drug trafficking inflicts violence and corruption on our communities. It violates the rule of law and cannot be tolerated. Law enforcement is the first line of defense against such unacceptable activity. Moreover, the criminal activity that comes with drug trafficking has both a domestic and international component. Domestic traffickers are often linked with international organizations. Our law enforcement efforts must include investigations and prosecutions to address both components of this criminal enterprise. Both domestic investigation and prosecution of drug trafficking organizations are important components of the *National Drug Control Strategy*.

The *Strategy* also stresses the need to protect borders from drug incursion and to cut drug supply more effectively in domestic communities. We have developed initiatives to share information and intelligence,[4] make use of technology, and coordinate efforts to stop the flow of drugs. Since the Southwest border is a major gateway for the entry of illegal drugs into the United States, the *Strategy* focuses on this area to synchronize technology, intelligence, and operations, and work cooperatively with Mexico to decrease drug trafficking. The *Strategy* anticipates that as we gain success at the U.S.-Mexican border, drug dealers will redouble their efforts there and elsewhere. Therefore, resources have been allocated simultaneously to close other avenues into the United States including the Virgin Islands, Puerto Rico, maritime approaches to the United States, the Canadian border, and all air and sea ports of entry.

The *Strategy* also seeks to curtail illegal drug trafficking in the transit zone between the source countries and the United States. Multinational efforts in the Caribbean, Central American, European, Far Eastern, and trans-oceanic regions will be coordinated to exert maximum pressure on drug traffickers as they seek to bring drugs in and get money out. The *Strategy* supports a number of international efforts aimed at curbing trafficking within and across international borders. Such initiatives are being coordinated with the United Nations (UN), the European Union (EU), and the Organization of American States (OAS).

The most efficient supply-reduction operations can be mounted at the source: the Andean Ridge for cocaine as well as some of the heroin supply; Mexico for a significant share of methamphetamine, heroin, and marijuana; and Southeast Asia and South Central Asia for much of the heroin. The *Strategy* describes a number of efforts to eliminate cultivation, processing, and manufacturing of illegal drugs at the source. Where our access to source regions is limited because of political or security reasons, the *Strategy* supports international efforts to curtail drug production and trafficking.

Overall, the *National Drug Control Strategy* is based on the best available research and well-designed technological, information, and intelligence systems. The *Strategy* is linked to a budget through on-going feedback from ONDCP's performance measures of effectiveness system in order to apply increasingly more effective approaches to the nation's drug problem. In that conditions are fluid, the *Strategy* will change as new drug trends develop. We will measure — target by target — how successful we are in achieving the goals and objectives. Yet we recognize that the federal government cannot meet these goals by itself. Only a truly national effort that is buttressed by international cooperation can achieve them. Constant reassessment will allow the *Strategy* to adapt continually in the face of new realities. The *Strategy* is informed by — and therefore seeks — input and feedback from all governmental and non-governmental agencies, organizations, and individuals committed to the lessening of drug abuse.

In the end, we have only one overriding objective. We seek to keep Americans safe from the threats posed by illegal drugs. We want to see a healthier, more secure, less violent, and more stable nation unfettered by illegal drugs and those who traffic in them.

Elements of the *1999 National Drug Control Strategy*

Democratic: Our nation's domestic challenge is to reduce illegal drug use and its criminal, health, and economic consequences while protecting individual liberty and the rule of law. Our international challenge is to develop effective, cooperative programs that respect national sovereignty and reduce the cultivation, production, trafficking, distribution, and use of illegal drugs while supporting democratic governance and human rights.

Outcome-oriented: To translate words into deeds, the *Strategy* must ensure accountability. *Performance Measures of Effectiveness: Implementation and Findings*[5] details long- and mid-term targets that gauge progress toward each of the *Strategy's* goals and objectives.

Comprehensive: Successfully addressing the devastating drug problem in America requires a multi-faceted, balanced program that attacks both supply and demand. Prevention, education, treatment, workplace programs, research, law enforcement, interdiction, and drug-crop reduction must all be components of the response. The *1999 Strategy* continues to adhere to a principle that appeared originally ten years ago, that no single tactic, pursued alone or to the detriment of other possible and valuable initiatives, can work to contain or reduce drug use. We can expect no panacea, no "silver bullet," to solve the nation's drug-abuse problem. We will have to move forward simultaneously on several paths at once if we are to be successful.

Long-term: No short-term solution is possible to a national drug problem that requires the education of each new generation and resolute opposition to criminal drug traffickers. We must adhere to our principles over the long term. Only with a consistent approach that is internally coherent can we hope to turn back the threat of rising drug abuse.

Wide-ranging: Our response to the drug problem must support the needs of families, schools, and communities. It also must address international aspects of drug control through bilateral, regional, and global accords.

Realistic: Some people believe drug use is so deeply embedded in society that we can never decrease it. Others feel that draconian measures are required. The *1999 Strategy* rejects both these views. Although we cannot eliminate illegal drug use, history demonstrates that we can control this cancer without compromising American ideals.

Science-based: Facts, rather than ideology or anecdote, must provide the foundation for rational drug policy. The informational basis of this *Strategy* is grounded in research. Its effectiveness is gauged over time by objective performance measurements. Over the years it will be adjusted in accordance with the findings of the research and performance measurement efforts.

Goals of the *1999 Strategy*

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.

The five goals and thirty-one objectives* reflect the need for prevention and education to protect all Americans, especially children, from the perils of drugs; treatment to help the chemically dependent; law enforcement to bring traffickers and other drug offenders to justice; interdiction to reduce the flow of drugs into our nation; international cooperation to confront drug cultivation, production, trafficking, and use; and research to provide a foundation based on science.

* The goals and objectives are displayed at the center of the *Strategy.*

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The metaphor of a "war on drugs" is misleading. Although wars are expected to end, drug control is a continuous challenge. The moment we believe ourselves victorious and drop our guard, the drug problem will resurface with the next generation. In order to reduce demand for drugs, prevention efforts must be ongoing. The chronically addicted should be held accountable for negative behavior and offered treatment to help change destructive patterns. Addicts must be helped, not defeated. While we seek to reduce demand, we also must target supply.

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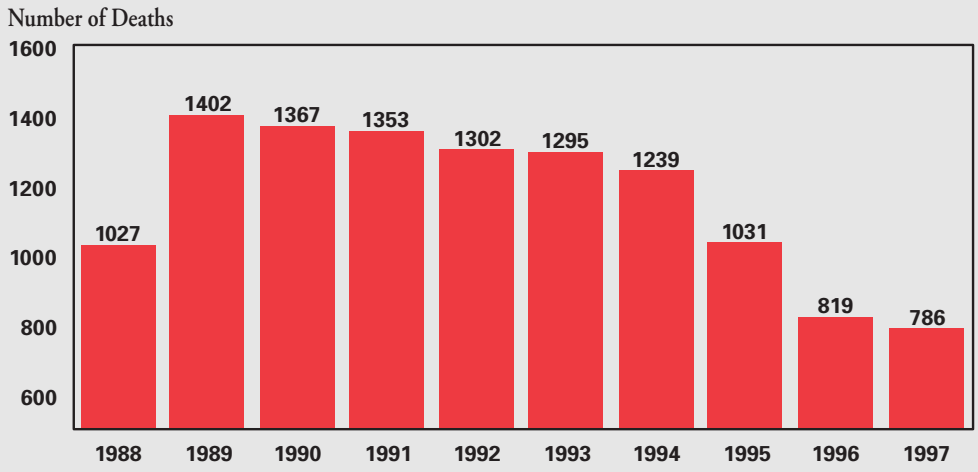
Drug Related Murders Continue to Decline

Murders related to narcotic drug laws

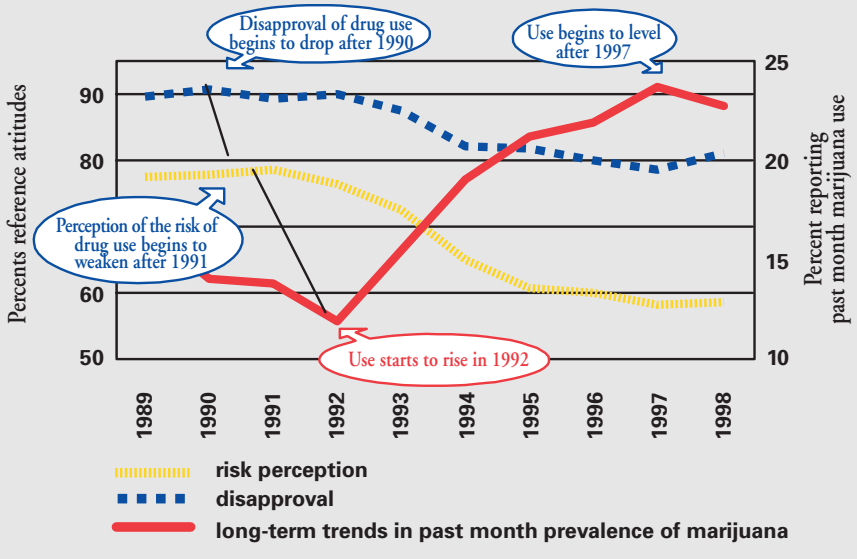


Source: FBI, Uniform Crime Reports.

National Anti-Drug

Youth Attitudes Determine Youth Marijuana Use

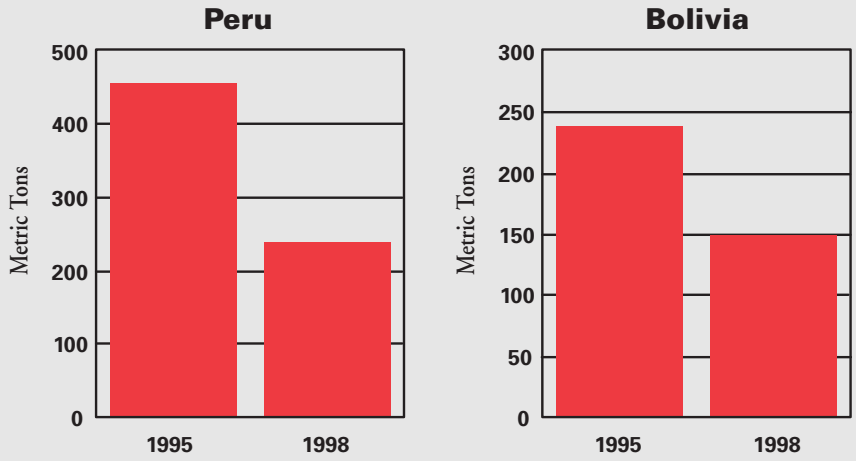
The Case of 12th Graders



Source: 1998 Monitoring the Future Study

Cocaine Production in Peru and Bolivia has Declined Dramatically

1995 to 1998

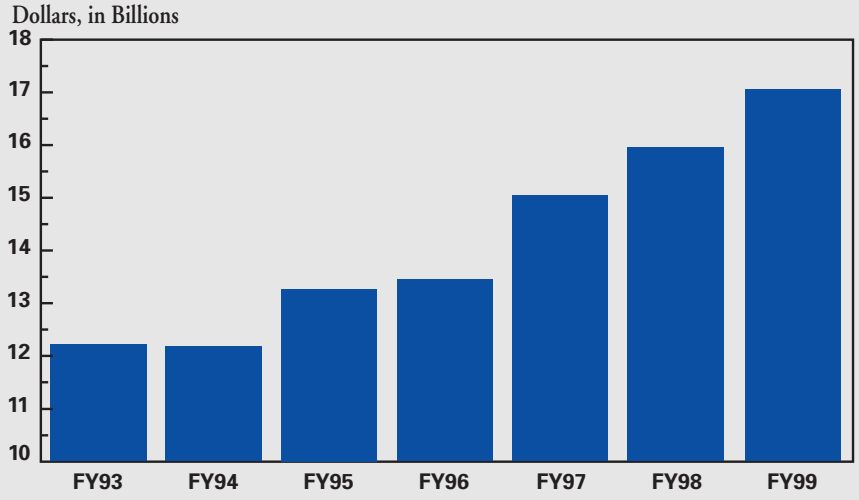


Source: ONDCP 1999

Policy is Working

Federal Counterdrug Spending Has Increased

Fiscal Year 1993-1999

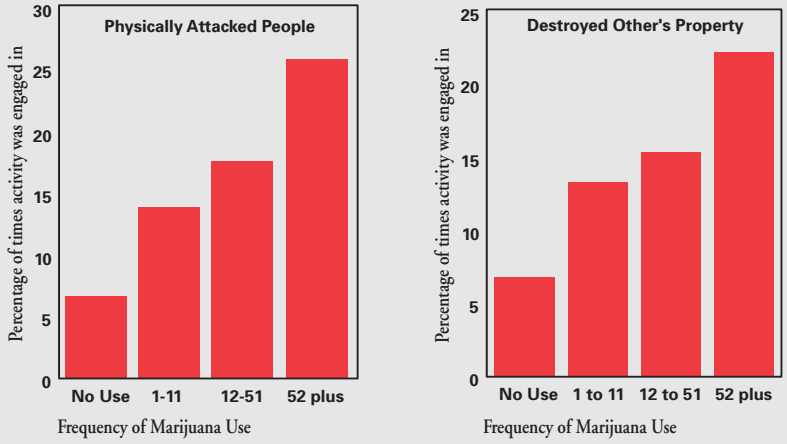


- **Almost 40% Increase in Prevention**
- **17% Increase in Treatment**

Source: OMB, 1999

Aggressive Anti-Social Behavior is Clearly Linked to Marijuana Use

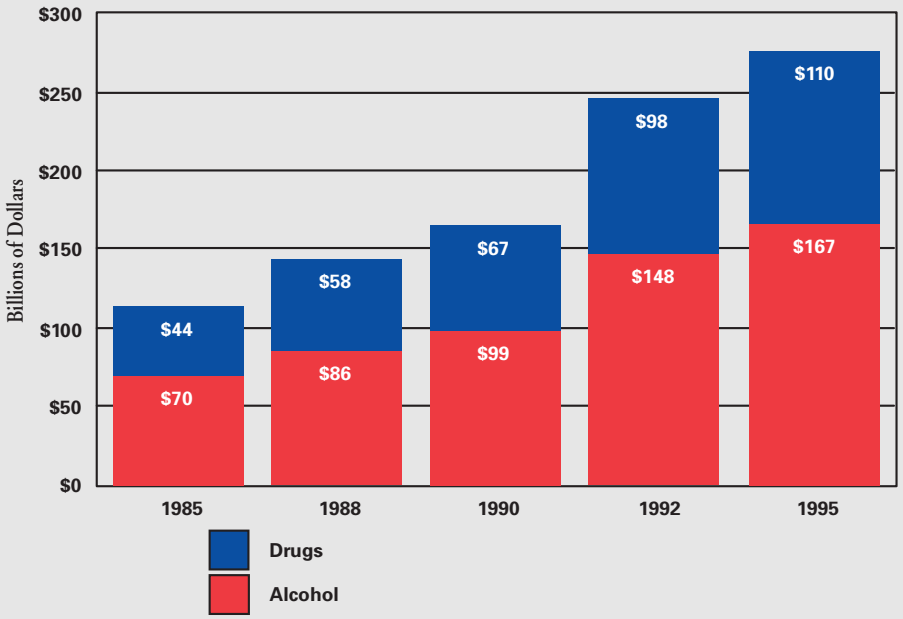
Percentage of those ages 12 to 17 who reported aggressive behavior in past 6 months, by number of days marijuana was used in the past year



Source: NHSDA Household Survey Data, 1994-1996

But We Still

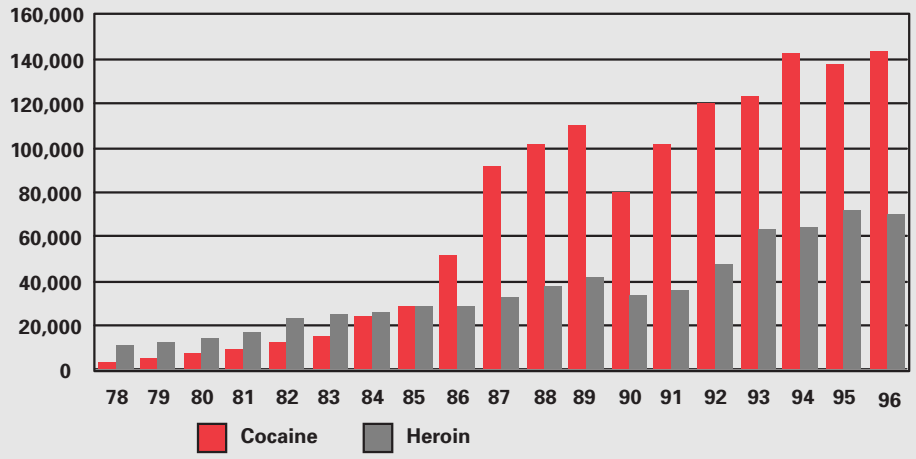
The Social Costs of Drug and Alcohol Abuse



Sources: Rice et al. 1990; Robert Wood Johnson Foundation, 1993; National Institute on Drug Abuse & National Institute on Alcohol Abuse and Alcoholism, March 1998

The Health Impact of Drug Abuse

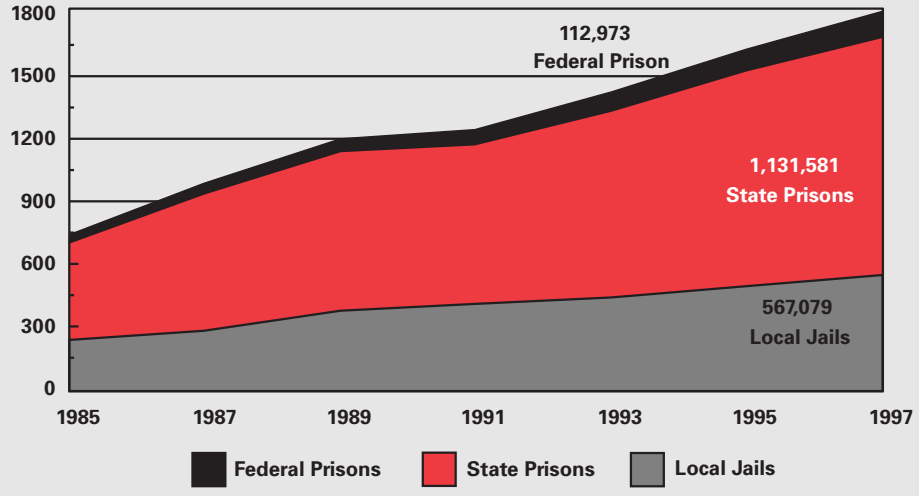
Cocaine and heroin hospital emergency room mentions, 1978-1996



Source: HHS Drug Abuse Warning Network

Have A Challenge.

1.8 Million Americans are Incarcerated: An All-time High



Source: Bureau of Justice Statistics, 1998

II. America's Drug Use Profile

DRUG USE AMONG AMERICANS

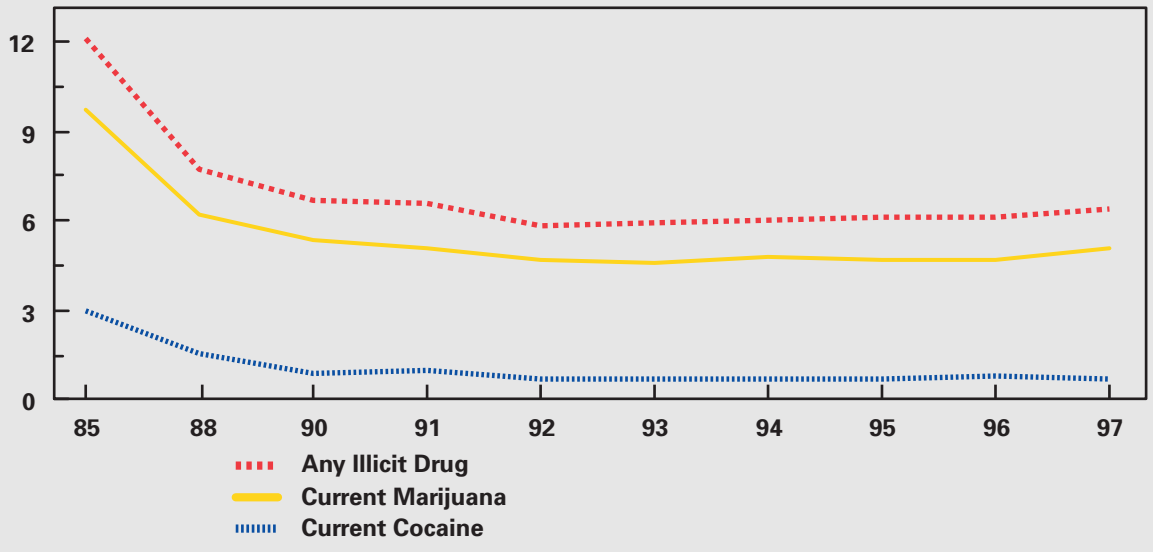
The use of illicit drugs is one of the most serious problems facing American society. The devastation wrought by drugs plays a part in virtually every major social issue in America today, be it health care, crime, mental illness, the dissolution of families, child abuse, or the spread of disease. It is a problem of both domestic and international dimensions. Overseas, drug traffickers often ally with guerrillas or corrupt government officials to subvert the rule of law. Drug abuse and the trade it establishes rob honest men and women around the world of good government, crime-free lives, adequate medical systems and the fullness of human potential. Within our own borders, illegal drugs spread ruin and destroy human potential.

Fifty-six percent of Americans think that drug abuse is one of the top three most serious problems facing children in America.[1] Many are troubled by youth drug use which, in recent years, has been on the rise. The most current data, however, indicate that this trend is flattening and, in some cases, reversing. Nevertheless, drug use by our young people today will, in some measure, translate into addiction tomorrow. We cannot afford to be less than vigilant.

The encouraging news is that overall drug use rates are about half of what they were in the late

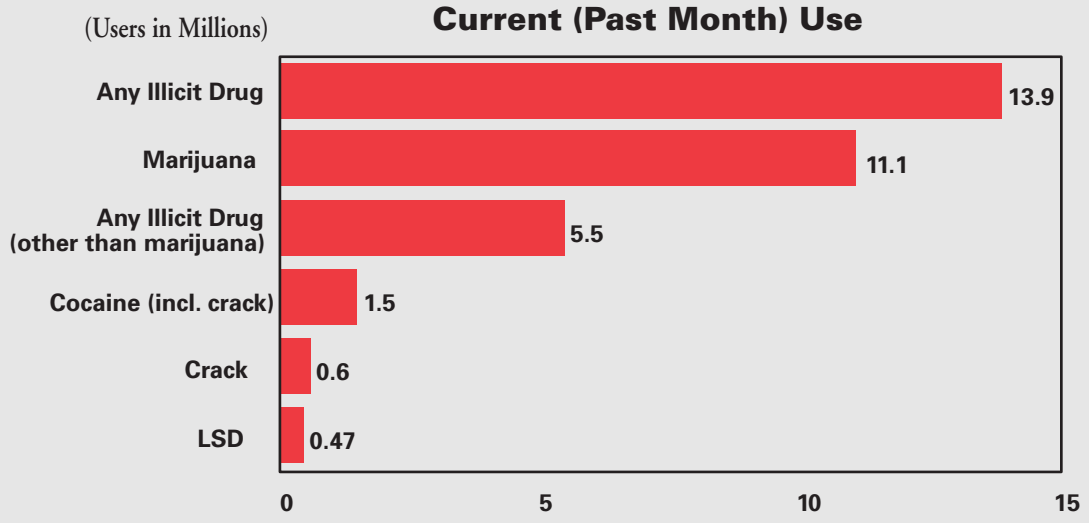
Since 1985, Current Drug Use is Down Substantially

Percentage of Household Population Reporting Past Month Drug Use



Source: 1997 National Household Survey on Drug Abuse

In 1997, 14 Million Were Current (past month) Users of an Illicit Drug



Source: 1997 National Household Survey on Drug Abuse

1970s. In 1997 there were 13.9 million current users of any illicit drug in the total household population aged 12 and older, down from the peak year of 1979, when twenty-five million (or 14.1 percent of the population) abused illegal drugs.[2]* The 13.9 million number represents 6.4 percent of the total population and is statistically unchanged from 1996.[3] The most commonly abused drug is marijuana: sixty percent of these users abused marijuana only.[4] But even with the dramatic drop in overall use, far too many Americans still use drugs. Thirty-six percent of those aged twelve and older have used an illegal drug in their lifetime. Of these, more than 90 percent used either marijuana or hashish and approximately 30 percent tried cocaine.[5]

Current rates of addiction are also very troubling. Today there are an estimated 4 million chronic drug users in America: 3.6 million chronic cocaine users (primarily crack cocaine) and 810,000 chronic heroin users.[6] Most of them started using marijuana, alcohol, and tobacco in their youth and then moved on to heroin or cocaine. Addiction affects more than just addicts — indeed, the families, friends, and employers of drug addicts are drained by the broken promises, deteriorating relationships, and lost productivity associated with addiction. Approximately 45 percent of Americans report knowing someone in their family or a close friend who used illegal drugs.[7] Even those Americans who do not come into contact with users of illicit drugs are not exempt from the burden of drug abuse. All of us pay the toll in the form of higher health care costs, dangerous neighborhoods, and overcrowded criminal justice systems.

* A "current user" is an individual who consumed an illegal drug in the month prior to being interviewed.

CONSEQUENCES OF ILLEGAL DRUG USE

Illegal drugs — such as heroin, marijuana, cocaine and methamphetamine — inflict serious damage upon America and its citizens every year. Accidents, crime, domestic violence, illness, lost opportunity, and reduced productivity are the direct consequences of substance abuse. Drug and alcohol use by children often is associated with other forms of unhealthy, unproductive behavior, including delinquency and high-risk sexual activity.

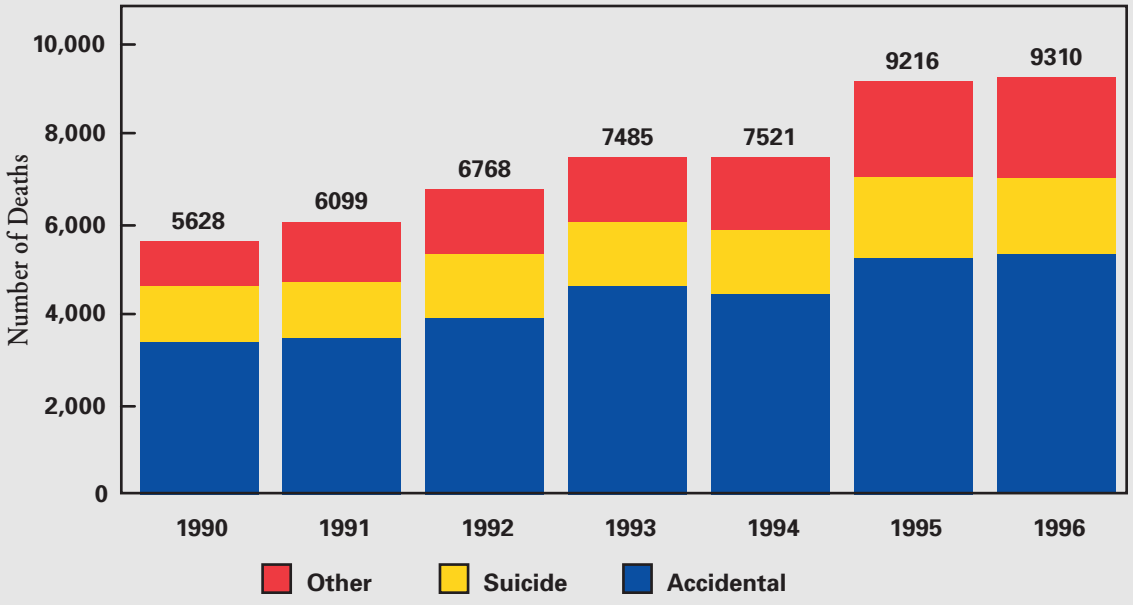
Illegal drugs cost our society approximately $110 billion each year.[8] The greatest cost of drug abuse is paid in human lives, either lost directly to overdose, or through drug abuse-related diseases such as tuberculosis, sexually transmitted diseases (STDs), hepatitis, and acquired immunodeficiency syndrome (AIDS). Traffic accidents caused by alcohol- and drug-impaired drivers; street crime committed by addicts to support their addiction; and resources expended to apprehend, sentence, treat, and incarcerate drug abusers are the burdens borne by taxpayers year after year.

Drug use erodes human potential. It is associated with a broad array of antisocial behavior that limit children from the outset of their lives. Children who begin to smoke marijuana at an early age are much more likely to not finish school and to engage in acts of theft, violence and vandalism and other high-risk behavior than are children who do not smoke marijuana.[9] Studies of adult users of cocaine and heroin have found that youth use of marijuana correlates strongly with later use of cocaine and heroin. Children aged twelve to seventeen who use marijuana are eighty-five times more likely to use cocaine than children of the same age who have never used those substances.[10] But no study, statistic, or survey accurately reflects the suffering and heartbreak that occurs when a loved one sinks into addiction.

Drug-related deaths remain near historic highs. The Substance Abuse and Mental Health Services Administration (SAMHSA)'s Drug Abuse Warning Network (DAWN) Medical Examiner Report annually examines drug-related deaths — exclusive of deaths from AIDS, homicide, and where the drug of abuse was unknown — in forty-one major metropolitan areas across the country. DAWN reports drug-related deaths climbed throughout the 1990s,

Drug-Related Deaths are Rising

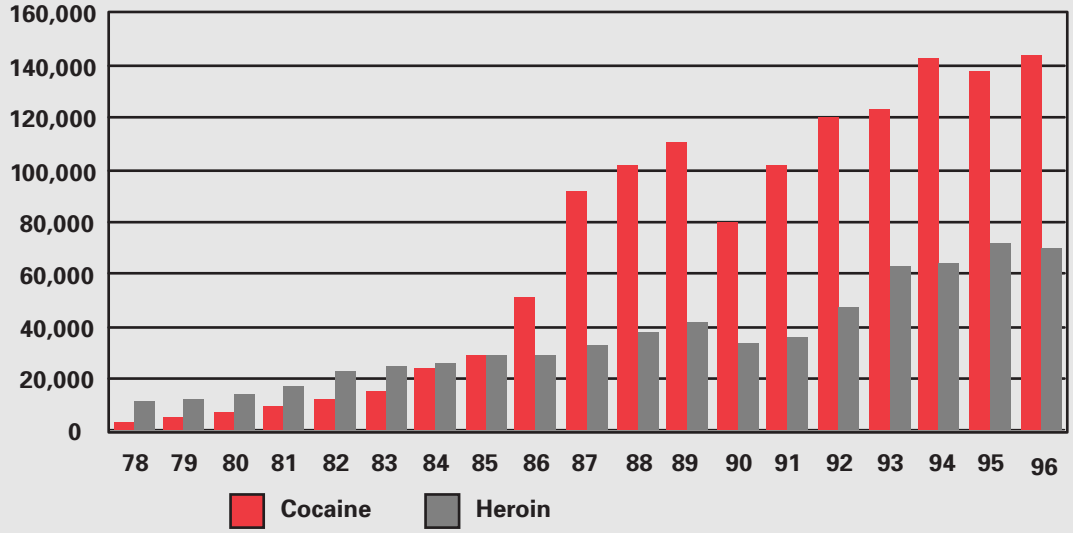
DAWN Medical Examiner Data



Source: HHS Drug Abuse Warning Network

The Health Impact of Drug Abuse

Cocaine and heroin hospital emergency room mentions, 1978-1996

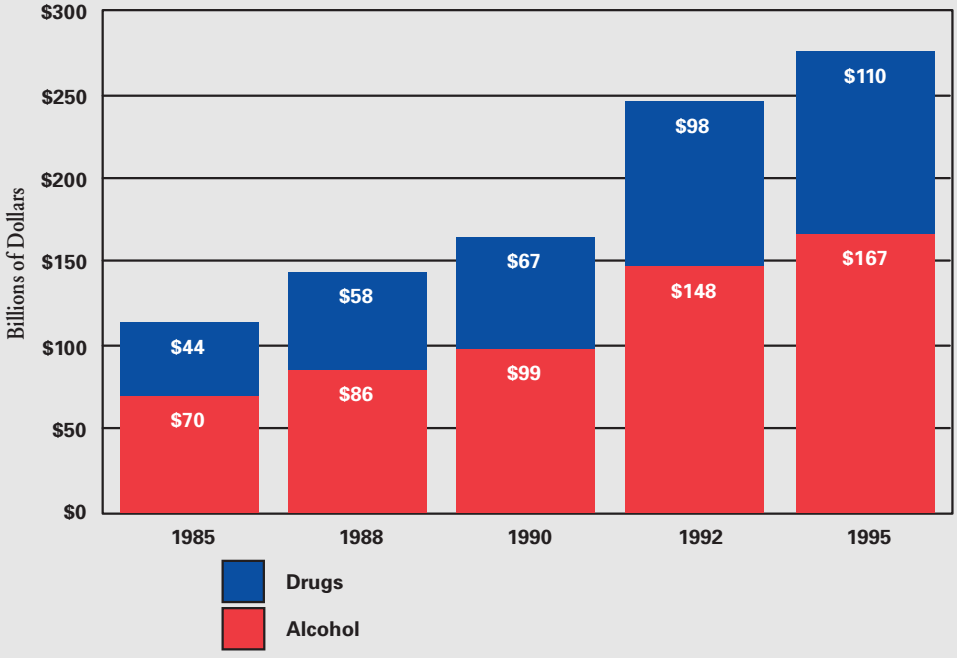


Source: HHS Drug Abuse Warning Network

but appear to have leveled off at about 9,300 per year.[11] Drug-related deaths declined among those aged eighteen to thirty-four, but were offset by an increase among those aged thirty-five and older, particularly those aged forty-five to fifty-four. This trend may reflect the aging of the drug-abusing population in America, indicating that those who started drug abuse in the 1960s and 1970s are now succumbing to the cumulative health effects of years of abuse.

The National Center for Health Statistics (NCHS) reports 14,843 drug-induced deaths for 1996. Drug-induced deaths, a subset of drug-related deaths, are more narrowly defined. They are identified from death certificate information indicating the cause of death to be drug psychoses, drug dependence, non-dependent use of drugs, accidental drug poisoning, suicide using drugs, assault by using drugs, and other drug poisoning deaths. Drug-induced causes exclude accidents, homicides, and other causes such as AIDS that are indirectly related to drug use.[12]

Drug-related medical emergencies remain near historic highs. The DAWN program reports drug-related hospital emergency room visits and provides a snapshot of the health consequences of America's drug problem.[13] DAWN indicates that drug-related emergency room episodes remained statistically constant, with 514,347 episodes in 1996 and 527,058 in 1997.[14] The only age group showing a statistically significant increase from 1996 to 1997 was ages 18-23, which saw a 6 percent increase from 98,625 episodes in 1996 to 104,647 episodes in 1997. The most frequently recorded reason for drug-related emergency room visits in 1997 was overdose, which comprised 46 percent of all episodes. The most common motive for drug use — the reason the patient took the drug which led to the emergency room visit — was suicide attempt or gesture, which comprised 36 percent of all episodes, followed by drug dependence as a motive for drug use (34 percent), then recreational use as a motive (11 percent).[15]



Sources: Rice et al. 1990; Robert Wood Johnson Foundation, 1993; National Institute on Drug Abuse & National Institute on Alcohol Abuse and Alcoholism, March 1998

Reported emergency rooms mentions for both cocaine and heroin in 1997 showed no statistically significant change from 1996, when mentions were at their highest levels since 1978. Cocaine-related mentions remained statistically constant from 1996 to 1997, at about 160,000. While the total number of cocaine cases remained constant, the largest percentage of increase in cocaine mentions during this period (1996–1997) was among those aged twelve to seventeen (41 percent, which increased from 2,581 to 3,360).[16] Even with this huge increase in youth mentions, a high percentage of cocaine episodes involved older Americans. In the second half of 1990, those aged thirty-five and older accounted for three in every ten cocaine episodes. By the first half of 1997, this age group accounted for nearly half of all admissions, implying that the population of cocaine abusers is aging.[17]

Heroin-related emergency room mentions showed a slight, statistically insignificant decline between 1996 (73,846) and 1997 (72,010), although this number is significantly higher than in 1991.[18] Methamphetamine-related emergency room episodes in 1997 (17,154) were more than 50 percent higher than in 1996 (11,002), and approached the level of the peak year of 1994.[19] The increase in 1997 may reflect that methamphetamine, which was relatively scarce in 1996, is now more readily available. It may also indicate a data anomaly in 1996, which appears to be an unusually low year for methamphetamine mentions. Indeed, geographic analysis of admissions to treatment for methamphetamine use shows a clear, tide-like spread of methamphetamine use from the west coast into the Midwest. Marijuana and hashish mentions continued to climb upward, continuing a trend that began in the first half of 1992. 1997 saw 64,744 emergency room mentions for marijuana/hashish, an increase of 20 percent from the year before.

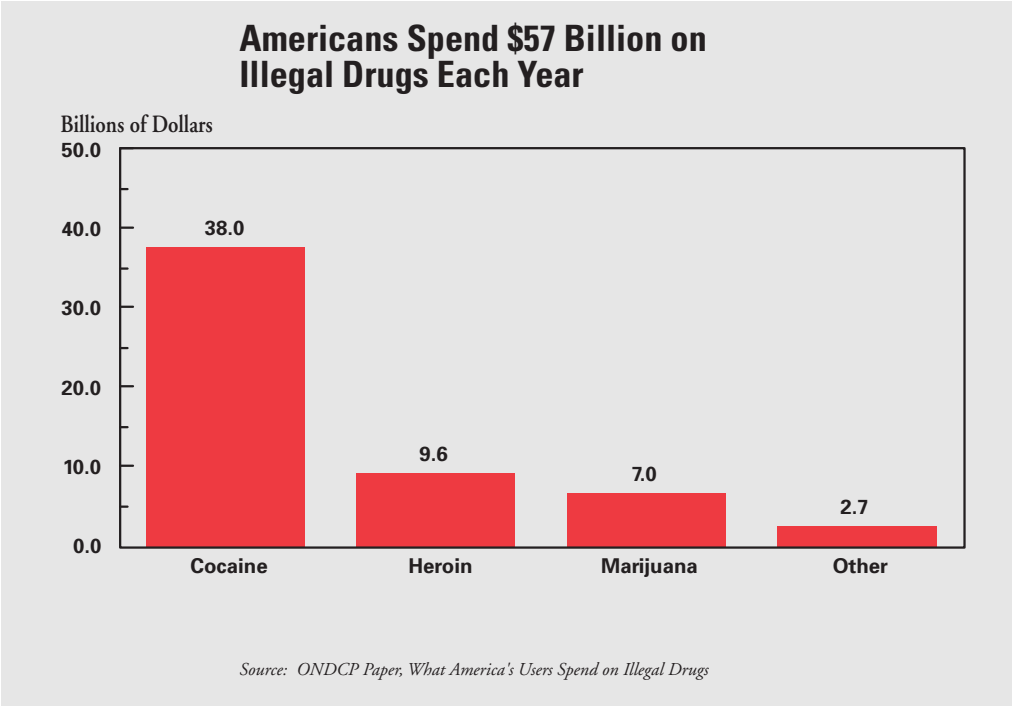
Spreading of infectious diseases. Illegal drug users and people with whom they have sexual contact run high risks of contracting gonorrhea, syphilis, HIV, hepatitis, and tuberculosis. Chronic users are particularly susceptible to infectious diseases and are considered "core transmitters." The National Institute on Drug Abuse (NIDA) has

concluded that drug abuse is both a serious health and social issue since drug abuse is a major vector for the transmission of many serious infectious diseases — particularly AIDS, hepatitis and tuberculosis — and for the infliction of violence.[20] Finally, in an era in which health care costs are rising, drug abuse poses an intolerable burden on an already strained system. NIDA estimated that health care expenditures due to drug abuse cost America $9.9 billion in 1992 and nearly twelve billion dollars in 1995.[21]

Homelessness. A correlation exists between drug abuse and homelessness. Ventura County, California, authorities estimate that 40 percent of their homeless population abuse drugs or alcohol.[22] A San Francisco study found that from December 1997 to November 1998 drug abuse was the leading killer of the homeless. Of the estimated 4,000 homeless, there were 157 deaths in a twelve-month period. Sixty-two were attributed to drug overdose. Other causes of death, such as suicide and AIDS, may have had an origin, if not a proximate cause, in drug abuse as well.[23]

Cost of drug abuse to workplace productivity. According to SAMHSA's 1997 National Household Survey on Drug Abuse (NHSDA), an estimated 6.7 million (or 60 percent of current illegal drug users who are of working age) current illegal drug users were employed full-time. This represents 6.5 percent of the full-time labor force aged eighteen and older.[24] Another 1.6 million current users (or 14 percent of working age drug users) worked part-time.[25] This translates to a current drug use rate of 7.7 percent among part time workers. In the same period, an estimated 13.8 percent of unemployed Americans were current drug users; thus, drug abuse is twice as prevalent among the unemployed compared to those employed full-time.[26] Overall, 73 percent of working age Americans who are current drug users are employed.

Drug users are less dependable than other workers and decrease workplace productivity. They are more likely to have taken an unexcused absence in the past month; 12.1 percent did so compared to 6.1 percent of drug-free workers. Illegal drug users get fired more frequently (4.6 percent were terminated within the past year compared to 1.4 percent of non-users). Drug users also switch jobs more frequently; 32.1 percent worked for three or more employers in the past year, compared to 17.9 percent of non-drug-using workers. One-quarter of drug users left a job voluntarily in the past year.[27] This high turnover increases training and other productivity-related costs to American businesses. NIDA and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) estimated that the cost to America in lost productivity due to drug abuse was $69.4 billion in 1992.[28]



Source: ONDCP Paper, What America's Users Spend on Illegal Drugs

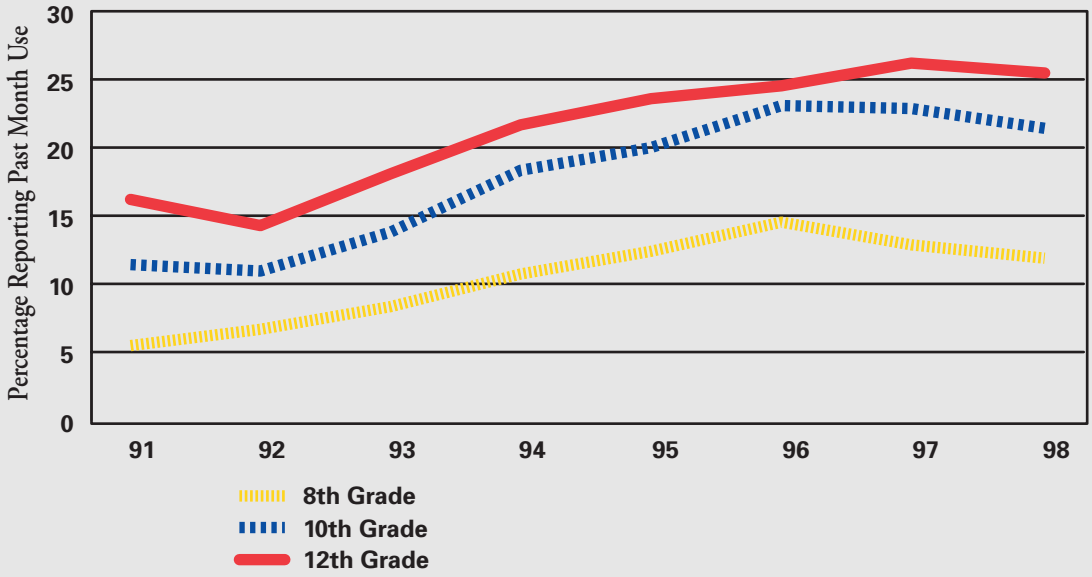
YOUTH DRUG USE: A PROBLEM WITH PROFOUND IMPLICATIONS

Young Americans are especially vulnerable to drug abuse. Their physical and psychological states of development cause them to be highly susceptible to the ill-effects of drug use not only at the moment of use, but for years to come as well. Moreover, the behavior patterns that result from teen and preteen drug use often result in tragic consequences. The self-degradation, loss of control, and disruptive, anti-social attitudes that young people develop as a result of drug use cause untold harm to themselves and their families.

Drug use among youth rose dramatically from 1992 to 1996. One of the most disturbing trends of the 1990s, reflected by the University of Michigan's Monitoring the Future (MTF) survey, was the increase in use of drugs by youth. From 1991 to 1996, current illicit drug use among 8th graders more than doubled, from 5.7 percent to 14.6 percent. Current illicit drug use among 10th graders also doubled in the same period, from 11.6 percent to 23.2 percent. Current illicit drug use among 12th graders increased by 50 percent, from 16.4 percent to 24.6 percent. Presaging this increase in drug abuse was an erosion in youth disapproval of drug abuse and in the perceived risks of drug abuse by youth. The other main statistical indicator, the NHSDA, also found that drug use among those aged twelve to seventeen doubled from the historic low year of 1992, when only 5.3 percent of those aged twelve to seventeen were current drug users, to 11.4 percent in 1997. This level still remains below the 1979 rate of 14.2 percent.[29]

Youth Drug Use Has Leveled Off

Past Month Use of Any Illicit Drug

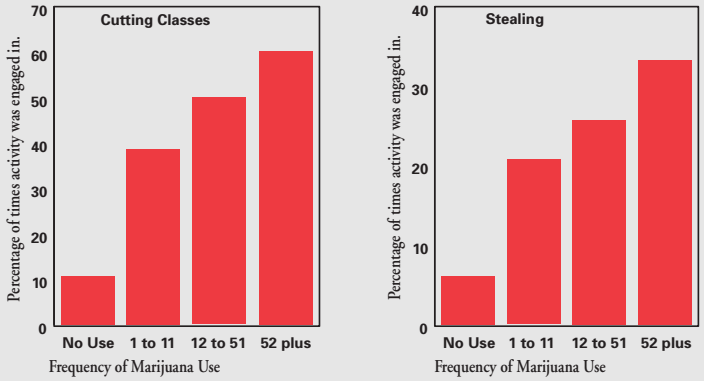


Source: 1998 Monitoring the Future Study

Youth drug use is linked to antisocial behavior and crime. Youth marijuana use has been associated with a wide range of dangerous behavior. Nearly one million youth aged sixteen to eighteen (11 percent of the total) reported driving in the past year at least once within two hours of using an illegal drug (most often marijuana).[30] A number of descriptive studies have demonstrated that people who use drugs are more likely to have mental disorders, physical health problems, and family problems.[31] In addition, a recent study showed that marijuana use by teenagers who have prior serious antisocial problems can quickly lead to dependence on the drug.[32] The correlation between youth use of marijuana and antisocial behavior was dramatically demonstrated by a NHSDA analysis. For youth aged twelve to seventeen, those who smoked marijuana within the past year were more than twice as likely to cut class, steal, attack people, and destroy property than were those who did not smoke marijuana. The more frequently a youth smoked marijuana, the more likely he or she was to engage in these types of antisocial behavior.[33] An analysis of Maryland juvenile detainees found that 40 percent were in need of substance abuse treatment. Of this 40 percent, 91 percent needed treatment for marijuana dependence.[34]

Delinquent Behavior is Clearly Linked to Marijuana Use

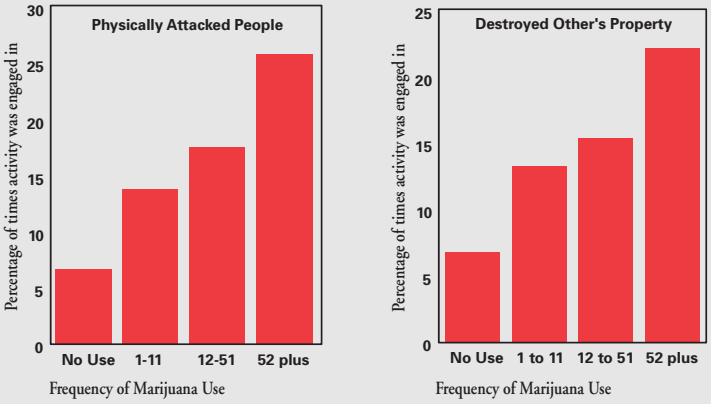
Percentage of those ages 12 to 17 who reported delinquent behavior in past 6 months, by number of days marijuana was used in the past year



Source: NHSDA Household Survey Data, 1994-1996

Aggressive Anti-Social Behavior is Clearly Linked to Marijuana Use

Percentage of those ages 12 to 17 who reported aggressive behavior in past 6 months, by number of days marijuana was used in the past year



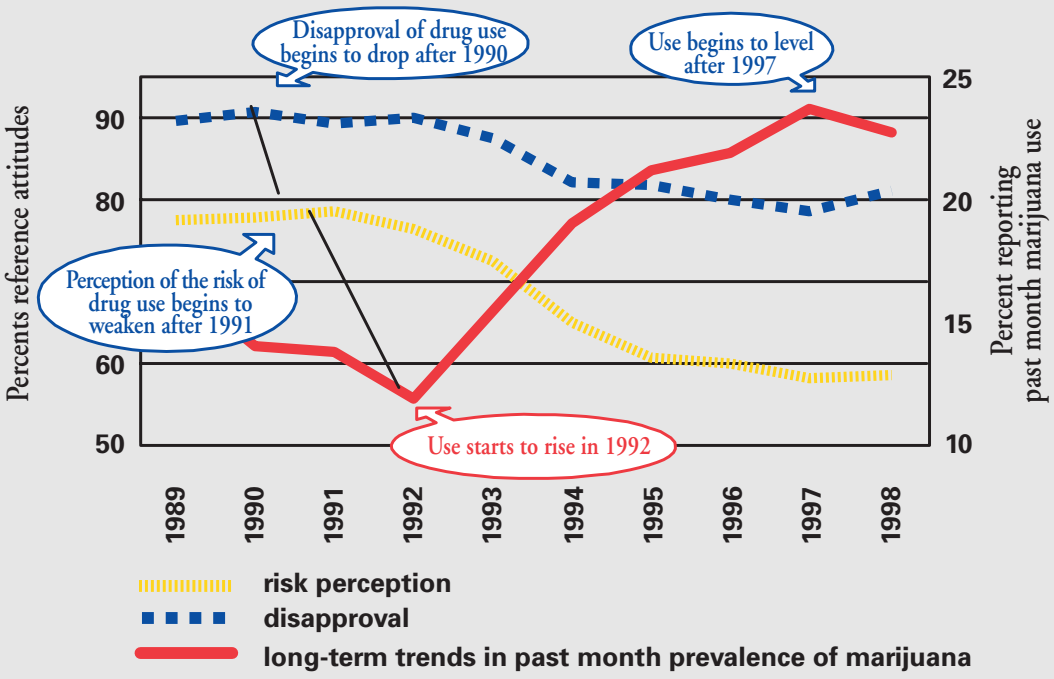
Source: NHSDA Household Survey Data, 1994-1996

1998 Monitoring the Future Survey: A Change for the Better. Starting in 1997, the MTF survey reported a leveling off of youth drug use. In 1998 this survey noted that overall youth drug rates remained flat and, in fact, began to decline in some areas. In 1997, for the first time in six years, the use of marijuana and other illegal drugs did not increase among 8th graders. Nor did it increase in 1998, a year that saw a decrease in use of marijuana and any illicit drug among 10th graders, and stable use among 12th graders.[35] Furthermore, attitudes regarding drugs, which are key predictors of use, began to reverse in 1997 after several years of erosion. This disapproval by youth of drugs is likely to increase as social disapproval of drug abuse takes root. The rising drug use trends observed by MTF in the 1990s appears to have ended.

It is interesting to note that the MTF data were gathered in the spring of 1998, prior to the implementation of ONDCP's Youth Anti-Drug Media Campaign. It is anticipated that the Media Campaign will further increase youth awareness (and thus disapproval of) drugs and drug abuse.

