The National Drug Control Strategy: 2001 Annual Report

Foreword

This report provides information on progress over the past year in implementing the National Drug Control Strategy. It details trends in drug use and availability; assesses the costs of drug abuse to our society; and outlines accomplishments of federal prevention, treatment, law enforcement, interdiction, and international programs.

We remain committed to the Strategy that focuses on shrinking America's demand for drugs through prevention and treatment while attacking the supply of drugs through law enforcement and international cooperation.

Drug abuse is preventable. If children reach adulthood without using illegal drugs, alcohol, or tobacco, they are unlikely to develop chemical-dependency problems later in life. 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 addiction 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 for reducing drug use. 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 land borders and at air terminals and seaports will reduce the volume of illegal drugs reaching American communities.

Drug trafficking threatens both the rule of law and human rights. Supply-reduction programs attack international criminal organizations, strengthen democratic institutions, and honor our drug-control commitments abroad.

We are confident that a balanced strategy 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: 2001 Annual Report

Table of Contents

I. Annual Report and the *National Drug Control Strategy*: An Overview

Annual Report on Implementing the *National Drug Control Strategy*

Prior to 1999, Congress required the Administration to submit a *National Drug Control Strategy* each year. The most recent *Strategy* was submitted in February 1999. Public Law 105-277 now requires the president to submit an Annual Report to Congress on the progress made in implementing the *Strategy*.* An initial Annual Report was submitted in February 2000. General reporting requirements of the Annual Report include:

1. Assessment of federal success in achieving *National Drug Control Strategy* goals and objectives (using the *Strategy*'s Performance Measures of Effectiveness system). This analysis includes an assessment of drug abuse and availability in the United States as well as prevention, treatment, law enforcement, interdiction, and international programs.
2. Modifications during the preceding year of the *National Drug Control Strategy* or national drug control performance measurement system.
3. Explanation of how the Administration's budget proposal is intended to implement the *National Drug Control Strategy*.
4. Measurable data from the annual performance measures.
5. An assessment of private-sector initiatives and cooperative efforts dealing with drug control among federal, state, and local governments.

This Annual Report addresses specific reporting requirements outlined in PL 105-277.

- **Chapter 1** summarizes the *National Drug Control Strategy*.
- **Chapter 2** provides information on abuse, availability, and health and social consequences of illicit drugs. This information is based on the most recent national, state, and local surveys, among other studies. Given that these data instruments sometimes cover different timeframes, consistent comparisons of data over the same period are not always possible. The National Household Survey on Drug Abuse (released in August 2000), for example, provides information about drug use in 1999 while the Monitoring the Future Survey (released in December 2000) contains 2000 data. The Data Appendix summarizes the instruments used to prepare this Annual Report and outlines steps being taken to improve the information that supports national drug policy.
- **Chapter 3** outlines accomplishments of (and modifications to) prevention, treatment, law enforcement, interdiction, and international programs (including private-sector and governmental initiatives and cooperative efforts).
- **Chapter 4** reviews drug-control budget trends from FY 1992 to FY 2000. It also summarizes drug-control funding priorities established by ONDCP for FY 2002 to FY 2006.
- **Chapter 5** summarizes the consultation process followed by the Office of National Drug Control Policy during 2000 in implementing the drug strategy.
- **The *National Drug Control Strategy*** also includes a Classified Annex, which is transmitted to Congress separately. This document is the president's interagency plan for countering international drug cultivation, production, and trafficking.

* A revised National Drug Control Strategy may, however, be submitted at any time upon determination by the president, in consultation with the ONDCP director, that the National Drug Control Strategy is not sufficiently effective or when a new president or ONDCP director takes office.

Two companion volumes provide information about ONDCP's High Intensity Drug Trafficking Program and ONDCP's Counter-Drug Technology Assessment Center:

- *Counterdrug Research and Development Blueprint Update* — reviews the research agenda of ONDCP's Counter-Drug Technology Assessment Center and contains the *Annual Report on Development and Deployment of Narcotics Detection Technology* required by 21USC/505a.
- *2001 Annual Report: The High Intensity Drug Trafficking Area Program* — provides an overview of the program and information about the drug threat in each of twenty-six HIDTA regions and actions taken to address these threats.

Mandate for a National Drug Control Strategy

The development of the *National Drug Control Strategy* has responded to 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.
- **The Comprehensive Crime Control Act of 1984** and other statutes passed by the 98th Congress reformed the bail and sentencing laws applicable to drug trafficking and other crimes, created a new offense with an enhanced penalty for distributing drugs near schools, and revised civil and criminal forfeiture laws.
- **The Anti-Drug Abuse Act of 1986** enhanced penalties for drug trafficking. It also created a new offense with a greater penalty for using a juvenile to commit a drug offense, amended the forfeiture laws, proscribed trafficking in controlled substance "analogues" (sometimes referred to as "designer" drugs), created money-laundering offenses, and proscribed use of interstate commerce to distribute drug paraphernalia.
- **Executive Order No. 12564 (1986)** made refraining from illegal drug use a condition of employment for all federal employees. This order requires 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 specified 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 young people 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 of government 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 Drug-Free Communities Act of 1997** authorized the Office of National Drug Control Policy to carry out a national initiative that awards federal grants directly to community coalitions in the United States. Such coalitions work to reduce substance abuse among adolescents, strengthen collaboration among organizations and agencies in both the private and public sectors, and serve as catalysts for increased citizen participation in strategic planning to reduce drug use over time.
- **The Media Campaign Act of 1998** directed ONDCP to conduct a national media campaign for the purpose of reducing and preventing drug abuse among young people in the United States.
- **The Office of National Drug Control Policy Reauthorization Act of 1998** expanded ONDCP's mandate and authority. It set forth additional reporting requirements and expectations, including:

- Development of a long-term national drug strategy
- Implementation of a robust performance-measurement system
- Commitment to a five-year national drug-control program budget
- Permanent authority granted to the High Intensity Drug Trafficking Areas (HIDTA) program along with improvements in HIDTA management
- Greater demand-reduction responsibilities given to the Counter-Drug Technology Assessment Center (CTAC)
- Statutory authority for the President's Council on Counter-Narcotics
- Increased reporting to Congress on drug-control activities
- Reorganization of ONDCP to allow more effective national leadership
- Improved coordination among national drug control program agencies
- Establishment of a Parents' Advisory Council on Drug Abuse

Evolution and Overview of the National Drug Control Strategy

National drug-control strategies were produced annually between 1989 and 1999. These strategies increasingly recognized the importance of preventing drug use by young people and a recognition that no single approach can rescue the nation from drug abuse. Consensus was reached that drug prevention, education, treatment, and research must be complemented by supply-reduction abroad, on our borders, and within the United States. Each strategy expressed a commitment to maintain and enforce anti-drug laws. All the strategies, with growing 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 current *Strategy* and will guide federal drug-control agencies over the next five years. These goals are useful for state and local governments as well as the private sector.

Drug abuse and related crime permeate every corner of our society, afflicting inner cities, affluent suburbs, and rural communities. Drugs affect rich and poor, educated and uneducated, professionals and blue-collar workers, young and old. Seventy-seven percent of drug users in America are employed.[1] Some of the elderly suffer from addiction as do people in the prime of their lives. Drug abuse is prevalent among the young although it is not as widespread as many children and adolescents think.

The history of drug abuse in America indicates that this blight is cyclic in nature. When the nation fails to pay attention and take precautions, drug abuse spreads. The introduction of cocaine in the late nineteenth century exemplifies how attitudes affect the incidence of drug abuse. Cocaine use skyrocketed, in part because the psycho-pharmacological effects of this drug were poorly understood. The alleged benefits of cocaine were touted by health authorities whose unproven claims were the basis for commercial advertising. Only when the negative consequences of cocaine addiction were recognized and publicized did perceptions change. Drug abuse was condemned, and new laws were passed producing a healthier nation with a lower crime rate.

When people forgot, ignored, or denied the problem of drug abuse, it resurfaced. Cultural amnesia allowed new drugs to be introduced, some of which were more potent than their predecessors. Associated with these new drugs were subcultures with special appeal for the young and impressionable. Once again, drug abuse increased as did its deleterious consequences. Twice in this century drug use rose and then fell. Illegal drugs never disappeared entirely although the percentage of Americans who used them declined dramatically.

If we aren't careful, the number of drug abusers could rise again. Drug use among children is a particularly urgent concern. Beginning around 1990, teens and preteens adopted more permissive attitudes toward drugs. Soon thereafter, actions followed perceptions, and use of illegal drugs increased among young people. This trend continued through 1996 before stabilizing in 1997. In 1999, 6.7 percent (14.8 million) of Americans twelve and older were current users of illicit drugs. This figure is down from the 14.1 percent of the U.S. population twelve and older who were current users in 1979.

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

The National Response to Drug Abuse: Protecting Public Health and Safety

The *National Drug Control Strategy* takes a long-term, holistic view of the drug problem and recognizes the devastating effect drug abuse has on the country's public health and safety. The *Strategy* maintains that no single solution can solve this multifaceted challenge. The *Strategy* focuses on prevention, treatment, research, law enforcement, shielding our borders, drug-supply reduction, and international cooperation. It provides general guidance while identifying specific initiatives. Through a balanced array of demand-reduction and supply-reduction actions, we strive to reduce drug use and availability by half and the consequences of drug abuse by at least 25 percent by 2007. If this goal is achieved, just 3 percent of the household population aged twelve and over will be using illegal drugs. This level would be the lowest documented drug-use rate in American history; drug-related health, economic, social, and criminal costs are expected to drop commensurately.

Preventing drug abuse in the first place is preferable to addressing the problem later through treatment and law enforcement. The *Strategy* focuses on young people, seeking to teach them about the many negative consequences associated with illegal drugs, alcohol, and tobacco. In addition to drug-prevention for children, intervention programs must help young adults as they leave home to start college or join the workforce.

There are approximately five million drug abusers who need immediate treatment and who constitute a major portion of domestic demand. Without help, many of these adults and their families will suffer from the impact of poor physical and mental health, unstable employment and family relations, and possible involvement with the criminal-justice system. Since parental substance abuse is a significant predictor of youth drug use and often contributes to child abuse and neglect, treatment for parents is key to breaking the inter-generational cycle of addiction. Accordingly, the *Strategy* focuses on treatment. Research clearly demonstrates that treatment works. We must take advantage of all opportunities — in the workplace, the health and social-services system, the criminal-justice system, and our communities — to encourage drug abusers to become drug-free.

Substance abuse by law breakers is another area of concern. A December 1998 Bureau of Justice Statistics study found that 33 percent of state and 22 percent of federal prisoners said they committed their current offense while under the influence of drugs, and about one in six of both state and federal inmates said they committed their offense to get money for drugs.[2] Approximately 20 percent of state prisoners and 60 percent of federal prisoners are incarcerated for a drug-related crime. A drug program that includes treatment for substance abuse disorders during and after incarceration is essential for safe reentry into the community. Prisons and detention centers are just a temporary response that address a third of the offenders under government supervision; the remaining 4.4 million offenders are in community programs. Treatment, in lieu of incarceration, will help large numbers of non-violent, drug-related offenders. Experience proves that drug courts, drug testing, and drug treatment within the criminal-justice system can reduce drug consumption and recidivism. Over time, expanded alternatives to incarceration promise to decrease the addicted population and reduce both crime and the incarceration rate in America. The ultimate goal is to help people with drug problems renounce crime and enter the workforce as productive, self-sufficient, tax-paying members of society. Education, job training, and social skills instruction are important accompaniments to treatment.

Over the years, we have come to understand that drug abuse is a complex phenomenon that affects both public health and safety. We also realize that breaking the cycle of drugs, violence, and crime is an important first step toward securing the health of individuals and communities.

The Public-Health Dimension of Substance Abuse

Drug abuse, whether directly or indirectly, is now a major vector for the transmission of infectious diseases, including acquired immunodeficiency syndrome (AIDS), hepatitis B, hepatitis C, and tuberculosis. Increasing numbers of such cases are being reported among the partners of intravenous drug users. Most HIV-infected newborns have mothers who acquired this disease through their own drug use or sexual activity with a drug user. In addition, research is demonstrating that minority populations may face unique risks that must be addressed. The National Institutes of Health has developed a strategic plan, for reducing and ultimately eliminating health disparities among minority groups, which currently suffer disproportionately from HIV and AIDS. Because drug abuse causes a complex set of health problems, we must continue addressing it through a variety of educational and other prevention efforts, early intervention, treatment, and research.

To address these health disparities as well as other factors that affect the health of the nation, the Surgeon General developed "Ten Leading Health Indicators"[3] intended to elicit wide participation in improving health. These indicators are designed to act as a national health report card for the next decade so communities, counties, states, and the entire country, can assess individual and collective progress. in achieving a nation of healthy people.

As we continue strengthening our efforts to reduce the use of illegal drugs, underage alcohol, and tobacco, while improving overall physical and mental health, we will need to rely on scientific advances consistently.

Particularly over the past decade, science has increased our understanding of addiction and better approaches for dealing with it. Research now defines substance abuse as preventable behavior and addiction as a treatable, chronic, relapsing disease of the brain. Addiction is characterized by compulsive drug-seeking that results from the brain's prolonged exposure to drugs. Animal and human studies have demonstrated that chronic drug use changes the brain in fundamental ways that persist long after drug use has stopped. By using advanced brain imaging technologies, we can see what we believe to be the biological basis of addiction.

Public-Safety Dimensions of Substance Abuse

Hundreds of thousands of people enter the criminal and juvenile-justice systems each year due to substance-use disorders. Our prisons and jails hold more approximately 2,054,694 persons,[4] and 4.4 million offenders are in community programs. On any given day, our jails house more than 25,000 people suffering from both mental illness and substance-use disorders. Over 300,000 are affected by one or the other type of disability. Over half the inmates in state and federal prisons have a mental-health or substance abuse disorder — nearly 700,000 in all.[5]

A million offenders under criminal justice supervision need, and are not getting, drug treatment. Each year over 550,000 people return to their communities from state and federal prisons; most are untreated, and many are dangerous, unemployable, or sick. Over 350,000 (two-thirds) will be rearrested within three years of release. With treatment during and after incarceration, this level of recidivism can be sharply reduced.[6]

Drug treatment has been shown to have an immediate impact on the level of drug use and associated crime, and retention in drug treatment is also significant for future behavior. Longitudinal studies have repeatedly shown that drug use and criminal activity decline upon entry into treatment and remain below pre-treatment levels for up to six years. Public safety is the primary beneficiary of drug treatment programs.

Law Enforcement

Effective law enforcement is essential for reducing drug-related crime within the United States. Illegal drug trafficking inflicts violence and corruption on our communities. The criminal activity that accompanies drug trafficking has both a domestic and international component. Domestic traffickers are often linked with international organizations. Federal, state, and local law enforcement organizations, working together through programs like the Organized Crime Drug Enforcement Task Force (OCDETF) and High Intensity Drug Trafficking Area (HIDTA), must share information and resources in order to maximize their impact on criminal drug trafficking organizations.

The *Strategy* stresses the need to protect borders from drug incursion and cut the supply of drugs in communities along our borders. Sharing intelligence and making use of the latest technology can make a big difference. The Southwest border is a major gateway for the entry of illegal drugs into the United States. Resources have been allocated to close other avenues of drug entry into the United States, including the Virgin Islands, Puerto Rico, the Canadian border, and all air terminals and seaports.

International Initiatives

The United States seeks to curtail illegal drug trafficking in the transit zone between source countries and the U.S. Multinational efforts in the Caribbean, Central America, Europe, and the Far East are being coordinated to exert maximum pressure on drug traffickers. The United States supports a number of international efforts against drug trafficking that are being coordinated with the United Nations (UN), the European Union (EU), and the Organization of American States (OAS).

Supply-reduction operations can best be mounted at the source: the Andean Ridge for cocaine and heroin; Mexico for methamphetamine, heroin, and marijuana; and Southeast Asia and South Central Asia for heroin. Where access to source regions is limited by political complications, we support international efforts to curtail the drug trade.

Research-Based Policy

The *National Drug Control Strategy* is based on sound research, technology, and intelligence. The *Strategy* will be adjusted according to feedback from ONDCP's Performance Measures of Effectiveness system. Conditions are fluid, so the *Strategy* will change to respond to emerging issues. We can measure — target by target — how successful we are in achieving goals and objectives. The *Strategy* receives input from a wide range of organizations, individuals, and government branches.

The overriding objective of our drug-control strategy is to keep Americans safe from the threats posed by illegal drugs. We hope to create a healthier, less violent, more stable nation unfettered by drugs and drug traffickers as well as the corruption they perpetrate.

Goals of the National Drug Control Strategy

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

Drug use is preventable. If children reach adulthood without using illegal drugs, alcohol, or tobacco, they are unlikely to develop a chemical-dependency problem later in life. To this end, the *Strategy* fosters initiatives to educate children about the dangers associated with drugs. ONDCP involves 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.

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

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 problems while protective factors reduce the chances of drug involvement. Risk factors include a chaotic home environment, ineffective parenting, anti-social behavior, drug-using peers, general approval of drug use, and the misperception that an overwhelming majority of peers are substance users. Protective factors include, but are not limited to, 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 use is unacceptable.

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

Drug addiction is a chronic, relapsing disorder that exacts an enormous cost on individuals, families, businesses, communities, and nations. Addicted individuals may engage in self-destructive and criminal behavior. Treatment programs have been found to reduce the consequences of addiction for the individual and society. The ultimate goal of treatment is to help people stop using drugs and maintain drug-free lifestyles while achieving productive functioning within families, at work, and in society. Providing access to treatment for America's chronic drug abusers is a worthwhile endeavor. It is both compassionate public policy and a sound investment.

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

The United States is obligated to protect its citizens from 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.

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:

- Eliminate illegal drug cultivation and production.
- Destroy drug-trafficking organizations.
- Interdict drug shipments.
- Encourage international cooperation.
- Safeguard democracy and human rights. Additional information about international drug-control programs is contained in the Classified Annex to this *Strategy*. The United States continues to focus international drug-control efforts on source countries. Drug-trafficking organizations and their production and trafficking infrastructures are most concentrated, detectable, and vulnerable to law enforcement in source countries. In addition, cultivation and production of coca and opium poppy into cocaine and heroin are labor-intensive activities. Consequently, cultivation and processing are relatively easier to disrupt than other 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 dismantle trafficking organizations, including their command and control structure along with its financial underpinnings.

Drug Control is a Continuous Challenge

The metaphor of a "war on drugs" is misleading. Although wars are expected to end, drug education — like all schooling — is a continuous process. The moment we believe ourselves victorious and drop our guard, drug abuse will resurface in the next generation. To reduce the demand for drugs, prevention must be ongoing. Addicted individuals should be held accountable for their actions and offered treatment to help change destructive behavior.

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, social, and financial — to check the spread of the disease and improve the patient's prognosis. Symptoms of the illness must be managed while the root cause is attacked. The key to reducing the incidence of drug abuse and cancer is prevention coupled with treatment and accompanied by research.

Endnotes

1 Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies, Summary of Findings from the 1998 National Household Survey on Drug Abuse (NHSDA), DHHS Publication No. (SMA) 00-3466, (Rockville, MD: U.S. Department of Health and Human Services, 2000).

2 Mumola, Christopher, "Substance Abuse and Treatment, State and Federal Prisoners, 1997" NCJ-172871), Bureau of Justice Statistics. Released January 5, 1999.

3 These indicators are: 1) physical activity 2) overweight and obesity 3) tobacco use 4) substance abuse 5) responsible sexual behavior 6) mental health 7) injury and violence 8) environmental quality 9) immunization 10) access to health care. Seven of these ten indicators are directly linked to the goals and objectives of the *Strategy*, particularly those related to reducing the incidence of drug use, co-occurring disorders, crime, and violence.

4 Bureau of Justice Statistics, Prison and Jail Inmates at Midyear 1999, April 2000.

5 National GAINS Center, "The Prevalence of Co-Occurring Mental and Substance Abuse Disorders in the Criminal Justice System," Just the Facts, spring 1997.

6 U.S. Department of Justice, Office of Justice Programs. "Reentry Courts: Managing the Transition from Prison to Community, A Call for Concept Papers," September 1999. Remarks of the Honorable Janet Reno, Attorney General of the United States, on the Reentry Court Initiative, John Jay General of the United States, on the Reentry Court Initiative, John Jay General of the United States, on the Reentry Court Initiative, John Jay College of Criminal Justice, New York, New York, February 10, 2000.

HOW TO WRITE AN OBITUARY FOR YOUR TEENAGER.

YOU sit and watch your child sleep. The hospital intercom serves as a constant reminder of where you are. You tuck in the blanket around his feet. He hasn't moved since you last tucked it in, but it gives you something to do. It's been two days since your child's friends carried him into the emergency room. The doctor says it's a losing battle. You're not ready for that.

* LISTING THE *cause of death in the obituary is at the family's discretion.*

When the hospital called, you thought it was a minor cut, another broken collarbone. The hospital nurse mentioned inhalants. That was a mistake, you thought. But you soon learned "sniffing" — inhaling household products to get high — was not a mistake. It was a habit. A habit that could've started with over 100 ordinary, everyday products like gasoline, correction fluid and spray paint. A habit that makes paraphernalia out of socks, soda cans, lunch bags. A habit that can damage the brain, heart, kidneys, liver. A habit that can even kill the very first time. You stare at your child and wonder if maybe that wouldn't have been better.

* IT IS APPROPRIATE *to include the child's nickname if well-known.*

It's been 16 hours since your child was pronounced dead. The relatives you phoned didn't know about inhalants. It seems no one did. You haven't slept in two days, but somehow you keep going. Because you have a funeral to arrange. And people to console. And someone from the obituary section is on the phone. They need to know about the child you just lost.

* FAMILIES WILL *often prefer to have the funeral home handle the obituary.*

Could this be your child? We hope not. Protect your children by telling them never to sniff inhalants. Set rules. Be firm. They'll listen.

IF YOU DON'T WANT TO LEARN ABOUT OBITUARIES, TELL YOUR CHILD NOT TO SNIFF INHALANTS. 1-800-788-2800

Communication. The Anti-Drug.

www.theantidrug.com www.drugfreeamerica.org

Office of National Drug Control Policy/Partnership for a Drug-Free America®

II. America's Drug Use Profile

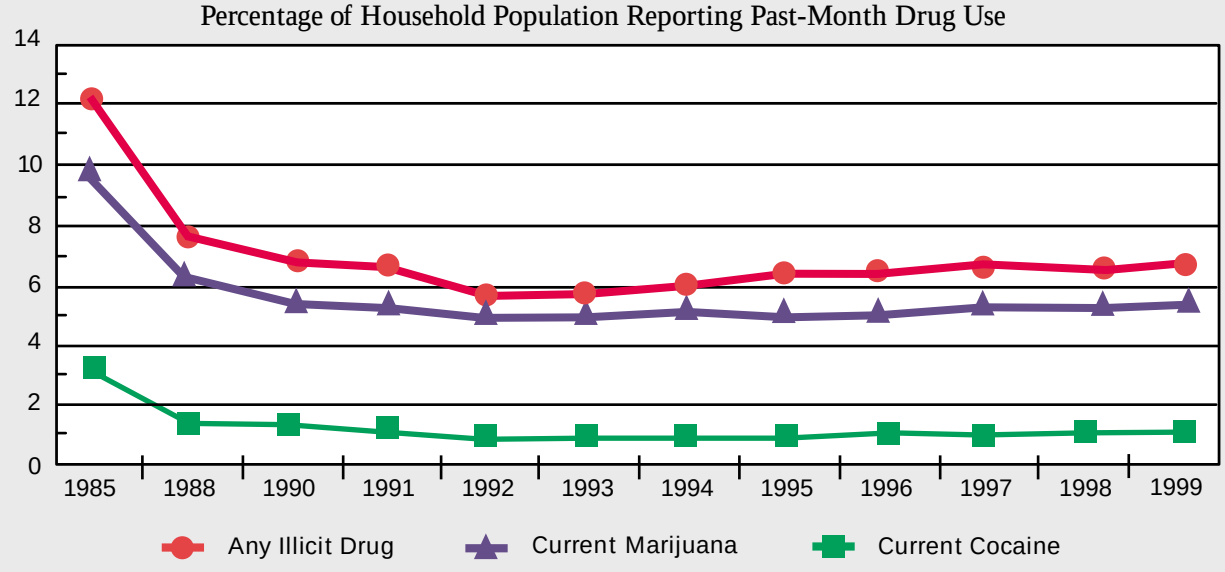
In 1999, an estimated 14.8 million Americans twelve years of age and older were current illicit drug users,* meaning they had used an illicit drug during the month prior to interview.[1] This number represents 6.7 percent of the population twelve and older. Drug use reached peak levels in 1979 when 14.1 percent of the population (25 million) age twelve and over were current users. This figure declined significantly between 1979 and 1992, from 23 million to twelve million. Since 1992 the number of current users has gradually increased, with statistically insignificant changes occurring each year. An estimated 3.6 million people met diagnostic criteria for dependence on illegal drugs in 1999, including 800,000 youths between the ages of twelve and seventeen.[2]

Drug use affects all Americans. More than half of our citizens (53 percent) say their concern about drug use has increased over the past five years; alarm is growing most in minority and low-income communities.[3] In 1999, a study by the National League of Cities cited use of illegal drugs, alcohol, and tobacco among youth as one of the top threats to America in the new millennium.[4] Even citizens who do not come into contact with illegal drug users share the burden of drug abuse. All of us pay the toll in the form of higher health-care costs, dangerous neighborhoods, and an overcrowded criminal justice system.

* The term "drug" is defined in the Office of National Drug Control Policy Reauthorization (21 USC 1701) as: "the meaning given the term 'controlled substance' in section 102(6) of the Controlled Substances Act (21 USC 802(6))." The Annual Report provides an assessment of current drug use (including inhalants) and availability, impact of drug use, and treatment.

Current Drug-Use Rates

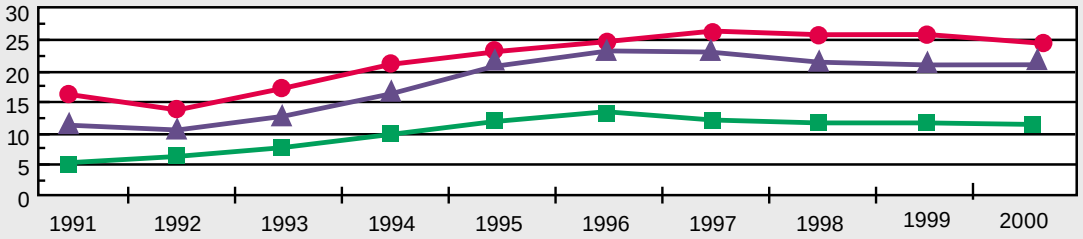
Percentage of Household Population Reporting Past-Month Drug Use



Source: SAMHSA, National Household Survey on Drug Abuse (various years)

Youth Trends in Current (Past-Month) Use of Any Illicit Drug

Percent Who Report Use



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
12th Grade	16.4	14.4	18.3	21.9	23.8	24.6	26.2	25.6	25.9	24.9
10th Grade	11.6	11.0	14.0	18.5	20.2	23.2	23.0	21.5	22.1	22.5
8th Grade	5.7	6.8	8.4	10.9	12.4	14.6	12.9	12.1	12.2	11.9

Source: 2000 Monitoring the Future Study

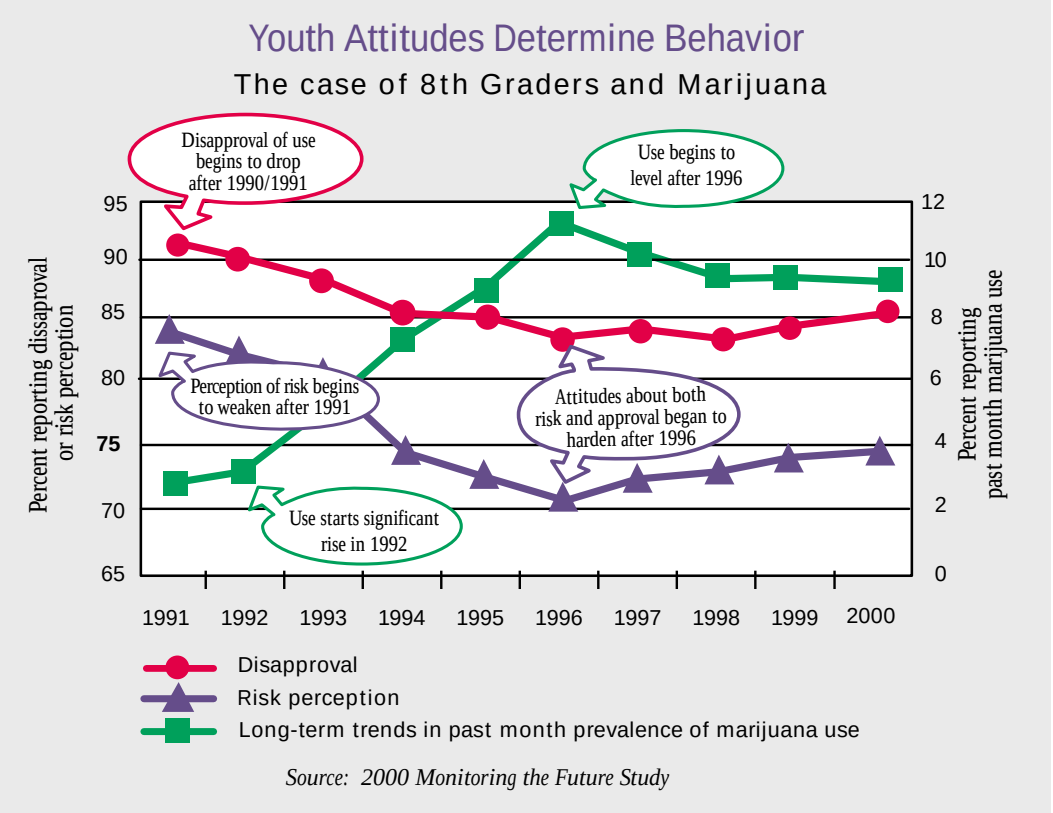
YOUTH DRUG USE TRENDS

Young Americans are especially vulnerable to drug abuse. Their immature physical and psychological development makes them highly susceptible to the ill effects of drugs for years to come. Moreover, behavior patterns that result from teen and preteen drug use often produce tragic consequences. Self-degradation, loss of control, disruptive conduct, and antisocial attitudes can cause untold harm to themselves and their families.

Trends of drug-use rates – According to the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration's (SAMHSA) 1999 National Household Survey on Drug Abuse (NHSDA), 9.0 percent of youth age twelve to seventeen reported current use of an illegal drug in 1999 – a 21 percent decrease from 11.4 percent in 1997. For the age group between eighteen to twenty-five years of age, current use of any illegal drug has been rising since 1994 and currently stands at 18.8 percent. This increase of 28 percent over the last two years (rising from 14.7 percent in 1997 and 16.1 percent in 1998) reflects the maturing of youth that experienced greater drug-use rates between 1992 and 1996. General changes in drug use are often linked to marijuana – the most frequently used illegal drug.[5]

Marijuana use is linked to crime and antisocial behavior – Marijuana use by young people has been associated with a wide range of dangerous behavior. Children who begin smoking "pot" at an early age are less likely to finish school and more apt to engage in acts of theft, violence, vandalism, and other high-risk behavior than children who do not smoke marijuana.[6] In 1996, nearly one million adolescents, age sixteen to eighteen, reported at least one incident of driving within two hours of using an illegal drug (most often marijuana) in the past year.[7] An analysis of Maryland juvenile detainees found that 40 percent were in need of substance-abuse treatment. Among this group, 91 percent needed treatment for marijuana dependence.[8] The link between early marijuana use and long-term substance abuse is demonstrated by "an almost four-fold increase in the likelihood of problems with cigarettes and a more than doubling of the odds of alcohol and marijuana problems."[9] Additionally, the 1999 NHSDA reports that the younger a person starts using marijuana, the higher the rate of adult illicit drug dependence. For example, 8.9 percent of adults who began smoking marijuana at age 14 or younger are drug dependent. In contrast, only 1.7 percent of adults who started using marijuana when they were 18 or older is drug dependent.[10]

Changing teen attitudes – The Partnership for a Drug-Free America's 2000 Partnership Attitude Tracking Study (PATS) indicates that disapproval of drugs among 7th through 12th graders reflected their knowledge of drug-related risks. The survey found teen attitudes and perceptions about marijuana trending in a positive direction, with more teens rejecting the drug. This year, more teens believe marijuana will make them lazy (48 percent, up from 44 percent in 1997), boring (32 percent, up from 29), or act stupidly or foolishly (54 percent, up from 51). Fewer see marijuana all around them (47 percent, compared to 59 percent in 1997), and fewer believe most people will use the drug (36 percent, down from 41).[11] Similarly, teens continue to view cocaine and crack as dangerous drugs, with 82 percent of teens agreeing that there is great risk associated with regular use of cocaine, and close to half (47 percent)



Source: 2000 Monitoring the Future Study

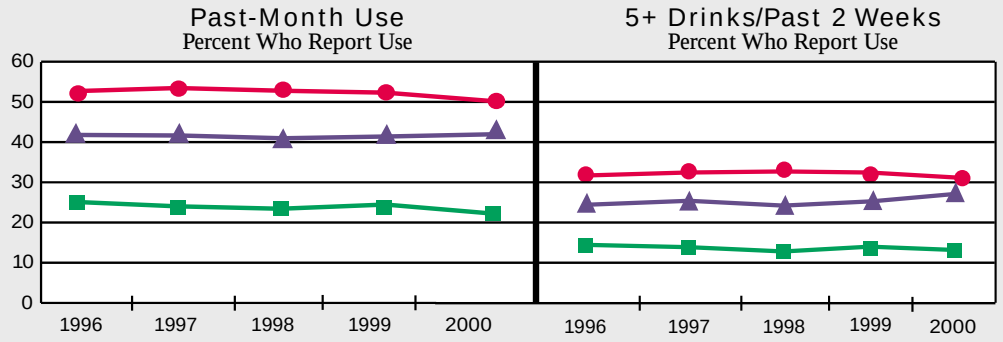
saying the same about trial use of these drugs. Additionally, three out of four teens (78 percent) continue to recognize the deadly consequences of using inhalants. This measure remained stable over the last year. Earlier PDFA research indicated that while teens associated high risk with regular use of inhalants, the same did not hold true for occasional use.

Emerging drug-use trends among youth – The increase in 3,4-methylenedioxymethamphetamine (MDMA) usage rates among 10th and 12th graders, according to the 2000 Monitoring the Future Survey, is of concern. The documented increase in use of this so-called "club drug" corroborates other recent indicators, including ONDCP' *Pulse Check*, and underscores the importance of NIDA's new research initiative on club drugs announced in October 2000. Among 10th graders, annual use of MDMA increased 33 percent (from 3.3 percent to 4.4 percent). Use of MDMA increased in all three use categories for 12th graders: 38 percent for lifetime use (from 5.8 percent to 8 percent); 56 percent for annual use (from 3.6 percent to 5.6 percent); and 67 percent for past 30-day use (from 1.5 percent to 2.5 percent). The 2000 Monitoring the Future study supports the NHSDA MDMA findings. Specifically, the MTF study reports that past-year use of ecstasy by 8th graders increased 82 percent (from 1.7 percent to 3.1 percent) between 1999 and 2000; past-month use increased 75 percent (from 0.8 percent to 1.4 percent). Past-month use of MDMA by 10th graders increased 44 percent (from 1.8 percent to 2.6 percent).

Increases in the use of steroids highlights the need for the international sports community to educate youth about the dangers of steroids and other performance-enhancing drugs. Among 10th graders, past year steroid use increased 29 percent between 1999 and 2000, from 1.7 percent to 2.2 percent.[12]

Underage use of alcohol – Young people use alcohol more than illegal drugs. The younger a person is when alcohol use begins, the greater the risk of developing alcohol abuse or dependence problems later in life. Over 40 percent of youth who begin drinking before age fifteen become dependent on alcohol compared with just 10 percent of those who begin drinking at age twenty-one.[13] Alcohol use among the young strongly correlates with adult drug use. For example, adults who start drinking at early ages are nearly eight times more likely to use cocaine than adults who did not drink as children.[14]

Youth and Alcohol



	1996	1997	1998	1999	2000	1996	1997	1998	1999	2000
12th Grade	50.8	52.7	52.0	51.0	50.0	30.2	31.3	31.5	30.8	30.0
10th Grade	40.4	40.1	38.8	40.0	41.0	24.8	25.1	24.3	25.6	26.2
8th Grade	26.2	24.5	23.0	24.0	22.4	15.6	14.5	13.7	15.2	14.1

Source: 2000 Monitoring the Future Study

The United States had 10.4 million underage current drinkers of alcohol in 1999. In this group, 6.8 million engaged in binge drinking, and 2.1 million were classified as heavy drinkers.[15] The 2000 MTF reports that daily alcohol use by eighth graders declined twenty percent from one percent to 0.8 percent. Other changes in alcohol use, between 1999 and 2000, by 8th, 10th, and 12th graders were statistically insignificant. In 1999, past-month alcohol use for eighth graders in metropolitan areas was lower than for eighth graders in rural areas (21.7 percent versus 28.1 percent).[16]

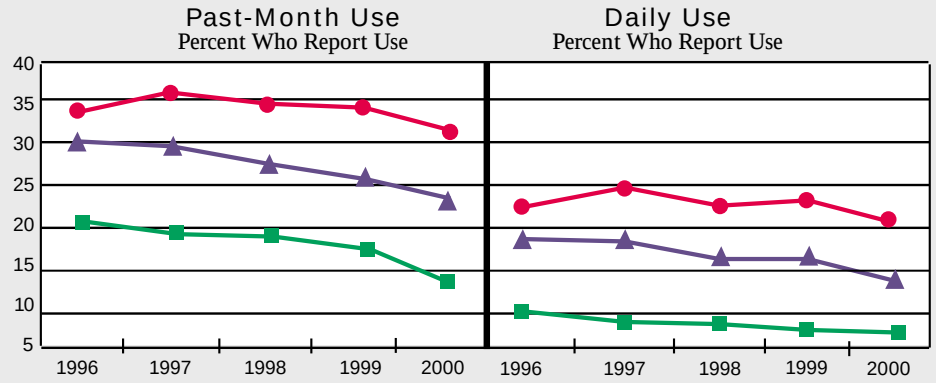
Underage use of tobacco – The younger a person is when smoking begins, the greater the risk of contracting a disease attributable to smoking. The NHSDA estimates that every day more than six thousand people aged eighteen or younger try their first cigarette, and about three thousand people eighteen or younger become daily smokers.[17] If these trends continue, approximately five million individuals now under eighteen will die early from a preventable disease associated with smoking. Widely available and legal for those of required age, tobacco is one of the easiest illicit substances of abuse for children to obtain.

Smoking tobacco and use of illegal drugs appear to be linked. The 1999 NHSDA indicates that youths age twelve to seventeen that currently smoked cigarettes were 7.3 times more likely to use illegal drugs and fifteen times more likely to drink heavily than youths that did not smoke were.[18] An estimated 15.9 percent of people in this age group were current cigarette smokers in 1999.[19] This rate has declined since 1997, when the rate was 19.9 percent. In 1997, 39.7 percent of white high school students currently smoked cigarettes, compared with 34 percent for Hispanics and 22.7 percent for African-Americans.[20] According to the 1999 National Youth Tobacco Survey, these numbers decreased to 32.8 percent, 25.8 percent, and 15.8 percent, respectively.[21] This survey also reports that about one in ten (9.2 percent) middle school students and more than a quarter (28.4 percent) of high school students are current cigarette smokers; 12.8 percent of middle school students and 34.8 percent of high school students use *any* type of tobacco.[22] In rural America, eighth graders are twice as likely to have smoked cigarettes in the past month than their peers in large metropolitan areas (26.1 percent versus 12.7 percent) and almost five times more likely to have used smokeless tobacco (8.9 percent versus 1.8 percent).[23]

The recent entry of Indian "bidis"* into the American market poses a new tobacco-related health problem, especially in relation to youth. This type of cigarette is available at gas stations, liquor stores, ethnic food shops, selected health stores, and through the Internet. Bidis must be puffed more frequently than regular cigarettes, and inhaling a bidi requires great pulmonary effort due to its shape and poor combustibility. Consequently, bidi smokers breathe in greater quantities of tar and other toxins than smokers of regular cigarettes.[24] In addition, bidis contain in excess of three times

* Dubbed the "poor man's cigarette" in India, bidis (pronounced beedies) are unfiltered cigarettes packed with tobacco flakes and hand-rolled in tendu, temburni, or other leaves that are secured with a string at one end. Bidis produced for the American market are flavored to taste like chocolate and various fruits or spices, making them more attractive to minors. Bidis look like marijuana cigarettes, are easy to buy, and are often cheaper than conventional cigarettes.

Youth and Cigarettes



	Past-Month Use					Daily Use				
	1996	1997	1998	1999	2000	1996	1997	1998	1999	2000
12th Grade	34.0	36.5	35.1	34.6	31.4	22.2	24.6	22.4	23.1	20.6
10th Grade	30.4	29.8	27.6	25.7	23.9	18.3	18.0	15.8	15.9	14.0
8th Grade	21.0	19.4	19.1	17.5	14.6	10.4	9.0	8.8	8.1	7.4

Source: 2000 Monitoring the Future Study

the amount of nicotine and five times the tar than regular cigarettes.[25] Bidi smokers have twice the risk of contracting lung cancer compared to people who smoke filtered cigarettes; five times the risk of suffering heart disease; and a considerably greater risk for cancer of the oral cavity, pharynx, larynx, lungs, esophagus, stomach, and liver.[26]

Clubs and Raves – The use of synthetic drugs has become a popular method of enhancing the dance club and "rave" experience.* While these events were not originally intended to serve as a nexus for illicit drug sales, the culture surrounding the events has created a favorable environment for illegal drug trafficking. "Club Drugs" is a general term for a number of illicit drugs (primarily synthetic; i.e. MDMA, Ketamine, GHB, GBL, Rohypnol, LSD, PCP, methamphetamine, and inhalants) that are most commonly encountered at nightclubs and raves. The drugs have gained popularity due to the false perception that they are not as harmful, nor as addictive, as mainstream drugs such as heroin. In fact, rave party attendees who ingest such substances are at risk of dehydration, hyperthermia, and heart or kidney failure. These risks are due to a combination of these drugs' stimulant effect that allows the user to dance for long periods of time and the hot, crowded atmosphere of rave parties. The combination of crowded all-night dance parties and synthetic drug use has caused fatalities.

An additional danger associated with this emerging drug market is that drug composition may vary significantly and substitute drugs often are sold when suppliers are unable to provide the drug currently in demand. Club drug users risk taking dangerous combinations of drugs. Not only can this lead to a greater risk of drug overdose, the lack of knowledge regarding what drug was ingested can complicate the task of emergency response personnel.[27]

Drug abuse and sexual activity – Juvenile abuse of alcohol and other drugs is strongly associated with risk-taking behavior, including promiscuity. According to the 1999 National Center on Addiction and Substance Abuse (CASA) study "Dangerous Liaisons," increased promiscuity leads to a greater risk for sexually transmitted diseases and unplanned teenage pregnancy.[28] Adolescents aged fourteen and younger who use alcohol are twice as likely to engage in sexual behaviors than non-drinkers; drug users are five times more likely to be sexually active than youth who are drug-free. Teens between the age of fifteen and nineteen who drink are seven times more likely to have sex and twice as likely to have four or more partners than those who refrain from alcohol. Furthermore, more than 50 percent of teenagers say that sex while drinking or on drugs often produces unplanned pregnancies.[29] An Ohio study of high school girls who tried cocaine indicated that these adolescents were five times more likely to have experienced an unintended pregnancy than peers who avoided cocaine.[30]

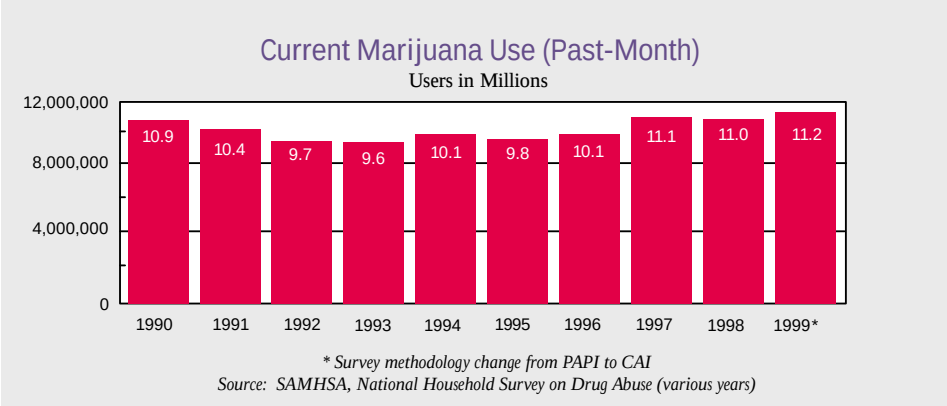
* A rave is a dance party, characterized by loud, rapid-tempo "techno" music, light shows, smoke or fog, and pyrotechnics. Originating in Western Europe and England in the early 1990's, these events have moved out of the underground and into the mainstream, often attracting crowds of underage youth with advertisements citing "safe, alcohol-free" environments with police-type security. Raves often are advertised on the internet and attendance can range from less than 100 to several thousand.

MARIJUANA

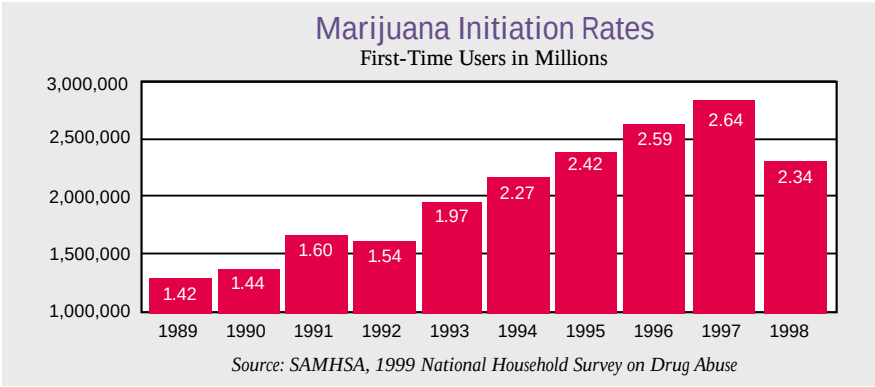
Overall usage – In 1999, 11.2 million of Americans aged twelve and older were current (past-month) marijuana users – this number is not statistically different from the 11 million (5 percent) reported in 1998 and the 11.1 million (5.1 percent) reported in 1997. An estimated 75 percent of current illicit drug users use marijuana.[31] An estimated 2.3 million Americans tried marijuana for the first time in 1998.[32] This number translates to about 6,400 new marijuana users per day and has increased from approximately 1.4 million in 1990 to 2.6 million in 1996, remained level in 1997, then dropped between 1997 and 1998. There has been an increasing trend toward marijuana use since 1997 among young adults, age 18-25 years (12.8 percent in 1997, 13.8 percent in 1998, and 16.4 percent in 1999) and a decreasing trend since 1997 for youths age 12-17 years (9.4 percent in 1997, 8.3 percent in 1998 and 7.0 percent in 1999).[33]

Use among youth – Marijuana is the major illicit drug used by youths, age 12-17; 7.7 percent of youths were current users of marijuana in 1999.[34] More than two-thirds of the 2.3 million new users reported in 1999 were under the age of 18. According to the 2000 MTF, use of marijuana was stable between 1999 and 2000. Past-year use of marijuana among 8th graders declined 15 percent (from 18.3 percent to 15.6 percent) between 1996 and 2000; past-year marijuana use among 10th graders declined ten percent between 1997 and 1998 and has remained stable since then.[35] However, the rates of marijuana initiation for youth during 1995 through 1998 are at their highest levels since the peak levels in the late 1970s.[36] The rate had increased between 1991 and 1995 from 46 per thousand potential new users* in 1991 to 80 per thousand potential new users in 1995. Use of marijuana by youths who had never previously used the substance doubled during that time period. However, the 1998 rate for youth (81.0) was significantly lower than the 1997 rate (90.8).[37] The 2000 MTF reports that disapproval of trying marijuana once or twice increased three percent (from 70.7 percent to 72.5 percent) among 8th graders, a continuation of a trend started in 1997 when 67.6 percent of 8th graders expressed disapproval. Among 12th graders, disapproval of trying marijuana increased eight percent from 48.8 percent to 52.5 percent), reversing the trend observed through the previous nine years.

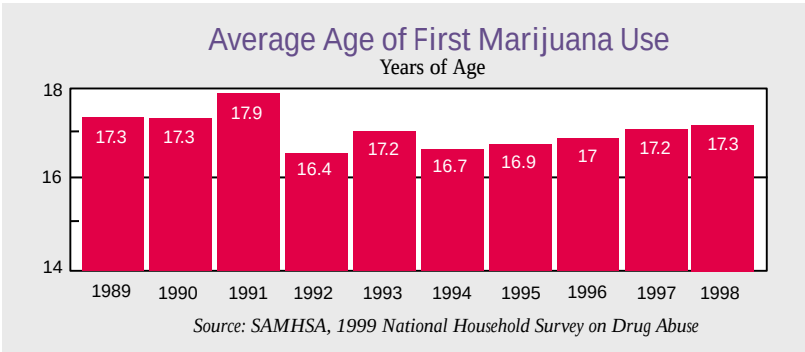
Availability – Marijuana is the most readily available illegal drug in the United States. Further, the NDIC reports an upswing in the number of investigations, arrests, and seizures in and around high schools, indicative of the ease with which



Survey methodology change from PAPI to CAI
Source: SAMHSA, National Household Survey on Drug Abuse (various years)



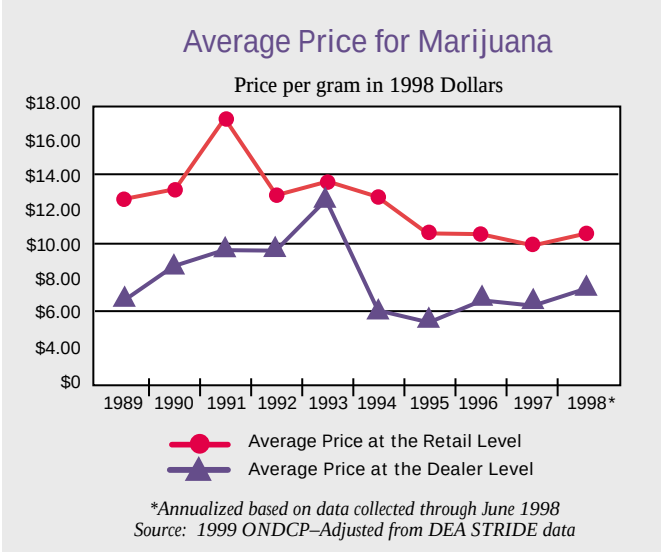
Source: SAMHSA, 1999 National Household Survey on Drug Abuse



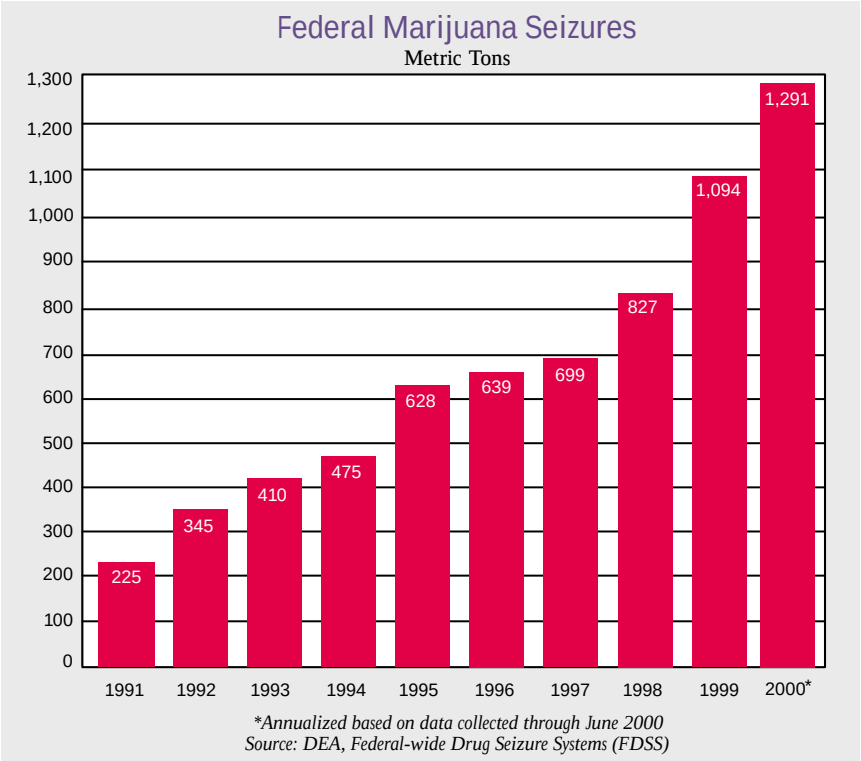
Source: SAMHSA, 1999 National Household Survey on Drug Abuse

* A potential new user is an individual in the subgroup who has not used the drug being surveyed.

youth can access this dangerous drug.[38] The majority of the marijuana in the U.S. was foreign-grown. Mexico, Colombia, and Jamaica are primary source nations; Canada, Thailand, and Cambodia are secondary sources.[39] Although the full scope of domestic marijuana cultivation is unknown, the National Drug Intelligence Center indicates that every state in the nation reports some level of indoor and outdoor cultivation.[40] The DEA's Domestic Cannabis Eradication/ Suppression Program show that authorities eradicated 2.2 million outdoor marijuana plants in 1998 and 3.2 million in 1999. Further, preliminary DEA reporting indicates that 1.4 million plants had been eradicated in just 30 states between January and September 2000. In 1999,the leading states for outdoor cannabis growth – California, Hawaii, Kentucky, and Tennessee – accounted for nearly 2.49 million cultivated outdoor plants. This represents roughly 75 percent of the total number of plants eradicated last year.[41] In the past year, the Department of Agriculture and the U.S. Forest Service report an escalation of in the amount of marijuana cultivation on federal public land – 632,310 plants destroyed in 2000 up from 490,300 in 1999.[42]



*Annualized based on data collected through June 1998
Source: 1999 ONDCP–Adjusted from DEA STRIDE data



*Annualized based on data collected through June 2000
Source: DEA, Federal-wide Drug Seizure Systems (FDSS)

Indoor cultivation of marijuana provides a controlled environment conducive to year-round production of high-potency sinsemilla* and can be accomplished in a variety of settings from closets to elaborate greenhouses. Indoor cannabis cultivators frequently employ advanced agronomic practices such as cloning; hydroponics; and automatic light metering, irrigation, fertilizing, and insecticides to enhance the rate of growth. Nationally, drug law-enforcement authorities seized 208,027 indoor-grown marijuana plants in 1999, a slight decrease from the 232,839 seized in 1998.[43] Law enforcement speculates that this decrease may be indicative of the increased sophistication in clandestine cultivation methods employed by growers.

Prices for commercial-grade marijuana have remained relatively stable over the past decade, ranging from approximately $400 to $1,000 per pound in U.S. Southwest border areas to between $700 and $2,000 per pound in the Midwest and Northeast United States. According to data from the Potency Monitoring Project at the University of Mississippi, the tetrahydrocannabinol (THC) content of commercial-grade marijuana rose from under 2 percent in the early 1980s to 4.43 percent in 1998 and to 4.87 percent in 1999.[44] THC levels in sinsemilla increased from 12.41 percent in 1998 to 13.55 percent in 1999. As of June 2000, the average TCH potency level for commercial grade domestic marijuana increased to 5.58 percent. The highest concentration of THC found in a marijuana sample submitted for analysis was 33.12 percent in a seizure submitted by the Oregon State Police to the University of Mississippi.[45]

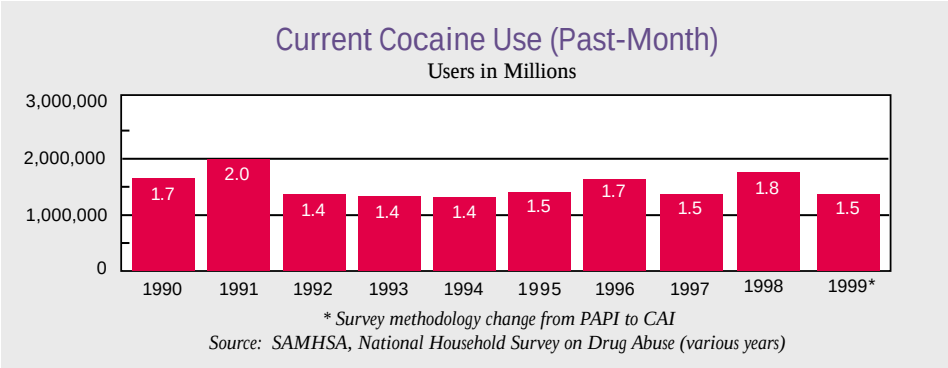
* Spanish for "without seed." These unpollinated flowering tops of the female *Cannabis sativa L.* plant are valued for high tetrahydrocannabinol (THC) content.

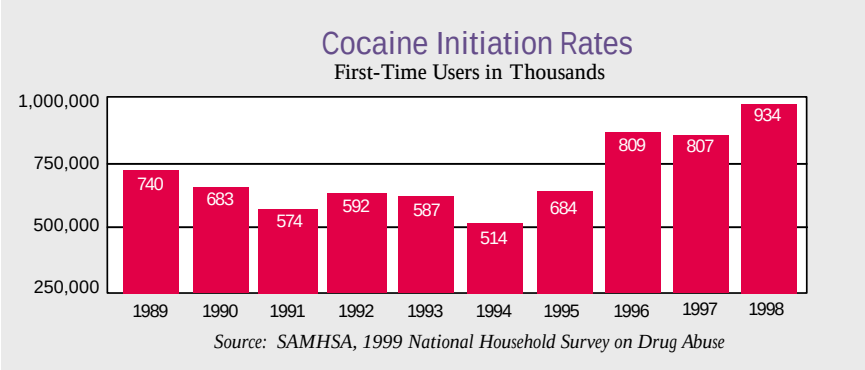
COCAINE

Overall usage – Cocaine use stabilized in the United States between 1992 and 1999. Past-month cocaine use declined from 3 percent of the population in 1985 to 0.7 percent in 1992 and did not change significantly through 1999, in which 0.8 percent of the population reported past-month use.[46] Despite the stabilization of use, the number of new users has increased. In 1998, there were 934,000 new users of cocaine. This number represents a 37 percent increase from 1990, when there were 683,000 new users.[47] This level is still lower than during the 1980s when the new initiate figures were between one and 1.6 million per year.

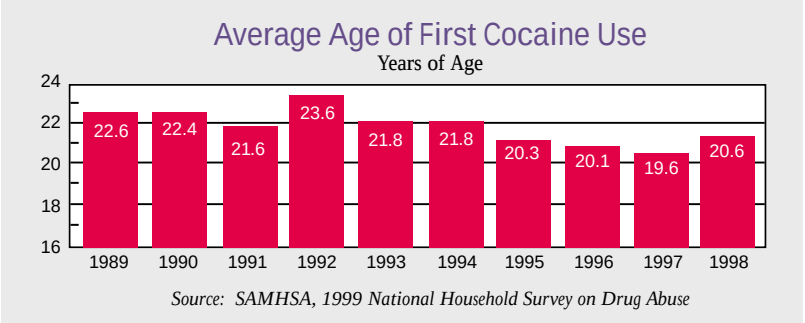
In recent years, domestic cocaine availability has been estimated at 288 pure metric tons for 1996, 312 metric tons for 1997, 291 metric tons for 1998 and 276 metric tons for 1999.[53] According to most recent data, the average wholesale purity of cocaine remained relatively stable since 1990 – between 65 and 80 percent (with retail purity varying widely according to local supply and demand).[54] Law-enforcement agencies throughout the nation continue to report serious problems with cocaine, crack, and related criminal activity.

Use among youth – In 1999, 0.7 percent of youths, age 12-17 reported past-month use of cocaine. This number is not significantly different from the 0.8 percent reported for 1998 and the 1 percent reported in 1997; it is however, significantly higher than the 0.3 percent reported in 1994.[48] The 2000 MTF reports that use of cocaine showed significant declines in 2000 in several categories among 12th graders. Specifically, past-year use of any type of cocaine declined from 6.2 percent in 1999 to 5.0 percent in 2000; past-year crack use decreased from 2.7 percent to 2.3 percent and past-year use of powder cocaine declined 24 percent, from 5.8 percent to 4.5 percent. The rate of initiation among youths age 12-17 increased from 5.1 in 1992 to 13.1 in 1996, and has remained level since then.[49]



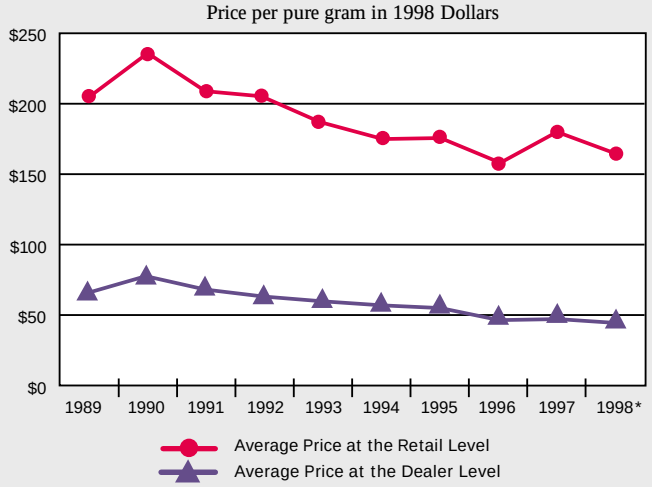


Availability – Cocaine continues to be readily available in nearly all major metropolitan areas.[50] The Mid-Year 2000 report of the Interagency Assessment of Cocaine Movement estimated that 242 metric tons of cocaine arrived in the United States in the first six months of 2000, an almost 40 percent increase over the 174 metric tons estimated to have arrived over the same period in 1999.[51] A significant amount of the cocaine smuggled into the U.S. traveled through the Mexico-Central America Corridor.[52]



Average Price For Cocaine

Price per pure gram in 1998 Dollars



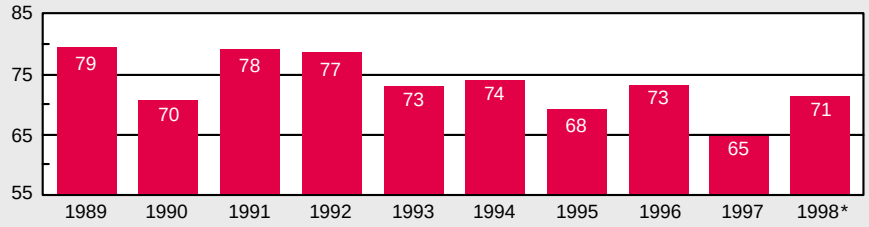
**Annualized based on data collected through June 1998*
Source: 1999 ONDCP–Adjusted from DEA STRIDE Data

The National Drug Intelligence Center (NDIC) observes that the production and availability of crack is directly linked to the availability of cocaine powder.* Despite the stabilization of domestic cocaine use between 1992 and 1999, improvements in the criminal distribution and production of cocaine and crack have increased their availability in suburban and rural communities.[55]

* NDIC reports some state and local law-enforcement agencies have noted significant increases in the purity of crack cocaine—up to 85 percent.

Cocaine Purity at the Retail Level

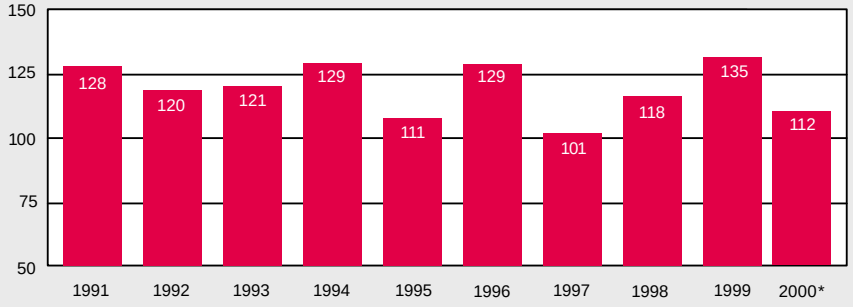
Percent per gram



**Annualized based on data collected through June 1998*
Source: 1999 ONDCP–Adjusted from DEA STRIDE Data

Federal Cocaine Seizures

Metric Tons



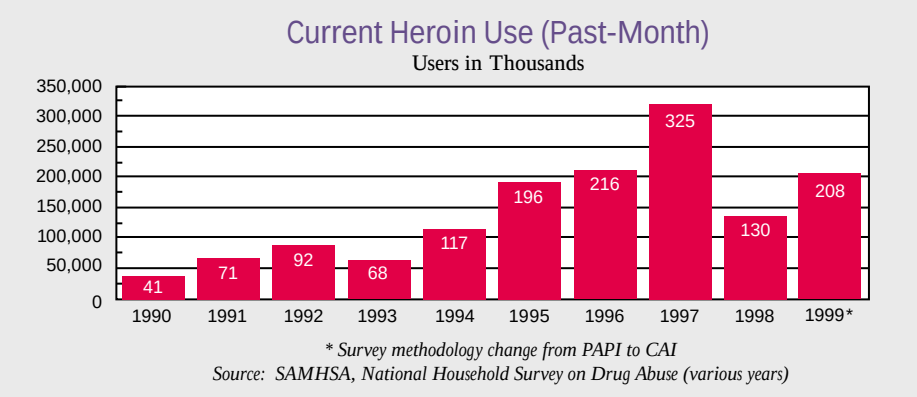
**Annualized based on data collected through June 2000*
Source: DEA, Federal-wide Drug Seizure Systems (FDSS)

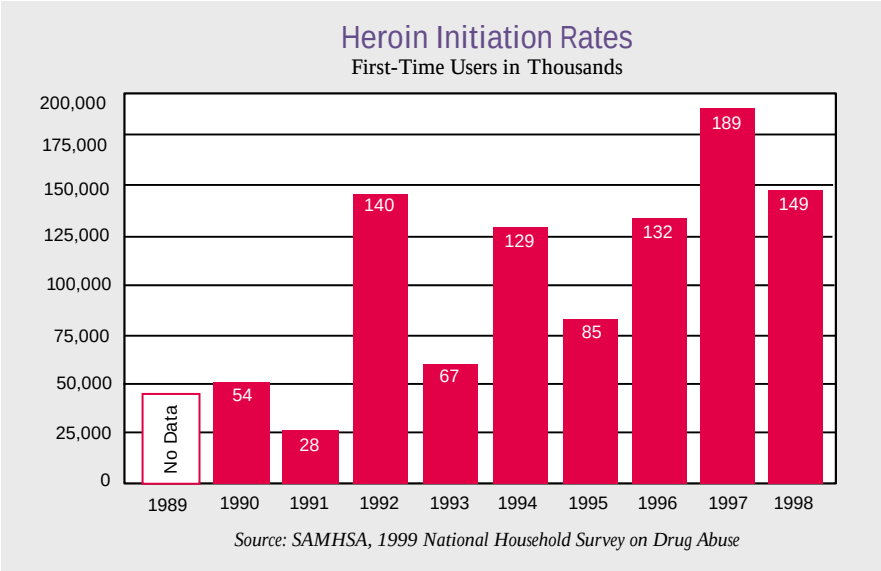
HEROIN

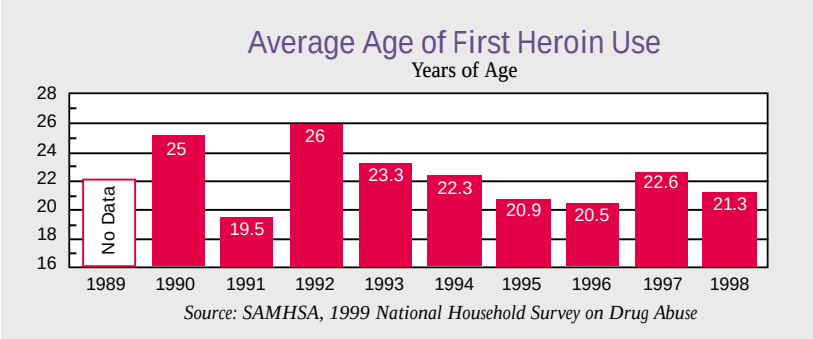
Overall usage – Heroin use in the United States has stabilized since 1992. Approximately, 0.1 percent of the household population reported past-month use of heroin in 1999, which is the same as the 0.1 percent that reported in 1994,1995,1996, and 1998 (0.2 percent of the population reported past-month use in 1997).[56] An estimated 149,000 new users were reported in 1998, which is not statistically different than the 189,000 new users in 1997 or the 132,000 new users in 1996.[57] Injection remains the most prevalent method of ingestion, particularly for low purity heroin. The increased availability of high purity heroin and the fear of injection from the Human Immunodeficiency Virus (HIV), sometimes transmitted through shared needles, has made snorting and smoking the drug more common. In addition to avoiding the negative stigma of intravenous drug use, some teenager heroin users smoke or snort heroin under the false impression that such routes of admission are less addictive.

Use among youth – In 1999, past-month use of heroin among youth age 12-17, was 0.1 percent, not statistically different from the 0.2 percent reported in 1995-1998.[58] The rate of heroin initiation for youth increased from less than one per 1,000 potential new users during the 1980s to nearly two per 1,000 potential new users between 1996 through 1998.[59] Among the estimated 471,000 persons who used heroin for the first time during 1996 through 1998, a quarter (125,000) were under age 18. The 2000 MTF[60] reports that past-year use among 8th graders peaked in 1995 and 1996 and has declined 21 percent, from 1.4 percent to 1.1 percent in 2000. Past-year use among 10th graders peaked in 1997 and has remained at that level each year through 2000. The peak year for past-year and past-month use among 12th graders, however, was 2000 at 1.5 percent. This number represents an increase of 275 percent from the 10-year low of 0.4 percent in 1991.

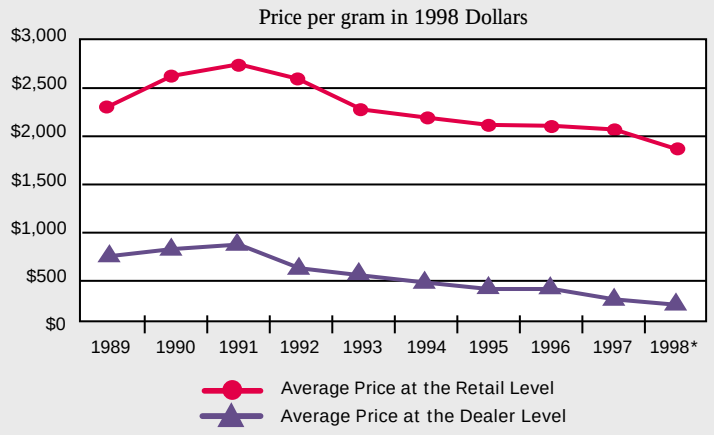
Availability – Heroin purity is a reflection of the drug's availability. Unprecedented retail purity and low prices in the United States indicate that heroin is readily accessible.[61] When the drug is hard to find, it is cut with other substances. High purity levels may also reflect changes in trafficking patterns. A decrease in the number of middlemen involved in getting South





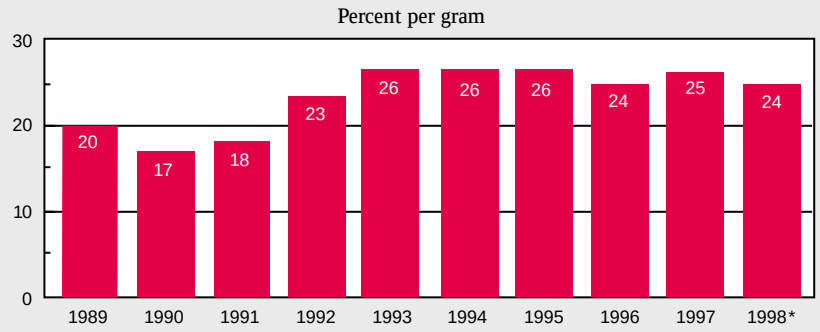


Average Price For Heroin



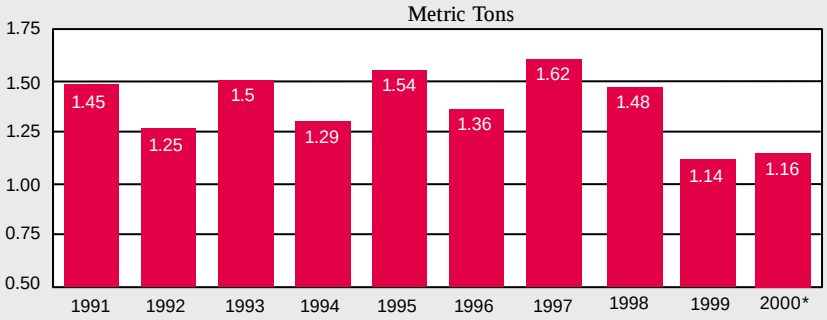
**Annualized based on data collected through June 1998*
Source: 1999 ONDCP–Adjusted from DEA STRIDE Data

Heroin Purity at the Retail Level



**Based on annualized data through June 1998*
Source: 1999 ONDCP–Adjusted from DEA STRIDE Data

Federal Heroin Seizures



**Annualized based on data collected through June 2000*
Source: DEA, Federal-wide Drug Seizure Systems (FDSS)

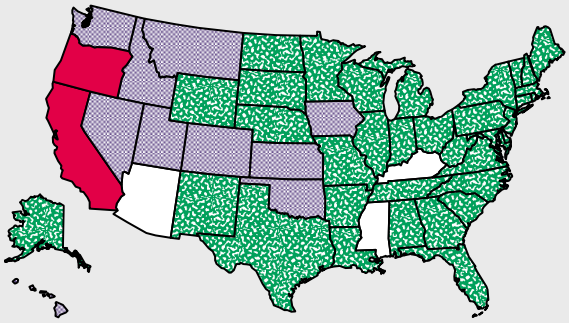
American and Mexican heroin to customers bypasses mid-level individuals and minimizes cutting and adulteration that historically has reduced heroin purity. For example, the Central Florida High Intensity Drug Trafficking Area reports heroin sampled from 1999 seizures with purity levels up to 97 percent.[62] Consumption-based modeling estimates that U.S. heroin availability in 2000 will remain unchanged from the 1999 level of 12.9 metric tons; meanwhile, the average price per gram remained constant at just over $1,000.[63] A supply-based approach has also been used to estimate heroin availability, applying data from DEA's Heroin Signature Program and potential production estimates. This methodology has resulted in an estimate of 16 metric tons of domestically available heroin in 1999 – an uncertain figure due to the lack of information on Latin American poppy cultivation.

The Spread of Methamphetamine

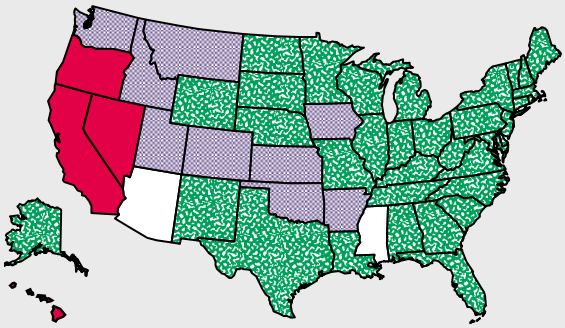
Methamphetamine Treatment Admission Rates (per 100,000)

50+ | 10-50 | < 10 | No data

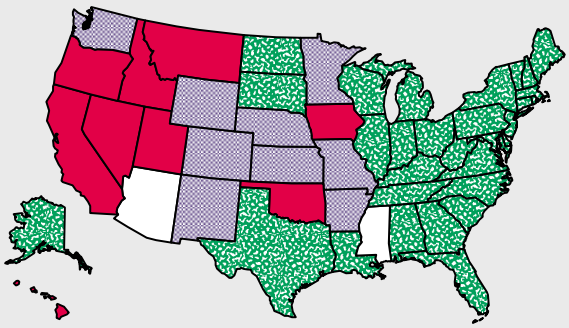
1992



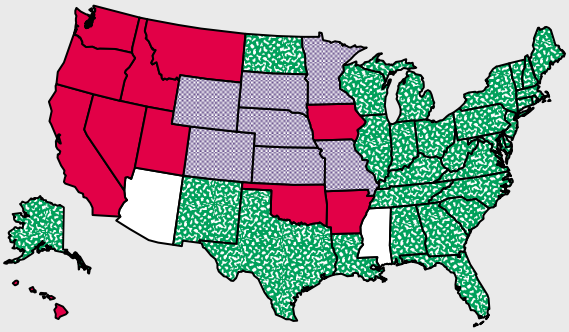
1993



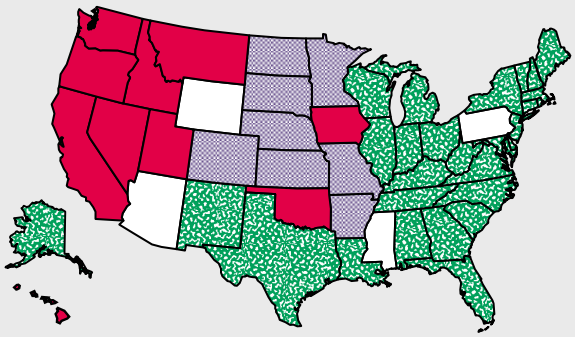
1994



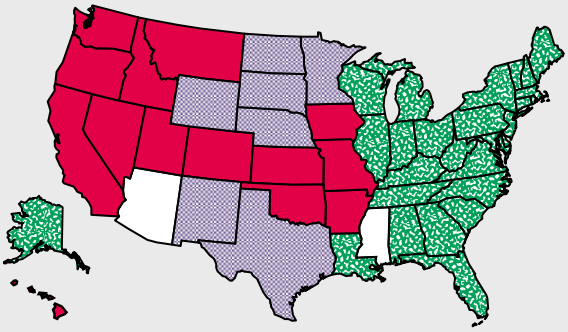
1995



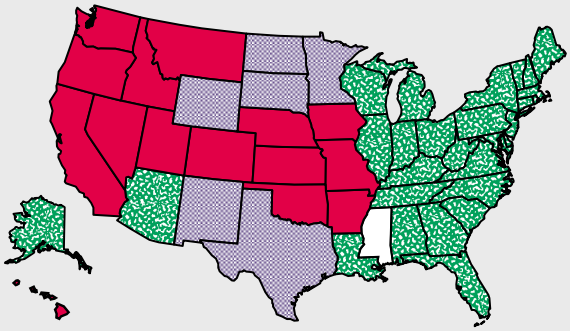
1996



1997



1998



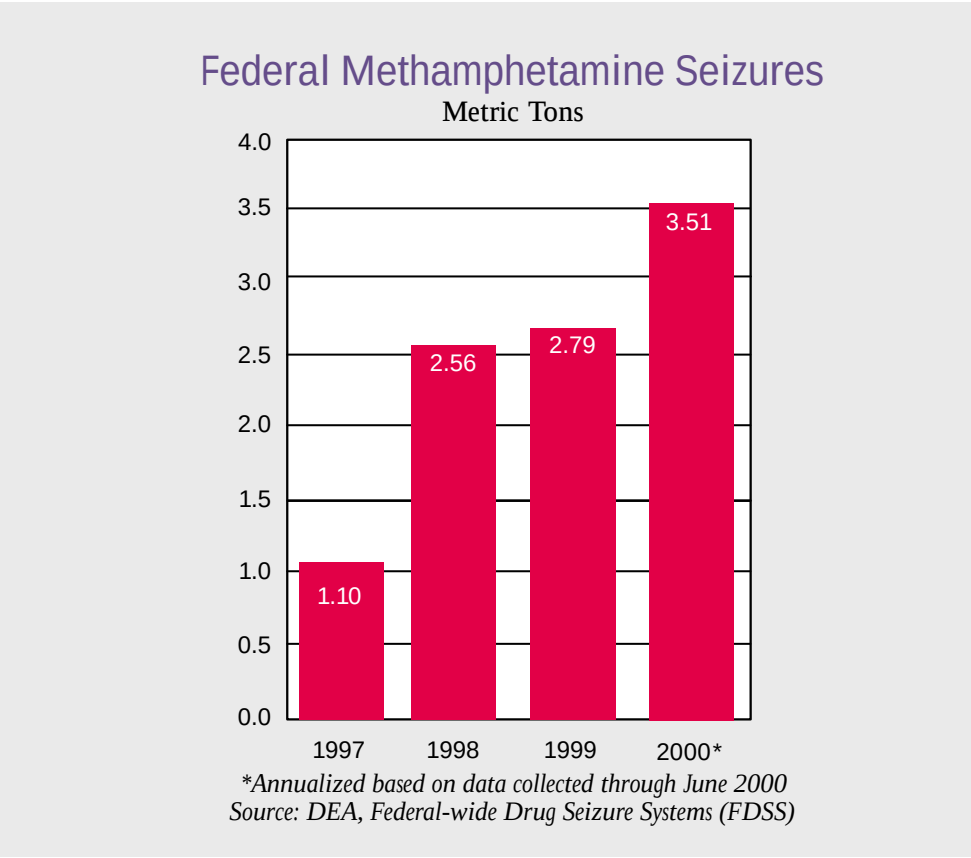
Source: SAMHSA, OAS, TEDS

METHAMPHETAMINE

General Methamphetamine is a highly addictive stimulant that can be manufactured using products commercially available anywhere in the United States. The stimulant effects from methamphetamine can last for hours, instead of minutes as with crack cocaine. Many methamphetamine users try to alleviate the effect of a methamphetamine "crash" by buffering the drug with other substances like alcohol or heroin. As is the case with heroin and cocaine, methamphetamine can be snorted, smoked, or injected. The chemicals used in producing methamphetamine are extremely volatile, and the amateur chemists running makeshift laboratories can cause deadly explosions and fires. The by-products of methamphetamine production are extremely toxic and present a threat to the environment. The El Paso Intelligence Center estimates that clandestine methamphetamine laboratories, each of which costs between $3,100 and $150,000 to clean up (depending on size), produce as much as twenty metric tons of toxic waste each year.[64] Methamphetamine traffickers display no concern over environmental hazards when manufacturing the drug and disposing of its chemical by-products.