Youth Attitudes Determine Youth Marijuana Use

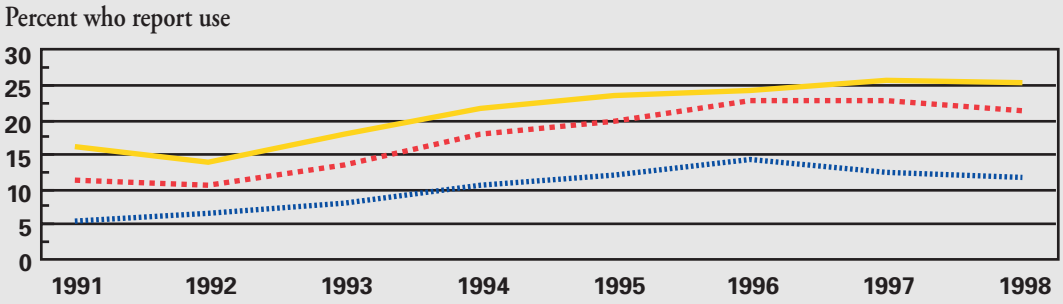
The Case of 12th Graders



Source: 1998 Monitoring the Future Study

Youth Drug Abuse, Although Decreasing, is Still Unacceptably High

Current (past month) Use of Any Illicit Drug

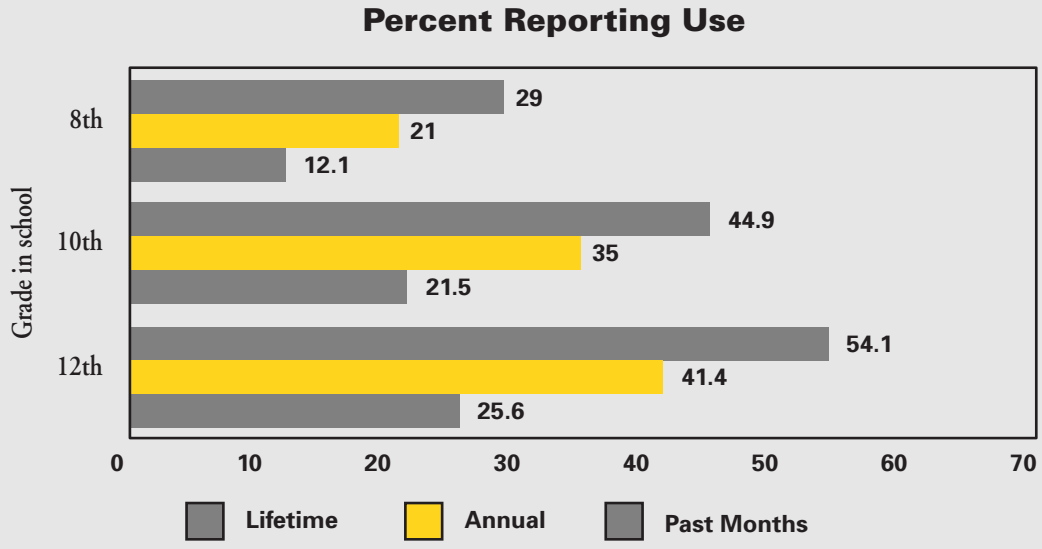


	1991	1992	1993	1994	1995	1996	1997	1998
8th Grade	5.7	6.8	8.4	10.9	12.4	14.6	12.9	12.1
10th Grade	11.6	11.0	14.0	18.5	20.2	23.2	23.0	21.5
12th Grade	16.4	14.4	18.3	21.9	23.8	24.6	26.2	25.6

Source: 1998 Monitoring the Future Study

Drug Use Among Children, Although Down, Remains Unacceptably High

Any Illicit Drug



Source: 1998 Monitoring the Future Study

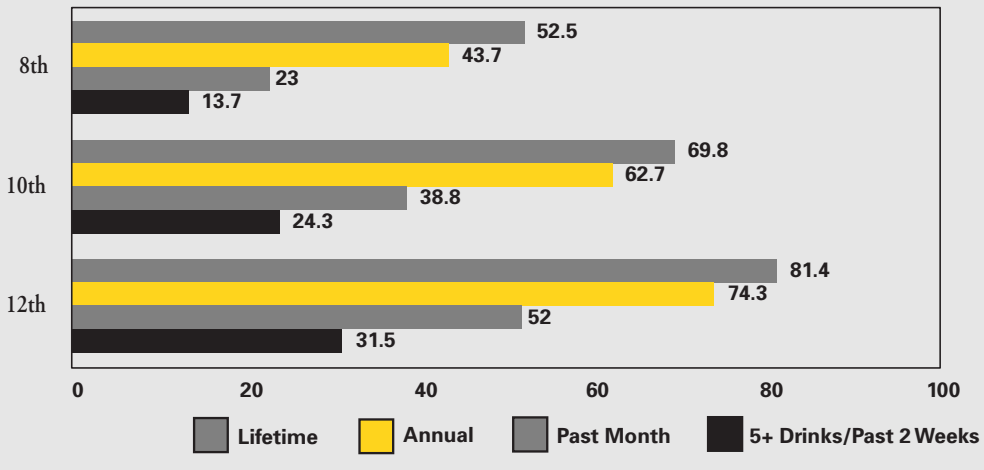
Following are the highlights of the **1998 MTF Study**:

- **1998 is the second straight year without significant increases in past month or past year overall use of any illicit drug.**
- **Marijuana use was significantly lower among 10th graders,** with past month use declining from 20.5 percent to 18.7 percent.
- **All other drug use either remained statistically unchanged or decreased significantly,** except for increases in barbiturate and tranquilizer use among 12th graders and crack use among 8th graders.
- **The softening trend in youth attitudes about drug use also appears to be ending,** except for LSD. There were **significant increases in the perception of harmfulness of marijuana use among 8th graders,** from 43.1 percent to 45 percent.
- Based on the last two years of MTF results, **we could be at the threshold of a turnaround in the youth drug situation.**

Underage use of alcohol. Youth alcohol use strongly correlates with later adult drug use. For example, adults who started drinking as children are nearly eight times more likely to use cocaine than are adults who did not drink as children.[36] Alcoholism has profound social and economic costs. In 1992, the total cost to society from alcohol and alcoholism was estimated by the NIAAA at $148 billion.[37] Prevention of alcohol use by children is critical if we are to reduce the costs of drug addiction and alcoholism. Seen in this light, the MTF survey gives cause for guarded optimism. Use of alcohol by teenagers is either stable or declining. The 1998 MTF survey reported that alcohol use decreased among 10th graders, remained stable among 8th graders for the past few years, and remained stable more recently among 12th graders, albeit at unacceptably high levels. Lifetime use of alcohol by 10th graders dropped from 72 percent in 1997 to 69.8 percent in 1998. The percentage of 8th graders who reported being drunk in a 30 day period increased from 8.2 percent to 8.4 percent, a statistically insignificant rise. In the same period the percentage of 10th graders who had been drunk declined from 22.4 percent to 21.1 percent, while among 12th graders the percentage decreased from 34.2 percent to 32.9 percent. Data from SAMHSA's FY 1997 State Alcohol and Drug Abuse

By 12th Grade, More Than Three-Fourths of Students Have Used Alcohol in Their Lifetime; 52 Percent Are Current Drinkers and 31.5 Percent Binge Drinkers

Alcohol (any use) Percent Reporting Use



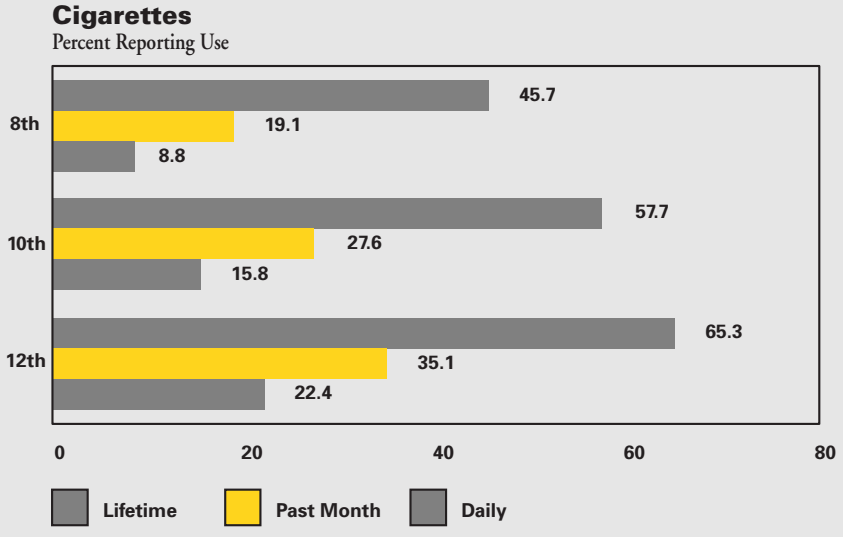
Source: 1998 Monitoring the Future Study

Profile Data on Substance Abuse Prevention and Treatment Block Grant indicate more than 1,200 children under the age of twelve were admitted for treatment for alcohol problems in programs supported by Block Grant funds. While this does not tell us the extent of alcohol consumption for children under the age of 12, it is a reminder that even very young children are consuming alcohol.

Tax increases on alcohol have been effective at reducing adolescent consumption of alcohol. A study that appeared in a recent issue of the *Journal of Health Economics* finds that increases in alcohol prices, such as the beer tax, actually decrease the amount of marijuana consumed by adolescents, not increase it as was once thought.[38] Parents who assume that their children are safe because they are using only alcohol and not marijuana are taking false comfort. The only valid message is that both alcohol and marijuana have their individual dangers.

Underage use of tobacco. Tobacco use is the single leading preventable cause of death in the United States. The younger a person is when he begins smoking, the greater the risk for smoking-attributable disease. The NHSDA estimates that every day more than 6,000 people aged eighteen or younger try their first cigarette, and more than 3,000 people aged eighteen or younger become daily smokers. If these trends continue, approximately five million people now younger than eighteen will die an early preventable death from a smoking-attributable disease. Researchers have also noted a correlation between underage use of tobacco and later use in life of cocaine and heroin.[39] As a widely available, legal (albeit regulated and taxed) substance, tobacco is one of the easiest illicit substances of abuse for children to obtain. Given these stakes, prevention of youth use of tobacco is critical. The MTF survey shows that youth use of tobacco has either stabilized or declined. Thirty-day use of cigarettes slightly declined among 8th, 10th, and 12th graders from 1997 to 1998; for 8th graders the decline was from 19.4 percent to 19.1 percent, for 10th graders from 29.8 percent to 27.6 percent, and for 12th graders from 36.5 percent to 35.1 percent. Daily use of cigarettes also declined in all grades from 1997 to 1998, though the decline was statistically insignificant among 8th graders. For 8th graders the decline was from 9.0 to 8.8 percent, for 10th graders from 18.0 to 15.8 percent, and for 12th graders from 24.6 to 22.4 percent. Use of smokeless tobacco likewise saw small declines in all three grades. For 8th graders the decline was from 5.5 to 4.8 percent, for 10th graders from 8.9 to 7.5 percent, and for 12th graders from 9.7 to 8.8 percent. Perceived availability of alcohol decreased among 8th graders, and perceived availability of cigarettes decreased among both 8th and 10th graders.

Nearly Two-Thirds of 12th Graders Have Used Cigarettes in Their Lifetime, and Almost One-Quarter are Daily Users



Source: 1998 Monitoring the Future Study

DRUGS AND CRIME: AN UNDENIABLE NEXUS, A HEAVY PRICE

Drug trafficking and violence go hand in hand. While national crime rates in general continue to decline, more than 1.5 million Americans were arrested for drug-law violations in 1997, an all-time high.[40] Many crimes (e.g., murder, assault, prostitution, and robbery) are committed under the influence of drugs or may be motivated by a need to obtain money for drugs.

Arrestees frequently test positive for recent drug use. The National Institute of Justice's (NIJ's) Arrestee and Drug Abuse Monitoring (ADAM) drug-testing program found that more than 60 percent of adult male arrestees tested positive for drugs in twenty of twenty-three cities in 1997.[41] In Manhattan, 78.6 percent of males arrested for assault tested positive for illegal drugs.[42] In recent years, cocaine abuse has been largely a problem among older arrestees. In the 1980s as much as 80 percent of male arrestees in large cities tested positive for cocaine use. This trend has slowly decreased, but the drop has been dramatic among young arrestees. Currently approximately 5 percent of young arrestees (aged fifteen to twenty) test positive for cocaine in cities such as Detroit and Washington, D.C., compared with the 50 percent positive rate for arrestees aged 36 and older.[43] This would suggest that the population of addicts is aging and illustrates the persistent nature of addiction.

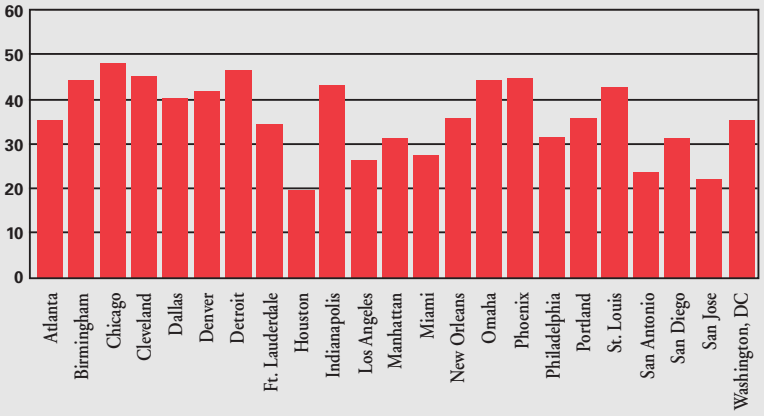
Heroin use is also found primarily among older arrestees, although in some cities such as Philadelphia, New Orleans, and St. Louis, there is an increase in heroin use among young arrestees.[44] Heroin use is often connected with property crime, as addicts seek to steal and convert stolen goods in order to buy more heroin.

For young adult males, the median rate of marijuana prevalence exceeded 64 percent in all cities in 1996, but then declined in 15 cities in 1997.[45] However, marijuana use among arrestees is still concentrated disproportionately among youthful arrestees.[46]

Methamphetamine use, after declining among arrestees in 1996, rebounded in 1997 in the West and Southwest. Scant evidence exists, however, that methamphetamine use is reaching the East or Southeast in appreciable numbers. The fluctuations in use and the regional concentration suggest that methamphetamine is more sensitive than are other illicit drugs to law enforcement activity.[47]

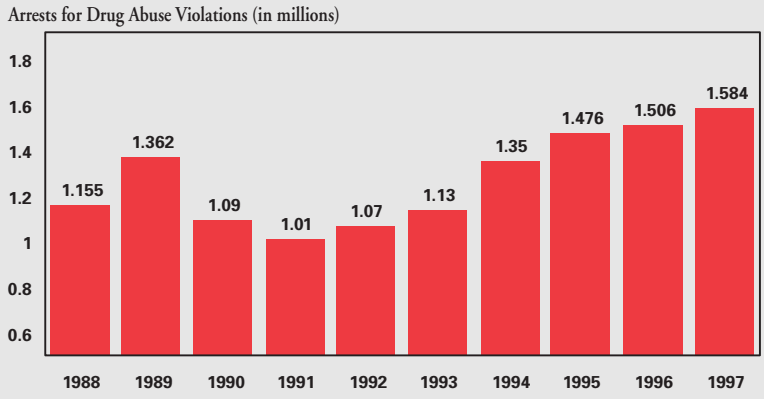
Marijuana Use Correlates with Violent Crime

Percentage of male arrestees for violent crimes testing positive for marijuana, 1997



Source: ADAM, 1997

Drug Related Arrests are Rising



Source: Uniform Crime Reports, FBI.

Drug offenders crowd the nation's prisons and jails. More than 1.8 million Americans were incarcerated as of January 1998. One in every 117 men in the United States was incarcerated in a state or federal prison at year end 1997.[48] More Americans were behind bars than on active duty in the armed forces. The number of sentenced prisoners rose by 5.2 percent in 1997. Between 1990 and 1996, the number of female inmates serving time in state prisons for drug offenses doubled and drug offenders accounted for 25 percent of the total growth in the state inmate population.[49] More than 62.5 percent of the inmates in the Federal prison system in 1997 were sentenced for drug offenses, up from 53 percent in 1990.[50] In 1997, 18,813 people were sentenced in Federal court for drug violations. Just under half of these cases involved cocaine.[51]

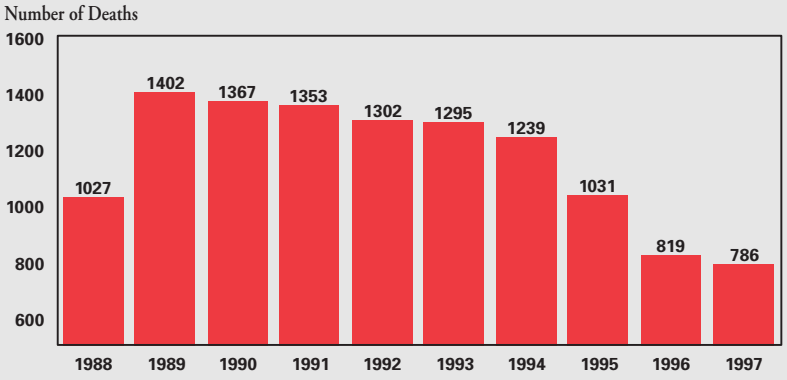
This high rate of incarceration is spread disproportionately among different ethnic groups. In 1996 the rate of incarceration among African-American males was 3,098 per 100,000 compared to 1,278 for Hispanic males and 370 for white males.[52] A March 1997 study by the Bureau of Justice Statistics (BJS) found that African-American men were nearly twice as likely to be incarcerated in their lifetime (28.5 percent) as Hispanic men (16.0 percent) and six times more likely than white men (4.4 percent).[53]

Costs for incarceration continue to rise. In 1993 state correction expenses exceeded nineteen billion dollars, an increase of 243 percent from 1982.[54] Some states now spend more on prisons than on education. Across the nation, states spent 30 percent more on prison budgets and 18 percent less on higher education in 1995 than they did in 1987.[55]

Substance abuse, family violence, and child maltreatment. Researchers have found that one-fourth to one-half of men who commit acts of domestic violence also have substance-abuse problems. Women who abuse alcohol and other drugs are more likely to become victims of domestic violence than non-alcohol and drug-using women. A survey of state child welfare agencies by the National Committee to Prevent Child Abuse found substance abuse to be one of the top two problems exhibited by 81 percent of families reported for child maltreatment.[56] Research on the link between parental substance abuse and child maltreatment suggests that chemical dependence is present in at least one-half of the families involved in the child welfare system.[57] In a January 1999 report, the National Center on Addiction and Substance Abuse at Columbia University (CASA), estimates that substance abuse causes or contributes to seven of ten cases of child maltreatment and accounts for some ten billion dollars in federal, state, and local government spending on child welfare systems.[58]

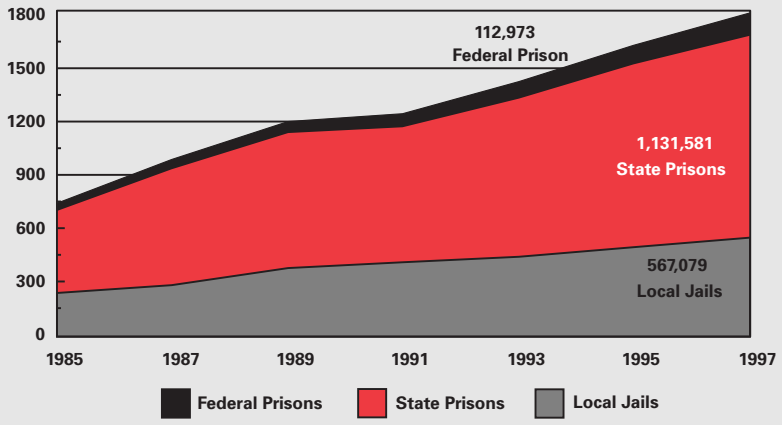
Drug Related Murders Continue to Decline

Murders related to narcotic drug laws



Source: FBI, Uniform Crime Reports.

1.8 Million Americans are Incarcerated: An All-time High



Source: Bureau of Justice Statistics, 1998

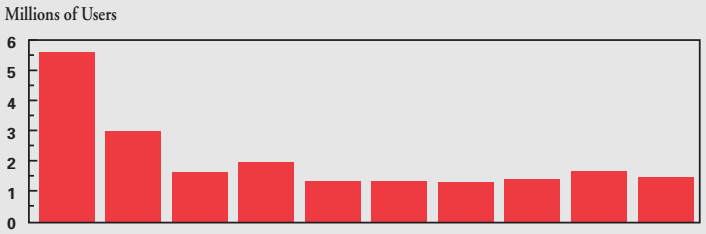
COCAINE ABUSE: WE ARE STILL PAYING THE PRICE FOR THE 1980s

Cocaine use, which devastated America's inner cities in the 1980s, is not as prevalent today. Occasional use of cocaine is just a fraction of what it was in the 1980s. Studies such as ADAM and ONDCP's *Pulse Check* indicate that the population of chronic cocaine users is aging. It is this aging population that is most problematic. The increase in emergency room mentions for cocaine abuse (up by 39 percent since 1992) indicates that the cohort of cocaine users is suffering health consequences that are becoming more manifest. Today we are paying accelerated health care costs for those addicts who began their cocaine use in the 1980s.

Overall usage. In 1997 an estimated 1.5 million Americans were current cocaine users. This figure represents 0.7 percent of the household population aged twelve and older, a slight decline from 1996 and a substantial decline from the 1985 figure of 5.7 million. The current-use rate, however, has not changed significantly in the last seven years.[59] The number of first-time users in 1996 (675,000) was significantly lower than in the years between 1977 and 1987, when more than one million Americans tried cocaine each year. This rate, however, reflects a steady increase from the seventeen-year low point of first-time cocaine users in 1991.[60] Estimates of the number of chronic cocaine users vary, but 3.6 million is a widely accepted figure within the research community.[61]

Use among youth. Cocaine use is not prevalent among young people. The 1998 MTF survey found that the proportion of students reporting use of powder cocaine in the past year to be 3.1 percent, 4.7 percent, and 5.7

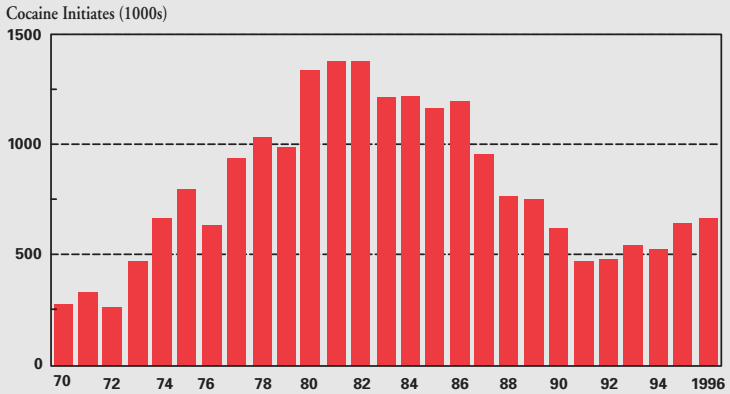
Current Use of Cocaine is Down Significantly



1985	1988	1990	1991	1992	1993	1994	1995	1996	1997
5.7	3.1	1.7	2.0	1.4	1.4	1.4	1.5	1.8	1.5

Source: 1997 National Household Survey on Drug Abuse

Cocaine Initiation Rates are a Fraction of the 1970s Rate, But are Rising



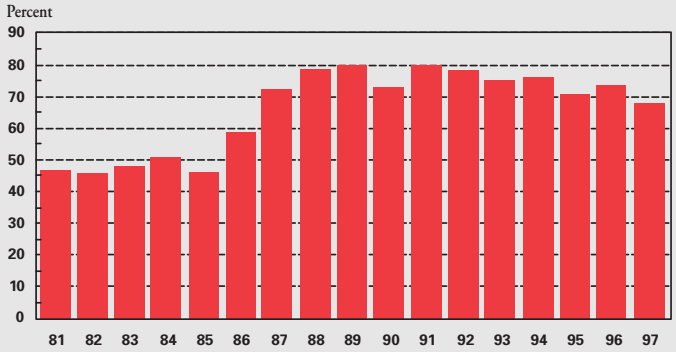
Source: 1997 Household Survey

percent among 8th, 10th, and 12th graders, respectively. This rate represents no statistically significant change from 1997. While year-to-year changes in use of cocaine have been slight and insignificant, the trend since 1993 has been steadily increasing and significant. The overall youth use rates are low but are still a cause for concern. Young people are experimenting with cocaine, underscoring the need for effective prevention. This requirement is substantiated by the NHSDA's finding of a steady decline in the mean age of first use from 22.6 years in 1990 to 18.7 years in 1996 — the lowest since 1969.[62]

Availability. The August 1998 Semiannual Interagency Assessment of Cocaine Movement estimated that 151 metric tons of cocaine arrived in the United States in the first six months of 1998.[63] Powder cocaine retailed at approximately $169 per pure gram in 1998, a slight decline from 1997's price — the first year the average price increased since 1990 — but slightly above 1996's price.[64] Cocaine was readily available in all major metropolitan areas. Purity declined at the wholesale level, from 67 percent pure in 1997 to 65.9 percent in 1998, but increased at the retail level from 65 percent to 71 percent over the same period. Overall purity of cocaine at both levels has steadily declined since 1991.[65] Retail purity levels vary widely according to local supply and demand. An ONDCP sponsored PME drug flow working group analysis based on source and seizure data puts the total amount of cocaine available in the United States at 289 metric tons in 1997, the lowest amount since the 1980s and far below the peak of 529 metric tons in 1992.[66]

Cocaine Purity has Declined Since 1991's Peak

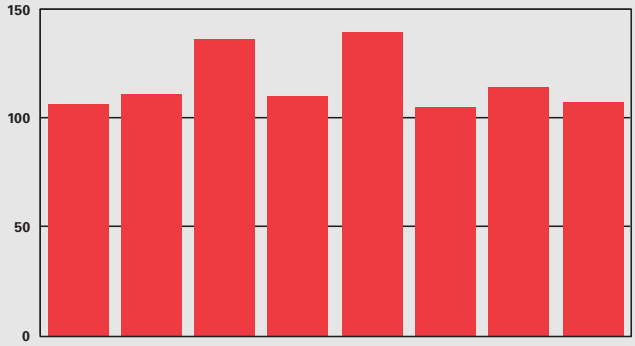
(Purity for Purchases of 1/8 oz. or less)



Source: Abt Associates for ONDCP

Cocaine Seizures Remain Constant

Federal-wide seizures in metric tons



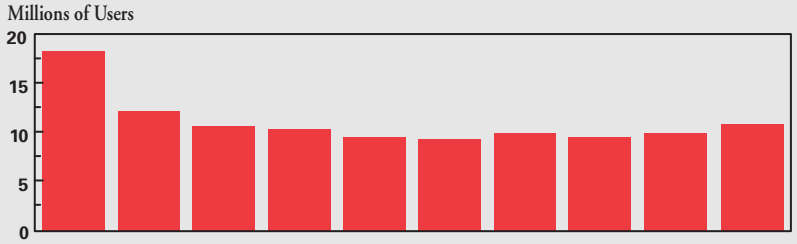
Source: FDSS

MARIJUANA: THE MOST COMMONLY USED ILLEGAL DRUG

Overall usage. The 1997 NHSDA estimated that 5.1 percent (11.1 million people) of the population aged twelve and older were current marijuana or hashish users, an increase of 0.4 percent from 1996.[67] Marijuana is the most prevalent illegal drug in the United States: approximately four of five (80 percent) current illegal drug users used marijuana or hashish in 1997.[68] The number of first time users in 1997 increased by more than 100,000 to 2.5 million, continuing a trend that began in 1991. The mean age of initiation in 1996 was 16.4 years old, the lowest recorded.[69]

Use among youth. The 1998 MTF survey shows that marijuana continues to be the illegal drug most frequently used by young people. Among high school seniors, 49.1 percent reported using marijuana at least once in their lives, a decrease of one-half of a percentage point from 1997. By comparison, the figure was 44.9 percent for high school seniors in 1996 and 41.7 percent in 1995. Current use of marijuana by 10th graders declined from 34.8 percent to 31.1 percent. There was evidence of a reduction in the rate of increase of current use among 8th and 12th graders.

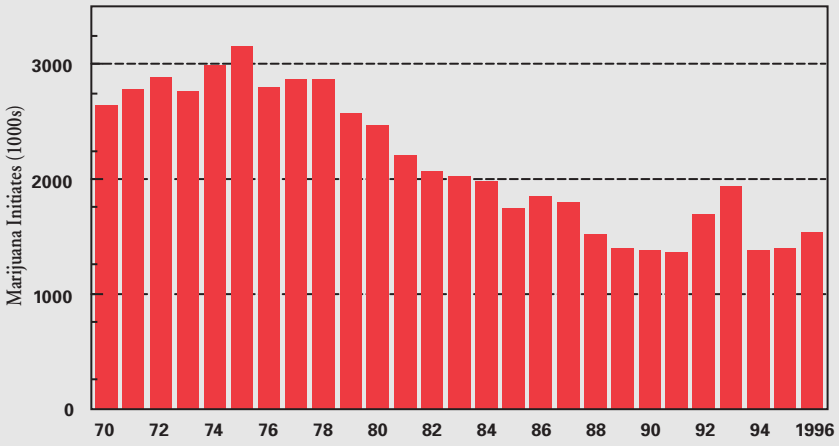
Current Use of Marijuana is Down Significantly



1985	1988	1990	1991	1992	1993	1994	1995	1996	1997
18.6	12.4	10.9	10.4	9.3	9.4	10.1	9.8	10.1	11.1

Source: 1997 National Household Survey on Drug Abuse

Marijuana Initiation Rates Are Less Than Half That of the 1970s, But Are Rising

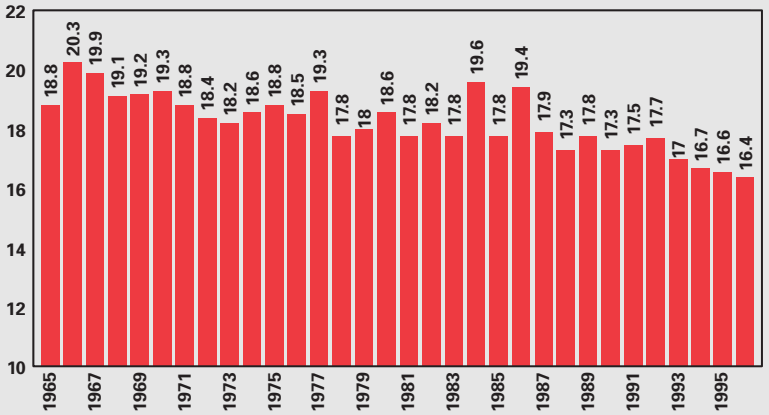


Source: 1997 National Household Survey

Availability. No precise system, comparable to that used for analyzing cocaine, is available to estimate the amount of marijuana cultivated in the United States. ONDCP's *Pulse Check* has noted the widespread availability of marijuana for a number of years, suggesting that the supply of marijuana is either stable at high levels or increasing. The average price of marijuana dropped from $2.63 per gram at the wholesale level in 1997 to $2.59 in 1998. In the same period, the price of marijuana at the retail level increased from ten dollars per gram to $10.41.[70] California, Hawaii, Kentucky, Tennessee and West Virginia are major growing states. In addition to the United States and Mexico, Canada is emerging as a marijuana source nation. Press accounts from the Pacific Northwest point to a new pattern in the trafficking of marijuana grown indoors in Canada and then sold in the United States as far south as San Diego. This marijuana is so psychoactively powerful that it is bartered by criminal gangs for cocaine on a pound-for-pound basis.[71] During the late 1970s and early 1980s, the THC content of commercial-grade marijuana averaged below 2 percent and marijuana sold for prices ranging from $350 to $600 per pound. In 1997 the sale price typically did not fall below $1,300 per pound, and the average tetrahydrocannabinol (THC) content in samples analyzed by DEA — which tends to be skewed towards the low end of the range — was 5 percent.[72]

Average Age of First Marijuana Use is Declining

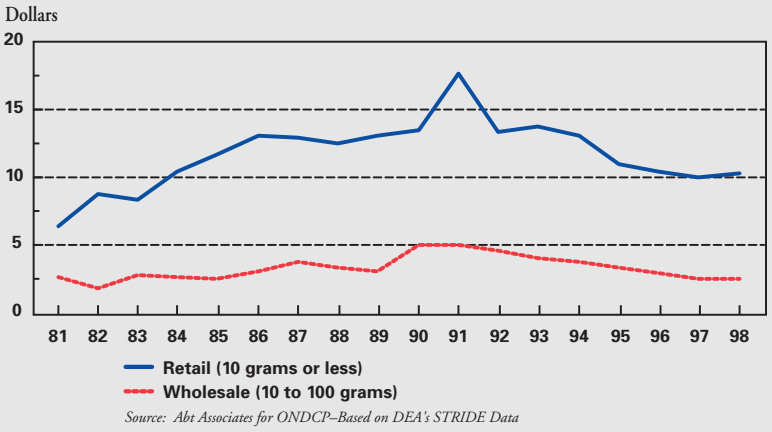
Average age of first use of marijuana, 1965-96



Source: 1997 Household Survey

Marijuana Average Price 1981-1998

(Average Price, Only – No Potency Data)



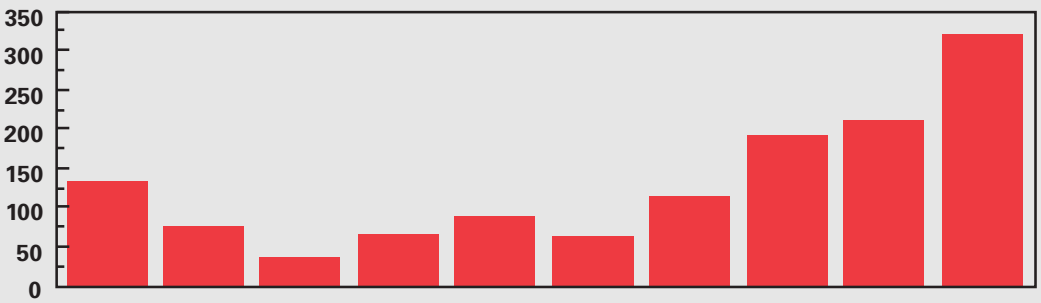
Source: Abt Associates for ONDCP–Based on DEA's STRIDE Data

HEROIN ABUSE: A RESURGENT MENACE

Overall usage. In the United States, approximately 325,000 current past-month users in the household population and 810,000 chronic users consume heroin.[73] Injection remains the most efficient means of administration, particularly for low-purity heroin. However, the increased availability of high-purity heroin has made snorting and smoking the drug more common and has profoundly altered the pattern of heroin use. With high purity heroin, a user can snort or smoke the drug and get a very potent effect without ever having to inject it. Among heroin users (those who have used heroin at sometime during their lifetime), those who have smoked or snorted it — vice those who have injected it — has risen from 55 percent in 1994 to 71 percent in 1997.[74] However, it appears that recent public information efforts on the threat of heroin, regardless of the route of administration, may be having some effect. From 1996 to 1997, the percentage people in the U.S. population aged twelve and older who had ever smoked heroin declined by about 40 percent, and the percentage of those who had ever snorted it declined by about 50 percent.[75]

Use among youth. While relatively low, rates of heroin use among teenagers rose significantly among 8th, 10th, and 12th graders during the 1990s. The ability to snort or smoke, instead of injecting heroin, undoubtedly played a major role in increasing use of this drug. The 1998 MTF survey found no change between 1997 and 1998 among 10th graders, but concluded that use among 8th and 12th graders has leveled-off and may have declined. Certainly the upward trend has been arrested. Youth attitudes towards heroin remained statistically constant, with the highest perceived risk among 10th graders. The 1997 NHSDA found that the mean age of initiation declined from 27.3 years in 1988 to 18.1 in 1996, a drop from 19.4 in 1995 and the lowest since 1972.[76] It appears as though America's youth have yet to understand fully the danger and the devastation caused by heroin and heroin abuse. While disapproval of heroin use among 12th graders is currently at a twenty-three-year high, with 57.8 percent seeing "great risk" in trying heroin, that number is still too low.[77] Ethnographers noted a disturbing increase in teenage heroin use in San Francisco, Newark, Miami, and Atlanta, with users starting in some cities at age thirteen and becoming chronic users by the time they were aged fifteen to seventeen.[78]

Current Heroin Use, Though Still Low, Has Increased Significantly



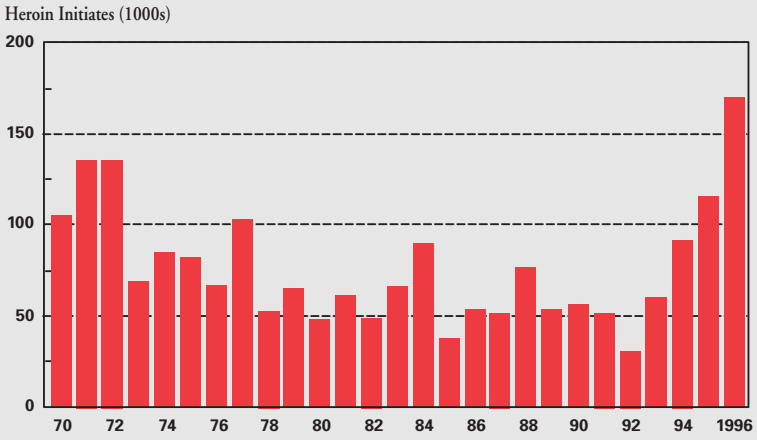
1985	1988	1990	1991	1992	1993	1994	1995	1996	1997
137	79	41	71	92	68	117	196	216	325

Source: 1997 National Household Survey on Drug Abuse

Availability. Information about the price and purity of heroin is imprecise. In 1998 the average retail price for a pure gram of heroin was approximately $1,799; the wholesale price was $318. These prices were significantly lower than in 1981, when the retail price per gram was estimated to be $3,115 and the wholesale price $1,194.[79] The System to Retrieve Information from Drug Evidence (STRIDE) found that the average purity for retail heroin in 1998 was 25 percent, much higher than the average of 19 percent reported one decade ago and equaled in 1991.[80]

Ethnographers suggest that heroin is increasingly available in many cities. For example, ONDCP's summer 1998 *Pulse Check* found that heroin use rose in some cities (San Francisco, Newark, Atlanta, and Baltimore), remained stable at high levels in others (Bridgeport and Chicago) and stabilized in a few other cities (San Diego and Seattle). No city experienced a decline.[81] This may signal increased availability. South American heroin became common in the Northeast in 1997, leading to speculation that cocaine trafficking and distribution organizations may be using existing cocaine distribution and sales networks to sell heroin. Analysis of seized heroin as well as arrest rates and intelligence data indicated that there are two distinct heroin markets in the United States, demarcated along the Mississippi River. In the East, high-purity white powdered heroin from South America was predominantly available. In the West, lower purity Mexican "black tar" and brown heroin were the predominant forms available.[82]

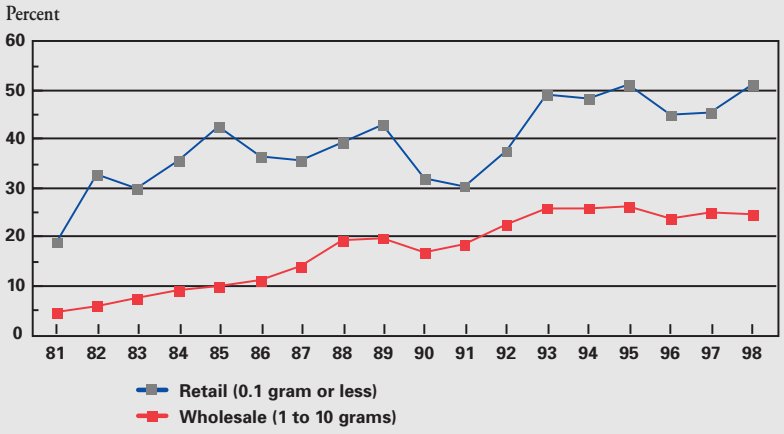
The Number of Heroin Initiates is Increasing



Source: Household Survey

Heroin Average Purity

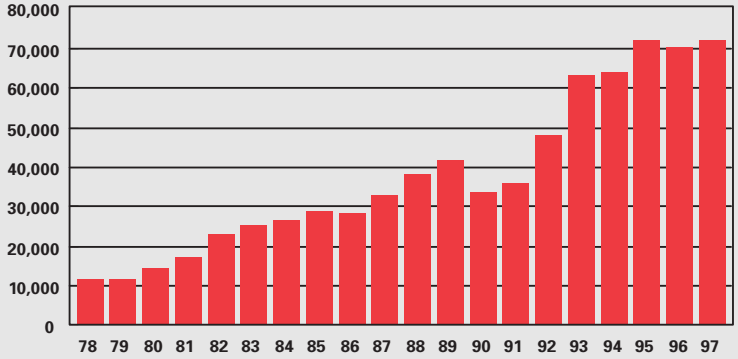
1991-1998



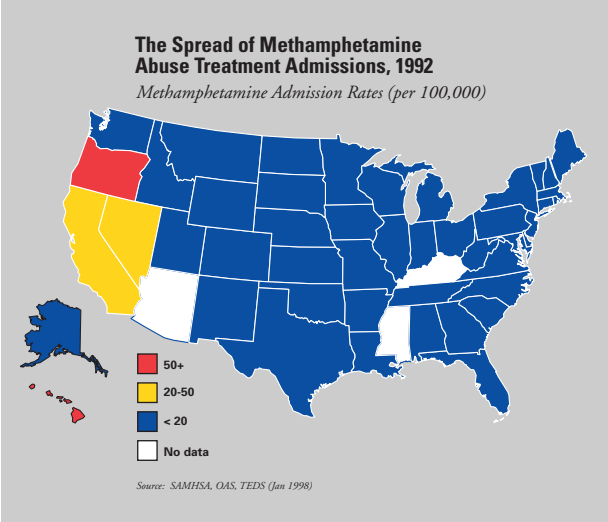
Source: Abt Association for ONDCP

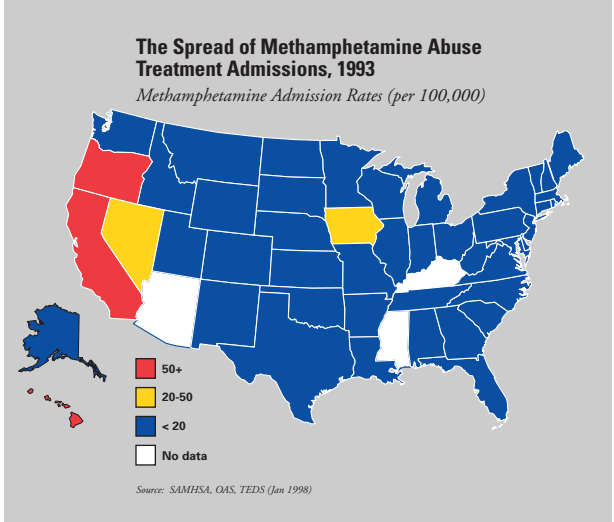
The Health Impact of Heroin

Heroin hospital emergency room mentions, 1978-1997



Source: DAWN





METHAMPHETAMINE: A DANGEROUS DRUG, A SPREADING THREAT

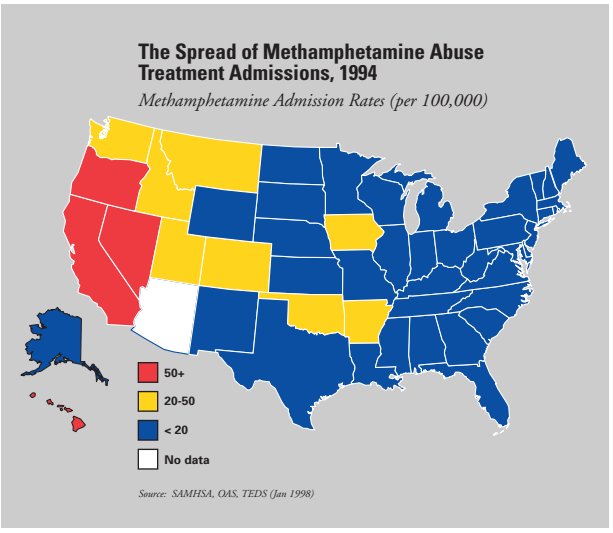
Methamphetamine is a highly addictive drug that can be manufactured by using products commercially available anywhere in the United States. The chemicals used in producing methamphetamine are extremely volatile, and the amateur chemists running makeshift laboratories — often in hotels or areas where children are present — cause deadly explosions and fires. The by-products of methamphetamine production are extremely toxic. Methamphetamine traffickers display no concern about environmental hazards when it comes to manufacturing and disposing of methamphetamine and its by-products.

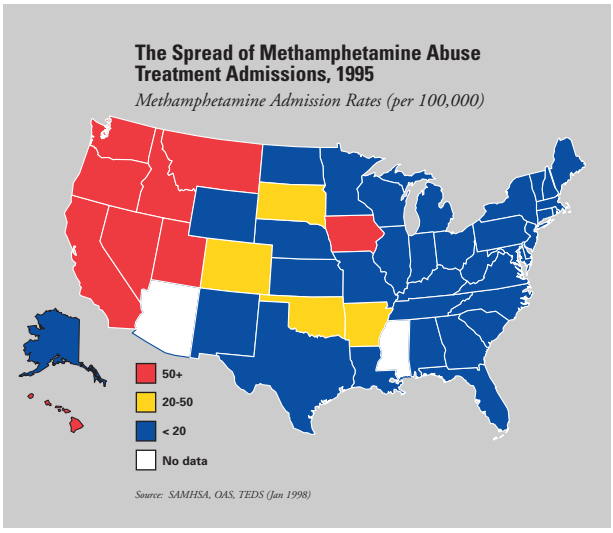
The effects of methamphetamine on humans are profound. SAMHSA is currently testing the effectiveness of various treatment regimens for methamphetamine, an addiction that is extremely difficult to treat. The stimulant effects from methamphetamine can last for hours, instead of minutes as with crack cocaine. Often the methamphetamine user remains awake for days. As the high begins to wear off, the methamphetamine user enters a stage called "tweaking," in which he or she is prone to violence, delusions, and paranoia. Many methamphetamine users try to alleviate the effect of the methamphetamine "crash" by buffering the effects with other drugs such as cocaine or heroin. Like heroin and cocaine, methamphetamine can be snorted, smoked, or injected.

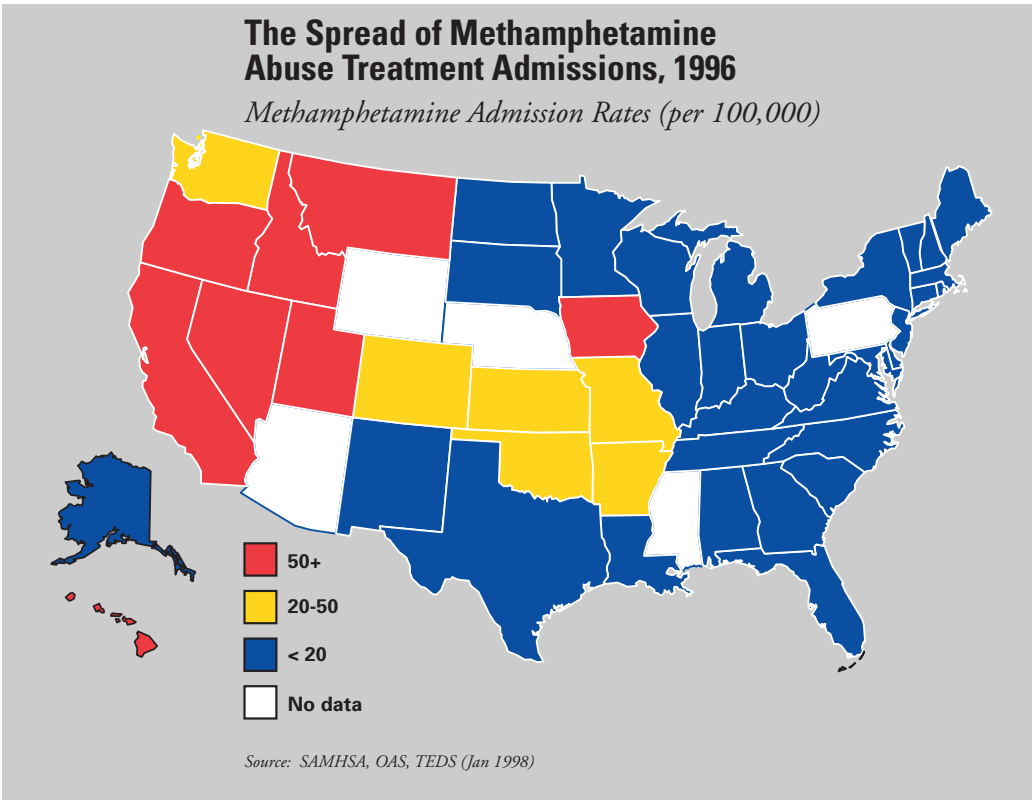
Overall usage. The 1997 NHSDA estimated that 5.3 million Americans (2.5 percent of the population) have tried methamphetamine in their lifetime, up significantly from the 1994 estimate of 1.8 million. The ADAM system reports that methamphetamine use continues to be more common in the western United States than in the rest of the nation. Methamphetamine use, according to ADAM, increased substantially in 1997, negating the progress achieved in 1996. In San Diego, roughly 40 percent of both male and female arrestees tested positive for methamphetamine.[83]

Use among youth. The 1998 MTF survey asked 12th graders about the use of crystal methamphetamine known as "ice"— which is smoked or burned in rock form. The survey found that lifetime ice use — which had leveled-off at 4.4 percent in 1997 after a four-year rise — rose in 1998 to 5.7 percent. The perceived harmfulness of methamphetamine among youth has also declined steadily since 1992 — when 61.9 percent of 12th graders perceived "great risk" in trying "ice" once or twice — to 1998, when only 52.7 percent perceived great risk.

Availability. Methamphetamine is by far the most prevalent synthetic controlled substance clandestinely manufactured in the United States. In the West and Southwest, it is increasingly significant as a drug of abuse: 52 percent of all those arrested in San Jose for







drug possession, for example, test positive for methamphetamine.[84] The Midwest has also seen an increase in methamphetamine production, trafficking and consequences. While the drug is not commonly found in the East and Southeast an analysis of methamphetamine treatment admissions as well as increased seizures suggest that the use of the drug maybe spreading eastward. The number of methamphetamine laboratory seizures reported to the Drug Enforcement Administration (DEA) in 1997 increased dramatically, to 1,431 from 879 in 1996. This reflects the widespread proliferation in the manufacture, trafficking, and use of the drug across the West and Midwest and portions of the South.[85] During 1997 methamphetamine prices nationwide ranged from $3,500 to $30,000 per pound, $400 to $2,800 per ounce, and 37 dollars to $200 per gram.[86]

OTHER SUBSTANCES

Overall usage. The 1997 NHSDA reported no significant change in the prevalence of inhalants, hallucinogens (like LSD and phencyclidine [PCP]), or psychotherapeutics (tranquilizers, sedatives, analgesics, or stimulants) used for nonmedical purposes between 1995 and 1997.[87] There was no statistically significant change between 1996 and 1997. The number of first-time hallucinogen users dropped from 1.2 million in 1995 to 1.1 million in 1996. Unfortunately the mean age of initiation also dropped from the previous all-time low of 17.3 years to 17.2 years.[88] Current-use rates for psychotherapeutics dropped from 1.4 percent of the U.S. population aged twelve and older in 1996 to 1.2 percent in 1997.[89] In absolute numbers, 2.6 million Americans used psychotherapeutics in 1997, less than one-half the number in 1985.[90] The total percentage of lifetime inhalant abuse rose slightly from 5.6 to 5.7 percent of the U.S. population aged twelve and older.[91] Inhalants can be deadly, even with first-time use, and often represent the initial experience with illegal substances.

Use among youth. The 1998 MTF survey reported that among 8th graders, use of inhalants declined among 8th graders from 5.6 percent in 1997 to 4.8 percent in 1998, and current use of LSD declined from 1.5 percent to 1.1 percent over the same period. Ethnographers continue to report "cafeteria use"* of hallucinogenic or sedative drugs like ketamine, LSD, methylene dioxy methamphetamine (MDMA), and gamma-hydroxybutyrate (GHB) throughout the country, often times tied into "rave culture."

* "Cafeteria use" denotes the proclivity to consume any readily available drug. Young people often take mood-altering pills or consume drugged drinks in night clubs without knowing either what the drug is or the dangers posed by its use alone or in combination with alcohol or other drugs.

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III. Goals, Objectives, Targets, and Performance Measures of Effectiveness

INTRODUCTION

This chapter explains the logic behind the **goals** that orient the national effort to reduce drug abuse and its consequences in the United States over the next five years. These five goals are succinct statements of the strategic aims of our national drug control policy: to prevent drug abuse (goal 1); to reduce the social harms associated with drug abuse (goals 2 and 3); to stop illegal drugs from entering the United States (goal 4); and to diminish illegal drug production (goal 5). Together, these goals define the end states of the *Strategy*. The five goals are comprehensive in that they cover the three broad aspects of drug control: demand reduction, supply reduction, and adverse consequences of drug abuse and trafficking. In addition, these goals are national in that they state what we must collectively achieve; they are not markers for solely a federal effort. Finally, these goals are research-based, quantifiable, and long-range.

This chapter presents **objectives** that support each of the *Strategy's* five overarching goals. The thirty-one objectives are more narrowly focused than the broader goals and stipulate the specific ways in which the five strategic goals will be attained. Under the prevention goal (goal 1), for example, nine supporting objectives articulate the specific ways that illegal drug use and underage consumption of alcohol and tobacco products will be discouraged. Programmatic initiatives will be tied directly to one or more of these objectives. The national youth anti-drug media campaign, for example, supports objective 2 ("pursue a vigorous advertising and public communications program") and objective 7 ("create partnerships with the media, entertainment industry, and professional sports organizations") of goal 1.

This chapter also presents **targets** that will be used to measure progress toward the envisioned end-state of the *Strategy*: the reduction of illegal drug use and availability by 50 percent and the reduction of their health and social consequences by at least twenty-five percent. ONDCP — in broad consultation with Congress, national drug control program agencies, state and local officials, and private citizens and organizations with experience in demand and supply reduction — developed in 1998 a performance measures of effectiveness (PME) system that links outcomes, programs, and resources.[1] The nucleus of the PME system consists of twelve "impact targets" that define results to be achieved by the *Strategy's* five goals. Eighty-five supporting measures further delineate mid- and long-term targets for the *Strategy's* thirty-one objectives.