Overall usage – In 1998, there were an estimated 378,000 new methamphetamine users, up from 149,000 in 1990. For young adults age 18-25, there was an increase in the rate of first use between 1990 and 1998 (from 3.0 to 6.1 per 1,000 potential new users).[65] While use of this drug is spreading east, methamphetamine continues to be more common in the western U.S. The number of hardcore methamphetamine users in 1998 was estimated to be 356,000 compared with 310,000 in 1997.[66]

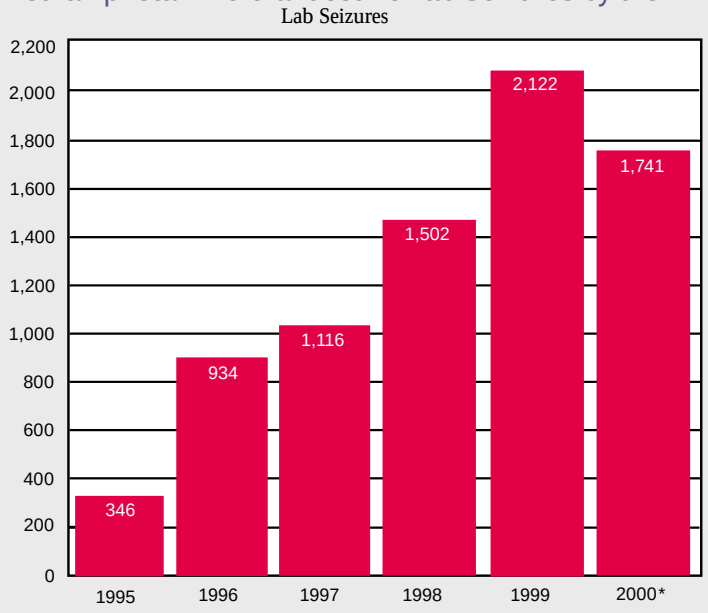
Use among youth – The rate of first use among youths age 12-17 rose significantly from 1990 to 1998, from 2.2 to 7.4 per 1,000 potential new users.[67] The 2000 MTF reports slight declines, among 8th, 10th, and 12th graders, in annual use of methamphetamine between 1998 and 2000. However, these declines are not statistically significant. CASA reports that past-month methamphetamine use for eighth graders in rural areas is 5.1 percent versus 2.5 percent for their peers in larger cities.[68]



**Annualized based on data collected through June 2000*
Source: DEA, Federal-wide Drug Seizure Systems (FDSS)

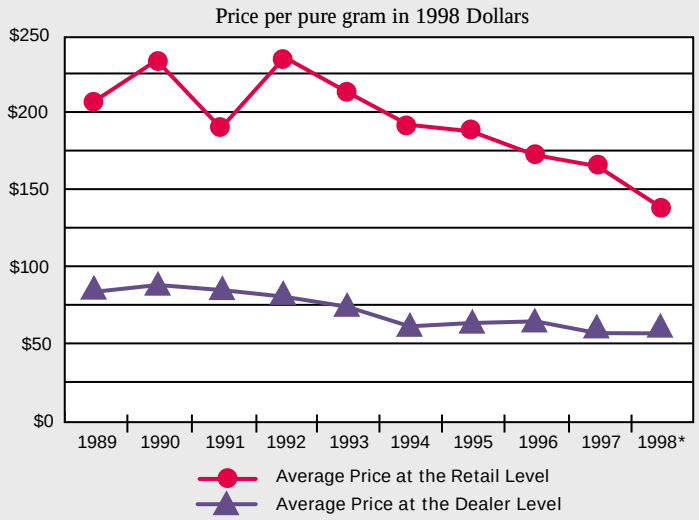
Availability – Methamphetamine is the most prevalent synthetic drug clandestinely manufactured in the United States.[69] Historically, the methamphetamine problem has been concentrated in the west and southwestern United States. It is now in most major metropolitan areas (except in the northeast) and is emerging in small towns and rural communities.[70] Methamphetamine manufacturing is experiencing unprecedented growth. The total number of clandestine laboratories seized by federal, state, and local law-enforcement agencies in CY 1999 totaled 7,544. Between January and October 2000, these agencies seized 4,600.[71] Clandestine laboratory seizures by the DEA alone increased over 41 percent from 1,502 in CY 1998 to 2,122 in CY 1999. Between January and October 2000, DEA had seized 1,741 labs. [72]In the Midwest, lab seizures made by state and local authorities, working in Midwest HIDTA, more than tripled between CY 1997 to 1999.[73] This increase in seizures may reflect efforts by individuals operating small clandestine laboratories on the periphery of the methamphetamine market to exploit demand for the drug and satisfy personal use.[74] According to consumption-based modeling estimates, U.S. methamphetamine availability at the retail level increased from 11.9 metric tons in 1997 to 15.9 metric tons in 1998. For 1999 and 2000, methamphetamine availability is estimated at 15.5 metric tons. The average retail price per pure gram remained constant at approximately $140.[75]

Methamphetamine Clandestine Lab Seizures by the DEA



**Annualized based on data collected through November 2000*
Source: Drug Enforcement Administration- El Paso Intelligence Center

Average Price For Methamphetamine



**Annualized based on data collected through 1998*
Source: 1999 ONDCP–Adjusted from DEA STRIDE Data

MDMA

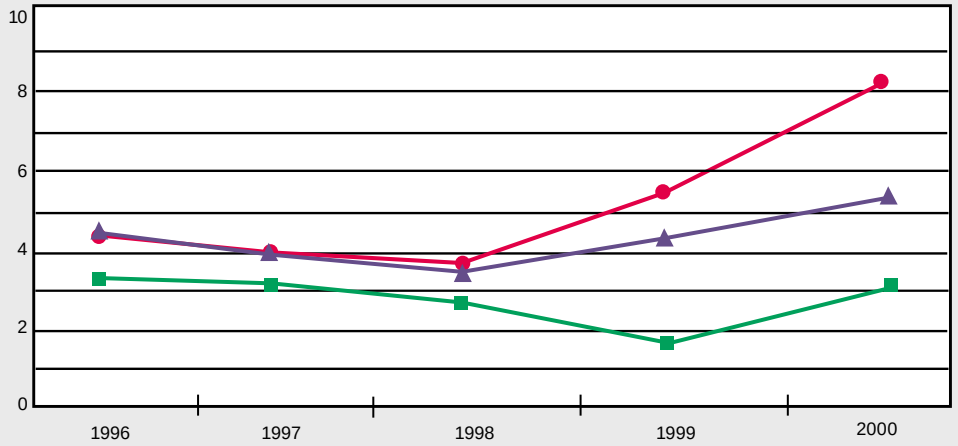
General – MDMA (3,4-methylenedioxymethamphetamine), commonly called ecstasy or XTC, is a synthetic, psychoactive drug possessing stimulant and mild hallucinogenic properties. The substance gained popularity in the late 1980s and early 1990s as an alternative to heroin and cocaine. MDMA customarily is sold and consumed at "raves," which are all-night parties and concerts. Use appears to be widespread within virtually every major U.S. city with indications of trafficking and abuse in smaller towns. MDMA is considered a "designer drug," which is a substance on the illegal market that is a chemical analogue or variation of another psychoactive drug. MDMA is similar in stimulant properties to amphetamine or methamphetamine, and it resembles mescaline in terms of hallucinogen qualities. Illicitly marketed as a "feel good" drug, it has been dubbed the "hug drug." Risks associated with MDMA include severe dehydration and death from heat stroke or heart failure.[76] A review of several studies by the National Institute on Drug Abuse (NIDA) concludes that heavy MDMA users have significant impairments in visual and verbal memory compared to non-users.[77] Further findings by Johns Hopkins University and the National Institute of Mental Health (NIMH) suggest that MDMA use may lead to impairment in other cognitive functions, such as the ability to reason verbally or sustain attention.[78]

Overall usage – Ecstasy is often used in conjunction with other drugs and is extremely popular among some teenagers and young professionals. Furthermore, growing numbers of users – primarily in the Miami and Orlando areas – combine MDMA with heroin, a practice known as "rolling." If this trend continues, MDMA may become a "gateway" drug that leads to the consumption of a variety of other substances. Emergency room mentions increased from sixty-eight in 1993 to 2,200 in 2000.[79]MDMA also suppresses the need to eat, drink, or sleep and subsequently allows people to stay up all night, dancing at raves.[80]

Use among youth – MDMA use is widespread, particularly among white adolescents in the Northeast. The Partnership for a Drug-Free America's Attitude Tracking Survey reports that teen trial use of ecstasy has doubled since 1995. Trial use of MDMA is now on par with teens' trial use of cocaine, crack, and LSD; more teens in the United States have now tried ecstasy than heroin. Trial use of ecstasy has increased from five percent in 1995 to seven percent last year to ten percent this year. Nearly one-third (32 percent) of teens in 2000 reported they had close friends who used ecstasy, up significantly from 24 percent in 1998 and 26 percent in 1999. The 2000 MTF study reports that past-year use of ecstasy by 8th graders increased 82 percent (from 1.7 percent to 3.1 percent) between 1999 and 2000; past-month use increased 75 percent (from 0.8 percent to 1.4 percent). Past-month use of MDMA by 10th graders

Ecstasy (MDMA) and Our Youth Trends in Annual Use

Percent Who Report Use

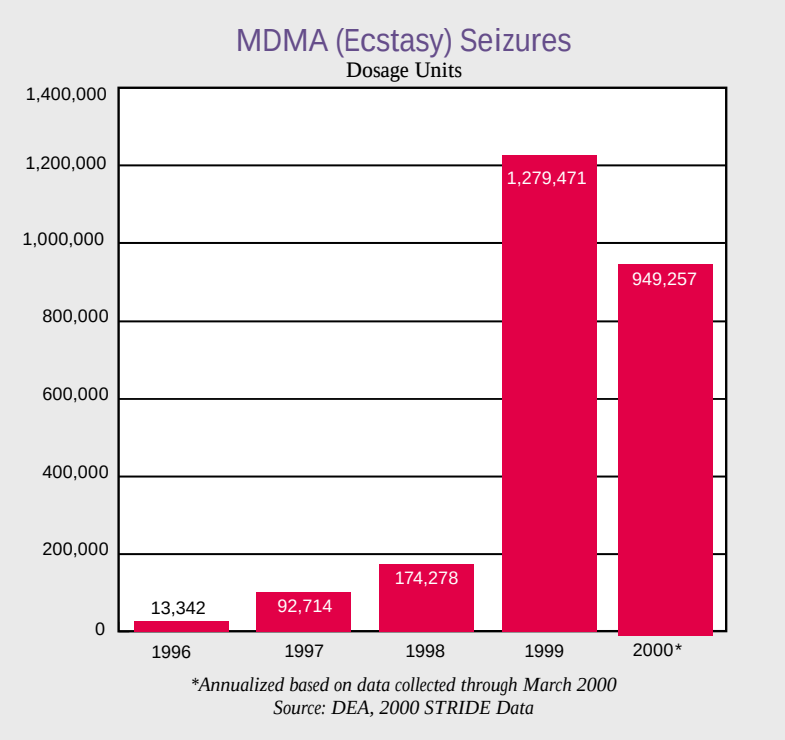


	1996	1997	1998	1999	2000
12th Grade	4.6	4	3.6	5.6	8.2
10th Grade	4.6	3.9	3.3	4.4	5.4
8th Grade	3.4	3.2	2.7	1.7	3.1

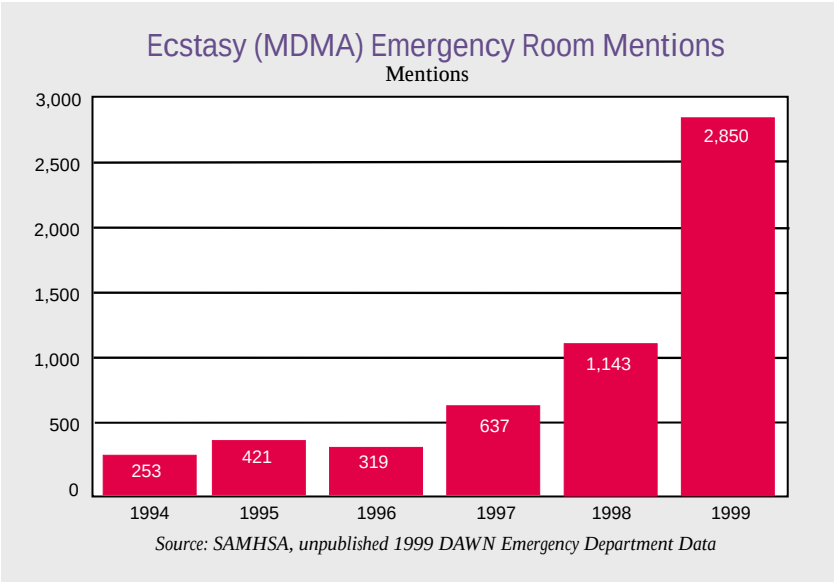
Source: 2000 Monitoring the Future Study

increased 44 percent (from 1.8 percent to 2.6 percent) and past-year use by 12th graders increased 46 percent, from 5.6 percent to 8.2 percent. Among 12th graders, the perceived availability of ecstasy rose sharply – an increase of 28 percent (11.3 percentage points, from 40.1 percent to 51.4 percent). This is the largest one-year percentage point increase in the availability measure among 12th graders for any drug class in the 26-year history of the MTF study.

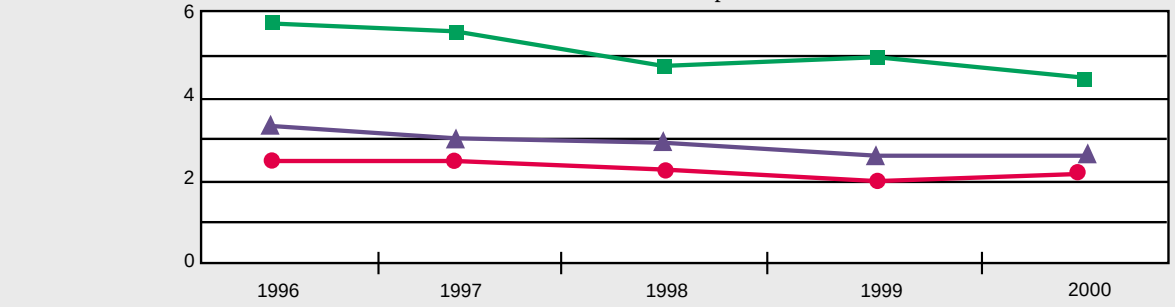
Availability – Numerous data reflect the increasing availability of MDMA in the United States – in metropolitan centers and suburban communities alike.[81] Law-enforcement agencies consider MDMA to be among the most immediate threats to youth and to law enforcement.[82] Law-enforcement agencies report a surge in MDMA seizures between 1998 and 2000. Domestically, the DEA seized 174,278 MDMA tablets in 1998, over a million in 1999, and more than 949,000 between January and October 2000.[83] Similarly, the United States Customs Service (USCS) reports that its MDMA seizures surged 165 percent between FY 1999 and 2000. USCS officers seized approximately 9.3 million ecstasy tablets in FY 2000, compared to 3.5 million in FY 1999 and 750,000 in FY 1998.[84] Further signaling increased availability, U.S. Customs reports that individual shipments of MDMA are increasing in size and weight, from under ten pounds several years ago to some in excess of 1,100 pounds in July 2000.[85] Production of MDMA is centered in Europe (predominately Belgium, the Netherlands, and Luxembourg).[86] Further encouraging the importation of MDMA to the United States is the drug's high profit margin – production costs are as low as two to twenty-five cents per dose while retail prices in the U.S. are between twenty dollars and forty-five dollars per dose.[87] Increasing involvement of organized criminal groups – particularly Western European, Russian, and Israeli crime syndicates – indicates a move toward "professionalization" of MDMA markets.[88] More recently, law-enforcement agencies report that drug organizations based in the Dominican Republic may be spearheading an effort to step-up MDMA trafficking in the Caribbean.[89] Law-enforcement reports indicates criminal groups that have proven capable of producing and smuggling significant quantities of MDMA into the United States are expanding distribution networks from coast to coast.[90] Finally, MDMA has spread into branches of the military. The Air Force reports that the number of its internal investigations involving MDMA nearly doubled from 35 in 1998 to 66 in 1999. Between January and November 2000, this number skyrocketed to 337 cases.[91]



**Annualized based on data collected through March 2000*
Source: DEA, 2000 STRIDE Data



Source: SAMHSA, unpublished 1999 DAWN Emergency Department Data



	1996	1997	1998	1999	2000
12th Grade	2.5	2.5	2.3	2.0	2.2
10th Grade	3.3	3	2.9	2.6	2.6
8th Grade	5.8	5.6	4.8	5	4.5

Source: 2000 Monitoring the Future Study

INHALANTS

General – The term "inhalants" refers to more than a thousand different household and commercial products that can be intentionally abused by sniffing or "huffing" (inhaling through one's mouth) for an intoxicating effect. These products are composed of volatile solvents and substances commonly found in commercial adhesives, lighter fluids, cleaning solutions, and paint products. Their easy accessibility, low cost, and ease of concealment make inhalants one of the first substances abused by many young Americans.

Overall usage – In 1999, approximately 0.3 percent of the population age 12 or older reported past-month use of inhalants. This number has been unchanged since 1998. There were an estimated 991,000 new inhalant users in 1998, up from 390,000 in 1990.[92] Inhalants can be deadly, even with first-time use.

Use among youth – In 1999, 0.9 percent of youths age 12-17, reported past-month use of inhalants. This number represents a statistically significant decline from the two percent reported in 1997 and the 1.6 percent reported in 1994.[93] The rate of first use among youths age 12-17 rose significantly from 1990 to 1998, from 11.6 to 28.1 per 1,000 potential new users.

Availability – Inhalant abuse typically involves substances readily available in any home or school. Examples include: adhesives (airplane glue, rubber cement), aerosols (spray paint, hair spray, air freshener), cleaning agents (spot remover, degreaser), food products (vegetable cooking spray, canned dessert topping), gases (butane, propane), solvents and gases (nail polish remover, paint thinner, typing correction fluid, lighter fluid, gasoline).

OTHER ILLICIT SUBSTANCES

Overall usage – The 1999 NHSDA reports that past-month use of hallucinogens among persons age 12 or older has remained relatively stable since 1995. However, the 0.7 percent who used hallucinogens in 1999 represents a statistically significant increase over the 0.5 percent in 1994.[94] The rate of current hallucinogens use did not change significantly between 1997 and 1999 (0.8 percent versus 0.7 percent, respectively). Data are not available to describe emerging threats from other illicit substances like ketamine, gamma-hydroxybutyrate (GHB), gamma-butyrolactone (GBL), and rohypnol. Nevertheless, ethnographers continue to report "cafeteria use"* of hallucinogenic or psycho-sedative drugs like ketamine, LSD, and GHB. The increasing popularity of "raves" within the dance culture has sparked a resurgence of designer drugs.

Steroid use is becoming more prevalent among adolescents. The repercussions of steroid use are enormous. Among teens, steroid use can lead to an untimely halting of growth due to premature skeletal maturation and accelerated puberty changes. All steroid users risk liver tumors, high blood pressure, severe acne, and trembling.[95]

Use among youth – The 1999 NHSDA reports that past-month use of hallucinogens has remained relatively stable since 1994; the current percentage for 1999 is 1.6 percent, down slightly (not statistically significant) from 2.0 percent in

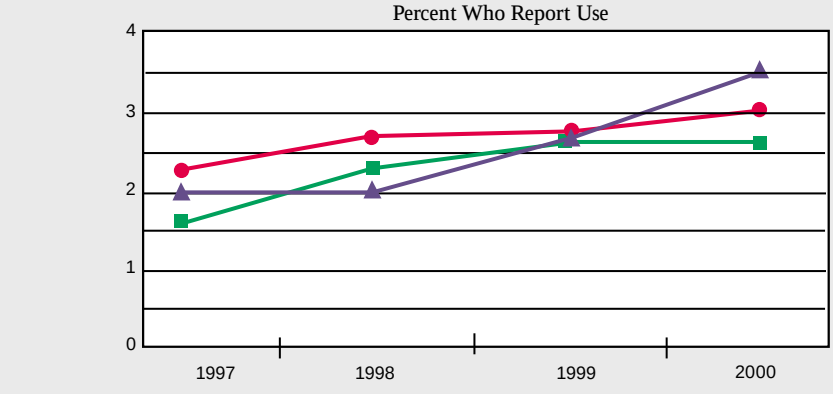
* Denotes the proclivity to consume any readily available drug. Young people often take mood-altering pills or consume drugged drinks in night clubs without knowing what the drug is or the dangers posed by its use, alone or in combination with alcohol and other drugs.

1996.[96] The incidence rate of using prescription-type pain relievers non-medically has increased from 6.3 per 1,000 potential new users in 1990 to 32.4 per 1,000 potential new users in 1998.[97] The MTF reports that despite a sharp rise in the use of MDMA — which the MTF classifies as an hallucinogen — past-year and past-month use of hallucinogens, in general, showed declines among 10th and 12th graders. Specifically, past-year and past-month use among 12th graders was down 14 percent (from 9.4 percent to 8.1 percent) and 26 percent (from 3.5 percent to 2.6 percent), respectively. Past-month use among 10th graders was down 21 percent (from 2.9 percent to 2.3 percent). Past-year use of LSD among 12th graders declined ten percent (from 8.1 percent to 6.6 percent) and past-month use declined 44 percent (from 2.7 percent to 1.6 percent).

Availability – The Community Epidemiology Working Group reports that designer drugs in most parts of the country are easily obtainable and used primarily by adolescents and young adults at clubs, raves, and concerts.[98] GBL and 1,4-butanediol (both chemical precursors to GHB) are easily obtainable over the Internet. Individuals seeking illicit substances can also exploit Internet sites specializing in the sale of veterinary pharmaceuticals and prescription medications.

Controlled Substances Diversion – Attention must be paid to the misuse of a great variety of pharmaceuticals, narcotics, depressants, and stimulants. Manufactured in the United States and overseas to meet legitimate medical needs, these drugs are subject to diversion into the illicit trade.[99] Of the 2.8 billion prescriptions written in 1999, approximately 457million were for controlled substances; this is up from 254 million in 1998. An unknown quantity is diverted into illicit traffic, but legally controlled substances account for over 30 percent of all reported deaths and injuries associated with drug abuse.[100] In 1999, the United States Customs Service seized 9,275 packages containing prescription drugs – about 4.5 times as many as in 1998. The number of pills and tablets impounded by the Customs Service jumped to 1.9 million from 760,720 in 1998.[101] DEA had 723 arrests for pharmaceutical diversion during the first three-quarters of FY 2000.[102] The availability of "prescription-free pharmaceuticals" via the Internet and overseas pharmacies represents an emerging challenge for the United States.[103] This challenge has been exacerbated by Internet pharmacies shipping medications via "express consignment operators" (ECO; i.e. FedEx, UPS, DHL, etc.) rather than the US Postal Service. USCS prescription drug seizures from ECOs jumped from 294 in fiscal year 1998 to 518 in fiscal year 1999.

Precursor Chemicals – Of all the major drugs of abuse, only marijuana is available as a natural, harvested product. The others must be manufactured using various chemicals and techniques. Illegal drug trafficking is heavily dependent on the availability of commodities from legitimate sources in order to obtain the substances required for criminal production or synthesis.[104] Traffickers are able to obtain chemicals in large quantities at relatively low cost as a result of ignorance, indifference, or collusion by pharmaceutical distributors and international brokers.[105] The problem of chemical diversion continues to be pursued through various legislative measures, cooperative law-enforcement programs, and participation in multilateral agreements, and operational chemical control, and enforcement initiatives. Aggressive action by federal law-enforcement agencies continues in order to prevent the diversion of pseudoephedrine cold tablets to methamphetamine manufacturing laboratories.



	1997	1998	1999	2000
12th Grade	2.4	2.7	2.9	2.5
10th Grade	2	2	2.7	3.5
8th Grade	1.6	2.3	2.7	3.0

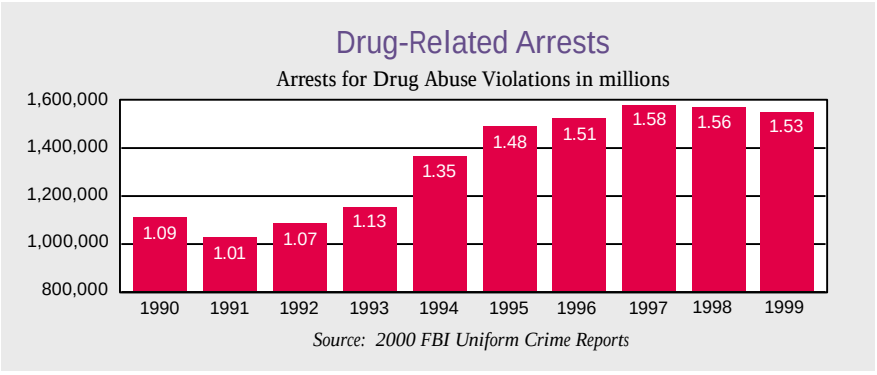
Source: 2000 Monitoring the Future Study

THE LINK BETWEEN DRUGS AND CRIME

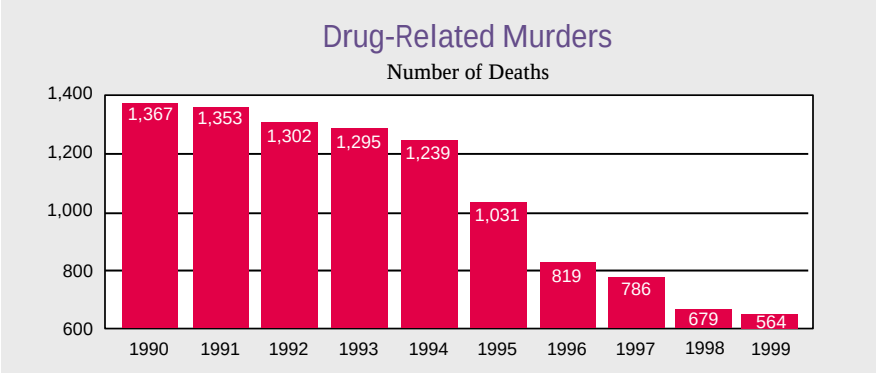
The problem of drug-related crime in the United States is not going away. More than 1.5 million Americans were arrested for drug-law violations in 1999, and drug abuse violations and alcohol-related arrests combined accounted for an estimated 31 percent of the overall arrests in 1999. However, a comparison of data for drug abuse violations indicates that in 1999 the total number of arrests for these offenses were 2 percent lower than in 1998. In 1999, 19.5 percent of drug law violations were for the sale or manufacturing of illegal drugs and 80.5 percent were for possession of illegal substances.[106] Over 80 percent of all jail and state prison inmates said they had previously used drugs, and over 60 percent reported having regularly used drugs, i.e., and at least once a week for at least a month. BJS surveys have revealed that, among inmates reporting past regular drug use, approximately 1 in 7 jail inmates and 1 in 3 state inmates had participated in substance abuse programs or treatment since admission.[107] In order to break the link between drugs and crime, the criminal justice system must work with treatment agencies to decrease the demand for illegal drugs by providing substance abusers with the skills to become clean and sober.

Arrestees frequently test positive for recent drug use –The National Institute of Justice's (NIJ's) Arrestee Drug Abuse Monitoring (ADAM) drug-testing program collected data from adult male arrestees in 34 sites. All 34 sites reported that "at least 50 percent of adult males arrested tested positive for at least one drug."[108] This cohort tested positive most frequently for marijuana in 24 of the 34 reporting sites, and cocaine was detected most frequently in the other 10 sites. Therefore it appears that despite the popularity of other drugs such as methamphetamine and PCP in certain parts of the country, marijuana is still the drug of choice for most male arrestees. This trend was particularly apparent among young males. In 8 of the 34 sites, more than 70 percent of the 15- to 20- year-old male arrestees tested positive for marijuana.[109] Additionally, the average rate for multiple drug use by adult males remained constant from 1998 to 1999.[110]

ADAM collected data from adult female arrestees in 32 sites. Among female adult arrestees, the average rate of drug use was three percent higher in 1999 than in 1998. For women, cocaine, not marijuana, was detected most often in 25 of the 32 sites.[111] It also appears that multiple drug use is growing in popularity among female offenders. In 1999, the median rate of multiple drug use for female adults was up



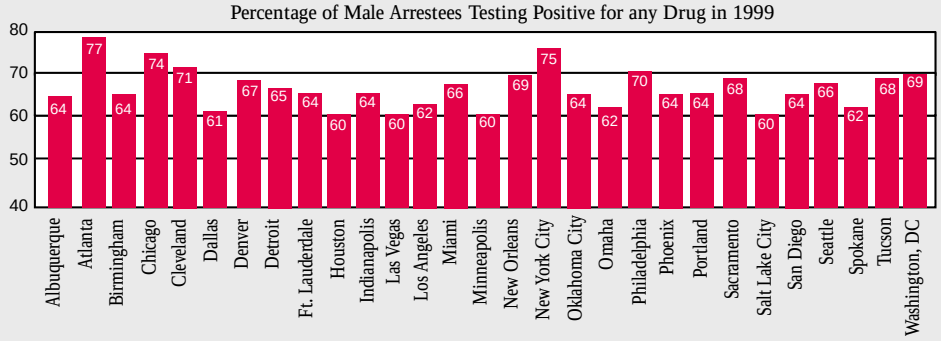
Source: 2000 FBI Uniform Crime Reports



Source: 2000 FBI Uniform Crime Reports

Drug Use Correlates with Crime

Percentage of Male Arrestees Testing Positive for any Drug in 1999



Source: 1999 Arrestee Drug Abuse Monitoring Program (ADAM)

three percent from 1998. Multiple drug use seems to be more common among particular types of drug users which may help explain why multiple drug use has increased among women but not among men. Proportionally, female arrestees tested positive for opiates more than male arrestees, and in the entire adult ADAM sample, more than three-fourths of the arrestees who tested positive for opiates also tested positive for some other drug.[112]

Information on juvenile male detainees was obtained in nine sites, and six sites reported data for juvenile female detainees.[113] All nine sites reported similar drug use trends. Marijuana was the most commonly used drug for both juvenile male and female detainees, with cocaine use a distant second. None of the nine sites reported any significant opiate use for male or female juveniles.[114]

ADAM data suggests that methamphetamine use is much more prevalent in the western part of the United States. In Atlanta, both male and female results were less than one percent positive for methamphetamine[115] and in New York City both male and female arrests had rates of zero percent.[116] These rates are drastically different from the adult female methamphetamine-positive rate of 36 percent in San Diego and 28 percent for males in Sacramento.[117] Actually, in most sites where methamphetamine use was substantial, females tested positive for its use at higher rates than males.[118]

State and federal prison authorities had 1,284,894 people physically in their custody at year-end 1999.[119] In addition to state and federal prisons, there were 1,621 inmates in 69 Indian country jails and detention centers, and 105,790 juveniles were held in 1,121 public and 2,310 private residential placement facilities. The U.S. Immigration and Naturalization Service (INS) reported 7,675 detainees were held in INS-operated facilities or other confinement facilities, and at year-end 1999, U.S. military authorities held 2,279 prisoners in 65 facilities and 18,394 inmates held in U.S. territorial prisons.[120] Thus, [overall,] the U.S. incarcerated 2,026,596 persons at year-end 1999 — the equivalent of 1 in every 137 residents in the U.S. and its territories.[121] There are still significant racial disparities among these prison populations. In 1999 the rate among black males in their late twenties reached 9,392 prisoners per 100,000 residents compared to 3,126 among Hispanic males and 990 among white males.[122]

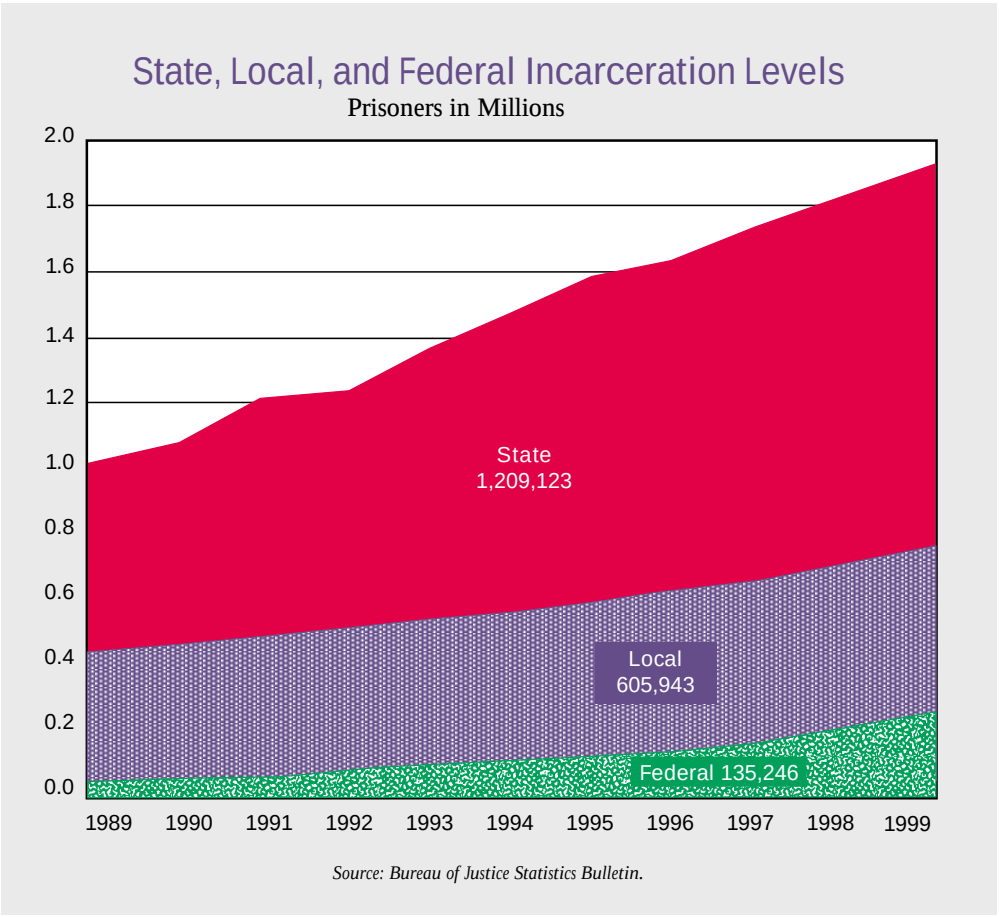
Prison incarceration rates have increased drastically over the last decade. Since 1990 the number of sentenced prisoners per 100,000 residents has risen from 292 to 476, even though in 1999 the prison population grew at the lowest rate since 1979.[123] During 1999 the number of female prisoners rose by 4.4%, totaling 90,668 at year-end, which was greater than the increase in male prisoners (3.3%). The number of males prisoners was 1,276,053 at the end of 1999.[124] State prison population growth rates in the last ten years can be partly explained by declining rates of release of inmates and increases in the amount of time served. The rise of federal prison populations can be explained by increases in number of convictions in U.S. District Courts, increases in the number of those sentenced to a period of incarceration, and an increase in the average length of custodial sentences.[125]

Drug offenders accounted for the largest source of the total growth among female inmates (36%), compared to 18% among male inmates.[126] Nonetheless, drug offenders account for only 19% of state prison population growth while large numbers of violent offenders are responsible for 51% of the growth.[127] However, the number of parole violators who are returned to prison for drug offenses has doubled since 1990. Drug offenders also

account for more than half (52 percent) of the total rise in the number parolees who have their parole revoked and are returned to State prison. The number of drug offending parolees returned to prison increased from 30,900 in1990 to 68,600 in 1998.[128]

Another group of inmates recently studied is military veterans who are serving time in state prisons and local jails. In 1998, 225,700 of the nation's veterans were incarcerated. While data appears to show that veterans are more likely to be violent offenders than other inmates are, they are not as likely as other inmates to be convicted of drug offenses are. In fact, they report lower levels of recent drug abuse and were less likely than other inmates to report having used drugs in the month before the offense for which they were incarcerated. They were, however, more likely than other inmates to report a history of alcohol abuse.[129] As for veterans held in military correctional facilities at year-end 1997, sex offenders accounted for 1 in 3 prisoners. That same year, 20 percent of veterans incarcerated in military facilities were serving time for drug offenses.[130]

In 1998 an estimated 7 in 10 local jail inmates (or 417,000 inmates) had used drugs regularly or had committed a drug offense. This number compares to 261,000 jail inmates in 1989 who regularly used drugs or had committed a drug offense. In addition, more than half of both jail (55 percent) and state prison (57 percent) inmates reported they had used drugs in the month before the offense.[131] It is estimated that 61,000 (16 percent) convicted jail inmates committed the current offense in order to obtain money to buy drugs, and approximately 138,000 convicted jail inmates were under the influence of drugs at the time they perpetrated their crimes. At the time of their offense, about 72,000 convicted jail inmates had used marijuana or hashish and 59,000 had used crack cocaine. Therefore, the link between drugs and crime is undeniable and to decrease crime rates, drug use must also be decreased.

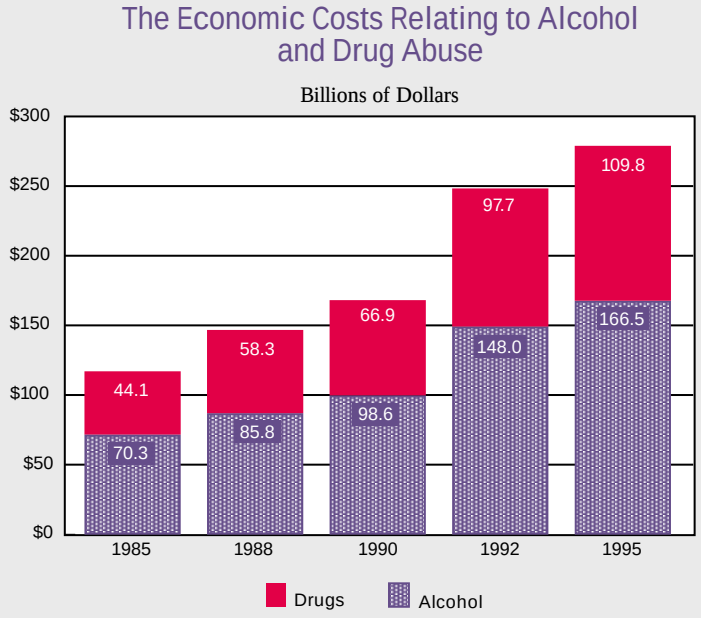


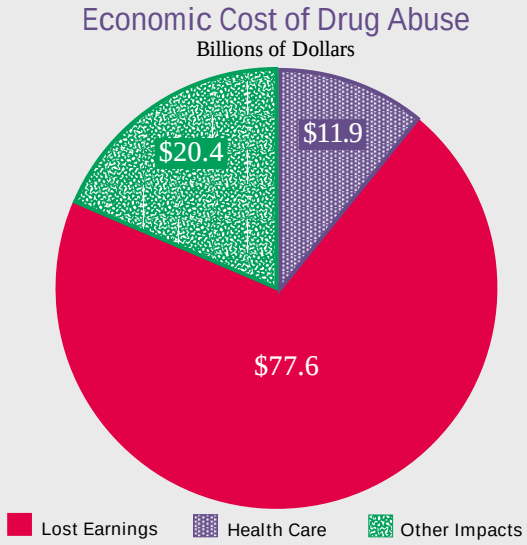
Source: Bureau of Justice Statistics Bulletin.

THE CONSEQUENCES OF ILLEGAL DRUG USE

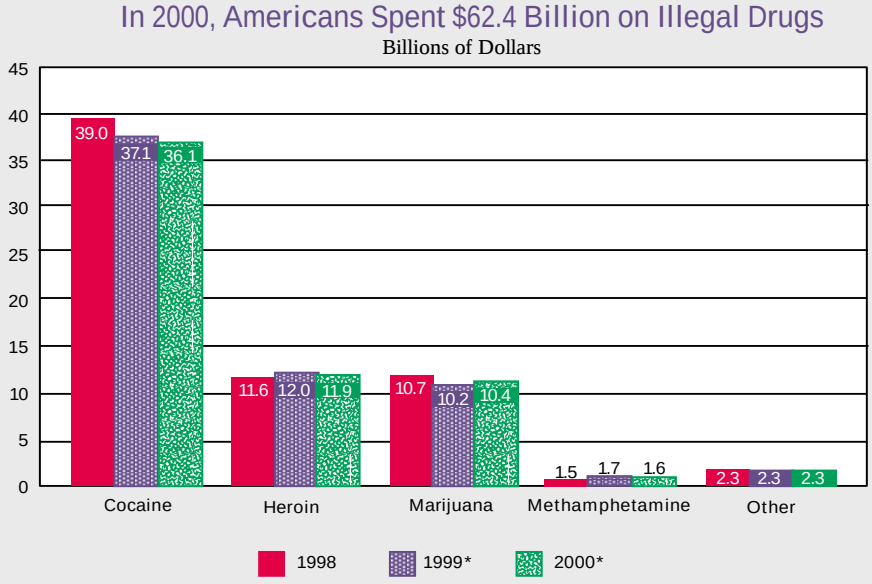
Increased crime, domestic violence, accidents, illness, lost job opportunities, and reduced productivity can be linked to illegal drug use. Every year Americans of all ages engage in unhealthy, unproductive behavior as a result of substance abuse.

Economic loss – Illegal drugs exact a staggering cost on American society. In 1995, they accounted for an estimated $110 billion in expenses and lost revenue.[132] This public-health burden is shared by all of society, directly or indirectly. Tax dollars pay for increased law enforcement, incarceration, and treatment to stem the flow of illegal drugs and counter associated negative social repercussions. NIDA estimated that health-care expenditures due to drug abuse cost America $9.9 billion in 1992 and nearly twelve billion dollars in 1995.[133]





Source: 1998 National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism

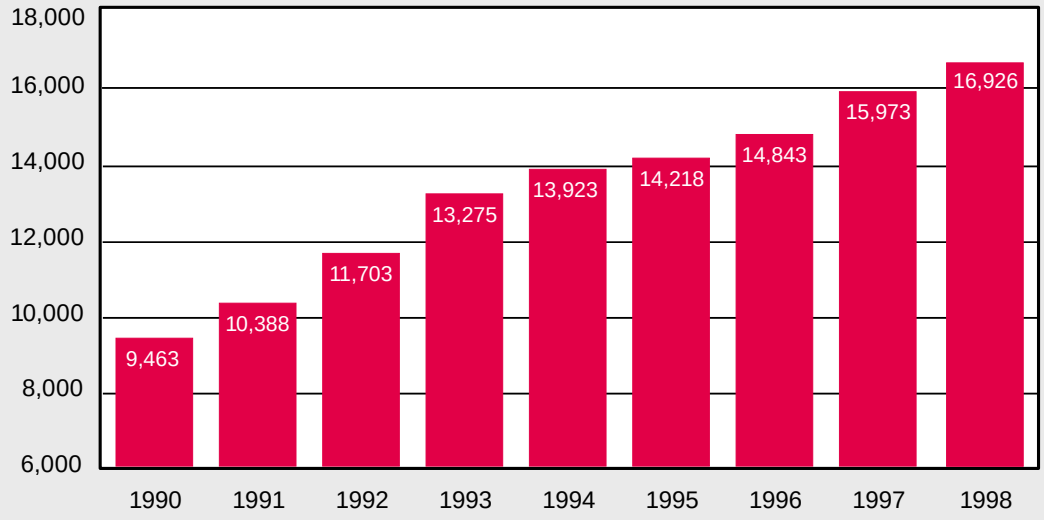


**Projected figures from models based on 1998 data*
Source: 2000 ONDCP–What American Users Spend on Illegal Drugs

Drug-related deaths – Illegal drug use is responsible for the deaths of thousands of Americans annually. In 1997, the latest year for which death certificate data are published, there were 15,973 drug-induced deaths in America.[134] Drug-induced deaths result directly from drug consumption, primarily overdose.* In addition, other causes of death, such as HIV/AIDS, are partially due to drug abuse. Using a methodology that incorporates deaths from other drug-related causes, ONDCP estimates that in 1995 there were 52,624 drug-related deaths. This figure includes 14,218 drug-induced deaths for that year, plus mortalities from drug-related causes.** SAMHSA's Drug Abuse Warning Network (DAWN) collects data on drug-related deaths from medical examiners in forty-one major metropolitan areas. DAWN found that drug-related deaths have steadily climbed throughout the 1990s.[135]

* Overdose deaths, including accidental and intentional drug poisoning, accounted for 90 percent of drug-induced mortalities in 1995. Other drug-induced causes of death involved drug psychoses, drug dependence, and nondependent use of drugs.

**Based on a review of the scientific literature, 32 percent of HIV/AIDS deaths were drug-related and included in the estimate of drug-related deaths. The following were also counted: 4.5 percent of deaths from tuberculosis, 30 percent of deaths from hepatitis B; 20 percent of deaths from hepatitis non-A/non-B; 14 percent of deaths from endocarditis; and 10 percent of deaths from motor vehicle accidents, suicide (other than by drug poisoning), homicide, and other deaths caused by injuries.

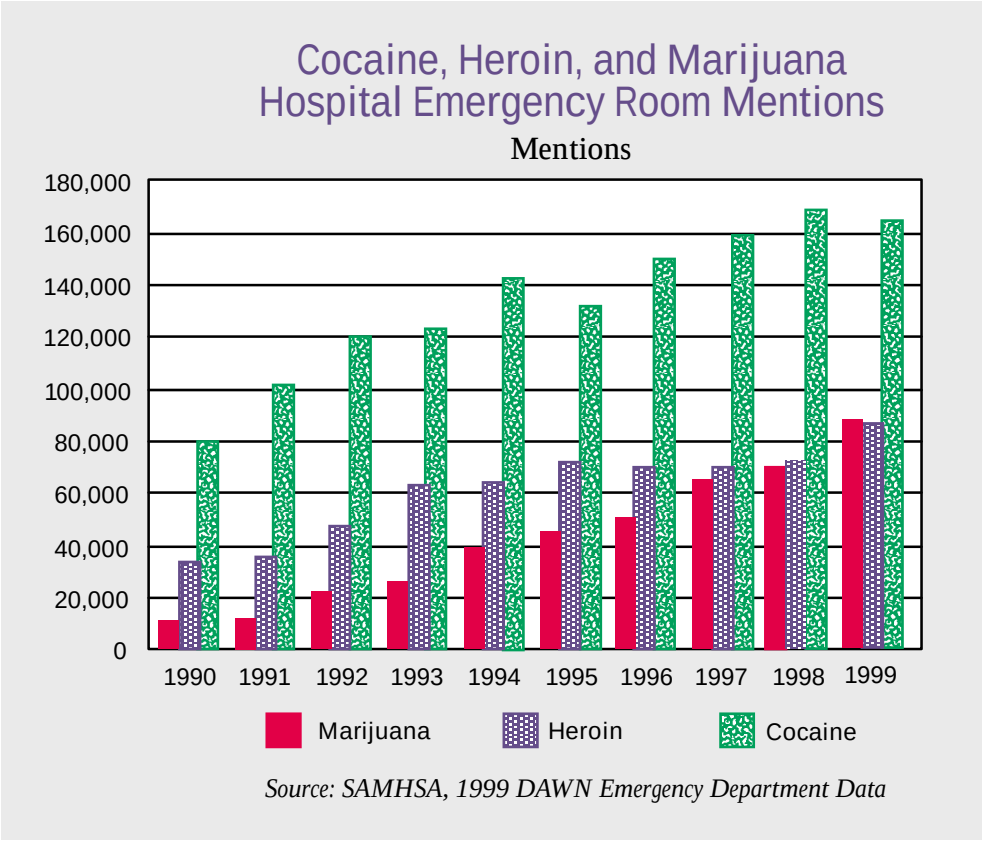


Source: 2000 Centers for Disease Control and Prevenion

Drug-related medical emergencies – More than two thirds of people suffering from addiction see a primary-care or urgent-care physician every six months, and many others are seen regularly by medical specialists.[136] The Drug-Abuse Warning Network (DAWN) survey provides information on the health consequences of drug use by capturing data on emergency department (ED) episodes that are related to the use of an illegal drug or the nonmedical use of a legal drug.* It is important to remember that DAWN data show only one dimension of the total consequences of drug use. It does not measure the prevalence of drug use in the population, the untreated health consequences of drug use, or the impact of drug use on health-care settings other than hospital EDs.

The number of emergency department drug episodes has been increasing over the 1990s. In 1999, there were an estimated 554,932 drug-related ED episodes in the United States, compared to 371,208 in 1990 – a 49 percent increase.[137] Alcohol in combination with drugs continued to be the most frequently mentioned (196,277) in ED reports.[138] Cocaine continued to be the most frequently mentioned illicit drug, comprising 30 percent of episodes (168,763 mentions) in 1999. Cocaine was followed in frequency by marijuana/hashish (16 percent, 87,150 mentions) and heroin/morphine (15 percent, 84,409) In 1999, marijuana/hashish mentions exceeded heroin/morphine mentions, changing a rank ordering of illicit drug mentions that had been constant since 1990.[139]

* A drug episode is an emergency department visit that was related to the use of an illegal drug(s) or the nonmedical use of a legal drug for patients aged six years and older. A "drug mention" refers to a substance that was mentioned (as many as four) during a single drug-related episode.



Source: SAMHSA, 1999 DAWN Emergency Department Data

Spreading of infectious diseases – Among the serious health and social issues related to drug abuse is the spread of infectious diseases. Drug abuse is a major vector for the transmission of HIV and other sexually transmitted diseases, hepatitis, and tuberculosis — and for the infliction of violence.[140] Chronic users are particularly susceptible to infectious illnesses and are considered "core transmitters." Of the 17,537 cases of tuberculosis reported to CDC in 1999, 2.6 percent were drug-related, down from 2.9 percent in 1999.[141] There was a decline in injection drug-related AIDS cases between 1998 and 1999 among men from 26 percent in 1998 to 25 percent in 1999; among women, this number declined from 29 percent in 1998 to 27 percent in 1999.[142] No new data for Hepatitis B have been analyzed for this report, although in the past the number of Hepatitis B cases has been declining.[143]

Homelessness – Drug abuse is a contributing factor in the problem of homelessness. Although only a minority (thirty-one percent) of the homeless suffer from drug abuse or alcoholism exclusively, inappropriate use of these substances compounds other diseases for many homeless people with mental illness who are "dually diagnosed."[144] Substance abusers with other illnesses experience homelessness of a longer duration and are more likely to be chronically without a residence.[145] Homelessness generates tremendous social and human costs. The general public is poorly served by having people with serious and chronic illnesses, such as addiction, living on the street. Further, addiction treatment tends to be less effective when recipients lack stable housing.[146] Of those who are currently homeless, twenty-five percent have ever been treated for drug abuse – thirty-six percent have received inpatient treatment and twenty-seven percent have received outpatient care.[147] Thirty-eight percent of those who are currently homeless have received inpatient treatment three or more times.[148] Homeless persons may be able to obtain residential treatment but with no recovery venue other than a shelter, such treatment is often ineffective.

Drug use in the workplace – According to the 1999 NHSDA, current employment status is highly correlated with rates of illicit drug use. An estimated 16.4 percent of unemployed adults (age 18 and older) were current illicit drug users in 1999, compared with 6.5 percent of full-time employed adults and 8.6 percent among part-time employed adults. More than 77 percent of current illicit drug users aged 18 and older are employed full or part-time — numbering approximately 9.42 million workers.

Other significant workforce data from the1999 NHSDA indicate illicit drug use is also highly correlated with age and educational status. Among youth aged 12 to 17 years, 10.9 percent had used an illicit drug within the 30 days prior to interview. Among persons aged 18-25 years, 17.1 percent reported current use. The rates of use generally decline in each successively older age group, with only 1.7 percent of those aged 50-65 reporting current illicit use. An exception to this pattern is the 8.6 percent rate reported by the 40-44 year old age group, somewhat higher than the 6.6 percent rate for persons aged 35-39 years and the 4.1 percent for those aged 45-49. Members of the cohort of 40-44 year olds were teenagers during the 1970s, a period when drug use incidence and prevalence rates rose dramatically.

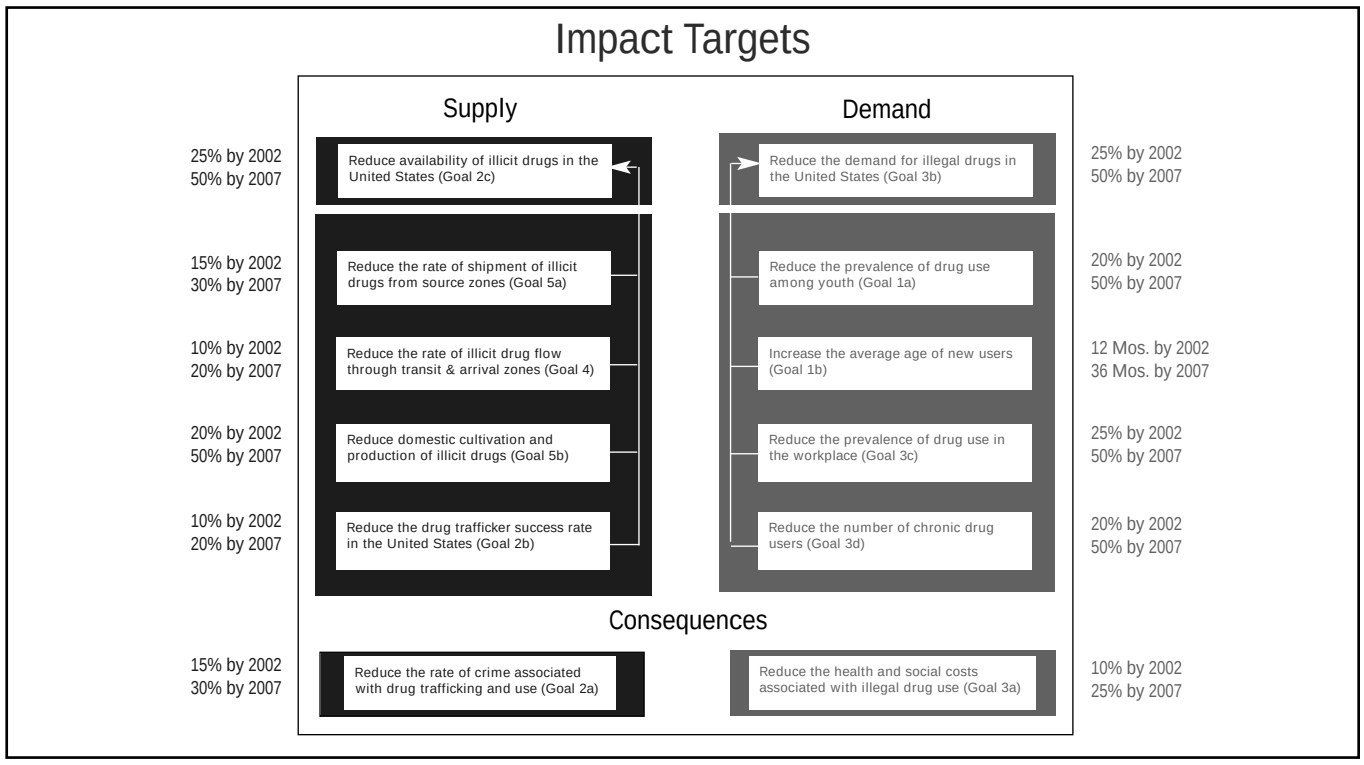
Performance Measures of Effectiveness (PME)

The stated intent of the *National Drug Control Strategy* is to reduce drug use and availability by 50 percent and decrease health and social consequences a minimum of 25 percent by 2007 (compared to 1996 baseline levels). The *Strategy* charts the course for accomplishing this end. Progress toward the *Strategy's* five goals and thirty-one objectives must be continuously assessed in order to gauge success or failure and adjust the *Strategy* accordingly. ONDCP has consulted with Congress, federal drug-control agencies, state and local officials, private citizens, and organizations with experience in demand and supply reduction to develop a Performance Measurement of Effectiveness (PME) system to gauge national drug-control efforts.

The PME system: (1) assesses the effectiveness of the Strategy and its supporting programs, (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-control budget management. The PME system fulfills congressional guidelines that the *National Drug Control Strategy* contain measurable objectives and specific targets to accomplish long-term quantifiable goals. These targets and annual reports are intended to inform congressional appropriations and authorizing committees as they restructure appropriations in support of the *Strategy* to ensure that resources necessary to attain ambitious long-term performance goals are provided.

The nucleus of the PME system consists of twelve "impact targets" that define measurable results to be achieved by the *Strategy's* five goals. There are five impact targets for demand reduction, five for supply reduction, and two for reducing the adverse health and criminal consequences associated with drug use and trafficking. Eighty-five additional targets further delineate mid- (2002) and long-term (2007) targets for the *Strategy's* thirty-one objectives. They are "stretch targets" in that they require progress above that attained in previous years. This system is in accordance with recommendations from the National Academy of Public Administration, the General Accounting Office, and other organizations advocating good government practices. The performance system is described in detail within a companion volume to this *Strategy — Performance Measures of Effectiveness 2001*.

Progress toward each goal and objective is assessed using new and existing data sources. The Monitoring The Future (MTF) and the National Household Survey on Drug Abuse (NHSDA), for example, both estimate risk perception, rates of current use, age of initiation, and lifetime use for alcohol, tobacco, and most illegal drugs. 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 Drug Control Research, Data, and Evaluation Committee (an advisory committee to the ONDCP Director), Subcommittee on Data, Research, and Interagency Coordination is developing additional instruments



and measurement processes required to address the demographics of chronic users, domestic cannabis cultivation, drug availability, and other data shortfalls.[149]

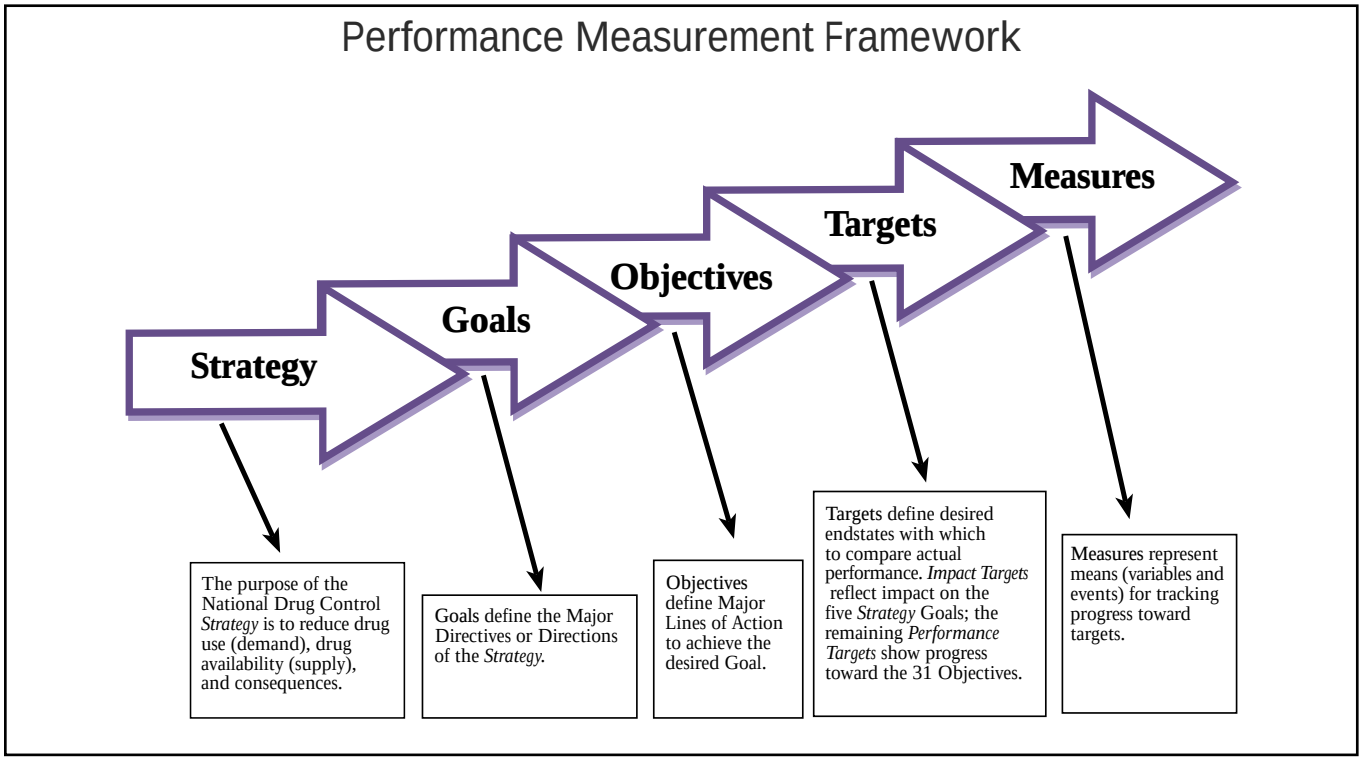
The measurement part of the PME System is now in place although there is more work to be done to streamline the data collection process and fill the data gaps. Refinement of the targets and measures is an ongoing process with more dramatic changes likely in a new Administration. Nonetheless, ONDCP designed the PME System to be flexible so that it could accommodate such changes, by incorporating the key elements of any drug control strategy – prevention, law enforcement, treatment, interdiction, and source country efforts. The weighting, especially for resource allocation, may change but these components are likely to be included in any new strategy.

Recognizing that measuring the success of the national drug control community does not automatically mean achievement of these ambitious, long-term PME targets, ONDCP embarked upon a deliberate process of developing small groups of stakeholders committed to meeting these targets. Using tools of Performance Management, we have brought together interagency working groups to focus on identifying what needs to be done between now and 2007 in order to meet the targets, which agencies are responsible, and how to monitor this process. These groups have developed logic models and action plans for the PME targets: these are staff working documents that will be calibrated regularly to reflect budget realities and evaluation findings. We have begun the process of linking these action plans to the budget. We have just started the process of "nationalizing" the process by involving key participants from state, local, and private sectors.

For the *Strategy* to be most effective, other levels of government must share the sense of community and joint vision at the federal level. By partnering with state and local governments, we gain a better understanding of the trends and obstacles communities, and neighborhoods.

ONDCP has pioneered formal performance partnerships between the federal government and state or municipal governments to coordinate policy actions and share lessons-learned to enhance national efforts toward reducing illicit drug use and drug-related crime and violence. Performance partnerships operate on the principle of mutual need for cooperation to achieve common goals and a belief that target-focused collaboration will improve the effectiveness of drug control activities at all levels of government. ONDCP has initiated three Performance Partnerships, two with the states of Oregon and Maryland and a third with the City of Houston, Texas.

Finally, it is extremely rare to find interagency action plans, based on target-focused logic models, in a mission area that cuts across several agencies. The nationalizing process, although time-consuming and iterative, will widen the debates on policies and institutions. But the dialogue will focus on "how best to achieve the PME targets", that is, it will be target-focused. ONDCP will continue to use these logic models and action plans to develop cohesive national communities committed to developing agendas and resource allocation decisions around the targets of the national *Strategy*.



Endnotes

1 Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies, *Summary of Findings from the 1999 National Household Survey on Drug Abuse (NHSDA)*, DHHS Publication No. (SMA) 00-3466, (Rockville, MD: U.S. Department of Health and Human Services, 2000) p.13.

2 Ibid, p.G-81.

3 The Gallup Organization, *Consultation with America: A Look at How Americans View the Country's Drug Problem, Final Report* (Rockville, MD: The Gallup Organization, November 22, 1999).

4 National League of Cities, National School Boards Association, Joe DiMaggio Children's Hospital and Youth Crime Watch,*Ten Critical Threats to America's Children: Warning Signs for the Next Millennium* (Alexandria, VA: The National League of Cities, November 1999), p. 13.

5 1998 NHSDA, p. 15.

6 Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *Analyses of Substance Abuse and Treatment Need Issues*, Analytic Series A-7, DHHS Publication No. SMA98-3227, (Rockville, MD: U.S. Department of Health and Human Services, 1998), p. 93.

7 Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *Driving After Drug or Alcohol Use: Findings from the 1996 National Household Survey on Drug Abuse*, Analytic Series A-8, DHHS Publication No. SMA99-3273, (Rockville, MD: U.S. Department of Health and Human Services, 1998), p. 50.

8 Thomas A. Gray and Eric D. Wish, *Substance Abuse Need for Treatment Among Arrestees (SANTA) in Maryland: Youth in the Juvenile Justice System* (Rockville, MD: Maryland Alcohol and Drug Abuse Administration, 1998).

9 Brook, J.S., Balka, E.B., and Whiteman, M., *The Risks for Late Adolescence of Early Adolescent Marijuana Use*, American Journal of Public Health, 1549-1554, 1999, p. 89.

10 1999 NHSDA, p.36.

11 Partnership for a Drug-Free America, *2000 Partnership Attitude Tracking Study: Teens in Grades 7 through 12*, (New York, NY: PDFA, fall 2000).

12 Johnston, L.D., O'Malley, P.M., & Bachman, J.G.,, *National survey results on drug use from the Monitoring the Future study, Volume I: Secondary school students*, NIH Publication No. 99-4660, (Rockville, MD: National Institute on Drug Abuse, 2000.

13 National Institute on Alcohol Abuse and Alcoholism, "Advancing Knowledge through Research" Fact Sheet, fall, 1999.

14 Merrill, Jeffrey, Kimberly Fox, Susan Lewis and Gerald Pulver, *Cigarettes, Alcohol, Marijuana: Gateways to Illicit Drug Use* (New York: National Center on Addiction and Substance Abuse, Columbia University, 1994), p. 15.

15 Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *Results from the 1999 National Household Survey on Drug Abuse*, p. 21. Binge drinking is defined as consuming five or more drinks on one occasion during the past thirty days. A heavy drinker is defined as one who consumes five or more drinks on one occasion five or more days during the past thirty days.

16 National Center on Addiction and Substance Abuse at Columbia University (CASA), *No Place to Hide: Substance Abuse in Mid-Size Cities and Rural America*, Commissioned by the United States Conference of Mayors and Funded by the DEA with Support from the National Institute on Drug Abuse, January 1999, p. 3.

17 1999 NHSDA, unpublished SAMHSA data.

18 Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *Results from the 1999 National Household Survey on Drug Abuse* supplemental tables..

19 Ibid.

20 U.S. Department of Health and Human Services, *Healthy People 2010: Understanding and Improving Health*. (Washington, D.C.: U.S. Department of Health and Human Services, Government Printing Office, 2000), p. 31.

21 The Department of Health and Human Services, The Centers for Disease Control and Prevention, "Tobacco Use Among Middle and High School Students – United States 1999," *Morbidity and Mortality Weekly Report*, Vol. 49. No.3, January 28, 2000, pp. 49-53.

22 Ibid.

23 National Center on Addiction and Substance Abuse at Columbia University (CASA), *No Place to Hide: Substance Abuse in Mid-Size Cities and Rural America*, Commissioned by the United States Conference of Mayors and Funded by the DEA with Support from the National Institute on Drug Abuse), January 1999, p. 3.

24 Jayant K., Pakhale S.S., *Toxic constituents in bidi smoke*, in Sanghvi LD, Notani P, eds. Tobacco and health: the Indian scene, (Bombay, India: Tata Memorial Center, 1989).

25 Rickert W.S., *Determination of yields of "tar," nicotine, and carbon monoxide from bidi cigarettes: final report*. (Ontario, Canada: Labstat International, Inc., 1999).

26 Gupta P.C., Hamner J.E. III, Murti P.R., eds. *Control of tobacco-related cancers and other diseases; proceedings of an international symposium*. Bombay, India: Tata Institute of Fundamental Research, Oxford University Press, 1992.

27 Drug Enforcement Administration *Drug Intelligence Brief – An Overview Club Drugs*, February 2000, p.1.

28 National Center on Addiction and Substance Abuse at Columbia University, *Dangerous Liaisons: Substance Abuse and Sex* (New York: National Center on Addiction and Substance Abuse at Columbia University, December 1999).

29 Ibid.

30 Rome, E.S., Rybicki, M.S., & Durant, R.H. (1998), "Pregnancy and Other Risk Behaviors Among Adolescent Girls in Ohio," *Journal of Adolescent Health*. 22(1), pp. 50-55.

31 1999 NHSDA, p.13.

32 1999 NHSDA, p.4.

33 1999 NHSDA, p. 30

34 NHSDA, p.2.

35 2000 Monitoring the Future Study. (MTF).

36 1999 NHSDA, p.4.

37 1999 NHSDA, p.4.

38 National Drug Intelligence Center, *Draft National Drug Threat Assessment 2001: The Domestic Perspective*, p. vii.

39 Drug Enforcement Administration, *Drug Intelligence Brief – Drug Trafficking in the United States, September 1999*, p. 9.

40 National Drug Intelligence Center, *Draft National Drug Threat Assessment 2001: The Domestic Perspective* (Johnstown, PA: U.S. Department of Justice, October 2000), p. 42.

41 Drug Enforcement Administration, *Drug Intelligence Brief – The Cannabis Situation in the United States, December 1999*, p. 4.

42 USDA Statistics provided for ONDCP, November 2000.

43 Drug Enforcement Administration, 2000 Domestic Cannabis Eradication/Suppression Program Statistics.

44 Drug Enforcement Administration, *Drug Intelligence Brief – Drug Trafficking in the United States, September 1999*, p. 11.

45 Ibid.

46 1999 NHSDA, p.170.

47 1999 NHSDA, p.168.

48 1999 NHSDA, p.171.

49 1999 NHSDA, p.31.

50 Drug Enforcement Administration, *Drug Intelligence Brief – Drug Trafficking in the United States, September 1999*, p. 2.

51 Office of National Drug Control Policy, *Mid-Year Interagency Assessment of Cocaine Movement* (Washington, D.C.: Office of National Drug Control Policy, August 2000), p.4 .

52 Office of National Drug Control Policy, *Mid-Year Interagency Assessment of Cocaine Movement* (Washington, D.C.: Office of National Drug Control Policy, August 2000), p. 4.

53 Office of National Drug Control Policy, *What America's Users Spend on Illegal Drugs, 1988-1999* (Washington, DC: Office of National Drug Control Policy, 1999), 20. This analysis is based on a composite model which integrates or compares data from the following sources: 1) coca cultivation figures developed by the Central Intelligence Agency's Crime and Narcotics Center, 2) the foreign movement analysis derived from the "Interagency Assessment Cocaine Movement," 3) loss figures (law enforcement seizures and non-US consumption estimates), and 4) the domestic US cocaine consumption estimate.

54 Ibid.

55 National Drug Intelligence Center, *Draft National Drug Threat Assessment 2001: The Domestic Perspective* (Johnstown, PA: U.S. Department of Justice, 2000), p. 2.

56 1999 NHSDA, p.170.

57 1999 NHSDA, p.31.

58 1999 NHSDA, p.171.

59 1999 NHSDA, p.31.

60 The MTF study is not a particularly precise source of estimates for heroin because of the small umber of respondents reporting its use. Consequently, the estimates are relatively unstable and show a certain degree of variability in the trend over time.

61 Drug Enforcement Administration, *Drug Intelligence Brief – Drug Trafficking in the United States*, September 1999, p. 6.

62 Office of National Drug Control Policy, *High Intensity Drug Trafficking Area Program* (Washington, D.C.: Office of National Drug Control Policy, 1999), p. 15.

63 Office of National Drug Control Policy, *Draft - What America's Users Spend on Illegal Drugs*, 1988-1998 p. 20.

64 U.S. Department of Justice, Drug Enforcement Administration, El Paso Intelligence Center, *Methamphetamine Trafficking Trends* (El Paso, TX: EPIC, 1999), pp. 3-4.

65 1999 NHSDA, p.33.

66 Office of National Drug Control Policy, *Draft - What America's Users Spend on Illegal Drugs*, 1988-1998, p. 21.

67 1999 NHSDA, p.33.

68 National Center on Addiction and Substance Abuse at Columbia University (CASA), *No Place to Hide: Substance Abuse in Mid-Size Cities and Rural America*, p. 3.

69 National Drug Intelligence Center, *Draft National Drug Threat Assessment 2000: An Interim Report* (Johnstown, PA: U.S. Department of Justice, 1999), p. 5.

70 National Institute of Justice, *Interim Report of the Methamphetamine Interagency Task Force*, (Washington, D.C.: U.S. Department of Justice, 1999), p. 9.

71 El Paso Intelligence Center Statistics provided to ONDCP, November 6, 2000. The vast majority of labs reported to EPIC were methamphetamine labs. However, a small number of labs reported produced LSD, MDMA, or methcathinone.

72 El Paso Intelligence Center, Statistics provided to ONDCP, November 6, 2000.

73 Office of National Drug Control Policy, the Midwest High Intensity Drug Trafficking Area, December 11, 2000. In Kansas, the Kansas Bureau of Investigation seized 99 labs in 1997, 189 in 1998, and 511 in 1999. In Missouri, the Missouri State Highway Patrol seized 319 labs in 1997, 485 in 1998, and 920 in 1999. In Iowa, the Iowa Division of Narcotics Enforcement seized 85 labs in 1997, 339 in 1998, and 514 in 1999.

74 Drug Enforcement Administration, *Drug Intelligence Brief – Drug Trafficking in the United States, September 1999*, p. 8.

75 Office of National Drug Control Policy, *Draft - What America's Users Spend on Illegal Drugs, 1988-1998*, p. 24. Because a portion of the methamphetamine consumed in the United States is produces domestically by numerous small clandestine laboratories, often for selective chose customers, a meaningful assessment of domestic consumption is very difficult to develop. Additionally, this data represents the first attempt at estimating methamphetamine consumption; some uncertainty may exist.

76 Drug Enforcement Administration, *Drugs of Concern: MDMA (Ecstasy)*, www.usdoj.gov/dea/concern/mdma.htm, January 13, 2000.

77 See Hatzidimitriou, G., McCann, U.D., and Ricaurte, G.A. "Altered Serotonin Innervation Patterns in the Forebrain of Monkeys Treated with (±)3,4-Methylenedioxymethamphetamine Seven Years Previously: Factors Influencing Abnormal Recovery," *The Journal of Neuroscience*, June 15, 1999, 19(12):5096-5107 and McCann, U.D., Eligulashivili, V., Ricuarte, G.A., "Cognitive Performance in (+/-) 3,4 Methylenedioxymethamphetamine Users: A Controlled Study," *Psychopharmacology*, April 1999, 143(4):417-25.

78 Ibid.

79 Substance Abuse and Mental Health Services Administration, Office of Applied Studies, Year-End 1999 *Emergency Department Data from the Drug Abuse Warning Network Annua*l, DHHS Publication No. SMA00-3462, (Rockville, MD: U.S. Department of Health and Human Services, August 2000).

80 Drug Enforcement Administration, *Drugs of Concern: MDMA (Ecstasy)*,www.usdoj.gov/dea/concern/mdma.htm, January 13, 2000.

81 Drug Enforcement Administration, *Drug Intelligence Brief: MDMA – June 1999*, p. 2.

82 Drug Enforcement Administration, *Report of the International Conference on Ecstasy & Club Drugs*, October 2000, p. ii. The National Drug Intelligence Center, *Draft National Drug Threat Assessment 2001: The Domestic Perspective*. p. 49.

83 Ibid., p. 2.

84 United States Customs Service, Office of Public Affairs, *Ecstasy Seizures and Smuggling Methods Fact Sheet*, January 5, 2000.

85 National Drug Intelligence Center, *Draft National Drug Threat Assessment 2001: The Domestic Perspective*, October 2000.

86 National Drug Intelligence Center, *MDMA Trafficking* – unclassified briefing for the Office of National Drug Control Policy, Washington, D.C., December 15, 1999.

87 National Drug Intelligence Center, *MDMA Trafficking* – unclassified briefing for the Office of National Drug Control Policy.

88 Drug Enforcement Administration, *Drug Intelligence Brief – Drug Trafficking in the United States*, September 1999, p. 13.

89 Drug Enforcement Administration, *Drug Intelligence Brief—Caribbean MDMA Trends*, February 2000.

90 Drug Enforcement Administration, Drug Intelligence Brief: MDMA – June 1999, p. 1.

91 Department of the Air Force, Office of Special Investigations, Letter from Brigadier General F.X. Taylor to Joseph Peters, ONDCP, December 7, 2000.

92 1999 NHSDA, p.32.

93 1999 NHSDA, p.171.

94 1999 NHSDA, p.170.

95 National Institute on Drug Abuse, National Institutes of Health, *Anabolic Steroids: A Threat to Mind and Body, NIDA Research Reports*, (Washington, DC: U.S. Department of Health and Human Services, NIH, NIDA, 1991) (DHHS Publication No. (ADM)91-1810).

96 1999 NHSDA, p.171.

97 1999 NHSDA, p.32.

98 National Institute on Drug Abuse, Community Epidemiology Work Group, *Epidemiological Trends in Drug Abuse, Volume I* (Washington, D.C.: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, 1999), p. 77.

99 Drug Enforcement Administration, *The Diversion of Drugs and Chemicals* (Washington, D.C.: U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control, 1999), p. 6.

100 Drug Enforcement Administration, *The Diversion of Drugs and Chemicals*, p. 7.

101 United States Customs Service, Office of Public Affairs, unpublished seizure statistics.

102 Drug Enforcement Administration, Office of Diversion Control Statistics, January 13, 2000.

103 See http://www.drugquest.com/ (January 20, 2000) and http://www.feral.org/vitality/in_1main.htm (January 20, 2000).

104 Drug Enforcement Administration, *The Diversion of Drugs and Chemicals*, p. 4.

105 Ibid., p. 11.

106 Wilson, Doris James, "Drug Use, Testing, and Treatment in Jails," Bureau of Justice Statistics, May 2000 and Mumola, Christopher, "Substance Abuse and Treatment, State and Federal Prisoners, 1997," Bureau of Justice Statistics, January 1999.

107 Wilson, Doris James, "Drug Use, Testing, and Treatment in Jails," Bureau of Justice Statistics, May 2000 and Mumola, Christopher, "Substance Abuse and Treatment, State and Federal Prisoners, 1997," Bureau of Justice Statistics, January 1999.

108 National Institute of Justice, *1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees*, June 2000, p.1.

109 National Institute of Justice, *1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees*, June 2000, p.3.

110 National Institute of Justice, *1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees*, June 2000, p.2.

111 National Institute of Justice, *1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees*, June 2000, p.1.

112 National Institute of Justice, *1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees*, June 2000, p.2.

113 National Institute of Justice, *1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees*, June 2000, p.1

114 National Institute of Justice, *1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees*, June 2000, p.4

115 National Institute of Justice, *1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees*, June 2000, p.24.

116 National Institute of Justice, *1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees*, June 2000. p.58.

117 National Institute of Justice, *1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees*, June 2000, p.3.

118 National Institute of Justice, *1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees*, June 2000, p.3.

119 U.S. Department of Justice, Bureau of Justice Statistics, *Prisoners in 1999*, August 2000, p.2.

120 U.S. Department of Justice, Bureau of Justice Statistics, *Prisoners in 1999*, August 2000, p.2.

121 U.S. Department of Justice, Bureau of Justice Statistics, *Prisoners in 1999*, August 2000, p.2.

122 U.S. Department of Justice, Bureau of Justice Statistics, *Prisoners in 1999*, August 2000, p.1.

123 U.S. Department of Justice, Bureau of Justice Statistics, *Prisoners in 1999*, August 2000, p.1.

124 U.S. Department of Justice, Bureau of Justice Statistics, *Prisoners in 1999*, August 2000, p.5.

125 U.S. Department of Justice, Bureau of Justice Statistics, *Prisoners in 1999*, August 2000, p.12-13.

126 U.S. Department of Justice, Bureau of Justice Statistics, *Prisoners in 1999*, August 2000, p.10.

127 U.S. Department of Justice, Bureau of Justice Statistics, *Prisoners in 1999*, August 2000, p.10.

128 U.S. Department of Justice, Bureau of Justice Statistics, *Prisoners in 1999*, August 2000, p.11.

129 Mumola, Christopher J., *Veterans in Prison or Jail*, January 2000, Bureau of Justice Statistics, p.9-10.

130 Mumola, Christopher J., *Veterans in Prison or Jail*, January 2000, Bureau of Justice Statistics, p.5.

131 Wilson, Doris James, *Drug Use, Testing, and Treatment in Jails*, May 2000, Bureau of Justice Statistics, p.1-2.

132 National Institute on Drug Abuse, National Institute on Alcohol Abuse and Alcoholism, *The Economic Costs of Alcohol and Drug Abuse in the United States* (Rockville, MD: U.S. Department of Health and Human Services, 1998), http://www.nida.nih.gov/EconomicCosts/Chapter1.html#1.10, January 11, 2000.

133 Ibid., http://www.nida.nih.gov/EconomicCosts/Chapter1.html #1.2, January 23, 2000.

134 Hoyert, D.L., Kochanek, K.D., Murphy, S.L. "Deaths: Final Data for 1997." *National Vital Statistics Report*, Vol. 47, No. 19, (Hyattsville, MD: National Center for Health Statistics, 1999).

135 Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *Drug Abuse Warning Network Annual Medical Examiner Data 1998*, p. 50.

136 Leshner, A, "Science-Based Views of Drug Addiction and its Treatment," *Journal of the American Medical Association*, October 13, 1999, http://jama.ama-assn.org/issues/v282n14/full/ jct90020.html, January 27, 2000.

137 Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *Year-End 1999 Emergency Department Data from the Drug Abuse Warning Network*, DHHS Publication No. SMA00-3462, (Rockville, MD: U.S. Department of Health and Human Services, August 2000), p. 66.

138 Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *Drug Abuse Warning Network Annual Medical Examiner Data 1999*, p. 66.

139 Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *Drug Abuse Warning Network Annual Medical Examiner Data 1999*, p. 11.

140 Alan Leshner, "Addiction is a Brain Disease — And It Matters," *National Institute of Justice Journal*, October 1998, p. 3.

141 Centers for Disease Control and Prevention (CDC), *Reported Tuberculosis in the United States*, 1999, August 2000, pp.34-36.

142 CDC, HIV/AIDS Surveillance Report, 1999; 11(2): 14.

143 Centers for Disease Control and Prevention, Summary of Notifiable Diseases, U.S., 1997, *Morbidity and Mortality Weekly Report* 1998; 46(54).

144 The United States Conference of Mayors A Status on Hunger and Homelessness in America's Cities 1999: A 26-City Survey, Washington, D.C., December 1999.

145 Culhane, Dennis P., Edmund F. Dejowski, Julie Ibanez, Elizabeth Needham and Irene Macchia, "Public Shleter Admission Rates in Philadelphia and New York City: The Implications of turnover for Sheltered Population Counts," in Understanding Homelessness: New Policy and Research Perspectives, edited by Dennis P. Culhane and Steven P. Hornburg, Fannie Mae Foundation, Washington, D.C., 1997.

146 Rog, Deborah and C. Scott Holupka, "Reconnecting Homeless Individuals and Families to the Community," Practical Lessons: The 1998 National Symposium on Homelessness Research, (Washington, D.C.: U.S. Department of Housing and Urban Development and U.S. Department of Health and Human Services, August 1999).

147 Interagency Council on the Homeless, *Homelessness: Programs and the People They Serve*, Technical Report, prepared by The Urban Institute, December 1999, pp. 8-18.

148 Ibid.

149 The Data Appendix to this Annual Report traces the reporting requirements outlined by Congress, the existing data instruments used to compile this report, areas where data is insufficient or infrequently collected, and steps being taken to remedy data inadequacies. *The Performance Measures of Effectiveness: 2001 Report* outlines accomplishments in 2001 by ONDCP's Data Subcommittee that can help close the PME system data gap.

III. Report on Programs and Initiatives

1. INITIATIVES TO PREVENT DRUG USE

The adoption of effective drug abuse prevention programs by communities nationwide will significantly reduce the toll of drug abuse and addiction on our society, especially our nation's youth. Over the next five years, research advances in the following areas will significantly enhance our nation's prevention efforts:

- Understanding of the genetic and environmental risk and protective factors that can prevent or lead to drug abuse and addiction.
- Enhancement of the assessment of drug problems at a local level by providing communities with effective research-based tools.
- Translation of research-based prevention principles for the specific needs of local communities.
- Determining the link between drug abuse and infections such as HIV and hepatitis to reduce the local impact of these devastating illnesses.

Understanding what determines vulnerability to substance abuse is crucial to the development of effective prevention programming. At this point, there is no evidence that a single, unique factor determines which individuals will abuse drugs; rather, drug abuse appears to develop as the result of a variety of genetic, biological, emotional, cognitive, and social risk factors that interact with features of the social context. Thus, both individual-level factors and social context-level factors appear to make an individual more or less at risk for drug abuse and influence the progression from drug use to drug abuse to drug addiction.

Studies supported by NIDA and SAMHSA have already identified many risk factors associated with the development of drug problems. These factors typically have been organized into categories that represent individual, familial, and social risks. For example, we now know that individual-level risks include shy, aggressive, and impulsive personality traits and poor academic achievement; and family-level risks include poor monitoring by parents and exposure to substance use by parents and siblings. School-level risk factors include a pro-drug-use norm and availability of drugs on or near the school campus; and community-level risks include lack of positive academic and recreational programming for children and adolescents after school hours and on weekends, as well as low levels of law enforcement with respect to minors' use of licit and illicit substances. This sampling of risk factors illustrates the breadth and complexity of the risks that can confront any one person.