GOALS, OBJECTIVES, AND TARGETS

Goals and Objectives

The *Strategy* is a long-term plan to reduce drug abuse in the United States by decreasing drug use (demand), drug availability (supply), and the consequences associated with drug abuse and trafficking. The *Strategy's* five goals and thirty-one objectives constitute a comprehensive, balanced effort encompassing education, prevention, treatment, research, enforcement, interdiction, crop eradication, alternative development, and international cooperation. Most importantly, the *Strategy* integrates efforts in these areas to generate a whole greater than the sum of its parts.

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

The *Strategy* focuses on youth for both moral and practical reasons. Children must be nurtured and protected from drug use and other forms of risky behavior to ensure that they grow up as healthy, productive members of society. As youngsters grow, they assimilate what they observe.

Drug use is preventable. If children reach adulthood without using illegal drugs, alcohol, or tobacco, they are unlikely to develop a chemical-dependency problem. To this end, the *Strategy* fosters initiatives to educate children about the real dangers associated with drugs. ONDCP seeks to involve parents, coaches, mentors, teachers, clergy, and other role models in a broad prevention campaign. ONDCP encourages businesses, communities, schools, the entertainment industry, universities, and sports organizations to join these national anti-drug efforts.

Researchers have identified important factors that place youth at risk for drug abuse or protect them against such behavior. Risk factors are associated with greater potential for drug use while protective factors reduce the potential for use. Risk factors include a chaotic home environment, ineffective parenting, anti-social behavior, drug-using peers, general approval of drug use, and the misperception that the overwhelming majority of one's peers are substance abusers. Protective factors include parental involvement; success in school; strong bonds with family, school, and religious organizations; knowledge of dangers posed by drug use; and the recognition by young people that substance abuse by their peers is abnormal behavior, not the commonplace, socially acceptable activity they are led to believe.

Objective 1: Educate parents or other care givers, teachers, coaches, clergy, health professionals, and business and community leaders to help youth reject illegal drugs and underage alcohol and tobacco use.

Rationale: Values, attitudes, and behavior are forged by families and communities. Alcohol, tobacco, and drug-prevention for young people is most successful when parents and other concerned adults are involved. Information and resources must be provided to adults who serve as role models for children so that young people will learn about the consequences of drug abuse.

Objective 2: Pursue a vigorous advertising and public communications program dealing with the dangers of illegal drugs, alcohol, and tobacco use by youth.

Rationale: Anti-drug messages conveyed through multiple outlets have proven effective in increasing knowledge and changing attitudes about drugs. Anti-drug publicity on the part of the private sector and non-profit organizations must be reinforced by a federally funded, science- and research-based campaign to change young people's attitudes about illegal drugs, alcohol, and tobacco.

Objective 3: Promote zero tolerance policies for youth regarding the use of illegal drugs, alcohol, and tobacco within the family, school, workplace, and community.

Rationale: Children are less likely to use illegal drugs or illicit substances if such activity is discouraged throughout society. Prevention programs in schools, workplaces, and communities have already demonstrated effectiveness in reducing drug use. Such success must be increased by concerted efforts that involve multiple sectors of the community.

Objective 4: Provide students in grades K–12 with alcohol, tobacco, and drug prevention programs and policies that are research based.

Rationale: The federal government is uniquely equipped to help state and local governments and communities gather and disseminate information on successful approaches to the problem of drug abuse.

Objective 5: Support parents and adult mentors in encouraging youth to engage in positive, healthy lifestyles and modeling behavior to be emulated by young people.

Rationale: Children listen most to adults they know and love. Providing parents with resources to help children refrain from using alcohol, tobacco, and other drugs is a wise investment. Mentoring programs also create bonds of respect between youngsters and adults, which can help young people resist drugs.

Objective 6: Encourage and assist the development of community coalitions and programs in preventing drug abuse and underage alcohol and tobacco use.

Rationale: Communities are logical places to form public-private coalitions that can influence young people's attitudes toward drugs, alcohol, and tobacco. Thousands of groups around the country have already established broad community-based anti-drug efforts.

Objective 7: Create partnerships with the media, entertainment industry, and professional sports organizations to avoid the glamorization, condoning, or normalization of illegal drugs and the use of alcohol and tobacco by youth.

Rationale: Discouraging drug abuse depends on factual anti-drug messages being delivered consistently throughout our society. Celebrities who are positive role models can convey accurate information about the benefits of staying drug-free.

Objective 8: Develop and implement a set of research-based principles upon which prevention programming can be based.

Rationale: Drug prevention must be research-based. Prevention programs must take into account the evolving drug situation, risk factors for students, and specific community problems.

Objective 9: Support and highlight research, including the development of scientific information, to inform drug, alcohol, and tobacco prevention programs targeting young Americans.

Rationale: Reliable prevention must be based on programs that have been proven effective. We must influence youth attitudes and actions in positive ways and share successful approaches with other organizations.

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

The negative social consequences of drug-related crime and violence mirror the tragedy that substance abuse wreaks on individuals. A large percentage of the twelve million property crimes committed each year are drug-related as is a significant proportion of nearly two million violent crimes. The nation's 4.1 million chronic drug users contribute disproportionally to this problem.

Drug-related crime can be reduced through community-oriented policing and other law-enforcement tactics, which have been demonstrated by police departments in New York and other cities where crime rates are plunging. Cooperation among federal, state, and local law-enforcement agencies also makes a difference. So, too, do operations targeting gangs, trafficking organizations, and violent drug dealers. Equitable enforcement of fair laws is critical. We are a nation wedded to the prospect of equal justice for all. Punishment must be perceived as commensurate with the offense. Finally, the criminal justice system must do more than punish. It should use its coercive powers to break the cycle of drugs and crime. Treatment must be made available to the chemically dependent in our nation's prisons.

Objective 1: Strengthen law enforcement — including federal, state, and local drug task forces — to combat drug-related violence, disrupt criminal organizations, and arrest and prosecute the leaders of illegal drug syndicates.

Rationale: Dismantling sophisticated drug-trafficking organizations calls for a task-force approach. Criminal syndicates exploit jurisdictional divisions and act across agency lines. Promoting inter-agency cooperation and cross-jurisdictional operations will make law enforcement more efficient.

Objective 2: Improve the ability of High Intensity Drug Trafficking Areas (HIDTA) to counter drug trafficking.

Rationale: Special assistance is needed when drug trafficking is so widespread that it poses extreme challenges to law enforcement. Coordinating federal, state, and local responses with federal resources through HIDTA, Organized Crime Drug Enforcement Task Forces (OCDETF), and other federal, state, and local task forces can reduce drug-related crime.

Objective 3: Help law enforcement to disrupt money laundering and seize and forfeit criminal assets.

Rationale: Targeting drug-dealer assets and the organizations that launder money can take the

profitability out of drug trafficking and drive to prohibitive levels the cost of laundering money. Law enforcement is most effective when a multi-disciplinary approach is combined with anti-money laundering regulations and support from financial institutions.

Objective 4: Break the cycle of drug abuse and crime.

Rationale: Our nation has an obligation to assist all who come in contact with the criminal-justice system to become drug-free. Recidivism rates among inmates who are given treatment decline substantially. The reduction of drug abuse by persons within the criminal-justice system will also drive down crime.

Objective 5: Support and highlight research, including the development of scientific information and data, to inform law enforcement, prosecution, incarceration, and treatment of offenders involved with illegal drugs.

Rationale: Law-enforcement programs and policies must be informed by updated research. When success is attained in one community, it should be analyzed quickly and thoroughly so that appropriate lessons can be applied elsewhere.

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

Drug dependence is a chronic, relapsing disorder that exacts an enormous cost on individuals, families, businesses, communities, and nations. Addicted individuals frequently engage in self- destructive and criminal behavior. Treatment can help them end dependence on addictive drugs. Treatment programs, moreover, can reduce the consequences of addictive drug use on the rest of society. The ultimate goal of treatment is to enable a patient to become abstinent and to improve functioning through sustained recovery. On the way to that goal, reducing drug use, improving the addict's ability to function, and minimizing medical consequences are useful interim outcomes. Treatment options include therapeutic communities, behavioral treatment, medication (e.g., methadone, levo-alph-acetyl-methadol (LAAM), or naltrexone for heroin addiction), outpatient drug free programs, hospitalization, psychiatric programs, twelve-step recovery programs, and treatment that combines two or more of these options.

Providing treatment for America's chronic drug users is both compassionate public policy and a sound investment. For example, the recent Drug Abuse Treatment Outcome Study (DATOS) found that outpatient methadone treatment reduced heroin use by 70 percent, cocaine use by 48 percent, and criminal activity by 57 percent, and increased employment by 24 percent.[2] The same survey also revealed that long-term residential treatment achieved similar successes.

SAMHSA's 1997 *Services Research Outcome Study*, the Center for Substance Abuse Treatment's (CSAT's) 1997 *National Treatment Improvement Evaluation Study* (NTIES), the 1994 *California Drug and Alcohol Treatment Assessment* (CALDATA), and other studies demonstrate that treatment reduces drug use, criminal activity, high-risk behavior, and welfare dependency.[3] NTIES' principal conclusions are that:[4]

- ***Treatment reduces drug use.*** Clients reported reductions in drug use of about 50 percent in the year following treatment.
- ***Many types of programs can be effective.*** Methadone programs, outpatient treatment, and both short- and long-term residential programs reduced drug use among participants.
- ***Criminal activity declines after treatment.*** Approximately one half (48.2 percent) of the NTIES respondents were arrested in the year before treatment, but only 17.2 percent were arrested in the year after treatment. Similar decreases were observed among respondents who claimed their primary income source were illegal activities.
- ***Health improves after treatment.*** Following treatment, substance abuse-related medical visits decreased by more than 50 percent and in-patient mental health visits by more than 25 percent. So, too, did risk indicators for sexually-transmitted diseases.

- **Treatment improves individual well-being.** Following treatment, employment rates increased while homelessness and welfare receipts decreased.

The 1994 CALDATA study was a retrospective cost-benefit analysis that examined the cost benefit of treatment services in the state from the perspective of both taxpayers and society. The study found that the department's programs cost taxpayers 209 million dollars in 1992 and yielded benefits of 1.5 billion dollars in reduced crime.

Objective 1: Support and promote effective, efficient, and accessible drug treatment, ensuring the development of a system that is responsive to emerging trends in drug abuse.

Rationale: A significant number of American citizens have been debilitated by drug abuse. Illness, dysfunctional families, and reduced productivity are costly by-products of drug abuse. Effective treatment is a sound method of reducing the health and social costs of illegal drugs.

Objective 2: Reduce drug-related health problems, with an emphasis on infectious diseases.

Rationale: Drug users, particularly injection users, put themselves, their children, and those with whom they have sexual contact at higher risk of contracting infectious diseases like HIV/AIDS, hepatitis, syphilis, gonorrhea, and tuberculosis.

Objective 3: Promote national adoption of drug-free workplace programs that emphasize a comprehensive program that includes: drug testing, education, prevention, and intervention.

Rationale: Drug abuse decreases productivity. Approximately three-quarters of adult drug users are employed. Comprehensive workplace policies that incorporate drug testing and employee assistance programs that include prevention, intervention, and referral to treatment can reduce drug use.

Objective 4: Support and promote the education, training, and credentialing of professionals who work with substance abusers.

Rationale: Many community-based prevention and treatment providers currently lack professional certification. The commitment and on-the-job training of these workers should be respected by a flexible credentialing system that recognizes first-hand experience even as standards are being developed.

Objective 5: Support research into the development of medications and related protocols to prevent or reduce drug dependence and abuse.

Rationale: The more we understand about the neurobiology and neurochemistry of addiction, the better will be our capability to design interventions. It is well established that pharmacotherapies are effective for heroin. They may also be effective against cocaine, methamphetamine, and other addictive drugs. Research and evaluation will broaden treatment options, which currently include detoxification, counseling, psychotherapy, and self-help groups.

Objective 6: Support and highlight research and technology, including the acquisition and analysis of scientific data, to reduce the health and social costs of illegal drug use.

Rationale: Efforts to reduce the cost of drug abuse must be based on scientific data. Therefore, federal, state, and local leaders should be given accurate, objective information about treatment modalities.

Objective 7: Support and disseminate scientific research and data on the consequences of legalizing drugs.

Rationale: Drug policy should be based on science, not ideology. The American people must understand that control of substances that are likely to be abused is based on sound research and intended to protect public health.

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

The United States is obligated to protect its citizens from the threats posed by illegal drugs crossing our borders. Interdiction in the transit and arrival zones disrupts drug flow, increases risks to traffickers, drives them to less efficient routes and methods, and prevents significant quantities of drugs from reaching the United States. Interdiction operations also produce information that can be used by domestic law enforcement agencies against trafficking organizations.

Each year, more than sixty-eight million passengers arrive in the United States aboard 830,000 commercial and private aircraft. Another eight million

individuals arrive by sea, and a staggering 365 million people cross our land borders driving approximately 115 million vehicles. Ten million trucks and cargo containers and ninety thousand merchant and passenger ships also enter the United States annually, carrying some four hundred million metric tons of cargo. Amid this voluminous trade, drug traffickers seek to hide approximately three-hundred metric tons of cocaine, thirteen metric tons of heroin, vast quantities of marijuana, and smaller amounts of other illegal substances.

Objective 1: Conduct flexible operations to detect, disrupt, deter, and seize illegal drugs in transit to the United States and at U.S. borders.

Rationale: Our ability to interdict illegal drugs is made more difficult by the volume of drug traffic and the ease with which traffickers have switched modes and routes. Efforts to interrupt the flow of drugs require technologically advanced and capable forces, supported by timely intelligence that is well coordinated and responsive to changing drug-trafficking patterns.

Objective 2: Improve the coordination and effectiveness of U.S. drug law enforcement programs with particular emphasis on the Southwest Border, Puerto Rico, and the U.S. Virgin Islands.

Rationale: The Southwest border, Puerto Rico, and the U.S. Virgin Islands continue to be principal axes for illegal drugs destined for the United States. We need to focus our efforts in these places — without neglecting other avenues of entry — by improving intelligence and information-guided operations and supporting law-enforcement agencies with technology. Flexible law-enforcement operations will allow us to attack criminal organizations, retain the initiative, and curtail the penetration of drugs into the United States.

Objective 3: Improve bilateral and regional cooperation with Mexico as well as other cocaine and heroin transit zone countries in order to reduce the flow of illegal drugs into the United States.

Rationale: Mexico, both a transit zone for cocaine and heroin and a source country for heroin, methamphetamine, and marijuana, is key to reducing the flow of illegal drugs into the United States. Also important in this regard are Caribbean, Central America, and Asian nations. The more we can work cooperatively with these countries to enhance the rule of law, the better will be our control of illegal drugs. Mutual interests are best served by joint commitment to reducing drug trafficking.

Objective 4: Support and highlight research and technology — including the development of scientific information and data — to detect, disrupt, deter, and seize illegal drugs in transit to the United States and at U.S. borders.

Rationale: Scientific research and applied technologies offer a significant opportunity to interrupt the flow of illegal drugs. The more reliable our detection, monitoring, apprehension, and search capabilities become, the more likely we are to turn back or seize illegal drugs.

Goal 5: Break foreign and domestic drug sources of supply.

The rule of law, human rights, and democratic institutions are threatened by drug trafficking and consumption. International supply-reduction programs not only reduce the volume of illegal drugs reaching our shores, they also attack international criminal organizations, strengthen democratic institutions, and honor our international drug-control commitments. The U.S. supply-reduction strategy seeks to: (1) eliminate illegal drug cultivation and production; (2) destroy drug-trafficking organizations; (3) interdict drug shipments; (4) encourage international cooperation; and (5) safeguard democracy and human rights. Additional information about international drug-control programs is contained in a classified annex to this *Strategy*.

The United States continues to focus international drug-control efforts on source countries. International drug-trafficking organizations and their production and trafficking infrastructures are most concentrated, detectable, and vulnerable to effective law-enforcement action in source countries. In addition, the cultivation of coca and opium poppy and production of cocaine and heroin are labor intensive. For these reasons, cultivation and processing are relatively easier to disrupt than other downstream aspects of the trade. The international drug control strategy seeks to bolster source country resources, capabilities, and political will to reduce cultivation,

attack production, interdict drug shipments, and disrupt and dismantle trafficking organizations, including their command and control structure and financial underpinnings.

Objective 1: Produce a net reduction in the worldwide cultivation of coca, opium, and marijuana and in the production of other illegal drugs, especially methamphetamine.

Rationale: Eliminating the cultivation of illicit coca and opium is the best approach to combating cocaine and heroin availability in the United States. Cocaine and heroin can be targeted during cultivation and production. Cultivation requires a large labor force working in identifiable fields of coca and opium poppies, and production involves a sizable volume of precursor chemicals.

Objective 2: Disrupt and dismantle major international drug trafficking organizations and arrest, prosecute, and incarcerate their leaders.

Rationale: Large international drug-trafficking organizations are responsible for the majority of illegal drugs that enter the United States. These crime syndicates also pose enormous threats to democratic institutions. Their financial resources can corrupt all sectors of society. By breaking up these organizations and forcing them to forfeit their ill-gotten wealth, we can make them more vulnerable to law enforcement and deny them experienced leadership, political power, and economies of scale that have enabled them to be so successful in the past.

Objective 3: Support and complement source country drug control efforts and strengthen source country political will and drug control capabilities.

Rationale: The United States must continue assisting major drug-producing and transit countries that demonstrate the political will to attack illegal drug production and trafficking. We should reinforce institutional capabilities to reduce drug-crop cultivation, drug production, trafficking, and related criminal activities in all countries where our help is accepted.

Objective 4: Develop and support bilateral, regional, and multilateral initiatives and mobilize international organizational efforts against all aspects of illegal drug production, trafficking, and abuse.

Rationale: Drug production, trafficking, and abuse are not problems solely affecting the United States. The scourge of illegal drugs damages social, political, and economic institutions in both developed and developing countries. The United States must continue providing leadership and assistance to strengthen the international anti-drug consensus. It is in America's interest to encourage all nations to join together against the threat of illegal drugs. The United States must also support multilateral drug control by maintaining full compliance with the United Nations' (UN) 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances and the 1996 Organization of American States' (OAS) Anti-Drug Strategy in the Hemisphere.

Objective 5: Promote international policies and laws that deter money laundering and facilitate anti-money laundering investigations as well as seizure and forfeiture of associated assets.

Rationale: Money laundering is a global problem that requires a global response. Drug traffickers depend upon the international financial system to launder ill-gotten gains so they can invest in legal enterprises that facilitate illegal activity. Significant progress in suppressing money laundering can be made through multilateral efforts, such as the Financial Action Task Force (FATF) and other initiatives that encourage countries to criminalize money laundering, share information, collaborate in investigations, and forfeit illicit proceeds. Similarly, U.S. law-enforcement agencies must continue to train and share experiences with foreign counterparts so that anti-money laundering regimes remain steadfast.

Objective 6: Support and highlight research and technology, including the development of scientific data, to reduce the worldwide supply of illegal drugs.

Rationale: Research must focus on more effective and environmentally sound methods of eliminating drug crops and moving the cultivators of illicit drugs into legal pursuits. Production and movement of

drugs around the globe must be understood more thoroughly. Technology can be used to monitor drug shipments and prevent the diversion of precursor chemicals.

Targets

The ONDCP Reauthorization Act of 1998 stipulates that the *Strategy* will include specific targets that the ONDCP Director determines may be achieved in future years. The Act specifies the inclusion of the following specific targets:

- Reduction of unlawful drug use to 3 percent or less of the U.S. population by December 31, 2003 (as measured in terms of overall illicit drug use during the past thirty days by National Household Survey on Drug Abuse (NHSDA)) and achievement of at least 20 percent of such reduction during 1999, 2000, 2001, 2002, and 2003, respectively.
- Reduction of unlawful adolescent drug use (as measured in terms of illicit drug use during the past thirty days by the Monitoring the Future (MTF) study of the University of Michigan or the National PRIDE survey conducted by the Parents' Resource Institute for Drug Education) to 3 percent or less of the U.S. adolescent population by December 31, 2003, and achievement of at least 20 percent of such reduction during 1999, 2000, 2001, 2002, and 2003, respectively.
- Reduction of cocaine, heroin, marijuana, and methamphetamine availability in the United States by 80 percent by December 31, 2003.
- Reduction of the nationwide average street purity levels for cocaine, heroin, marijuana, and methamphetamine (as estimated by the interagency drug-flow assessment process, the Drug Enforcement Administration, and other national drug-control program agencies) by 60 percent by December 31, 2003, and achievement of at least 20 percent of such reduction during 1999, 2000, 2001, 2002, and 2003, respectively.
- Reduction of drug-related crime in the United States by 50 percent by December 31, 2003, and achievement of at least 20 percent of such reduction during 1999, 2000, 2001, 2002, and 2003, respectively, including the following:
  - Reduction of state and federal unlawful drug trafficking and distribution.
  - Reduction of state and federal crimes committed by persons under the influence of unlawful drugs.
  - Reduction of state and federal crimes committed for the purpose of obtaining unlawful drugs or obtaining property that is intended to be used for the purchase of unlawful drugs.
  - Reduction of drug-related emergency room incidents in the United States (as measured by the Drug Abuse Warning Network), including incidents involving gunshot wounds and automobile accidents in which illicit drugs are identified in the bloodstream of the victim, by 50 percent by December 31, 2003.

Congress believes these targets are important to the reduction of overall drug use in the United States, and that the *Strategy* should seek to achieve them. Accordingly, this *Strategy* lists ninety-seven specific, quantifiable, and measurable targets for 2002 and 2007. Collectively, they will orient a national effort that can reduce illegal drug use and availability by 50 percent over the next eight years and the consequences of drug abuse by at least 25 percent. The twelve impact targets follow.

Demand Reduction

1. Reduce the overall prevalence of illicit drug use by 25 percent by 2002 and by 50 percent by 2007 (compared with the base year — 1996). In 1996 the past-month (i.e., current) rate of drug use in the United States was 6.1 percent. A 50 percent reduction would yield a national drug-use rate of 3 percent. This rate would be the lowest recorded since the federal government began systematically tracking such data.

2. Reduce the prevalence of illicit drug and alcohol use among youth 20 percent by 2002 and 50 percent by 2007. Reduce the prevalence of tobacco consumption among youth 25 percent by 2002 and 55 percent by 2007 (compared with the base year — 1996). In 1996 the prevalence of drug use in the twelve to seventeen-year-old population

was 9 percent. The 50 percent reduction from the 1996 prevalence rate will produce a 4.5 percent rate in 2007. Achieving these critical targets will allow the nation's sixty-eight million young to fulfill their potential as healthy, productive members of society.

3. Increase the average age of first-time drug use by twelve months by 2002 and thirty-six months by 2007 (compared with the base year — 1996). In 1996 the mean age for first-time use of marijuana 16.4 years. Research establishes that individuals who do not use alcohol, tobacco products, or psychoactive substances during adolescence have a greatly reduced likelihood of ever developing substance-abuse problems. Delaying the initial use of illicit substances and illegal drugs by thirty-six months will reduce substantially the number of individuals who have lasting substance-abuse or chemical-dependency problems.

4. Reduce the prevalence of drug use in the workplace by 25 percent by 2002 and 50 percent by 2007 (compared with the base year — 1996). In 1996 there were approximately 6.1 million employed drug users. Workplace-based drug prevention and education programs can contribute to a reduction in the number of drug users and improve the health, safety, and productivity of the American workforce. Attainment of this target will reduce that number by three million.

5. Reduce the number of chronic drug users by 20 percent by 2002 and 50 percent by 2007 (compared with the base year — 1996). Chronic drug users consume the vast majority of the available cocaine, heroin, and methamphetamine in the United States. The estimated 3.6 million chronic cocaine users and 810,000 chronic heroin users place enormous burdens on our society in the form of health and social costs. Reducing their numbers by one half will curtail significantly the associated criminal and health consequences of drug abuse and reduce overall consumption by approximately one third.

Supply Reduction

6. Reduce the domestic availability of illegal drugs by 25 percent by 2002 and 50 percent by 2007 (compared with the base year — 1996). Availability is estimated indirectly. Variations in wholesale and retail prices and purities of drugs are indirect and often inaccurate estimates of availability as a result of their dependence on both supply and demand. Reduced supply, for example, would result in higher prices and lower purity levels were demand to remain constant. Conversely, reduced demand and constant supply would result in lower prices and higher purity levels. Accurate measures of drug-crop cultivation and potential production allow the modeling of drug flows and the computation of macro estimates of availability.

7. Reduce the rate of shipment of illegal drugs from source countries by 15 percent by 2002 and 30 percent by 2007 (compared with the base year — 1996). In 1996 South America potential cocaine production was 760 metric tons. In 1997 that figure dropped to 650 metric tons.

8. Reduce the rate at which illegal drugs enter the United States by 10 percent by 2002 and 20 percent by 2007 (compared with the base year — 1996). The Interagency Assessment of Cocaine Movement, published semiannually, provides an official estimate of cocaine flow through the transit and arrival zones. ONDCP is leading an interagency effort to develop estimates for heroin, marijuana, and other illegal drugs.

9. Reduce the production of methamphetamine and cultivation of marijuana in the United States by 20 percent by 2002 and 50 percent by 2007 (compared with the base year — 1996). There is currently no national estimate of marijuana cultivation or methamphetamine production. Congress has directed that the Department of Agriculture conduct annual estimates of domestic drug-crop cultivation in order to track progress towards this target. ONDCP will coordinate the development of official estimates for the domestic availability of both these drugs.

10. Reduce trafficker success rate in the United States. Reduce by 10 percent the rate at which illicit drugs of U.S. venue reach the U.S. consumer by 2002 and 20 percent by 2007 (Compared with the base year — 1996). There is currently no estimate of trafficker success at the national, regional, or local levels.

Consequences

11. Reduce crime associated with drug trafficking and use by 15 percent by 2002 and 30 percent by 2007 (compared with the base year — 1996). Drug-related crime is not limited to highly publicized violent acts. Drug abuse is also linked to corruption, prostitution, trafficking, possession, money laundering, forgery and counterfeiting, embezzlement, and weapons violations. In 1996 the rate of arrest for drug law violations was 594 per 100,000. Reducing drug-related crime will increase significantly the safety of our nation's streets.

12. Reduce the health and social costs associated with drug trafficking and use by 10 percent by 2002 and 25 percent by 2007 (compared with the base year — 1996). Drug abusers engage in high-risk behavior, making them and their associates susceptible to a range of diseases like tuberculosis, HIV, and hepatitis. Drug use contributes to birth defects and infant mortality, facilitates the spread of infectious diseases, undermines workplace safety, and leads to premature death. According to the Centers for Disease Control and Prevention (CDC), 1,919 cases of tuberculosis that were reported in 1996 were related to drug use (11.5 percent of all cases).

MONITORING THE *STRATEGY'S* EFFECTIVENESS

Strategy links ends, ways, and means. Progress toward a strategy's goals and objectives must be constantly assessed in order to gauge success or failure and adjust the strategy accordingly. ONDCP has therefore, in conjunction with national drug-control program agencies, Congress, state and local officials, and private citizens with experience in demand and supply reduction, developed a Performance Measurement of Effectiveness (PME) system to orient drug-control efforts. This system (1) assesses the effectiveness of the *Strategy*, (2) provides information to the entire drug-control community on what needs to be done to refine policy and programmatic directions, and (3) assists with drug program budget management.

The PME system identifies ninety-seven performance targets, of which twelve (outlined in the preceding section) indicate the impact of national drug-control activities on the *Strategy's* five overarching goals. The other eighty-five measure progress toward the *Strategy's* thirty-one supporting objectives. These targets represent desired end-states for the years 2002 and 2007. They are "stretch targets" in that they require progress above that attained in previous years. This assessment is in keeping with recommendations of the National Academy of Public Administration, the General Accounting Office, and other organizations advocating good government practices. The overall performance system is described in detail in a companion volume to this *Strategy — Performance Measures of Effectiveness: Implementation and Findings*.

Progress toward each goal and objective will be gauged using existing research and new surveys. MTF and the NHSDA, for example, both estimate risk perception, rates of current use, age of initiation, and life-time use for alcohol, tobacco, and most illegal drugs. The ADAM system and DAWN indirectly measure the consequences of drug abuse. The State Department's annual *International Narcotics Control Strategy Report* (INCSR) provides country-by-country assessments of initiatives and accomplishments. INCSR reviews statistics on drug cultivation, eradication, production, trafficking patterns, and seizure along with law-enforcement efforts including arrests and the destruction of drug laboratories. The Subcommittee on Data, Research, and Interagency Coordination will consider additional instruments and measurement processes required to address the demographics of chronic users, domestic cannabis cultivation, drug availability, and data shortfalls related to drug policy.

The relationship between goals, objectives, targets, and federal and non-federal resources will be reassessed and refined continuously to reflect the dynamic drug-abuse problem and progress in reducing its scope. Non-achievement of a target over a period of time will trigger an in-depth interagency program evaluation to identify problems and recommend corrective action. Such measures might include a range of options such as modifying programs, reinforcing them with more resources, or eliminating them altogether. This ongoing review process will also allow reinforcement of successful programs.

This PME system complies with congressional guidance that the *Strategy* contain measurable objectives and specific targets to accomplish long-term quantifiable goals. Indeed, the ONDCP Reauthorization Act of 1998 strongly endorses this performance measurement system. In accordance with the Act, this system establishes clear outcomes for reducing drug use nationwide during the next five years and is linked to all federal drug control program agencies and budgets. These targets and the accompanying performance measurement system will allow congressional appropriations and authorizing committees to restructure appropriations in support of the *Strategy* to ensure that resources necessary to attain ambitious long-term performance goals are provided.

Implementation of the PME system began within the federal government in 1998 with the publication of the first PME report. Federal drug-control program agencies formed five steering groups and twenty-one working groups. The former consist of high-level agency representatives who provide guidance for the PME development and implementation processes. The latter assessed the adequacy of data sources to support the eighty-five performance targets of the PME system. The working groups determined that thirty-seven performance targets are milestones and do not require quantitative databases. Of the forty-eight performance targets requiring quantitative databases, eight can be measured with existing databases, twenty require either modifications to existing databases or development of new databases, and twenty can be measured with administrative records maintained by the agency implementing the associated program. ONDCP, through its data subcommittee, is working with data managers from all federal agencies with a drug control function to develop or modify the required data systems.

These interagency "expert" groups have also been working on logic models to determine optimum ways of achieving these targets. These logic models seek to identify factors (or independent variables) that influence the desired target (or dependent variable). This exercise enables practitioners to identify external factors over which they do not have control. Eventually, this process should result in drug control agencies forging partnerships with non-drug-control agencies that influence extraneous factors. Based on the conceptual framework of the logic models, the working groups identified draft action plans for each target. These plans outline what needs to be done between now and 2007 in order to meet each target. In 1999 ONDCP will incorporate state, local, and private agency input into this process in order to develop intergovernmental logic models and action plans to focus programs and resources on PME targets nationally. The working groups have also projected preliminary annual targets for those numerical PME targets that are supported by established databases. In most cases linear glide paths were selected to depict projected progress. As logic models are refined, more appropriate annual targets will be adopted.

The process of integrating PME system targets and programs is underway. The Fiscal Year 2000 *Budget Summary* which is a second companion volume to the *1999 Strategy*, associates for the first time federal drug-control budget requests with performance targets. This linkage will be strengthened in the FY 2001 budget submission. As the logic models and action plans are refined in 1999 with state, local, and private-sector input, action plans will be reflected in ONDCP's budget guidance to federal drug-control program agencies. However, the budgetary implications of the PME system will not be completely understood until annual targets and supporting action plans are finalized by each agency. Consequently, targets and budget submissions will be iteratively refined as agencies base budget requests on priorities for achieving performance targets.

The Administration is committed to examining and perfecting the PME system goals and targets — through a comprehensive review involving federal agencies, state and local government, foreign countries, international organizations, and the private sector. The federal government alone cannot attain the ambitious goals of reducing illegal drug demand and supply by 50 percent and the consequences of drug abuse by 25 percent by 2007 simply by altering its own spending and programs any more than the United States can unilaterally reduce cocaine production in South America or opium cultivation in Asia. A coalition of government, the private sector, communities, and individuals — a truly national effort — must embrace such a commitment for it to be successful.

Endnotes

1 *Performance Measures of Effectiveness: Implementation and Findings,* published simultaneously with this document and on the ONDCP Web site (*http://www.whitehousedrugpolicy.gov*).

2 D. Dwayne Simpson and Susan J. Curry, eds., "Special Issue: Drug Abuse Treatment and Outcomes Study (DATOS)," *Psychology of Addictive Behaviors*, 11, No. 4 (1997).

3 Substance Abuse and Mental Health Services Administration, *Services Research Outcomes Study (SROS)* (Bethesda, MD: U.S. Department of Health and Human Services, 1997); National Institute on Drug Abuse, *Drug Abuse Treatment Outcome Study (DATOS)* (Bethesda, MD: U.S. Department of Health and Human Services, 1997); and California Department of Alcohol and Drug Programs, *Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment* (CALDATA No. ADP 94-629) Sacramento, CA (1994).

4 Center for Substance Abuse Treatment, *The National Treatment Improvement Evaluation Study. Preliminary Report: The Persistent Effects of Substance Abuse Treatment — One Year Later* (Rockville, MD: Substance Abuse and Mental Health Services Administration, September 1996).

IV. A Comprehensive Approach

The preceding chapter detailed the goals and objectives that comprise the *Strategy*. This chapter provides the action plan for accomplishing the goals and objectives. Governments set policy, but policy can only be implemented through specific, funded programs. The following pages identify components of the national drug problem, outline challenges in each of these areas, and describe programs to reduce drug abuse and its consequences. This chapter presents the core of the *Strategy.*

1. A NATIONAL STRATEGY

The *Strategy* is national in scope and purpose. The desired end is to decrease drug abuse and its consequences throughout America. As the data indicate, the problem is not compartmentalized. Illegal drugs permeate the entire country, cutting across socioeconomic backgrounds, ethnic groups, educational levels, and metropolitan, suburban, and rural boundaries. Unless we recognize drug abuse as an affliction threatening all our citizens and neighborhoods, we will be unsuccessful in achieving our purpose. Like cancer, drug abuse that is left unchecked will spread to other parts of the body politic.

The United States is not an island disconnected from the rest of the world. Although we grow or manufacture many of the illegal drugs we consume (such as marijuana and methamphetamine), America's demand for drugs and willingness to pay high prices makes us a choice target for international traffickers. We further understand that as we bring down our consumption, drug traffickers will search for markets elsewhere, creating problems for other nations. The *Strategy* therefore, includes bilateral, multilateral, and international initiatives designed to lessen our own drug problem and help all countries address the illegal drug threat — a threat that jeopardizes their own well-being and national security.

Domestically, the job of reducing drugs in America cannot be done without coordination at the federal, state, and local level or close cooperation between the public and private sector. Such effort is motivated by the strong concern Americans have for their children in light of the drug threat. In a 1997 poll that asked for a list of the top problems facing children, respondents cited drugs more than twice as often as the second-most-mentioned problem (crime) and almost four times the rate as for basic issues like good education.[1] This concern has resulted in a significant commitment from the federal government whose aggregate counterdrug budget has grown from $13.5 billion in fiscal year 1996 to $17.8 billion in 1999. More than fifty federal agencies work together under the guidance of this *Strategy* to reduce the scope and intensity of the national drug problem.

State and Local Government

The federal government cannot accomplish the objectives laid out in this *Strategy* without the support of the fifty states and four U.S. territories as well as the thousands of city, county, and local governments threatened by illegal drugs. State governments, for example, have enormous potential for addressing the drug problem. They administer the school systems, exercise far-reaching jurisdictional power, channel money and resources to specific needs, and educate citizens about the dangers of illegal drugs. States' funds account for much of the spending on drug prevention and treatment, providing

funds to thousands of community-based treatment programs and prevention providers. Counties and cities, play an equally important role, providing essential services such as emergency medical care, education, and law enforcement. Public officials in municipalities and counties are frequently most attuned to the specific requirements of their communities. State and local government can and should play an important role in integrating federal funding and coordinating statewide responses to the drug threat. All levels of government must become partners with the federal government in countering illegal drugs.

State Drug Laws

State drug laws play a critical role in the effort to reduce drug availability and use. In recognition of this fact, in 1988 Congress mandated the creation of a bipartisan, presidentially-appointed commission to develop model state drug legislation. The resulting President's Commission on Model State Drug Laws developed forty-four exemplary drug laws. Since 1993, the Alliance for Model State Drug Laws has been holding workshops throughout the country to focus attention on state policies and laws concerning drugs. The adoption of the Model State Drug Laws, and the continued efforts of the Alliance, are important to national drug-control efforts.

The Role of Communities

Government response is only a small part of the national effort to counter illegal drugs. Communities are significant partners for local, state and federal agencies working to reduce drug use, especially among young people and deserve continued support. Communities around the country have formed coalitions that coordinate local reactions to the illegal drug problem. Coalitions typically include schools, businesses, law enforcement agencies, social service organizations, faith communities, medical groups, and youth groups, as well as county and local government. Community Anti-Drug Coalitions of America (CADCA) supports these organizations through technical assistance, leadership development, and information dissemination.[2] The Corporation for National Service assists coalitions through initiatives like Learn and Serve, AmeriCorps, and SeniorCorps. The National Guard helps communities by providing administrative help, logistical support, and prevention programs like Adopt-a-School. The Drug-Free Communities Act of 1997 provides vital support to communities. The program's genesis and growth has been fueled by an unprecedented level of bipartisan support. Last year, grants were provided to ninety-two communities, an initial training and technical assistance conference was conducted, and a presidentially appointed Advisory Commission was established. Two-hundred additional grants will be made during fiscal year 1999. CSAP's five regional Centers for the Application of Prevention Technologies (CAPTs) provide communities with effective coalition training and related materials.

Civic and Service Alliance

Civic, service, fraternal, veterans', and women's organizations also contribute to the national counter-drug effort. Since November 1997, there has been a continued effort to bring together leading civic organizations in an alliance to help young people pursue healthy, drug-free lifestyles. To date, forty-seven national and international organizations have signed a resolution and are member organizations of the "Prevention Through Service" Alliance.* Member organizations

* Current member organizations are: 100 Black Men, Inc., AMBUCS, AMVETS, Benevolent and Protective Order of Elks, Big Brothers Big Sisters, Boys and Girls Clubs, Boy Scouts of America, B'nai B'rith Youth Organization, Camp Fire Boys and Girls, Campus Outreach Opportunity League, Civitan International, Fraternal Order of Eagles, General Federation of Women's Clubs, Girls, Inc., Girl Scouts of the U.S.A., Improved Benevolent and Protective Order of Elks of the World, Independent Order of Odd Fellows, Jack and Jill of America, Inc., Junior Chamber International, Knights of Columbus, Lions Clubs International, Moose International, Masonic National Foundation for Children, Mothers Against Drunk Driving, National Beta Ckub, National Council of Negro Women, National Council of Youth Sports, National Exchange Club, National 4-H Council, National FFA Organization, National Panhellenic Conference, National Retired Teachers Association, Optimist International, Pilot International, Quota International, United Native Indian Tribal Youth, Rotary International, Ruritan International, Sertoma International, Soroptimist International, The LINKS, Inc., Veterans of Foreign Wars, YMCA of the USA, Youth Power, Youth to Youth International, YWCA of the USA, and Zeta Phi Beta Sorority Inc.

represent major service clubs, fraternal and veterans organizations, college student service organizations, youth development agencies, and youth sports programs. They represent more than one hundred million volunteers belonging to nearly one million local affiliated chapters across the country. Highlights of the civic alliance include increasing public awareness, promoting communication about effective prevention, networking among organizations and communities, providing leadership and scholarships, and encouraging volunteerism, as well as service to those in need. Member organizations of the civic alliance support the national anti-drug youth media campaign by sponsoring community-based prevention message activities.[3]

Workplace Initiatives

According to the 1997 NHSDA, 6.7 million current illegal drug users were employed full-time. This number represents 6.5 percent of full-time employees aged eighteen and older. Drug-abusing employees affect the productivity of any business; in some industries they pose an obvious threat to the safety and security of Americans.

In the interest of safety, the Omnibus Transportation Employees Testing Act of 1991 requires alcohol and drug testing throughout the transportation industry. The Department of Transportation (DOT), the industry leader in drug-free workplace programs, oversees approximately eight million employees in the United States who work in regulated business within the aviation, motor, carrier, rail, transit, pipeline, and maritime industries. DOT requires workers in safety-sensitive positions who test positive for drugs to be referred to substance-abuse professionals before returning to work. If substance abuse is diagnosed, the employee must receive treatment before resuming duties. This program — which also requires drug-testing for operators of commercial motor vehicles from Canada and Mexico — has become a model for non-regulated employers throughout the United States and other countries around the world. The current percentage of positive drug tests in the transportation industry is very low, having dropped considerably since the program started.

As the nation's largest employer, the federal government has set the example for the past eleven years. Currently, 120 federal agencies have drug-free workplace plans certified by the HHS, Office of Personnel Management, and DOJ. These agencies represent about 1.8 million employees — the vast majority of the federal civilian workforce. As a result, substance-abuse problems and positive drug tests are at record low levels — .005 percent. The U.S. military is a prime example of how institutional values and leadership can minimize workplace substance-abuse problems. A generation ago, the uniformed ranks were notoriously drug ridden. Today, a minuscule proportion (approximately one per cent) of defense personnel, uniformed and civilian, use illegal drugs. That turn-around was achieved by prevention, education, and drug-testing combined with strong first-line supervisory leadership that made it clear that illegal drug use was unacceptable behavior.

Because of the federal government's example and experience, comprehensive drug-free workplace programs have expanded throughout the nation. Today, over 80 percent of all companies with more than five thousand employees have drug-free workplace programs. Private sector results parallel the federal experience, with rates of positive drug tests decreasing over the past ten years. Clearly, comprehensive workplace programs provide both incentives and models for smaller employers to build upon in coming years. Drug-free employees have fewer work-related accidents and less absenteeism, use fewer health-care benefits, and file fewer workers compensation claims than their drug-abusing colleagues.

Effective workplaces strategies include written anti-drug and substance-abuse policies, education for employees, employee assistance programs, referral to treatment for both employees and family members, drug testing, and training for supervisors so that they can recognize the signs of drug use reflected in job performance and refer employees for help. Programs that employ these strategies improve productivity and reduce employers' costs associated with employee recruitment, training, and retention.

Businesses receive information on creating drug-free workplace programs through the Department of

Labor's (DOL) *Working Partners for an Alcohol- and Drug-Free Workplace* initiative, which includes specific outreach to small business and a repository of materials in the Web-based Substance Abuse Information Database (SAID).[4] CSAP also assists businesses implement drug-free workplace programs through its telephone help line, supplemental materials, and training programs.[5]

Recognizing that it is often difficult for small businesses to institute drug-free workplace programs, Congress passed the Drug Free Workplace Act of 1998 that establishes a demonstration program within the Small Business Administration (SBA). Under this program, the SBA will make grants to eligible business development centers to educate businesses on the benefits of a drug-free workplace program, provide technical assistance in establishing programs, and educate working parents on how to keep children drug-free.

Another workplace-related challenge is helping long-term unemployed substance-abusers become employable. The Workforce Investment Act of 1998, administered by DOL, allows administrative funds to be used for drug testing and referral to treatment in programs that target unemployed youth and adults. The Job Corps program, for example, enforces a zero-tolerance policy, and includes drug testing, assessment, and referrals to treatment. DOL also administers the Welfare-to-Work grants to help individuals overcome barriers to employment, like substance abuse and lack of education. These grants target the roughly 20 percent of the adult welfare population who are most at risk of long-term dependency. To date, eighty-eight million dollars worth of grants that specifically address substance abuse have been awarded.

Athletic Initiative

Organized athletic programs can reach young people and engage them in drug-free activities. Each year approximately 2.5 million students play football and basketball in high school and junior high. Millions of children are involved in soccer leagues, among other sports. Studies show that a young person involved in sports is 40 percent less likely to get involved with drugs than an uninvolved peer. Scores of children admire professional athletes, but these stars often convey mixed messages pertaining to drugs, if not outright pro-drug attitudes. In 1998, ONDCP launched an Athletic Initiative to reduce drug use within sports, encourage the athletic world to condemn drug use, and urge youth to get involved with sports.[6] ONDCP's "National Coachathon Against Drugs" involves professional and amateur sports leagues. During 1998 one hundred thousand copies of the *Coach's Playbook Against Drugs* were distributed to coaches around the nation.[7] As a result of the athletic initiative, eighteen Major League Baseball clubs and several National Football League teams now show anti-drug messages in their stadiums. In 1999, ONDCP will conduct a national summit to address the full range of sports-related drug issues.

Faith Initiative

The faith community plays a vital role in building social values, informing the actions of individuals and inculcating life skills that are critical to resisting illegal drugs. The clergy — rabbis, priests, and ministers — all serve as civic leaders. Many run programs that provide much-needed counseling and drug treatment for members of their communities. Consequently, ONDCP is expanding its outreach to the faith community. In 1999, ONDCP encourages religious communities to speak out against drugs and further develop faith-based initiatives to prevent and treat drug use.

Countering Attempts to Legalize Drugs

Given the negative impact of drugs on American society, the overwhelming majority of Americans reject illegal drug use. Indeed, millions of Americans who once used drugs have turned their backs on such self-destructive behavior. While most Americans remain steadfast in condemning drugs, small elements at either end of the political spectrum argue that prohibition — and not drugs — create problems. These people offer solutions in various guises, but one of the most troublesome is the argument that eliminating the prohibition against dangerous drugs would reduce the harm that results from drug abuse. Such legalization proposals are often presented under the guise of "harm reduction."

All drug policies claim to reduce harm. No reasonable person advocates a position consciously designed to be harmful. The real question is: which policies actually decrease harm and which increase good? The approach advocated by people who say they favor "harm reduction" when they are really advocating drug legalization would in fact harm Americans.

The theory behind what legalization advocates call "harm reduction" is that illegal drugs cannot be controlled by law enforcement, education, public-health interventions, and other methods. Therefore, proponents say, harm should be reduced by decriminalization of drugs, heroin maintenance, and other intermediate measures. The real intent of many harm-reduction supporters is the legalization of drugs, which would be a mistake.

Some people argue that they are not calling for the legalization of all drugs but only for "soft" drugs. Since many users enter treatment every year for help recovering from chronic abuse of marijuana and similar "soft" drugs, this idea overlooks the danger posed by such drugs. Other people support decriminalization of drugs so that drug use would remain against the law but penalties would be minimal. Illegal drug use would become analogous to minor indiscretions like jay-walking. Still others defend the therapeutic value of specific drugs or the economic viability of a drug-related product. By making drug use more acceptable, these people argue, society would reduce the harm associated with drug abuse.

The truth is that drug abuse wrecks lives. It is criminal that more money is spent on illegal drugs than on art or higher education, that crack babies are born addicted and in pain, that thousands of adolescents lose their health and future to drugs. Addictive drugs were criminalized because they are harmful; they are not harmful because they were criminalized. The more a product is available and legitimized, the greater will be its use. If drugs were legalized in the U.S., the cost to the individual and society would grow astronomically.

Many harm reduction partisans consider drug use a part of the human condition that will always be with us. While we agree that crime can never be eliminated entirely, no one is arguing that we legalize other harmful activities. At best, harm reduction is a half-way measure, a half-hearted approach that would accept defeat. Increasing help is better than decreasing harm. Pretending that harmful activity will be reduced if we condone it under the law is foolhardy and irresponsible.

Countering Attempts to Legalize Marijuana

Marijuana is a Schedule I drug under the provisions of the Controlled Substance Act, Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, because of its high potential for abuse and lack of accepted medical use. Federal law prohibits the prescription, distribution, or possession of marijuana and other Schedule I drugs like heroin and LSD and strictly controls Schedule II drugs like cocaine and methamphetamine. Federal law also prohibits the cultivation of *Cannabis sativa*, the marijuana plant. Marijuana is similarly controlled internationally through inclusion on Schedule I of the U.N. Single Convention on Narcotic Drugs. In the past decade, data regarding the negative impact of marijuana on our youth has accumulated. As described in Chapter II, marijuana use by young people correlates with delinquent and antisocial behavior.

In response to anecdotal claims about marijuana's medical effectiveness, the NIH have sponsored conferences involving leading researchers and is supporting peer-reviewed research on the drug's safety and efficacy. ONDCP is supporting a comprehensive review of existing research on marijuana's potential benefits and harms. This eighteen-month study, conducted by the National Academy of Science's Institute of Medicine, is considering scientific evidence on several topics related to marijuana, including the drug's pharmacological effects; the state of current scientific knowledge; marijuana's ability to produce psychological dependence; risks posed to public health; marijuana's history and current pattern of abuse; and the scope, duration, and significance of abuse.

The U.S. medical-scientific process has not closed the door on marijuana or any other substance that may offer therapeutic benefits. However, both law and common sense dictate that the process for establishing substances as medicine be thorough and science-based. By law, laboratory and clinical trial data are submitted to medical experts in the DHHS, including the FDA, for evaluation of safety and efficacy. If scientific evidence, including results of adequate and well controlled clinical studies demonstrates that the benefits of a drug product outweigh associated risks, the substance can be approved for medical use. This rigorous process protects public health. Allowing marijuana or any other drug to bypass this process is unwise.

Permitting hemp cultivation would result in de facto legalization of marijuana cultivation because both hemp and marijuana come from the same plant — *Cannabis sativa*, which contains THC, the active ingredient in marijuana. Chemical analysis is the only way to differentiate between cannabis variants intended for hemp production and hybrids grown for their psychoactive properties.[8] In June 1998, a New Hampshire magistrate determined that the Controlled Substances Act unambiguously prohibits the cultivation of hemp. The magistrate found that hemp is marijuana under the statute's definition.

According to a Department of Agriculture review of university studies, hemp is unlikely to be a sustainable, economically viable alternative crop given the uncertainty of demand and market prices. The current U.S. market for hemp products is small, and the potential seems high to reach a situation of oversupply quickly in this niche market. For every proposed use of industrial hemp, competing raw materials and proven manufacturing practices already exist. The ready availability of other lower cost raw materials is a major reason for a 50 percent drop in worldwide hemp production since the early 1980s.

Given concerns about encroaching efforts to justify legalization of harmful psychoactive drugs, the *1999 Strategy* outlines specific steps to counter the potential harm such activities pose. Such measures, which have been elaborated throughout this document, include:

(1) Presenting information that demonstrates the harm caused by substance abuse.

(2) Teaching youth that substance abuse is detrimental to their health and well-being.

(3) Supporting established scientific procedures to ensure that only safe and effective drugs are used for the treatment of medical ailments.

(4) Informing state and local government as well as community coalitions and civic organizations about the techniques associated with the drug legalization movement.

(5) Ensuring the rule of law.

(6) Working with the international community to reinforce mutual efforts against drug legalization.

2. PREVENTING DRUG ABUSE

Preventing or delaying use of psychoactive drugs, alcohol, and tobacco among adolescents is a critical, national public health goal. The simplest and most cost-effective way to lower the human and societal costs of drug abuse is to prevent it in the first place. More than 255 million Americans do not use illegal drugs. Some sixty-one million Americans who once used illegal drugs have now rejected them; many suffered as a result of drug abuse. Accidents, addiction, criminal involvement, damaged relationships, impaired judgement, and lost educational or employment opportunities were common. Of the fourteen million Americans who currently use illegal drugs, some four million are chronic abusers. Preventing America's sixty-eight million children from using drugs, alcohol, and tobacco will help safeguard our society. Preventing drug abuse is one of the best investments we can make in our country's future. Doing so is preferable to dealing with the consequences of drug abuse through law enforcement or drug treatment.

Prevention is most promising when it is directed at impressionable youngsters. Adolescents are most susceptible to the allure of illicit drugs. Delaying or preventing the first use of illegal drugs, alcohol, and tobacco is essential. Not only does hazardous drug use put young people at risk of negative short-term experiences, but those who do not use illegal drugs, alcohol, or tobacco during adolescence are less likely to develop a chemical-dependency problem. Like education in general, drug prevention is demonstrably most effective among the young. In addition to deterring some

initiations completely, drug prevention programs help people who use drugs to use smaller quantities. Successful substance-abuse prevention leads to reductions in traffic fatalities, violence, unwanted pregnancy, child abuse, sexually transmitted diseases, HIV/AIDS, injuries, cancer, heart disease, and lost productivity.