For many years, our focus was on discovering the factors that put people, particularly children, at risk for drug use, abuse, and addiction. We now know that there are also protective or resiliency factors that protect individuals from developing drug-related problems. NIDA-supported research has already uncovered many such protective factors that operate at the individual and contextual levels through the family, peer group, school, community, workplace, and the media, among others. Examples of protective or resiliency factors include a stable temperament, a high degree of motivation, a strong parent-child bond, consistent parental supervision and discipline, bonding to pro-social institutions, association with peers who hold conventional attitudes, and consistent, community-wide anti-drug-use messages and norms. An accumulation of protective factors may counteract the negative influences of a few risk factors.

The challenge for the future is to understand how risk and protective factors interact to make individuals more or less vulnerable to trying drugs, abusing drugs, and/or becoming

addicted to drugs. Additionally, we must understand the unique risk and protective factors that contribute to drug abuse among minority populations. This knowledge will allow prevention researchers and providers to design programs that can be more effectively tailored to individual needs.

To give communities the science-based tools to prevent drug abuse, we must have research in several emerging areas of prevention. Strategies that can help communities better determine their own local needs and their readiness for interventions are needed. For example, communities must be given the epidemiological tools to assess their needs. Research is needed also to aid understanding of the organization, management, financing, and delivery of prevention services. In the treatment arena there are established systems such as clinics, hospitals, outpatient centers, HMOs, and clinician training and certification systems. However, there are no defined systems for provision and financing of prevention services or training and credentialing of providers. Thus, it is difficult to determine how decisions are made about prevention implementation. A full understanding of these issues will help integrate prevention strategies and programs into existing community-level service delivery systems and sustain them.

Having the skills to resist drugs is critical to the prevention of initial drug use. There is an emerging body of research that is beginning to focus on the role that ethnicity and gender play in adolescent drug use and refusals of drug offers. Knowing the situations in which drug offers typically occur among various groups can help better prepare individuals how to refuse those offers. Re-designing drug prevention skills to address differences in terms of gender, ethnicity, and circumstances can be an important contribution to improving drug abuse prevention intervention efforts.

The Central Role of Parents

While all parents exert a critical influence on their children, mothers and fathers of eight to fourteen year olds are especially influential. Young people in this age group normally condemn drug use. Such attitudes and attendant behavior are easily reinforced by involved parents. Adults who wait until their children are older to guide their offspring away from drugs, allow peers to have more influence on their children's decision to use drugs.

SAMHSA/CSAP's High Risk Youth program has found that protective factors and family bonding drop dramatically between ages ten and fourteen. Based on such evidence, SAMHSA/CSAP has established a new Parenting and Family Strengthening program to increase the availability of family-based prevention interventions. This two-year program funded ninety-six cooperative agreements to increase local effective parenting and family programs, document the decision-making processes for selecting and testing interventions in community settings, and determine the impact of the interventions on target families. The program works to raise awareness of the fact that good parenting and strong families are key to preventing youth substance abuse. Through CSAP's Parenting IS Prevention Initiative, significant collaborative efforts have been made with major parenting organizations such as the Child Welfare League of America, Parents Without Partners International, The National Council on Family Relations, and the Head Start Association. As a result, these organizations are offering training and other resources to their members. Finally, SAMHSA/CSAP has launched a prevention program aimed at Spanish-speaking parents and grandparents called "Hablemos En Confianza."

Children whose parents abuse alcohol or illicit drugs face heightened risks of developing substance-abuse problems themselves. An estimated eleven million such children under age eighteen live in the United States. Every day, these young people receive conflicting and confusing messages about substance abuse. Nevertheless, specially crafted prevention interventions can break through the levels of denial inherent in these families. SAMHSA/CSAP's Children of Substance-Abusing Parents program is developing community-based interventions for these youth that involve integrated services as determined by individual client- and provider-developed family service plans.

Substance-Abuse Prevention in Early Childhood

Early childhood is a perfect time for prevention that targets risk factors. Intervention for substance abuse is critically important during this time because it is from infancy to the preschool period when brain development is rapid and much more vulnerable to environmental influences.[1] Children who have not developed crucial intellectual, emotional, and social abilities by age three are more likely to have problems that can limit lifelong potential. Early risk factors include parental criminality and substance abuse, low verbal ability, social disorganization and violence in the neighborhood, poor family management practices, inconsistent or harsh parenting,

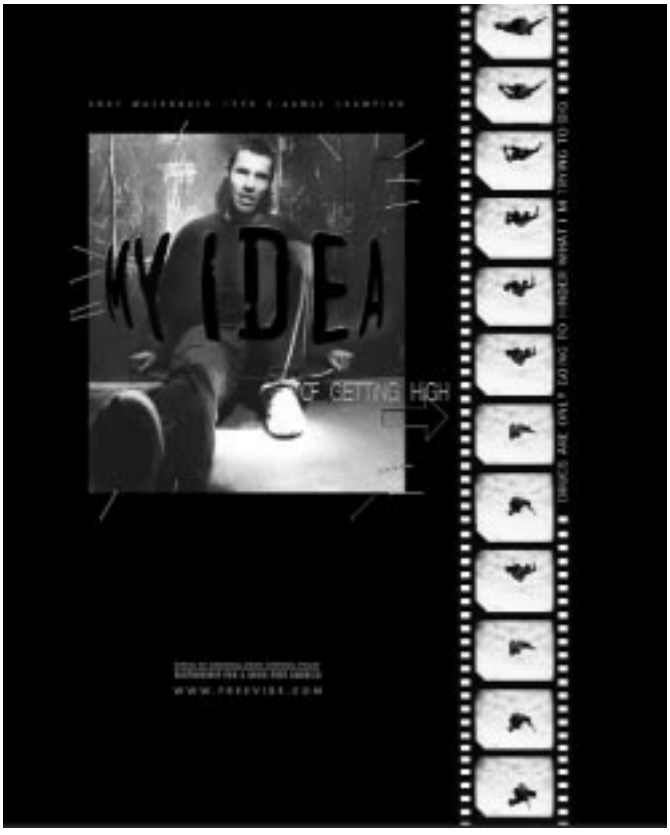
low socioeconomic status, and exposure to media violence. Prevention works well at this early stage when children and caregivers are susceptible to learning. SAMHSA/CSAP has initiated several programs addressing prevention in early childhood. Starting Early Starting Smart, developed and conducted collaboratively with the Health Resources and Services Administration, the Administration for Children and Families, the U.S. Department of Education, the National Institutes of Health, and The Casey Family Program, is testing the effectiveness of integrating behavioral health services with primary care and/or early childhood service settings. SAMHSA/CSAP also sponsors a Predictor Variables investigation program, which is seeking to develop further the knowledge about effective prevention interventions for young children (ages 3-14) by linking them with appropriate developmental stages. This study, in its final year, has shown significant improvement in the intervention group relative to the control group in a number of areas, including improved parenting practices; increased family cohesion and organization; decreased family conflict; decreased use of harsh parenting strategies such as spanking, shouting, and threatening; and lower drug use from baseline to program exit. Another ongoing program is the SAMHSA/CSAP Community-Initiated Prevention Interventions Grant program, which tests interventions that have been shown to prevent, delay, or reduce alcohol, tobacco, or other illegal drug use and/or associated social, emotional, behavioral, cognitive, and/or other factors. Grants awarded so far include targeted interventions for the elderly, the dually diagnosed, the disabled, and single gender groups, as well as community-wide prevention interventions. Since 1992, the Robert Wood Johnson Foundation has supported Free to Grow: Head Start Partnerships to Promote Substance-Free Communities. This program provides early childhood education, health, and social services to more than 750,000 low-income children in urban, suburban, and rural communities throughout the United States. The initiative addresses the problem of substance abuse by strengthening families and neighborhoods. Free to Grow supports the design and implementation of model substance-abuse prevention projects within local Head Start programs.

National Youth Anti-Drug Media Campaign

The goal of ONDCP's bipartisan five-year National Youth Anti-Drug Media Campaign is to harness the media to educate America's youth to reject illegal drugs. Advertising, television programming, movies, music, the Internet, and print media have a powerful influence on young people's view of drugs and other dangers. The campaign focuses on primary prevention — heading off drug use before it starts — for three reasons:

1. It targets the underlying causes of drug use and therefore has the greatest chance of success.
2. Over time, it will reduce the need for drug treatment, which is in short supply.
3. A media campaign has more potential to affirm the anti-drug attitudes of youth who are not involved with drugs than to persuade regular drug users to give up drugs.

The media campaign, which is based on medical and behavioral research, was developed in consultation with scores of experts in behavioral science, medicine, drug prevention, teen marketing, advertising and communications, and representatives from professional, civic, and community-based organizations.



The media can play a critical role in public-health campaigns because of its educational ability to impart information and influence behavior. A carefully planned mass media campaign can reduce substance abuse by countering false perceptions that drug use is normal. In the past, media campaigns have proved successful in changing risky behaviors, such as driving under the influence of alcohol or without seat belts. The media campaign needs to be integrated with anti-drug programs and other outreach initiatives based in homes, schools, places of worship and community-based organizations.

An integrated communications approach was instituted in 1999, at which time the Office of National Drug Control Policy focused on specific anti-drug themes and messages for advertising and other outreach efforts, such as partnerships, entertainment industry, Interactive media and sports. The advertising program is divided into four to six-week periods — a process called flighting — during which time a specific anti-drug message "platform" is communicated. Local coalitions and other partners can amplify these messages by adding their own messages and conducting related local events and activities.

Matching contributions from media outlets also multiply the impact of these messages. Media outlets must make a public service donation in support of the Campaign on a dollar-for-dollar value basis for every dollar of paid advertising space or time they provide. Most matches involve ad for ad contributions. Magazine inserts, program content, web site development, and community events may also qualify for the pro-bono match.

Partnerships are a key component of the Campaign. The Advertising Council, which is well known for creating over 1,000 multi-media public service announcement campaigns, supports the Campaign in three crucial ways: overseeing the clearinghouse and review for ads that qualify for the pro-bono match; reviewing all production costs; and creating the "You Can Help" community drug prevention campaign. "You Can Help" was launched in 2000, with the goal of mobilizing individuals and community groups to adopt the drug prevention issue and focus volunteer efforts on successful strategies. The campaign includes media material that local groups can customize to their needs.

WASTED

DREAMS.

STILL THINK POT ENHANCES PERFORMANCE? KEEP TELLING YOURSELF THAT WHILE YOU RIDE OUT THE SLUMP.

OFFICE OF NATIONAL DRUG CONTROL POLICY
PARTNERSHIP FOR A DRUG-FREE AMERICA™

WASTED

FRIENDSHIP.

IF YOUR NEW FRIENDS ARE SO COOL, HOW COME THEY ONLY COME AROUND WHEN YOU'VE GOT WEED?

OFFICE OF NATIONAL DRUG CONTROL POLICY
PARTNERSHIP FOR A DRUG-FREE AMERICA™

WASTED

LOVE.

PARENTS YELL. YOU TOKE. YOU TOKE. PARENTS YELL. PARENTS YELL. YOU TOKE. YOU TOKE. PARENTS YELL. SEE A PATTERN DEVELOPING HERE?

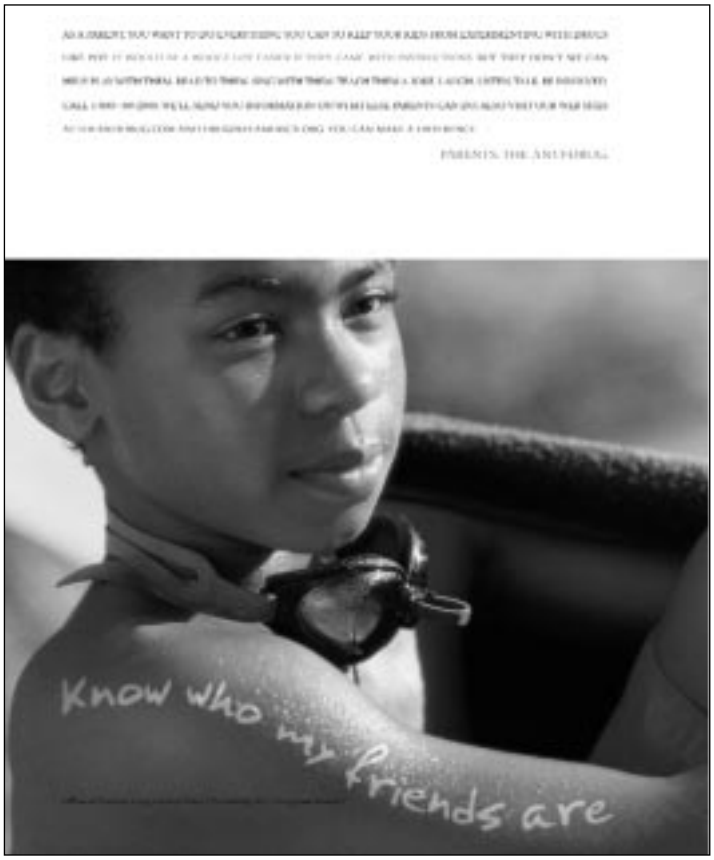
OFFICE OF NATIONAL DRUG CONTROL POLICY
PARTNERSHIP FOR A DRUG-FREE AMERICA™

WASTED

MONEY.

$80 FOR THE BAG OF WEED. $35 FOR CONCERT SEATS. $2.50 FOR ROLLING PAPERS. BUT THE RIDE HOME IS FREE.

OFFICE OF NATIONAL DRUG CONTROL POLICY
PARTNERSHIP FOR A DRUG-FREE AMERICA™



The Partnership for a Drug Free America (PDFA), a private, non-profit, non-partisan coalition of professionals from the communications industry, is another critical partner. Its mission is to reduce demand for illicit drugs in America through media communications. The Partnership had concluded that intense competition, brought on by the splintering of the media, brought new economic realities to the media industry in the 1990s. With media donations to the Partnership down more than $100 million since 1991, the outlook for national media was uncertain. The ONDCP campaign promised something unprecedented for PDFA's public service advertising: precise placement of the right ads, targeting the right audience running in the right media, consistently, over time. To this point, PDFA has developed for the media campaign over 280 TV, radio, and print messages targeted to parents and at-risk youth.

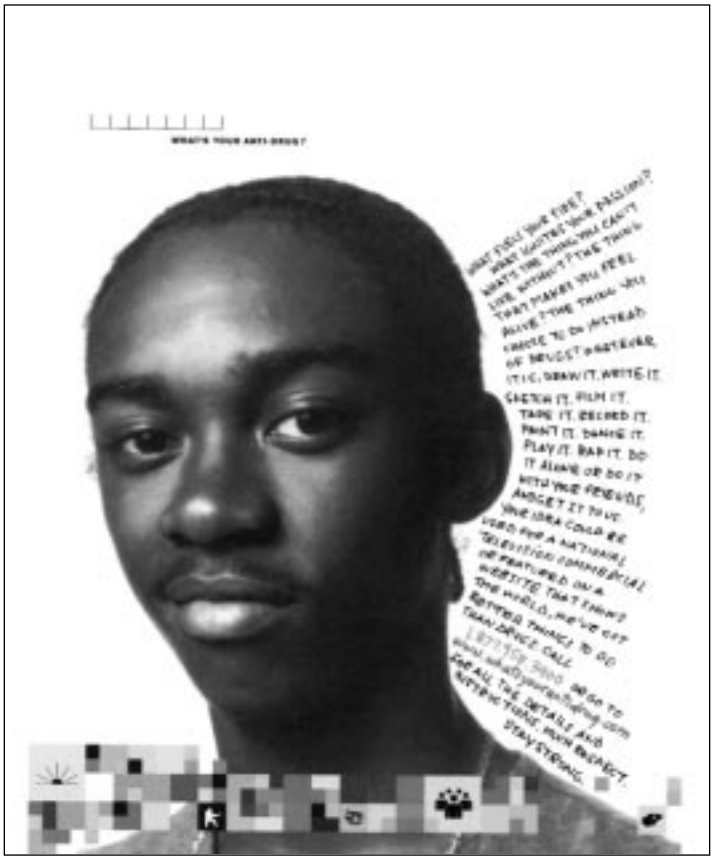
In the year 2000, the Office of National Drug Control Policy undertook the ambitious task of launching a new "brand" for youth audiences. For years, advertisers and marketers have used traditional "branding" to create a consistent identity for a product or company, and through repeated exposure, keep the image top of mind for the consumer. We now understand that successful "brands" are those that not only generate awareness, but occupy a meaningful "place" in consumers lives.

Over the course of a year, ONDCP conducted extensive research, talking to hundreds of teens and tweens (11-13 year-olds) from communities across the country, to find out if young people would embrace the idea of an "anti-drug" — something important enough in their lives to stand between them and drugs. Not only did teens and tweens find ownership and empowerment in the idea of an "anti-drug" brand that reflected their own values and passions (i.e. Soccer, My Anti-Drug; Dreams, My Anti-Drug), they suggested that the brand could serve as an invitation to other youth to reflect on what their anti-drugs might be.

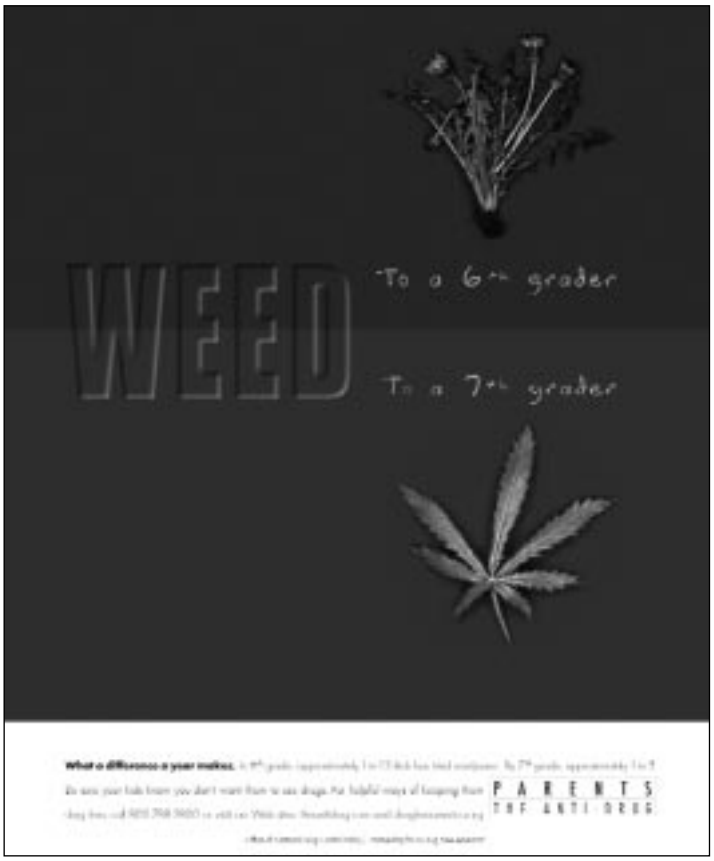
In September, ONDCP, in conjunction with the Partnership for a Drug-Free America, launched this new brand by posing the question "What's Your Anti-Drug?" to America's youth, engaging them individually in the prevention message. The launch culminated in November, with a national advertising campaign that featured anti-drug submissions of youth from across the country.

ONDCP partnered with youth organizations nationwide in launching "my anti-drug." Through community outreach efforts, the YMCA, CADCA, Future Farmers of


Get to your kids before marijuana does.
PARENTS: THE ANTI-DRUG

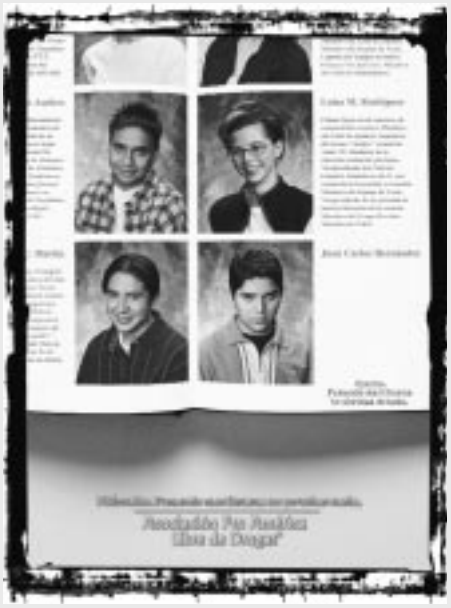

WHAT'S YOUR ANTI-DRUG?


WHAT'S YOUR ANTI-DRUG?


WEED
To a 6th grader
To a 7th grader
What a difference a year makes.
PARENTS
THE ANTI-DRUG

TRANSLATION

Her favorite person was always YOU.
You are the hero. Talk: The Anti-Drug.
Office of National Drug Control Policy
Partnership for a Drug-Free America



TRANSLATION

It's True. If you smoke marijuana you prove nothing.
Office of National Drug Control Policy
Partnership for a Drug-Free America

America, Girl Scouts, and Boys and Girls Clubs were among those who galvanized youth within their own organizations to participate in this important initiative. The website (whatsyourantidrug.com) is also expected to remain live beyond the launch of the brand, in order to build an interactive groundswell of youth anti-drug expressions.

New, major multicultural outreach was initiated in 2000. For example, within the American Indian community, print advertising was developed that not only reflects the values that exist within Native culture, but lay the groundwork for extending the campaign's prevention message within local community-based programs. Another outreach effort on Father's Day resulted in over 55 million media impressions being delivered to ethnic fathers.

The Media Campaign also supports a major Interactive component, including a suite of Web sites specifically designed for target audiences and an aggressive outreach effort to place drug prevention content on Web sites popular among kids and parents. Since the Campaign's inception, over 5 million Internet-users have visited its Web sites and thousands have subscribed to an e-mail parenting-tips newsletter.

Partnering with an ever-increasing number of civic, service and youth-serving organizations, the Campaign promotes the integration of core anti-drug messages into partner communications vehicles and programs in order to institutionalize prevention messages. Through recent collaborations, the American Bar Association (ABA), American Medical Association (AMA), Girl Scouts (GSUSA), Boys and Girls Clubs of America and over 100 Youth Service America (YSA) affiliated organizations, and the National Education Association, the Campaign has expanded its reach and effectiveness.

Over the past year, media campaign advertising reached 95 percent of America's youth 7.5 times a week and communicated messages in eight languages to youth and adults of various ethnic groups. Of particular note was the campaign's ability to refine its target of "sensation seeking" tweens and teens, who are most vulnerable for drug use, reaching them in the household and in the schoolyard, at the mall, on the Internet — everywhere they are.

Since its inception in 1998, the campaign's messages have become ubiquitous in the lives of America's youth and their parents. From network television advertisements to school-based educational materials, from murals to Internet websites, and from local soccer competitions to national youth organizations, the campaign's messages reach Americans wherever they are — work, play, school, worship, and home.

TRANSLATION

Also presented in Guam and Samoa, Filipino, Korean and Vietnamese.

TRANSLATION

For Too Many Parents,
Drugs Can Cause Blindness

Many [Chinese, Filipino, Korean, Vietnamese, Japanese] children have tried drugs. Sadly, too many parents don't believe that their own children could use drugs. There are several things you can do to help keep your children's life drug-free. First of all, talk with them about the dangers of drugs. Also, know who their friends are,
and make sure that your children have something to do after school like homework or sports. Let them see that you care about keeping drugs out of their future.

Office of National Drug Control Policy
Partnership for a Drug-Free America

Safe and Drug-Free Schools and Communities[2]

The U.S. Department of Education's Safe and Drug-Free School Program (SDFSP) is the federal government's primary vehicle for reducing drug, alcohol, and tobacco use, and violence, through education and prevention activities in our nation's schools. The program provides support for research-based approaches to drug and violence prevention that are designed to prevent violence in and around schools and to strengthen programs that prevent the illegal use of alcohol, tobacco, and drugs; that involve parents; and that are coordinated with related Federal, State, and community efforts and resources.

The SDFSP consists of two major parts: 1) State Grants for Drug and Violence Prevention Program; and 2) National Programs. State Grants is a formula grant program that provides funds to state and local education agencies, and governors, for a broad range of school- and community-based education and prevention activities. National Programs carries out a variety of discretionary initiatives that respond to emerging needs and national priorities. To improve the accountability of grants funded under the Safe and Drug-Free Schools and Communities Act (SDFSCA), Department regulations require that State and local grant recipients use their funds for prevention strategies that are based on the SDFSP Principles of Effectiveness. Examples of National Programs activities include direct grants to school districts and communities with severe drug and violence problems, program evaluation, and information development and dissemination.

Key initiatives of the Safe and Drug-Free Schools Program in 2000 have included the following discretionary grant programs: 1) Safe Schools/Healthy Students Initiative; 2) Middle School Drug Prevention and School Safety Program Coordinators Initiative; and 3) Effective Alternative Strategies to Reduce Student Suspensions and Expulsions and Ensure Educational Progress of Suspended and Expelled Students.

The Safe Schools/Healthy Students Initiative, now in its second year, is a unique grant program jointly administered by the U.S. Departments of Education, Health and Human Services, and Justice. In April 2000, President Clinton announced more than $41 million in grants to 23 communities to make schools safer, to foster children's healthy development and to prevent aggressive and violent behavior and drug and alcohol use among youth. The Initiative supports urban, rural, suburban and tribal school district efforts to link prevention activities and community-based services, including enhanced educational, mental health, social service, law enforcement, and as appropriate, juvenile justice system services. Added to 54 Safe Schools/Healthy Students (SS/HS) projects funded in 1999, the new grants bring the total number of SS/HS grants to 77 nationwide. A national evaluation of the Safe Schools/Healthy Students Initiative is being conducted to document the effectiveness of collaborative community-wide efforts to promote safe schools and provide opportunities for healthy childhood development.

The Middle School Drug Prevention and School Safety Program Coordinators Initiative is based on research indicating that well-trained, full-time school safety and drug prevention coordinators can help reduce drug use, discipline problems and violent incidents. In 2000, the second year of the initiative, 113 school districts in 35 states received grants amounting to a total of $45 million to recruit, hire, and train middle school coordinators. In 1999, the first year of the program, 97 school districts received $34.6 million in grants. The three-year grants have been awarded to school districts and consortia of smaller districts with significant drug, discipline and violence problems in middle schools. Key responsibilities of the coordinators include assisting schools in adopting successful, research-based drug and violence prevention strategies, and developing, conducting and analyzing assessments of school drug and crime problems.

The purpose of Alternative Strategies to Reduce Student Suspensions and Expulsions and Ensure Educational Progress of Suspended and Expelled Students is twofold: 1) to decrease the number of suspensions and expulsions; and 2) to ensure continued educational progress for suspended and expelled students, through the use of high-quality programs and strategies that work. In 2000, $10.4 million was awarded to 14 school districts and other nonprofit organizations to create effective alternative programs and help educate students who have been suspended or expelled. While there is no single strategy that ensures an effective alternative setting, there are promising characteristics that include: small class size; clearly stated mission; measurable program goals and discipline codes; parental involvement; caring faculty that receives continual staff development; high expectations for student achievement; learning programs specific to the students' learning styles; exposure to and preparation for the world of work; flexible school schedules with community support; and total commitment to each student's success.

In addition to the discretionary grant programs described above, initiatives have also included interagency agreements for a broad range of activities. Examples of these include agreements between the Department of Education (ED) and the Department of Health and Human Services to provide support for the Centers for the Application of Prevention Technologies, for a multi-year study concerning the diffusion of prevention research and its effects on practice, and for grants to institutions of higher education that address issues related to binge drinking among college students.

In 1999, the Department of Education developed, and the president transmitted, to Congress a reauthorization proposal for the Safe and Drug-Free Schools and Communities Act (SDFSCA), which reflected the direction the Safe and Drug-Free Schools Program (SDFSP) is taking to promote improvements in programs funded under the SDFSCA. The proposal would have improved program accountability by emphasizing the importance of research-based programs and concentrating funds on areas of high need. Specifically, the proposal would have required states to (1) award subgrants competitively to school districts and other applicants in accordance with the quality of the applicants proposal for the use of funds and how closely it is aligned with the SDFSCP Principles of Effectiveness; and (2) ensure that grants are of sufficient size and scope to help improve safety and order in the school and reduce student drug use. Congress did not complete work on the reauthorization proposal.

After-School Initiatives

Reducing the precursors of drug use — aggression, conduct disorders, shyness, and lack of school and family attachment — can be achieved through after-school activities. Mentoring programs increase the involvement of high-risk youth with caring adults. Mentors help children by modeling, teaching, and reinforcing positive behavior. In FY 1999, the Departments of Justice and Education collaborated to support twelve grants providing one-to-one mentoring programs for youth at risk of educational failure, dropping out of school, or involvement in delinquent activities including gangs and drug use. SAMHSA/CSAP'S Project Youth Connect is evaluating the comparative benefits of youth-only approaches versus programs that involve parent and youth mentors. CSAP's public education campaign, Your Time-Their Future, encourages adults to get involved with youth to help young people build skills, self-discipline, and competence to resist alcohol, tobacco, and illicit drugs. SAMHSA/CSAP's State Incentive Grant Program provides funding to communities and encourages them to utilize science-based programs, including those which focus on children and parents both in and out of the school setting.

Transitioning from elementary school to middle school or junior high, is a particularly challenging time for most youth. NIDA supported researchers found that prevention planners need to develop programs that provide support during these highest-risk periods. Prevention programs that bring together a variety of audiences, such as those that are tailored to both parents and schools are showing some positive results. The Adolescents Transitions Program is one example of a school-based program that focuses on parenting practices and integrates interventions that are universal (geared to the general population), selective (targeted to groups at risk), and indicated (designed for individuals). In short, NIDA researchers have found that the school setting has been shown to be an effective place to engage families in promoting drug abuse prevention.

Drug-Free 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. Local coalitions, comprised of a broad sector of community leadership, are working to devise sound strategies based on local data and knowledge of a growing body of scientifically supported program ideas. Local leaders know that they must sustain their efforts into the foreseeable future if we are to significantly reduce demand for illegal drugs at the community level.

The Drug-Free Communities (DFC) Program, created through the Drug-Free Communities Act of 1997, provides funds, knowledge, and other resources to help local leaders prevent youthful drug problems, including the underage use of alcohol, tobacco, and inhalants. This program now supports 307 communities located in forty-nine states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. Applicant communities must match their grant awards with equivalent funding from non-federal sources. Communities may re-apply for federal funds for additional years, depending upon annual appropriations. The intent of Congress is to support programs that have promise to be self-sustaining in the future.

The DFC Program operates with an unusually high level of federal agency and private-sector collaboration. Administrative and policy oversight of the program is carried out by ONDCP. Day-to-day program management and financial monitoring is the primary responsibility of the Office of Juvenile Justice and Delinquency Prevention in the Department of Justice. Additional technical and scientific support and training is provided by the Center for Substance Abuse Prevention (CSAP) in the Department of Health and Human Services. CSAP utilizes regional Centers for the Application of Prevention Technologies (CAPT) offices to offer high quality, research-based knowledge and information to state and community prevention programs. Several major information clearinghouses, including the CSAP-sponsored National Clearinghouse for Alcohol and Drug Information (NCADI) provide free or low-cost material directly to all U.S. communities.[3]

The Drug-Free Communities Program is complemented by a number of private sector organizations, including the National Association of State Alcohol and Drug Abuse Directors (NASADAD), the National Prevention Network, Mothers Against Drunk Driving (MADD), the National Inhalant Prevention Coalition, as well as other public agencies such as the National Guard Bureau, the Bureau of Indian Affairs, and the federal AmeriCorps program. These entities provide useful information, research, and frequent communications that inform and involve the Drug-Free Community Coalitions. The program is ably guided by the Advisory Commission on Drug-Free Communities, an eleven member, presidentially-appointed expert group representing many sectors and organizations across the United States. The Community Anti-Drug Coalitions of America (CADCA) is a coalition membership organization that provides a wide array of technical support, program ideas, and advocacy to community coalitions around the U.S. CADCA[4] actively assists the Drug-Free Community grantees on a regular basis. Join Together, a Boston University based organization,[5] examines and reports on critical issues of interest to communities around the issues of drugs, guns, and violence.

During FY 2001, as many as 150 new grants may be awarded to other community coalitions that submit qualified applications in the national competition. The development and support of community coalitions and other local demand reduction strategies and activities continues to be an important component of ONDCP's long-term demand reduction strategy.

At the national level, future initiatives will involve creating new training capabilities, detailed descriptions of successful local innovations that can be replicated through public/private coalitions, and better dissemination and utilization of scientific knowledge about the application of prevention strategies in the natural environments of neighborhoods and communities. New collaborative efforts with The National Guard Bureau will expand low-cost distance learning capabilities to more rapidly disseminate science-based prevention and treatment practices throughout the nation. In addition, efforts on the local level should be focused on improved data collection and analysis which can inform coalition leadership, so that they may make educated financial and personnel decisions in the best interest of the coalitions.

Housing Initiatives

The Department of Housing and Urban Development's (HUD) Public and Indian Housing Drug Elimination Program (PHDEP) provides funds to public housing agencies, Indian tribes and their tribally designated housing entities, and owners of federally assisted low-income housing to support their anti-drug and anti-crime efforts. Since 1989 HUD has awarded over 7,000 grants totaling more than $2.2 billion to public housing agencies and tribally designated housing entities. Grantees have used these resources to fight crime by increasing police coverage and security and by providing residents with alternatives to crime and violence. In particular, they have used their PHDEP funding to employ security personnel and investigators; to contract with private security services; to reimburse local law-enforcement agencies for above-baseline services; to establish volunteer resident patrols; to implement physical improvements to enhance security; and to establish and operate drug prevention, intervention, and treatment programs, as well as youth violence prevention initiatives. Beginning with fiscal year 1999 grantees receive PHDEP funding through a formula allocation system. Prior to fiscal 1999, grantees were funded on a competitive basis.

Prevention through Service Alliance

Volunteer-based organizations continue to make major contributions to the national counter-drug effort. Since November 18, 1997, at a signing ceremony at the Indian Treaty Room of the Old Executive Office Building in Washington, DC, an alliance of civic, fraternal, service, veterans, sports, and women's groups has been helping young people pursue healthy, drug-free lifestyles. The Alliance represents more than a hundred million volunteers who are members of a "Prevention Through Service Alliance."* Through the original resolution agreement, member organizations have pledged to increase substance-abuse prevention messages to their members and the youth they serve, establish a communication link to share programs and resources, collaborate on community prevention efforts, promote service opportunities for youth, and publicly recognize young people involved in community service. Alliance organizations offer mentoring programs, school-based curricula dealing with drug prevention, and educational brochures for youth. Other Alliance-supported activities that promote a drug-free lifestyle include youth groups, sports teams, scholarships, and specific drug-free events. Many Alliance groups have assisted in the ONDCP National Youth Anti-Drug Media Campaign. During this coming year, a significant number of Alliance partner organizations will provide pro-bono contributions to the media campaign through their national publications and web sites.[6]

Workplace Prevention Initiatives

In 1999, more than 77 percent of all current drug users were employed — more than 9.4 million individuals, with 6.5 percent of full-time employed adults and 8.6 percent of part-time workers reporting use of illicit drugs in the past 30 days. This trend of slight increases over the past few year's mirrors national employment figures — as unemployment rates have decreased, the proportionate rates of current drug use among the employed have risen. Of those unemployed, a rate of 16.5 percent was reported, down from 18.2 percent in 1998.[7]

Emerging trends in workforce drug use — 1) a significantly higher rate of current illicit drug use by the next generation entering the workforce, and 2) a continued strong economy with its concurrent low rates of unemployment indicate a need to redouble effective workplace drug abuse intervention and prevention initiatives to successfully address our national commitments to reduce youth drug abuse and welfare dependency by increasing employment while sustaining our current record productivity gains. Making workplace prevention and intervention services available for new employees may be key to enabling those with untreated substance abuse barriers to make the successful transition from youth and welfare into successful work habits.

One important new comprehensive prevention and treatment integration initiative is focusing on Ecstasy, or MDMA (3, 4-Methylenedioxymethamphetamine) a Schedule I synthetic, psychoactive drug possessing stimulant and hallucinogenic properties. Because of the recent and rapid increases of Ecstasy use by youth, nationally, SAMHSA is addressing the urgent, national requirement for improved drug tests to detect current use in job applicants, employees, and in clinical treatment, and criminal justice settings. Additionally, work continues to get the prevention message out to youth, their families, schools, health care providers, and employers.

Since 1986, Executive Order 12564, the Drug-Free Federal Workplace, has mandated a comprehensive drug-free workplace program for all Executive Branch federal agencies. Elements include a clear policy of no use; employee education about the dangers of illicit drug use and the workplace consequences of drug use; supervisor training about their responsibilities under the policy; access to employee assistance programs (EAPs) and treatment referral; and accurate and reliable drug testing, consistent with the policy. These programs have been implemented in 120 federal agencies, with 1.8 million employees. As the nation's largest employer, the federal government has continued to provide leadership by example. For federal job applicants and employees, the positive rate remains constant at 0.5 percent, compared to 4.6 percent for other workplaces nationally.[8]

The level of positive drug test results in the private sector has declined by 66 percent since 1988 — from 13.6 percent in 1988 to 4.6 percent in 1999, based on over six million workplace drug tests conducted by the largest commercial drug testing provider. Of these test results, marijuana use represented 62 percent of all positive results, up from 59 percent in 1998.[9]

In the interest of public safety, the Department of Transportation's (DOT) oversees the largest mandatory drug-free initiative in our national workforce. This program has reduced illicit drug and alcohol abuse in the transportation industry for nearly a decade. Covering over

8.5 million safety-sensitive transportation workers in the industries of motor carriers, railroads, aviation, maritime, transit, and pipelines. These requirements include testing, education, supervisory training, employee evaluation and rehabilitation and have become a recognized standard for many non-regulated drug-free workplace programs. Currently, the Department of Transportation is introducing a substantial revision of its workplace procedures and regulations. The revised procedures represent a collaborative effort of the public and private stakeholders to incorporate the best practices and standards to produce clearer, better organized, and simpler rules for the transportation industry. These new regulations strike an excellent balance between public safety and cost and paperwork reduction issues.

To assist small businesses in achieving the same benefits of drug-free workplace programs experienced by big business, the Federal government has continued its long time commitment to assisting private sector employers to implement comprehensive and effective drug-free workplace programs. The Small Business Administration has completed its first year of an innovative program funded under the Drug-free Workplace Act of 1998. This demonstration grant/contract program allows SBA to make funds available to eligible intermediaries to assist small businesses in establishing drug-free workplace programs. Activities made possible by this program include: providing financial assistance to small businesses to provide free or reduced costs for Employee Assistance services and/or drug testing; educating small businesses on the benefits of a drug-free workplace; encouraging small business employers and employees to participate in drug-free workplace programs; and educating parents that work for small businesses on how to keep their children drug-free through its website www.sba.gov/news/drugfree.

Other Federal agencies such as the Center for Substance Abuse Prevention assist businesses to implement drug-free workplace programs through its website www.health.org/workplace, the Workplace Helpline, and by providing supplemental materials and training programs on request. The Department of Labor also provides assistance through its Working Partners for an Alcohol-and Drug-Free Workplace initiative which includes industry-specific small business materials, an interactive on-line Drug-free Workplace Program Builder, and informational materials on addressing substance abuse problems within the welfare and workforce development systems all available through its website www.dol.gov/dol/workingpartners.

Preventing Youth Drug Use Through Athletics and Drug-Free Sports

Each year approximately 2.5 million students play football and basketball in high school and junior high. Millions of children are involved in soccer and softball leagues, among other sports. Studies show that a young person involved in sports is 49 percent less likely to get involved with drugs than an uninvolved peer.[10] Children admire professional athletes, but some stars often convey mixed messages pertaining to drugs. ONDCP's Athletic Initiative uses sports as a vehicle to help prevent young people from turning to drugs.

Since its inception in 1998, ONDCP (with assistance from the Department of Justice) has reached out to America's youth through their coaches with the distribution of over 100,000 copies of the *Coaches Playbook against Drugs*. Partnerships and cooperation from 18 Major League Baseball teams, the National Collegiate Athletic Association, Major League Soccer, and National Football League players and coaches have delivered anti-drug messages to young athletes and fans nationwide. Through grants from the Department of Housing and Urban Development, each year, over 67,000 at-risk youth in 47 states and the District of Columbia were able to participate in summer programs that combine drug education with sports.

While seeking to employ sports as an alternative to drug use, American youth are increasingly endangered by the threat of performance enhancing drug-use within sport. The Monitoring the Future Study found past-year steroid use by eighth and tenth graders increased 50 percent between 1998 and 1999.[11] To address all aspects of drug use in sport, both internationally and domestically, a comprehensive federal policy was developed through a full inter-agency process in October 1999. In August 2000, the President issued an Executive Order creating a White House Task Force on Drugs and Sport to ensure the effective implementation of this strategy.

Working with the international community, ONDCP led efforts that resulted in the 2000 creation of an effective and independent World Anti-Doping Agency (WADA). ONDCP serves on the WADA Board as the representative of the United States. For the 2000 Summer Olympic Games the WADA conducted 2,500 out-of-competition tests of the Sydney competitors. In addition, a team of independent observers from the WADA

oversaw all aspects of the Summer Games drug-testing program, to ensure that this program was above reproach. These WADA efforts helped make the 2000 Games the most drug-tested games in history.

To build upon the success of the 2000 Summer Games, working with the Congress, the Federal government has provided $3.3 million to support the anti-doping program of the upcoming 2002 Salt Lake City Games. Through ONDCP and the White House Task Force on Drug Use in Sports, we will continue to assist the Salt Lake Olympic Committee in implementing a transparent and effective anti-doping program.

ONDCP has also led efforts to help improve purely domestic anti-doping programs. ONDCP assisted the United States Olympic Committee in the development of the new United States Anti-Doping Agency, and provided $3 million in funding.