Evidence from controlled studies, national cross-site evaluations, and CSAP grantee evaluations demonstrates that prevention programs work. Good junior high school interventions affect knowledge and attitudes about drugs, use of cigarettes and marijuana, and persist into the twelfth grade.[9] Examples of CSAP prevention successes are encouraging. A Cornell University study of six thousand students in New York state found that the odds of drinking, smoking, and using marijuana were 40 percent lower among students who participated in a school-based substance-abuse program in grades seven through nine than among their counterparts who did not. Similarly, an assessment of Project STAR found that forty-two participating schools in Kansas City, Missouri reported less student use of alcohol, tobacco, and marijuana than control sites.[10]

Prevention programs are not vaccinations that inoculate children against substance abuse. Sadly, significant numbers of young people who participate in the best programs will go on to use drugs. The "no-use" message must be reinforced consistently by parents, teachers, clergy, coaches, mentors, and other care givers. The effectiveness of prevention is difficult to measure given the lag time from when a young person goes through a program and when he or she starts using drugs. MTF historical data, for example, demonstrates that marijuana use among adolescents tends to change in inverse proportion to the percentage of youths who disapprove of marijuana use or perceive such use to be risky. According to MTF data, drug-usage rates change two years after attitudes. Prevention affects the number of new and light users much more than it does the number or consumption patterns of heavy users. Finally, since rates of drug use seem to spread in a manner similar to an epidemic, prevention will be more effective when undertaken early in the cycle when use is proliferating with existing users introducing others to drugs. At this time, enabling one person to abstain can prevent other initiations. Rather than be reactive, prevention programs should be proactive and reach each rising cohort.[11]

The Central Role of Parents

While all parents are critical influencers of children, parents of children aged eight to twelve are especially influential. Children in this age group normally condemn drug use. Such attitudes and attendant behavior are easily reinforced by involved parents. Parents who wait to guide their children away from drugs until older ages when youngsters are more readily influenced by peers or may have started using alcohol, tobacco, and other drugs, decrease their ability to positively influence children.

Parental example is a determinant of adolescent drug use. Children whose parents abuse alcohol or other drugs face heightened risks of developing substance-abuse problems themselves. There are an estimated eleven million such children under age eighteen in the United States. Every day, these youngsters receive conflicting and confusing messages about substance abuse. Nevertheless, specially crafted prevention messages can break through the levels of denial inherent in these families. SAMHSA's Children of Substance Abusing Parents program is developing community-based interventions services to reduce those risks.

Teachers, coaches, youth workers in all areas of life from faith communities to scouts, and extended family members also provide youth with important protection from drug abuse and support for positive parental training by modeling, teaching, and reinforcing positive behavior. Such "occasional preventionists" are vital in touching the lives of children from chemically dependent families. Adult addiction can have a devastating impact on children. By taking small steps, adult mentors can make a permanent difference in the course of a child's life.

National Youth Anti-Drug Media Campaign

The goal of this bipartisan five-year campaign is to use the full power of the media to educate and enable America's youth to reject illegal drugs. This goal includes preventing drug abuse and encouraging current users to quit. For three reasons, the campaign focuses on primary prevention, which means preventing drug use *before* it starts. First, primary prevention targets the underlying causes of drug use and therefore has the greatest potential to

reduce the scope of the problem. Second, over time a primary prevention campaign will lessen the need for drug treatment, which is in short supply. Third, a media campaign has greater potential to affirm the anti-drug attitudes of youth who are not involved with drugs than to persuade experienced drug users to change their behavior.

The media have come to play an increasingly important role in public health campaigns due to their wide reach and ability to influence behavior. There is significant evidence that carefully planned mass media campaigns can reduce substance abuse by countering false perceptions that drug use is normative and influencing personal beliefs that motivate drug use. Media campaigns have been used to prevent or reduce consumption of illegal drugs and smoking along with risky behavior like driving under the influence of alcohol or without seat belts. For all their power to inform and persuade, the media alone are unlikely to bring about large, sustained changes in drug use. The anti-drug campaign will be truly successful only if media efforts are coordinated with initiatives that reinforce one another in homes, schools, and communities.

The anti-drug media campaign began in January 1998 in twelve test sites and was expanded nationwide in July. Once ads began to run in the twelve test sites, anti-drug awareness increased and requests for anti-drug publications increased by more than 300 percent. The campaign harnesses a diverse mix of television, video, radio, Internet, and other forms of new media to deliver anti-drug messages. Its objectives are "universal," aiming at all adolescents, parents, and primary care-givers. Messages and channels through which they are being delivered are tailored for specific regional, ethnic, cultural, gender, and age differences among members of the target audiences. Paid and public-service advertising, news, public-affairs programming, and entertainment venues are being used in the media campaign. So far, media outlets are matching paid advertisements with public-service time for advertisements and pro-bono programming content. Public-service advertising space generated by the paid campaign is being dedicated to messages that target underage drinking and smoking, as well as other messages related to the campaign's communications objectives. We have also developed partnerships with a broad range of community and civic groups, professional associations, government agencies, and corporations.

In 1998, thirty television programs focused on themes and messages supportive of the campaign. While the campaign's goal was to reach 90 percent of the target audience with four messages a week, by January 1999, 95 percent of the target audience was receiving seven anti-drug messages a week.

Safe and Drug-Free Schools and Communities

The Department of Education's Safe and Drug-Free Schools and Communities Program (SDFSP) provides funds for virtually every school district to support drug and violence prevention programs and to assist in creating and maintaining safe learning environments. The President has announced his intention to overhaul the program to improve its effectiveness. The proposal will require schools to adopt effective drug and violence policies and programs, annual safety and drug use report cards, links to after school programs, and efforts to involve parents. The Department has already implemented principles of effectiveness which require that all SDFSP-funded programs be research-based. The program is moving in a direction designed to ensure that SDFSP fund recipients, including governors, state education agencies, local education agencies, institutions of higher education, and community organizations, adopt programs, policies and practices that are based on research and evaluation. To assist in the identification and adoption of effective approaches, an expert review panel will identify promising or exemplary drug and violence prevention programs. The new Drug Prevention and School Safety Program Coordinators initiative will help school districts recruit, hire, and train drug and violence prevention coordinators in middle schools. Coordinators will be responsible for identifying promising drug and violence prevention programs and strategies; assisting schools in adopting the most successful strategies; developing, conducting and analyzing assessments of school drug and crime problems; working with community resources to ensure collaboration; and providing feedback to state educational agencies on programs and activities that have proven to be successful in reducing drug use and violent behavior.

Mentoring Initiative

This CSAP initiative will implement a national mentoring program to focus on some of the problems young people face, including alcohol and drug abuse. Adult mentors will be recruited and trained to reach at-risk youth in at least four states through demonstration programs. If evaluations prove positive, the program will be expanded to more states by FY 2004. The National Family Strengthening Initiative will help communities adopt effective, science-based programs to strengthen tutoring and mentoring, both of which enhance youth resiliency and reduce psychosocial factors that put families at risk.

Child Welfare and Welfare Reform

The safety of children and well-being of families are jeopardized by the strong correlation between chemical dependency and child abuse. Several studies have recently found that approximately two-thirds of the over 500,000 children in foster care have parents with substance-abuse problems.[12] Yet, according to the Child Welfare League of America, last year only 10 percent of child welfare agencies were able to locate treatment within a month for clients who needed it.[13] According to SAMHSA, 37 percent of substance-abusing mothers of minors received treatment in the past year.[14] A new federal law regarding adoption and child welfare, the Adoption and Safe Families Act (P.L. 105-89), makes it essential that substance-abuse services for parents be provided promptly if parents are to be afforded realistic opportunities for recovery before children in foster care are placed for adoption.

In addition to compromising parents' ability to care for their children, substance abuse may also interfere with parents' capacity to acquire or maintain employment. An estimated 15 to 20 percent of adults receiving welfare have substance-abuse problems that interfere with employment.[15] Yet our welfare systems do not adequately address substance abuse and its familial consequences. If prevention and treatment are not provided to this high-risk population, the same families will remain extensively involved in the welfare and criminal-justice systems at great cost to society and with devastating emotional consequences for affected children. Welfare agencies are generally inexperienced in dealing with substance-abuse issues and may need technical assistance to identify addiction and make appropriate referrals.

Youth Substance Abuse Prevention Initiative

SAMHSA/CSAP coordinates this HHS-wide initiative that is designed to reduce marijuana use by twelve to seventeen year-olds. Major components of the initiative are regional Centers for the Application of Prevention Technologies (CAPTs) and State Incentive Grants (SIGs). CAPTs provide states and communities technical assistance and information about research-based prevention. SIGs encourage collaboration with private and community-based organizations. Nineteen grants have already been awarded to states.

Youth Tobacco Initiative

The Youth Tobacco Initiative is a multifaceted HHS campaign, coordinated by the Centers for Disease Control and Prevention (CDC). Its purpose is to reduce availability of and access to tobacco and the appeal of tobacco products to youth. The campaign includes funding for tobacco prevention and cessation programs, research, legislative initiatives, regulation, and enforcement. It is supported by the FDA, NIH, and SAMHSA. The FDA, under the Food, Drug and Cosmetics Act, regulates and enforces federal age and identification requirements regarding the sale of tobacco products. The FDA also conducts an extensive advertising campaign to deter retailers from selling tobacco products to minors. The NIH, through the National Cancer Institute, NIDA, and others supports biomedical and clinical research on tobacco. SAMHSA, through its Substance Abuse Prevention and Treatment (SAPT) Block Grant, administers the SYNAR Amendment which requires state legislative and enforcement efforts to reduce the sale of tobacco products to minors. Since the enactment of SYNAR in 1994, states have increased their retailer compliance rates from approximately 30 percent to 74 percent in 1998.

States are at the forefront of efforts to prevent tobacco use by youth. Arizona, California, Florida, and Massachusetts are conducting paid anti-tobacco

media campaigns, restricting minors' access to tobacco, limiting smoking in public places, and supporting school-based prevention. CDC provides funding for state health departments and national organizations to conduct tobacco use prevention and reduction programs including media and educational campaigns, training, and surveys. CDC's Office on Smoking and Health has developed a four- point prevention and control strategy to support state campaigns and provides. CDC's Media Campaign Resource Center provides states television and radio advertisements as well as printed material. A critical federal responsibility is the diffusion of science-based models and strategies in support of state and community efforts. Accordingly, CDC funds evaluations of specific programs and disseminates information to the public. CDC's *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction,* for example, includes recommendations on school tobacco-use policies, tobacco prevention education, teacher training, family involvement, tobacco-use cessation programs, and evaluation.

Youth Alcohol Use Prevention

Alcohol is by far the drug of choice among American youth. Although the legal drinking age in all states is twenty-one, preliminary data from the 1997 NHSDA indicates that more than 50 percent of young adults age eighteen to twenty are consuming alcohol and more than 25 percent report binge drinking (five or more drinks on the same occasion) in the past month. Of those reporting binge drinking, close to half are considered heavy drinkers.[16] Rates of alcohol use, binge drinking, and heavy alcohol use increase dramatically in early teen years rising from 6.7 percent among twelve and thirteen year-olds, to 21.1 percent among fourteen and fifteen year-olds, to 33.4 among sixteen and seventeen year olds. Data from NIAAA's National Longitudinal Alcohol Epidemiologic Survey provides convincing evidence that the younger an individual is when drinking begins, the greater the chances are of developing substance-abuse problems in the future.[17] The risk for many alcohol-related illnesses rises with the quantity and frequency of alcohol consumption. Other adverse consequences include motor vehicle crashes, injuries, high-risk activities, unprotected sex, violence, crime, and costs to society for police, courts, and jails.

NIAAA has a number of specific initiatives underway to address youth alcohol use including: Alcohol Screening Day, NIAAA National Advisory Council's Subcommittee on College Drinking, Kettering Foundation National Issue Forums on alcohol, and the Surgeon General's Initiative on Underage Drinking. SAMHSA/CSAP, in collaboration with NIAAA, is supporting a five-year research grant program entitled *Effects of Alcohol Advertising on Underage Drinking* which explores short- and long-term relationships among youth of exposure to alcohol advertising, alcohol expectancies and other mediating variables, and actual consumption of alcohol by youth. CSAP, NIAAA, and the Department of Education are supporting another five-year grant program entitled *Prevention of Alcohol-Related Problems among College Students* which will identify, test, and/or develop interventions which are effective in the prevention and reduction of alcohol-related problems among college students. SAMHSA supports activities to reduce underage alcohol consumption through its substance abuse prevention grants.

3. TREATING THE ADDICTED

Despite our best efforts, some people invariably will use drugs. A proportion will become addicted. Since they constitute a group that causes untold damage to themselves, their families, and their communities, the addicted population is a group that must be targeted as a vital part of the *Strategy*. In any given year, addicts consume most of the heroin and cocaine in America. By reducing the number of addicts, we can greatly decrease the negative social and human consequences of drug abuse. Drugs have severe negative consequences for abusers' mental and physical health. Drug abuse and addiction also have tremendous implications for the health of the public since drug use is now a major vector for the transmission of infectious diseases, particularly HIV/AIDS, hepatitis, and tuberculosis — and for the infliction of violence as well. Because addiction is such a complex and pervasive health issue, overall strategies must encompass a committed public health approach, including extensive education and prevention efforts, treatment, and research.

Research on Addiction[18]

Scientific research and clinical experience have yielded a greater understanding of the essence of addiction, manifested by compulsive drug seeking and use, even in the face of negative health and social consequences. Virtually all drugs of abuse have common effects, either directly or indirectly, on a single pathway deep within the brain: the mesolimbic reward system. Activation of this system appears to be what motivates substance abusers to keep taking drugs. All addictive substances affect this circuit. Not only does acute drug use modify brain function in critical ways, but prolonged drug use causes pervasive changes in brain function that persist long after the individual stops taking the drug. Significant effects of chronic use have been identified for many drugs at all levels: molecular, cellular, structural, and functional.

The addicted brain is distinctly different from the non-addicted brain, as manifested by changes in brain metabolic activity, receptor availability, gene expression, and responsiveness to environmental cues. Some of these long-lasting brain changes are unique to specific drugs, whereas others are common to many different drugs. We can actually see these changes through use of recently developed technologies, such as positron emission tomography. Understanding that addiction is, at its core, a consequence of fundamental changes in brain function means that a major goal of treatment must be either to reverse or compensate for brain changes through medication or behavioral modification.

Addiction is not just a brain disease. The social context in which the disease develops and expresses itself is critically important. The case of thousands of returning Vietnam veterans who were addicted to heroin clearly illustrates this point. In contrast to addicts on the streets of America, the returning veterans were relatively easy to treat. The American soldier in Vietnam became addicted in a totally different setting from the one to which he returned. At home in the United States, he was exposed to very few of the conditioned environmental cues that had been associated with drug use in Vietnam. Conditioned cues can be a major factor in causing recurrent drug cravings relapses even after successful treatment.

Addiction is rarely an acute illness. For most people, it is a chronic, relapsing disorder with a significant volitional dimension. Total abstinence for the rest of one's life is a relatively rare outcome from a single experience in treatment. Relapses are not unusual. Thus, addiction must be approached like other chronic illnesses — diabetes, chronic hypertension — rather than like an acute illness, such as a bacterial infection or broken bone. This approach has tremendous implications for how we evaluate the effectiveness of treatment. Viewing addiction as a chronic, relapsing disorder means that a good treatment outcome may be a significant decrease in drug use and long periods of abstinence, with only occasional relapses. Abstinence, however, should always be the goal.

Closing the Public Treatment System Gap

In 1996, approximately 4.4 to 5.3 million people were estimated to need drug treatment.[19] Slightly less than two million people currently receive drug treatment. Clearly, there is a substantial gap between the number of persons in need of treatment and the number receiving it. One aspect of the Administration's efforts to reduce this gap is the expansion of SAMHSA's Substance Abuse Prevention and Treatment Block Grant. This grant is awarded annually to states based on a formula that includes funding for prevention activities and treatment services for drug and alcohol abuse as well as a number of other purposes including tuberculosis services and early intervention services for HIV. The grants specifically target substance-using pregnant women, women with dependent children, and injection drug users. SAMHSA estimates that each federal dollar spent on treatment through this grant program generates 1.5 dollars in state and local spending on treatment.

The second component of the federal effort to reduce the public treatment system gap is expansion of the Targeted Capacity Expansion program that makes awards directly to states, counties, cities, and service providers. The goal of this program is to address gaps in treatment capacity by supporting rapid and strategic responses to demand for treatment. Grants will target communities with serious, emerging drug problems as well as communities with innovative solutions to unmet needs. In 1999,

these programs will include an HIV/AIDS component targeting minority populations at risk of contracting HIV/AIDS or living with HIV/AIDS. The goal is to enhance and improve existing substance abuse treatment services for minority populations in states and cities significantly affected by the twin epidemics of substance abuse and HIV/AIDS. An associated challenge is providing comprehensive services that address the complex needs of substance abusers with co-occurring mental disorders. These people experience greater functional impairment and are more likely to have multiple health and social problems.

Expanding Treatment for Adolescents

The need for community-based treatment for troubled teens who are dependent on drugs is particularly great, and there is an even more dramatic shortage of treatment in the juvenile correctional system. Adolescents with alcohol and drug problems are not adequately served in most existing drug-treatment programs designed for adults. IOM's 1990 report, *Treating Drug Problems* estimated that about four hundred thousand people under eighteen years of age were annually in need of treatment. Adolescents rarely seek help for problems related to alcohol and other drug use. Referrals by juvenile courts are too often the first intervention. By this time, substance abuse has contributed to delinquent behavior, violence, and high risk activities like unprotected sex and driving while intoxicated. There is also a paucity of research-based information about the effectiveness of juvenile treatment. SAMHSA is addressing these problems by evaluating adolescent-focused interventions and providing communities grants for adolescent treatment through its Targeted Capacity Expansion program.

Services for Women

Although women use illegal drugs at lower rates than men, women experience the use and consequences of drugs and alcohol differently from men and require gender-appropriate prevention and treatment services. Women who use illegal drugs, alcohol, or tobacco during pregnancy create health risks to themselves and to the fetus in-utero. Exposure to these substances in-utero is associated with increased risk for Fetal Alcohol Syndrome, Fetal Alcohol Effects, infant mortality and morbidity, attention deficit disorder, and other health problems. Women face unique barriers to treatment like the stigma associated with being a substance abusing mother, fear of losing custody of children or housing, and lack of child care. Substance abuse by older women including alcohol and misuse of prescription and over-the-counter drugs is a problem that merits increasing attention as our population ages.

Providing Services for Vulnerable Populations

For prevention and treatment to be effective, we must address the unique needs of different populations. As a result of managed care and changes in the welfare and health-care delivery system, needed services may be less available to vulnerable populations, including racial and ethnic minorities such as African-Americans, Native Americans, Hispanics, and Asian American/Pacific Islanders; the children of substance-abusing parents; the disabled; youth living in poverty; and people with co-occurring mental disorders. Our overall challenge is to help chronic drug users overcome dependency so that they can lead healthy and productive lives and the social consequences of illegal drug abuse are lessened.

Substance Abuse and Co-Occurring Mental Disorders

According to the National Comorbidity Survey, more than 40 percent of persons with addictive disorders also have co-occurring mental disorders. Survey data suggests that mental disorders precede substance abuse more than 80 percent of the time, generally by five to ten years.[20] This strongly indicates the existence of a significant window of opportunity for substance abuse prevention and the clear need to target substance abuse prevention activities to children with serious emotional disturbance and other, less severe mental health problems. In addition, treatment providers must recognize and address co-occurring mental disorders in order to prevent relapse and improve the likelihood of recovery from addiction.

Medications for Drug Addiction

Pharmacotherapies are essential for reducing the number of addicted Americans. Methadone therapy, for example, is one of the longest-established, most thoroughly evaluated forms of drug treatment. NIDA's Drug Abuse Treatment Outcome Study found that methadone treatment reduced participants' heroin use by 70 percent and criminal activity by 57 percent while increasing full-time employment by 24 percent. A 1998 review by the General Accounting Office put the situation this way: "Research provides strong evidence to support methadone maintenance as the most effective treatment for heroin addiction." Methadone therapy helps keep more than 100,000 addicts off heroin, off welfare, and on the tax rolls as law-abiding, productive citizens. SAMHSA is conducting a comprehensive review of the current system for regulating opioid treatment programs (OTPs). The intent is to develop a regulatory proposal that will transfer regulatory oversight from the FDA to SAMHSA, and incorporate accreditation as a requirement for federal approval of OTPs.

NIDA will continue to fund a high-priority program for discovering new medications to treat drug abuse. These research projects may result in new pharmacotherapies. Specific projects include development of an anti-cocaine agent, a controlled-release dosage form of oral methadone, medications to treat withdrawal symptoms in babies born to opiate-dependent mothers, and medications to treat methamphetamine addiction. SAMHSA will develop treatment standards as required by the Narcotic Addict Treatment Act (NATA).

National Drug Abuse Treatment Clinical Trials Network

Over the past decade, NIDA-supported scientists have developed and improved pharmacological and behavioral treatment for drug addiction. However, most of these newer methods are not widely used in practice, because they have been studied only in relatively short-term, small-scale studies conducted in academic settings on stringently selected populations. To reverse this trend and improve treatment nationally, NIDA is establishing a National Drug Abuse Treatment Clinical Trials Network (CTN) to conduct large, rigorous, statistically powerful, multi-site treatment studies in community settings using diverse patients. Science-based therapies that are ready for testing in the CTN include new cognitive behavioral therapies, operant therapies, family therapies, brief motivational enhancement therapy, and manualized approaches to individual and group drug counseling. Medications to be studied include naltrexone, LAAM, buprenorphine for heroin addiction, and a few currently being developed by NIDA for cocaine.

Treatment Research and Evaluation

NIDA supports over 85 percent of the world's research on drugs of abuse. Recent research in the area of pharmacotherapies and behavioral therapies for abuse of cocaine/crack, marijuana, opiates and stimulants, including methamphetamine will improve the likelihood of successfully treating substance abuse. In addition, a comprehensive epidemiological system needs to be developed to measure the success of the new therapies. NIDA will conduct clinical and epidemiological research to improve the understanding of drug abuse and addiction among children and adolescents. These findings will be widely disseminated to assist in the development of effective prevention programs. To ensure that the basic research supported by NIDA and others is applied in communities throughout the country, SAMHSA supports applied research including effectiveness studies of pharmacotherapies and behavioral therapies and establishes epidemiological measurement systems. For example, SAMHSA is funding evaluations of eight- and sixteen-week methamphetamine interventions in non-residential (outpatient) psychosocial treatment settings in California, Hawaii, and Montana. The objective is to determine whether promising results in methamphetamine treatment attained by the MATRIX Center in Los Angeles can be replicated.

Improving Federal Drug-Related Data Systems

This initiative will develop a comprehensive data system that adequately informs drug policy makers. It will specifically support the ninety-four targets that constitute the *Strategy's* PME system. The ONDCP-

coordinated Advisory Committee on Drug Control Research, Data, and Evaluation is reviewing existing data systems to identify "data gaps" and determine what modifications can be made to enhance the system. SAMHSA, for example, is increasing the sample size and scope of NHSDA to provide state-by-state data and greater information about drug use by twelve to seventeen year olds. More frequent estimates of the social costs of drug abuse will be made. The U.S. interdiction coordinator will complete a "cocaine flows" estimate model.

Behavioral Treatment Initiative

Behavioral therapies remain the only effective treatment for many drug problems, including cocaine addiction, where viable medications do not yet exist. Furthermore, behavioral intervention is needed even when pharmacological treatment is being used. An explosion of knowledge in the behavioral sciences is ready to be translated into new therapies. NIDA is encouraging research in this area to determine why particular interventions are effective, to develop interventions to reduce AIDS risk behavior, and to disseminate new interventions to practitioners in the field. More specifically, this initiative will focus on adolescent drug use.

Reducing Infectious Disease Among Injection Drug Users

Although the number of new AIDS cases has declined dramatically during the past two years because of the introduction of combination therapies, HIV infection rates have remained relatively constant. CDC estimates that 650,000 to 900,000 Americans are now living with HIV, and at least forty-thousand new infections occur each year. HIV rates among African Americans and Hispanics are much higher than among whites. Studies of HIV prevalence among patients in drug treatment centers and women of child-bearing age demonstrate that the heterosexual spread of HIV in women closely parallels HIV among injection drug users (IDUs). The highest prevalence rate in both groups has been observed along the East Coast and in the South. Hepatitis B and C are also spreading among IDUs. IDUs represent a major public-health challenge. Addicted IDUs frequently have multiple health, mental health, and complex social issues that must be overcome in order to successfully address their addiction, criminal recidivism, and disease transmission problems.

NIDA has created a center on AIDS and other Medical Consequences of Drug Abuse to coordinate a comprehensive, multi-disciplinary research program that will improve the knowledge base on drug abuse and its relationship to other diseases through biomedical and behavioral research. This research incorporates a range of scientific investigation from basic molecular and behavioral research to epidemiology, prevention, and treatment. Knowledge from each of these areas is essential to understanding the links between drug abuse and AIDS, TB, and hepatitis and for developing effective strategies for stemming infectious diseases spread through injection drug users. NIDA is also conducting public-health campaigns to increase awareness of infectious diseases. SAMHSA will continue its support of early intervention services for HIV through the SAPT block grants, fund a National Minority AIDS Council that will examine HIV/AIDS and related substance-abuse issues among minorities, and work with the National Alliance of State and Territorial AIDS Directors to improve program coordination.

Training for Substance Abuse Professionals

Many health care professionals lack the training to identify the symptoms of substance abuse. Most medical students, for example, receive little education in this area. If physicians and other primary-care managers were more attuned to drug-related problems, abuse could be identified and treated earlier. Many competent community-based treatment personnel lack professional certification. Consequently, SAMHSA/CSAT has worked collaboratively with the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) and the International Certification Reciprocity Consortium/Alcohol and Other Drugs (ICRC) to improve the states' credentialing systems that respect the experiences of individual treatment providers while they earn professional credentials. CSAT's publication *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*, which was developed in consultation with CSAT's National Curriculum

Committee of the Addiction Technology Transfer Centers, NAADAC, ICRC, International Coalition of Addiction Studies Educators (INCASE), and the American Academy of Health Care Providers in the Addictive Disorders, provides a developmental framework for the acquisition of the knowledge and skills required for professional counselor certification.[21]

4. BREAKING THE CYCLE OF DRUGS AND CRIME

Drug-dependent individuals are responsible for a disproportionate percentage of our nation's violent and income-generating crimes like robbery, burglary, or theft. According to ADAM data, between one-half and three-quarters of all arrestees tested in twenty-three cities around the country had drugs in their system at the time of arrest. About half of those charged with violent or income-generating crimes test positive for more than one drug. In 1997, a third of state prisoners and about one in five federal prisoners said they had committed the offenses that led to incarceration while under the influence of drugs. Nineteen percent of state inmates and 16 percent of federal inmates said they committed their current offense to obtain money for drugs (up from 17 percent and 10 percent, respectively, in 1991).[22]

Most of the largest volume drug buyers are frequent arrestees. Chronic drug users consume two-thirds of the cocaine in the United States. Reducing the number of drug-dependent criminals is a sure way to decrease the drugs consumed, the size of illegal drug markets, the number of dealers, and drug-related crime and violence.

Drug-law offenders are filling our prisons and the expense is overwhelming. The nation's incarcerated population is now more than 1.8 million. By 2002, this figure could reach 2.1 million. Prisoners sentenced for drug offenses constituted the largest group of federal inmates (60 percent) in 1996, up from 53 percent in 1990. Between 1990 and 1996, the number of drug offenders in state prisons grew by 87,900.[23]

The criminal justice system is addressing substance-abuse problems among adult and juvenile offenders. According to the Bureau of Prisons, the number of federal inmates receiving residential substance abuse treatment increased from 1,236 in 1991 to 10,006 in 1998. The number of arrestees who require drug treatment may exceed two million a year, including many chronic users of cocaine, heroin, and methamphetamine. When not incarcerated, many in this hard-core group remain under the jurisdiction of the criminal justice system through probation or parole. Just a small fraction of non-violent drug offenders and individuals on probation or parole are involved in diversionary programs. Drug courts reach only 1 or 2 percent of non-violent drug-law offenders.

Another challenge for the criminal justice system is to reach beyond the immediate defendant to address family crises, domestic violence, juvenile delinquency, abuse and neglect, and related problems. The justice system must incorporate means of intervening in a child's initial exposure to adult problems, often in his or her own home during the first years of life. Community involvement in legal issues, particularly when they intersect with families and children, is essential for breaking the cycle of substance abuse, crime, and violence. An example of this concept in action are Unified Family Courts — such as New Jersey's, which encompass a network of six thousand community volunteers — that can bring together diverse segments of the court and community to collaborate on effective approaches to families in crisis.

Incarcerating offenders without treating underlying substance-abuse problems simply defers the time when they are released back into our communities to start harming themselves and the larger society. Between 60 and 75 percent of untreated parolees with histories of cocaine and/or heroin use reportedly return to those drugs within three months of release. As a crime-control measure alone, drug treatment for criminally active addicts is strikingly cost-effective. It offers the potential of reducing crime by about two-thirds at a fraction of the cost for a prison cell. Imprisoning an addict costs more than twenty-five thousand dollars a year. By comparison, outpatient treatment costs less than five thousand dollars a year, and residential treatment ranges between five and fifteen thousand dollars annually. A variety of programs based in the criminal justice system are demonstrating their effectiveness across the country.[24]

Treatment Accountability for Safer Communities (TASC)

Created in the early 1970s and originally named Treatment Alternatives to Street Crime, TASC has demonstrated that the coercive power of the criminal justice system can be used to get individuals into treatment and manage their behavior without undue risk to communities. Through TASC, some drug offenders are diverted out of the criminal justice system into community-based supervision. Others receive treatment as part of probation, and still others are placed into transitional services as they leave an institutional program. TASC monitors client progress and compliance — including expectations for abstinence, employment, and improved personal and social functioning — and reports results to the referring criminal justice agency.[25]

Delaware's In-prison Programs

The Delaware Corrections Department, which has provided institutional and transitional drug treatment since the late 1980s, is an example of what could be done in other areas of the country. Individuals who participated in both institutional and transitional treatment programs were 57 percent less likely to be re-arrested on charges involving drugs and 37 percent less likely to use drugs within eighteen months of release from custody compared to the non-treatment group.[28]

Drug Courts

Drug courts seek to reduce drug use and associated criminal behavior by retaining drug-involved offenders in treatment. Defendants who complete the drug court program either have their charges dismissed (In a diversion or pre-sentence model) or probation sentences reduced (In a post-sentence model). Title V of the Violent Crime Control and Law Enforcement Act of 1994 (P.L. 103-322) authorizes the Attorney General to make grants to state and local governments to establish drug courts. In October 1998, 323 drug courts were operating nationwide, and more than two hundred were in the planning stages, up from a dozen in 1994. Drug courts have been a real step forward in diverting non-violent offenders with drug problems into treatment and other community resources, leaving the criminal justice system to deal with violent and criminal acts. More than 100,000 persons have entered drug courts, 70 percent of whom have graduated or remain as active participants. A review of thirty evaluations involving twenty-four drug courts found that these facilities keep felony offenders in treatment or other structured services at roughly double the retention rate of community drug programs. Drug courts provide closer supervision than other treatment programs and substantially reduce drug use and criminal behavior among participants.[26]

The Federal Bureau of Prisons' Drug Treatment Program

The Federal Bureau of Prisons (BOP) provides drug treatment for inmates prior to release. The number of institutions offering residential treatment has grown from thirty-two to forty-two since FY 1994. In 1998 nearly 34,000 inmates participated in BOP treatment services. A joint BOP/NIDA study is examining the effects and has provided an interim report addressing the first six months after release from custody. This period is significant because recidivism is generally highest within the first year after prison. The study found that the treatment population was 73 percent less likely to be re-arrested and 44 percent less likely to use drugs than a comparison group that received no treatment.[27]

Breaking the Cycle (BTC)

BTC encompasses the integrated application of testing, assessment, referral, supervision, treatment and rehabilitation, routine progress reports to maintain judicial oversight, graduated sanctions for noncompliance, relapse prevention and skill building, and structured transition back into the mainstream community. Since its inception in Birmingham, Alabama in June 1997, two thousand offenders have participated in all aspects of the program as a condition of release from jail. Preliminary results are encouraging. BTC has achieved compliance rates of 70 to 85 percent. So far, those completing the program have exhibited about a 1 percent rearrest rate. The program was expanded in November 1998 to Jacksonville, Florida and

Tacoma, Washington. Eugene, Oregon has been invited to submit a proposal under a separate juvenile BTC program.

The Drug-Free Prison Zone Demonstration Project

This initiative was designed to reduce the presence of drugs in prisons. Demonstration projects began in federal prisons in October 1998 and selected state prisons in January 1999. Drug-control measures at the federal and state level include regular inmate drug testing, advanced detection technologies, and staff training. The BOP is testing ion spectrometry equipment, which is capable of quickly and accurately detecting microscopic traces of drugs on skin, clothing, and other surfaces, at twenty-eight facilities. Ninety-day tests of this technology at the Federal Correctional Institution in Tucson and the Metropolitan Detention Center in Los Angeles produced a reduction in the rate of serious drug-related inmate misconduct (introduction, use, or possession of drugs) by 86 percent and 58 percent, respectively.

Zero Tolerance Drug Supervision Initiative

This Presidential initiative proposes comprehensive drug supervision to reduce drug use and recidivism among offenders. The federal government will help states and localities implement tough new systems to drug test, treat, and sanction prisoners, parolees and probationers. This initiative will ensure that states fully implement the comprehensive plans to drug test prisoners and parolees that they are required by law to submit to the Justice Department, while also supporting the efforts of states like Maryland and Connecticut to begin drug testing probationers on a regular basis.

The Need for Partnership Between the Corrections and Treatment Professions

The corrections and treatment professions must join in common purpose to break the tragic cycle of drugs and crime by reducing drug consumption and recidivism among individuals in the criminal justice system. We should accelerate the expansion of programs that offer alternatives to imprisonment for non-violent drug law offenders. Treatment must be made more available for drug-dependent inmates and those on probation or parole. Finally, adequate transitional programs should support inmates following detention. The end result will be fewer addicts and drug users, less demand for drugs, less drug trafficking, less drug-related crime and violence, safer communities, and fewer people behind bars. In 1999 the federal government will convene a national summit on substance abuse and criminal justice policy to encourage the expansion by state and local jurisdictions of alternatives to incarceration for non-violent offenders and treatment for drug-dependent offenders in all phases of the criminal justice system.

5. ENFORCING THE NATION'S LAWS

The correlation between drugs and crime is high. Drug users commit crimes at several times the rate of those who do not use drugs. According to the Department of Justice, as many as 83 percent of incarcerated people are past drug users. More than 51 percent reported substance abuse while committing the offense which led to their conviction. The heavy toll drug use exacts on the United States is most easily measured by the related criminal and medical costs that total over $67 billion. Almost 70 percent of this total is attributable to the cost of crime.

Law-enforcement professionals show supreme dedication and face risks daily to defend citizens against criminal activity. Since 1988, nearly seven hundred officers throughout the country have been killed in the line-of-duty, and over 600,000 officers were assaulted. We owe a debt of gratitude to the men and women who put their lives on the line in defense of our safety.

Our nation is based on the rule of law that ensures the safety and security of all people. Reducing drugs and crime are among the nation's most pressing social problems. Trafficking and use of illicit drugs are inextricably linked to crime and place a tremendous burden on the economic and social conditions of our communities. Drugs divert precious resources that support the quality of life all Americans strive to

achieve. They create widespread problems that corrode communities with fear, violence, and corruption, leaving residents afraid to go out of their homes, legitimate businesses to flee, and the quality of life to suffer. The data in Chapter II gives clear indication of the nexus between drugs and crime. Strong law-enforcement policies contribute a great deal to reducing drug abuse and its consequences by:

Reducing demand. By enforcing the laws against drug use, law enforcement reinforces societal disapproval of drug use and discourages potential users from using drugs. Moreover, for many addicts an arrest — and the resulting threat of imprisonment — offers a powerful incentive to take treatment seriously.

Disrupting supply. The movement of drugs from the sources of supply to our nation's streets requires sophisticated organizations. When law enforcement detects and dismantles a drug organization, less drugs find their way to our streets. Seizures also reduce availability.

To most effectively use the power of law enforcement, the *Strategy* promotes coordination, intelligence sharing, better technology, equitable sentencing policies, and a focus on criminal targets that cause the nation the most damage.

Coordination Among Law-Enforcement Agencies

In unity there is strength. The more local, state, and federal law-enforcement agencies and operations reinforce one another, the more they share information and resources, the more they "deconflict" operations, establish priorities, and focus energies across the spectrum of criminal activities, the more effective will be the outcome of separate activities. The trafficking of dangerous drugs is not a local problem but rather national and international in scope. Drug trafficking gangs and organizations do not confine their activity to any specific geographic boundary. Intelligence gathering and dissemination to assist in identifying all levels of criminal trafficking organization is essential for coordination and to prevent duplication of effort. Accordingly, various federal, state, and local agencies have joined forces on national as well as regional levels, to achieve better results.

The federal government provides extensive support to state and local law-enforcement agencies through the Edward Byrne Memorial State and Local Law Enforcement Assistance Program. Grants support multi-jurisdictional task forces, demand-reduction education involving law-enforcement officers, and public and private agencies and non-profit organizations for activities that are directly related to reducing and preventing drug-related crime and violence. Even in the absence of federal participation, state and local law enforcement agencies are encouraged to adopt task force approaches.

Community Oriented Policing

Community Oriented Policing is a philosophy that recognizes that crime problems are best addressed when the police and the community work together to identify and solve problems. Cooperation between civilians and police forces working together within communities across the country have successfully decreased drug-related crime. The Community Oriented Policing Services (COPS) program has funded over 92,000 new and redeployed officers to help police the streets and we expect to reach 100,000 officers this year. The COPS program has buttressed community policing anti-drug actions at the street level, including efforts to curtail trafficking in the dangerous drug of methamphetamine. Building on the successful COPS initiative, the President has proposed a new 21st Century Policing Initiative which will continue to help communities to hire, redeploy, and retain police officers; provide the latest crime-fighting technologies; and target funds to engage the entire community in anti-crime measures. The COPS program relies on long-term innovative approaches to community-based problems and reinforces already successful efforts to reduce drug-related crime in our communities.

Organized Crime Drug Enforcement Task Forces (OCDETF)

These multi-agency task forces draw on the expertise of federal, state, and local law enforcement and prosecutorial agencies to coordinate investigations and prosecutions of domestic and international drug

trafficking organizations, money laundering operations, gangs, and public officials involved in drug trafficking enterprises. The collaboration between law enforcement and U.S. Attorneys as well as the state and local levels of district attorneys and attorneys general plays an integral part in OCDETF's fight against drug traffickers. In 1998, a three-year OCDETF operation in St. Louis culminated in the arrest and federal indictment of a drug-ring leader and thirty-two defendants. These individuals were responsible for trafficking more than 45 kilograms of "black tar" heroin across numerous state lines. Through cooperative efforts and an array of investigative techniques, the entire drug operation was dismantled.

High Intensity Drug Trafficking Areas (HIDTA)

HIDTAs are regions with critical drug-trafficking problems that harmfully affect other areas of the United States. These locations are designated by the ONDCP Director in consultation with the Attorney General, heads of drug-control agencies, and governors. There are currently twenty-one HIDTAs. HIDTAs assess regional drug threats, design strategies to address the threats, develop integrated initiatives, and provide federal resources to implement these initiatives. HIDTAs strengthen America's drug-control efforts by forging partnerships among local, state, and federal law enforcement agencies; they facilitate cooperative investigations, intelligence sharing, and joint operations against trafficking organizations. The Department of Defense provides priority support to HIDTAs in the form of National Guard assistance, assignment of intelligence analysts, and technical training. In 1998, new HIDTAs were designated in central Florida (including Orlando and Tampa), the Milwaukee metropolitan area, and the marijuana-growing regions of Kentucky, Tennessee, and West Virginia.

Intelligence/Information Sharing

Intelligence gleaned from the collection, evaluation, analysis, and synthesis of information must be shared in order to reduce cultivation, production, trafficking, and distribution of drugs. Cooperation in sharing and deconflicting strategic and operational intelligence is critical for combating the international and domestic drug problem. Tactical intelligence is time sensitive and crucial to the effective execution of arrests and seizures. Agencies must be able to share relevant information and intelligence across jurisdictional boundaries without risk of compromise to intelligence and the operations that derive from it.

Technology

Technology can play a dramatic role in combating drug-related crime. Law enforcement agencies increase their effectiveness by integrating technology and coordinating their operations. ONDCP's Counterdrug Technology Assessment Center (CTAC) was established by the Counter-Narcotics Technology Act of 1990 (P.L. 101-510). CTAC is the federal government's central drug-control research and development organization and coordinates the activities of twenty federal agencies. CTAC identifies short, medium, and long-term scientific and technological needs of federal, state, and local drug-enforcement agencies — including surveillance; tracking; electronic support measures; communications; data fusion; and chemical, biological, and radiological detection. CTAC also encourages research in support of prevention and treatment. CTAC's *Ten Year Counterdrug Technology Plan and Development Roadmap* provides a framework for law-enforcement exploitation of technological advances.

The Prosecution Process

Another vehicle for law-enforcement coordination is the prosecution process. A wide range of federal efforts intersect through the U.S. Attorneys' Offices, which prosecute federal crimes. U.S. Attorneys maintain close collaboration with various federal, state, and local law-enforcement entities in their jurisdictions. This broad perspective allows federal prosecutors to foster greater cooperation within the law-enforcement community. Involving federal prosecutors in the development of cases and strategies improves coordination of counter-drug efforts. At the state and local levels, attorneys general and district attorneys also play critical roles in coordinating law-enforcement actions against drug dealers.

Targeting Gangs and Violence

Initiatives targeting gangs and violent crime have reduced drug trafficking substantially. Gangs are involved in the national distribution of drugs and frequently use automatic weapons. Thirty years ago, only twenty cities reported gang activity. Today, more than seven hundred do. The DEA and FBI lead federal efforts to break up trafficking organizations. The FBI has established 166 Safe Street task forces to address violent crime, most of which is drug-related. In early 1995, DEA launched the MET program as a manifestation of its commitment to assist state and local police agencies combat the problem of drug-related violent crime in their communities. DEA has assigned 24 METs in twenty of its twenty-two divisions, and, at the request of state and local authorities, initiated 193 deployments.The Department of Justice is using the National Gang Tracking Network, a comprehensive computer database that keeps tabs on gangs and gang members operating across state lines. The Bureau of Alcohol, Tobacco, and Firearms (ATF) targets armed drug traffickers through the Achilles Program, which oversees task forces in jurisdictions where drug-related violence is severe. The ATF also conducts Gang Resistance Education and Training (G.R.E.A.T.) in schools. Since 1992, more than two million children have received G.R.E.A.T. instruction. HIDTAs and OCDETFs also coordinate multi-agency attacks on criminal drug organizations.

Equitable Sentencing Policies

The Administration supports the revision of the 1986 federal law which mandates a minimum five-year prison sentence for anyone possessing either five-hundred grams of powder cocaine or a mere five grams of crack cocaine. This law, which punishes crack cocaine involvement one hundred times more severely than powder cocaine crimes, is problematic for two reasons. First, since crack is more prevalent in black, inner-city neighborhoods, the law has fostered a perception of racial injustice in our criminal justice system. In fact, 90 percent of those convicted on crack cocaine charges are African American. Second, harsher penalties for crack possession over powder have resulted in long incarceration levels for low-level crack dealers instead of a greater focus on the apprehension of middle and large scale movers of powder cocaine.

The Administration recommends that federal sentencing treat crack as ten times worse than powder, not one hundred times worse. Specifically, the amount of powder cocaine required to trigger a five-year mandatory would be reduced from 500 to 250 grams, while the amount of crack cocaine required to trigger the same sentence would increase slightly from 5 grams to 25 grams. This difference would reflect — without gross exaggeration — the greater addictive potential of crack (which is smoked) compared to powder (when snorted), the greater violence associated with the trafficking of crack cocaine, and the importance of targeting mid- and higher-level traffickers as opposed to smaller-scale dealers. The Administration also recommends that mandatory minimums be abolished for simple possession of crack. Among all controlled substances, crack is the only one with a federal mandatory minimum sentence for a first offense of simple possession for personal use.

Community support is critical to the success of law enforcement. When people lose confidence in the fairness and logic of the law as has been the case with the 1986 statute, law-enforcement efforts suffer. By revising the inequitable sentencing structure for powder versus crack cocaine, the Administration's intent is to restore overall respect for the law and to foster a more effective division of responsibility between federal, state, and local law enforcement authorities.

6. SHIELDING U.S. BORDERS FROM THE DRUG THREAT

Borders delineate the sovereign territories of nation-states. Borders and ports of entry are the entrance and exit points for all conveyances, goods, and persons entering or departing a country. Controlling borders and ports of entry is vital in order to ensure the rule of law and prevent the flow of contraband — including illegal drugs. All our borders, seaports, and airports are vulnerable to the drug threat. Puerto Rico; the U.S. Virgin Islands; South Florida; the Southwest border; gateway airports in Chicago, Honolulu, Miami, New York, and Seattle; seaports along the Atlantic Seaboard, the Gulf of Mexico, and the Pacific coast; the Great

Lakes region; and the land border with Canada have all experienced problems with drug trafficking. By curtailing the flow of drugs across our borders, we reduce drug availability throughout the United States and greatly reduce the consequences of drug abuse and trafficking in our communities. Drug smuggling is an intolerable affront to the nation's well-being. Countering it is a function that must be performed by federal, state, and local law-enforcement agencies.

We must stop drugs everywhere they enter the United States, be it through the Gulf Coast, Puerto Rico, the U.S. Virgin Islands, Florida, the northeastern and northwestern United States, or the Great Lakes region. Neither will we ignore the vulnerability of Alaska, Hawaii, or the U.S. Territories. Florida's location, geography, and dynamic growth will continue to make the state particularly vulnerable to traffickers for the foreseeable future. Florida's six-hundred miles of coastline rendered it a major target for shore and air-drop deliveries in the 1980s. The state is located astride Caribbean and Gulf of Mexico trafficking routes. The busy Miami and Orlando airports and Florida's seaports — gateways to drug-source countries in South America — are used as distribution hubs by international trafficking organizations. To varying degrees, Florida's predicament is shared by other border areas and entry points. As we focus efforts on specific parts of our borders, we must anticipate activities elsewhere. In the end, we need to shield the entire border from the flow of illegal drugs into the United States.

The U.S. Customs Service has primary responsibility for ensuring that all movements of cargo and passengers through ports of entry comply with federal law. Customs is the lead agency for preventing drug trafficking through airports, seaports, and land ports of entry. Customs is also responsible for stemming the flow of illegal drugs into the United States through the air. It accomplishes this task by detecting and apprehending drug smuggling aircraft entering the country. Customs' Aviation Interdiction program conducts twenty-four-hour surveillance along the entire southern tier of the United States, Puerto Rico and the Caribbean using a wide variety of civilian and military ground-based radar, tethered aerostats, reconnaissance aircraft, and other sensors. Customs' drug seizures along the Southwest border in the first half of 1998 increased by 45 percent as a result of Operation Brass Ring.

The U.S. Border Patrol is the primary federal drug interdiction agency along our land borders with Canada and Mexico. The Border Patrol specifically focuses on drug smuggling between land ports of entry.

The Coast Guard is the lead federal agency for maritime drug interdiction and shares lead responsibility for air interdiction with the U.S. Customs Service. Our Armed Forces provide invaluable support to federal, state, and local law enforcement agencies, involved in drug-control operations, particularly in the Southwest Border region.

All of these agencies and their personnel deserve great credit for unending efforts to defeat drug smugglers. The task of strategy is to coordinate activities in a coherent way so that individual efforts contribute to the overall objective of reducing drug availability in the United States.

Trafficking Across the Southwest Border

In 1998, 278 million people, 86 million cars, and four million trucks and rail cars entered the United States from Mexico. More than half of the cocaine on our streets and large quantities of heroin, marijuana, and methamphetamine enter the United States across the Southwest border. Illegal drugs enter by all modes of conveyance — car, truck, train, and pedestrian border-crossers. They cross the open desert in armed pack trains as well as on the backs of human "mules." They are tossed over border fences and then whisked away on foot or by vehicle. Planes and boats find gaps in U.S./Mexican coverage and position drugs close to the border for eventual transfer to the United States. Small boats in the Gulf of Mexico and the eastern Pacific seek to outflank our interdiction efforts and deliver drugs directly to the United States. Whenever possible, traffickers try to exploit incidences of corruption in U.S. local, state, and federal border agencies to facilitate drug smuggling. It is a tribute to the vast majority of U.S. officials dedicated to the anti-drug effort that integrity, courage, and respect for human rights overwhelmingly characterize their service. Rapidly

growing commerce between the United States and Mexico will complicate our efforts to keep drugs out of cross-border traffic. Since the Southwest border is presently the most porous part of the nation's borders, it is there that we must mount a determined coordinated effort to stop the flow of drugs. At the same time, we cannot concentrate resources along the Southwest border at the expense of other vulnerable border regions, for traffickers follow the path of least resistance and will funnel the flow of drugs to less defended areas.

Organizing for Success

The problems our law enforcement officials face in stemming the flow of drugs into the United States are significant but not insurmountable. Twenty-three separate federal agencies and scores of state and local governments are involved in drug-control efforts along our borders, air, and seaports. Improved coordination can ensure unity of effort from national policy to state and local levels with case-centered criminal investigations. The departments of Justice and Treasury and other agencies with responsibilities along the Southwest border continue to enhance their collective capabilities in this vulnerable region. Timely dissemination of information can allow agencies to target trafficking organizations more effectively. An ongoing review of the counterdrug intelligence system is addressing this requirement.

All cross-border movements are subject to inspection. We cannot, however, paralyze commerce and travel to search for contraband. Non-intrusive inspection technologies that are cued to high-risk cargo by intelligence are being deployed to keep drugs out of legal commerce. Access roads, fences, lights, and surveillance devices can prevent the movement of drugs between ports of entry while serving the legal, economic, and immigration concerns of the United States, Canada, and Mexico. We must continue to make appropriate staffing investments to ensure adequate numbers of trained and well-equipped inspectors, agents, investigators, and prosecutors. Last year, for example, the Border Patrol hired a thousand additional agents. We must ensure adequate staffing resources throughout the entire border security system.

Border Coordination Initiative (BCI)

To improve coordination along the land borders of the United States, the departments of Justice and Treasury, along with other agencies with border responsibilities, established the Border Coordination initiative (BCI). Organized as a five-year program and initially emphasizing the Southwest border, BCI envisions the creation of an integrated border management system that improves the effectiveness of the joint effort. It emphasizes increased cooperation efforts supporting the interdiction of drugs, illegal aliens, and other contraband, while maintaining the flow of legal immigration and commerce. BCI implementation plans call for:

Port Management. A Customs and INS Port Management Model that will streamline enforcement, traffic management, and community partnership plans at each of the SWB's twenty-four POEs.

Investigations. A unified strategy for SWB seizures that capitalizes on investigative enforcement operations at and between POEs and the dissemination of investigative intelligence to enhance inspections.

Intelligence. Joint intelligence teams staffed with personnel from Customs and INS with enhanced local intelligence collection and intelligence products focused on drug interdiction, illegal aliens, currency and document fraud.

Technology. A joint technology plan to capitalize on future technology advances while making better use of existing capabilities.

Communications. Inter-operable, secure, mutually supportive, wireless communications through coordinated fielding, joint user training, compatible systems, and shared frequencies.

Aviation and Marine. Joint air interdiction operations and the identification of opportunities to share air and marine support facilities.

Port and Border Security Initiative

This initiative seeks to reduce drug availability by preventing the entry of illegal substances into the United States. The initiative covers all U.S. ports-of-entry and borders but focuses on the Southwest border. Over the next five years, this initiative will

result in appropriate investments in Immigration and Naturalization Service (INS) inspectors and Border Patrol agents, Customs' agents, analytic, and inspection staff, improved communication and coordination between Customs and INS, employment of advanced technologies and information management systems, and greater U.S.-Mexico cooperation.

Working With the Private Sector to Keep Drugs Out of America

Agreements with the private sector can deter drug smuggling via legitimate commercial shipments and conveyances. As the primary drug-interdiction agency at ports of entry, the U.S. Customs Service is implementing innovative programs like the air, sea, and land Carrier Initiative Programs (CIP), the Business Anti-Smuggling Coalition (BASC), and the Americas Counter-Smuggling Initiative (ACSI) to keep illegal drugs out of licit commerce. These initiatives have resulted in the seizure of 168,000 pounds of drugs since 1995.

Harnessing Technology

Technology is an essential component in the effort to prevent drug smuggling across our borders and via passenger and commercial transportation systems. Technology can help stop drugs while facilitating legal commerce. Automated targeting systems can analyze databases to assess the likelihood that a particular individual, vehicle, or container is carrying drugs. Non-intrusive inspection devices can detect drugs; X-ray systems inspect the inside of cars, trucks, or containers while high energy neutron interrogation systems measure the density of tires, fuel tanks, panels, and cargo. Technology can also prevent trafficking in unoccupied spaces. The Immigration and Naturalization Service's Integrated Surveillance Information System/Remote Video Surveillance (ISIS/RVS) project, for example, is improving the Border Patrol's effectiveness between ports of entries along the Southwest border. This initiative will increase inspection capabilities at all vulnerable ports of entry.

Review of Counterdrug Intelligence Architecture

Drug intelligence and information collection, analysis, and dissemination are essential for effective drug control. An extensive interagency review of counterdrug intelligence activities was conducted during 1998 under the auspices of the secretaries of Defense, State, Transportation, and Treasury, the Attorney General, the Director of Central Intelligence, and the Director of National Drug Control Policy. The review suggested how federal, state, and local drug-control efforts could be better supported by drug intelligence and law-enforcement information. An interagency plan is being drafted based on this review.

7. REDUCING THE SUPPLY OF ILLEGAL DRUGS

Supply reduction is an essential component of a well-balanced strategic approach to drug control. Demand reduction cannot be successful without limiting drug availability. When illegal drugs are readily available, the likelihood increases that they will be abused. Heroin is a case in point. Increasing heroin purity in recent years has resulted in greater numbers of initiates because injection is no longer a prerequisite for use. Undeterred by abhorrence of needles, would-be heroin users are more inclined to partake. Indeed, heroin has become more available, in part because criminal Colombian drug organizations made a strategic decision earlier in this decade to cultivate opium poppy, produce heroin, and sell it in the United States. According to DEA seizure data, Colombian heroin, which accounts for less than 2 percent of the global production potential, is making heavy inroads in the heroin market in the eastern United States. Cocaine traffickers have responded to a decline in demand for powder and crack cocaine by also selling heroin.

Supply reduction has both domestic and international dimensions. Within the United States, supply reduction includes regulation (through the Controlled

Substances Act), enforcement of anti-drug laws, eradication of marijuana cultivation, control of precursor chemicals, Customs' inspection of commerce and persons entering the country, screening for drugs in prisons, and the creation of drug-free school zones. Internationally, supply reduction includes building consensus; bilateral, regional, and global accords; coordinated investigations; interdiction; control of precursors; anti-money-laundering initiatives; drug-crop substitution and eradication; alternative development; strengthening public institutions; and foreign assistance.*

Coordinated Interdiction Operations

Despite our best efforts, we will never seize all the drugs that arrive at our borders or air and seaports. Nevertheless, the fewer drugs that reach the boundaries of the United States, the less will enter our sovereign territory. Interdiction in the transit and arrival zones disrupts drug flow, increases risks to traffickers, drives them to less efficient routes and methods, and prevents significant amounts of drugs from getting to the United States. Interdiction also generates intelligence that can be used against trafficking organizations in both international and domestic operations.

Drug traffickers are adaptable, reacting to interdiction successes by shifting routes and changing modes of transportation. Large international criminal organizations have extensive access to sophisticated technology and resources to support their illegal operations. The United States must surpass traffickers' flexibility, quickly deploying resources to changing high-threat areas. Consequently, the U.S. government designs coordinated interdiction operations that anticipate shifting trafficking patterns. Such integrated operations are led by the three Joint Inter-Agency Task Forces (based in Key West, FL, Alameda, CA, and Panama) that coordinate transit zone activities; the Customs' Domestic Air Interdiction Coordination Center (in Riverside, CA) that monitors air approaches to the United States; and the El Paso, Texas-based Joint Task Force Six and Operation Alliance that coordinate activities along the Southwest border.

Interdiction resources, mostly for one time capital acquisitions, will increase significantly in 1999 as the result of Congressional appropriation of $870 million for international drug-control and interdiction spending, of which agencies attribute $844 million directly going to drug-related activities. In 1999, the merger of Joint Inter-Agency Task Forces East and South will improve the capacity to interdict drugs as they are moved to the United States from South America by way of the Caribbean, Central America, and Mexico.

Transit Zone Operations

Drugs coming to the United States from South America pass through a six-million square-mile transit zone that is roughly the size of the continental United States. This zone includes the Caribbean, Gulf of Mexico, and eastern Pacific Ocean. In 1998, eighty metric tons of cocaine were seized in the transit zone. Smuggling through "Go-Fast" boats is a significant threat in the Caribbean. Many of these high-speed craft can leave Colombia near dusk and deliver drugs to Haiti, or to vessels along its coast before dawn. They are difficult to detect and intercept. Analysis of detected trafficking events in 1998 suggests that the Jamaica-Cuba- Bahamas vector is being used more frequently by traffickers. Cuban authorities reportedly seized 220 "bundles" of drugs from failed drops. In December 1998, Colombian authorities seized more than seven metric tons of cocaine which reportedly were to be shipped to Havana, Cuba and probably onwards to Europe. Traffickers will likely seek to exploit the Cuban government's diminishing capabilities to control the island-nation's sovereign air and sea space.

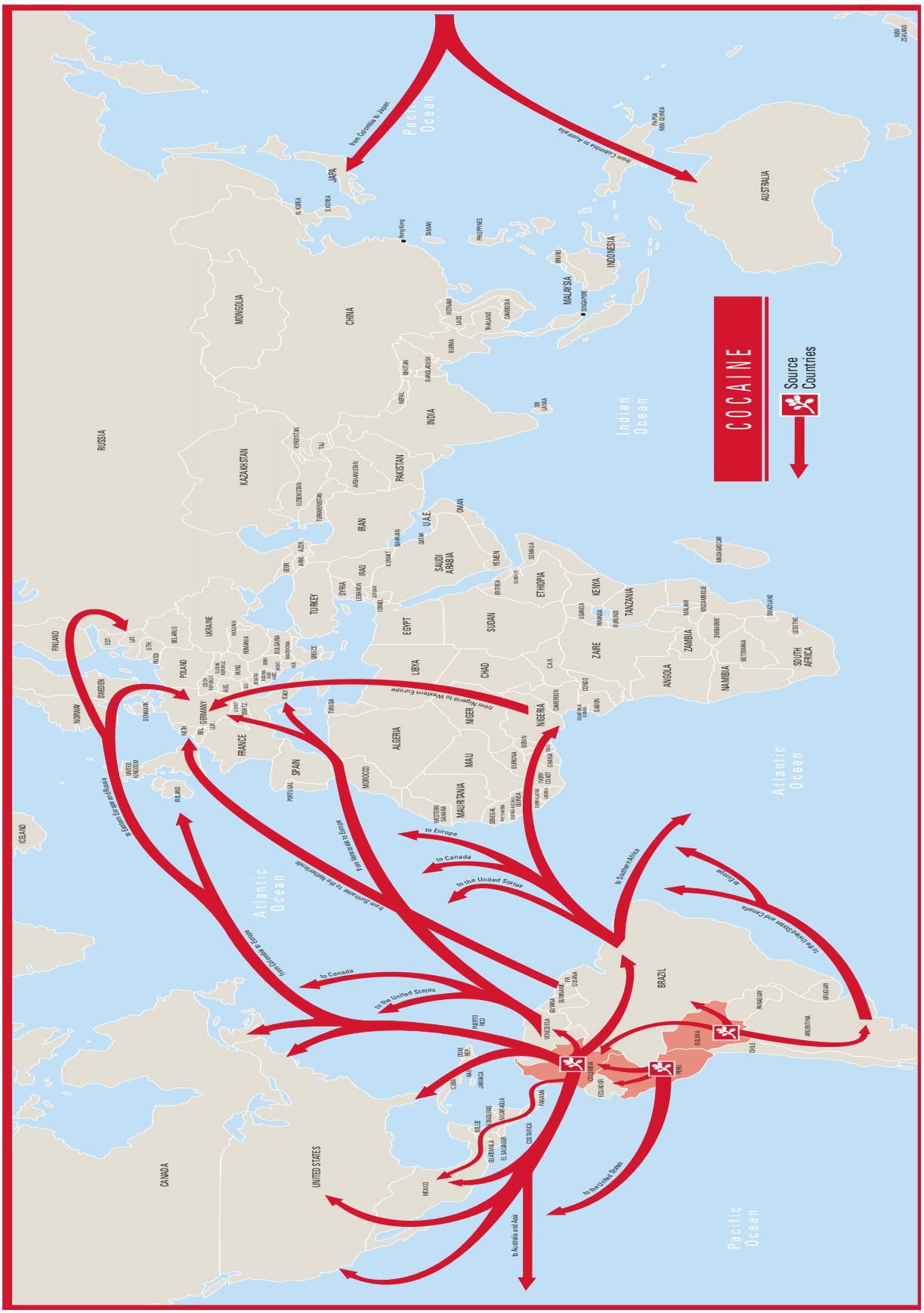
The Coast Guard is the lead federal agency for maritime interdiction and co-lead with U.S. Customs for air interdiction. The interagency mission is to reduce the supply of drugs from source countries by denying smugglers the use of air and maritime routes in the transit zone. In patrolling this vast area, U.S. federal agencies closely coordinate their operations with the interdiction forces of a number of nations. In fiscal year 1998, Coast Guard assets participated in the seizure of thirty-eight metric tons of cocaine, fourteen metric tons of marijuana products, and 3.4 pounds of heroin. The retail value of these drugs was three billion dollars.

* Additional information about U.S. supply reduction programs is contained in a classified annex to this *Strategy.*

The Department of Defense (DoD) provides vital support to the national effort to reduce the flow of illegal drugs into the United States by performing detection and monitoring operations. Information gathered by DoD allows interdiction forces to intercept and act against traffickers. Customs also conducts detection and monitoring missions in the transit zone as well as taking direct action against traffickers.

Stopping drugs in the transit zone involves more than intercepting drug shipments at sea or in the air. It also entails denying traffickers safe haven in countries within the transit zone and preventing their ability to corrupt institutions or use financial systems to launder profits. Consequently, international cooperation and assistance is an essential aspect of a comprehensive transit zone strategy. Accordingly, the United States is helping Caribbean and Central American nations to implement a broad drug-control agenda that includes modernizing laws, strengthening law-enforcement and judicial institutions, developing anti-corruption measures, opposing money laundering, and backing cooperative interdiction. Interagency transit-zone operations contribute to the interdiction of drugs at our borders, air, and sea ports — collectively known as the arrival zone. In 1998, sixty-four metric tons of cocaine were seized in this zone.

International Cocaine Trafficking Flows (Source: DEA)



Breaking Cocaine Sources of Supply

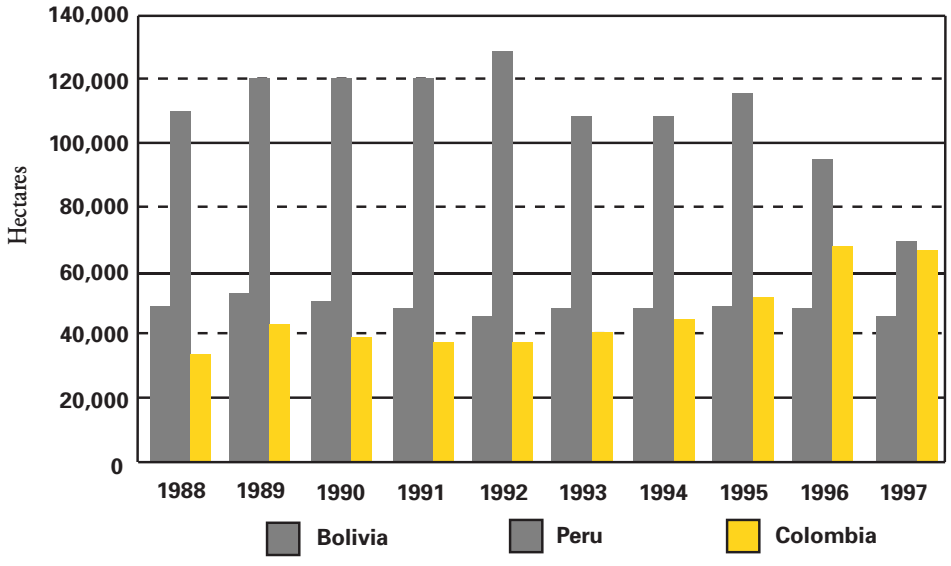
Coca, the raw material for cocaine, is grown in the South American countries of Bolivia, Colombia, and Peru. Regional efforts to eradicate this crop have been quite successful in the past three years. Coca cultivation in Peru plummeted by 56 percent from 115,300 hectares in 1995 to 51,000 hectares in 1998. Potential cocaine production declined from 460 metric tons to 240 metric tons over the same period in Peru while in Bolivia potential production declined from 255 metric tons in 1994 to 150 metric tons in 1998. These su cesses are attributed to many factors, including: political will in both countries to confront the illegal drug trade, the regional air interdiction campaign that targeted drug-laden aircraft flying between coca-growing regions of Peru and processing laboratories in Colombia, control of precursor chemicals, diminished strength of insurgent forces in Peru, and alternate crop programs. The fact that coca leaf prices dropped more than 50 percent in Peru over the past three years suggests that this progress can be sustained.

The estimated 325 metric ton decline in potential cocaine production in Peru and Bolivia has been slightly offset by a potential increase of 45 metric tons in Colombia between 1995 and 1997. Virtually all of the coca cultivation in Colombia is in remote, underdeveloped regions outside the government's control and often under the influence of guerrilla or paramilitary forces. This makes eradication and interdiction operations difficult. Moreover, without greater security in the countryside, the government cannot deliver adequate alternative development programs to provide licit income to growers who abandon coca cultivation. The growth of Colombian illicit drug cultivation has added substantially to the war chests of the guerrilla and paramilitary groups, which protect and/or control various aspects of the drug industry.

Despite these challenges, the Colombian National Police (CNP) report that they sprayed more than 60,000 hectares of illicit crops in 1998. In response, traffickers have increased plantings in regions controlled by armed insurgent organizations. The Colombian government has formed a joint task force with elements from all the military services and the CNP to mount counterdrug operations in guerrilla-controlled territory. The CNP also instituted a general aviation aircraft control system, which resulted in the seizure of 54 trafficker aircraft in 1998.

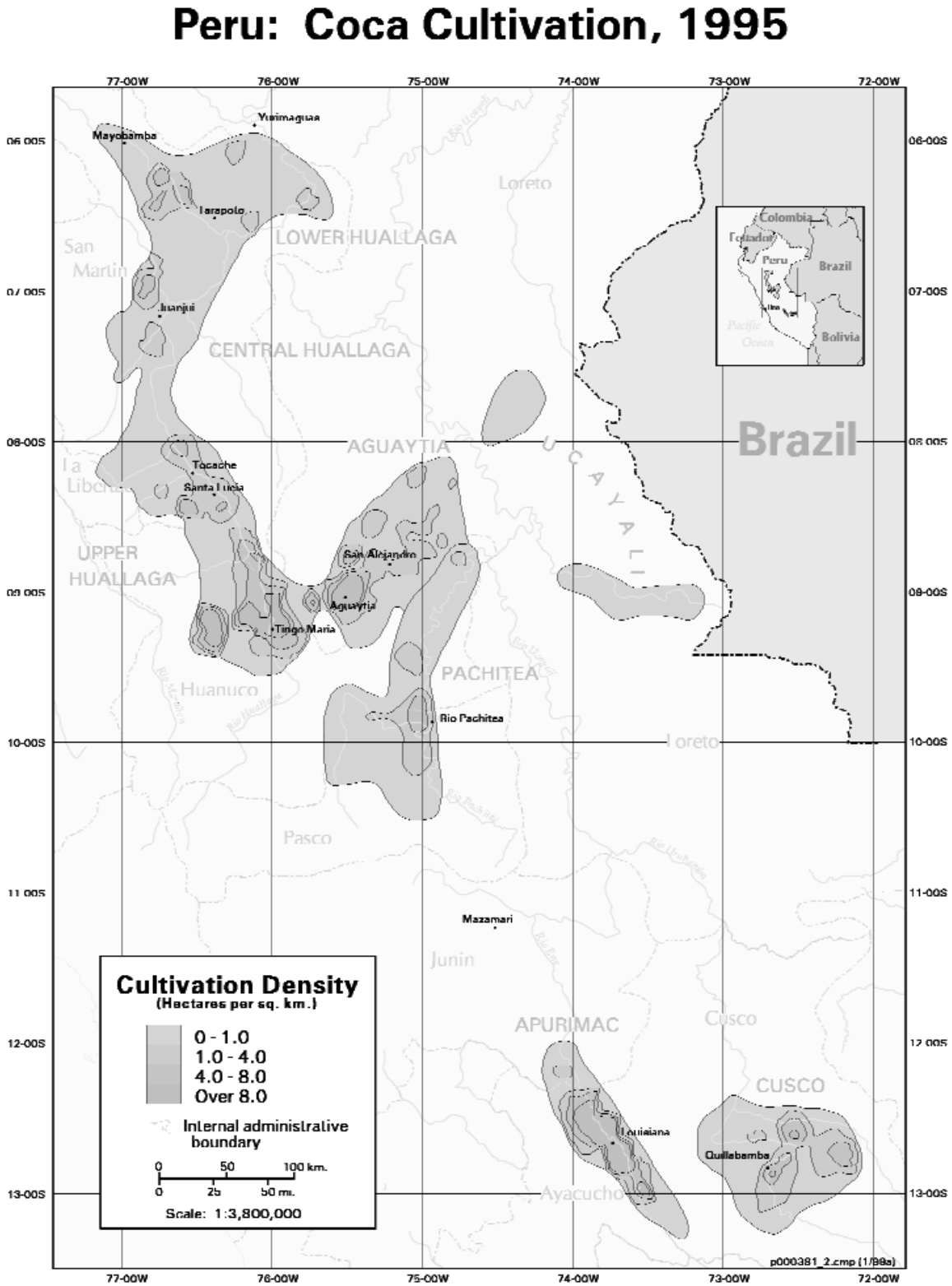
The United States will support the government of Colombia's national alternative development plan in those areas where the government of Colombia can assure security conditions necessary to administer and enforce such a program. The United States will continue to support environmentally sound eradication and alternative development in all three countries; suppress aerial, riverine, and maritime trafficking; strengthen the anti-drug capabilities of judicial systems, law-enforcement agencies, and security forces; and encourage greater regional cooperation. The objective is to reduce total South American coca cultivation by 20 percent over the next four years and 40 percent by 2007.

Net Coca Cultivation (Global)

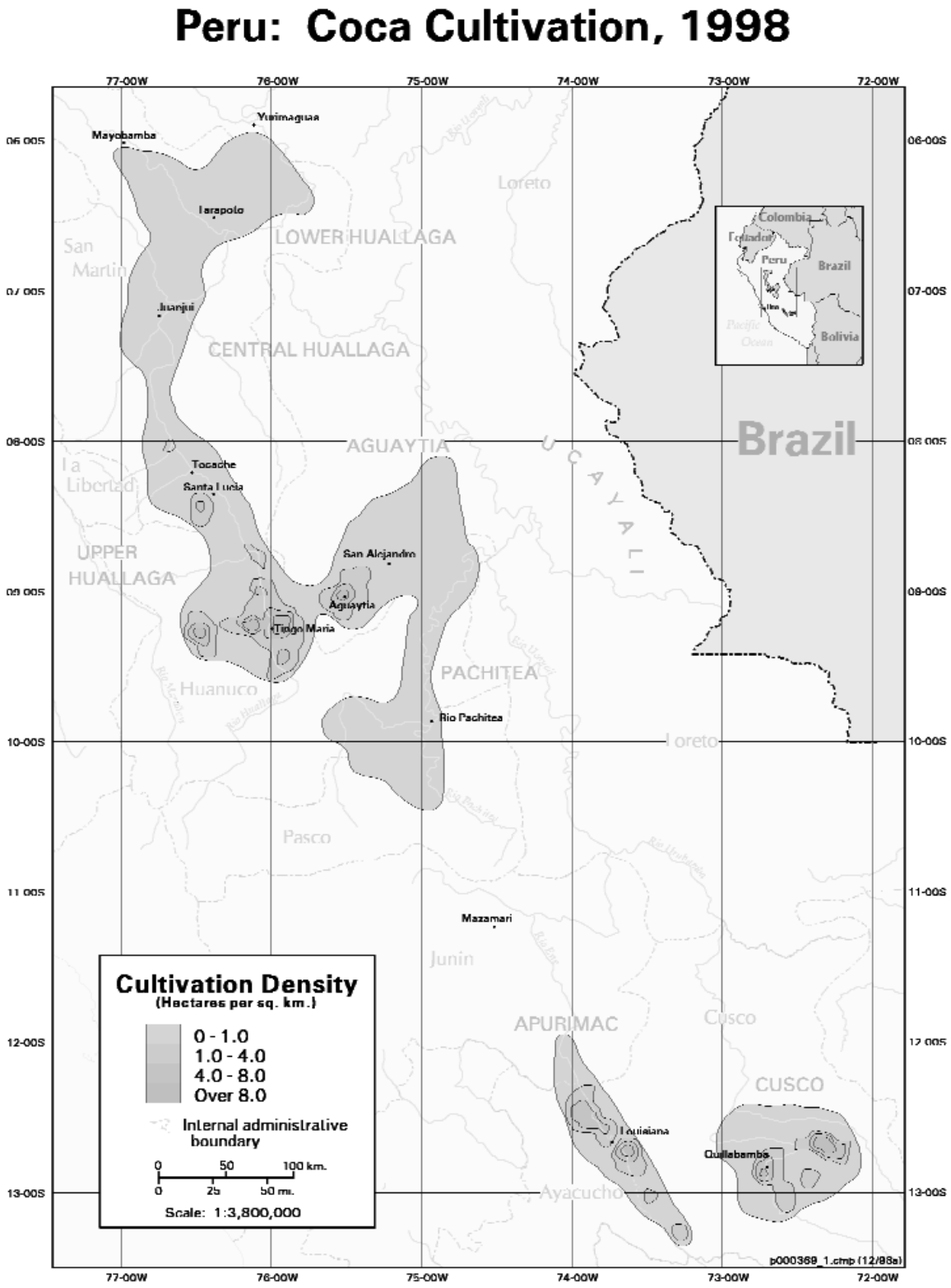


Source: U.S. Department of State, 1998

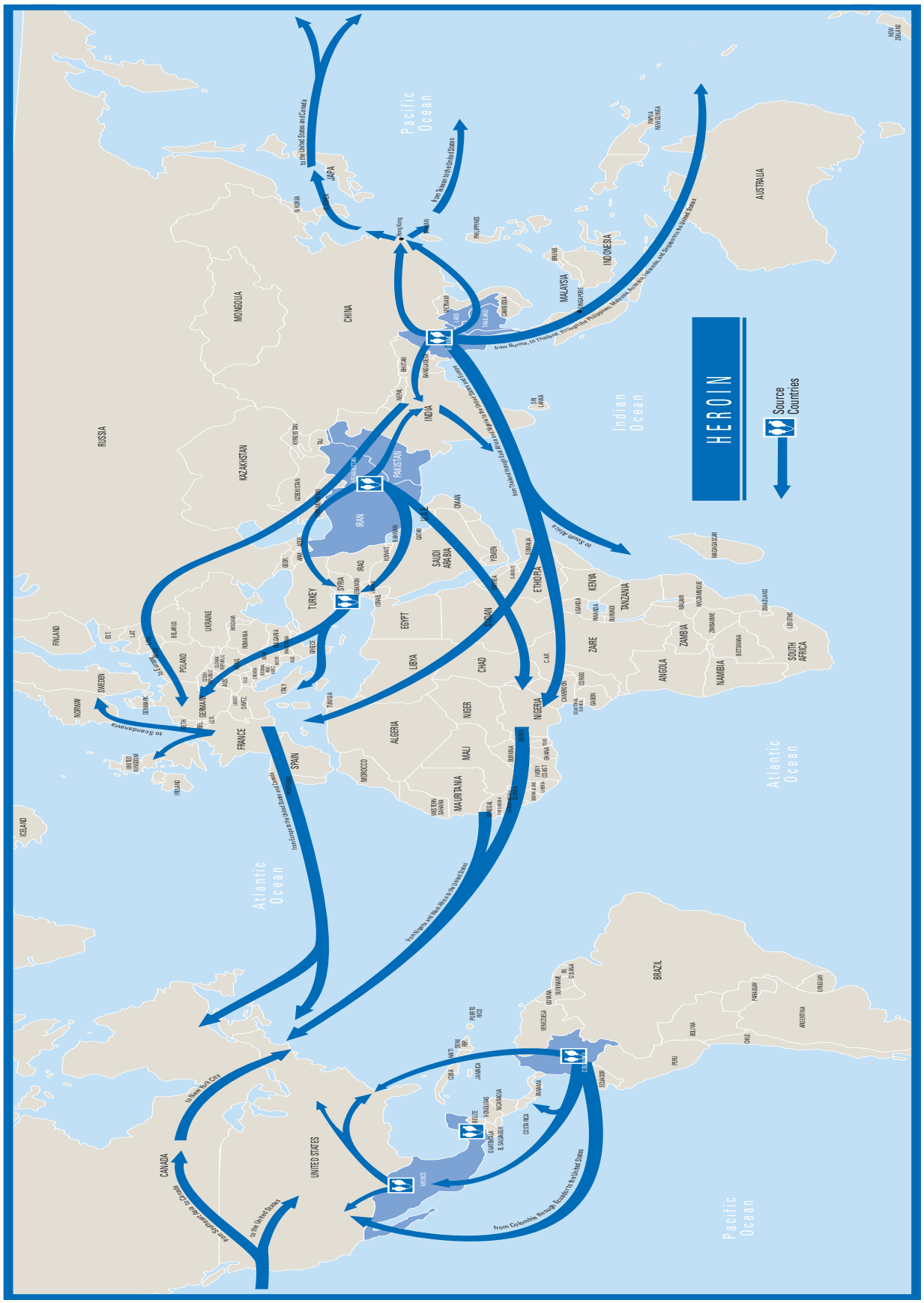
Peru: Coca Cultivation



Declines 56 Percent



International Heroin Trafficking Flows (Source: DEA)



Breaking Heroin Sources of Supply

Efforts to reduce domestic heroin availability face significant challenges. Worldwide illicit opium production has doubled since 1986 and was estimated at 3,465 metric tons in 1998, down 16 percent from 1997's figure. A modest decline in Burmese opium production was offset by increases in Laos and Afghanistan. Opium production in Latin America remained in check — Mexican and Colombian farmers face significant eradication programs — and continued to account for less than 5 percent of worldwide production. Opium cultivation and production in the Golden Triangle area of Southeast Asia continue to far outpace any other region. Burma, the world's largest opium producer, could potentially produce 217 metric tons of heroin. The United States has limited access or influence in Afghanistan and Burma which collectively account for 92 percent of the world's potential heroin production. The U.S. heroin market consumes only about 3 percent of the world's production, indicating that every pound of heroin that law enforcement takes off domestic markets can be readily replaced through the international supply. Widely dispersed growing areas, multiple trafficking organizations, and diversified routes and concealment methods make supply reduction difficult.

Colombian, Dominican, and Mexican trafficking organizations continue to be a significant threat to the United States as traffickers with links to those nations exploit cocaine and marijuana distribution networks and employ aggressive marketing techniques to expand heroin sales. Heroin produced in Mexico, either in black tar or brown powdered form, is marketed in the western half of the United States. Heroin produced in Southeast and Southwest Asia is typically smuggled into the U.S. with the help of ethnic enclaves throughout Canada and the United States. Asian gangs and Nigerian organizations are prominent in the international heroin trade.

Still, progress is achievable if governments can cordon off growing areas, increase their commitment, and implement counternarcotics programs. U.S.-backed crop control programs have eliminated or are reducing illicit opium cultivation in countries like Guatemala, Mexico, Pakistan, Thailand, and Turkey. However, progress is unlikely in Afghanistan where the ruling Taliban does not appear committed to narcotics control. The United States will continue supporting UN drug-control programs in Burma and encourage other countries to press the Burmese government to take effective anti-drug action. In Colombia, the United States will provide additional support to the CNP opium poppy eradication campaign. We will also help strengthen law-enforcement efforts in heroin source and transit countries by supporting training programs, information sharing, extradition of fugitives, and anti-money laundering measures. Finally, the United States will work through diplomatic and public channels to increase the level of international cooperation and support the ambitious UNDCP initiative to eradicate illicit opium poppy cultivation in ten years.

Domestic heroin demand-reduction programs are all the more essential due to difficulties in attacking heroin sources of supply. U.S. law-enforcement agencies use strategic information about domestic heroin distribution rings to break up international criminal organizations. Coordinated federal, state, and local anti-heroin efforts are important. The ad-hoc task force established in Plano, Texas is an excellent example of this approach. It consists of representatives from numerous area sheriffs' offices and police departments as well as the Texas Department of Public Safety, the U.S. Attorneys' Offices, the U.S. Immigration and Naturalization Service, the FBI, and DEA.

Countering the Spread of Methamphetamine

Since the mid-1980s, the world has faced a wave of synthetic stimulant abuse with approximately nine times the quantity seized in 1993 than in 1978, equivalent to an average annual increase of 16 percent.[29] The principal synthetic drugs manufactured clandestinely are amphetamine-type stimulants. Domestic manufacture and importation of methamphetamine pose a continuing public-health threat. In the past, methamphetamine was largely produced and supplied by outlaw motorcycle gangs. More recently, Mexico-based trafficking groups are dominating wholesale trafficking in the United States.

These organized crime groups have developed large-scale laboratories — both in Mexico and the United States — which are capable of producing enormous quantities of methamphetamine. The manufacturing process involves toxic and flammable chemicals. Abandoned labs require expensive, dangerous clean-up. Between January 1, 1994 and September 30, 1998, the DEA was involved in the seizure of over 4,140 methamphetamine laboratories throughout the country, including 1,240 labs in the first nine months of 1998. State and local law-enforcement authorities, especially in California but increasingly in other states, uncovered thousands of additional clandestine labs.

The 1996 National Methamphetamine Strategy (updated in May of 1997) remains the basis of the federal response to this problem. It was buttressed by the Comprehensive Methamphetamine Control Act of 1996, which increased penalties for production and trafficking while expanding control over precursor chemicals (like ephedrine, pseudoephedrine, and phenylpropanolamine). In addition, the Methamphetamine Trafficking Penalty Enhancement Act of 1998 was signed into law as part of the omnibus spending agreement for FY 1999, further stiffening sanctions against trafficking this dangerous drug. Federal, state, and local investigators and prosecutors are targeting companies that supply precursor chemicals to methamphetamine producers. The DEA also supports state and local law-enforcement agencies by conducting training in Kansas City and San Diego. Many retailers are adopting tighter controls for over-the-counter drugs containing ingredients that can be made into methamphetamine. Useful actions include educating employees, limiting shelf space for these products, and capping sales.

Internationally, the United States is promoting controls over precursor chemicals. Cooperation with Mexico, which is home to powerful methamphetamine trafficking organizations, is crucial. A bilateral chemical-control-working group oversees cooperative investigation of cases that interest both countries and exchanges information on legal and regulatory matters. Mexico recently came into compliance with the 1988 U.N. Convention against Traffic in Narcotic Drugs and Psychotropic Substances.

Reducing Domestic Marijuana Cultivation

Marijuana is the most readily available illegal drug in the United States. While no comprehensive survey of domestic cannabis cultivation has been conducted, the DEA estimates that much of the marijuana consumed in the United States is grown domestically, both outdoors and indoors, by commercial and private operators. The Department of the Interior has deep concerns about marijuana cultivation on public and tribal lands. Suppression of marijuana cultivation (and of clandestine drug laboratories) on the approximately 525 million acres for which it has stewardship a priority for its four bureaus with major law-enforcement responsibilities. The Department of Agriculture's Forest Service, likewise, is gravely concerned about the significant amount of marijuana cultivation and clandestine drug laboratories on the 191 million acres of public land it manages. Recognizing that successful domestic cannabis eradication efforts must be supported by accurate information about the acreage of illegal drug cultivation, Congress has directed the Secretary of Agriculture to annually submit to the ONDCP Director an assessment of the acreage of illegal drug cultivation in the United States.[30] Congress also appropriated funds in FY 1999 for USDA to research and develop environmentally sound biological control techniques to eliminate illicit drug crops, including cannabis, coca, and opium poppy, both in the United States and in foreign countries.

8. INTERNATIONAL DRUG CONTROL COOPERATION

Our efforts to reduce drug availability, abuse, and adverse consequences within the United States are supported by extensive international activities. Indeed, only the federal government can undertake international supply reduction. This specific function is reflected in this *Strategy*, the accompanying *Classified Annex*, and the programs and budgets that implement it. International programs confront illegal drug cultivation, production, trafficking, abuse, diversion of precursor chemicals, and the corrosive effects of the

illegal drug trade, including corruption, violence, environmental degradation, undermining of democratic institutions, and economic distortion.

A series of bilateral, multilateral, sub-regional, regional, and global accords create a strong backdrop for effective anti-drug measures. The international community's maturing understanding of the scope of the global problem is helping to dissolve the myth that the United States' market is the engine that drives the global drug trade. Indeed, the United States comprises just 2 percent of the world's consumers. Even with the relatively high price Americans are willing to pay for illegal drugs, they still account for only 10 to 15 percent of more than four hundred billion dollars spent globally on drugs every year.[31]

The legislatively mandated annual certification process is an important instrument in our international narcotics control policy. Under this law, the President is required annually to identify the major illicit drug producing and transit countries and then "certify" whether they have cooperated fully with the United States or taken adequate steps on their own to implement the 1988 U.N. Drug Convention. The President must impose certain economic sanctions on countries that do not meet these requirements unless the President certifies that the vital interests of the United States require that sanctions not be imposed. The sanctions include cutting off our foreign assistance, other than our humanitarian and counternarcotics foreign assistance, to countries denied certification and voting against their requests for loans from certain multilateral lending institutions. The annual certification process has helped to underscore the importance the United States attaches to international narcotics control and has encouraged some countries to take narcotics control steps they might not otherwise have taken. At the same time, however, the unilateral certification process is contentious in many countries.

The International Anti-Drug Consensus

The United States seeks to improve international cooperation to strengthen regional enforcement efforts and deny sanctuary to international criminal organizations. Because traffickers do not respect national borders, no country can be effective unilaterally in tackling this global problem. Multinational coordination is necessary when dealing with an operation this widespread. In June 1998, a special session of the United Nations General Assembly underscored the need for international opposition to the illegal drug trade. As a result, the world community adopted the proposal made in the *1998 United States Drug Control Strategy* for a ten-year conceptual framework to counter the drug problem and set five and ten-year target dates for reducing supply and demand for illicit drugs.

The political declaration on global drug control adopted during the session represents a forceful, high-level commitment to addressing all elements of the drug problem at both the national and international levels. It emphasized the importance of a balanced approach to reduce drug abuse, eliminate illicit supply, and counter drug trafficking. It also set clear target dates for member states to take action required in specified areas. A target date of 2003 was established for national action to stem the tide of abuse and trafficking in amphetamine-type stimulants, national legislation on money laundering, promotion of judicial cooperation, and implementing demand-reduction strategies. The year 2008 is the target date for achieving significant results in demand reduction; eliminating or reducing illicit drug cultivation; and reducing the manufacture and trafficking in psychotropic substances, including synthetic designer drugs and precursor chemicals.

The accompanying "Guiding Principles on Drug Demand Reduction" makes clear that demand reduction is an indispensable pillar of the global response to the drug problem. The declaration is the closest the global community has come so far to an international treaty in this area. The balanced approach being pursued by the United Nations International Drug Control Programme will help improve the illegal drug problem in the United States.

Promoting International Demand Reduction

The problem of increasing drug abuse is shared by many nations. In the United Kingdom (UK), for example, 48 percent of sixteen to twenty four year-olds questioned in 1996 said they had used illegal drugs in their lifetime, and 18 percent were past-month users. The number of offenders dealt with under the UK

Misuse of Drug Act of 1971 increased from 86,000 in 1994 to 95,000 in 1996. The number of UK drug users in treatment was 24,879 in the six-month period ending September 1996, 48 percent higher than the equivalent period three years earlier. The number of deaths in the UK attributable to the misuse of drugs rose from 1,399 in 1993 to 1,805 in 1995.[32] In Mexico, the government is responding to increasing drug abuse by increasing funding for treatment, conducting a "Live Without Drugs" public service campaign, and providing educational programs in schools and on the Internet.[33] In Brazil, cocaine abuse has become more prevalent. In the capital of Brasilia, 50 percent of drug abusers smoke cocaine in either crack or "merla" form. Nationally, injecting drug users most frequently inject cocaine. Drug injection is associated with more than 50 percent of new HIV infections in major cities and 21 percent of all cases in the country. In 1998, the federal government launched a five-point national drug-control strategy to reduce drug abuse, availability, and its consequences by 50 percent in the next ten years.[34]

Recognizing that no government can reduce drug use and its consequences by itself, the United States encourages and supports private-sector initiatives in drug prevention education. Examples include the *Consejo Publicitario Argentino*, the *Parceria Contra Drogas* in Brazil, and the *Alianza para una Venezuela sin drogas*. The 120,000 U.S. tax-payer dollars that helped establish these national organizations contributed to the generation of more than $120 million in anti-drug media messages in these three countries. The U.S. is helping to launch a similar organization in Uruguay in the spring of 1999. The United States Information Agency supports public diplomacy campaigns that publicize the threat drug abuse and trafficking poses to societies in source and transit nations.

Supporting Democracy and Human Rights

Experience teaches that countries which enjoy political, economic, and social stability derived from effective democratic institutions are most capable of mounting coherent policies to reduce drug cultivation, production, trafficking and money laundering. Accordingly, all U.S. international counter-drug assistance is carefully coordinated by our ambassadors to ensure that drug-policy objectives support U.S. foreign policy goals of promoting democracy and protecting human rights. In nations with the political will to fight drug-trafficking, the United States provides training and resources so that these countries can reduce narcotics cultivation, production, trafficking, and consumption. In many instances, such assistance takes the form of building social and political institutions that further democratic governance while confronting the drug trade.

Drug Control in the Western Hemisphere

The era in which hemispheric anti-drug efforts were characterized by bilateral initiatives between the United States and selected Latin American and Caribbean nations is giving way to growing multilateral initiatives. Nations in the Americas have recognized that the lines demarcating source, transit, and consuming nations have become blurred as drug abuse and drug-related social harms become a shared problem. The growing trend toward greater cooperation in the Western Hemisphere is creating unprecedented drug-control opportunities.

The institutions required for successful hemispheric cooperation are firmly established. Many of the requisite mechanisms and processes are also in place or under development. The anti-drug action agenda signed during the 1994 Miami Summit of the Americas is being implemented. All members of the Organization of American States endorsed the 1995 Buenos Aires Communique on Money Laundering and the 1996 Hemispheric Anti-Drug *Strategy*. The hemisphere's thirty-four democratically elected heads of states agreed during the 1998 Summit of the Americas in Santiago, Chile to a Hemispheric Alliance Against Drugs. All nations agreed to broaden drug prevention efforts; cooperate in data collection and analysis, prosecutions, and extradition; establish or strengthen anti-money laundering units; and prevent the illicit diversion of chemical precursors. The centerpiece of the agreement is a commitment to create a multilateral evaluation mechanism — essentially, a hemispheric system of performance measurement. Substantial progress was made by the Organization of American

States' Inter-American Drug Abuse Control Commission this past year in developing this evaluation system. Specific performance indicators have been accepted, including requirements for comprehensive national strategies; national laws to combat illegal chemicals, money laundering, and firearms; central coordination government bodies; development of drug-use prevalence surveys; and inventories of prevention and treatment programs.

Bilateral Cooperation with Mexico

The complex and highly interdependent relationship between Mexico and the U.S. is of major importance to the United States. Economics, history, culture, and geography closely link our two countries. Cooperation with Mexican authorities is essential for progress against Mexico-based major drug-trafficking organizations. Most of the cocaine and much of the marijuana, heroin, and methamphetamine consumed in the U.S. comes through Mexico. Mexican drug-trafficking networks control a substantial portion of the illicit drugs distributed in the United States. Conversely, cash and firearms derived from illegal drug trafficking move south from the U.S. into Mexico.

These criminal activities generate violence; feed corruption; inspire fear; divert scarce resources; and undermine legitimate trade, commerce, and investment. Mexico's economic stability and political transition are particularly threatened by the crime, violence, and social decay engendered by illegal drug trafficking.

Strong political will at the senior levels of the Mexican government confronts the serious national security threat posed by drug trafficking and drug-related corruption and violence. Mexico is challenged, however, by corruption, weak counter-drug institutions, and a legal system that can be exploited by well-funded drug traffickers. A long-term commitment by Mexico's government to achieve concrete results will be needed to disrupt major trafficking organizations and to reduce the amount of drugs that enter Mexico and the United States.

In the last three years, Mexico has investigated and prosecuted high-ranking public officials for corruption. It has enacted anti-crime laws that strengthen law enforcement institutions and provide the basis for more effective prosecution. We have improved cooperation in the past three years in information sharing, air and maritime interdiction, cooperative investigations, extraditions, and military counterdrug coordination. Major traffickers like Juan Garcia Abrego and (for now) the Amezcua brothers have been taken out of circulation.

Last year, the United States and Mexico developed a comprehensive U.S.-Mexico Binational Drug Strategy. The strategy builds upon the Binational Drug Threat Assessment and the U.S.-Mexico Alliance Against Drugs signed by Presidents Clinton and Zedillo in 1997. The agreement demonstrates our shared commitment to address drug challenges forthrightly while upholding the principles of sovereignty, mutual respect, territorial integrity, and nonintervention. An agreed set of measures of effectiveness for the Binational Drug Strategy will be completed in early 1999. Public-health officials will also conduct a second binational demand-reduction conference in Mexico City in the summer of 1999.[35]

Over the long term, we need to preserve institutions of cooperation such as the US-Mexico High-Level Contact Group (HLCG) for Drug Control and the Senior Law Enforcement Plenary and help strengthen Mexican law-enforcement institutions and anti-corruption efforts. With healthy binational ties, we can establish the conditions under which the United States and Mexico can work effectively through small, special counter-drug units that target trafficking organizations and are reasonably secure from corruption. The success of such specialized units and continued strengthening of law enforcement institutions can increase Mexico's counter-drug capacity enough to reduce the flow of drugs through that country and into the United States.

Mexico/Central American Initiative

This initiative supports programs designed to reduce drug trafficking through Central America and Mexico and targets trafficking organizations operating in that region. Components of the initiative include training for law enforcement agencies, treatment providers, and judiciaries; illicit crop eradication; military-to-military cooperation; joint investigations; and assignment of additional U.S. law enforcement officials.

Caribbean Violent Crime and Regional Interdiction Initiative

Drug smuggling in the Caribbean is increasing as traffickers respond to successful interdiction efforts along the Southwest border. To counter this increase, this initiative will expand counterdrug operations targeting drug trafficking-related criminal activities and violence in the Caribbean region including South Florida, Puerto Rico, the U.S. Virgin Islands, and the independent states and territories of the eastern Caribbean. This initiative will: implement mutual cooperative security agreements between the United States and Caribbean nations; implement commitments made by the U.S. President during the Caribbean Summit held in Barbados in May 1997; develop regional maritime law enforcement capabilities; increase the capability of Caribbean nations to intercept, apprehend, and prosecute drug traffickers through modest expansion of training, equipment upgrades and maintenance support; institutionalize the Americas Counter Smuggling Initiative (ACSI) to provide at-risk commercial carriers, industry, and government offices with training to prevent goods and conveyances from being used to smuggle illegal drugs; and, increase interdiction capabilities and support law enforcement activities in the Caribbean.

Targeting International Drug Trafficking Organizations

The malevolence and unbounded greed of the criminal organizations trafficking in drugs cannot be ignored or understated. These organizations are frequently characterized by centralized control at senior levels and compartmentalization at lower levels. International criminal organizations appear to have no problems recruiting couriers, enforcers, and farmers. U.S.-supported programs help disrupt and dismantle international drug organizations, attacking their leadership, trafficking, production, and distribution infrastructure, as well as their financial underpinnings. The objectives of these programs are to break the power of drug organizations, reduce the threat they pose to democratic institutions, and reinforce the political will of our allies to confront traffickers. Going after top-level leadership is the most effective way to break these organizations. In addition, domestic trafficking organizations are often inextricably linked with foreign traffickers. To be successful in controlling the drug problem in the U.S., we must target both foreign and domestic trafficking organizations.

The success of international operations targeting trafficking organizations has changed the face of the cocaine industry. Large international cocaine cartels have been injured or destroyed. A looser confederacy of smaller, more specialized trafficking groups have replaced them. The United States and allied nations in the transit and source zones will identify and target these emerging criminal organizations.

Following the Money

The drug trade generates billions of dollars in profits. In most cases, traffickers seek to disguise drug profits by converting ("laundering") them into legitimate holdings. Trafficking organizations are vulnerable to enforcement actions because of the volume of money that must be processed. Americans spend fifty-seven billion dollars a year on illegal drugs (thirty-eight billion on cocaine, 9.8 billion on heroin). Drug dealers seek to place these funds in the financial system as close as possible to drug-dealing locations for eventual investment within the United States or repatriation in other countries. In recent years, money laundering has become an increasingly professional undertaking. At the same time, it has become much more international as a result of the integration of markets and traffickers routing profits to countries whose financial systems lack adequate enforcement mechanisms.

Illegal-drug profits are laundered via traditional bank or non-bank financial institutions. However, a significant amount of illicit funds are laundered via non-traditional financial systems or methods. The black market peso exchange is one of the most popular mechanisms used to repatriated drug proceeds to Colombia. In this laundering method, Colombian drug organizations sell drug-related U.S. currency to Colombian black market peso exchangers who, in turn, place the currency into U.S. bank accounts. The "hawala" or "hundi" remittance systems, which operate parallel to "western" banking systems, are

prevalent in Pakistan, India, and South Asia. As with the black market peso exchange, the value of the money is transferred without the currency itself ever being moved. The system operates on trust and functions using a network of hawala brokers around the world. Hawala has been seen as a component of various money laundering schemes associated with a variety of predicate offenses in U.S. cases.

The Department of Treasury works extensively with U.S. banks, wire remitters, vendors of money orders and travelers' checks, and other money service businesses to combat placement of drug proceeds. The federal government uses the provisions of the Bank Secrecy Act to detect suspicious transactions and prevent money laundering. Federal, state, and local law-enforcement agencies also target individuals, trafficking organizations, businesses, and financial institutions suspected of money laundering. The Geographical Targeting Order issued by the Department of Treasury in 1996 to prevent drug-related wire transfers from the New York City area and DOJ's prosecution of such cases are examples of effective interagency counter-measures. Private-sector support for anti-laundering measures is critical. Compliance with money-laundering regulations is essential for the credibility of financial institutions competing in a global economy.

A multi-agency assistance and training program is helping central banks and law enforcement agencies in emerging democracies develop capabilities to deter and detect money laundering. The United States also supports global efforts to disrupt the flow of illicit capital, track criminal sources of funds, forfeit ill-gained assets, and prosecute offenders. For example, with the assistance of Colombian law enforcement and private sector organizations, the United States has imposed economic sanctions pursuant to the International Economic Emergency Powers Act against more than four hundred businesses affiliated with Colombian criminal drug organizations. Elsewhere, U.S. experts have helped draft regulations to protect foreign financial sectors. Twenty-six nations are members of the Financial Action Task Force (FATF), which develops international anti-money-laundering standards and helps member nations develop regulations to protect their financial sectors. Treasury's Financial Crimes Enforcement Network (FinCEN) has been working with FATF member countries to develop Financial Intelligence Units (FIUs) which are central units that receive, analyze, and, where appropriate, refer suspicious or unusual financial transactions reported by financial institutions. In 1991, there were only four FIUs in the world. Today there are thirty-eight, with more under development. The goal of FIU development is to promote greater international cooperation through information sharing, using technology, training, and technical assistance.

Drug profits can also be attacked by seizing and forfeiting illegally gained assets. The Department of Justice consulted and assisted in the drafting of asset-forfeiture legislation in Bermuda, Bolivia, Brazil, Colombia, Mexico, South Africa, and Uruguay. The Department of Justice also coordinates international forfeiture cases in Austria, Britain, Luxembourg, Mexico, Switzerland, and other countries. The department's Criminal Division, for example, secured a commitment from the Swiss government to seize two hundred million dollars deposited in Swiss banks by a major cocaine trafficker.

Controlling Precursor Chemicals

The twenty-two chemicals used most commonly in the production of cocaine also have extensive commercial and industrial applications. Nevertheless, we can disrupt illegal drug production if essential chemicals are difficult to obtain. The bulk of chemicals seized globally are intended for the clandestine manufacture of cocaine. Between 1990 and 1994, approximately four billion "potential dosage units" of precursors — or the amount of precursors needed to produce as many doses — were seized annually.[36] The importance of controlling precursor chemicals has been established in international treaties and laws. For example, article 12 of the 1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances establishes the obligation of parties to the treaty to institute controls to prevent the diversion of chemicals from legitimate commerce to illicit drug manufacture.

The tracking of international shipments and the investigation of potentially illegal diversions are demanding tasks, yet major strides have been made in international efforts to prevent the illegal diversion of chemicals. In 1997, the United States and the

European Union signed an agreement to enhance cooperation in chemical diversion control. In Brazil, the government regulates the sale of gasoline, which can be used as a precursor chemical and to fuel trafficker aircraft and boats in the Amazon region. The United States continues to urge the adoption and enforcement of chemical-control regimes by governments that do not have them or fail to enforce them. The goal is to prevent diversion of chemicals without hindering legitimate commerce.

Reducing Corruption

Corruption is a serious impediment to expanded bilateral and multilateral cooperation. The widespread existence of corruption engenders a lack of confidence among law enforcement agencies in various countries that might otherwise be able to attack drug-trafficking organizations by sharing information and coordinating operations. Ruthless trafficking organizations, with deep pockets for bribes and a demonstrated readiness to use violence, have penetrated the highest reaches of government in some nations. Corruption weakens the rule of law, erodes democratic institutions, and sometimes threatens the lives of officials. A decade ago, corruption was all-too-often ignored or tolerated. Today, the world's democracies are taking steps to confront the problem. The United States will continue supporting multilateral efforts to fight corruption such as the OAS Hemispheric Convention against Corruption, which was signed in 1998 by all the organization's members. At the same time, we will remain vigilant against corruption within our own institutions. Adequate resources and investigative efforts will be dedicated to ensuring full compliance with the rule of law in all counter-drug efforts. In 1999, the U.S. vice president will host a conference on corruption that will bring global focus on the serious challenge corruption poses to democratic values.

Endnotes

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V. The National Drug Control Budget

The FY 2000 National Drug Control Budget supports the five goals and 31 objectives of the *National Drug Control Strategy (Strategy)* and is structured to make progress towards the performance targets outlined in the national drug control *Performance Measures of Effectiveness* (PME) system. In total, funding recommended for FY 2000 is $17.8 billion, an increase of $735 million (4.3 percent) over FY 1999 regular appropriations of $17.0 billion. In addition to regular appropriations, federal drug control agencies received $844 million for emergency purposes in FY 1999. With this emergency funding, drug control appropriations total $17.9 billion in FY 1999. A summary of drug-control spending for FY 1996 through FY 2000 is presented in Figure 5-1.

Spending by Department

Funding by department for FY 1998 to FY 2000 is displayed in Table 5-1. Included in the funding totals shown in Table 5-1 are additional resources for supply-reduction programs in the Departments of Justice, Treasury, Transportation, State, and Defense, which will support security along the Southwest border; aid efforts in the Andean Ridge region, Mexico, and the Caribbean; and continue enforcement operations targeting domestic sources of illegal drugs. Demand-reduction efforts by the Departments of Health and Human Services and Education will support programs to increase public drug treatment, provide basic research on drug use, and continue prevention efforts aimed at school children.

Figure 5-1: National Drug Control Budget Funding Trend Up

FY 1996 to FY 2000

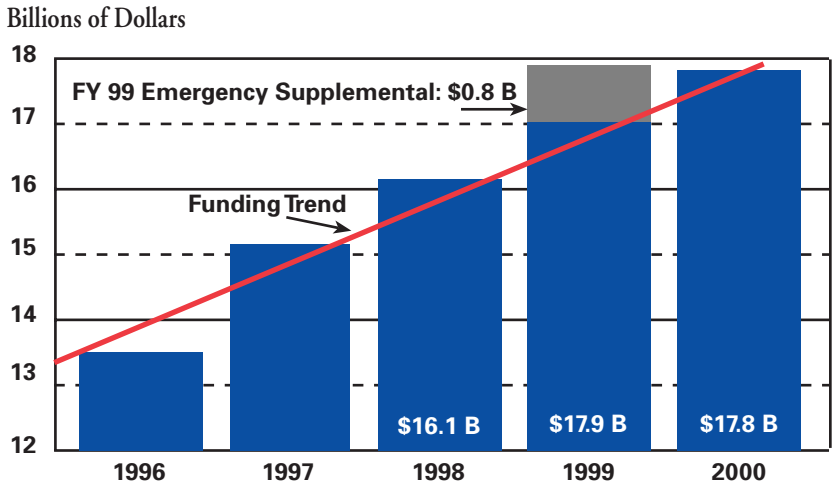

Table 5-1: Drug Spending by Department ($ Millions)

Department	FY98 Actual	FY 99 Enacted	FY 99 Supp.*	FY 99 Total	FY 00 Request	Change: 99 Enacted to 00 Req.	% Change
Defense	831.6	895.1	42.0	937.1	954.6	59.5	6.6
Education	650.0	663.0	0.0	663.0	689.6	26.6	4.0
HHS	2,523.2	2,859.0	0.0	2,859.0	3,054.6	195.6	6.8
HUD	310.0	310.0	0.0	310.0	310.0	0.0	0.0
Justice	7,340.0	7,696.3	11.7	7,708.0	7,895.8	199.5	2.6
ONDCP	428.2	447.5	3.2	450.7	454.2	6.7	1.5
State	219.7	245.2	232.6	477.8	276.6	31.4	12.8
Transportation	538.8	556.7	264.7	821.4	624.6	67.9	12.2
Treasury	1,346.5	1,392.7	266.7	1,659.4	1,454.4	61.7	4.4
Veterans Affairs	1,097.8	1,125.7	0.0	1,125.7	1,125.7	0.0	0.0
All Other	811.5	851.1	23.0	874.1	937.1	86.0	10.1
Total	16,097.3	17,042.3	843.9	17,886.2	17,777.2	734.8	4.3

* Emergency Supplemental funding provided by P.L. 105-277. These funds are in addition to each department's annual appropriation.