To set the agenda for future efforts at all levels in this area of policy, the White House Task Force on Drug Use in Sports held a field meeting in December of 2000, bringing together representatives from sports, youth groups, coaches' organizations, and the Federal government. The Task Force will report out on the results of this agenda setting meeting early in 2001. Detailed information on all of ONDCP's anti-doping activities can be found on the Internet at www.playclean.org.

To specifically address the problems of performance-enhancing drug use by youth, NIDA-supported researchers have developed a steroid abuse prevention program, Adolescents Training and Learning to Avoid Steroids (ATLAS). Consisting of interactive classroom and training sessions given by peer educators and facilitated by coaches and strength trainers, an evaluation of the program's effectiveness showed that an athlete's intent and actual use of steroids was significantly lower among participating students. As an additional benefit, illicit drug use and alcohol use was reduced, as were incidents of student drinking and driving and use of dietary supplements.

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 of faith-based organizations serve as civic leaders. Many run programs that provide much-needed counseling and drug treatment for members of their communities. Consequently, ONDCP encourages religious communities to speak out against drugs and further develop faith-based initiatives to prevent and treat drug use.

SAMHSA's Center for Substance Abuse Treatment, in collaboration with the Congress of National Black Churches, One Church One Addict, and the Johnson Foundation Institute, convened five Faith Initiative conferences in Chicago, IL; Baltimore, MD; Washington, DC; Austin, TX ; and Minneapolis, MN.

It is anticipated that approximately 30 of SAMHSA/CSAT's Targeted Capacity Expansion (TCE) and TCE HIV grantees will receive supplemental funds in FY 2001 to develop and implement faith initiative activities in their communities. These activities will consist of forming faith organization coalitions to address substance abuse and violence in the community, supporting substance abuse treatment activities, and providing substance abuse treatment education activities for both clergy and lay persons.

Drug Prevention through Law Enforcement

Many federal agencies form government partnerships to prevent drug abuse. DEA's Demand-Reduction Program supports youth-oriented drug prevention through educational activities like the Boys Scouts of America's Law Enforcement Explorer Program. The FBI's Community Outreach disseminates prevention material and sponsors youth programs like Adopt-A-School and Junior Special Agent Classrooms. The Bureau of Justice Assistance (BJA) helped revise the Drug Abuse Resistance Education (D.A.R.E.) curriculum. D.A.R.E. is an extremely popular program for school-based drug abuse and violence prevention. It is being implemented by more than 8,600 law-enforcement agencies. The ATF's Gang Reduction Education and Training (GREAT) program helps teach seventh graders to reject gangs and the drugs often associated with them. The United States Customs Service actively supports the Explorer program, maintaining over 30 posts that provide young adults with drug abuse prevention training for dissemination to the community. Additionally, it regularly sends officers, aircraft, and vessels to schools and community-sponsored events to educate the public about the negative impact of illegal drugs on society and how families can assist in combating the problem at the local level. The Office of Juvenile

Justice and Delinquency Prevention (OJJDP) supports projects related to juvenile substance abuse, like Enforcing the Underage Drinking Laws (EUDL) Program and the Juvenile Mentoring program. The National Citizens' Crime Prevention Campaign focuses on reducing juvenile crime and drug use. The Office of Justice Programs supports projects related to juvenile substance abuse, like Combating Underage Drinking and the Juvenile Mentoring program. All Weed and Seed sites are required to have "Safe Havens" — after-school programs where anti-drug education joins a range of constructive activities. The DOJ- Drug Education for Youth (DEFY) program promotes positive life choices, including drug resistance, among youths age 9-12. DEFY's two-phased curriculum covers summer leadership camp coupled with a school-year mentoring program.

Legalization, Decriminalization, and Harm Reduction

Given the negative impact of drugs on society, the overwhelming majority of Americans reject illegal drug use. Indeed, millions of citizens who once used drugs have turned their backs on such self-destructive behavior. Study after study confirms that Americans want to guard against the risks of these deadly substances. A 1998 poll of voters conducted by the Family Research Council found that eight of ten respondents rejected the legalization of drugs like cocaine and heroin, with seven out of ten in strong opposition. Moreover, when asked if they supported making these drugs legal in the same way that alcohol is, 82 percent said they opposed legalization. Similarly, a 2000 Gallup poll found that 64 percent of Americans oppose the legalization of marijuana.[12] Many drug users enter treatment every year to help recover from chronic abuse of marijuana and other so-called "soft" drugs. The idea of legalizing even these substances overlooks the dangers they pose.

Decriminalization means that although drug use and possession would remain illegal, the penalties against these offenses would be so minimal–similar to those against jaywalking–that drug use would *de facto* be legal. In 1975 the Alaska Supreme Court decriminalized small amounts of marijuana for personal use. Even though marijuana remained illegal for children, the perception that marijuana was harmful decreased, and marijuana use rates among Alaskan youth increased significantly. Decriminalization ignores the facts that drug use affects the brain, may lead to addiction, causes untold misery to the user and his/her family, and costs society $110 billion annually in health and social costs.

Harm reduction is a theory that says because use of illegal drugs cannot be controlled by law enforcement, education, public-health intervention or other methods, we can at least reduce some of the harms associated with inevitable drug use. According to the theory of harm reduction, dispensing clean needles to addicts, for example, can reduce the incidence of AIDS; maintaining heroin addicts on heroin can reduce the amount of crime they would commit to maintain their habit.

The truth is that drug abuse wrecks lives. Addictive drugs were criminalized because they are harmful; they are not harmful because they were criminalized. If drugs were legalized, decriminalized or made more available through harm reduction policies, the costs to the individual and society would grow astronomically. It is shameful that more money is spent on illegal drugs than on art or higher education, that drug-exposed babies are born addicted and in pain, that thousands of adolescents lose their health and future to drugs.

The Use of Marijuana as Medicine

Because of its high potential for abuse and lack of accepted medical use, the manufacture, acquisition, distribution, and possession or marijuana is subject to regulation under Schedule I of the Controlled Substances Act, the most restrictive of the five federal classes of controlled substances. The medical use of Schedule II, drugs such as cocaine and methamphetamine, is also strictly controlled. Marijuana is regulated internationally by the Single Convention on Narcotic Drugs, to which the United States is a party. In the past decade, data has been gathered relative to the negative impact of marijuana on young people. As described in Chapter II, marijuana use by adolescents correlates with delinquent and antisocial behavior.

The Administration is adamantly opposed to the use of marijuana outside of authorized research.[13] However, legitimate medications containing marijuana components have proven effective in relieving the symptoms of some medical conditions. Dronabinol, a synthetic form of the major psychoactive component in marijuana — tetrahydrocannabinol (THC) — has been approved by the Food and Drug Administration (FDA) to stimulate appetite in

AIDS patients and to control nausea in cancer patients receiving chemotherapy. The pill form of THC has been available for fifteen years and sold under the trade name Marinol. Dronabinol was rescheduled in 1999 to Schedule III of the Controlled Substances Act, making it easier for patients to obtain.

The Administration has provided information to states considering ballot initiatives on "medical marijuana" so that citizens will be informed about the ways such measures undermine the scientific process for establishing safe and effective medicines. These initiatives also contradict federal law and are potential vehicles for the legalization of recreational marijuana use. Ballot initiatives to date generally have not limited use of marijuana to a small number of terminally-ill patients, as most voters envisioned. Rather, they commonly allow marijuana to be obtained without prescription and used indefinitely without evaluation by a physician.

The U.S. medical and scientific communities have 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. Persons who intend to study or seek approval of marijuana for use in the cure, mitigation, treatment, or prevention of disease are subject to the "drug" and "new drug" provisions of the Federal Food, Drug, and Cosmetic Act (FDC Act) (21 USC 321 et seq.). The FDC Act requires an applicant to submit data from well-controlled clinical trials to the FDA for evaluation of the safety and efficacy of a proposed product. A New Drug Application (NDA) must contain sufficient information to satisfy the statutory standards for marketing approval. This rigorous process is in the interest of public health. Allowing marijuana, or any other drug, to bypass this process would be unwise and unlawful.

In light of the need for research-based evidence, ONDCP asked the Institute of Medicine (IOM) in January 1997 to review all scientific evidence concerning the medical use of marijuana and its constituent cannabinoids. ONDCP felt that an objective, independent evaluation of such research was appropriate given the ongoing debate about the health effects of cannabis. The IOM published *Marijuana and Medicine: Assessing the Science Base* in March 1999.[14] This study is the most comprehensive summary of what is known about marijuana. It emphasizes evidence-based medicine (derived from knowledge and experience informed by rigorous analysis) as opposed to belief-based opinion (derived from judgment or intuition untested by science).

The IOM study concluded that there is little future in smoked marijuana as medication. Although marijuana smoke delivers THC and other cannabinoids to the body, it also contains harmful substances, including most of those found in tobacco smoke. The long-term harms from smoking make it a poor drug delivery system, particularly for pregnant women and patients with chronic diseases. In addition, cannabis contains a variable mixture of biologically active compounds. Even in cases where marijuana can provide symptomatic relief, the crude plant does not meet the modern expectation that medicines be of known quality and composition. Nor can smoked marijuana guarantee precise dosage. If there is any future for cannabinoid medications, it lies with agents of certain composition and delivery systems that permit controlled doses. Medical marijuana must conform to classical pharmacological practices that characterize clinical research.

The United Nations' International Narcotics Control Board (INCB), which ensures an adequate world supply of drugs for medical purposes, has stressed that research must not become a pretext for legalizing cannabis. If the drug is determined to have medicinal value, the INCB maintains that its use needs to be subjected to the same stringent controls applied to cocaine and morphine. "Should the medical usefulness of cannabis be established," the 1998 INCB annual report states, "it will be a drug no different from most narcotic drugs and psychotropic substances. Those drugs, however, must continue to be used for medical purposes only, in line with the requirements of the international drug control treaties."[15] The INCB report concluded: "Political initiatives and public votes can easily be misused by groups promoting the legalization of all use of cannabis for recreational use under the guise of medical dispensation."

"Industrial" Hemp

For centuries, civilization has derived hemp products from the fibers and seeds of various fibrous plants, including the *Cannabis sativa* and jute plants, just to name a few. Until relatively recently, it was believed that hemp products had no harmful effects on society. They were thought not to contain any psychoactive ingredients, such as tetrahydrocannabinol (THC) or other controlled substances.

Such a belief formed the basis for a 1937 statutory definition of marihuana (also known as marijuana). In that definition, certain parts of the *Cannabis sativa* plant (specifically the fibers in the stalk and products derived from sterilized seeds) were excluded from the definition. However, in the enactment of the Controlled Substances Act in the early 70's, the Congress augmented the definitional exclusion. The enactment provides a separate provision that specifies that any material, compound, mixture or preparation that contains any quantity of tetrahydrocannabinol (THC) is a Schedule I substance, unless it is specifically excepted or listed in another schedule.

With what we know today, the mere fact that a product is derived from parts of the *Cannabis sativa* plant excluded from the definition of marijuana is not enough to establish that it is not a Schedule I controlled substance. Should the product contain THC or other controlled substances, the product is controlled, unless specific action has been taken under the Controlled Substances Act to place it in another schedule or to specifically except it from control. Schedule I substances and the plants from which they are derived cannot be imported into the United States nor cultivated domestically without DEA registration and permits.

Although hemp products — fiber for use in the manufacture of cloth, paper and other products, as well as sterilized seed for birdseed and other products — were authorized for importation during the last decade, over the past several years, the Drug Enforcement Administration (DEA) received information that sterilized cannabis seed, not solely birdseed, has been imported for the manufacture of products intended for human consumption. DEA has also learned, from the Department of Defense and other federal agencies, that individuals who tested positive for marijuana use subsequently raised their consumption of hemp products as a defense against their positive drug test. Consequently, the Administration is reviewing the importation of cannabis seeds and oil because of their THC content. We hope to have decisive DEA regulations addressing these issues in the very near future.

The government is also concerned that hemp cultivation may be a stalking horse for the legalization of marijuana. According to a recent report by the Department of Agriculture, U.S. markets for hemp fiber, yarn, fabric and seed in 1999 could have been produced on less than 5,000 acres of land. Further, the potential exists for these markets to quickly become oversupplied. Uncertainty about long run demand for hemp products and the potential for oversupply discounts the prospects for hemp as an economically viable alternative crop for American farmers.

Child Welfare Initiatives

The safety of children and families is jeopardized by the strong correlation between chemical dependency and child abuse. Several studies recently demonstrated that approximately two-thirds of more than 500,000 children in foster care have parents with substance-abuse problems. A new federal law regarding adoption and child welfare, the Adoption and Safe Families Act (P.L. 105-89), requires that substance-abuse services be provided promptly for parents so that families are given realistic opportunities to recover from drug problems before children in foster care are placed for adoption.

In addition to compromising parental ability to raise children, substance abuse interferes with the acquisition and maintenance of employment. An estimated 15 to 20 percent of adults receiving welfare have substance-abuse problems that prevent them from working. If drug prevention and treatment are not provided for this high-risk population, these families will remain extensively involved in the welfare and criminal-justice systems at great cost to society and with devastating consequences for children. Historically, welfare agencies have not played a direct role in addressing substance abuse and therefore may need assistance in identifying addiction and making appropriate referrals.

To address these issues, SAMHSA/CSAP's Parenting Adolescents and Welfare Reform Program focuses on the parenting adolescent (who often must rely on welfare) to prevent or reduce alcohol, tobacco, and drug use; improve academic performance; reduce subsequent pregnancies; and foster improvement in parenting, life skills, and general well-being. The Administration for Children and Families (ACF) has taken several steps to improve the delivery of substance abuse services to clients involved with child protection and welfare programs. Five states are implementing child welfare waiver demonstrations that test strategies to engage and retain clients in substance abuse treatment. Conferences and technical assistance workshops have been held around the nation, in cooperation with SAMHSA, to encourage improved partnerships between human services and substance abuse agencies and to highlight model programs. In addition, grants have been made to several schools of social work to develop cross-training curricula in these fields. Finally, research is being conducted on how to screen and assess substance abuse and other barriers to work and to evaluate a model of addressing clients' substance abuse problems.

Welfare-to-Work Initiatives

Although states have experienced remarkable success in decreasing welfare rolls, many of those who remain on welfare suffer from alcohol or drug addiction, which impedes their ability to secure and retain employment. To provide workforce preparation and job retention services to eligible long-term welfare recipients and non-custodial parents, DOL, through the $3 billion Welfare-to-Work (WtW) program, has awarded formula grants to States, and through States to local communities, totaling almost $2 billion. Many of these grants address substance abuse as one of the many barriers to be addressed in preparing eligible participants for employment. More specifically, seventeen of the 190 WtW competitive grants have a targeted focus on substance abuse and on providing substance abuse-related services. These substance abuse focused grants total almost $65 million.

In FY 1999, Congress authorized $24 billion for states to spend on children's health services, to provide a safety net for children with substance abuse problems, whose parents are off welfare either because they have found jobs or have been taken off welfare. Subsequently at least nine have developed plans that specifically include substance-abuse services. Alabama, for instance, will provide specialty care to uninsured children and those with special needs. Delaware's Children's Health Insurance Program (CHIP) includes 31 days of substance abuse and mental health treatment services annually, plus outpatient mental-health care. Florida's health-care and children's agencies will provide Medicaid and state-funded addiction and mental-health services, while the state mental-health agency will work with at-risk youth in the criminal justice system.

The Partners Project in Pittsburgh, Pennsylvania, funded by a one million dollar grant from the Department of Housing and Urban Development, provides comprehensive services to welfare recipients, and their children, in recovery from substance abuse problems. This project offers specialized addiction treatment and other services to families living in 22 subsidized apartments. In addition to the Housing Authority of the City of Pittsburgh, a treatment program, child development center at the University of Pittsburgh Medical Center, and a local women's center for victims of domestic violence are part of the project.

Studies estimate that 15 to 20 percent of adults receiving Temporary Assistance for Needy Families (TANF) have substance abuse problems that can significantly impair parents' judgement and priorities, render them unable to provide consistent care, supervision, and guidance to their children, and interfere with their ability to acquire or maintain employment.

As welfare caseloads decline, States report that such problems may be even more common among those clients who remain on the welfare rolls. Reform of the Federal welfare and child protection laws in recent years has placed increased emphasis on parental responsibility for the financial support and social development of their children. Limited availability and duration of public support, and focused State and local efforts on preparing welfare recipients for work, makes it imperative that substance abuse problems among this population be addressed or the children will suffer the consequences.

Welfare agencies have limited experience in dealing with clients' substance abuse problems and require technical assistance to design and implement effective procedures to identify clients' addictions and refer them to appropriate treatment services.

It is critical to the long-term success of welfare reform that these issues be addressed throughout the welfare, child welfare and workforce development systems. A five-year national study by the Center for Substance Abuse Treatment (1997) found a 19 percent increase in employment among people who completed treatment and an 11 percent decrease in the number of clients who received welfare after treatment. Local communities must seize opportunity to intervene, treat, and support recovery for those whose addiction has exacerbated the barriers they face in achieving self-sufficiency.

Those responsible for assessing job readiness, training welfare recipients in job skills, making job placements, and managing the welfare-to-work transition must understand the impact of addictions on job readiness, learning, on-the-job behavior, and job retention. They need tools (such as screening surveys/questionnaires) and procedures for identifying those in need of substance abuse treatment and training in how to use such tools as part of an effective referral process. Treatment must be readily available, easily accessible, and affordable. The quantity and the quality of the treatment available to these families are both critically important. When a parent is unable to care for a child due to alcohol or drug use, the parent is likely to have developed a serious addiction requiring intensive outpatient or inpatient services. Inpatient programs, and especially those which can accommodate children in

residence, are most costly, but also offer important advantages to attracting, and retaining a mother in treatment, and to developing the mother's ability to be an effective, sober parent. Supportive services must extend long after the initial treatment episode, be available to workers, and include specialized on-the-job supports to assist in workplace integration, guard against relapse and increase job retention and wage progression.

States may use the federal TANF funds to pay for non-medical aspects of substance abuse treatment under the TANF if such treatment is not otherwise available to the participant.

Substance abuse is only one among a number of health and behavioral barriers that thwart efforts of welfare clients to leave welfare and gain self-sufficiency through employment — many of which co-exist and exacerbate one another. It is however, among the most insidious because of denial and societal stigma associated with addiction and employer reluctance to knowingly "take a risk" on drug users. A relapsing, disease characterized by denial and often misattributed to moral failings, successful treatment requires a lifetime commitment with no guarantee of a "cure." In WtW Partnership survey most employers (66 percent) agree that substance abuse is a problem they cannot overlook when making a decision to hire someone off welfare."

In short, the success of these significant social services reform movements depends on the availability of high quality substance abuse treatment services tailored to the needs of parents and the provision of appropriate supportive services following job placement.

Progress to date:

Several efforts are underway to assist state and local agencies and employers successfully address substance abuse problems of welfare recipients seeking to enter the workforce and maintain employment. These include :

- Promoting Awareness — The Office of Family Assistance has been collaborating with the Substance Abuse and Mental Health Services Administration for the past two years on welfare reform issues. We have jointly funded and developed seven conferences, issued joint guidance and co-sponsored publications. These conferences have emphasized the importance of addressing substance abuse as a barrier to employment and have highlighted promising approaches from around the nation to address clients' substance abuse while promoting work. Emphasis is currently on identifying individuals with substance abuse problems and making effective referrals for appropriate services.
- Training and Technical Assistance — We are now building on this work with SAMHSA by providing technical assistance to stakeholders serving welfare and low-income populations with substance abuse and mental health barriers to self-sufficiency. We are basing this technical assistance on the research and lessons learned by SAMHSA. SAMHSA is providing the majority of the funding for this joint initiative with the ACF regional offices and their respective States.
- The workshops will be designed to help agencies develop skill sets to identify and provide self-sufficiency services for TANF and low-income populations with substance abuse and mental health barriers. These workshops are also designed to help stakeholders detect and provide services to address the underlying causes of abuse and addiction (e.g., depression, domestic violence, post-traumatic stress disorder, etc.), and to recognize the need to coordinate with other systems (e.g., child welfare).
- Demonstration Grants — OFA provided fund to Anne Arundel County Department of Social Services in Maryland to address changing the culture of the welfare office. Included in this initiative was training for front-line workers on identifying barriers to employment such as substance abuse and mental health issues. As part of this initiative, a technical assistance video was produced by Maryland Public Television in June 2000 entitled " Lessons Learned."
- Research — ACF/OFA has funded research to fill important information gaps related to substance abuse and welfare reform. Mathematica Policy Research, Inc. developed two guides that were published in July 2000.[18]

In addition, the Office of Planning, Research, and Evaluation in conjunction with the Assistant Secretary for Planning and Evaluation is funding two additional efforts. An evaluation of New Jersey Substance Abuse Research Demonstration will provide information about the effectiveness of a type of evaluation several states are experimenting with to move substance abusing welfare clients toward self-sufficiency. The intervention New Jersey is implementing includes screening of welfare recipients for substance abuse problems, treatment referral mechanisms with enhanced case management, and substance abuse treatment coordinated with employment

and training or vocational services. The evaluation will, using a random assignment model, compare two models for providing such services, looking at outcomes in several domains including employment and family self-sufficiency, substance use and associated behaviors, child development and family functioning, and child welfare involvement. The intervention being evaluated is intended to improve the post-welfare prospects of TANF recipients with substance abuse problems. The evaluation is being conducted in two New Jersey counties, Essex County and Atlantic County.

A study entitled "Screening and Assessment in TANF/WtW" will highlight and discuss critical issues in the development and use of screening and assessment tools designed to identify TANF and/or WtW recipients who experience barriers to employment. The barriers of specific interest for this study include substance abuse, mental health or illness, low basic skills, physical/developmental disabilities (including learning disabilities) and domestic violence. The project will describe state and local efforts to incorporate screening and assessment tools and procedures in their efforts to assist these recipients make the transition from welfare to work. Finally, this project will provide opportunities for federal, state, and local TANF/WtW staff and other interested parties share information on screening and assessment.

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 and access to tobacco and the appeal tobacco products have for youth. 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 increased retailer compliance rates from approximately 30 percent to nearly 81 percent in 1999, reported in 2000. SAMHSA provides states with support and guidance through the development of best practices documents and provision of individual technical assistance to assist them in meeting the Synar requirements. For example, to provide States with guidance for conducting compliance checks of tobacco retail outlets, SAMHSA developed the Teens Taking Action training program and the implementation guide, Implementing the Synar Regulation: Tobacco Outlet Inspection.

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. The CDC's Office on Smoking and Health has developed a four-point prevention and control strategy to support state campaigns. CDC's Media Campaign Resource Center provides states with television and radio advertisements as well as printed materials. The federal government is responsible for the diffusion of science-based models and strategies in support of state and community efforts. Accordingly, the CDC funds evaluations of specific programs and disseminates information to the public. The CDC's *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction*, for example, includes recommendations for tobacco-use policies, tobacco prevention education, teacher training, family involvement, tobacco-use cessation programs, and evaluation.

Youth Alcohol Use Prevention

SAMHSA and NIAAA have a variety of programs and projects to help curb underage alcohol use. Within SAMHSA's prevention and treatment budget, it is estimated that $88.6 million is designated to fight underage alcohol use and NIAAA targeted $36.3 million to curb youth alcohol abuse. HHS' existing projects include a collaboration between SAMHSA, NIAAA, and the Department of Education to fund five new grants, totaling approximately $2.9 million, to test a variety of interventions that have the potential to reduce alcohol abuse on college campuses, and a 5-year SAMHSA/ NIAAA partnership, totaling $3.9 million annually, to fund research programs related to treatment among adolescents. NIAAA recently published "Make a Difference: Talk to Your Child About Alcohol," a guide for parents of kids, aged ten to fourteen years old. In addition, The National Youth Anti-Drug Media Campaign's pro-bono match requirement has generated more than twelve million dollars in public service advertising time and space for organizations like Mothers Against Drunk Driving and NCADD.

The Department of Education's Safe and Drug Free Schools Program awarded grants to nine colleges and universities to prevent high-risk drinking and violent behavior among college students. The awards range from $188,000 to $226,000 for twenty-seven month period. In addition, ED made grant awards to six universities to identify innovative and effective alcohol and other drug-prevention models. These one year awards range from $50,000 to $90,000. ED also funds The Higher Education Center for Alcohol and Other Drug Prevention, which provides support to all institutions of higher education in their efforts to address alcohol and other drug problems through training, technical assistance, evaluation, and publications and materials.

High-Risk Youth

A recently completed CSAP-sponsored cross-site evaluation of 48 high risk youth demonstration prevention programs yielded a number of important findings. 1) Youth who have already started to use cigarettes, alcohol, and marijuana before entering a CSAP prevention program reduced their use after entering the program. 2) The more communities gave youth opportunities to take part in prevention activities, the greater the positive impact on substance use. 3) Prevention program results differed in that substance use outcomes were more positive for males than for females at program's end but, positive outcomes emerged later and lasted longer for females. 4) More than two thirds of the programs had positive effects on youth's substance use and/or on factors that made them less likely to use substances. 5) The programs that offered after-school programs were more effective in reducing substance use than those delivered during school hours. 6) High-risk youth who were connected to positive social environments (such as school and family) used substances less than those who lacked such connections. For youth at risk, connection plays an important role in effective program efforts.

Comprehensive Prevention Systems

It has been well established that prevention works best when a comprehensive approach is used — including youth, family, school, and community activities. Results from SAMHSA/CSAP's Community partnership and coalition programs reflect the positive nature of such an approach.

SAMHSA/CSAP's State Incentive Grant (SIG) program is designed to coordinate all substance-abuse prevention funding within a state and to implement prevention programs in selected communities. This competitive grant program serves as an incentive for synchronizing state-wide prevention with private and community-based organizations. Eighty-five percent of SIG funds must be devoted to actual prevention programming, and 50 percent or more of the activities must involve science-based programs. To date, twenty-seven grants have been awarded to states and the District of Columbia. Some governors report having leveraged as much as ten dollars for every one dollar invested. For example:

- In Vermont, funds from United Way agencies, Safe and Drug-Free Schools, and other grants from state and local agencies and private businesses have been merged to support local prevention activities.
- The SIG program in Oregon calls upon the state to work with every county to develop a comprehensive plan incorporating substance-abuse prevention in schools, the juvenile justice system, and teen pregnancy programs. The state is also working for the first time with nine tribal governments to implement substance-abuse prevention.
- In Kansas the SIG prompted the governor to issue an executive order establishing a Governor's Substance-Abuse Prevention Council. This Cabinet-level group has already conducted a county-level resource assessment and developed a science-based prevention publication that integrates guidelines and strategies across multiple federal and state funding sources.

So far, the SIGs have implemented 227 science-based programs, affecting more than 125,000 youth.

Through its National Registry of Effective Prevention Programs (NREPP), CSAP identifies model and promising programs. Fifteen criteria are used to assess programs, including theoretical foundation, threats to internal validity, and replication. To date, 19 models have been identified (on the CSAP website: , and 11 additional programs have been identified and will soon be included in the formal listing. CSAP also vigorously promotes model programs and engages national organizations as partners to ensure maximum dissemination.

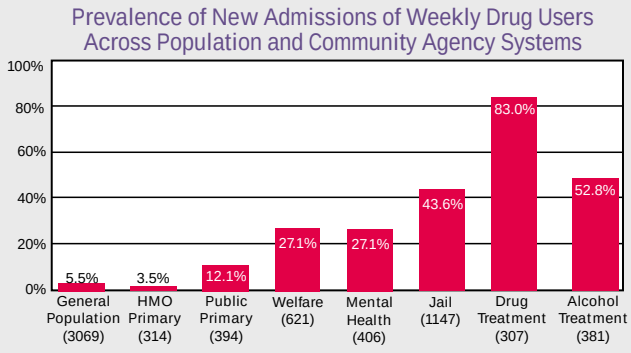
Centers for the Application of Prevention Technologies (CAPTs)

The CAPTs are the major national resource supporting the dissemination and application of substance abuse prevention programs that are scientifically sound and effective at the state and community levels. The CAPTs are prominently placed programmatically within SAMHSA/CSAP's Knowledge Development and Application (KDA) and Targeted Capacity Enhancement (TCE) programs. The CAPT program is also an important part of the DHHS Secretarial Initiative called the Youth Substance Abuse Prevention Initiative, and ONDCP's National Drug Control Strategy's Goal 1.

The CAPTs' primary clients are States receiving funds through CSAP's State Incentive Cooperative Agreements for Community-Based Action (SIGs) program. Secondary clients include non-SIG States, U.S. Territories, Indian Tribes and tribal organizations, local communities, substance abuse prevention organizations, and practitioners.

Since 1997, the CAPTs have provided essential services to their clients in all fifty States and to thousands of prevention organizations within all congressional districts across the US. Among the strategies that each CAPT uses are:

- Establishing of technical assistance networks using local experts from each region.
- Convening of a regional advisory committees and learning communities.
- Conducting training conferences and workshops to promote skill development in prevention methods related to evidence-based models of prevention.



Source: Connie Weisner, Ph.D - Alcohol Research Group

- Providing direct services to their clients via technical assistance and technology transfer.

The primary purpose of CAPTs technical assistance and training is to help their client consistently apply the latest research-based knowledge about effective substance abuse prevention programs, practices, and policies. These services to clients include (but are not limited to):

- Developing client readiness and ability to acquire and apply "best practices" and new prevention technologies (e.g., web based decision support systems).
- Evaluating and reporting process and outcomes of prevention programs.
- Increasing competencies in applying specific prevention methods or skills.
- Repackaging and adapting effective scientific prevention materials, products or services to fit the unique circumstances of local cultural contexts and environments.
- Analyzing and facilitating development of local and State prevention infrastructures.
- Identifying how the clients' programs contribute to the national prevention system.

CSAP created the CAPT program as a necessary intermediary infrastructure that accelerates the application of scientific knowledge into effective prevention actions. Thus, the CAPTs are designed to help practitioners to Apply Prevention that Works by connecting scientific dissemination of prevention knowledge with effective application of that scientific knowledge.

Decision Support System (DSS)

The Center for Substance Abuse Prevention has developed an on-line substance abuse prevention decision support system for the use of prevention specialists throughout the nation. The system is highly interactive software program that actively guides community practitioners and State system managers toward making well-informed decisions about a broad range of useful options for prevention programs.

The system provides step-by-step procedures for assessing community needs, building capacity and identifying resources, selecting and implementing "best and promising" interventions, developing outcome evaluations, and

writing reports. On-line technical assistance and training is provided each step of the way. State system managers can also access a special software developed for managing Substance Abuse Prevention and Treatment Block Grant funds.

Prevention scientists, service providers, experts in computer information technology, and leaders from the nation's public and private sectors all worked collaboratively with CSAP staff to design and develop the DSS.

The DSS will be updated every six months with new features and additional information.

2. TREATING ADDICTED INDIVIDUALS

Not everyone who tries drugs or regularly uses drugs becomes addicted; however, those who do become addicted find that not only does the compulsion to take drugs take over their life, but these compulsive behaviors come with a wide range of dysfunctional behaviors that can interfere with normal functioning in the family, the workplace, and the broader community. Addiction also can place people at increased risk for a wide variety of other illnesses. These illnesses can be brought on by behaviors, such as poor living and health habits, that often accompany life as an addict, or because of toxic effects of the drugs themselves. Because addiction has so many dimensions and disrupts so many aspects of an individual's life, treatment for this illness is never simple. Drug treatment must help the individual stop using drugs and maintain a drug-free lifestyle, while achieving productive functioning in the family, at work, and in society. Effective drug abuse and addiction treatment programs typically incorporate many components, each directed to a particular aspect of the illness and its consequences.

Drug Addiction Treatment is Effective

Overall, treatment of addiction is as successful as treatment of other chronic diseases, such as diabetes, hypertension, and asthma. Drug treatment reduces drug use by 40 to 60 percent and significantly decreases criminal activity during and after treatment. Research shows that drug addiction treatment reduces the risk of HIV infection and that interventions to prevent HIV are much less costly than treating HIV-related illnesses. Drug injectors who do not enter treatment are up to six times more likely to become infected with HIV than injectors who enter and remain in treatment. Treatment can improve the prospects for employment, with gains of up to 40 percent after a single treatment episode. Although these effectiveness rates hold in general, individual treatment outcomes depend on the extent and nature of the patient's presenting problems, the appropriateness of the treatment components and related services used to address those problems, and the degree of active engagement of the patient in the treatment process.

Research on Addiction[19]

Scientific research and clinical experience have increased our understanding of addiction, which is characterized by compulsive drug-seeking and use — even in the face of negative consequences. Virtually all drugs of abuse affect 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. Not only does acute drug use modify brain function in important ways, but prolonged drug use causes pervasive changes in the brain that persist long after the individual stops taking a 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 metabolic activity, receptor availability, gene expression, and responsiveness to environmental cues. Some of these long-lasting changes are unique to specific drugs whereas others are common to many substances. We can actually see these changes through use of imaging technologies, like 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 to compensate for brain changes through medication or behavior modification.

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

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

Status of Drug Treatment

A significant treatment gap — defined as the difference between individuals who would benefit from treatment and those receiving it — exists. According to recent estimates drawn from the National Household Survey on Drug Abuse (NHSDA), the Uniform Facility Data Set (UFDS), and other sources, approximately five million drug users needed immediate treatment in 1998 while 2.1 million received it. The NIAAA report, *Improving the Delivery of Alcohol Treatment and Prevention Services*, estimates that there are fourteen million alcohol abusers whereas the 1998 NHSDA found approximately ten million dependent on alcohol. Certain parts of the country have little treatment capacity of any sort. Likewise, some populations — adolescents, women with small children, and racial as well as ethnic minorities — are woefully under-served. According to the Child Welfare League of America, in 1997 only 10 percent of child welfare agencies were able to locate treatment within a month for clients who needed it.[16] According to SAMHSA, 37 percent of substance-abusing mothers of minors received treatment in 1997.[17] Some modalities — namely methadone — fall short of needed capacity; 179,000 patients were in methadone treatment at the close of 1998. Furthermore, while treatment should be available to those who request it, society also has a strong interest in helping populations that need treatment but will not seek it. Drug-dependent criminal offenders and addicts engaging in high-risk behavior are important candidates for treatment, whether they want it or not.

Ultimately, calculations of the treatment gap should include both actual demand and populations that society has a special interest in treating due to the high social cost associated with their drug abuse. Starting in 2000, a new methodology — based on clinical criteria — will be employed in the NHSDA. This approach will provide improved national estimates by August 2001. More precise numbers will be helpful in determining the magnitude of the treatment gap and targeting resources to the areas where the gap is greatest.

Limited funding for substance-abuse treatment is a major factor that restricts the availability of treatment. Over the last decade, spending on substance-abuse prevention and treatment rose to an estimated annual level of $12.6 billion. Of this amount, public spending is estimated at $7.6 billion. The public sector includes Medicaid, Medicare, federal agencies like the Veterans Administration, the Substance Abuse Prevention and Treatment (SAPT) Block Grant, and other state and local government expenditures. Private spending is estimated at $4.7 billion and includes individual out-of-pocket payment, insurance, and other non-public sources. One of the main reasons for the higher outlay in public spending is the frequently limited coverage by private insurers. The lack of coverage and recent changes in payment structures affect attitudes, resources, treatment plans, and the quality of treatment. Private and public insurers are not working collaboratively; thus, more public resources are utilized, and government funds — which were intended to be a safety net — have become a primary option for many individuals.

In addition to resource limitations, other factors limit treatment, including restrictive policies and regulations, incomplete knowledge of best practices, resistance to treatment on the part of certain populations in need, and limited information on treatment at the state and local level. Action in the following areas can make treatment more available:

- Increase SAPT Block Grant funding to close the treatment gap. Increase funding for NIDA's National Drug Abuse Treatment Clinical Trials Network (CTN) program to improve the quality of drug abuse treatment throughout the country and to ensure the delivery of effective therapies in community-based treatment programs.
- Use funding under SAMHSA's Targeted Capacity Expansion program; expansion of services to vulnerable and underserved populations; more outreach programs for those at risk of HIV/AIDS; and increased community options for sanctions among criminal and juvenile justice clients.

- Use regulatory change to make proven modalities more accessible: reform regulation of methadone/LAAM treatment, maintain and improve program quality; train treatment professionals and physicians to employ the proper administration of opiate agonists and emerging pharmacotherapies; conduct demonstrations of administration by doctors of opiate agonists; and provide comprehensive evaluation of the impact of regulatory reform on treatment access, quality, and cost.
- Continue examining possible changes in policy to remove barriers, such as lack of parity in insurance coverage. For example, the President recently announced that the federal Employees Health Benefits Plan (FEHB) would provide parity for both substance abuse and mental health services.
- Review policies, practices, and federal statutory requirements, such as the statutory exclusion of Medicaid funding for Institutes for Mental Disease (IMD), which may affect access to residential treatment services for substance abuse.
- Prioritize research, evaluation, and dissemination — including state-by-state estimates of drug-treatment need, demand, and treatment resources; dissemination of best treatment practices; guidance on ways to increase retention and reduce relapse; and foster progress from external coercion to internal motivation.
- Reduce stigma associated with drug treatment.

To improve treatment accountability, ONDCP is piloting an information system with treatment programs around the country that will be expanded by DHHS into the National Treatment Outcome Monitoring System (NTOMS). Under NTOMS, treatment performance will be measured and compared. In addition, an agreement has been negotiated with the states to establish a common set of outcome measures to be applied to programs receiving federal funding.

Treatment services are being fostered through manuals created by NIDA, Treatment Improvement Protocols and addiction curricula by CSAT, clinical guidelines by the Department of Veterans Affairs (VA), and a comprehensive curriculum for treatment by the Federal Bureau of Prisons (BOP). State and local treatment programs with promising results are applying these resources. CSAT has joined with the Certification Board for Addiction Professionals of Florida and a number of national stakeholder organizations to develop core competencies for substance-abuse counselors. Ultimately, these efforts will lead to a body of certified professionals equipped with manuals reflecting the most advanced approaches to treatment.

Adolescents with alcohol and drug problems are not adequately served in most existing drug-treatment programs designed for adults. Adolescents rarely seek help for problems related to drug and alcohol 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. There is also a paucity of research-based information about juvenile treatment. SAMHSA/CSAT, in collaboration with NIAAA, is supporting a five-year research grant, titled *Treatment for Adolescent Alcohol Abuse and Alcoholism*, which will contribute to the development of good programs for adolescents.

Providing state-of-the-art treatment services that are scientifically validated for adolescents is a work in progress. The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), is a the forefront of advancing these services.

The questions regarding what works, for whom, and when, are among the great unknowns in adolescent treatment. However, it is first important to understand the need for services. Is there really a large group of adolescents in need of treatment who are not receiving services? Official estimates indicate that only one in five of every adolescent in need of treatment services actually receives treatment. Other estimates indicate that only one of every 10 adolescents in need of treatment, currently in school (grades 6-12), received treatment services. Most state estimates are problematic from a methodological perspective, but taken at face value, their most recent reports show a much higher rate of treatment need, with only one in 35 adolescents in need of treatment actually receiving services. However, it is important to note that since 1992, admissions for adolescents have increased by 45 percent.

To identify effective treatment approaches, CSAT began in 1997 with the Cannabis Youth Treatment (CYT) program to test new models of treatment that were theory based. They announced preliminary findings in September of 2000 that validated five different models of treatment. It was reported that six months after intake to treatment these programs were able to increase the percentage of adolescents with no past month use 8 fold (from 4 percent to 34 percent) and the percent reporting no past-month abuse or

dependence symptoms by 3 fold (from 19 percent to 61 percent). Treatment reduced days of use by 36 percent, and reduced the number of adolescents with past month substance related problems by 61 percent. The decrease in rate of use is better than all prior studies of adolescent outpatient treatment in community settings.

The Adolescent Treatment Models (ATM) program (initiated in 1999) is in the process of evaluating 10 potentially exemplary programs to determine the most effective, looking at individual client outcomes and cost-effectiveness. Results from the earliest of the ATM projects will be available in 2001. Each of these programs is also developing a manual that will allow for replication of the intervention.

No Wrong Door

The development of an interactive system that matches care to need regardless of the point of entry is crucial in establishing inter-system linkages. In developing its treatment plan, CSAT has drawn upon research like that of Connie Weisner, Ph.D. a senior scientist with the Alcohol Research Group. Dr. Weisner discusses the prevalence of weekly drug users among new admissions across population and community agency systems. Dr. Weisner's estimates of cross system drug users included: 12.7 percent in the public primary health care; 27.1 percent in the welfare system; 27.1 percent in the mental health system; and 43.6 percent in the criminal justice system.

Services for Women

Although women use alcohol and illegal drugs at lower rates than men, the consequences of women's substance abuse is greater than their lower consumption levels would imply. These adverse effects range from increased mortality related to cardiovascular and liver disease to increased incidence and prevalence of HIV/AIDS. Children born to substance abusing women are at risk for Fetal Alcohol Syndrome, Fetal Alcohol Effects, infant mortality, attention deficit disorder and other health problems.

Women experience substance abuse differently than men and need access to quality gender specific substance abuse treatment. The barriers to treatment for women include: the stigma and shame associated with a women's substance abuse, the lack of early identification by professionals, the lack of child care, the lack of residential treatment programs that can accommodate mothers with children and the lack of transportation to and from treatment sessions. SAMHSA is addressing the lack of quality treatment for women through the "Grants to Expand Substance Abuse Treatment Capacity in Targeted Areas of Need." This program is designed to address gaps in treatment capacity by supporting rapid and strategic responses to demands for substance abuse treatment services.

Women in recovery report histories of elevated rates of childhood physical and sexual abuse. Consequently, the trauma caused by the abuse must be addressed in treatment. SAMHSA's Women, Co-occurring Disorders, and Violence Study seeks to discover ways to improve treatment outcomes for women and their children. This study is developing a comprehensive integrated services delivery system.

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. Data suggests that mental disorders precede substance abuse more than 80 percent of the time, generally by five to ten years.[18] We must take advantage of this window of opportunity to predict drug-abuse and prevent it. In addition, treatment providers must recognize co-occurring mental disorders and addiction in order to prevent relapse and improve the likelihood of recovery.