Major Increases in FY 2000

The following major increases in drug-control funding are included in the President's FY 2000 budget for **prevention and treatment** programs:

- **Drug Intervention Program: +$100 million.** This initiative, funded through the Office of Justice Programs, will provide drug abuse assistance to state and local governments to develop and implement comprehensive systems for drug testing, drug treatment and graduated sanctions for offenders.
- **Youth Tobacco Prevention: +$61.0 million.** The CDC will receive an increase of $27.0 million in drug-related funds to extend state-based efforts to conduct comprehensive programs to reduce and prevent tobacco use. The FDA will receive an additional $34.0 million in drug-related funding in FY 2000 to expand implementation of its final rule intended to halt the supply of tobacco products to children.
- **Treatment Capacity Expansion Grants: +$55 million.** This additional funding will help SAMHSA expand the availability of drug treatment in areas of existing or emerging treatment need.
- **Substance Abuse Block Grant Program: +$30 million** ($24.8 million drug-related). This increase for SAMHSA's Substance Abuse Block Grant will provide funding to states for treatment and prevention services. This program is the backbone of federal efforts to reduce the gap between those who are actively seeking substance abuse treatment and the capacity of the public treatment system.
- **School Coordinators: +$15 million.** These additional resources will expand the School Coordinator program, started in FY 1999. With this increase, total funding for this initiative will be $50 million in FY 2000. This program will support the hiring of drug prevention coordinators in nearly half of the middle schools across the country to help improve the quality and effectiveness of drug prevention programs.
- **National Youth Anti-Drug Media Campaign: +$10 million.** This additional funding brings the budget for ONDCP's Media Campaign to $195 million in FY 2000. With this money, ONDCP will continue its targeted, high impact, paid media campaign designed to change naive adolescent perceptions of the dangers and social approval of drug use.
- **Drug Courts: +$10 million.** These additional resources will bring total funding for the Drug Courts program to $50 million in FY 2000. This program provides alternatives to incarceration through using the coercive power of the court to

force abstinence and alter behavior with a combination of escalating sanctions, mandatory drug testing, treatment, and strong aftercare programs.

The following major increases in drug-control funding are included in the President's FY 2000 budget for **supply reduction** programs:

- **Southwest border - INS: +$50 million** ($7.5 million drug-related). INS will continue to deploy the Integrated Surveillance Information System (ISIS). ISIS, which incorporates infrared and color cameras with ground sensors, will aid Border Patrol enforcement efforts and drug interdiction along the Southwest border.
- **International Programs - State: +$29 million.** These new resources over FY 1999 (excluding emergency funding) are requested for the Bureau of International Narcotics and Law Enforcement Affairs (INL). This additional funding includes support for Andean countries, Mexico, and assistance to international organizations.
- **DEA Drug Intelligence: +$22 million.** This funding will provide $13 million to accelerate implementation of DEA's FIREBIRD office automation system. FIREBIRD includes e-mail, uniform word processing and other forms of office automation that will provide DEA with more sophisticated electronic investigative records. Once fully deployed, FIREBIRD will allow DEA components located around the world to act as one cohesive unit through instantaneous access to critical law enforcement and intelligence information. In addition, $9 million will enhance DEA's Special Operations Division by providing critical support for Title III investigations aimed at dismantling drug trafficking organizations.
- **Forward Operating Locations - DoD: +$73.5 million.** The drug control budget for the Department of Defense includes these additional resources in FY 2000 for restructuring SOUTHCOM's theater counterdrug architecture, which will include the development of three Forward Operating Locations (FOLs). These FOLs will support transit and source zone air operations in SOUTHCOM's area of responsibility.

Spending by Strategy Goal

Funding by *Strategy* Goal is summarized in Table 5-2. Funding priorities include resources to reduce drug use by young people (Goal 1), make treatment available to chronic users (Goal 3), interdict the flow of drugs at our borders (Goal 4), and target sources of illegal drugs and crime associated with criminal enterprises (Goals 2 and 5). In FY 2000, funding will be $2.1 billion for Goal 1, a net increase of almost $21 million over FY 1999, and $3.5 billion for Goal 3, an increase of 4.2 percent over FY 1999.

Table 5-2: Drug Funding by Goal ($ Millions)

Goal	FY98 Actual	FY 99 Enacted	FY 99 Supp.*	FY 99 Total	FY 00 Request	Change: 99 Enacted to 00 Req.	% Change
1. Reduce youth drug use	1,861.3	2,080.6	1.7	2,082.3	2,101.5	20.9	1.0
2. Reduce drug-related crime	7,275.5	7,441.0	12.0	7,453.0	7,711.2	270.2	3.6
3. Reduce consequences	3,130.0	3,383.7	0.0	3,383.7	3,527.2	143.5	4.2
4. Shield air, land, and sea frontiers	2,032.5	2,159.3	525.9	2,685.2	2,295.8	136.5	6.3
5. Reduce sources of supply	1,798.0	1,977.7	304.3	2,282.0	2,141.5	163.8	8.3
Total	16,097.3	17,042.3	843.9	17,886.2	17,777.2	734.8	4.3

* Emergency Supplemental funding provided by P.L. 105-277. These funds are in addition to each department's annual appropriation.

Further, multiagency efforts, which target ports-of-entry and the Southwest border, will expand funding for Goal 4 to $2.3 billion in FY 2000, an increase of 6.3 percent. Funding for Goal 2 will be $7.7 billion in FY 2000, an increase of $270.2 million, and resources devoted to Goal 5 will reach $2.1 billion in FY 2000, an increase of 8.3 percent.

Federal Funding Priorities: FY 2000–FY 2004

By law, ONDCP must annually report its program and budget priorities over a five-year planning period. These priorities also are highlighted in ONDCP's consolidated five-year *Drug Control Budget: FY 2000 to FY 2004*. This volume, required by statute, is produced each November for the consideration of the President and the President's Council on Counter-Narcotics. Through FY 2004, funding for the following major program areas will be emphasized through ONDCP's drug-budget authorities:

- National Youth Anti-Drug Media Campaign
- Criminal Justice Treatment/Break-the-Cycle Programs
- Close the Public System Treatment Gap
- School Drug-Prevention Coordinators
- Southwest Border Programs
- Follow-on Resources to Support FY 1999 Emergency Supplemental Activities
- Andean Coca Reduction

VI. Consultation

The Office of National Drug Control Policy Reauthorization Act of 1998 requires ONDCP to consult a wide array of experts and officials while developing the *National Drug Control Strategy.* Specifically, Section 706 requires the ONDCP Director to consult with the heads of the National Drug Control Program agencies; Congress; state and local officials; private citizens and organizations with experience and expertise in demand reduction; private citizens and organizations with experience and expertise in supply reduction; and appropriate representatives of foreign governments.

ONDCP fully met this congressional requirement in 1998 by consulting with Congress, heads of federal drug-control agencies, state and local officials, medical experts, law-enforcement officials, academics, researchers, scientists, business leaders, civic organizations, community leaders, private citizens, and representatives of foreign governments and organizations.

Consultation with Congress

The development and implementation of a comprehensive national drug strategy has long been a major congressional concern. In response, this *Strategy* provides detailed long-term plans for addressing domestic and international trends in drug use, production, and trafficking. It also recognizes that it is only the federal government that can undertake international supply reduction. Congress has been particularly concerned about accountability in our counter-drug efforts and the long-standing absence of any serious presentation of performance standards or measures of success. This congressional concern for achieving measurable results was heightened by the dramatic increases in drug use among youth. Accordingly, this *Strategy* includes specific benchmarks for the base year (1996) and hard data on results in 1997 and 1998 (where such data is available). Finally, this Strategy includes initiatives to reinforce parents and families as they work to keep our young people drug free; expands treatment; counters drug legalization at home and abroad; and takes aim at the growing problem of the major international criminal organizations responsible for much of the world's drug production and trafficking.

During 1998, the executive and legislative branches worked on a bipartisan basis to pass comprehensive legislation to address all facets of the drug problem. Major accomplishments this past year include:

- Reauthorization of ONDCP for five years which expanded ONDCP's authorities.
- Launching the National Youth Anti-Drug Media Campaign.
- Implementation of the Drug-Free Communities Act of 1997.
- Enhancement of the HIDTA program.
- Reducing the problem of drugs in prisons by including a provision in the Office of Justice Program's appropriation allowing up to 10 percent of funds going to states for prison construction to be used for drug testing and treatment.
- Progress in developing a plan to more effectively gather and utilize counterdrug intelligence.
- Passage of the Drug-Free Western Hemisphere Act.
- Passage of the Drug-Free Workplace Act of 1998.

ONDCP was pleased to testify and brief the Congress on all aspects of drug control, including prevention, treatment, drug legalization, interdiction, international drug control, bilateral cooperation with Mexico, the federal drug-control budget, and the *National Drug Control Strategy's* supporting Performance Measures of Effectiveness system, drug abuse prevention and treatment, counterdrug cooperation in the Western Hemisphere, interdiction of illegal drugs, and Southwest Border and Intelligence Architecture. ONDCP also welcomed and incorporated suggestions from senators, representatives, and supporting staff in the 1*999 National Drug Control Strategy.*

Consultation with National Drug-Control Program Agencies

Agencies charged with overseeing drug prevention, education, treatment, law enforcement, corrections, and interdiction contributed to the *1999 Strategy*. Input from fifty-two federal agencies was used to update goals and objectives; develop performance measures; and formulate budgets, initiatives, and programs. ONDCP chaired interagency demand-reduction and supply-reduction working groups. Interdiction operations were shaped by the United States Interdiction Coordinator (USIC) and The Interdiction Committee (TIC). A White House Task Force on Counterdrug Intelligence Architecture produced a report and recommendations related to counterdrug intelligence. ONDCP also coordinated the activities of U.S. members of the U.S.-Mexico High Level Contact group for Drug Control.

Consultation with State and Local Officials

The *Strategy* incorporated the suggestions of governors from all states and territories. State drug-control agencies also provided input in the areas of prevention, treatment, and enforcement. ONDCP worked closely throughout the year with organizations such as the National Governor's Association, the Council of State Governments, the U.S. Conference of Mayors, and the National Association of Counties to coordinate policies and programs. Perspectives were solicited from every mayor of a city with populations of at least 100,000 people and key county officials. Additionally, community prevention experts, treatment providers, and law-enforcement officials provided local perspectives on the drug problem along with potential solutions.

Consultation with Private Citizens and Organizations

ONDCP gathered opinions from community anti-drug coalitions, chambers of commerce, editorial boards, the entertainment industry, law-enforcement and legal associations, medical associations and professionals, non-governmental organizations, professional organizations, and religious institutions. A list of private sector groups whose views were considered during formulation of the *1999 Strategy* is provided at the end of this chapter.

Consultation with Representatives of Foreign Governments and International Organizations

The United States coordinated international drug-control policies carefully with global and regional organizations including the U.N. (particularly UNDCP), the EU, the OAS, the Caribbean Community (CARICOM), and the Association of South East Asian Nations (ASEAN). The U.S. agencies also worked in partnership with authorities in major transit and source nations to confront major international criminal organizations, develop comprehensive plans to stop money laundering, deny safe havens to international criminals, and protect citizens and democratic institutions from corruption and subversion.

Publications

Each year ONDCP and national drug-control program agencies publish periodic reports, assessments, and studies to inform the public about drug-control research and policy. Samples of these publications are described below:

National Drug-Control Strategy: Budget Summary. Contains detailed drug-control budget data by agency, function, and goal. This document is released as a companion volume to the *National Drug Control Strategy.*

Performance Measures of Effectiveness: Implementation and Findings. Released as a companion volume to the *1999 Strategy*, it describes the process of implementing the performance measurements of effectiveness system, a mechanism by which to measure progress towards the *Strategy's* goals and objectives.

Methamphetamine Abuse and Addiction Research Report Series (1998). Includes description of this potent psychostimulant; the drug's effects, scope of methamphetamine abuse in the United States; how the drug is used; how the drug differs from other stimulants such as cocaine; medical complications of methamphetamine abuse; and effective treatments.

National Survey Results on Drug Use From the Monitoring the Future Study 1975-1997: Volume I, Secondary School Students (1998). Provides data from school years 1995-1996 and 1996-1997. Data provide key indicators of trends in substance use among adolescents and young adults. Collects data from 8th, 10th, and 12th graders in the United States.

National Survey Results on Drug Use From the Monitoring the Future Study 1975-1997: Volume II, College Students and Young Adults (1998). Reports the results of all surveys through 1997 from the Monitoring the Future study of American secondary students, college students, and young adults. Presents the results of the 1977 through 1997 follow-up surveys of the graduating high school classes of 1976 through 1996 as these respondents have progressed through young adulthood.

Nicotine Addiction—Research Report Series (1998). Describes what nicotine is, presents current epidemiological research data regarding its use, and reports on the medical consequences of nicotine use. Emphasizes the effects of nicotine on the brain as well as current research findings about use during pregnancy. Includes treatment approaches.

Drug Addiction Research and the Health of Women (1998). Builds on presentations at the September 1994 conference "Drug Addiction Research and the Health of Women," sponsored by NIDA to assess and begin to fill gaps in knowledge about drug abuse and women's health. Leading researchers present state-of-the-science findings, discuss research issues, and lay the framework for NIDA's research agenda in women's health.

A Cognitive-Behavioral Approach: Treating Cocaine Addiction (1998). First in the "Therapy Manuals for Drug Addiction" series. Describes cognitive-behavioral coping skills treatment, which is a short-term, focused approach to helping cocaine-dependent individuals become abstinent from cocaine and other substances.

A Collection of NIDA Notes Articles on Drug Abuse Treatment (1998). Presents articles from 1995 to 1997 newsletters, including "Voucher System is Effective Tool in Treating Cocaine Abuse"; "Rats Immunized Against Effects of Cocaine"; and "Rate and Duration of Drug Activity Play Major Roles in Drug Abuse, Addiction, and Treatment."

A Community Reinforcement Plus Vouchers Approach: Treating Cocaine Addiction (1998). Second in the "Therapy Manuals for Drug Addiction" series. This treatment integrates a community reinforcement approach (CRA) with an incentive program that uses vouchers. Patients can earn points exchangeable for retail items by remaining in treatment and maintaining abstinence from cocaine. Chapters include drug avoidance skills, early counseling sessions, lifestyle change components, and relationship counseling.

Estimating Costs and Outcomes of Substance Abuse Prevention Strategies (1998). This CSAP technical report reviews cost-outcome methodologies, discusses important conceptual issues that arise from cost-outcome analyses of prevention programs, and provides prevention professionals with a clearer understanding of the economics involved in decisions concerning the investment of prevention dollars.

Medications Development for the Treatment of Cocaine Dependence: Issues in Clinical Efficacy Trials (RM 175) (1998). Intended to be used as a state-of-the-art handbook by clinical investigators, pharmaceutical scientists, and treatment researchers to effectively conduct clinical trials of safety and efficacy of treatment medications for cocaine addiction.

Assessing Drug Abuse Within and Across Communities (1998). Helps communities understand their local drug abuse problems and develop drug abuse epidemiologic surveillance systems to assess local drug patterns and trends. Based on the work of NIDA's Community Epidemiology Work Group (CEWG), a national surveillance network composed of researchers from around the country who meet biannually to monitor drug use and abuse trends around the Nation. Can be used by states, counties, cities, and communities.

Cost-Benefit/Cost-Effectiveness Research of Drug Abuse Prevention: Implications for Programming and Policy (RM 176) (1998). Provides definitions of prevention program types, discusses effects to be expected from program delivery, and assesses (in financial and social terms) the benefits to society of effective drug abuse prevention programs and policies. Guides future developments in prevention programming, informs policy makers, legislators, and program managers concerning advanced prevention program strategies, and disseminates to the scientific research community an overview of the state-of-the-art of drug abuse prevention.

Economic Cost of Alcohol and Drug Abuse in the United States—1992 (1998). Developed to update information on the cost of alcohol and drug abuse in the United States. Provides current findings and interpretations of data in the areas of cost and cost analysis. Important to the discussion of all aspects of reducing drug and alcohol use, including health care services, financing, and service delivery.

Drug Abuse Among Racial/Ethnic Minorities (Revised 1998). Draws together data from multiple sources to address the issue of substance use and related consequences for minority subgroups of the U.S. population. Serves as an information source for the direction and scope of prevention and intervention programs.

Marijuana: Facts for Teens (Revised 1998). Provides teenagers with answers to some frequently asked questions about marijuana and the latest scientific information on its effects. Explains the current knowledge about marijuana, what it is, who uses it, how it affects a person physically and mentally through short-term and long-term usage, and where to seek help. Includes reactions to marijuana use by teenage users and nonusers.

Marijuana: Facts Parents Should Know (Revised 1998). Provides valuable information from research on the dangers of marijuana and gives parents details about the drug. Includes answers to some of the most frequently asked questions about marijuana, explanations of the latest scientific information, and suggestions about how to talk to teenagers about marijuana. For parents, grandparents, care givers, teachers, and recreation and community leaders.

The Brain's Response to Drugs: Teacher's Guide (1998). Developed to accompany the *Mind Over Matter* magazine series. Chapters describe the effects of specific drugs or drug types on the anatomy and physiology of the brain and body. Includes classroom activities. Promotes understanding of the physical reality of drug use, as well as curiosity about neuroscience.

National Conference on Drug Abuse Prevention: Presentations, Papers, and Recommendations (1998). Represents the outcome of more than 20 years of research. Compiles keynote speeches, plenary presentations, and recommendations from work groups for use in community prevention programs.

Pulse Check. A biannual report released by ONDCP providing information on chronic drug use and illegal drug markets in selected cities. Data is supplied by police, ethnographers, and treatment providers.

Treatment Improvement Protocol #25, ***Substance Abuse Treatment and Domestic Violence, (January 1998).*** This SAMHSA/CSAT volume provides diagnostic tools to help drug addiction counselors recognize when clients are victims or perpetrators of domestic violence, and also aids those who counsel abused women in need of protection to recognize drug and alcohol addiction.

Treatment Improvement Protocol #26, ***Substance Abuse Among Older Adults (May 1998).*** This SAMHSA/CSAT volume is designed to alert health care providers that substance abuse in the older population is a serious problem and to assist the health care community to detect and treat alcohol and medication abuse among older patients.

Treatment Improvement Protocol #27, ***Comprehensive Case Management for Substance Abuse Treatment, (July, 1998).*** This SAMHSA/CSAT volume provides models and practical information on how to coordinate treatment for alcohol abuse or illicit drug use with additional services patients may require.

Treatment Improvement Protocol #28, ***Naltrexone and Alcoholism Treatment (October 1998).*** This SAMHSA/CSAT volume outlines best practices guidelines for use of Naltrexone in treating alcoholism.

Treatment Improvement Protocol (TIP) #30, ***Continuity of Offender Treatment for Substance Use Disorders From Institution to Community (January 1999).*** This SAMHSA/CSAT volume is designed to help substance abuse professionals and criminal justice professionals create transitions for offenders being released from prisons or jails, making it less likely that the offender will regress into substance abuse and crime, and eventually go back to prison.

Uniform Facility Data Set (UFDS): Data for 1996 and 1980-1996 (Drug and Alcohol Services Information System Series) (January 1998) An annual report that provides data on facility and client characteristics from a census of all identified, State-recognized substance abuse treatment providers.

The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits, (March 1998). This SAMHSA/CSAT volume provides a literature review on mental health and substance abuse parity, discusses state parity laws, includes case studies from five states with parity laws, and estimates premium increases for full and partial parity options. It concludes that family insurance premiums in tightly managed private health insurance plans would increase less than one percent.

Estimating Costs and Outcomes of Substance Abuse Prevention Strategies (April 1998). This technical report reviews cost-outcome methodologies, discusses important conceptual issues that arise from cost-outcome analyses of prevention programs, and provides prevention professionals with a clearer understanding of the economics involved in decisions concerning the investment of prevention dollars.

Preventing Substance Abuse Among Children and Adolescents: Family-Centered Approaches (June 1998) This reference guide summarizes state-of-the-art approaches and intervention designed to strengthen the role of families in substance abuse prevention. The topic was chosen in response to the field's expressed need for direction and in recognition of the important role of the family as the first line of defense against the dangerous, insidious, and additive consequences of substance abuse.

A Guide for Evaluating Prevention Effectiveness (July 1998) This guide was created to give evaluator-practitioner teams the concepts and tools necessary for producing useful and credible evaluations. It addresses how evaluation designs must be tailored to specific interventions and how various research designs and techniques affect credibility when evaluators make assertions about intervention effectiveness.

Prevalence of Substance Use among Racial and Ethnic Subgroups in the United States, 1991-1993 (Analytic Series) (July 1998). This report presents data on racial/ethnic patterns of substance use in the U.S., using a more detailed classification of race/ethnicity than has been possible in previous reports. It uses 1991, 1992, and 1993 NHSDA data to estimate the prevalence of substance use, alcohol dependence, and the need for illicit drug abuse treatment within racial/ethnic subgroups.

Substance Abuse and Mental Health Statistics Source Book, 1998 (Analytic Series) (July 1998). A report that provides graphical presentation of recent data from a variety of SAMHSA and other data sources to address issues of substance abuse, mental illness, and co-occurring mental disorders.

Preliminary Results from the 1997 National Household Survey on Drug Abuse (National Household Survey on Drug Abuse Series) (August 1998) An annual report that presents preliminary results from the 1997 National Household Survey on Drug Abuse, an ongoing national survey of the civilian non-institutionalized U.S. population aged twelve and older. The report presents data on the use of illicit drugs, non-medical use of licit drugs, and use of alcohol, and tobacco. This report provides an overview of newly released data.

National Expenditures for Mental Health, Alcohol, and Other Drug Abuse Treatment (September 1998). This SAMHSA/CSAT volume is the first in an annual series that will track expenditures for drug and alcohol treatment and mental health services in the same way that the costs of other medical services are followed by the Health Care Financing Administration.

Analyses of Substance Abuse and Treatment Need Issues (Analytic Series) (September 1998). This report is a compilation of working papers that address various substance abuse issues of current interest, using data from various sources such as the National Household Survey on Drug Abuse (NHSDA) and the Drug Abuse Warning Network (DAWN). The report addresses issues such as drug abuse patterns, adolescent self-reported problems associated with marijuana use, children at risk because of parental substance abuse, and treatment need.

Drug Abuse Warning Network Annual Medical Examiner Data 1996 (Drug Abuse Warning Network Series) (September 1998). An annual report that provides estimates of the number of drug-related deaths.

National Admissions to Substance Abuse Treatment Services: The Treatment Episode Data Set (TEDS) 1992-1996 (Drug and Alcohol Services Information System Series) (September 1998). An annual report on the flow of admissions to alcohol and drug treatment. TEDS is an administrative data set obtained from the States that describes clients admitted to publicly-funded substance abuse treatment facilities. Trend data is provided for 1992–1996.

Services Research Outcomes Study (SROS) Report (Analytic Series) (September 1998). A one-time report of outcomes for a national sample of persons treated for drug abuse. The survey compares reported status from five years before to five years after the treatment episode.

Mid-Year Preliminary Estimates from the 1997 Drug Abuse Warning Network (Drug Abuse Warning Network Series) (September 1998). Provides mid-year estimates (January–June) of drug-related emergency department episodes for 1997 from the Drug Abuse Warning Network (DAWN), an ongoing national survey of hospital emergency departments. This report provides an overview of newly released data.

National Directory of Drug Abuse and Alcoholism Treatment and Prevention Programs 1997 (Drug and Alcohol Services Information System Series) (September 1998). A 1997 directory listing of state-recognized public and private programs that provide prevention and/or treatment services for alcoholism and/or drug abuse. This annual directory serves as a resource for making treatment referrals.

Driving After Drug and Alcohol Use: Findings from the 1996 NHSDA (Analytic Series) (December 1998). Reports the data results of the 1996 NHSDA Driving Behaviors Module and will show the percent of drivers who drove under the influence of alcohol and illicit drugs in 1996.

Technical Assistance Publication #21, ***Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice (March 1998).*** This SAMHSA/CSAT volume represents a consensus of certifying groups, health educators in the addiction field, and health care providers on the appropriate qualifications for those who treat the disease of addiction.

Technical Assistance Publication #22, ***Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers*** (September 1998). This SAMHSA/CSAT volume outlines the various legal requirements for health care procurement in the private sector and provides information about avoiding pitfalls when contracting for managed care.

Many of these publications and other reference materials can be viewed on the ONDCP Web site (www.whitehousedrugpolicy.gov). ONDCP policy statements, speeches, editorials, and congressional testimony are also maintained at this site.

ONDCP also informs the public of drug-policy issues through an extensive media and outreach program. In 1998, more than a thousand newspaper stories and 788 national television and radio programs specifically addressed ONDCP's efforts.

Detailed briefings were provided to editorial boards of nineteen newspapers and magazines. Spanish-language materials were produced for domestic and Latin American organizations. Op-eds, journal articles, and published speeches were placed in major publications.

The ONDCP Drug Policy Information Clearinghouse is another source of information. It performs customized bibliographic searches, advises the public on data availability and maintains the ONDCP Web site and a public reading room. The Clearinghouse is staffed by drug-policy information specialists. The toll-free number is 1-800-666-3332.

Conferences and Meetings

Federal drug-control program agencies convened or participated in the following gatherings to coordinate drug-control efforts, evaluate trends, and consult with experts.

National Drug-Free Workplace Alliance Annual conference, (November 1998) - convened in Washington, D.C, and co-sponsored by the Division of Workplace Programs, CSAP, SAMHSA, the Demand Reduction Section, DEA, and the U.S. Chamber of Commerce. Representatives from state and local coalitions dedicated to helping businesses establish drug-free workplace programs gathered to share concerns and receive updates on relevant federal and state legislation and ongoing federal initiatives.

Faith Initiative Conference, May 1998 - convened in Chicago and co-sponsored by SAMHSA/CSAT, Recovery Point of Chicago, and Cleveland Comprehensive Assessment, Referral, and Evaluations Systems. The conference considers community linkages and spiritual interventions.

U.S./Mexico High Level Contact Group (HLCG) on Drug Control - created in March 1996, this group met April 6-7, 1998 in Mexico City and December 14-16, 1998, in Washington, D.C. February 6, 1998, the HLCG released the U.S.-Mexico binational Drug Control Strategy which outlined domestic and cooperative counterdrug goals and actions for the two countries.

Interagency Heroin Conference - U.S. Government conference at Camp Smith, Honolulu, Hawaii, November 11-13, 1998. Participants included NSC-Global, State/INL, Justice, DoD, and Washington-based law enforcement and intelligence community agencies, as well as senior U.S. embassy representatives from a number of Pacific-rim countries. A total of 110 attendees participated in discussions on policy, operational, and strategy developments addressing efforts against international heroin trafficking.

Interagency Cocaine Conference - an interagency conference held in Washington, D.C., November 22-24, 1998, with participants from the State, Treasury, Justice, and Defense departments, as well as several Washington-based law enforcement and intelligence community agencies. Discussions focused on combined efforts to address recent operational developments in international cocaine trafficking.

Caribbean Regional Drug Control Conference - ONDCP and the Department of State hosted this conference in Miami, October 14-16, 1998. The conference involved the participation of more than 150 high-level attendees, including Caribbean Ministers from fifteen island nations; representatives from British, French, and Dutch Caribbean territories; Puerto Rico and U.S. Virgin Islands; drug-policy officials from France, UK, the Netherlands, Spain, UNDCP, OAS/CICAD, Austria (as EU President), and the European Commission; academics; and, U.S. Government drug officials.

Central America Counternarcotics Conference - Guatemala City, Guatemala, November 30- December 4, 1998. Participants included NAS, State/INL, Justice, DOD, and Central American-based U.S. law enforcement and intelligence community agencies, as well as U.S. embassy representatives from all Central American countries. Attendees discussed policy, operational, and strategy developments addressing efforts against regional trafficking.

Southern Frontiers Law Enforcement Issues Meeting - chaired by Attorney General Janet Reno, November 16, 1998 in Washington, D.C. Attendees included deputy-level officials from FBI, DEA, DOJ, Customs, and Border Patrol, as well as other

representatives from the interagency. Discussions were held on several topics, including anti-narcotics enforcement on the Southwest border, development of "Performance Measures of Effectiveness" for the US/Mexican Drug Strategy, US/Mexican law enforcement cooperation, and implementation of the interagency plan for Central America.

Meetings of The Interdiction Committee (TIC) - the Interdiction committee is an advisory board to the Director, ONDCP and the United States Interdiction Coordinator (USIC) that is chartered to discuss and resolve interagency issues related interdiction coordination. TIC is composed of Commissioner, USCS, the DoD Drug Coordinator, the AsstSecState(INL), Commandant, USCG, Administrator, DEA, Commissioner, INS, Director of Operations, Joint Staff, and the Deputy Director of Supply Reduction, ONDCP. TIC seeks to promote a seamless and effective integration of international, border, and domestic interdiction efforts in support of the *National Drug Control Strategy.*

Meetings of the Counter-Narcotics Interagency Working Group (CN-IWG) - ONDCP hosts monthly interagency meetings in Washington, D.C. to address key issues affecting international counternarcotics policy. The membership includes high-level representatives from the relevant U.S. government agencies and organizations.

J-3/USIC Counterdrug Conferences - held in Washington, D.C., these quarterly meetings provide a bridge between field operations and policy development in Washington and are a forum for high-level interagency discussions of international drug-interdiction.

Non-Governmental Organizations

Views of the following organizations were considered during formulation of the *1999 Strategy:*

100 Black Men of America, Inc.
Academy of TV, Arts and Sciences
Addiction Research and Treatment Corporation
Ad Council
Adjutant General Association of the United States
Advertising Council
AFL-CIO
African American Parents for Drug Prevention
Alcohol and Drug Problems Association of North America
Alcohol Policy Coalition
Alcohol Policy Foundation
Alcoholics Anonymous World Services
Alianza para un Puerto Rico sin Drogas
America's Promise
American Academy of Addiction Psychiatry
American Academy of Family Physicians
American Academy of Healthcare Providers in the Addictive Disorders
American Academy of Nurse Practitioners
American Academy of Pediatrics
American Academy of Physician Assistants
American Anthropological Association
American Association of Halfway House Alcoholism Programs
American Association of Health Plans
American Association of Pastoral Counselors
American Association of Preferred Provider Organizations
American Association of School Administrators
American Association of University Women
American Bar Association
American College of Emergency Physicians
American College of Neuropsychopharmacology
American College of Nurse Practitioners
American College of Physicians
American College of Preventive Medicine
American Correctional Association
American Council for Drug Education
American Counseling Association
American Enterprise Institute
American Federation of Government Employees
American Federation of State, County and Municipal Employees
American Federation of Teachers
American Foundation for AIDS Research
American Friends Service Committee
American Legion
American Managed Behavioral Healthcare Association
American Management Association
American Medical Association
American Medical Student Association
American Medical Women's Association
American Methadone Treatment Association, Inc.
American Nurses Association
American Occupational Therapy Association
American Pharmaceutical Association
American Physical Therapy Association
American Psychiatric Association
American Psychological Association
American Psychological Association
American Public Health Association
American Public Welfare Association
American Red Cross
American School Counselors Association
American Society for Pharmacology and Experimental Therapeutics
American Society of Addiction Medicine
American Speech/Language/Hearing Association
American Youth Work Center
Amnesty International
AMVETS
Annenberg School of Communications
Asian Community Mental Health Services
ASPIRA
Association for Health Services Research
Association for Hospital Medical Education
Association for Medical Education and Research in Substance Abuse (AMERSA)
Association for Worksite Health Promotion
Association of Academic Health Centers
Association of Caribbean Commissioners of Police
Association of Jesuits Colleges and Universities
Association of Junior Leagues
Association of State Correctional Administrators
Association of Southeast Asian Nations
BACCHUS and GAMMA Peer Education
Baltimore Council of Foreign Affairs
Benevolent and Protective Order of Elks
Bensinger DuPont & Associates
Big Brothers Big Sisters of America
Black Psychiatrists of America
Bodega de la Familia (New York City)
Boy Scouts of America
Boys and Girls Clubs of America
Brookings Institute
Business Roundtable
B'nai B'rith International
B'nai B'rith Youth
California Border Alliance Group
California Narcotics Officers Association
California School Board Association
Camp Fire Boys and Girls
Caribbean Common Market and Community
Caribbean Customs Law Enforcement Council
Carter Center
Catholic Charities U.S.A.
Center for Alcohol and Drug Research Education
Center for Health Promotion
Center for Media Education, Inc.
Center for Media Literacy
Center for Medical Fellowships in Alcoholism and Drug Abuse
Center for Science in the Public Interest
Center on Addiction and Substance Abuse of Columbia University (CASA)
Chicago Project for Violence Prevention
Child Welfare League of America, Inc.
Children's Defense Fund
Christian Life Commission
Church of Jesus Christ and Latter Day Saints
Church Women United
Cities in Schools
Civitan International
Cobb County Chamber of Commerce
College on Problems of Drug Dependence
Commission on Narcotic Drugs of the United Nations Economic and Social Council
Communitarian Network
Community Anti-Drug Coalitions of America

Community Crusade Against Drugs
Congress of National Black Churches
Consortium of Social Science Associations
Corporate Alliance for Drug Education (CADE)
Corporations Against Drug Abuse
Council of State Governments
Council on Foreign Relations
D.A.R.E. America
Delancey Street Foundation
Drug Strategies
Drug Watch International
Drugs Don't Work
Educational Video Center
Emergency Nurses Association
Employee Assistance Professionals Association
Employee Assistance Society of North America
Employee Health Programs
Empower America
Entertainment Industries Council, Inc.
European Commission
Families and Schools Together (FAST)
Families U.S.A. Foundation
Family Research Council
Federal Law Enforcement Officers Association
Florida Alcohol and Drug Abuse Association, Inc.
Florida Chamber of Commerce
Foster Grandparents Program
Fox Children's Network
Fox News Channel
Fraternal Order of Eagles
Fraternal Order of Police
Gaudenzia Program (Pennsylvania)
Gateway Foundation
Gay Men's Health Crisis
General Federation of Women's Clubs
Generations United
George Meany Center for Labor Studies
Georgia State University, Department of Psychology
Girl Scouts of the U.S.A.
Girls, Incorporated
Hadassah
Haight-Ashbury Free Clinic
Harvard Inter-Disciplinary Working Group on Drugs and Addiction
Harvard University School of Public Health
Hazelden
Heritage Foundation
Hispanic American Command Officers Association
Hispanic American Police Officers Association
Hispanic American Police Command Officer's Association
Houston's Drug Free Business Initiative
Human Rights Watch
Illinois Drug Education Alliance
Independent Order of Odd Fellows
Institute for a Drug-Free Workplace
Inter-American College of Physicians/Surgeons
Inter-American Drug Abuse Control Commission of the Organization of American States
International Association of Chiefs of Police
International Association of Junior Leagues
International Brotherhood of Police Officers
International Brotherhood of Teamsters
International Certification and Reciprocity Consortium
International City Managers Association
International Drug Strategy Institute
International Criminal Police Organization
International Narcotic Control Board
International Olympics Committee
Institute for the Advancement of Social Work Research
Johns Hopkins University School of Medicine
Johnson Institute Foundation
Join Together
Junior Achievement of the National Capital Area, Inc.
Junior Chamber International, Inc.
"Just Say No" International
Kaiser Family Foundation
Kids in a Drug-Free Society (K.I.D.S.)
Kiwanis International
Knights of Columbus
Latino Council on Alcohol and Tobacco
Lawyer's Committee for Human Rights
League of United Latin American Citizens
Legal Action Center
Life Steps Foundation, Inc.
Linden Grove
Lindesmith Center
Lions Club International
Little League Foundation
Los Alamos Citizens Against Substance Abuse (LACASA)
Lutte Contra La Toxicomanie
LUZ Social Services
Major City Chiefs Organization
Maryland Underage Drinking Prevention Coalition
Mediascope
Metropolitan Atlanta Crime Commission
Millennium Project
Milton Eisenhower Foundation
Milwaukee Council on Alcoholism and Drug Dependence
Moose International
Mothers Against Drunk Driving (MADD)
Nar-Anon Family Groups
Narcotics Anonymous
National Education Association
National 4-H Council
National Academy of Public Administration
National Alliance for Model State Drug Laws
National Alliance for the Mentally Ill
National Alliance of Methadone Advocates
National Alliance of State Drug Enforcement Agencies
National Alliance of State Territorial AIDS Directors
National Asian Pacific American Families Against Substance Abuse (NAPAFASA)
National Asian Women's Health Organization
National Assembly of Voluntary Health and Social Welfare Associations
National Association for Children of Alcoholics (NACOA)
National Association for Family and Community Education
National Association for Native American Children of Alcoholics
National Association for the Advancement of Colored People
National Association of Addiction Treatment Providers
National Association of Alcoholism and Drug Abuse Counselors
National Association of Asian Pacific Islanders
National Association of Biology Teachers
National Association of Black Law Enforcement
National Association of Blacks in Criminal Justice
National Association of Black Psychologists
National Association of Chain Drug Stores
National Association of Chiefs of Police Organizations
National Association of Community Health Centers, Inc.
National Association of Counties
National Association of County and City Health Officials
National Association of County Behavioral Health Directors
National Association of Drug Court Professionals
National Association of Elementary School Principals

National Association of Governor's Councils on Physical Fitness and Sports
National Association of Managed Care Physicians
National Association of Manufacturers
National Association of Municipalities
National Association of Native American Children of Alcoholics (NANACOA)
National Association of Neighborhoods
National Association of People with AIDS
National Association of Police Organizations
National Association of Prenatal Addiction Research
National Association of Prevention Professionals and Advocates, Inc. (NAPPA)
National Association of Protection and Advocacy Systems
National Association of Psychiatric Health Systems
National Association of Regional Councils
National Association of School Nurses
National Association of Secondary School Principals
National Association of Social Workers
National Association of State Alcohol and Drug Abuse Directors
National Black Alcoholism and Addiction Council
National Black Caucus of Local Elected Officials
National Black Caucus of State Legislators
National Black Child Development Institute, Inc.
National Black Police Association
National Black Prosecutors
National Caucus of Hispanic School Board Members
National Center for Missing and Exploited Children
National Center for State Courts
National Center for Tobacco-Free Kids
National Coalition for the Homeless
National Coalition of Hispanic Health and Human Services Organizations (COSSMHO)
National Coalition of State Alcohol and Drug Abuse Directors
National Collegiate Athletic Association
National Committee for the Furtherance of Jewish Education
National Committee to Prevent Child Abuse
National Conference of Christians and Jews
National Conference of Puerto Rican Women
National Conference of State Legislators
National Congress of Parents and Teachers
National Consortium of TASC Programs
National Consumers League
National Council for Community Behavioral Healthcare
National Council of Catholic Men
National Council of Catholic Women
National Council of Churches
National Council of Jewish Women
National Council of Juvenile and Family Court Judges
National Council of La Raza
National Council of Negro Women
National Council on Alcoholism and Drug Dependence
National Council on Disability
National Council on Patient Information and Education
National Crime Prevention Council
National Criminal Justice Association
National District Attorneys Association
National Drug Court Institute
National Drug Prevention League
National Drug Strategy Network
National Education Association
National Exchange Club
National Families in Action
National Family Partnership
National Federation of Independent Businesses
National Federation of Parents for Drug-Free Youth
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National Hispanic Radio
National Inhalant Prevention Coalition
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National Institute of Citizen Anti-Drug Policy
National Jewish Community Relations Advisory Council
National Latino Children's Institute
National League of Cities
National League of Counties
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National Masonic Foundation for Children
National Medical Association
National Mental Health Association
National Minority Health Association
National Narcotics Officers' Associations Coalition
National Network of Runaway and Youth Services
National Nurses Society on Addiction
National Opinion Research Center
National Organization of Black County Officials
National Organization of Black Law Enforcement Executives
National Organization on Fetal Alcohol Syndrome
National Panhellenic Conference
National Parents and Teachers Association
National Pharmaceutical Association
National Pharmaceutical Council, Inc.
National Prevention Network
National Puerto Rican Coalition
National Recreation and Parks Association
National Rural Alcohol and Drug Abuse Network
National Rural Health Association
National School Boards Association
National Sheriffs Association
National Strategy Center
National Telemedia Council
National Treatment Accountability for Safer Communities
National Treatment Consortium
National Troopers Coalition
National Urban Coalition
National Wellness Association
National Wholesale Druggists Association
National Women's Health Resource Center
Neighborhood Drug Crisis Center
New York Hospital Cornell Medical Center
New York University Medical Center
Nonprescription Drug Manufacturers Association
North American Conference of Grand Masters
Northwest Center for Health and Safety
Odyssey House
One Church - One Addict
Operation PAR, Inc.
Optimist International
Organization of American States
Organization of Chinese Americans, Inc.
Orthodox Union
Parents Collaborative
Parents' Resource Institute for Drug Education, Inc. (PRIDE)
PAR, Inc.
Partners in Drug Abuse Rehabilitation Counseling
Partnership for a Drug-Free America
Patrician Movement
Pediatric AIDS Foundation
Penn State University
Pharmaceutical Research and Manufacturers of America

Phoenix House
Physicians for Prevention (PFP)
Physicians Leadership on National Drug Policy
Pilot International
Points of Light Foundation
Police Executive Research Forum
Police Foundation
Presbyterian Women-Presbyterian Church USA
Pretrial Services Resource Center
Prevention, Intervention and Treatment Coalition for Health (PITCH)
Professional Actors Guild
Professional Directors Guild
Professional Writers Guild
Public Agenda, Inc.
Public Relations Society of America
Quota International
RAND Corporation
Religious Action Center
Resource Center on Substance Abuse Prevention and Disability
Robert Wood Johnson Foundation
Rotary International
Ruritan National
Safe Streets
San Diego World Affairs Council
San Francisco AIDS Foundation
Scott Newman Center
Sertoma International
Siouxland Cares
Society for Applied Anthropology
Society for Neuroscience
Society for the Advancement of Women's Health Research
Society for Prevention Research
Society for Research in Child Development
Sons and Daughters in Touch
Soroptimist International of the Americas
Southern Christian Leadership Conference
State Justice Institute
Student National Medical Association
Students Against Destructive Decisions (SADD)
Substance Abuse Foundation for Education and Research (SAFER)
Substance Abuse Program Administrators Association (SAPAA)
Support Center for Alcohol and Drug Research and Education
Temple University, Department of Pharmacology, College on Problems of Drug Dependence
Texans' War on Drugs
Texas A&M University - Department of Marketing
The Center for Drug Free Living, Inc.
The Church of Jesus Christ of Latter-Day Saints
The LINKS, Inc.
The Matrix Institute on Addictions
The North American Committee
The Recovery Network
The Robert Wood Johnson Foundation
The Salvation Army
The Village, Inc.
Therapeutic Communities of America
Town Hall of Los Angeles
Travelers Aid International
Treatment Accountability for Safer Communities
Treatment Alternatives for Safe Communities (TASC)
Troy Michigan Communities Coalition
Twentieth Century Fund
Two Hundred Club of Greater Miami
U.S. Chamber of Commerce
U.S. Conference of Mayors
U.S. Hispanic Chamber of Commerce
U.S. Olympic Committee Union of American Hebrew Congregations
United Church of Christ
United Methodist Association of Health and Welfare
United Methodist Church, Central Pennsylvania Conference
United National Indian Tribal Youth, Inc.
United Nations Economic and Social Council
United Nations International Drug Control Programme
United States Catholic Conference
United States Conference of Mayors
United Synagogue of Conservative Judaism
United Way of America
University of California, Los Angeles
Drug Abuse Research Group
Graduate School of Management
Neuropsychiatric Group
University of Delaware, Division of Criminal Justice
University of Kentucky
Center for Prevention Research and
Department of Communication
University of Maryland, Center for Substance Abuse Research (CESAR)
University of Michigan Survey Research Center
University of Nebraska Medical Center
University of North Carolina, Department of Curriculum and Instruction
University of Pennsylvania
Health System
Treatment Research Center
University of Southern California, Center for Prevention Policy Research
University of Washington, College of Education and Alcohol and Drug Abuse Institute
Urban Institute
Urban League
Veterans of Foreign Wars
Virginia Association of Alcoholism and Drug Abuse Counselors
Visiting Nurses Association of America
Washington Business Group on Health
Washington Office on Latin America
Wellness Council of America
World Affairs Council of San Diego
World Affairs Council of Washington, D.C.
Yale University School of Medicine
Yerkes Regional Primate Research Center, Emory University
YMCA of the USA
YWCA of the USA
Youth Service America
Youth to Youth
Zeta Phi Beta, Inc.
Zonta International

Appendix: Drug-Related Data

Up-to-date information on the availability and prevalence of illegal drugs and the criminal, health, and social consequences of their use is vital to the implementation of the *National Drug Control Strategy*. Such information is also important for measuring the effectiveness of Federal, state, and local drug-control programs. The Office of National Drug Control Policy's (ONDCP) Advisory Committee on Research, Data, and Evaluation coordinates the development and analysis of drug-control information in support of the *Strategy*. The Office of National Drug Control Policy Reauthorization Act of 1998 defines ONDCP's reporting requirements to include "an assessment of current drug use (including inhalants) and availability, impact of drug use, and treatment availability." The legislation specifies that this assessment shall include the following:

(i) Estimates of drug prevalence and frequency of use as measured by national, State, and local surveys of illicit drug use and by other special studies of:

- — casual and chronic drug use;
- — high-risk populations, including school dropouts, the homeless and transient, arrestees, parolees, probationers, and juvenile delinquents; and
- — drug use in the workplace and the productivity lost by such use;

(ii) An assessment of the reduction of drug availability against an ascertained baseline, as measured by:

- — the quantities of cocaine, heroin, marijuana, methamphetamine, and other drugs available for consumption in the United States;
- — the amount of marijuana, cocaine, heroin, and precursor chemicals entering the United States;
- — the number of hectares of marijuana, poppy, and coca cultivated and destroyed domestically and in other countries;
- — the number of metric tons of marijuana, heroin, cocaine, and methamphetamine seized;
- — the number of cocaine and methamphetamine processing laboratories destroyed domestically and in other countries;
- — changes in the price and purity of heroin and cocaine, changes in the price of methamphetamine, and changes in tetrahydrocannabinol level of marijuana;
- — the amount and type of controlled substances diverted from legitimate retail and wholesale sources; and
- — the effectiveness of Federal technology programs at improving drug detection capabilities in interdiction, and at United States ports of entry;

(iii) An assessment of the reduction of the consequences of drug use and availability, which shall include estimation of:

- — the burden drug users placed on hospital emergency departments in the United States, such as the quantity of drug-related services provided;
- — the annual national health care costs of drug use, including costs associated with people becoming infected with the human immunodeficiency virus and other infectious diseases as a result of drug use;

— the extent of drug-related crime and criminal activity; and

— the contribution of drugs to the underground economy, as measured by the retail value of drugs sold in the United States;

(iv) A determination of the status of drug treatment in the United States, by assessing:

— public and private treatment capacity within each State, including information on the treatment capacity available in relation to the capacity actually used;

— the extent, within each State, to which treatment is available;

— the number of drug users the Director estimates could benefit from treatment; and

— the specific factors that restrict the availability of treatment services to those seeking it and proposed administrative or legislative remedies to make treatment available to those individuals; and

— a review of the research agenda of the Counter-Drug Technology Assessment Center to reduce the availability and abuse of drugs.

Data are available for many of the areas listed above; however, there are specific areas for which measurement systems are not yet fully operational. The tables presented in this appendix contain the most current drug-related data on the areas the 1998 ONDCP Reauthorization Act requires ONDCP to assess.

Data Source Descriptions

The following sections provide brief descriptions of the major data sources used to develop this appendix.

What America's Users Spend on Illegal Drugs: 1988–1995 (Source for Tables 1, 3, and 28)

This report estimates total U.S. expenditures on illicit drugs based on available drug supply and demand data. Data are provided on estimated numbers of users, yearly and weekly expenditures for drugs, trends in drug supply, and retail prices of drugs. The report was written for ONDCP by Abt Associates, Inc., in 1993 and was updated in 1995 and in 1997.

National Household Survey on Drug Abuse (Source for Table 2)

The National Household Survey on Drug Abuse (NHSDA) measures the prevalence of drug and alcohol use among household members aged 12 and older. Topics include drug use, health, and demographics. In 1991 the NHSDA was expanded to include college students in dormitories, persons living in homeless shelters, and civilians living on military bases. The NHSDA was administered by the National Institute on Drug Abuse (NIDA) from 1974 through 1991; the Substance Abuse and Mental Health Services Administration (SAMHSA) has administered the survey since 1992.

Monitoring the Future: A Continuing Study of the Lifestyles and Values of Youth (Source for Tables 4 and 5)

Often referred to as the "High School Senior Survey," the *Monitoring the Future* (MTF) study provides information on drug use trends as well as changes in values, behaviors, and lifestyle orientations of American youth. The study examines drug-related issues, including recency of drug use, perceived harmfulness of drugs, disapproval of drug use, and perceived availability of drugs. Although the focus of the MTF study has been high school seniors and graduates who complete followup surveys, 8th and 10th graders were added to the study sample in 1991. The study has been conducted under a grant from NIDA by the University of Michigan since 1975.

Youth Risk Behavior Survey (Source for Tables 5, 6, 7, 8, 9, and 18)

The Youth Risk Behavior Survey (YRBS) is a component of the Youth Risk Behavior Surveillance System (YRBSS), maintained by the Centers for Disease Control and Prevention. The YRBSS currently has the following three complementary components: (1) national school-based surveys, (2) state and local school-based surveys, and (3) a national household-based survey. Each of these components provides unique information about various subpopulations of adolescents in the United States. The school-based survey was initiated in 1990, and the household-based survey was conducted in 1992. The school-based survey is conducted biennially in odd-numbered years among national probability samples of 9th through

12th graders from public and private schools. Schools with a large proportion of black and Hispanic students are over sampled to provide stable estimates for these subgroups. The 1992 Youth Risk Behavior Supplement was administered to one in-school youth and up to two out-of-school youth in each family selected for the National Health Interview Survey. In 1992, 10,645 youth aged 12 to 21 were included in the YRBS sample. The purpose of the supplement was to provide information on a broader base of youth, including those not currently attending school, than usually is obtained with surveys and to obtain accurate information on the demographic characteristics of the household in which the youth reside.

PRIDE USA Survey (Source for Table 10)

The National Parent's Resource Institute for Drug Education (PRIDE) conducts an annual survey of drug use by middle school and high school students. The PRIDE survey collects data from students in 6th through 12th grades and is conducted during the school year between September and June. Participating schools are sent the questionnaires with detailed instructions for administering the anonymous, self-report instrument. Schools participate on a voluntary basis or in compliance with a school or state request. The study conducted during the 1997–98 school year involved approximately 150,000 students in 28 states.

Arrestee Drug Abuse Monitoring/Drug Use Forecasting Program (Source for Tables 11 through 16)

The National Institute of Justice established the Drug Use Forecasting (DUF) program in 1987 to provide an objective assessment of the drug problem among those arrested and charged with crimes. In 1997 this program became the Arrestee Drug Abuse Monitoring (ADAM) program. The ADAM program collected data in 23 major metropolitan sites across the United States. Arrestees are interviewed and asked to provide urine specimens that are tested for evidence of drug use. Urinalysis results can be matched to arrestee characteristics to help monitor trends in drug use. The sample size of the dataset varies to some extent from site to site. Generally, each site collects quarterly data from 200 to 250 adult male arrestees, 100 to 150 female arrestees, 100 to 150 juvenile male arrestees (at 12 sites), and a smaller sample of female juvenile arrestees (at 8 sites). Together, the 1997 data comprised 19,736 adult male arrestees, 7,547 adult female arrestees, and a smaller sample of juvenile arrestees. The ADAM system is expanding to more cities in the coming years.

Current Population Survey (Source for Table 17)

As mandated by the U.S. Constitution, Article 1, Section 2, the U.S. Bureau of the Census has conducted a census every 10 years since 1790. The primary purpose of the census is to provide population counts needed to apportion seats in the U.S. House of Representatives and subsequently determine state legislative district boundaries. The information collected also provides insight on population size and a broad range of demographic background information on the population living in each geographic area. The individual information in the census is grouped together into statistical totals. Information such as the number of persons in a given area, their ages, educational background, and the characteristics of their housing enable government, business, and industry to plan more effectively.

The Monetary Value of Saving a High-Risk Youth (Source for Tables 19 and 20)

Based on estimates of the social costs associated with the typical career criminal, the typical drug user, and the typical high school dropout, this study calculates the average monetary value of saving a high-risk youth. The base data for establishing the estimates are derived from other studies and official crime data that provide information on numbers and types of crimes committed by career criminals, as well as the costs associated with these crimes and with drug abuse and dropping out of school.

Drug Abuse Warning Network (Source for Table 22)

The Drug Abuse Warning Network (DAWN) provides data on drug-related emergency department episodes and medical examiner cases. DAWN assists federal, state, and local drug policy makers to examine drug use patterns and trends and assess health hazards associated with drug abuse. Data are available on deaths and emergency department episodes by type of drug, reason for taking the drug, demographic characteristics of the user, and metropolitan area.

NIDA maintained DAWN from 1982 through 1991; SAMHSA has maintained it since 1992.

Uniform Crime Reports (Source for Table 23)

The Uniform Crime Reports (UCR) is a nationwide census of thousands of city, county, and state law enforcement agencies. The goal of the UCR is to count in a standardized manner the number of offenses, arrests, and clearances known to police. Each law enforcement agency voluntarily reports data on crimes. Data are reported for the following nine index offenses: murder and manslaughter, forcible rape, robbery, aggravated assault, burglary, larceny, theft, motor vehicle theft, and arson. Data on drug arrests, including arrests for possession, sale, and manufacturing of drugs, are included in the database. Distributions of arrests for drug abuse violations by demographics and geographic areas also are available. UCR data have been collected since 1930; the FBI has collected data under a revised system since 1991.

Survey of Inmates of Local Jails (Source for Table 24)

The Survey of Inmates of Local Jails provides nationally representative data on inmates held in local jails, including those awaiting trials or transfers and those serving sentences. Survey topics include inmate characteristics, offense histories, drug use, and drug treatment. This survey has been conducted by the Bureau of Justice Statistics (BJS) every 5 to 6 years since 1972.

Survey of Inmates in Federal Correctional Facilities and Survey of Inmates in State Correctional Facilities (Source for Table 24)

The Survey of Inmates in Federal Correctional Facilities (SIFCF) and Survey of Inmates in State Correctional Facilities (SISCF) provide comprehensive background data on inmates in federal and state correctional facilities, based on confidential interviews with a sample of inmates. Topics include current offenses and sentences, criminal histories, family and personal backgrounds, gun possession and use, prior alcohol and drug treatment, and educational programs and other services provided in prison. The SIFCF and SISCF were sponsored jointly in 1991 by the BJS and the Bureau of Prisons and conducted by the Census Bureau. Similar surveys of state prison inmates were conducted in 1974, 1979, and 1986. In 1997 the Surveys of Inmates in State and Federal Correctional Facilities (SISFCF) was conducted.

National Prisoner Statistics Program (Source for Table 24)

The National Prisoner Statistics Program provides an advance count of federal, state, and local prisoners immediately after the end of each calendar year, with a final count published by the BJS later in the year.

Uniform Facility Data Set/National Drug and Alcoholism Treatment Unit Survey (Source for Tables 25 and 26)

The Uniform Facility Data Set (UFDS) measures the location, scope, and characteristics of drug abuse and alcoholism treatment facilities throughout the United States. The survey collects data on unit ownership, type, and scope of services provided; sources of funding; number of clients; treatment capacities; and utilization rates. Data are reported for a point prevalence date in the fall of the year in which the survey is administered. Many questions focus on the 12 months prior to that date. The UFDS, then called the National Drug and Alcoholism Treatment Unit Survey (NDATUS), was administered jointly by NIDA and the National Institute of Alcohol Abuse and Alcoholism from 1974 to 1991. Since 1992 SAMHSA has administered UFDS.

National Drug Treatment Requirements (Source for Table 27)

The U.S. Department of Health and Human Services (HHS) is mandated by Congress to report to the Office of Management and Budget on its goals for enrolling drug abusers in treatment facilities and the progress it has made in achieving those goals. HHS provides data on the estimated number of clients who receive treatment, as well as persons who need treatment but are not in treatment.

System To Retrieve Information From Drug Evidence (Source for Table 29)

The System To Retrieve Information From Drug Evidence (STRIDE) compiles data on illegal substances purchased, seized, or acquired in DEA investigations. Data are gathered on the type of drug seized or bought, drug purity, location of confiscation, street price of the drug, and other characteristics. Data

on drug exhibits from the FBI; the Metropolitan Police Department of the District of Columbia; and some exhibits submitted by other federal, state, and local agencies also are included in STRIDE. STRIDE data have been compiled by DEA since 1971.

Federal-Wide Drug Seizure System (Source for Table 30)

The Federal-Wide Drug Seizure System (FDSS) is an online computerized system that stores information about drug seizures made within the jurisdiction of the United States by the DEA, FBI, Customs Service, and Coast Guard. The FDSS database includes drug seizures by other Federal agencies (e.g., the Immigration and Naturalization Service) to the extent that custody of the drug evidence was transferred to one of the four agencies identified above. The database includes information from STRIDE, the Customs Law Enforcement Activity Report, and the U.S. Coast Guard's Law Enforcement Information System. The FDSS has been maintained by the DEA since 1988.

International Narcotics Control Strategy Report (Source for Table 33)

The International Narcotics Control Strategy Report (INCSR) provides the President with information on the steps taken by the main illicit drug-producing and transiting countries to prevent drug production, trafficking, and related money laundering during the previous year. The INCSR helps determine how cooperative a country has been in meeting legislative requirements in various narcotics control areas. Production estimates by source country also are provided. The INCSR has been prepared by the U.S. Department of State since 1989.

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Drug User Expenditures

Table 1. Total U.S. Expenditures on Illicit Drugs, 1988–95 ($ billions)

Year	Cocaine	Heroin	Marijuana	Other drugs	Total
1988	$61.2	$17.7	$9.1	$3.3	$91.4
1989	56.7	16.8	10.9	2.8	87.2
1990	51.5	14.3	11.0	2.2	79.0
1991	45.9	11.9	10.7	2.3	70.7
1992	41.7	10.2	11.5	2.0	65.4
1993	40.3	9.8	8.8	1.5	60.4
1994	37.4	9.3	8.2	2.6	57.5
1995	38.0	9.6	7.0	2.7	57.3

Note: Amounts are in constant 1995 dollars.

Source: Office of National Drug Control Policy. 1997. *What America's Users Spend on Illegal Drugs, 1988–1995.* Washington, DC: U.S. Government Printing Office.

Drug Use

Table 2. Trends in Selected Drug Use Indicators, 1979–97 (in millions of users)

Selected drug use indicators	Any illicit drug use[1]	Current cocaine use[1]	Occasional (less than monthly) cocaine use	Current marijuana use[1]	Lifetime heroin use	Any adolescent[2] illicit drug use[1]
1979	25.4	4.7	—	23.8	2.3	4.1
1982	—	4.5	—	21.5	1.8	2.8
1985	23.3	5.7	7.1	18.6	1.8	3.2
1988	15.2	3.1	5.1	12.4	1.7	1.9
1990	13.5	1.7	3.7	10.9	1.5	1.6
1991	13.4	2.0	3.8	10.4	2.4	1.4
1992	12.0	1.4	3.0	9.7	1.7	1.3
1993	12.3	1.4	2.7	9.6	2.1	1.4
1994	12.6	1.4	2.4	10.1	2.1	1.8
1995	12.8	1.5	2.5	9.8	2.5	2.4
1996	13.0	1.7	2.6	10.1	2.4	2.0
1997	13.9	1.5	2.6	11.1	2.0	2.6

— Data not available.

[1] Data are for past month (current) use.

[2] Ages 12 to 17 years.

Note: Any illicit drug use includes use of marijuana, cocaine, hallucinogens, inhalants, (except in 1982), heroin, or nonmedical use of sedatives, tranquilizers, stimulants, or analgesics. The exclusion of inhalants in 1982 is believed to have resulted in under estimates of any illicit use for that year, especially for adolescents.

Source: National Household Survey on Drug Abuse, National Institute on Drug Abuse (1979–91), and Substance Abuse and Mental Health Services Administration (1992–97).

Table 3. Estimated Number of Hardcore and Occasional Users of Cocaine and Heroin (thousands), 1988–95

Year	Cocaine users		Heroin users	
	Occasional[1]	Hardcore[2]	Occasional[1]	Hardcore[2]
1988	6,000	4,100	170	880
1989	5,300	3,900	150	880
1990	4,600	3700	140	780
1991	4,500	3500	170	730
1992	3,500	3500	210	690
1993	3,300	3600	200	790
1994	2,900	3600	210	800
1995	3,100	3600	320	810

Note: Data in this table are preliminary composite estimates derived from the National Household Survey on Drug Abuse (NHSDA) and the Drug Use Forecasting (DUF) program (see W. Rhodes "Synthetic Estimation Applied to the Prevalence of Drug Use," *Journal of Drug Issues,* 23(2):297–321, 1993 for a detailed description of the methodology). The NHSDA was not administered in 1989. Estimates for 1989 are the average for 1988 and 1989.

[1] "Occasional" means used less often than weekly.

[2] "Hardcore" means used at least weekly.

Source: Office of National Drug Control Policy. 1997. *What America's Users Spend on Illegal Drugs, 1988–1995.* Washington, DC: U.S. Government Printing Office.

Table 4. Trends in 30-Day Prevalence of Selected Drugs Among 8th, 10th, and 12th Graders, 1991–98

Selected drug/grade	30-Day prevalence								
	1991	1992	1993	1994	1995	1996	1997	1998	1997–98 Change
Marijuana/hashish									
8th grade	3.2	3.7	5.1	7.8	9.1	11.3	10.2	9.7	–0.5
10th grade	8.7	8.1	10.9	15.8	17.2	20.4	20.5	18.7	–1.8*
12th grade	13.8	11.9	15.5	19.0	21.2	21.9	23.7	22.8	–0.9
Inhalants[1, 2]									
8th grade	4.4	4.7	5.4	5.6	6.1	5.8	5.6	4.8	–0.8*
10th grade	2.7	2.7	3.3	3.6	3.5	3.3	3.0	2.9	–0.1
12th grade	2.4	2.3	2.5	2.7	3.2	2.5	2.5	2.3	–0.2
Hallucinogens[3]									
8th grade	0.8	1.1	1.2	1.3	1.7	1.9	1.8	1.4	–0.4
10th grade	1.6	1.8	1.9	2.4	3.3	2.8	3.3	3.2	–0.1
12th grade	2.2	2.1	2.7	3.1	4.4	3.5	3.9	2.8	–0.1
LSD									
8th grade	0.6	0.9	1.0	1.1	1.4	1.5	1.5	1.1	–0.4*
10th grade	1.5	1.6	1.6	2.0	3.0	2.4	2.8	2.7	–0.1
12th grade	1.9	2.0	2.4	2.6	4.0	2.5	3.1	3.2	+0.1
Cocaine									
8th grade	0.5	0.7	0.7	1.0	1.2	1.3	1.1	1.4	+0.3
10th grade	0.7	0.7	0.9	1.2	1.7	1.7	2.0	2.1	+0.1
12th grade	1.4	1.3	1.3	1.5	1.8	2.0	2.3	2.4	+0.1
Stimulants									
8th grade	2.6	3.3	3.6	3.6	4.2	4.6	3.8	3.3	–0.5
10th grade	3.3	3.6	4.3	4.5	5.3	5.5	5.1	5.1	0.0
12th grade	3.2	2.8	3.7	4.0	4.0	4.1	4.8	4.6	–0.2
Alcohol (any use)[4]									
8th grade	25.1	26.1	24.3	25.5	24.6	26.2	24.5	23.0	–1.5
10th grade	42.8	39.9	38.2	39.2	38.8	40.4	40.1	38.8	–1.3
12th grade	54.0	51.3	48.6	50.1	51.3	50.8	52.7	52.0	–0.7

* = 0.05 level of significance of 1997–98 difference. Any apparent inconsistency between the 1997–98 change estimate and the respective prevalence estimates is due to rounding error.

Approximate weighted N's	1991	1992	1993	1994	1995	1996	1997	1998
8th grade	17,500	18,600	18,300	17,300	17,500	17,800	18,600	18,100
10th grade	14,800	14,800	15,300	15,800	17,000	15,600	15,500	15,000
12th grade	15,000	15,800	16,300	15,400	15,400	14,300	15,400	15,200

[1] For 12th graders only: Data based on five of six questionnaire forms; N is five-sixths of N indicated.

[2] Unadjusted for underreporting of amyl and butyl nitrites.

[3] Unadjusted for underreporting of PCP (phencyclidine).

[4] For all grades: In 1993, the question text was changed slightly in one-half of the forms to indicate that a "drink" meant "more than a few sips." In 1993, N is one-half of N indicated for all groups. Data after 1993 were based on all forms for all grades.

Source: Monitoring the Future study, Institute for Social Research, University of Michigan (December 1998).

Table 5. Trends in Harmfulness of Drugs as Perceived by 8th, 10th, and 12th Graders, 1991–98

Drug	Percentage saying "great risk"[1]								
	1991	1992	1993	1994	1995	1996	1997	1998	1997–98 Change
8th grade									
How much do you think people risk harming themselves (physically or in other ways), if they . . .									
• Try marijuana once or twice	40.4	39.1	36.2	31.6	28.9	27.9	25.3	28.1	+2.8**
• Smoke marijuana occasionally	57.9	56.3	53.8	48.6	45.9	44.3	43.1	45.0	+1.9*
• Smoke marijuana regularly	83.8	82.0	79.6	74.3	73.0	70.9	72.7	73.0	+0.3
• Try crack once or twice[2]	62.8	61.2	57.2	54.4	50.8	51.0	49.9	49.3	–0.6
• Take crack occasionally[2]	82.2	79.6	76.8	74.4	72.1	71.6	71.2	70.6	–0.6
• Try cocaine powder once or twice[2]	55.5	54.1	50.7	48.4	44.9	45.2	45.0	44.0	–1.0
• Take cocaine powder occasionally[2]	77.0	74.3	71.8	69.1	66.4	65.7	65.8	65.2	–0.6
Approximate N	17,437	18,662	18,366	17,394	17,501	17,926	18,765	18,100	
10th grade									
How much do you think people risk harming themselves (physically or in other ways), if they . . .									
• Try marijuana once or twice	30.0	31.9	29.7	24.4	21.5	20.0	18.8	19.6	+0.8
• Smoke marijuana occasionally	48.6	48.9	46.1	38.9	35.4	32.8	31.9	32.5	+0.6
• Smoke marijuana regularly	82.1	81.1	78.5	71.3	67.9	65.9	65.9	65.8	–0.1
• Try crack once or twice	70.4	69.6	66.6	64.7	60.9	60.9	59.2	58.0	–1.2
• Take crack occasionally	87.4	86.4	84.4	83.1	81.2	80.3	78.7	77.5	–1.2
• Try cocaine powder once or twice	59.1	59.2	57.5	56.4	53.5	53.6	52.2	50.9	–1.3
• Take cocaine powder occasionally	82.2	80.1	79.1	77.8	75.6	75.0	73.9	71.8	–2.1*
Approximate N	14,719	14,808	15,298	15,880	17,006	15,670	15,640	15,000	
12th grade									
How much do you think people risk harming themselves (physically or in other ways), if they . . .									
• Try marijuana once or twice	27.1	24.5	21.9	19.5	16.3	15.6	14.9	16.7	+1.8
• Smoke marijuana occasionally	40.6	39.6	35.6	30.1	25.6	25.9	24.7	24.4	–0.3
• Smoke marijuana regularly	78.6	76.5	72.5	65.0	60.8	59.9	58.1	58.5	+0.4
• Try crack once or twice	60.6	62.4	57.6	58.4	54.6	56.0	54.0	52.2	–1.8
• Take crack occasionally	76.5	76.3	73.9	73.8	72.8	71.4	70.3	68.7	–1.6
• Try cocaine powder once or twice	53.6	57.1	53.2	55.4	52.0	53.2	51.4	48.5	–2.9
• Take cocaine powder occasionally	69.8	70.8	68.6	70.6	69.1	68.8	67.7	65.4	–2.3
Approximate N	2,549	2,684	2,759	2,591	2,603	2,449	2,579	2,500	

Note: * = 0.05 level of significance of difference and ** = 0.001 level of significance of 1997–98 difference. Any apparent inconsistency between the 1997–98 change estimate and the respective prevalence estimates is due to rounding error.

[1] Answer alternatives were: (1) no risk, (2) slight risk, (3) moderate risk, (4) great risk, and (5) can't say, drug unfamiliar.

[2] 8th and 10th grade: Beginning in 1997, data based on two-thirds of N indicated due to changes in questionnaire forms.

Source: Monitoring the Future study, Institute for Social Research, University of Michigan (December 1998).

Table 6. Percentage of High School Students Who Used Selected Drugs by Sex and Grade, 1990, 1991, 1993, 1995, and 1997

Behavior and grade	Both sexes					Male					Female				
	1990	1991	1993	1995	1997	1990	1991	1993	1995	1997	1990	1991	1993	1995	1997
Lifetime marijuana use															
9th	20.6	—	24.4	33.8	38.8	—	—	28.8	38.9	41.3	—	—	19.7	27.9	36.1
10th	27.9	—	28.8	41.4	45.9	—	—	30.9	43.2	48.1	—	—	26.7	39.5	43.3
11th	34.7	—	36.0	45.8	50.3	—	—	40.8	48.0	55.6	—	—	30.8	43.6	43.8
12th	42.2	—	40.8	47.0	52.4	—	—	45.5	50.4	56.1	—	—	35.8	43.8	47.7
All grades	31.4	31.0	32.8	42.4	47.1	35.9	33.0	36.8	46.2	50.7	27.0	30.0	28.6	39.4	42.9
Current marijuana use[1]															
9th	9.5	—	13.2	20.9	23.6	—	—	16.3	23.9	26.8	—	—	9.7	17.3	20.1
10th	13.5	—	16.5	25.6	25.0	—	—	18.2	28.2	28.5	—	—	14.7	22.6	20.9
11th	13.9	—	18.4	27.6	29.3	—	—	22.1	30.1	34.7	—	—	14.4	25.1	22.9
12th	18.5	—	22.0	26.2	26.6	—	—	25.0	30.8	30.3	—	—	18.9	21.6	21.9
All grades	13.9	15.0	17.7	25.3	26.2	16.9	17.0	20.6	28.4	30.2	11.1	12.0	14.6	22.0	21.4
Lifetime cocaine use[2]															
9th	3.6	—	4.2	5.7	6.7	—	—	4.6	7.2	6.6	—	—	3.8	3.9	6.8
10th	5.8	—	3.7	7.5	7.5	—	—	3.9	8.5	8.5	—	—	3.5	6.4	6.3
11th	7.6	—	5.1	7.2	9.1	—	—	5.5	9.4	10.1	—	—	4.5	4.8	7.9
12th	9.3	—	6.1	7.4	9.2	—	—	7.5	10.0	10.5	—	—	4.6	4.9	7.6
All grades	6.6	6.0	4.9	7.0	8.2	8.1	7.0	5.5	8.8	9.1	5.2	4.0	4.2	5.0	7.2
Current cocaine use[1]															
9th	1.0	—	1.6	3.1	3.9	—	—	2.2	4.8	4.1	—	—	1.0	1.2	3.6
10th	2.4	—	1.4	2.5	2.6	—	—	1.7	2.2	3.6	—	—	1.0	2.9	1.5
11th	2.5	—	2.1	3.6	3.1	—	—	2.4	5.3	3.7	—	—	1.7	1.8	2.2
12th	2.3	—	2.1	3.1	3.5	—	—	2.5	4.9	4.5	—	—	1.6	1.3	2.2
All grades	2.1	2.0	1.9	3.1	3.3	3.3	2.0	2.3	4.3	4.0	1.0	1.0	1.4	1.8	2.4
Lifetime crack or freebase use															
9th	—	—	2.7	4.7	5.1	—	—	2.7	6.1	5.7	—	—	2.7	3.1	4.5
10th	—	—	2.3	4.9	4.3	—	—	2.1	5.4	4.2	—	—	2.5	4.3	4.4
11th	—	—	2.7	4.4	4.8	—	—	3.1	5.8	5.6	—	—	2.1	2.8	3.9
12th	—	—	2.6	4.2	4.7	—	—	3.6	5.1	5.2	—	—	1.6	3.4	4.0
All grades	—	—	2.6	4.5	4.7	—	—	3.0	5.6	5.2	—	—	2.2	3.4	4.2
Lifetime use of illegal steroids															
9th	—	—	2.1	4.1	4.3	—	—	2.7	4.7	4.7	—	—	1.4	3.4	3.9
10th	—	—	2.0	3.6	3.0	—	—	2.4	4.2	4.1	—	—	1.6	3.1	1.7
11th	—	—	2.2	3.9	2.7	—	—	3.2	5.5	4.2	—	—	1.0	2.2	0.9
12th	—	—	2.3	2.9	2.5	—	—	3.5	4.8	3.3	—	—	1.0	1.0	1.4
All grades	—	3.0	2.2	3.7	3.1	—	4.0	3.1	4.9	4.1	—	1.0	1.2	2.4	2.0
Lifetime injected drug use															
9th	—	—	1.4	2.8	3.0	—	—	1.9	3.8	3.3	—		0.8	1.6	2.5
10th	—	—	1.4	2.2	2.5	—	—	1.5	2.7	2.7	—	—	1.4	1.7	2.2
11th	—	—	1.3	1.7	1.6	—	—	1.9	2.8	2.4	—	—	0.6	0.5	0.7
12th	—	—	1.2	1.6	1.5	—	—	1.9	2.8	2.0	—	—	0.4	0.4	0.8
All grades	—	—	1.4	2.0	2.1	—	—	1.9	3.0	2.6	—	—	0.8	1.0	1.5
Episodic heavy drinking[3]															
9th	27.7	—	22.0	24.5	25.7	—	—	24.0	27.6	25.5	—	—	19.7	20.2	25.8
10th	35.7	—	26.2	30.3	29.9	—	—	27.2	32.1	32.7	—	—	25.3	28.3	26.3
11th	39.6	—	31.3	34.9	37.5	—	—	37.1	37.8	45.2	—	—	25.1	31.8	28.2
12th	44.0	—	39.1	39.0	39.3	—	—	45.0	46.5	44.0	—	—	33.0	31.6	33.6
All grades	36.9	31.0	30.0	32.6	33.4	43.5	36.0	33.7	36.2	37.3	30.4	26.0	26.0	28.6	28.6

— Data not available.

[1] Used one or more times during the last 30 days.

[2] Ever tried any form of cocaine, including powder, crack, or freebase.

[3] Drank 5 or more drinks of alcohol on at least one occasion on 1 or more days during the last 30 days.

Source: *Morbidity and Mortality Weekly Report*, "Tobacco, Alcohol and Other Drug Use Among High School Students—United States," 40, no. 45 (1990): 776–84, 41, no. 37 (1991): 698–703; *Morbidity and Mortality Weekly Report*, "Youth Risk Behavior Surveillance—United States (1993, 1995, and 1997)," Centers for Disease Control and Prevention, Public Health Service, Department of Health and Human Services.

Table 7. Percentage of High School Students Who Used Selected Drugs by Race/Ethnicity, 1993, 1995, and 1997

Behavior and race/ethnicity	Both sexes			Male			Female		
	1993	1995	1997	1993	1995	1997	1993	1995	1997
Lifetime marijuana use									
White, non-Hispanic	32.7	40.5	45.4	36.0	42.7	48.3	29.3	38.1	41.9
Black, non-Hispanic	33.6	47.2	52.2	41.1	54.2	59.3	26.3	42.0	45.4
Hispanic	35.4	49.2	49.5	41.5	53.2	54.7	29.5	46.4	43.2
All groups	32.8	42.4	47.1	36.8	46.2	50.7	28.6	39.4	42.9
Current marijuana use[1]									
White, non-Hispanic	17.3	24.6	25.0	19.7	26.8	28.0	14.7	22.1	21.2
Black, non-Hispanic	18.6	28.6	28.2	24.3	36.8	35.6	13.0	22.1	21.4
Hispanic	19.4	27.8	28.6	23.2	32.2	33.1	15.7	23.5	23.3
All groups	17.7	25.3	26.2	20.6	28.4	30.2	14.6	22.0	21.4
Lifetime cocaine use[2]									
White, non-Hispanic	4.6	6.5	8.0	5.3	8.2	8.5	3.9	4.6	7.5
Black, non-Hispanic	1.6	2.0	1.9	1.9	3.9	2.9	1.2	0.5	1.0
Hispanic	11.3	16.0	14.4	12.1	17.0	16.1	10.4	15.0	12.5
All groups	4.9	7.0	8.2	5.5	8.8	9.1	4.2	5.0	7.2
Current cocaine use[1]									
White, non-Hispanic	1.6	2.6	3.1	2.0	3.7	3.7	1.2	1.4	2.3
Black, non-Hispanic	1.0	1.3	0.7	1.5	2.7	1.2	0.5	0.2	0.2
Hispanic	4.6	7.5	6.2	6.2	9.3	6.9	3.0	5.8	5.3
All groups	1.9	3.1	3.3	2.3	4.3	4.0	1.4	1.8	2.4
Lifetime crack or freebase use									
White, non-Hispanic	2.3	4.2	4.5	2.6	5.4	4.7	2.0	2.9	4.3
Black, non-Hispanic	1.1	1.6	1.2	1.6	3.2	1.5	0.6	0.3	0.9
Hispanic	6.3	10.5	8.0	7.1	9.4	8.2	5.5	11.6	7.7
All groups	2.6	4.5	4.7	3.0	5.6	5.2	2.2	3.4	4.2
Lifetime use of illegal steroids									
White, non-Hispanic	1.9	3.8	3.1	2.8	5.3	3.9	1.0	2.2	2.0
Black, non-Hispanic	2.4	1.6	1.5	4.0	2.4	2.3	0.8	0.9	0.7
Hispanic	3.0	4.7	3.4	3.4	4.1	3.9	2.6	5.3	2.8
All groups	2.2	3.7	3.1	3.1	4.9	4.1	1.2	2.4	2.0
Lifetime injected drug use									
White, non-Hispanic	1.3	2.0	1.8	1.8	2.8	2.2	0.7	1.1	1.3
Black, non-Hispanic	0.9	1.1	1.0	1.4	2.1	1.6	0.4	0.3	0.4
Hispanic	1.5	2.2	2.2	1.8	3.5	2.9	1.1	0.9	1.3
All groups	1.4	2.0	2.1	1.9	3.0	2.6	0.8	1.0	1.5
Episodic heavy drinking[3]									
White, non-Hispanic	32.6	35.6	37.7	35.6	38.6	41.6	29.3	32.2	32.9
Black, non-Hispanic	19.1	18.8	16.1	25.1	24.9	21.0	13.3	13.0	11.5
Hispanic	33.4	37.7	34.9	39.4	39.4	40.0	27.6	36.1	26.8
All groups	30.0	32.6	33.4	33.7	36.2	37.3	26.0	28.6	28.6

[1] Used one or more times during the last 30 days.

[2] Ever tried any form of cocaine, including powder, crack, or freebase.

[3] Drank 5 or more drinks of alcohol on at least one occasion on 1 or more days during the last 30 days.

Source: *Morbidity and Mortality Weekly Report*, "Youth Risk Behavior Surveillance—United States (1993, 1995, and 1997)," Centers for Disease Control and Prevention, Public Health Service, Department of Health and Human Services.

Table 8. Percentage of High School Students Who Reported Engaging in Drug-Related Behaviors on School Property, by Sex and Grade, 1993, 1995, and 1997

Behavior and grade	Both Sexes			Male			Female		
	1993	1995	1997	1993	1995	1997	1993	1995	1997
Used marijuana on school property[1]									
9th	4.4	8.7	8.1	5.9	11.2	9.6	2.8	5.8	6.5
10th	6.5	9.8	6.4	9.2	12.9	8.2	3.6	6.6	4.2
11th	6.5	8.6	7.9	8.7	12.0	10.2	4.0	4.9	5.2
12th	5.1	8.0	5.7	7.3	11.2	8.2	2.7	4.7	2.6
All grades	5.6	8.8	7.0	7.8	11.9	9.0	3.3	5.5	4.6
Offered, sold, or were given an illegal drug on school property[2]									
9th	21.8	31.0	31.4	24.6	35.8	34.5	18.4	24.9	28.0
10th	23.7	35.0	33.4	27.9	43.0	40.0	19.2	26.4	25.3
11th	27.5	32.8	33.2	32.9	39.8	38.8	21.7	25.3	26.4
12th	23.0	29.1	29.0	28.2	36.2	36.4	17.5	22.0	19.6
All grades	24.0	32.1	31.7	28.5	38.8	37.4	19.1	24.8	24.7
Tried marijuana before age 13									
9th	–	9.2	14.9	–	12.0	18.9	–	5.9	10.6
10th	–	9.1	10.4	–	12.1	12.2	–	5.9	8.3
11th	–	6.7	8.3	–	8.6	11.3	–	4.7	4.6
12th	–	5.4	5.8	–	8.0	7.6	–	2.8	3.6
All grades	–	7.6	9.7	–	10.2	12.2	–	4.8	6.7
Tried cocaine before age 13[3]									
9th	–	1.3	1.8	–	1.8	1.9	–	0.6	1.8
10th	–	1.3	1.3	–	1.8	1.3	–	0.7	1.3
11th	–	1.4	1.0	–	2.4	1.7	–	0.3	0.3
12th	–	0.9	0.3	–	1.3	0.5	–	0.5	0.2
All grades	–	1.2	1.1	–	1.8	1.3	–	0.5	0.8

– Data not available.

[1] One or more times during the 30 days preceding the survey.

[2] During the 12 months preceding the survey.

[3] Including powder, crack, and freebase forms of cocaine.

Source: *Morbidity and Mortality Weekly Report*, "Youth Risk Behavior Surveillance—United States (1993, 1995, and 1997)," Centers for Disease Control and Prevention, Public Health Service, Department of Health and Human Services.

Table 9. Percentage of High School Students Who Reported Engaging in Drug-Related Behaviors, by Sex and Race/Ethnicity, 1993, 1995, and 1997

Behavior and race/ethnicity	Both Sexes			Male			Female		
	1993	1995	1997	1993	1995	1997	1993	1995	1997
Used marijuana on school property[1]									
White, non-Hispanic	5.0	7.0	5.8	7.1	9.7	7.3	2.8	4.0	3.9
Black, non-Hispanic	7.3	12.3	9.1	10.1	17.6	13.0	4.5	8.1	5.4
Hispanic	7.5	12.9	10.4	10.0	17.6	14.1	4.9	8.3	5.9
All groups	5.6	8.8	7.0	7.8	11.9	9.0	3.3	5.5	4.6
Offered, sold, or were given an illegal drug on school property[2]									
White, non-Hispanic	24.1	31.7	31.0	28.8	38.8	36.1	18.9	23.5	24.5
Black, non-Hispanic	17.5	28.5	25.4	20.3	35.3	34.6	14.8	22.5	16.7
Hispanic	34.1	40.7	41.1	41.5	46.7	46.8	26.8	34.9	34.4
All groups	24.0	32.1	31.7	28.5	38.8	37.4	19.1	24.8	24.7
Tried marijuana before age 13									
White, non-Hispanic	–	5.6	7.5	–	7.8	9.0	–	3.2	5.6
Black, non-Hispanic	–	11.1	11.0	–	16.5	15.6	–	6.7	6.5
Hispanic	–	12.6	13.2	–	16.5	17.2	–	8.8	8.3
All groups	–	7.6	9.7	–	10.2	12.2	–	4.8	6.7
Tried cocaine before age 13[3]									
White, non-Hispanic	–	0.9	0.9	–	1.4	1.1	–	0.4	0.7
Black, non-Hispanic	–	1.3	0.4	–	2.4	0.7	–	0.3	0.1
Hispanic	–	1.7	1.4	–	2.0	1.8	–	1.3	1.0
All groups	–	1.2	1.1	–	1.8	1.3	–	0.5	0.8

– Data not available.

[1] Used marijuana one or more times during the last 30 days.

[2] During the past 12 months.

[3] Including powder, crack, and freebase forms of cocaine.

Source: *Morbidity and Mortality Weekly Report*, "Youth Risk Behavior Surveillance—United States (1993, 1995, and 1997)," Centers for Disease Control and Prevention, Public Health Service, Department of Health and Human Services.

Table 10. Prevalence of Drug Use Among 6th–8th, 9th–12th, and 12th graders, 1994–95, 1995–96, 1996–97, and 1997–98

	Annual use					Monthly use				
	1994–95	1995–96	1996–97	1997–98	Change*	1994–95	1995–96	1996–97	1997–98	Change*
Cigarettes										
6th–8th	28.1	31.1	31.8	29.4	–2.4*	15.7	17.2	17.3	15.6	–1.7*
9th–12th	44.4	48.2	50.2	48.9	–1.3*	31.3	33.4	34.7	33.9	–0.8*
12th	46.8	50.0	52.4	54.0	+1.6	34.6	36.2	38.3	40.7	+2.4*
Beer										
6th–8th	30.8	33.1	33.2	30.3	–2.9*	11.8	12.5	12.1	10.7	–1.4*
9th–12th	57.4	59.1	59.6	57.0	–2.6*	33.3	34.3	34.4	31.9	–2.5*
12th	64.0	64.9	65.3	64.5	–0.8	40.6	41.2	41.7	41.0	–0.7
Wine coolers										
6th–8th	29.8	33.2	33.6	31.6	–2.0*	9.8	10.8	10.8	9.9	–0.9*
9th–12th	51.7	52.6	52.9	51.5	–1.4*	23.1	22.3	22.3	21.4	–0.9*
12th	56.5	54.5	55.4	54.9	–0.5	25.6	22.9	23.7	23.9	+0.2
Liquor										
6th–8th	21.3	22.9	23.7	21.0	–2.7*	8.5	9.0	9.1	8.0	–1.1*
9th–12th	51.5	53.4	54.9	52.1	–2.8*	27.4	28.2	28.7	26.9	–1.8*
12th	59.5	59.9	62.3	61.8	–0.5	32.5	32.8	34.0	34.1	+0.1
Marijuana										
6th–8th	9.5	13.6	14.7	12.5	–2.2*	5.7	8.1	8.6	7.1	–1.5*
9th–12th	28.2	34.0	35.8	33.4	–2.4*	18.5	22.3	22.7	20.8	–1.9*
12th	33.2	37.9	39.4	38.6	–0.8	20.9	24.3	24.4	23.6	–0.8
Cocaine										
6th–8th	1.9	2.7	3.0	2.8	–0.2*	1.2	1.5	1.7	1.6	–0.1*
9th–12th	4.5	5.6	5.9	6.0	+0.1	2.6	2.9	3.0	3.1	+0.1
12th	5.3	7.1	7.0	7.9	+0.9*	2.9	3.6	3.6	4.0	+0.4*
Uppers										
6th–8th	3.3	4.6	4.9	4.7	–0.2*	2.0	2.4	2.6	2.5	–0.1
9th–12th	9.3	10.5	10.3	10.4	+0.1	5.1	5.2	5.3	5.4	+0.1
12th	10.6	11.6	10.7	11.8	+1.1*	5.6	5.8	5.6	6.3	+0.7*
Downers										
6th–8th	2.4	3.5	4.0	3.6	–0.4*	1.5	1.9	2.1	1.9	–0.2*
9th–12th	5.5	7.1	7.2	7.7	+0.5*	3.4	3.8	3.8	4.2	+0.4*
12th	5.9	7.4	7.4	8.6	+1.2*	3.6	4.1	3.9	4.9	+1.0*
Inhalants										
6th–8th	6.3	8.5	8.9	8.1	–0.8*	2.9	3.5	3.7	3.3	–0.4*
9th–12th	7.5	7.6	7.1	7.1	0.0	3.5	3.4	3.1	3.1	0.0
12th	6.6	6.6	5.8	5.8	0.0	3.0	3.1	2.7	2.8	+0.1
Hallucinogens										
6th–8th	2.4	3.3	3.6	3.2	–0.4*	1.5	1.8	2.0	1.8	–0.2*
9th–12th	7.7	9.5	9.5	8.7	–0.8*	4.1	4.5	4.2	3.9	–0.3*
12th	9.7	12.1	11.7	11.3	–0.4	4.8	5.1	4.6	4.5	–0.1

* Level of significance of difference between the 1996–97 and 1997–98 surveys, s = 0.05, using chi-square with variables year and use/no use.

	Sample sizes			
Grade	1994–95	1995–96	1996–97	1997–98
6th–8th	92,453	58,596	68,071	68,149
9th–12th	105,788	70,964	73,006	86,201
12th	20,698	14,261	15,532	15,816

Source: PRIDE Questionnaire Report, 1994–95, 1995–96, 1996–97, and 1997–98.

Table 11. Percentage[1] of Adult Booked Arrestees Who Used Any Drug,[2] by Sex: 1991–97

	Males							Females						
	1991	1992	1993	1994	1995	1996	1997	1991	1992	1993	1994	1995	1996	1997
Atlanta	63	69	72	69	74	80	72	70	65	74	72	68	77	74
Birmingham	63	64	68	69	73	70	67	62	59	55	63	57	59	67
Chicago	74	69	81	79	79	82	80	—	—	—	—	—	—	—
Cleveland	56	64	64	66	65	67	64	79	74	77	82	71	70	57
Dallas	56	59	62	57	60	63	63	56	66	61	63	58	58	53
Denver	50	60	64	67	66	71	71	54	61	66	68	66	69	69
Detroit	55	58	63	66	67	66	62	68	72	76	62	78	69	69
Ft. Lauderdale	61	64	61	58	58	67	73	64	62	60	62	60	66	68
Houston	65	59	59	48	58	64	63	59	54	53	48	50	54	45
Indianapolis	45	52	60	69	64	74	63	54	50	58	69	72	72	67
Los Angeles	62	67	66	66	62	64	59	75	72	77	72	68	78	70
Manhattan	73	77	78	82	83	78	79	77	85	83	90	84	83	81
Miami	68	68	70	66	57	67	61	—	—	—	—	—	—	—
New Orleans	59	60	62	63	66	67	67	50	52	47	32	50	35	40
Omaha	36	48	54	59	54	63	62	—	—	—	58	56	51	54
Philadelphia	74	78	76	76	76	69	67	75	78	79	76	77	81	75
Phoenix	42	47	62	65	63	59	64	61	63	62	67	63	65	66
Portland	61	60	63	65	65	66	71	68	73	74	74	68	74	78
St. Louis	59	64	68	74	77	75	74	54	70	69	76	69	73	70
San Antonio	49	54	55	52	51	57	52	45	44	42	39	41	44	37
San Diego	75	77	78	79	72	71	73	73	72	78	76	73	62	73
San Jose	58	50	54	55	52	48	51	52	56	51	61	50	53	53
Wash., DC	59	60	60	64	64	66	69	75	72	71	67	65	58	57

— Data not available.

[1] Percent positive by urinalysis, January through December of each year. Percentages are rounded.

[2] "Any drug" includes cocaine, opiates, PCP, marijuana, amphetamines, methadone, methaqualone, benzodiazepines, barbiturates, and propoxyphene.

Source: 1991–1996 data from "Drug Use Forecasting" (1991–1996); 1997 data from "1997 Annual Report on Adult and Juvenile Arrestees," Arrestee Drug Abuse Monitoring Program, National Institute of Justice.

Table 12. Percentage[1] of Adult Booked Arrestees Who Used Marijuana, by Sex: 1991–97

	Males							Females						
	1991	1992	1993	1994	1995	1996	1997	1991	1992	1993	1994	1995	1996	1997
Atlanta	12	22	26	25	32	37	36	8	13	16	15	13	26	28
Birmingham	16	22	28	28	36	44	43	10	13	12	17	12	22	25
Chicago	23	26	40	38	41	47	48	—	—	—	—	—	—	—
Cleveland	12	17	23	28	29	37	46	7	11	13	16	11	22	22
Dallas	19	28	28	33	37	44	44	11	24	19	22	21	44	28
Denver	25	34	36	39	33	42	42	16	19	24	22	21	27	32
Detroit	18	27	37	38	42	46	44	4	11	10	16	18	19	28
Ft. Lauderdale	28	32	30	29	33	38	38	14	21	20	18	18	24	24
Houston	17	24	24	23	29	33	24	8	12	15	13	18	26	17
Indianapolis	23	35	42	39	38	51	44	22	26	25	22	24	31	30
Los Angeles	19	23	23	20	23	30	27	9	13	15	12	14	38	18
Manhattan	18	22	21	24	28	38	32	11	12	19	15	16	19	25
Miami	23	30	26	28	29	34	32	—	—	—	—	—	—	—
New Orleans	16	19	25	28	32	40	38	7	8	14	7	16	13	12
Omaha	26	38	42	44	42	52	33	—	—	—	28	24	33	33
Philadelphia	18	26	32	32	34	39	41	14	15	20	18	20	21	21
Phoenix	22	22	31	29	29	28	30	14	15	20	22	19	22	21
Portland	33	28	30	27	29	35	38	28	17	17	19	16	26	19
St. Louis	16	21	28	36	39	52	48	8	11	15	15	18	29	31
San Antonio	20	28	32	30	34	39	34	9	16	16	15	16	19	17
San Diego	33	35	40	36	35	40	38	20	25	25	20	20	23	24
San Jose	25	24	27	30	27	27	29	13	18	17	18	12	19	17
Wash., DC	11	20	26	30	32	40	39	6	8	9	10	18	23	19

— Data not available.

[1] Percent positive by urinalysis, January through December of each year. Percentages are rounded.

Source: 1991–1996 data from "Drug Use Forecasting" (1991–1996); 1997 data from "1997 Annual Report on Adult and Juvenile Arrestees," Arrestee Drug Abuse Monitoring Program, National Institute of Justice.

Table 13. Percentage[1] of Adult Booked Arrestees Who Used Cocaine, by Sex: 1991–97

	Males							Females						
	1991	1992	1993	1994	1995	1996	1997	1991	1992	1993	1994	1995	1996	1997
Atlanta	57	58	59	57	57	59	51	66	58	68	62	62	63	61
Birmingham	52	49	51	50	49	43	39	44	46	41	50	48	39	49
Chicago	61	56	53	57	51	52	49	—	—	—	—	—	—	—
Cleveland	48	53	48	48	42	41	27	76	66	69	74	63	52	39
Dallas	43	41	44	35	31	32	32	45	48	43	46	44	36	34
Denver	30	38	41	40	44	44	40	41	50	47	51	52	53	50
Detroit	41	37	34	34	30	27	23	62	62	64	46	61	53	48
Ft. Lauderdale	44	46	43	41	39	44	51	55	47	45	52	50	52	57
Houston	56	41	41	29	40	39	40	52	44	43	36	32	34	29
Indianapolis	22	23	32	47	39	42	31	26	25	36	56	54	52	45
Los Angeles	44	52	48	48	44	44	38	62	58	59	53	49	56	49
Manhattan	62	62	66	68	68	56	58	66	72	70	80	71	69	62
Miami	61	56	61	56	42	52	46	—	—	—	—	—	—	—
New Orleans	50	49	48	47	47	46	46	42	44	37	25	37	26	32
Omaha	14	16	19	26	19	24	21	—	—	—	34	30	28	17
Philadelphia	62	63	56	54	51	40	34	64	67	61	61	59	69	58
Phoenix	20	26	30	28	27	32	32	45	49	38	36	33	42	33
Portland	30	35	33	32	30	34	37	40	54	47	43	40	46	45
St. Louis	48	50	50	50	51	43	41	47	62	62	69	57	55	53
San Antonio	31	32	31	31	24	28	26	25	25	24	22	24	23	18
San Diego	45	45	37	30	28	27	21	40	37	36	18	28	22	23
San Jose	33	28	23	19	18	16	14	30	32	19	23	16	21	16
Wash., DC	49	44	37	38	35	33	33	68	64	62	55	46	40	39

— Data not available.

[1] Percent positive by urinalysis, January through December of each year. Percentages are rounded.

Source: 1991–1996 data from "Drug Use Forecasting" (1991–1996); 1997 data from "1997 Annual Report on Adult and Juvenile Arrestees," Arrestee Drug Abuse Monitoring Program, National Institute of Justice.

Table 14. Percentage[1] of Adult Booked Arrestees Who Used Opiates, by Sex: 1991–97

	Males							Females						
	1991	1992	1993	1994	1995	1996	1997	1991	1992	1993	1994	1995	1996	1997
Atlanta	3	4	3	2	3	3	2	4	5	4	4	3	3	3
Birmingham	5	3	4	4	2	4	5	11	4	4	3	3	6	5
Chicago	21	19	28	27	22	20	22	—	—	—	—	—	—	—
Cleveland	3	3	4	3	5	3	4	6	5	4	4	6	6	4
Dallas	4	4	4	3	5	5	4	9	8	10	7	5	5	5
Denver	2	2	4	4	5	5	4	2	5	6	5	6	5	6
Detroit	8	8	8	7	7	7	5	11	15	14	13	15	18	9
Ft. Lauderdale	1	1	1	1	2	2	3	4	3	3	3	3	3	4
Houston	3	3	2	3	5	8	10	4	4	4	6	3	4	5
Indianapolis	3	4	4	3	2	3	3	11	7	4	5	7	3	3
Los Angeles	10	10	9	10	7	6	6	18	13	14	12	10	17	11
Manhattan	14	18	20	19	20	17	19	21	24	23	30	19	27	20
Miami	2	2	2	2	3	1	2	—	—	—	—	—	—	—
New Orleans	4	4	5	5	7	7	11	7	6	5	2	4	3	3
Omaha	2	2	2	2	1	1	2	—	—	—	2	2	3	4
Philadelphia	11	12	11	14	12	11	11	9	11	14	18	14	16	16
Phoenix	5	5	6	6	8	9	9	17	15	14	12	12	13	8
Portland	9	11	11	12	15	13	14	17	22	19	21	18	26	27
St. Louis	6	7	9	11	11	10	10	7	7	16	8	8	7	9
San Antonio	16	15	14	13	10	10	10	21	14	14	14	13	13	9
San Diego	17	16	16	12	8	9	7	21	17	20	13	12	10	12
San Jose	8	4	6	6	5	5	6	7	9	8	10	10	9	12
Wash., DC	10	11	10	9	8	9	10	16	19	21	13	16	11	11

— Data not available.

[1] Percent positive by urinalysis, January through December of each year. Percentages are rounded.

Source: 1991–1996 data from "Drug Use Forecasting" (1991–1996); 1997 data from "1997 Annual Report on Adult and Juvenile Arrestees," Arrestee Drug Abuse Monitoring Program, National Institute of Justice.

Table 15. Percentage[1] of Adult Booked Arrestees Who Used Methamphetamine, by Sex: 1991–97

	Males							Females						
	1991	1992	1993	1994	1995	1996	1997	1991	1992	1993	1994	1995	1996	1997
Atlanta	0.2	0.1	0.4	0.1	0.4	—	0.6	0.3	0.0	0.3	0.3	0.6	—	0.7
Birmingham	0.1	0.0	0.0	0.2	0.1	—	0.6	0.3	0.0	1.2	1.2	0.0	—	0.5
Chicago	0.0	0.0	0.0	0.1	0.0	—	0.3	—	—	—	—	—	—	—
Cleveland	0.0	0.0	0.0	0.0	0.0	—	0.0	0.3	0.0	0.0	0.0	0.0	—	0.0
Dallas	0.6	0.9	2.0	2.0	2.2	—	2.6	1.5	2.7	3.3	3.3	3.7	—	2.8
Denver	0.8	1.0	1.2	2.1	4.1	—	5.0	1.7	1.4	2.1	2.1	3.2	—	4.6
Detroit	0.1	0.0	0.0	0.0	0.0	—	0.0	0.0	0.0	0.0	0.0	0.6	—	0.0
Ft. Lauderdale	0.0	0.0	0.0	0.0	0.1	—	0.1	0.0	0.0	0.2	0.2	0.0	—	0.0
Houston	0.1	0.1	0.1	0.0	0.1	—	0.0	0.9	0.0	0.2	0.2	0.9	—	0.5
Indianapolis	0.0	0.1	0.2	0.4	0.8	—	0.2	0.3	0.0	0.6	0.6	0.0	—	0.2
Los Angeles	5.4	4.8	8.2	7.7	5.8	—	4.7	6.8	8.0	9.8	9.8	11.3	—	8.9
Manhattan	0.2	0.0	0.1	0.3	0.0	—	0.0	0.0	0.0	0.0	0.0	0.2	—	0.0
Miami	0.0	0.0	0.0	0.0	0.0	—	0.0	—	—	—	—	—	—	—
New Orleans	0.2	0.2	0.0	0.1	0.0	—	0.0	0.3	0.5	0.5	0.5	0.0	—	0.0
Omaha	0.1	0.5	1.4	3.3	7.8	—	9.7	—	—	2.7	2.7	10.3	—	13.3
Philadelphia	0.5	0.5	0.4	0.1	0.4	—	0.6	0.2	0.4	0.7	0.7	1.1	—	0.0
Phoenix	4.5	5.1	15.6	25.4	22.0	—	16.4	5.6	6.9	26.0	26.0	21.7	—	25.6
Portland	7.5	5.9	11.3	16.3	18.1	—	15.9	11.5	7.3	21.4	21.4	19.7	—	20.7
St. Louis	0.2	0.1	0.0	0.5	0.6	—	0.4	0.0	0.0	0.0	0.0	0.3	—	2.1
San Antonio	1.3	0.8	0.6	1.0	1.1	—	1.7	1.6	1.6	0.7	0.7	2.5	—	2.4
San Diego	18.0	23.7	35.5	41.0	36.0	—	39.6	24.9	25.5	53.0	53.0	40.2	—	42.2
San Jose	6.6	5.9	15.3	19.9	16.3	—	18.4	7.1	11.3	23.3	23.3	23.6	—	24.9
Wash., DC	0.1	0.0	0.1	0.1	0.1	—	0.3	0.0	0.0	0.0	0.0	0.0	—	0.0

— Data not available.

[1] Percent positive by urinalysis, January through December of each year. Percentages are rounded.

Source: 1991–1996 data from "Drug Use Forecasting" (1991–1996); 1997 data from "1997 Annual Report on Adult and Juvenile Arrestees," Arrestee Drug Abuse Monitoring Program, National Institute of Justice.

Table 16. Percentage of Juvenile Male Booked Arrestees Who Used Selected Drugs,[1] 1994–97

	Any drug use[2]				Marijuana use				Cocaine use				Opiate use				Methamphetamine use			
	1994	1995	1996	1997	1994	1995	1996	1997	1994	1995	1996	1997	1994	1995	1996	1997	1994	1995	1996	1997
Birmingham	38	44	55	63	34	42	53	61	6	6	9	8	2	1	2	2	—	—	—	2.1
Cleveland	47	53	63	61	42	47	62	58	17	17	12	12	*	0	*	2	—	—	—	0.0
Denver	54	51	61	65	52	49	60	62	10	8	7	8	*	*	*	0	—	—	—	1.2
Indianapolis	30	34	44	42	26	33	43	39	8	5	6	3	1	*	*	1	—	—	—	0.2
Los Angeles	37	42	57	62	31	34	51	55	8	12	13	12	*	1	1	1	—	—	—	6.5
Phoenix	51	48	56	56	41	41	52	49	11	8	13	14	0	1	1	1	—	—	—	6.5
Portland	23	19	38	43	18	16	36	41	3	2	3	4	*	*	*	1	—	—	—	2.5
St. Louis	38	38	56	54	34	34	56	54	10	5	4	4	2	2	0	1	—	—	—	0.0
San Antonio	39	44	50	58	35	41	48	53	9	6	10	15	1	*	4	3	—	—	—	0.3
San Diego	42	53	53	63	33	48	48	53	2	4	5	4	1	1	1	2	—	—	—	17.2
San Jose	35	35	46	52	28	31	41	45	5	4	4	4	*	*	*	0	—	—	—	13.7
Wash., DC	64	58	67	66	61	54	65	65	9	4	4	4	*	1	*	0	—	—	—	0.0

— Data not available.

* Less than one percent.

[1] Percent positive by urinalysis, January through December of each year. Percentages are rounded.

[2] "Any drug" includes cocaine, opiates, PCP, marijuana, amphetamines, methadone, methaqualone, benzodiazepines, barbiturates, and propoxyphene.

Sources: "Annual Report on Adult and Juvenile Arrestees." 1997. Arrestee Drug Abuse Monitoring (ADAM) Research Report, National Institute of Justice; "Annual Report on Adult and Juvenile Arrestees." 1994, 1995, and 1996. Drug Use Forecasting (DUF) Research Report, National Institute of Justice.