Roughly ten million people in the United States have co-occurring substance abuse and mental disorders. These individuals experience more severe symptoms and greater functional impairment than persons with a single disorder, have multiple health and social problems, and require more care. In addition, dual disorders are often associated with unemployment, homelessness, contact with law enforcement, and other medical problems like HIV/ AIDS.

According to the Department of Veterans Affairs, about a third of adult homeless people once served their country in the armed services. On any given day, as many as 250,000 veterans (male and female) are living on the streets or in shelters, and perhaps twice as many experience homelessness at some point during the course of a year. About 45 percent of homeless veterans suffer from mental illness, and 70 percent have alcohol or other drug abuse problems. Considerable overlap exists between these two categories.

Treatment of co-occurring substance-abuse and mental-health disorders have has historically been provided by

multiple service delivery systems, which at times have been at odds with one another organizationally, philosophically, and financially — often to the detriment of the people in need. A new paradigm is necessary to provide services for a spectrum of co-occurring disorders. Early intervention, integrated treatment, cross-training of staff, licensing of medical personnel (psychiatrists, psychologists, etc.), consistent qualifications for other mental-health and addiction personnel, and sufficient funding are among the areas where innovative solutions are badly needed. Long-term studies of co-occurring disorders can help identify the best courses of treatment.

Moving Addiction Treatment into the Mainstream of Healthcare

For the past forty years, the addiction treatment system has evolved largely outside the larger health care system. In many cases, treatment approaches and treatment programs were created by individuals and groups that had overcome their own addiction, and built a system to help others. For example, recovering persons played an important in creating the 12-step oriented "Minnesota model" programs that are common in many public and private treatment settings, and recovering drug addicts were key to the development of therapeutic communities. Because of their history in the recovering community, many of these programs have remained outside the mainstream of the health care system. In addition, stigma against substance abuse has resulted in the isolation of providers who provide such treatment. For example, it has been difficult to site new methadone programs, despite the documents effectiveness of this form of treatment for opiate addiction.

This history of isolation has resulted in a lack of integration with other health care services and providers. This isolation is problematic because many substance abusers have co-occurring physical or mental health disorders; not addressing these issues can limit the effectiveness of treatment, and undermine recovery. The problem is particularly acute for vulnerable populations that do not have the ability to negotiate an often fragmented health care delivery system and that lack access to health insurance and transportation. Bringing substance abuse treatment into the mainstream, and integrating services when appropriate would improve outcomes for individuals in treatment, as well as improving the public health.

Parity for Substance-Abuse Treatment

From a scientific standpoint, management of addiction is similar to treating other chronic illnesses. Were insurance parity in place, substance-abuse treatment would be subject to the same benefits and limitations as other comparable disorders. Unfortunately, most employer-provided insurance policies currently place greater burdens on patients in terms of cost-sharing, co-payment, and deductibles while offering less coverage for the number of visits or days of coverage and annual dollar expenditures for treatment. Many health insurance companies impose lower lifetime limits on amounts that can be expended for drug and alcohol treatment than for other illnesses. Parity for substance-abuse treatment would correct these unfair practices and expand the amount of available treatment.

Parity is affordable. According to the SAMHSA report *The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits*, the average premium increase due to full parity would be 0.2 percent — just a dollar per month for most families. Furthermore, other medical expenses incurred by treated patients are less than for untreated clients. Therefore, substance-abuse prevention and intervention saves employers money in both the short and long term. Documentation and validation of best practices for health-service providers are currently being prepared. These figures will include added cost offset, cost benefit, and cost utility incentives for both private- and public-sector employers.

Ending the disparity between drug abuse and other diseases through legislation would reduce the treatment gap. Such action could be particularly useful for adolescents who are covered by parents' insurance plans. Parity legislation will help lessen demands by people with private insurance on publicly funded treatment. Parity and the ensuing privatization of treatment would encourage more effective interventions. Indeed, the lack of private insurance for drug-abuse treatment discourages the development of new therapies.[19] Legislation supporting parity will move drug treatment further into the mainstream of health care and reduce the stigma associated with addiction.

The federal government has taken an historic step with regard to drug abuse and is serving as a model for other employers. In June 1999, the President announced that the Federal Employee Health Benefit Program (FEHB) would offer parity for mental-health and substance-abuse

coverage by 2001. This unprecedented initiative will provide access to treatment for nine million people including federal employees, retirees, and their families. This move underscores the federal government's commitment to quality coverage for mental illness, substance abuse, and physical illness. In December, the FEHB began working with small businesses to provide these benefits.

Medications for Drug Addiction

Given that the development of new and effective treatments for addiction is both a national need and a NIDA priority, it is imperative that we capitalize on recent research advances to rapidly bring new treatments to the clinical tool boxes of front-line clinicians who are treating addiction. Just like other chronic diseases such as hypertension, diabetes, and cancer, for which medications have been developed, drug addiction is a disease that merits medication for its treatment. NIDA has already made great progress in bringing useful medications to drug abuse professionals to treat addicted individuals, such as: the readily available nicotine addiction therapies; the most effective medications to date for heroin addiction, methadone and LAAM (levo-alpha-acetyl-methadol, trademark ORLAAM); in addition, buprenorphine, a new treatment option for heroin addiction, is pending approval by the Food and Drug Administration (FDA).

A substantial body of NIDA-funded research has laid out the neurochemical details of how opiates, including heroin, produce their analgesic and behavioral effects, and perhaps important work in this area has characterized the receptors that opiate drugs bind to in various parts of the brain. This endeavor has led directly to the development of buprenorphine, which may soon become the latest pharmacological treatment for opiate addiction. For example, NIDA-supported research has shown that the so-called "mu" opiate receptor is responsible for the effects associated with morphine: analgesia, euphoria, sedation, and respiratory depression. Buprenorphine has the ability to bind to this particular receptor, but does not activate the receptor to the same extent as the opiates do. Thus it is classed as a partial agonist. As a partial agonist, buprenorphine does not produce the same high as heroin, for example, and is less likely to cause respiratory depression, the major toxic effect of opiate drugs. At the same time, buprenorphine leaves the mu receptor unusually slowly, so its effects last much longer than those of other opiates (methadone, for example).

NIDA and its private sector partners are also developing a buprenorphine-naloxone may combination tablet. As a partial mu agonist, buprenorphine has some potential for misuse, but, combination of buprenorphine with the opiate antagonist naloxone would significantly reduce the potential of this medication for abuse. If a heroin addict, for example, attempted to abuse the combination product by dissolving and intravenously injecting it, the individual would experience unpleasant withdrawal effects induced by the naloxone. The safety and effectiveness profiles for buprenorphine and the buprenorphine-naloxone combination suggest they may be valuable new tools for the treatment of opiate addiction.

NIDA is also engaged in clinical trials with lofexedine as a non-opioid medication to reduce or alleviate symptoms encountered in opiate detoxification, and dextromethorphan (a non-opioid NMDA receptor antagonist) given in combination with oral methadone to prevent relapse to injection opiate use. NIDA has produced a dosage form of the narcotic antagonist naltrexone in a long-lasting (30 days or more) depot formulation. In the area of cocaine dependence, NIDA is currently engaged in advanced clinical testing of selegiline, in both immediate release and a new transdermal patch formulation. Additionally, NIDA continues to test a variety of new agents to test various hypotheses concerning stimulant (cocaine and methamphetamine) abuse and dependence. NIDA has also seen encouraging results from three clinical trials of disulfiram as a potential treatment agent for cocaine addiction. Each of these trials was conducted at Yale University and indicated that disulfiram appears to reduce the use of cocaine. Larger trials, and trials in different locations and settings, will be conducted to further delineate the scope of these findings. NIDA has also supported several groups in their efforts to develop immunotherapies (vaccines) that would either prevent the use of cocaine or be useful as antidotes to overdose.

A medications development effort aimed specifically at the growing prevalence of methamphetamine dependence is now underway. After consultation with experts in the field, NIDA has assembled both an internal pre-clinical discovery program and an external set of clinical trials sites dedicated to the testing of potential treatment agents for methamphetamine addiction. Additionally, NIDA recently initiated its new National Drug Abuse Treatment Clinical Trials Network to encourage community treatment providers to become involved in the clinical testing

of new and existing pharmacological and behavioral treatments. The program is designed to rapidly infuse the developments of academic research into actual practice at the point of treatment delivery. Treatment providers will be actively involved in developing protocols and demonstrating and developing best practices within the context of their own unique community populations, settings, and service delivery systems. NIDA will continue funding a multi-faceted approach aimed at developing medications to treat addiction, withdrawal, and prevention of relapse.

SAMHSA's Center for Substance Abuse Treatment's Methadone Accreditation Study continues with 165 participating opioid agonist treatment programs (OTPs). To date, the Commission for Accreditation of Rehabilitation Facilities (CARF) has surveyed 50 OTPs; 44 have received accreditation decisions; only one of the CARF-surveyed programs was unable to attain accreditation. Seven OTPs have been surveyed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and have received accreditation. CSAT has provided considerable technical assistance to OTPs seeking accreditation.

Behavioral Treatment Initiative

Behavioral therapies have proven to be effective treatments for many drug problems, including cocaine addiction. Behavioral treatments, such as cognitive behavioral therapies, for example, have been shown in a wide variety of studies to treat addiction disorders. Behavioral interventions are especially beneficial when pharmacological treatments are being used. An explosion of knowledge in the behavioral sciences is ready to be translated into new therapies. NIDA is especially interested in taking what is learned from small-scale studies and translating the findings into real life settings through the new National Drug Addiction Clinical Trials Network. NIDA is encouraging research in this area to determine why particular interventions are effective, develop interventions that could reduce AIDS-risk behavior, and disseminate new interventions to practitioners in the field. More specifically, this initiative will focus on finding effective treatments to reducing adolescent drug use.

National Drug Abuse Treatment Clinical Trials Network

NIDA has declared the improvement of drug abuse treatment nationwide as one of its major goals. Behavioral and neuroscience research have provided substantial evidence in support of the concept that drug addiction is a chronic and, for many people, a recurring disease. As is the case for other chronic disorders, effective treatments for addiction do exist. However, the efficacy of these new treatments has been demonstrated primarily in specialized treatment research settings, with somewhat restricted patient populations. As a consequence, not enough of these new treatments are being applied on a wide-scale basis in real-life practice settings. In response, NIDA established the National Drug Abuse Treatment Clinical Trials Network (CTN),to provide a research infrastructure to test whether new and improved treatment components are effective in real-life settings with diverse patient populations.

Since its inception in September 1999, NIDA has made 11 CTN grant awards. Each of these centers will link with at least five community treatment programs in their region. When complete, the network will consist of 20 to 30 regional research treatment centers (RRTC). At the local level, each center will be linked with 10 to 15 community-based treatment programs (CTP) that represent a variety of treatment settings and patient populations available in that particular region of the country. Each RRTC will work in concert to conduct multi-site clinical trials research. They will deliver and test an array of behavioral and pharmacological treatments and determine conditions under which novel treatments are successfully adopted. Most studies to be conducted will span multiple sites, populations and geographic regions. Through this growing network, NIDA hopes to transport promising science-based behavioral and pharmacological treatments to communities across the Nation.

Science-based therapies that are ready for testing in the CTN include new cognitive behavioral therapies, operant therapies, family therapies, brief motivational enhancement therapy, individual and group drug counseling, aftercare behavior therapy and science based treatment with a court-diverted patient population. One behavioral study, for example, will develop and evaluate in a community treatment setting, motivational incentive procedures that have been shown to be effective in small scale research settings. The study will determine if these

incentives coupled with standard care therapy are more effective than standard care therapy alone in treating addiction. To address the real problem of relapse following residential treatment, another study will compare focused aftercare interventions to standard aftercare planning on longer-term outcomes.

Among the medications to be studied are: naltrexone, LAAM, buprenorphine for heroin addiction, and the new buprenorphine/naloxone combination coupled with psychosocial treatment in an adolescent population. New methods to treat adolescents dependent on heroin are sorely needed; the new buprenorphine/naloxone combination offers the possibility of a significant new treatment option for this group. A study will be undertaken to compare treatment retention, drug use outcome, psychosocial, and high risk behaviors among adolescent heroin addicts treated with the usual psychosocial treatment with or without daily buprenorphine/naloxone.

As the CTN grows over the next 5 years, its goal will be to bring researchers and practitioners together as partners to conduct full-scale testing of promising new medications and behavioral treatments in a wide range of community drug abuse treatment clinics with patients from a variety of ethnic and social backgrounds. The program is designed to rapidly infuse the developments of academic research into actual practice at the point of treatment delivery. Treatment providers will be actively involved in developing protocols and demonstrating and developing best practices within the context of their own unique community populations, settings, and services delivery systems.

The CTN also will be useful to other aspects of NIDA's research portfolio. For example, multi-site clinical trials with diverse patient populations could provide a valuable resource to researchers interested in elucidating genetic and environmental determinants of vulnerability. Ultimately, increased understanding of the roles played by genetics, environment, and their interaction in shaping an individual's susceptibility to drug addiction will lead to a variety of more targeted drug abuse prevention and treatment approaches.

Practice Research Collaboratives Program (PRC)

This SAMHSA/CSAT-supported initiative was undertaken to support and promote effective, efficient, and accessible community-based treatment. The goals of the program are to: Increase the usefulness of substance abuse treatment research to community-based treatment organizations, and Increase the capability of community-based treatment organizations to adopt evidence-based clinical and service delivery practices.

Through this program, community-based treatment organizations partner with researchers, policy-makers, and other stakeholders to implement evidence-based practices that are responsive to the needs of local providers and consumers of substance abuse services. Together, the PRC stakeholders assess community service delivery needs, identify evidence-based practices that are relevant and feasible to implement, and, conduct studies to evaluate the most effective methods of implementing these practices in community-based treatment settings. The PRC program will reduce the isolation of treatment providers, researchers, and policymakers and provide needed support to community-based organizations that serve as the primary sources of substance abuse treatment for underserved populations.

CSAT has awarded eleven PRC grants, including four developmental and seven implementation phase programs. During the one-year developmental phase, PRC grantees: develop an organizational stricture that provides a forum for diverse stakeholders to come together and work collaboratively toward the goal of implementing evidence-based practices in local community-based treatment organizations; conduct a community needs assessment, and, develop a knowledge adoption agenda that is endorsed by the PRC governing body of community stakeholders.

During the three-year implementation phase, the PRC grantees: Conduct network enhancement activities to promote researcher/practitioner collaborations, e.g. clearinghouses, mentoring programs, conferences, workshops, and technical consultation and liaison activities, and, involve PRC stakeholders in the design and conduct of community-based knowledge adoption studies responsive to locally defined needs.

PRC grantees include a mix of Statewide, metropolitan, and rural programs. PRC stakeholders include and diverse range of community-based treatment programs including programs serving ethnic and cultural minorities, clients involved with the criminal justice system, and clients with co-occurring mental health and substance abuse disorders and HIV/AIDS.

Treatment Research and Evaluation

Recent studies 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 new therapies. NIDA will conduct clinical and epidemiological research to improve the understanding of drug abuse among children and adolescents. These findings will be widely disseminated to assist in finding more effective approaches to prevention. ONDCP/CTAC will complete the development of the Drug Evaluation Network System (DENS) which can monitor and evaluate substance-abuse programs by tracking patients entering treatment, their characteristics and discharge status. The system software architecture is designed to host a wide variety of trends and treatment effectiveness methodologies. DENS is being transitioned to the SAMHSA/CSAT's National Treatment Outcome Measurement System (NTOMS) this year.

To ensure that basic research is put to good use, SAMHSA supports and evaluates applied research. For example, SAMHSA/CSAT's Methamphetamine Treatment Project (http://www.methamphetamine.org) is funding evaluations of sixteen-week methamphetamine interventions in non-residential (outpatient) psychosocial settings in California, Hawaii, and Montana. The objective is to determine whether promising results from stimulant treatment attained by the MATRIX Center in Los Angeles can be replicated.

Research into the Mechanisms of Addiction

In conjunction with the National Institute on Drug Abuse (NIDA), ONDCP/CTAC examines addiction research and the application of technology to expand the effectiveness or availability of drug treatment. These efforts seek to answer basic questions, such as:

- UnderWhy do some drug users become addicted while others do not?
- What changes occur in the brain that result in addiction and what can be done to reverse or mitigate the process?

For the past five years, brain imaging technology development projects that exploit advancements in Positron Emission Tomography (PET), functional Magnetic Resonance Imaging (fMRI) and Magnetic Resonance Spectrometry for drug abuse research have been developed with institutions such as NIDA's Intramural Research Program, Brookhaven National Laboratory, Massachusetts General Hospital, Emory University, University of Pennsylvania, University of California at Los Angeles and Harvard University/McLean Hospital. Each of these institutions have world-class medical research teams that have agreed to conduct leading edge research on drug abuse and addiction with the new equipment. They also have agreed to train other professionals with a concentration on drug abuse research to advance the current base of knowledge and understanding.

Last year, a 7 Tesla magnet was delivered to the Nuclear Magnetic Resonance Research Center at Massachusetts General Hospital. When the facility is completed this year, the new 7 Tesla fMRI system will serve as the cornerstone for a collaborative effort between Massachusetts Institute of Technology and Massachusetts General Hospital to conduct research on the brain circuitry. Research scientists will use this sophisticated brain imaging equipment to map brain reward circuitry, blood volume and flow associated with drug metabolism, and interactions with potential therapeutic medicines. They will be able to localize the brain circuitry that mediates drug addiction and characterize its temporal dynamics. This premier neuro-imaging facility also will support research to determine the extended circuitry of human motivation and its modification by functional illness. Using these findings, research scientists will be able to develop neuro-imaging tools for diagnosis and prognostic determination of treatment for substance abuse disorders.

Scientists at Yerkes Regional Primate Research Center at Emory University are seeking to find a medication to serve as a "front line" initial step in normalizing addicts for further treatment. This year they plan to demonstrate two to four compounds that help reduce cocaine intake in animals.

Researchers from the Research Triangle Institute, using PET brain scanning equipment located at the NIDA Intramural Research Program, are assessing the role of impaired cognitive functioning and looking for vulnerability factors or markers for specialized treatment regimens. In order to link rigorous experimentation done in non-human primates with clinical populations, a "micro" PET brain scanning capability is being developed with NIDA to resolve the small brain structures in non-human primates and rodents.

Reducing Infectious Disease Among Injecting 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. Exposure to HIV through injection drug use practices accounts for 22 percent of cumulative AIDS cases among men, but higher percentages of African Americans (34 percent) and Hispanics (36 percent) have contracted HIV directly through this mode of transmission. 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), with 42 percent of cumulative AIDS cases among women being attributable to injection drug use. 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, psychological, and social problems that must be overcome in order to address their addiction, criminal recidivism, and disease transmission.

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 about drug abuse and its relationship to other illnesses through biomedical and behavioral research. This work will incorporate a range of scientific investigation from basic molecular and behavioral research to epidemiology, prevention, and treatment. Information from each of these areas is essential for understanding the links between drug abuse and AIDS, TB, and hepatitis and for developing strategies for stemming infectious diseases spread through injection drug users. NIDA is conducting public-health campaigns to increase awareness of infectious diseases. If we are to make progress in addressing the dual problems of HIV/AIDS and substance abuse, it will be necessary to create linkages between addictions treatment, primary care, and mental health services for those with HIV.

SAMHSA will continue its support of early intervention services for HIV through the SAPT Block Grant. Under the Congressional Black Caucus Initiative aimed at reducing the disproportionate impact of HIV/AIDS on racial and ethnic minorities, SAMHSA awarded over $60 million to fund outreach, substance abuse prevention and treatment, and prevention services for women and youth in communities of color in FY 2000. The grants from SAMHSA's Targeted Capacity Expansion and Outreach Programs will improve substance-abuse treatment and prevention services in minority communities highly affected by the twin epidemics of substance abuse and HIV/AIDS. In addition, SAMHSA is working to foster collaboration regarding HIV/AIDS and substance abuse among a variety of federal agencies including the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and the Office of Minority Health.

Training for Substance-Abuse Professionals

In spite of their rigorous educational and licensing requirements, most health care professionals lack the training to identify the symptoms of substance abuse. A survey by the National Center on Addiction and Substance Abuse at Columbia University (CASA) demonstrated that 94 percent of primary care physicians (excluding pediatricians) failed to identify substance abuse in their patients.[20] Forty percent of physicians who treat teens missed an illegal drug abuse diagnosis in teens. Health care providers are simply not being trained to ask the right questions. The majority of health professionals can graduate from their basic and graduate educational programs without

ever having to take a course in addictions. However, there is evidence to suggest that interactive learning sessions can greatly increase the ability of medical professionals to screen patients for signs of substance abuse. For example, Boston University Medical School researchers designed and conducted a seminar on detection and brief intervention of substance abuse for doctors, nurses, physician's assistants, social workers and psychologists. When asked the usefulness of the information, 91 percent of the clinicians say that they are still using the techniques 1-5 years later.[21]

At present, the Health Resources and Services Administration (HRSA), the Center for Substance Abuse Treatment (CSAT), National Institute on Drug Abuse (NIDA), National Institute of Mental Health (NIMH) and Center for Substance Abuse Prevention (CSAP) are actively engaged in increasing health care professional's knowledge and ability to recognize and treat substance abuse. HRSA, for example, is engaged in the "HRSA-AMERSA Interdisciplinary Project to Improve Health Professional Education in Substance Abuse." CSAT supports Addiction Technology Transfer Centers (ATTCs) and CSAT's counselor training programs. NIDA's oversees a Clinical Training Program that prepares clinicians to be researchers. CSAP conducts a Faculty Development Program, and NIMH a Clinical Training Program.

ONDCP supports efforts to increase funding for these agencies in order that the substance abuse education of health care professionals be expanded. By increasing this targeted funding for the education of health professionals, more clinicians from diverse specialties will be able to recognize, refer and/or treat addictions. Increased funding would mainstream addiction prevention and treatment into various medical disciplines. It would have the ancillary effect of reducing substance abuse treatment costs in the future, as early intervention by a primary care practitioner will decrease the level of care needed to diagnose and treat the addiction.

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 system, much-needed services may be less available to vulnerable populations, including racial and ethnic minorities like African-Americans, Native Americans, Alaskans, Hispanics, Asian American/Pacific Islanders; children of substance-abusing parents; the disabled; the poor; the homeless; and people with co-occurring substance abuse and mental disorders. SAMHSA/CSAT is addressing this problem in the Targeted Capacity Expansion Program, which responds to the treatment needs of serves these vulnerable populations. Our overall challenge is to help chronic drug abusers overcome dependency and lead healthy, productive lives. In addition, SAMHSA/Center for Mental Health Service's PATH program supports services to individuals who are homeless or at risk of homelessness, including homeless families. Three out of every five clients served through this program also have a co-occurring substance abuse disorder.

Family Drug Treatment Courts

CSAT's Family Drug Treatment Court initiative is designed to stop the cycle of substance abuse and child neglect or abuse that occurs in many families, providing appropriate services to each family member so that families can be reunited, or children can be adopted when families cannot be reunited. In Family Drug Treatment Courts, alcohol and other drug treatment, combined with intervention and support services for the child and the family, are integrated with the legal processing of the family's case. To be effective these courts are a true three-way partnership between the child welfare, substance abuse treatment, and court systems.

Key components of Family Drug Treatment Courts include the following: screening and assessment using a non-adversarial approach; providing a continuum of alcohol and drug treatment with accompanying wrap-around rehabilitative and logistic services that support families and recovery; alcohol and other drug testing; and the judge, child welfare, and substance abuse treatment personnel work as a team to closely monitor participants' compliance with treatment through a system of rewards and sanctions administered during frequent court hearings.

One of the key benefits of Family Drug Treatment Courts is helping states comply with the Adoption and Safe Families Adoption Act of 1997, P.L. 105-89. Early indications are that using family drug treatment courts reduces the time taken for final disposition of abuse and neglect cases, and also increase the percentage of family reunification.

The National Treatment Plan Initiative

The problem of substance abuse and dependence has long troubled the nation, reflecting conflicting concerns for public safety, moral values, and health. SAMHSA's Center for Substance Abuse Treatment (CSAT) believes that further progress in the treatment of substance abuse and dependence will require a sustained and coherent approach that can address the whole range of issues associated with alcohol and drug problems. This approach is the purpose for initiating Changing the Conversation: Improving Substance Abuse Treatment: The National Treatment Plan Initiative (NTP).

To organize thinking about such a broad set of concerns, CSAT in collaboration with the NTP Steering Group selected five domains that can encompass the whole array while highlighting strategic issues central for the field: (1) Closing the Treatment Gap; (2) Reducing Stigma and Changing Attitudes; (3) Improving and Strengthening Treatment Systems; (4) Connecting Services and Research; and (5) Addressing Workforce Issues.

For each domain, CSAT, with input from the field, chose a panel of experts including consumers, providers of services, researchers and policy makers who represented diverse knowledge, experience, and views. Panel members were charged with considering and building on the work of previous reports and studies. Rather than duplicating prior work, the panels focused on what should be done in the future. CSAT also sponsored a series of six public hearings to obtain additional information and views, particularly from frontline providers, policymakers, and people in recovery and their families.

The NTP combines the recommendations of the five Expert Panels into a five-point strategy: (1) Invest for Results; (2) No Wrong Door to Treatment; (3) Commit to Quality; (4) Change Attitudes; and (5) Build Partnerships. The recommendations represent the collective vision of the participants in the NTP "conversation" over the past year. The goal of these recommendations is to ensure that an individual needing treatment-regardless of the door or system through which he or she enters-will be identified and assessed and will receive treatment either directly or through appropriate referral. Systems must make every door the right door.

3. BREAKING THE CYCLE OF DRUGS AND CRIME

Perpetrators of our nation's violent and income-generating crimes like robbery, burglary, or theft are more often than not illegal drug users. According to ADAM data, in 27 of the 34 sites reporting arrestee drug use data, over 60 percent of male adults had positive drug test results for at least of the following: cocaine, marijuana, methamphetamine, opiates, and/or PCP. The average rate for female adults was 67 percent in 1999, up three percent from 1998 data. Overall, however, most sites reported slight differences in drug use among male and female arrestees from 1998 to 1999.[22]

The nation's incarcerated population is now more than 2 million.[23] While the number of offenders in each major offense category increased, the number incarcerated in federal prisons for a drug offense accounted for the largest percentage of the total growth (63 percent). Public-order offenders accounted for 26 percent of the increase; violent offenders, 6 percent, and property offenders, 1 percent.[24] Prisoners sentenced for drug offenses constitute the largest group of federal inmates (58 percent) in 1998, up from 53 percent in 1990. As of September, 1998, when the last data was collected, federal prisons held 63,011 sentenced drug offenders, compared to 30,470 at yearend 1990.

Criminal justice policy-makers have begun to realize how important it is to provide substance abuse treatment for drug-offenders while they are incarcerated and after their release into the community. It is no longer viewed as just a public health issue or the "right thing to do." Correctional administrators have experienced the public safety and cost-saving benefits of providing these services in a continuum of care. Given the number of parole violators who are returned to prison for drug offenses, however, there is still much work to be done.

Correctional administrators and treatment providers alike look to the field of research and science to support their criminal justice policies. Delaware researchers have expended a great deal of effort to provide evidence that a "continuum of primary (in prison), secondary (work release) and tertiary (aftercare) therapeutic community treatment for drug-involved offenders" is effective in reducing incidents of relapse and recidivism. Past research had indicated substantial decreases in these two areas for offenders in the year after completing work release when they had participated in primary and secondary treatment. Unfortunately

these results do not appear to last into their third year of release. The positive effects of the substance abuse programs are enhanced significantly when the offenders participate actively in the therapeutic communities, complete the programs, and obtain follow-up treatment as with aftercare. "Clients who complete secondary treatment do better than those with no treatment or program dropouts, and those who receive aftercare do even better in remaining drug-and arrest-free."[25]

Results were similar for researchers studying in-prison therapeutic community treatment in Texas. "This study examined re-incarceration records for 394 nonviolent offenders during the 3 years following prison. Those who completed both ITC and aftercare were least likely to be re-incarcerated (25 percent), compared to 64 percent of the aftercare dropouts and 42 percent of the untreated comparison groups. Furthermore, those who completed high-severity aftercare were re-incarcerated only half as often as those in the aftercare dropout and comparison groups (26 percent vs. 66 percent and 52 percent). The findings support the effectiveness of intensive treatment when it is integrated with aftercare, and the benefits are most apparent for offenders with more serious crime and drug-related problems."[26]

Substance Abuse Treatment for Incarcerated Offenders

Both state and federal agencies have established substance-abuse treatment programs in correctional institutions. Incarcerating offenders without treating underlying substance abuse simply defers the time when addicts return to the streets and start harming themselves and the larger society. As a crime-control measure alone, drug treatment for criminally active addicts is strikingly cost-effective. It offers the potential of reducing crime by two-thirds at about half the cost of incarceration alone.

According to the Federal Bureau of Prisons (BOP), the number of federal inmates receiving residential substance abuse treatment increased from 1,236 in 1991 to 12,541in 2000. BOP provides drug treatment for inmates prior to release. In FY 2000, four existing residential drug abuse treatment programs expanded capacity, and three institutions opened new residential drug abuse treatment programs bringing the number of institutions providing residential drug abuse treatment to 47, up from 32 in 1994. In FY 2000, over 40, 000 inmates received some sort of drug abuse service. Six female institutions currently house residential drug abuse treatment programs and two more female sites will be implemented by the end of FY 2002. The Federal Medical Center (FMC) in Carswell, Texas also includes a specialized program for female inmates with co-occurring disorders. In 2000, over 44,500 inmates participated in all types of BOP drug treatment services. Since 1992, the number exceeds 230,000.

A joint BOP/NIDA study is examining the program and has provided a report addressing the first 36 months after release from custody. Unlike most studies of prison treatment effects, the BOP/NIDA study employs sophisticated methods (e.g., weighting) to remove any possible selection bias and is more likely than other studies to underreport treatment effects. Nonetheless, the study found that, after 36 months, the male treatment population was 19 percent less likely to be re-arrested on a new offense and 16 percent less likely to use drugs than a comparison group that received no treatment. The male treatment population was 16 percent less likely to be re-arrested or revoked for parole violation. The female treatment population was 18 percent less likely to be rearrested or revoked and 18 percent less likely to use drugs. The female treatment population was employed about 70 percent of the time, during the 36 months, the control group employed about 60 percent of the time. These results demonstrate savings in incarceration costs, an extended period of public safety for the community, and an increased contribution to local economies.

The Corrections Program Office (CPO) of the U.S. Department of Justice has funded state projects for substance abuse treatment through Residential Substance Abuse Treatment (RSAT) for State Prisoners grants. In addition, states may use 10 percent of the funds they receive through the formula Violent Offender Incarceration/Truth In Sentencing Grant Program (VOI/TIS) for aftercare components of their treatment programs. One example of these projects is Delaware's in-prison program which has provided institutional and transitional drug treatment since the late 1980s. State correctional authorities provide reports to CPO annually that demonstrate the effectiveness of these programs. These reports include drug testing results as well as data they have obtained regarding recidivism rates for the offenders who participated and completed their programs. In 1998, 555,153 urine specimens were collected from 1,099,131 inmates. 530,237 of these specimens tested negative for drugs. In 1999, of the 1,121,981 specimens tested from 1,139,373 inmates, 1,084,880 tested negative for illegal drugs. Of

the states able to report any data on recidivism (some programs have not been in operation long enough to have data on recidivism), an average of 94.2 percent ex-inmates who participated in RSAT treatment were conviction free one year after release.

Providing Treatment in Prisons and Jails

According to the Bureau of Justice Statistics (BJS), 6.3 million people were on probation, in jail or prison, or on parole at the end of 1999 — 3.1 percent of all U.S. adult residents. State and federal prison authorities had under their jurisdiction 1,366,721 inmates at the end of 1999. Local jails held or supervised 687,973 persons awaiting trial or serving a sentence at the middle of 1999. Between 1990 and 1999, the incarcerated population grew an average 5.7 percent annually. Population growth during 1999 was significantly lower in State prisons (up 2.1 percent) and local jails (up 2.3 percent) than in previous years. The population in custody of federal prison authorities rose by 13.4 percent.[27]

Substance abuse has a much higher prevalence among the offender population than among the general population. Yet only a fraction of substance-abusing offenders in correctional facilities have access to much-needed treatment. A BJS study found that 57 percent of state prisoners and 45 percent of federal prisoners surveyed in 1997 said they had used drugs in the month before their offense — up from 50 percent and 32 percent reported in the 1991 survey. Thirty-three percent of state and 22 percent of federal prisoners said they committed their current offense while under the influence of drugs, and about one in six of both state and federal inmates said they committed their offense to get money for drugs. About three-quarters of all prisoners can be characterized as being involved with alcohol or drug abuse in the time leading up to their arrest. Among those prisoners who had been using drugs in the month before their offense, 15 percent of both state and federal inmates said they had received professional drug abuse treatment during their current prison term — down from a third of such prisoners in 1991.

To ensure that gains made during treatment in prison continue after release, OJP requires that preference be given to programs with aftercare as an essential component. Aftercare services should involve coordination between the correctional treatment program and other human service and rehabilitation programs, such as education and job training, parole supervision, halfway houses, and self-help and peer group programs that may aid in rehabilitation. Although programs such as aftercare are not eligible for RSAT funding, states are required to ensure coordination between correctional representatives and alcohol and drug abuse agencies at the state and, if appropriate, local levels.

Dual Diagnosis/Dual Disorder

Effective treatment addresses a range of issues. Many juvenile and adult offenders who abuse or are dependent on drugs and alcohol also have co-occurring mental disorders, primary health care needs, and a host of related housing, employment, and social service needs. More and more our jails and prisons are experiencing the entry of people with mental illness. A key factor influencing this trend, among many others, is the desinstitutionalization of State mental hospitals beginning 30 years ago when there was, and still is, a dearth of community mental health centers with needed resources to expand treatment. Thus, many seriously mentally ill people end up in the criminal justice system, as well as on the streets.

Many of these individuals self-medicate with illegal drugs or as a result of their untreated mental disorders may behave in a disorderly way. By mid-year 1998, approximately 283,800 offenders with mental illness were being held in prisons and jails in the United States, and 547,800 offenders with mental illness were on probation. They are more likely than other inmates to be in prison for a violent offense (53 percent to 46 percent respectively) and are less likely than others to be incarcerated for a drug related offense (12 percent to 22 percent respectively). Even so, about 60 percent of mentally ill offenders state that they were under the influence of alcohol or drugs at the time of their current offense. The combination of the condition of mental illness and the concurrent use of substances is frequently the precursor to disorderly behavior, not the simple presence of mental illness by itself.

Who are these offenders with mental illness? These individuals have reported relatively high rates of previous physical and sexual abuse, loss of one or both parents from the primary caretaking role, serious problems with alcohol and drug abuse in one or both parents, and early developmental expressions of symptoms that may indicate emotional disorders that are typically unaddressed and untreated. Treatment programs will have to focus on the

mental health needs of such offenders with the same intensity that they address substance abuse issues. The two disorders are so closely linked that treatment requires attention to both issues. This is both a public safety issue as well as one of public health and humane treatment.

Drug Free-Prison Zone

The Drug Free-Prison Zone demonstration project is being conducted jointly by ONDCP, the National Institute of Corrections, and BOP to interdict and control the availability of drugs in prisons. The program combines policy, testing, technology, treatment, and training, including a program of regular inmate drug testing, the use of advanced technologies (e.g., ion spectrometry) for detection of drugs entering facilities, and the training of correctional officers and other institutional staff.

Twenty-eight BOP facilities are participating and gathering information on visitor screening, inmate drug testing, and five types of inmate misconduct. Interim results from the BOP show that through June 2000, over 140,000 visitors had been screened using a drug detection device and over 3,000 (2.6 percent) tested positive for one or more drugs and thus were denied the opportunity to visit. At the 28 institutions where visitor screening for visitors is being conducted, before and after comparisons of randomly tested inmates show substantial decreases (23 percent or more) in drug detections in medium security, low security, and administrative facilities. Among inmates tested in the suspect category (past history of drug use, etc.), drug detections were down substantially (22 percent or more) in highs, mediums, and administrative facilities. Other types of misconduct such as fighting, assaults, alcohol use, etc. were down somewhat in medium security facilities and considerably in administrative facilities.

Eight states (Alabama, Arizona, California, Florida, Kansas, Maryland, New Jersey, and New York) began participating in January 1999 and are employing a variety of education, training, interdiction, and treatment measures. The states have reviewed approaches to drug detection previously unknown to them. California has linked technology and intelligence with law-enforcement agencies such as DEA, leading to arrests. New Jersey has created a highly effective mobile interdiction team that moves among state prisons. New York and Maryland are linking treatment with enforcement efforts. All states are putting comprehensive policies in place and making extensive use of testing and detection equipment. The initiative is being independently evaluated.

Operating Standards for Prison-Based Therapeutic Communities (TCs)

The field testing of operating standards was conducted by Therapeutic Communities of America (TCA), with ONDCP support. The resulting document was made available in December 1999. This is a groundbreaking contribution that brings a new level of discipline to practitioner discussion of drug treatment. This comprehensive set of operating standards for prison-based TCs — over 120 standards across 11 program domains — has now been validated in operational prison settings. In its present form, the standards document provides a blueprint for state and local leaders, and it will eventually be put into a format appropriate for use by national accrediting organizations. The document is available at the National Assembly Star on the ONDCP web site.

Substance-Abuse Treatment Provided with Community Supervision

In 1996, states and localities spent over $27 billion in corrections, of which $22 billion was used for prison operations alone. The average annual cost per inmate was $20,142, ranging from a low of $8,000 to a high of $37,800. For the federal system, the annual cost per inmate was $23,500.[28] By comparison, probation and parole costs in 1997 ranged from $1,110 per year for regular supervision to $3,470 for intensive supervision, and $3,630 for electronic supervision. Cost variation is explained primarily by caseload. The average caseload for regular probation was 175, and sixty-nine for regular parole. Average caseloads for intensive supervision probation and parole were thirty-four and twenty-nine, respectively; electronic supervision was twenty and eighteen.

Using the Federal Bureau of Prisons as a representative program, the annual cost of residential and transitional treatment and services was estimated at $3,000 per inmate. Generally accepted estimates of annual treatment costs per person in the community are: regular outpatient, $1,800; intensive outpatient, $2,500; short-term residential, $4,400; and long-term residential, $6,800. Combining the most expensive community supervision with the most expensive treatment yields an estimated average cost of $10,430 per person per year compared to

$20,142 for incarceration alone, and $23,142 for incarceration combined with treatment and transitional services. Drug courts, TASC, BTC, and Zero-Tolerance have all helped make community supervision and treatment more effective.

Criminal Justice Treatment Networks

CSAT's Criminal/Juvenile Justice Treatment Networks (CJTN) project, a five-year systems integration initiative launched in FY95, continued its fifth year of federal funding in FY99. The networks have developed an integrated system of intake, supervision, and treatment across justice agencies for adult and juvenile offenders in eight metropolitan jurisdictions. In this past year, the networks expanded services and partnerships. In FY 1999, SAMHSA/CSAT published *Strategies for Integrating Substance Abuse Treatment and Juvenile Justice Systems: A Practice Guide*, which describes the range of substance-abuse treatment services provided in juvenile justice settings.

Drug Courts

Drug courts divert drug offenders out of jails or prisons and refer them to community treatment. Drug courts seek to reduce drug use and associated criminal behavior by retaining drug-involved offenders in treatment. Defendants who complete the 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. As of October 31, 2000, 593 drug courts were operating nationwide, including adult, juvenile, tribal, and family drug courts. Also, as of October 31, 2000, 456 were in planning stages, up from a dozen in 1994.[29]

Drug courts have been an important step forward in diverting non-violent offenders with drug problems into treatment and other community resources, leaving the criminal justice system to address violent acts. Fifty-seven thousand people have graduated from drug courts since their inception. 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.[30]

CSAT is piloting three Family Drug Courts projects in which alcohol and other drug treatment, combined with intervention and support services for children and families, are integrated into the legal processing of the family's case. In some jurisdictions there is coordination between the criminal courts and the civil Family Drug Court. Family Drug Courts should be able to help states comply with the Adoption and Safe Families Adoption Act of 1997, P.L. 105-89. Family Drug Courts will substantially reduce the time taken for final disposition of abuse and neglect cases and will increase the percentage of family reunification.

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.[31]

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, 8,891 assessments have been conducted on felony offenders to ascertain treatment needs. Currently, 1,676 offenders are active within the BTC Program. Over 72,447 drug tests have been performed on offenders, and over 6,652 treatment referrals have been made at the point of assessment. A bond has been implemented requiring felony offenders to report to TASC within 48 hours for assessment and urinalysis. The period of time that elapsed between a BTC offender's entry into the system and his/her TASC assessment has dropped from 24 days in

December 1997 to four days in August 1999. Disposition alternatives including the deferred and expedited dockets have been established. These sentencing options were designed to utilize BTC compliance information to qualify defendants for early dispositions. By diverting these cases prior to the grand jury, circuit court docket space is available for jail cases. These expedited calendars have allowed Birmingham to postpone construction of a new jail pending full review of needs.

According to results of the 1998 Arrestee Drug Abuse Monitoring Program, 64 percent of male offenders were positive for drug use at the time of arrest. In contrast, only 23 percent of BTC offenders tested positive during routine random urinalysis after intervention had occurred. Retention rates have exceeded 70 percent and the re-arrest rate has remained in the single digits. A Policy and Advisory Oversight Committee composed of criminal justice system representatives has proactively identified systemic barriers and made substantial steps to develop solutions, including the development of a management information system to automate the assessment, offender tracking, and drug testing functions of the TASC effort.

An outcome evaluation of Birmingham BTC, conducted by the Urban Institute, found arrests, illegal activities, drug use, family problems, and employment problems significantly lower for the BTC population than for the control group. Other findings of potential significance: many drug using offenders do not require formal treatment and can be managed with testing and monitoring alone; and the use of formal sanctions has a significant positive impact on compliance.