Table 17. Dropout Rates for Persons 18 to 24 Years Old by Sex and Race/Ethnicity, 1980–96

	All races, both sexes			All races, male			All races, female			White, both sexes			White, male			White, female		
	All persons	High school dropouts		All persons	High school dropouts		All persons	High school dropouts		All persons	High school dropouts		All persons	High school dropouts		All persons	High school dropouts	
		Number	Rate		Number	Rate		Number	Rate		Number	Rate		Number	Rate		Number	Rate
1996	24,671	3,147	12.8	12,285	1,628	13.2	12,386	1,519	12.3	19,676	2,458	12.5	9,897	1,275	12.9	9,778	1,182	12.1
1995	24,900	3,471	13.9	12,351	1,791	14.5	12,548	1,679	13.4	19,866	2,711	13.6	9,980	1,430	14.3	9,886	1,281	13.0
1994	25,254	3,365	13.3	12,557	1,804	14.4	12,696	1,561	12.3	20,171	2,553	12.7	10,123	1,377	13.6	10,048	1,175	11.7
1993	25,552	3,349	13.1	12,712	1,745	13.7	12,810	1,604	12.5	20,493	2,595	12.7	10,294	1,388	13.5	10,199	1,207	11.8
1992	24,278	3,083	12.7	11,965	1,617	13.5	12,313	1,466	11.9	19,671	2,398	12.2	9,744	1,300	13.3	9,928	1,098	11.1
1991	24,572	3,486	14.2	12,036	1,810	15.0	12,536	1,676	13.4	19,980	2,845	14.2	9,896	1,520	15.4	10,119	1,324	13.1
1990	24,852	3,379	13.6	12,134	1,689	13.9	12,718	1,690	13.3	20,393	2,751	13.5	10,053	1,430	14.2	10,340	1,322	12.8
1989	25,261	3,644	14.4	12,325	1,941	15.7	12,936	1,702	13.2	20,825	2,926	14.1	10,240	1,572	15.4	10,586	1,354	12.8
1988	25,733	3,749	14.6	12,491	1,950	15.6	13,242	1,799	13.5	21,261	3,012	14.2	10,380	1,594	15.4	10,881	1,418	13.0
1987	25,950	3,751	14.5	12,626	1,948	15.4	13,324	1,803	13.5	21,493	3,042	14.2	10,549	1,593	15.1	10,944	1,449	13.2
1986	26,512	3,664	13.8	12,921	1,937	15.0	13,591	1,741	12.8	22,008	2,974	13.5	10,803	1,581	14.6	11,205	1,393	12.4
1985	27,122	3,687	13.9	13,199	2,015	15.3	13,923	1,804	13.0	22,632	3,050	13.5	11,108	1,637	14.7	11,524	1,413	12.3
1984	28,031	4,142	14.8	13,744	2,184	15.9	14,287	1,958	13.7	23,347	3,281	14.1	11,521	1,744	15.1	11,826	1,535	13.0
1983	28,580	4,410	15.4	14,003	2,379	17.0	14,577	2,031	13.9	23,899	3,428	14.3	11,787	1,865	15.8	12,112	1,563	12.9
1982	28,846	4,500	15.6	14,083	2,329	16.5	14,763	2,171	14.7	24,206	3,523	14.6	11,874	1,810	15.2	12,332	1,713	13.0
1981	28,965	4,520	15.6	14,127	2,424	17.2	14,838	2,097	14.1	24,486	3,590	14.7	12,040	1,960	16.3	12,446	1,629	13.1
1980	28,957	4,515	15.6	14,107	2,390	16.9	14,851	2,124	14.3	24,482	3,525	14.4	12,011	1,883	15.7	12,471	1,642	13.2

	Black, both sexes			Black, male			Black, female			Hispanic origin,* both sexes			Hispanic origin,* male			Hispanic origin,* female		
	All persons	High school dropouts		All persons	High school dropouts		All persons	High school dropouts		All persons	High school dropouts		All persons	High school dropouts		All persons	High school dropouts	
		Number	Rate		Number	Rate		Number	Rate		Number	Rate		Number	Rate		Number	Rate
1996	3,637	581	16.0	1,682	292	17.4	1,956	288	14.7	3,510	1,210	34.5	1,815	657	36.2	1,694	554	32.7
1995	3,625	522	14.4	1,660	235	14.2	1,965	287	14.6	3,603	1,250	34.7	1,907	653	34.2	1,696	598	35.4
1994	3,661	568	15.5	1,733	303	17.5	1,928	265	13.7	3,523	1,224	34.7	1,896	685	36.1	1,628	539	33.1
1993	3,666	600	16.4	1,703	266	15.6	1,965	337	17.2	3,363	1,103	32.8	1,710	591	34.6	1,652	510	30.9
1992	3,521	575	16.3	1,676	259	15.5	1,845	315	17.1	2,754	936	33.9	1,384	531	38.4	1,369	405	29.6
1991	3,504	545	15.6	1,635	252	15.4	1,869	296	15.8	2,874	1,139	39.6	1,503	668	44.4	1,372	473	34.5
1990	3,520	530	15.1	1,634	223	13.6	1,886	306	16.2	2,749	1,025	37.3	1,403	559	39.8	1,346	455	34.5
1989	3,559	583	16.4	1,654	307	18.6	1,905	277	14.5	2,818	1,062	37.7	1,439	580	40.3	1,377	482	35.0
1988	3,568	631	17.7	1,653	312	18.9	1,915	318	16.6	2,642	1,046	39.6	1,375	553	40.2	1,267	492	38.8
1987	3,603	611	17.0	1,666	312	18.7	1,937	298	15.4	2,592	849	32.8	1,337	461	34.5	1,256	387	30.8
1986	3,665	605	16.6	1,687	300	17.8	1,966	311	15.8	2,514	864	34.4	1,339	500	37.4	1,175	365	31.1
1985	3,716	655	17.6	1,720	323	18.8	1,996	332	16.6	2,221	700	31.5	1,132	405	35.8	1,091	295	27.0
1984	3,862	712	18.4	1,811	362	20.2	2,052	349	17.0	2,018	691	34.2	956	338	35.4	1,061	353	33.2
1983	3,865	832	21.5	1,807	435	24.1	2,058	398	19.3	2,025	759	37.5	968	396	40.9	1,057	363	34.3
1982	3,872	851	22.0	1,786	458	25.6	2,086	393	18.8	2,001	740	37.0	944	347	36.8	1,056	393	37.2
1981	3,778	821	21.7	1,730	419	24.2	2,049	402	19.6	2,052	790	38.5	988	428	43.3	1,064	362	34.0
1980	3,721	876	23.5	1,690	440	26.0	2,031	436	21.5	2,033	820	40.3	1,012	431	42.6	1,021	389	38.1

Notes: Data for 1980 through 1992 use 1980 census-based population estimates; data for 1993 through 1996 use 1990 census-based population estimates; data for previous years are adjusted; numbers are in thousands.

* Persons of Hispanic origin may be of any race.

Source: U.S. Bureau of the Census, *Current Population Survey* (1980-1996).

Table 18. Prevalence of Past-Month Drug Use for Youth Ages 12–21, by Age, Dropout Status, Type of Drug Used, and Race/Ethnicity: 1992 Youth Risk Behavior Survey (in percentages)

Race/ethnicity	Age	Dropout status	Marijuana use past 30 days	Cocaine use past 30 days
White	12–15	Nondropout	4.02	0.34
		Dropout	4.12	*
	16–21	Nondropout	15.93	1.61
		Dropout	27.60	4.12
Black	12–15	Nondropout	1.21	—
		Dropout	16.21	—
	16–21	Nondropout	13.24	1.00
		Dropout	20.80	4.40
Hispanic	12–15	Nondropout	3.96	0.81
		Dropout	*	*
	16–21	Nondropout	14.92	2.89
		Dropout	11.56	2.83
Other	12–15	Nondropout	4.56	*
		Dropout	*	*
	16–21	Nondropout	5.85	*
		Dropout	*	—

* Low precision, no estimate reported.

— No respondents.

Source: National Health Interview Survey/Youth Risk Behavior Survey, Centers for Disease Control and Prevention, National Center for Health Statistics, 1992.

Table 19. The Lifetime Costs of Dropping Out of High School (1993 dollars)

	Total costs	Present value (2% discount rate)	Present value (10% discount rate)
Lost wage/productivity	$360,000	$186,500	$15,300
Fringe benefits	$90,000	$46,600	$3,800
Nonmarket losses	$113,000–450,000	$58,300–233,200	$4,900–19,200
Total	$563,000–900,000	$291,000–466,000	$24,000–38,300

Note: Numbers may not add due to rounding.

Source: Cohen, Mark. *The Monetary Value of Saving a High Risk Youth*, 1995.

Table 20. Summary of the Monetary Value of Saving a High-Risk Youth

	Total costs ($ thousands)	Present value with 2% discount rate ($ thousands)	Present value with 10% discount rate ($ thousands)
Career criminal	1,200–1,500	1,000–1,300	650–850
Heavy drug user	435–1,051	333–809	159–391
High school dropout	563–900	291–466	24–38
LESS duplication (crimes committed by heavy drug users)	(252–696)	(196–540)	(96–264)
Total	1,900–2,700	1,500–2,000	700–1,000

Note: Numbers may not add correctly due to rounding.

Source: Cohen, Mark. *The Monetary Value of Saving a High Risk Youth*, 1995.

DRUG USE CONSEQUENCES

Table 21. Number of Deaths and Death Rates for Drug-Induced Causes,[1] by Sex and Race: United States, 1979–96

Year	Both Sexes	Male	Female	White	All Non-White	Black[2]
		Number			Number	
1979	7,101	3,656	3,445	6,116	985	897
1980	6,900	3,771	3,129	5,814	1,086	1,006
1981	7,106	3,835	3,271	5,863	1,243	1,152
1982	7,310	4,130	3,180	5,991	1,319	1,212
1983	7,492	4,145	3,347	6,187	1,305	1,194
1984	7,892	4,640	3,252	6,309	1,583	1,480
1985	8,663	5,342	3,321	6,946	1,717	1,600
1986	9,976	6,284	3,692	7,948	2,028	1,906
1987	9,796	6,146	3,650	7,547	2,249	2,101
1988	10,917	7,004	3,913	8,409	2,508	2,395
1989	10,710	6,895	3,815	8,336	2,374	2,236
1990	9,463	5,897	3,566	7,603	1,860	1,703
1991	10,388	6,593	3,795	8,204	2,184	2,037
1992	11,703	7,766	3,937	9,360	2,343	2,148
1993	13,275	9,052	4,223	10,394	2,881	2,688
1994	13,923	9,491	4,432	10,895	3,028	2,780
1995	14,218	9,909	4,309	11,173	3,045	2,800
1996	14,843	10,093	4,750	11,903	2,940	2,682
		Rate per 100,000 population			Rate per 100,000 population	
1979	3.2	3.4	3.0	3.2	3.2	3.4
1980	3.0	3.4	2.7	3.0	3.4	3.8
1981	3.1	3.4	2.8	3.0	3.8	4.2
1982	3.2	3.7	2.7	3.0	3.9	4.4
1983	3.2	3.6	2.8	3.1	3.8	4.3
1984	3.3	4.0	2.7	3.1	4.5	5.2
1985	3.6	4.6	2.7	3.4	4.8	5.6
1986	4.2	5.4	3.0	3.9	5.5	6.6
1987	4.0	5.2	2.9	3.7	6.0	7.2
1988	4.5	5.9	3.1	4.1	6.5	8.1
1989	4.3	5.7	3.0	4.0	6.0	7.4
1990	3.8	4.9	2.8	3.6	4.6	5.6
1991	4.1	5.4	2.9	3.9	5.3	6.5
1992	4.6	6.2	3.0	4.4	5.6	6.8
1993	5.1	7.2	3.2	4.8	6.7	8.4
1994	5.3	7.5	3.3	5.0	6.9	8.5
1995	5.4	7.7	3.2	5.1	6.8	8.4
1996	5.6	7.8	3.5	5.4	6.5	8.0

1 Causes of death attributable to drug-induced mortality include ICD-9 No. 292, drug psychoses; No. 304, drug dependence; Nos. 305.2–305.9, nondependent use of drugs not including alcohol and tobacco; Nos. E850–E858, accidental poisoning by drugs, medicaments, and biologicals; Nos. E950.0–E950.5, suicide by drugs, medicaments, and biologicals; No. E962.0, assault from poising by drugs and medicaments; and Nos. E980.0–E980.5, poisoning by drugs, medicaments, and biologicals, undetermined whether accidentally or purposely inflicted. Drug-induced causes exclude accidents, homicides, and other causes indirectly related to drug use. Also excluded are newborn deaths associated with mother's drug use.

2 "Black" is a subgroup of "All Non-White."

Source: Peters, K.D., Kochanek, K.D., Murphy, S.L. "Deaths: Final Data for 1996." *National Vital Statistics Report*, Vol. 47, No. 9, Hyattsville, MD: National Center for Health Statistics, 1998.

Table 22. Trends in Drug-Related Emergency Room Episodes and Selected Drug Mentions, 1988–97

	Emergency room episodes and drug mentions				
	Total drug episodes (person cases)	Total drug mentions	Total cocaine mentions	Total heroin mentions	Total marijuana mentions
1988	403,578	668,153	101,578	38,063	19,962
1989	425,904	713,392	110,013	41,656	20,703
1990	371,208	635,460	80,355	33,884	15,706
1991	393,968	674,861	101,189	35,898	16,251
1992	433,493	751,731	119,843	48,003	23,997
1993	460,910	796,762	123,423	63,232	28,873
1994	518,521	900,317	142,878	64,013	40,183
1995	513,633	901,206	135,801	70,838	45,271
1996	514,347	907,561	152,433	73,846	53,789
1997	527,058	943,937	161,087	72,010	64,744

Source: Drug Abuse Warning Network, National Institute on Drug Abuse (1988–91) and Substance Abuse and Mental Health Services Administration (1992–97).

Table 23. Total Crime, Violent Crime, and Property Crime and Drug Arrests, 1989–97

	Total crime index	Total crime rate[1]	Violent crime index	Violent crime rate[1]	Total murder victims	Murders related to narcotic drug laws	Property crime	Property crime rate[1]	Arrests for drug abuse violations[2]
1989	14,251,400	5,741.0	1,646,040	663.1	21,500	1,402	12,605,400	5,077.9	1,361,700
1990	14,475,613	5,820.3	1,820,127	731.8	23,438	1,367	12,655,486	5,088.5	1,089,500
1991	14,872,883	5,897.8	1,911,767	758.1	24,703	1,353	12,961,116	5,139.7	1,010,000
1992	14,438,191	5,660.2	1,932,274	757.5	23,760	1,302	12,505,917	4,902.7	1,066,400
1993	14,144,794	5,484.4	1,926,017	746.8	24,526	1,295	12,218,777	4,737.6	1,126,300
1994	13,989,543	5,373.5	1,857,670	713.6	23,326	1,239	12,131,873	4,660.0	1,351,400
1995	13,862,727	5275.9	1,798,792	684.6	21,606	1,031	12,063,935	4,591.3	1,476,100
1996	13,493,863	5,086.6	1,688,540	636.5	19,645	843	11,805,323	4,450.1	1,506,200
1997	13,175,070	4,922.7	1,634,773	610.8	18,209	786	11,540,297	4,311.9	1,583,600

[1] Rates per 100,000 population.

[2] Arrests for drug abuse violations are total estimates from Section IV table entitled "Total Estimated Arrests, Unites States."

Source: *Crime in the United States: Uniform Crime Reports*, U.S. Department of Justice, Federal Bureau of Investigation (1990-98).

Table 24. Adults in Custody of State or Federal Prisons or Local Jails, 1989–97

	State prisons	Federal prisons	Total State and Federal prisons	Percent of prisoners who are drug offenders		Local jails
				Federal	State	
1989	629,995	53,387	683,382	49.9	19.1	395,553
1990	684,544	58,838	743,382	53.5	21.7	405,320
1991	728,605	63,930	792,535	55.9	21.3	426,479
1992	778,495	72,071	850,566	58.9	22.1	444,584
1993	828,566	80,815	909,381	59.2	22.1	459,804
1994	904,647	85,500	990,147	60.5	22.4	486,474
1995	989,004	89,538	1,078,542	59.9	22.7	507,044
1996	1,032,440	95,088	1,127,528	60.0	22.7	518,492
1997	1,059,588	99,175	1,158,763	62.6	20.7	567,079

Sources: Bureau of Justice Statistics Bulletin, *Prisoners in 1997* (August 1998). *Correctional Populations in the United States*, 1995; 1994; 1993; 1992; 1991; 1990; 1989. *Jails and Jail Inmates*, 1993–94. *Jail Inmates*, 1992; 1990. Data for 1997 percentages of drug offenders are estimated from Bureau of Justice Statistics Special Report, *Substance Abuse and Treatment, State and Federal Prisoners, 1997*. (January 1999).

DRUG TREATMENT

Table 25. One-Day Census of Clients in Treatment, by Facility Service Orientation, 1980–97

	Free standing substance abuse treatment	Mental health services	Physical health services	Other community services and settings	Correctional settings and services	Total
1980	250,378	106,157	57,365	62,860	12,143	488,903
1982	216,123	107,653	60,197	69,456	9,983	463,412
1984	346,980	139,411	107,167	63,426	13,303	670,279
1987	368,775	99,184	79,889	56,841	9,434	614,123
1989	455,970	120,063	81,063	73,663	14,196	734,955
1990	449,212	137,690	73,362	81,493	26,082	767,829
1991	493,967	140,895	71,004	66,683	39,270	811,819
1992	594,269	161,949	103,591	54,413	30,658	944,880
1993	565,293	150,519	94,368	95,682	37,368	944,208
1995	459,525	255,282	170,989	31,675	91,656	1,009,127
1996	514,265	189,853	120,015	38,382	77,626	940,141
1997	507,683	225,777	125,981	10,968	56,677	929,166

Source: Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *National Drug and Alcoholism Treatment Unit Survey (NDATUS) 1980-1993*; Uniform Facility Data Set Survey (UFDS), 1995-97.

Table 26. One-Day Census of Clients in Alcohol and/or Drug Abuse Treatment, by Age Group and Sex, 1980–97

	Age Group						Sex			
	20 years and under	21–44 years	45–64 years	65 years and over	Unknown	Total	Male	Female	Unknown	Total
1980	74,451	292,331	99,580	7,194	—	—	358,021	120,490	10,341	488,852
1982	63,115	289,935	89,274	6,734	—	449,058	337,245	113,407	12,760	463,412
1987	98,052	400,731	74,827	6,569	33,206	613,385	430,132	164,495	19,496	614,123
1989	114,818	474,210	82,191	7,134	56,602	734,955	494,095	207,510	33,350	734,955
1990	86,326	527,815	91,401	7,214	55,073	767,829	535,836	206,861	25,132	767,829
1991	82,242	553,067	95,598	7,464	73,448	811,819	562,388	213,681	35,750	811,819
1992	95,773	710,877	129,275	8,954	—	944,880	671,997	272,863	—	944,880
1993	105,359	697,735	131,352	9,762	—	944,208	663,968	280,240	—	944,208
1995	116,692	710,731	167,757	13,947	—	1,009,127	707,252	301,875	—	1,009,127
1996	—	—	145,819	15,443	—	940,141	640,369	299,772	—	940,141
1997	143,534	633,209	135,762	16,661	—	929,166	632,193	296,973	—	929,166

— Data not available.

Source: Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *National Drug and Alcoholism Treatment Unit Survey (NDATUS) 1980-1993*; Uniform Facility Data Set Survey (UFDS), 1995-97.

Table 27. Estimates of Number of Persons Needing and Receiving Treatment for Drug Abuse Problems, 1991–96

	Total drug abuse treatment need	Level 1*	Level 2*				
		Needs treatment	Needs treatment	Clients treated	Percent treated	Percent not treated	Treatment gap
1991	8,991	3,843	5,148	1,649	32	68	3,499
1992	8,599	3,881	4,718	1,814	38	62	2,904
1993	8,067	3,326	4,741	1,848	39	61	2,893
1994	8,329	3,719	4,610	1,984	43	57	2,626
1995	8,906	4,260	4,646	2,121	46	54	2,525
1996	9,383	4,080	5,303	1,973	37	63	3,330

* The need for treatment varies according to the severity of the problem. To reflect these differences, HHS divided those needing treatment into two categories, termed Level 1 and Level 2, based on intensity of drug use, symptoms, and consequences. The more severe category of need is Level 2, meaning the severity of symptoms make these users prime candidates for treatment. Level 2 users correspond to chronic, hardcore users discussed on the National Drug Control Strategy.

Note: Estimates for 1991–96 are ratio-adjusted to partially account for underestimation due to underreporting and undercoverage in the NHSDA. Estimates for 1991–93 are also adjusted for trend consistency to account for the change in the NHSDA questionnaire in 1994. Adjustment factors for trend consistency were 1.19020 for total treatment need and 1.21125 for Level 2 treatment need.

This methodology is currently being reviewed by an interagency working group. Treatment need is to be defined based on estimating those diagnosed with drug abuse or dependence according to DSM-IV criteria.

Source: Office of Applied Studies, SAMHSA. Unpublished data from the National Household Survey on Drug Abuse and Uniform Facility Data Set (1991–1996).

DRUG AVAILABILITY

Table 28. Trends in Cocaine Supply, 1989–95 (in metric tons)

	Cocaine HCl available for export from producing countries[1]	Cocaine destined for the United States	Foreign seizures of cocaine destined for the United States[2]	Cocaine shipped to the United States	Federal seizures[3]	Cocaine available for consumption in the United States	Retail value of cocaine in the United States (1996 dollars, billions)[4]
1989	709–842	603–716	56	547–660	115	432–545	$70–89
1990	714–851	595–709	86	509–624	96	413–528	$82–104
1991	777–931	635–760	96	539–664	128	412–532	$68–88
1992	834–972	667–778	84	583–694	120	437–555	$70–89
1993	581–692	455–542	80	375–462	110	364–463	$56–72
1994	558–670	428–513	56	371–456	120	258–345	$36–48
1995	616–738	462–553	41	421–513	98	287–376	$40–52

[1] Estimates of cocaine hydrochloride come from a computer model of cocaine production. The range is based on the error band reported by the Department of State for the area under cultivation.

[2] International Narcotics Control Strategy Report, 1995 (and previous years); Royal Canadian Mounted Police, National Drug Intelligence Estimate, 1994 (and previous years) and International Narcotics Control Board, Narcotic Drugs Statistic for 1991 (and previous years). The category excludes seizures of cocaine not destined for the United States.

[3] Drug Enforcement Administration, Federalwide Drug Seizures System, 1989-1995.

[4] Estimates are a two-year moving average of years T and T-1. The estimate for 1989 is for year 1989 alone.

Source: Office of National Drug Control Policy. 1997. *What America's Users Spend on Illegal Drugs, 1988–1995.* Washington, DC: U.S. Government Printing Office.

Table 29. Average Price and Purity of Cocaine and Heroin in the United States, 1981–97

	Cocaine				Heroin			
	Purchases of 1 gram or less[1]		Purchases of 10–100 pure grams[2]		Purchases of 0.1 gram or less[1]		Purchases of 1–10 pure grams[2]	
	Price per pure gram	Purity	Price per pure gram	Purity	Price per pure gram	Purity	Price per pure gram	Purity
1981	$378.70	40.02	$191.35	59.59	$3,114.80	4.69	$1,194.05	19.10
1982	392.97	39.58	175.56	59.72	3,097.95	5.79	1,185.42	32.84
1983	360.21	42.06	166.86	67.82	3,319.86	7.66	1,313.20	30.09
1984	335.49	45.98	145.51	74.88	3,135.70	9.27	1,290.00	35.95
1985	303.31	40.96	137.80	68.52	2,930.90	9.91	1,161.00	42.83
1986	291.09	52.51	122.73	74.48	3,263.59	11.13	1,131.95	36.61
1987	268.74	65.88	104.85	81.57	2,908.00	14.00	1,120.88	35.82
1988	218.33	75.99	78.84	83.53	2,874.19	19.22	947.32	39.48
1989	208.87	78.82	64.89	80.61	2,358.20	19.82	784.88	43.12
1990	246.03	69.86	66.05	67.68	2,615.49	16.85	833.68	31.95
1991	213.57	78.51	68.08	73.42	2,704.10	18.47	867.25	30.61
1992	208.54	76.87	56.93	77.87	2,539.44	22.81	678.30	37.66
1993	187.76	73.49	57.54	72.46	2,341.72	25.89	517.75	49.24
1994	171.54	73.74	54.08	73.31	2,332.28	25.82	436.59	48.31
1995	173.25	68.38	49.79	73.04	2,285.81	26.25	377.03	51.17
1996	159.05	72.50	49.45	68.44	2,175.88	23.95	373.30	45.21
1997	178.97	64.72	45.58	67.05	2,114.97	25.24	327.88	45.38
1998[3]	169.25	71.23	44.30	65.92	1,798.80	24.49	317.97	51.33

[1] Quantities purchased at the "retail" level.

[2] Quantities purchased at the "dealer" level.

[3] Figures are preliminary and subject to updating.

Source: System To Retrieve Information From Drug Evidence (STRIDE), Drug Enforcement Administration, 1981–97.

Table 30. Federalwide Cocaine, Heroin, and Cannabis Seizures, Fiscal Years 1989–97

	Cocaine (metric tons)	Heroin (kilograms)	Cannabis (metric tons)
1989	99.2	1,095.2	509.0
1990	107.3	815.0	227.0
1991	111.7	1,374.4	307.2
1992	137.6	1,157.2	357.6
1993	110.8	1,594.8	362.1
1994	140.5	1,309.6	473.1
1995	106.2	1,164.5	607.3
1996	115.4	1,530.6	663.7
1997	115.2	1,412.5	698.5
1998*	120.0	1,580.7	799.9

*Figures are preliminary and subject to updating.

Source: Federalwide Drug Seizure System, Drug Enforcement Administration, 1989–1997.

Table 31. Eradicated Domestic Cannabis by Plant Type, 1982–97 (number of plants in thousands)

	Cultivated Plants Outdoors[1]	Ditchweed	Indoor Plants	Total Plants Eradicated
1982	—	—	—	2,590
1983	—	—	—	3,794
1984	3,803	9,178	—	12,981
1985	3,961	35,270	—	39,231
1986	4,673	125,013	—	129,686
1987	7,433	105,842	—	113,275
1988	5,344	101,932	—	107,329
1989	5,636	124,289	—	129,925
1990	7,329	118,548	—	125,877
1991	5,257	133,786	283	139,326
1992	7,490	264,207	349	272,046
1993	4,049	387,942	290	392,281
1994	4,032	504,414	220	508,665
1995	3,054	370,275	243	373,572
1996	2,843	419,662	217	422,723
1997	3,827	237,140	224	241,193

— Data not available.

Note: Federal data only.

[1] May include tended ditchweed.

Source: Drug Enforcement Administration, 1982-1997.

Table 32. Methamphetamine Lab Seizures, by State: 1995–97

	1995	1996	1997
Alaska	0	1	0
Alabama	2	5	4
Arizona	16	83	129
Arkansas	19	74	164
California	108	155	178
Colorado	13	17	26
Connecticut	0	0	0
Delaware	1	0	1
District of Columbia	0	0	1
Florida	3	0	1
Georgia	3	4	10
Hawaii	0	0	3
Idaho	1	3	3
Illinois	0	5	14
Indiana	0	1	4
Iowa	4	10	22
Kansas	16	43	43
Kentucky	1	3	1
Louisiana	1	1	1
Maine	0	0	0
Maryland	0	0	0
Massachusetts	0	0	0
Michigan	3	2	4
Minnesota	10	14	14
Mississippi	0	1	0
Missouri	37	235	396
Montana	1	1	2
Nebraska	1	1	1
Nevada	23	37	19
New Hampshire	0	0	0
New Jersey	0	1	3
New Mexico	4	7	20
New York	0	0	0
North Carolina	0	0	2
North Dakota	1	1	1
Ohio	0	1	7
Oklahoma	8	71	106
Oregon	2	8	10
Pennsylvania	2	12	6
Rhode Island	0	0	0
South Carolina	0	0	0
South Dakota	1	1	2
Tennessee	2	2	22
Texas	10	12	24
Utah	29	63	112
Vermont	0	0	0
Virginia	0	0	2
Washington	2	1	4
West Virginia	0	0	0
Wisconsin	2	2	0
Wyoming	1	1	0
Total	327	879	1,362

Note: Federal data only.

Source: Drug Enforcement Administration (1995–1997).

Table 33. Worldwide Potential Net Production, 1988–97 (in metric tons)

Country	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Opium										
Afghanistan[1]	750	585	415	570	640	685	950	1,250	1,230	1,265
India	—	—	—	—	—	—	90	77	47	30
Iran[2]	—	—	—	—	—	—	—	—	—	—
Pakistan	205	130	165	180	175	140	160	155	75	85
Total Southwest Asia	**955**	**715**	**580**	**750**	**815**	**825**	**1,200**	**1,482**	**1,352**	**1,380**
Burma	1,280	2,430	2,255	2,350	2,280	2,575	2,030	2,340	2,560	2,365
China	—	—	—	—	—	—	25	19	—	—
Laos	255	380	275	265	230	180	85	180	200	210
Thailand	25	50	40	35	24	42	17	25	30	25
Total Southeast Asia	**1,560**	**2,860**	**2,570**	**2,650**	**2,534**	**2,797**	**2,157**	**2,564**	**2,790**	**2,600**
Colombia	—	—	—	—	—	—	—	65	63	66
Lebanon[3]	—	45	32	34	—	4	—	1	1	—
Guatemala	8	12	13	11	—	—	—	—	—	—
Mexico	67	66	62	41	40	49	60	53	54	46
Vietnam	—	—	—	—	—	—	—	—	25	45
Total Above	**75**	**123**	**107**	**86**	**40**	**53**	**60**	**119**	**143**	**157**
Total Opium	**2,590**	**3,698**	**3,257**	**3,486**	**3,389**	**3,675**	**3,417**	**4,165**	**4,285**	**4,137**
Coca Leaf										
Bolivia	78,400	77,600	77,000	78,000	80,300	84,400	89,800	85,000	75,100	70,100
Colombia	27,200	33,900	32,100	30,000	29,600	31,700	35,800	40,800	53,800	63,600
Peru	187,700	186,300	196,900	222,700	155,500	155,500	165,300	183,600	174,700	130,200
Ecuador	400	270	170	40	100	100	—	—	—	—
Total Coca Leaf	**293,700**	**298,070**	**306,170**	**330,740**	**265,500**	**271,700**	**290,900**	**309,400**	**303,600**	**263,900**
Cannabis										
Mexico	5,655	30,200	19,715	7,775	7,795	6,280	5,540	3,650	3,400	2,500
Colombia	7,775	2,800	1,500	1,650	1,650	4,125	4,138	4,133	4,133	4,133
Jamaica	405	190	825	641	263	502	208	206	356	214
Belize	120	65	60	49	0	0	0	0	0	0
Other	3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500
Total Cannabis	**17,445**	**36,775**	**25,600**	**13,615**	**13,208**	**14,407**	**13,386**	**11,489**	**11,389**	**10,347**

— Data not available.

[1] The U.S. Drug Enforcement Administration believes, based upon foreign reporting and human sources, that opium production in Afghanistan may have exceeded 900 metric tons in 1992 and 1993.

[2] While there is no solid information on Iranian opium production, the U.S. Government estimates that Iran potentially may produce between 35 and 75 metric tons of opium gum annually.

[3] There was no information for 1992 production. For 1994, a vigorous eradication campaign reduced potential production to insignificant levels.

Source: *International Narcotics Control Strategy Report (1988–1997)*, U.S. Department of State.

Glossary: Abbreviations and Acronyms

ACSI — Americas Counter-Smuggling Initiative.

ADAM — Arrestee Drug Abuse Monitoring System, formerly known as the Drug Use Forecasting (DUF) program.

AIDS — acquired immune deficiency syndrome.

ASEAN — Association of Southeast Asian Nations.

ATF — Bureau of Alcohol, Tobacco and Firearms.

ATS — amphetamine-type stimulants.

BASC — Business Anti-Smuggling Coalition, a program of the U.S. Customs Service.

BCI — Border Coordination Initiative

BJA — Bureau of Justice Assistance, part of the U.S. Department of Justice.

BJS — Bureau of Justice Statistics, part of the U.S. Department of Justice.

BOP — Bureau of Prisons, part of the U.S. Department of Justice.

BTC — Breaking The Cycle.

CADCA — Community Anti-Drug Coalitions of America.

CALDATA — California Drug and Alcohol Treatment Assessment.

CAPTs — Centers for the Application of Prevention Technologies.

CARICOM — Caribbean Community.

CASA — Center on Addiction and Substance Abuse, a research organization based at Columbia University.

CBT — cognitive-behavioral treatment.

CEWG — Community Epidemiology Work Group.

CDC — Centers for Disease Control and Prevention.

CICAD — Inter-American Drug Abuse Control Commission, a body of the Organization of American States.

CIP — Carrier Initiative Programs, an ongoing initiative of the U.S. Customs Service.

CNP — Colombian National Police.

CN-IWG — Counter-Narcotics Working Group.

COPS — Community Oriented Policing Services, a program of the Department of Justice.

CRA — community reinforcement approach.

CSAP — Center for Substance Abuse Prevention, a component of SAMHSA, an operating division within the Department of Health and Human Services.

CSAT — Center for Substance Abuse Treatment, a component of SAMHSA an operating division within the Department of Health and Human Services.

CTAC — Counter-Drug Technology Assessment Center.

CTN — National Drug Abuse Treatment Clinical Trials Network.

DAICC — Domestic Air Interdiction Coordination Center.

D.A.R.E. — Drug Abuse Resistance Education.

DATOS — Drug Abuse Treatment Outcome Study, run by the National Institute on Drug Abuse.

DAWN — Drug Abuse Warning Network, a SAMHSA-funded program which monitors drug abuse among persons admitted at hospital emergency rooms.

DEA — Drug Enforcement Administration, part of the Department of Justice.

DFS3 — Drug-Free Schools State Supplement.

DFWP — Drug-Free Workplace Program.

DOD — U.S. Department of Defense.

DOJ — U.S. Department of Justice.

DOL — U.S. Department of Labor.

DOT — U.S. Department of Transportation.

DUF — Drug Use Forecasting program. Now known as ADAM.

EAP — Employee Assistance Program.

EPA — U.S. Environmental Protection Agency.

EU — European Union.

FAS — Fetal Alcohol Syndrome.

FATF — Financial Action Task Force, an international grouping of nations that fight money laundering.

FBI — Federal Bureau of Investigation, part of the Department of Justice.

FDA — Food and Drug Administration, part of the Department of Health and Human Services.

FDSS — Federal-Wide Drug Seizure System.

FY — fiscal year.

GAO — Government Accounting Office

GHB — Gamma-hydroxybutyrate.

G.R.E.A.T. — Gang Resistance Education and Training.

GTO — Geographic Targeting Order, a tool used to fight money laundering.

Hcl — cocaine hydrochloride.

HHS — U.S. Department of Health and Human Services.

HIDTA — High Intensity Drug Trafficking Area, a counterdrug initiative overseen by the Office of National Drug Control Policy.

HIV — human immunodeficiency virus.

HLCG — U.S./Mexico High Level Contact Group on Drug Control.

HUD — U.S. Department of Housing and Urban Development.

ICRC — International Certification Reciprocity Consortium/Alcohol and Other Drugs.

IEEPA — International Emergency Economic Powers Act, a law that deals with money laundering and the financial proceeds of drug trafficking.

ILEA — International Law Enforcement Academy.

INCSR — International Narcotics Control Strategy Report.

IDU — injection drug user.

INCASE — International Coalition of Addiction Studies Educators.

INS — U.S. Immigration and Naturalization Service, part of the Department of Justice.

IOM — Institute of Medicine, part of the National Academy of Science.

ISIS/RVS — Integrated Surveillance Intelligence System and Remote Video Surveillance.

JIATF — Joint Interagency Task Force.

LAAM — levo-alph-acetyl-methadol.

LSD — lysergic acid diethylamide, a hallucinogen.

MDMA — 3, 4-methylenedioxymethamphetamine, an illegally produced stimulant that has hallucinogenic properties.

MTF — Monitoring the Future, a long-term study of youth drug abuse and attitudes, run by the University of Michigan and funded by NIDA.

NAADAC — National Association of Alcoholism and Drug Abuse Counselors.

NCHS — National Center for Health Statistics.

NDATUS — National Drug and Alcoholism Treatment Unit Survey.

NHSDA — National Household Survey of Drug Abuse, the most comprehensive of the many national surveys of drug abuse, funded by SAMHSA.

NHTSA — National Highway Traffic Safety Administration, part of the Department of Transportation.

NIAAA — National Institute on Alcohol Abuse and Alcoholism, one of the National Institutes of Health and part of the Department of Health and Human Services.

NICCP — National Interdiction Command and Control Plan.

NIDA — National Institute on Drug Abuse, one of the National Institutes of Health and part of the Department of Health and Human Services.

NIH — National Institutes of Health, part of the Department of Health and Human Services.

NIJ — National Institute of Justice, part of the Department of Justice.

NNICC — National Narcotics Intelligence Consumers Committee.

NRC — U.S. Nuclear Regulatory Commission.

NTIES — National Treatment Improvement Evaluation Study.

OAS — Organization of American States.

OCDETF — Organized Crime Drug Enforcement Task Force, a program of the Department of Justice.

OJJDP — Office of Juvenile Justice and Delinquency Prevention, part of the Department of Justice.

OJP — Office of Justice Programs, part of the Department of Justice.

OMB — Office of Management and Budget.

ONDCP — Office of National Drug Control Policy.

OPM — Office of Personnel Management.

PCP — Phencyclidine, a clandestinely manufactured hallucinogen.

PDFA — Partnership for a Drug-Free America, a private organization that promotes private-sector involvement in the creation of anti-drug messages.

PEPS — The Prevention Enhancement Protocols System developed by CSAP.

PME — performance measures of effectiveness.

POE — Port of Entry.

PRIDE — Parent's Resource Institute for Drug Education.

SAID — Substance Abuse Information Database.

SAMHSA — Substance Abuse and Mental Health Services Administration. An operating division within the Department of Health and Human Services.

SAPT — Substance Abuse Prevention and Treatment.

SBA — Small Business Administration.

SDFSP — Safe and Drug-Free Schools and Communities Program.

SIDS — Sudden Infant Death Syndrome.

SIG — State Incentive Grant.

SIFCF — Survey of Inmates in Federal Correctional Facilities.

SISCF — Survey of Inmates in State Correction Facilities.

SMART — Self Management and Resistance Training.

SROS — Services Research Outcomes Study.

STD — Sexually Transmitted Disease.

STRIDE — System To Retrieve Information from Drug Evidence, a program of the Drug Enforcement Administration.

SWBI — Southwest Border Initiative.

TASC — Treatment Alternatives to Street Crime.

THC — tetrahydrocannabinol, the psychoactive substance in marijuana.

TIC — The Interdiction Committee.

TIPS — treatment improvement protocols.

UCR — Uniform Crime Reports, a publication of the FBI.

UFDS — Uniform Facility Data Set, administered by SAMHSA.

UK — United Kingdom.

UN — United Nations.

UNGASS — UN General Assembly Special Session on Drugs.

UNDCP — United Nations International Drug Control Programme.

U.S. — United States.

USAID — U.S. Agency for International Development.

USCG — United States Coast Guard.

USCS — United States Customs Service.

USDA — Department of Agriculture.

USG — United States Government.

USIC — United States Interdiction Coordinator.

WtW — Welfare to Work.

XTC — a street name for MDMA.

YRBS — Youth Risk Behavior Survey.

Strategic Goals and Objectives of the 1999 National Drug Control Strategy

Strategic Goals and Objectives of the

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

Objective 1: Educate parents and other care givers, teachers, coaches, clergy, health professionals, and business and community leaders to help youth reject illegal drugs and underage alcohol and tobacco use.

Objective 2: Pursue a vigorous advertising and public communications program dealing with the dangers of illegal drugs, alcohol, and tobacco use by youth.

Objective 3: Promote zero tolerance policies for youth regarding the use of illegal drugs, alcohol, and tobacco within the family, school, workplace, and community.

Objective 4: Provide students in grades K- 12 with alcohol, tobacco, and drug prevention programs and policies that are research based.

Objective 5: Support parents and adult mentors in encouraging youth to engage in positive, healthy lifestyles and modeling behavior to be emulated by young people.

Objective 6: Encourage and assist the development of community coalitions and programs in preventing drug abuse and underage alcohol and tobacco use.

Objective 7: Create partnerships with the media, entertainment industry, and professional sports organizations to avoid the glamorization, condoning, or normalization of illegal drugs and the use of alcohol and tobacco by youth.

Objective 8: Develop and implement a set of research-based principles upon which prevention programming can be based.

Objective 9: Support and highlight research, including the development of scientific information, to inform drug, alcohol, and tobacco prevention programs targeting young Americans.

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

Objective 1: Strengthen law enforcement — including federal, state, and local drug task forces — to combat drug-related violence, disrupt criminal organizations, and arrest and prosecute the leaders of illegal drug syndicates.

Objective 2: Improve the ability of High Intensity Drug Trafficking Areas (HIDTAs) to counter drug trafficking.

Objective 3: Help law enforcement to disrupt money laundering and seize and forfeit criminal assets.

Objective 4: Break the cycle of drug abuse and crime.

Objective 5: Support and highlight research, including the development of scientific information and data, to inform law enforcement, prosecution, incarceration, and treatment of offenders involved with illegal drugs.

1999 National Drug Control Strategy

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

Objective 1: Support and promote effective, efficient, and accessible drug treatment, ensuring the development of a system that is responsive to emerging trends in drug abuse.

Objective 2: Reduce drug-related health problems, with an emphasis on infectious diseases.

Objective 3: Promote national adoption of drug-free workplace programs that emphasize a comprehensive program that includes: drug testing, education, prevention, and intervention.

Objective 4: Support and promote the education, training, and credentialing of professionals who work with substance abusers.

Objective 5: Support research into the development of medications and related protocols to prevent or reduce drug dependence and abuse.

Objective 6: Support and highlight research and technology, including the acquisition and analysis of scientific data, to reduce the health and social costs of illegal drug use.

Objective 7: Support and disseminate scientific research and data on the consequences of legalizing drugs.

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

Objective 1: Conduct flexible operations to detect, disrupt, deter, and seize illegal drugs in transit to the United States and at U.S. borders.

Objective 2: Improve the coordination and effectiveness of U.S. drug law enforcement programs with particular emphasis on the Southwest Border, Puerto Rico, and the U.S. Virgin Islands.

Objective 3: Improve bilateral and regional cooperation with Mexico as well as other cocaine and heroin transit zone countries in order to reduce the flow of illegal drugs into the United States.

Objective 4: Support and highlight research and technology — including the development of scientific information and data — to detect, disrupt, deter, and seize illegal drugs in transit to the United States and at U.S. borders.

Goal 5: Break foreign and domestic drug sources of supply.

Objective 1: Produce a net reduction in the worldwide cultivation of coca, opium, and marijuana and in the production of other illegal drugs, especially methamphetamine.

Objective 2: Disrupt and dismantle major international drug trafficking organizations and arrest, prosecute, and incarcerate their leaders.

Objective 3: Support and complement source country drug control efforts and strengthen source country political will and drug control capabilities.

Objective 4: Develop and support bilateral, regional, and multilateral initiatives and mobilize international organizational efforts against all aspects of illegal drug production, trafficking, and abuse.

Objective 5: Promote international policies and laws that deter money laundering and facilitate anti-money laundering investigations as well as seizure and forfeiture of associated assets.

Objective 6: Support and highlight research and technology, including the development of scientific data, to reduce the worldwide supply of illegal drugs.

The power of a Grandpa.

Children have a very special relationship with Grandma and Grandpa. That's why grandparents can be such powerful allies in helping keep a kid off drugs.

Grandparents are cool. Relaxed. They're not on the firing line every day. Some days a kid hates his folks. He never hates his grandparents. Grandparents ask direct, point-blank, embarrassing questions you're too nervous to ask:

"Who's the girl?"

"How come you're doing poorly in history?"

"Why are your eyes always red?"

"Did you go to the doctor? What did he say?"

The same kid who cons his parents is ashamed to lie to Grandpa. Without betraying their trust, a loving, understanding grandparent can discuss the danger of drugs openly with the child he adores. And should.

• The average age of first-time drug use among teens is 13. Some kids start at 9.

• 1 out of 4 American kids between 9 and 12 is offered illegal drugs. 22% of these kids receive the offer from a friend. And 10% named a family member as their source.

• Illegal drugs are linked to increased violence in many communities, to AIDS, to birth defects, drug-related crime, and homelessness.

As a grandparent, you hold a special place in the hearts and minds of your grandchildren. Share your knowledge, your love, your faith in them. Use your power as an influencer to steer your grandchildren away from drugs.

If you don't have the words, we do. We'll send you information on how to talk to your grandkids about drugs. Just ask for your free copy of *Keeping Youth Drug-Free*. Call 1-800-788-2800 or visit our websites, www.projectknow.com or www.drugfreeamerica.org.

Grandma, Grandpa. Talk to your grandkids. You don't realize the power you have to save them.

Office of National Drug Control Policy
Partnership for a Drug-Free America®

Some Research-Based Drug Prevention Programs

The following programs have been developed as part of a research protocol and tested in a family, school, or community setting over a reasonable period with positive results. These programs are categorized by a new series of definitions adopted by the prevention field, which describes the programs according to the audience for which they are designed. There are universal programs, selective programs, and indicated programs.

Universal programs reach the general population — such as all students in a school.

Selective programs target groups at risk or subsets of the general population — such as children of drug users or poor school achievers.

Indicated programs are designed for people who are already experimenting with drugs or who exhibit other risk-related behavior.

Project STAR (Pentz et al. 1989; Pentz 1995) This is a universal drug-abuse prevention program that reaches the entire community with a comprehensive school program, mass media efforts, a parent program, community organization, and health policy change. Research results for this project have shown positive long-term effects: Students who began the program in junior high, and whose results were measured in their senior year of high school, showed significantly less use of marijuana (approximately 30 percent less), cigarettes (about 25 percent less), and alcohol (about 20 percent less) than children in schools that did not offer the program. The most important factor found to have affected drug use among the students was increased perceptions of their friends' intolerance of drug use.

Life Skills Training Program (Botvin et al. 1990, 1995a,b) This universal classroom program is designed to address a wide range of risk and protective factors by teaching general personal and social skills in combination with drug resistance skills and normative education. Results indicate that this prevention approach can produce 59 to 75 percent lower levels (relative to controls) of tobacco, alcohol, and marijuana use. Booster sessions can help maintain program effects. Long-term follow-up data from a randomized field trial involving nearly six-thousand students from fifty-six schools found significantly lower smoking, alcohol, and marijuana use six years after the initial baseline assessment. The prevalence of cigarette smoking, alcohol use, and marijuana use for students who received the Life Skills Training program was 44 percent lower than for control students, while weekly use of multiple drugs was 66 percent lower.

Seattle Social Development Project (Hawkins et al. 1992) A universal program, the Seattle project is a school-based intervention for grades one through six that seeks to reduce shared childhood risks for delinquency and drug abuse by enhancing protective factors. Long-term results indicate positive outcomes for students who participated in the program: reductions in antisocial behavior, improved academic skills, greater commitment to school, reduced levels of alienation and better bonding to pro-social others, less misbehavior in school, and fewer incidents of drug use in school.

Adolescents Training and Learning to Avoid Steroids: The ATLAS Program (Goldberg et al. 1996a,b) ATLAS is a multi-component universal program, for male high school athletes, designed to reduce risk factors for use of anabolic steroids and other drugs while providing healthy sports nutrition and strength-training alternatives to illicit use of athletic-enhancing substances. Student athletes receiving the ATLAS program report better understanding of the effects of anabolic steroids and other drugs, greater belief in personal vulnerability to the adverse effects of anabolic steroids, and more certainty that their parents and coaches are intolerant of drug use. Importantly, these high school athletes continued to resist the temptation to use anabolic steroids and maintained better nutrition and exercise one year after the intervention.

Strengthening Families Program (Kumpfer et al. 1996) Strengthening Families is a selective prevention program, a multi-component, family-focused program that provides prevention programming for six to ten year-old children of substance abusers. The program began as an effort to help substance-abusing parents improve their parenting skills and reduce their children's risk factors. The program has been culturally modified and found effective (through independent evaluation) with African-American, Asian/Pacific Islander, and Hispanic families. This intervention approach has been evaluated in a variety of settings and with several racial and ethnic groups. The primary outcome of the program includes reductions in family conflict; improvement in family communication and organization; and reduction in youth conduct disorders, aggressiveness, and substance abuse.

Focus on Families (Catalano et al., in press) A selective program for parents receiving methadone treatment and for their children, Focus on Families has a primary goal of reducing parents' use of illegal drugs by teaching them skills for relapse prevention and coping. Parents also are taught how to manage their families better. Early results indicate that parents' drug use is dramatically lower and parenting skills significantly better than the results obtained in control groups. However, the program's effects on children have not yet been assessed.

Reconnecting Youth Program (Eggert et al. 1994, 1995) Reconnecting Youth is a school-based indicated prevention program that targets young people in grades nine through twelve who show signs of poor school achievement and potential for dropping out of high school. Research shows that this program improves school performance; reduces drug involvement; decreases deviant peer bonding; increases self-esteem, personal control, school bonding, and social support; and decreases depression, anger and aggression, hopelessness, stress, and suicidal behavior. Further analysis indicates that the support of Personal Growth Class teachers contributes to decreases in drug involvement and suicide risk behavior.

Adolescent Transitions Program (ATP) (Dishion et al., in press) The ATP is a school-based program that focuses on parenting practices and integrates the universal, selective, and indicated approaches for middle and junior high school interventions within a comprehensive framework. The goal, through collaboration with school staff, is to engage parents, establish norms for parenting practices, and disseminate information about risks for problem behavior and substance abuse.

Ten Actions Families Can Take to Raise Drug-Free Kids

Start: It is never too early to prevent your children from trying drugs. Building protective factors, such as letting your child know you care, plays an important role in protecting even the youngest children from drugs.

Connect: Take every opportunity to build lines of communication with your children. Do things as a family. Spend time together — eat dinner as a family, read together, play a game, attend religious services. Show that fun doesn't involve drugs.

Listen: Take a more active interest in what is going on in your child's life. Listen to their cares and concerns. Know what they are up to — what parties they are going to, with whom, and what will be served or available.

Learn: Children today are sophisticated. In order to educate your child about the danger of drugs, you need to educate yourself first. In many cases, you and your child can learn side by side. Sit down together and learn about the risks drugs pose.

Educate: Spend at least thirty minutes with your kids every month explaining with simple facts how drugs can hurt youngsters and destroy their dreams.

Care: Spend at least a few minutes each day telling and showing your children that you care. Make sure they know you care that they are drug-free. Explain to your child that you will always be there for them — no matter what happens. Make sure that they know to come to you first for help or information. The extended family plays a major role in influencing a child's life.

Be Aware: Look for the warning signs that your child may be developing a substance-abuse problem and get help before the problem occurs. Your pediatrician can help.

Set Limits: By setting limits on what is acceptable behavior, you show your children you care and help guide them to a safer, drug-free future. Declare limits: "This family doesn't do drugs. This family doesn't hang around people who do drugs." Enforce these limits. If you say no drugs or no drinking and driving, the rule applies to parents, too. Be consistent.

Get Involved: Effective prevention extends beyond the home into the community. Get involved in your community. Ensure that your community's streets, playgrounds, and schools are safe and drug-free. Start or join a community watch group or community anti-drug coalition. Become active in the PTA. Get involved in your church, synagogue, or faith.

Lead: Young people are as aware of what you do as much as what you say. Don't just say the right things; do the right things. Set a good example. If you, yourself, have a substance abuse problem, get help.

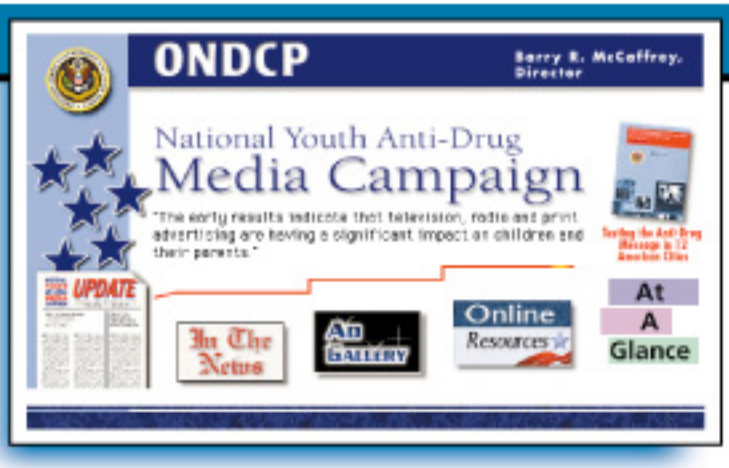
Office of National Drug Control Policy

www.whitehousedrugpolicy.gov

- The President' s drug policy
- Current data on drug use
- Prevention, treatment, and enforcement programs
- ONDCP initiatives, news, testimony
- Links to other valuable resources

www.mediacampaign.org

- Information for campaign stakeholders – anti-drug leaders, media executives, policy makers
- Communications strategy and integrated communications plan
- News, testimony , initiatives
- Online ad samples



www.projectknow.com

- The truth about drugs for campaign audiences – youth and parents
- Real stories about real families
- No-nonsense facts about drugs of abuse
- Tips for youth and parents

National Drug Clearinghouse: 1-800-666-3332

Media Campaign Clearing House: 1-800-788-2800

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