For Fiscal Year 2001, the Jefferson County Council set aside $1.4 million in state and local funds to continue the innovations begun under BTC, effectively transitioning the program from Federal grant to locally-owned initiative. In addition, Birmingham received $150,000 from the Bureau of Justice Assistance to implement a mental health court. The assessment, screening, and judicial oversight features of this court were patterned after those initiated under BTC.

In 1998, three additional jurisdictions were selected to participate under the Breaking the Cycle initiative. Jacksonville, Florida and Tacoma, Washington are conducting Breaking the Cycle in their adult criminal justice systems. Lane County (Eugene), Oregon is conducting a juvenile Breaking the Cycle program These sites are began implementation in October 1999 (Jacksonville and Tacoma) and May 2000 (Eugene). During the first year of implementation, over 5,500 drug-using offenders in Jacksonville and Tacoma combined and over 100 minors in Eugene have been ordered into BTC. All sites are subject to process and outcome evaluations.

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.

Initiatives Currently Underway

Over the past two years, ONDCP has joined with DOJ and HHS to lay the foundation for systemic collaboration between justice and public health. Working together, these federal agencies have documented the state-of-the-science at the March 1998 consensus meeting of scholars, clinicians, and other practitioners and then proceeded on two fronts:

- Applying the science: expanding breaking-the-cycle demonstrations to additional sites, demonstrating interdiction, intervention policies, and technology through the drug-free prison zone demonstration, and validating operating standards for prison-based TCs.
- Crafting a policy — in concert with federal, state, and local agencies as well as national organizations — to contribute to public safety and health.

This science-based policy calls for the criminal and juvenile justice systems to operate together with other service systems as a series of intervention opportunities for disordered drug and alcohol offenders. Intervention must be systematically applied as early as possible:

- To prevent entry into the criminal/juvenile justice system of individuals who can be safely diverted to community social-service systems.

- To limit entry into the criminal/juvenile justice system of adult and juvenile nonviolent offenders through community justice interventions in concert with other social-service systems.
- To intervene with people who must be incarcerated or securely confined, through appropriate treatment and supervision, both during and after the period of confinement.

One example of a current initiative is the Department of Justice's Operation Drug TEST (Testing, Effective Sanctions, and Treatment). This program is a pilot project designed to identify drug abusing defendants as soon as they enter the federal criminal justice system and to provide appropriate supervision, sanctions, and treatment to help them become and remain drug-free. It was developed in response to a 1995 Presidential directive to the Attorney General, who worked to secure the strong support of the federal judiciary for this project. The Department of Justice and the Administrative Office of the United States Courts (AO) entered into a Memorandum of Understanding and began implementing the program in 25 federal judicial districts in fiscal year 1997. One of these districts opted out of the program, leaving 24 as the core initial group. Since 1997, $4.7 million annually has been allocated for this program.

National Assembly

Over the past three years, ONDCP has joined with the Departments of Justice and Health and Human Services to lay the foundation for systemic collaboration between justice and public health. A March 1998 Consensus Meeting of scholars, policy makers, and practitioners, ONDCP, DOJ, HHS, took stock of existing knowledge regarding drug treatment and the justice system, probing scientific research and clinical experience to determine what is known with reasonable confidence. This was followed by a June 1999 meeting of forty stakeholder organizations to advise DOJ, HHS, and ONDCP, regarding policy to reflect established knowledge. Building on these efforts, a December 1999 a National Assembly on Drugs, Alcohol Abuse, and the Criminal Offender was co-sponsored by ONDCP, DOJ, and HHS. This unprecedented gathering of over 800 health and justice officials presented and discussed approaches to link the justice system with other service systems, to provide a series of opportunities for intervention with drug and alcohol disordered offenders:

- To prevent entry into the criminal/juvenile justice system for those who can be safely diverted to community social service systems.
- To limit penetration into the criminal/juvenile justice system for adult and juvenile nonviolent offenders through community justice interventions in concert with other social service systems.
- To intervene with those who must be incarcerated or securely confined, through appropriate treatment and supervision, both during and after confinement.

The National Assembly yielded widespread consensus regarding: the need for public safety and public health agencies to work together in a consistent, collaborative manner, to provide the breadth of services required and to make full use of limited funding; the need for formal agreements to overcome the obstacles presented in bringing all of the essential actors to the table; the need to seize the opportunity presented by the juvenile and criminal justice systems' authority to mandate treatment; the critical importance of thorough assessment at the beginning of the process, to properly match services with needs and manage compliance with treatment requirements; the critical importance of post-incarceration transitional and follow up services and support to foster safe re-entry into the community; and the need to make specific guidance on best practices available to practitioners.

The planning committee for the National Assembly formed an interagency committee, the Public Health/Corrections Working Group, to respond to requests for technical assistance, to develop a web site by which information on public health and public safety concerns could be disseminated, and to establish a national compendium of interventions for substance abusing persons involved with the justice system. This working group is comprised of representatives from the Justice Department, the Department of Health and Human Services, ONDCP, and the Department of Education. Together they have supported several states initiatives to host state assemblies and to establish systems that integrate corrections and treatment agencies. The group also assisted National TASC with their annual conference by participating in developing the agenda, obtaining funds, and making presentations at the event.

Other follow-up includes interagency agreements between CSAT, CPO, and the Surgeon General's office and a spring 2001 conference that will bring public safety and public health officials together to discuss the issues facing offenders with mental illness and co-occurring disorders.

Juvenile Justice

The juvenile justice system presents an opportunity to prevent the cycle of substance abuse and crime. The juvenile justice system was specifically developed to respond differently than the adult justice system to youth who commit crimes. Since its inception, the primary goal has been rehabilitation, rather than punishment, of the youth in the context of the family system. It is vital that we develop policy, pass laws, and implement programs which preserve and enhance this approach. Research in recent years has supported the wisdom of developing a separate juvenile justice system. By nature youth are risk takers and experimenters, and as part of the normal developmental process will engage in behaviors that are illegal. From a developmental perspective, adolescence is a major transitional phase that is defined by significant physical development coupled with increases in aggressive behavior, increased conflicts with parents and other authority figures, and an orientation away from family and towards peers and experimentation. Family, community, and schools all play prominent roles in a juvenile's development, and they must be incorporated into any comprehensive solution. The "strength-based approach" treatment approach looks to the positive attributes of youth, and builds on those, rather than focusing exclusively on what the youth has done wrong.

System Integration

Another challenge for the justice system is to reach beyond the immediate defendant and address family crises, domestic violence, juvenile delinquency, abuse and neglect, and a host of related problems. The justice system must incorporate means of intervening in a child's first problems with adults — often in his or her own home during the early 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 is New Jersey's Unified Family Courts, which encompass a network of six thousand volunteers who bring together diverse segments of the court and community to collaborate on effective approaches to families in crisis.

4. ENFORCING THE NATION'S LAWS

The correlation between drugs and crime is high. Drug users commit crimes at several times the rate of people who do not use drugs. More than 51 percent of inmates reported substance abuse while committing the offense that led to their conviction.[32] The heavy toll drug abuse exacts on the United States is reflected in related criminal and medical costs totaling over $67 billion. Almost 70 percent of this figure is attributable to the cost of crime.[33]

In twenty years, the drug trade has risen from a cottage industry into a global enterprise. In the last five years, particularly, U.S. drug-control agencies confronted several key trends that reflect the force of the global drug trade.

Today's drug trade is arguably more corrupt and powerful than any criminal enterprise in history. Largely because of its vast profits and corrosive influence, the drug trade now has the capacity to undermine democratic institutions, support anti-government movements, weaken national economies, and threaten the safety and health of entire nations. The drug trade has produced the world's most sophisticated criminal organizations. In addition to their wealth, these organizations have virtually unlimited resources and access to top talent in infrastructure areas like as finance, transportation, distribution, security, and technology. There has been an exponential decrease in the time required for a drug organization to reach its peak of power after initially forming. For instance, the La Cosa Nostra matured in the United States over fifty years and outlaw motorcycle gangs developed over decades. By contrast, the Medellin Cartel reached its peak in under twenty years, the Cali drug mafia in 10 years, and Mexico's drug syndicates were at their optimal level in under a decade. Due to advances in communication and travel, drug organizations have the capacity to develop new alliances and open trafficking routes in regions that were inaccessible even a decade ago.

U.S. law-enforcement agencies must work hard to keep pace with these accelerated trends. For example, they must stay current with technology, make greater use of intelligence, build up talent and expertise, and expand cooperation between agencies.

Dedicated law-enforcement professionals face daily risks in defending 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 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.

The United States is based on the rule of law that ensures the security of all people. Reducing drugs and crime is one of the nation's most pressing social problems. Illegal drug trafficking and substance abuse are inextricably linked to crime, which places a tremendous social and economic burden on our communities. Drugs divert precious resources that support the quality of life Americans strive to achieve. Illegal drugs create widespread problems and produce fear, violence, and corruption. Residents are afraid to go out of their homes, and legitimate businesses flee urban neighborhoods. The data in Chapter II documents the nexus between drugs and crime. Strong law-enforcement policies contribute a great deal to reducing drug abuse and its consequences by:

- Reducing demand – Through enforcing laws against drug use, police strengthen social disapproval of drugs and discourage substance abuse. Moreover, arrest – and the resulting threat of imprisonment – offer a powerful incentive for addicts to take treatment seriously.
- Disrupting supply – The movement of drugs from sources of supply to our nation's streets requires sophisticated organizations. When law enforcement detects and dismantles a drug ring, less heroin, cocaine, methamphetamine, club drugs (ecstasy, PMA, GHM, etc.), and marijuana find their way to our streets. Seizures reduce availability.

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

Law-Enforcement Coordination

In unity there is strength. The more local, state, federal, and tribal law-enforcement 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 successful will be the outcome of separate activities. The illegal drug trade is not a local but a national problem that is, in fact, international in scope. Drug-trafficking organizations do not confine their activities to limited geographic boundaries. Accordingly, federal, state, and local agencies have joined forces on national and regional levels to achieve better results. The El Paso Intelligence Center and the National Drug Intelligence Center (in Johnstown, Pennsylvania) produce strategic assessments of the drug threat and provide direct support to state and local law enforcement.

An example of outstanding collaborative efforts among law-enforcement agencies was the partnership between the United States Marshals Service (USMS), United States Customs Service, and Internal Revenue Service in 2000. Through sixty-three federal, state, and local Fugitive Apprehension Teams, thirty-six thousand federal and sixteen thousand state and local fugitives were arrested by the USMS in FY 2000. Over 52 percent of such arrests have a drug component.

Perhaps the finest example of federal law-enforcement coordination is the Special Operations Division (SOD). This is a joint national coordinating and support entity comprised of federal agents, analysts, and prosecutors from the Department of Justice, DEA, FBI, USCS, and the IRS. SOD's mission is to coordinate regional and national criminal investigations against major drug trafficking organizations. These drug rings operate across jurisdictional boundaries on regional, national, and international levels. SOD works closely with OCDETF, HIDTA, and the U.S. Attorneys offices nationwide. This year, SOD coordinated some of the nation's top drug investigations involving federal, state, and local agencies. Among these are:

- *Operation Impunity* was a two-year investigation that tied drug trafficking in the United States to the highest levels of the international cocaine trade. Initially, the operation identified three individuals based in the United States and linked to the Amado Carrillo-Fuentes drug-trafficking organization headquartered in Juarez, Mexico. The arrest of those three key defendants led authorities to arrest another ninety who ultimately helped dismantle this nationwide drug trafficking network. In addition, U.S. authorities seized of 12,434 kilograms of cocaine, 4,800 pounds of marijuana, and $26 million in currency and assets.
- *Operation Impunity II* was a multi-jurisdictional follow-on to *Operation Impunity*. The investigation targeted the cocaine and marijuana trafficking organization comprised of remnants of the Amado CARRILLO-Fuentes Organization (ACF) and the Gulf Cartel. In December 2000, nationwide enforcement actions coordinated by SOD resulted in the execution of approximately 100 arrest warrants.

- *Operation Tar Pit* targeted a criminal organization based in Tepic, Nayarit, Mexico that manufactured and imported black tar heroin from Mexico into the United States. Initially, the organization delivered heroin to organization members, or "cell heads," in Los Angeles where it was prepared for further distibution to other cell heads in San Diego, Bakersfield, Honolulu, Maui, Portland (OR), Denver, Cleveland, Columbus, Pittsburgh, Phoenix, Yuma, Albuquerque, and Charleston (WV). Operation Tar Pit culminated in June 2000 when federal, state, and local law-enforcement officials executed a nationwide roundup of 249 criminal defendants, along with sixty-four pounds of high-purity black tar heroin.
- *Operation Green Air* dismantled a marijuana trafficking organization that was based in Mexico and Jamaica. The organization smuggled marijuana from Mexico through U.S. Ports of Entry (POE) to warehouses in Southern California. From the warehouses, the marijuana was shipped by corrupt employees of an overnight delivery service to distribution cells in several East Coast cities. In April 2000, *Operation Green Air* culminated with the arrest of 106 people nationwide and the seizure of more than fifteen tons of marijuana and $4.5 million.
- *Operation Mountain Express* targeted criminal organizations that dealt with quantities exceeding a ton of pseudoephedrine, the precursor chemical for methamphetamine. Since January 2000, SOD coordinated a number of multi-jurisdictional investigations that traced these chemical shipments from importers to rogue registrants and eventually to extraction laboratories. Ultimately, *Operation Mountain Express* resulted in 189 arrests; the seizure of more than 12.5 tons of pseudoephedrine; eighty-three pounds of methamphetamine; $12 million in currency and assets; the closure of thirty-nine chemical companies; and the revocation, surrender, or denial of thirty-nine controlled substance registrations.

The DEA, FBI, Internal Revenue Service, and the U.S. Customs Service completed *Operation Red Tide*, an 18 month investigation against a multi-ethnic, transnational MDMA (ecstasy) and cocaine distribution organization in November 2000. All told, the operation has seized more than 4 million tablets (including a shipment of more than 1.2 million headed for Los Angeles), more than 40 suspects in six U.S. cities and in four European countries were arrested including the head of the organization, Tamer Adel Ibrahim. This operation was a cooperative effort between U.S. law-enforcement agencies and police from the Netherlands, Mexico, Israel, Germany, France, and Italy.

In July, after a six-year search, Mexico's Procuraduria General De La Republic arrested Agustin Vasquez-Mendoza — a fugitive on the FBI's Top Ten Most Wanted list. Working with the DEA and FBI, Mexican authorities arrested Vasquez Mendoza in the mountains of Mexico. Vasquez-Mendoza was wanted in connection with the July 1994 killing of DEA Special Agent Richard Fass.

Assisting State and Local Agencies

The Department of Justice has adopted a two-pronged approach to help state and local communities. First, DOJ provides funding and technical assistance to law-enforcement agencies at all levels. Second, DOJ funds initiatives by promoting testing and treatment for offenders, thus helping communities offer employment opportunities and prevent drug abuse. State and local law enforcement is also assisted through the seizure of assets associated with criminal drug activity. In addition to DOJ funding, numerous other federal agencies and programs support law enforcement at the community level. In FY 2000, the U.S. Customs Service alone shared over $71.9 million earmarked for state and local law-enforcement missions.

The U.S. Attorney, as chief federal law-enforcement officer in each judicial district and the Department of Justice as a whole, works with state and local law-enforcement agencies to develop priorities, implement strategies, and supply leadership. DOJ assists communities and neighborhoods through the Edward Byrne Memorial State and Local Law Enforcement Block Grants Program. Grants support multi-jurisdictional task forces, demand-reduction education involving police officers, and other activities directly related to preventing drug-related crime and violence. The local Law Enforcement Block Grant Program contributes funds for hiring police, improving school safety, purchasing equipment, and setting up multi-jurisdictional task forces.

High Intensity Drug Trafficking Area (HIDTA)

HIDTAs are regions of the country with critical drug-trafficking problems that harm other areas of the United States. The ONDCP director — in consultation with the Attorney General, Secretary of Treasury, heads of drug-control agencies, and appropriate governors — designates these locations. There are currently twenty-six HIDTAs and five HIDTA partnerships along the Southwest Border in Texas, New Mexico, Arizona, and California. In addition to coordinating drug-control efforts, HIDTAs assess regional drug threats, develop strategies to address the threats, integrate initiatives, and provide federal resources to implement initiatives. HIDTAs strengthen America's drug-control efforts by forging partnerships among local, state, and federal law-enforcement agencies. They facilitate cooperative investigations, intelligence and resource sharing, and joint operations against drug-trafficking organizations. The Department of Defense gives support to HIDTAs in the form of National Guard assistance, intelligence analysts, and technical training.

The HIDTA program advances the *National Drug Control Strategy* by providing a coordination "umbrella" for agencies to combine anti-drug efforts through an outcome-focused approach. The resulting synergy eliminates unnecessary duplication of effort, maximizes resources, and improves information sharing within and between regions. Intelligence is coordinated at HIDTA Investigative Support Centers, which offer technical, analytical, and strategic support to participating agencies with access to agency databases and supplemental personnel. Currently, 949 local, 172 state, and thirty-five federal law-enforcement agencies and eighty-six other organizations participate in 462 HIDTA-funded initiatives in forty states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.

Community-Oriented Policing

Community-Oriented Policing is an innovative crime-fighting strategy which recognizes that neighborhood problems can be solved best when police and community work together. This collaboration between civilians and officers has successfully decreased drug-related crime. The Office of Community Oriented Policing Services (COPS) advances policing of anti-drug actions at the street level. It has funded the addition of over 105,000 community police officers to the beat. The COPS Office supports three drug-related grant programs: (1) a Methamphetamine Initiative that combats production, distribution, and use (2) the COPS Technology Program, which runs the Southwest Border States Anti-Drug Information System; and (3) the Distressed Neighborhood Pilot Project in eighteen cities that face particularly high crime rates. More than thirty COPS grants have been awarded to twelve thousand law enforcement agencies, cornering 87 percent of the country.

Organized Crime Drug Enforcement Task Forces (OCDETF)

One of most effective way to attack sophisticated drug-trafficking organizations and attendant criminal activity — like money laundering, corruption, violence, organized crime, and tax evasion — is through coordinated, inter-agency task-forces. Accordingly, the Department of Justice calls upon the OCDETF program, with its nine federal law-enforcement agencies, to employ a wide range of expertise in disrupting and dismantling drug-trafficking organizations. The collaboration between law enforcement and U.S. Attorneys, as well as state and local district attorneys and attorneys general, plays an integral part in OCDETF's fight against drug traffickers. In 1998, OCDETF initiated 1,356 investigations with 2,447 indictments returned (more than double the number during the previous two years combined, with a 41.6 percent increase in indictments). In 1999, 1,487 OCDETF investigations were initiated, and 8,479 convictions were secured. Again during FY 2000, 1,400 OCDETF investigations were opened to target the drug trafficking organizations that threaten our nation and our neighborhoods.

Weed and Seed

Operation Weed and Seed is a strategy — rather than a grant program — which aims to prevent and reduce violent crime, drug abuse, and gang activity in targeted high-crime neighborhoods across the country. It is an innovative and comprehensive multi-agency approach to law enforcement, crime prevention, and community revitalization. Present in 250 sites across the nation under the leadership of U.S. Attorneys, this strategy brings together city, state, and federal officials as well as members of the community and the private sector. The elements of the Weed and Seed Strategy include law enforcement; community policing; prevention, intervention, and treatment;

and neighborhood restoration. The High Point, NC Community Against Violence Initiative and the several initiatives of Operation Weed and Seed in Austin, TX. In Highpoint, the initiative uses six components requiring a close relationship between law enforcement and the community to reduce drug trafficking in neighborhoods. Since 1997 the number of gang and drug-related homicides have decreased by 100 percent; criminal homicides by 69 percent; criminal homicides committed with a gun by 82 percent; and robberies and assaults with firearms by 48 percent. In Austin, TX the Broadmoor and Cameron initiative resulted in the first gang injunction lawsuit ever filed in Texas. Additionally in Operation Crackdown twenty-six dealers were arrested and prosecuted from the Weed and Seed area.

Anti-Money Laundering Initiatives

The success of drug-traffickers and organized crime is dependent on the ability to launder billions of dollars derived from illicit activities. Through money laundering, the criminal transforms illegal proceeds into funds with a seemingly legal source. This process can have devastating social and economic consequences. Criminals manipulate financial systems in the United States and abroad to promote a wide range of illicit activities. Left unchecked, money laundering can erode the integrity of financial institutions, cause greater volatility in foreign exchange markets, destabilize economies, place honest businesses at comparative disadvantage, undermine public trust, erode democratic institutions, and breed violence. Many agencies like the Department of the Treasury, the Department of Justice, the Postal Inspection Service, federal regulators, and state and local law enforcement agencies help protect specific sectors of the financial system that are most vulnerable to financial criminal activity. [34]

In light of the threat to national security concerns posed by money laundering, Congress passed the Money Laundering and Financial Crimes Act of 1998, which calls for the development of a five-year anti-money laundering strategy. The Departments of the Treasury and Justice developed the first National Money Laundering Strategy in 1999 and followed with the second NMLS in March 2000. The Strategy contains over sixty action items to help law enforcement and regulatory agencies in the fight against financial crimes including the money laundering.

Some key elements of the year 2000 NMLS include:

- The designation of High Intensity Financial Crime Areas (HIFCAs) that target financial crimes
- The development of legislation that would provide the Secretary of the Treasury with new discretionary authorities to crack down on foreign jurisdictions, institutions or classes of transactions that pose a serious money laundering threat
- The implementation of rules applying to suspicious activity reporting (SARs) requirements beyond depository institutions
- The continued identification of countries that pose serious threats due to their lack of action against money laundering.

In response to these goals, the National Money Laundering Strategy for 2000 announced the designation of New York/Northern New Jersey, the Los Angeles Metropolitan Area, San Juan, Puerto Rico, and the Southwest Border Area,* as High Intensity Financial Crime Areas (HIFCAs). HIFCAs focus on underlying criminal activities associated with money laundering and apply resources to counteract such crime. Overseen by a joint DOJ/Treasury committee of enforcement personnel, additional applications for HIFCAs are anticipated in 2001 as the program grows.

Because money laundering is not confined to designated HIFCA areas, Treasury Secretary Lawrence Summers and Attorney General Janet Reno issued a joint memorandum to U.S. Attorneys and federal law-enforcement field offices throughout the country, communicating the importance of money laundering enforcement and emphasizing steps to be taken. Key to this directive was the establishment of task forces to analyze information from financial institutions' Suspicious Activity Reports (SARs). The 2000 NMLS was augmented through the Financial Crime-Free Communities Grant Program. The C-FIC Program will fund state and local law-enforcement agencies to detect, prevent, and suppress money laundering and related financial crimes. Such grants are designed to help communities marshal information and expertise to build innovative approaches to money laundering control and enforcement. On October 26, 2000, Secretary Summers announced the first C-FIC grants, totaling $2.35 million, that were awarded to nine state and local law-enforcement agencies.

* The Southwest Border functional HIFCA specifically focues on bulk cash movements.

Banks are required to report financial activity they suspect involves funds derived from criminal activity.[35] This information is placed in a secure database co-owned by the primary bank and credit union regulators and administered by the Treasury Department. High priority has been given to problems raised by criminal abuse of financial service providers known collectively as "money services businesses" (MSBs). Measures to extend mandatory suspicious reporting requirements to other financial service providers, including money service businesses like money-wire transmitters, "*casas de cambio*," and sellers of money orders and travelers' checks continue to move forward. In August 1999, FinCEN issued regulations that will require the registration of all MSBs. MSBs must register with the Treasury Department by December 2001 and submit SARs beginning in January 2002. FinCEN launched a national education campaign targeting affected businesses. Eventually, reporting suspicious transactions will be required of casinos, brokers, insurance companies, travel agencies, and securities dealers.

DOJ's Special Operations Division (SOD) formed a Money Laundering Section comprised of senior agents and analysts from Customs, DEA, FBI, and IRS and supported by attorneys from the Justice Department's Criminal Division. This section will coordinate drug-related money laundering and financial investigations conducted by federal, state, and local law enforcement in coordination with United States Attorneys' offices. The section is designed to target and investigate foreign and domestic drug-trafficking organizations and their money laundering elements.

The U.S. Customs Service's Money Laundering Coordination Center (MLCC) is another example of interagency collaboration in money laundering. The MLCC, which is housed and supported by FinCEN, was created in 1997. With agents and analysts from USCS, IRS, OFAC, and USPS, the MLCC serves as a repository for all intelligence information gathered through undercover money laundering investigations and functions as a coordination center for domestic and international undercover money laundering operations. Plans are underway to expand MLCC's partnership with other federal agencies in the coming year. In addition, the Treasury Department created the National Center for State and Local Enforcement Training, located at the Federal Law Enforcement Training Center (FLETC) in Glynco, GA, to share federal experience, resources, and expertise in fighting money laundering.

Enhancing Asset Forfeiture

The Departments of Justice and Treasury use asset forfeitures to attack the economic infrastructure of drug-trafficking organizations and money laundering enterprises. Both strategically integrate this tool into an overall enforcement plan to strike traffickers at the source of power. Asset forfeiture is part of the department's Southwest Border Initiative. "Operation Kids" in Puerto Rico resulted in defendants being found liable for the forfeiture of $4.1 million in drug-related assets.

All federal law-enforcement agencies incorporate seizure and forfeiture of assets belonging to narcotics organizations as an integral part of their attack on narcotics organizations. The goal is to deny a criminal organization the wherewithal to continue operations and thus ensure its dismemberment. Federal, state, local, and foreign law-enforcement agencies follow the "money trail" wherever it may lead. From 1989 through December 2000, the Department of Justice-administered international asset sharing program has shared $168,439,888 with foreign governments who cooperated and assisted in investigations. In a joint investigation of the largest and longest-operating Thai marijuana smuggling group in Oregon, IRS-CI, USCS, DEA, and Swiss authorities were able to seize $11.7 million from a single drug trafficker. In FY 1999, IRS-CI alone confiscated in excess of $80 million and, through the Treasury Asset Forfeiture Fund, shared $19.5 million with foreign, federal, state, and local agencies. The Equitable Sharing Program encourages law-enforcement cooperation by dividing forfeiture proceeds among agencies that participated in the investigation.

Preventing Chemical Diversion

Chemicals are crucial for manufacturing most illicit drugs. In response to the rise in methamphetamine lab seizures, DOJ approved a plan targeting "rogue" chemical companies that knowingly supply precursors to methamphetamine producers. The plan combines law-enforcement action, regulatory reform, and outreach to the legitimate chemical industry through conferences sponsored by the Attorney General. Between 1997 and 1999, tightened DEA and U.S. Customs regulatory and import controls have prevented the diversion of 192 million tablets of ephedrine — enough to make nearly 17,000 pounds of pure methamphetamine (at a 60 percent conversion rate). Additionally, DEA cooperation with major chemical producing countries between 1998

and October 2000 blocked 343 metric tons of ephedrine and pseudoephedrine imports capable of producing over 200 metric tons of methamphetaime.

Targeting some of the nation's largest chemical trafficking organizations, U.S. Customs and DEA executed Operation Mountain Express in August 2000. This initiative resulted in 189 arrests in eight U.S. cities and the seizure of $8 million and twelve and a half metric tons of pseudoephedrine tablets, as well as eighty-three pounds of methamphetamine along with processing labs and chemical solvents. As part of this plan, DEA sponsored several national meetings in 2000 for prosecutors; senior law-enforcement management; and federal, state, and local investigators. These gatherings were designed to improve investigation and prosecution of chemical traffickers.

Drugs and Crime on America's Public Lands

Of 1.9 billion acres that constitute the total land within the United States, about 716 million acres (approximately 38 percent) are under the jurisdiction of federal land-management agencies. One of the most worrisome trends in connection with these public lands is the rise of drug-related crime and violence. The Department of the Interior (DOI) and the Department of Agriculture's Forest Service (USDA, FS), National Drug Intelligence Center, and state and local agencies all warn of sharp increases in drug cultivation, production, and trafficking on America's public and tribal lands.[36]

Stepped-up law enforcement and eradication in urban and rural areas have forced traffickers into the seclusion of more remote, thinly patrolled parks and forests. Vast areas of public land constitute some of the country's most active drug trafficking and production regions, including half of the 2000-mile Southwest border and nearly eight hundred miles of the U.S.-Canadian border. At the Arizona-Mexico border, the Department of the Interior has seen a 700 percent increase in smuggling over the last three years. Organized drug trading on America's public lands threatens the safety of visitors, residents, and employees.

From the mid-1980s to mid-1990s, marijuana plots discovered on public lands rarely exceeded several hundred to a few thousand plants. However, the extent and size of many gardens has grown significantly since then. In 1997 land management authorities discovered a seventy thousand-plant garden, which had been managed, operated, and protected by criminals linked to a major drug organization based in Mexico. Since this seizure, marijuana cultivation has risen steadily on public lands. In Arizona, authorities seized twenty thousand marijuana plants in one garden on public land. In 1999, land management agencies destroyed 900,320 marijuana plants. Preliminary reports show that 630,000 marijuana plants have already been eradicated from National Forest System (NFS) lands in the first nine months of 2000.

Methamphetamine producers also have settled on public land, which provides seclusion from law enforcement as well as convenient dumpsites for chemical by-products. In 1998 and 1999, law enforcement agencies reported more than five hundred clandestine labs found on public lands. Already in 2000, USDA's Forest Service reported three hundred laboratories or dumpsites located on or near the Mark Twain National Forest in Missouri.

Federal public lands in the proximity of our borders with Mexico and Canada are being used as corridors for smuggling drugs and illegal immigrants. DOI and Forest Service personnel seize tons of marijuana and other drugs each year. Ironically, pressure by other agencies patrolling private holdings along the Southwest border moves smuggling activities on to federal land. Illegal cross-border traffic inexorably follows the path of least resistance and highest pay-off. Where interdiction is least likely to occur, a high volume of contraband will be concentrated.

Land management agencies have witnessed a sharp increase in crime and violence associated with the marijuana and methamphetamine trade. One of the more glaring incidents occurred in the summer of 2000 when a father and son, while hiking through the El Dorado National Forest in California, were shot and seriously injured by an armed trafficker who was protecting his marijuana plot. Reports have also been made of intimidation by drug dealer of park visitors and residents. In the Coronado National Memorial, for instance, National Park Service employees and their families are under nearly constant surveillance by scouts working for marijuana drug trafficking organizations who are protecting drug-related activities. On numerous occasions, smugglers have confronted visitors and federal employees with threats, shootings, beatings, robberies, and rapes.

The danger to the environment and wildlife is another aspect of this problem. Marijuana cultivators have poached wildlife and poisoned considerable public acreage with pesticides and herbicides. Methamphetamine producers are dumping large quantities of chemicals

that negatively affect the soil, watersheds, and vegetation. Land management authorities point out the immediate threat of forest fires that could be ignited by precursor chemicals or toxic fumes that also threaten emergency personnel. In the Southwest, smugglers have destroyed fences and built roads that cross the border into our parks and public lands. In doing so, they have destroyed our natural resources and left tons of trash in their wake.

Policing crime on 525 million acres of Department of Interior lands is the job of 4,650 federal law enforcement officers[37] from the Bureaus of Indian Affairs and Bureau of Land Management, the National Park Service, and the U.S. Fish and Wildlife Service. USDA's Forest Service has 586 law-enforcement personnel to manage 191 million acres. In the last year, one of the top priorities of land management law-enforcement agencies has been to raise public and Congressional awareness of the emerging drug trade on America's lands, associated violence, and the resources needed to contain it.

Intelligence Sharing

Intelligence gleaned from the collection of information must be shared in order to reduce cultivation, production, trafficking, and distribution of illegal drugs. Cooperation in the use of strategic and operational intelligence is critical for combating the drug problem. Tactical intelligence is time-sensitive, and it contributes to arrests and drug seizures. Agencies must be able to share relevant data across jurisdictional boundaries without compromising intelligence or the operations related to it. The U.S. Marshal Service has pursued several information-sharing initiatives with a view toward interagency cooperation. This past year, the USMS became the first federal law-enforcement agency to share all its automated criminal intelligence with other agencies on the Anti-Drug Network (ADNET).

Under the authority of the Border Coordination Initiative (BCI), personnel from the U.S. Customs Service, Immigration and Naturalization Service, and Border Patrol have joined Intelligence Collection Analysis Teams along the Southwest border to gather and disseminate tactical intelligence. DOJ's Regional Information Sharing System is a network of centers that process intelligence on drug trafficking, violent crime, gang activity, and organized crime. In FY 1999, this network contributed to the arrest of 4,160 individuals and the seizure of drugs valued at $104 million. The HIDTA program has established Information Support Centers in designated areas specifically to create a communication infrastructure that can facilitate information-sharing between federal, state, and local law-enforcement agencies. Additional developments in counterdrug intelligence sharing are discussed in Section Five of this chapter.

ONDCP's Counterdrug Technology Assessment Center

Technology can play a dramatic role in combating drug-related crime. Law-enforcement agencies increase their effectiveness by integrating technology and coordinating 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 drug-control technology research and development organization. It coordinates the activities of twenty federal agencies. It identifies short, medium, and long-term scientific and technological needs of drug-enforcement agencies — including surveillance; tracking; electronic support measures; communications; data fusion; and chemical, biological, and radiological detection. It also works with the National Institute on Drug Abuse (NIDA) to apply technology and expand the effectiveness or availability of drug-treatment research.

Technological development supports law-enforcement by improving capabilities for drug detection, communication, and surveillance. An array of operational tests and activities are conducted to evaluate off-the-shelf and emerging technology prototypes for use in the field. In 1998, Congress authorized a Technology Transfer Program (TTP) for CTAC to provide advanced equipment developed by federal agencies to state and local law-enforcement. From FY 1998 through FY 2000, 1,808 pieces of equipment were delivered to 1,325 state and local law-enforcement agencies in all fifty states under the TTP. The program was successful in rapidly delivering technologies and training to approximately 9 percent of the 16,600 police departments and sheriffs' offices in the country over this three-year period.

For the past five years, brain-imaging technology development projects that exploit advances in Positron Emission Tomography (PET), functional Magnetic Resonance Imaging (fMRI), and Magnetic Resonance Spectrometry for drug-abuse research have been developed with institutions like NIDA's Intramural Research

Program, Brookhaven National Laboratory, Massachusetts General Hospital, Emory University, University of Pennsylvania, University of California at Los Angeles, and Harvard University/McLean Hospital. Each of these institutions have world-class medical research teams that have agreed to conduct research on drug abuse and addiction with the new equipment. They will be training other professionals specializing in drug-abuse research to increase knowledge in this field.

The companion volume to this annual report — *Counterdrug Research and Development Blueprint Update* — reviews CTAC's research agenda in support of efforts to reduce the availability and abuse of drugs. It also assesses the effectiveness of federal technology programs aimed at improving drug-detection capabilities used in interdiction and at ports-of-entry.

Law Enforcement's Ability to Keep Pace with Trafficker Technology

Technology is reshaping the nature of crime, particularly in U.S. and international drug trade. Federal law-enforcement agencies report that traffickers are turning increasingly to the Internet and other forms of wireless technology to protect, expand, and enhance criminal activity.

Internet technology provides drug traffickers with immediate and anonymous communication which, coupled with encryption, makes it difficult for law enforcement to penetrate criminal organizations. Consequently, law-enforcement agencies are being drawn into new areas of digital evidence, analysis, and investigations, which are placing ever-increasing demands on their attempt to keep pace with criminal technology.

Law-enforcement agencies are trying to conduct drug investigations in a technological environment that is constantly changing. They are developing and sharing advanced technology as well as cooperating in ways that will help them respond to digital technology being used by drug traffickers. Agents, officers, and analysts must be trained and retrained in digital and Internet investigations along with computer forensics. Law-enforcement entities like the FBI, Customs, DEA and Special Operations Division have initiated training programs to help their investigators and analysts penetrate criminal communications.

Law-enforcement officers are also cooperating in new ways to leverage their combined resources and expertise. The FBI, for instance, has invited the DEA to participate in research and development of communications intercept technology, an effort that has directly contributed to federal drug investigations.

Law-enforcement agencies anticipate an even greater technological leap in the global drug trade. Just as telephone communication has been the cornerstone of drug conspiracy investigations, the DEA expects that the Internet, digital evidence, and dual-use technology will become central to virtually all complex drug investigations.

Targeting Gangs and Violence

The Department of Justice, its Criminal Division, the USCS, DEA, FBI, USMS, and U.S. Attorneys, along with their state and local counterparts, are focusing on identifying, disrupting, and dismantling criminal gangs. The most effective tools available include federal racketeering statutes, federal, and state narcotics and weapons laws, and collaborative multi-agency task forces. DOJ's Anti-Violent Crime Initiative, which targets gangs and violent crime, has made substantial impact on communities across the country.

The DEA and FBI lead federal efforts against violent street gangs that are becoming increasingly involved in drug trafficking. The FBI's National Gang Strategy is a framework for combating such violence in America. Supporting this strategy is the FBI's Safe Streets Task Forces (SSTF), which confront violent crime and lend assistance to state, county, and local law enforcement. The task forces, comprised of FBI agents, state and local officers, and other federal personnel, concentrate long-term investigations on the most violent crimes and the apprehension fugitives. Since the program's introduction in 1992, SSTFs have been responsible for the arrest of 185,000 violent fugitives, a great many of whom were linked to illicit drug trafficking.

In 1995, DEA launched the Mobile Enforcement Team (MET) program to assist state and local police in combating the problem of drug-related crime and gang violence. As of September 30, 2000, there were 272 DEA agents assigned to METs, established in all but one domestic field office. Since the program's inception, a total of 287 METs have deployed across the country which resulted in 11,283 arrests. In fiscal year 2000, the DEA offered community mobilization and drug-demand reduction training to cities that requested it.

The Bureau of Alcohol, Tobacco, and Firearms (ATF) targets armed drug traffickers through the Armed Violent Criminal Apprehension Program, International Trafficking in Firearms, the Youth Crime Gun Interdiction Initiative (YCGII), and the Integrated Violence Reduction Strategy (IVRS). These programs are aimed at reducing crime and violence, much of it drug-related. The ATF also conducts Gang Resistance Education and Training (G.R.E.A.T.) in schools. Specially trained agents and officers deliver anti-violence and anti-gang information to students. In Fiscal Year 1999, 4,400 law-enforcement personnel nationwide taught approximately 334,443 children. Since 1992, 2.5 million children received G.R.E.A.T. instruction.

DOJ's Office of Justice Programs (OJP) provides state and local agencies with resources to combat gangs and drugs. In 1994, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) launched its Comprehensive Response to America's Youth Gang Problem. This initiative included: 1) the development of the National Youth Gang Center to collect and disseminate information to local communities; 2) the implementation of a comprehensive response to youth gang violence; 3) an evaluation of the model programs implemented; 4) training and technical assistance to local communities dealing with youth gang problems; and 5) targeted acquisition and dissemination of youth gang resources. The program, implemented with technical assistance and training support from the National Youth Gang Center, directly involves police (gang unit and patrol), probation (juvenile and adult), schools, community-based youth serving agencies, street outreach entities, grassroots (including faith-based organizations), community members, youth, prosecutors, judges, and others.

In 1998, OJJDP launched its Rural Gang Initiative (RGI) to provide rural communities experiencing gang problems with the opportunity to implement this unique approach to the gang problem. In 2000, OJJDP — in partnership with the Department of Health and Human Services, Department of Education, and the Department of the Treasury — launched a major new initiative to expand this initiative.

Equitable Sentencing Policies

The Administration supports revision of the 1986 federal law that 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 within our criminal justice system. In fact, 90 percent of people convicted on crack-cocaine charges are African American. Second, harsher penalties for crack possession compared to powder have resulted in long incarceration for low-level crack dealers instead of increased apprehension of middle and large-scale cocaine traffickers.

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 sentence would be reduced from five hundred to two hundred and fifty grams while the amount of crack cocaine required to trigger the same sentence would increase from five grams to twenty-five 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.

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 suffers. By revising the inequitable sentencing structure for powder versus crack cocaine, the Administration intends to restore overall respect for the law and foster a more effective division of responsibility between law-enforcement authorities.

State Drug Laws

State laws are an important vehicle for translating the concepts in the *National Drug Control Strategy* into action. The *Strategy's* policies are embodied within a tangible legislative framework with which state policymakers shape policies and laws. With this goal in mind, Congress in 1988 mandated the creation of a bipartisan commission to develop state drug laws. The resulting President's Commission on Model State Drug Laws drafted forty-four drug and alcohol laws and policies covering enforcement, treatment, education, prevention, intervention, employment, housing, and community issues.

Since 1996, the Commission's non-profit successor — the National Alliance for Model State Drug Laws — has been conducting state model law workshops. These workshops brought together hundreds of diverse participants on the state level who recommended more than a hundred pieces of drug and alcohol legislation, programming, funding, and coordination initiatives. With these recommendations, state and local leaders have adopted new statutes, formed more effective multi-disciplinary partnerships, and streamlined legislative and programmatic applications.

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

Borders delineate the sovereign territories of nation-states. Guarding our country's 9,600 miles of land and sea borders is one of the federal government's most fundamental responsibilities — especially in light of the historically open, lengthy borders with our northern and southern neighbors. The American government maintains three hundred ports-of-entry, including airports where officials inspect inbound and outbound individuals, cargo, and conveyances. All are vulnerable to the drug threat. By curtailing the flow of drugs across our borders, we reduce drug availability throughout the United States and decrease the negative consequences of drug abuse and trafficking in our communities.

In FY 2000, more than eighty million passengers and crew members arrived in the United States aboard commercial and private aircraft. Some eleven million came by marine vessels and 397 million through land border crossings. People entered America on 211,000 ships; 971,000 aircraft; and 139 million trucks, trains, buses, and automobiles. Cargo arrived in fifty-two million containers. This enormous volume of movement makes interdiction of illegal drugs difficult.

Even harder is the task of intercepting illegal drugs in cargo shipments because of the ease with which traffickers can switch modes and routes. Containerized cargo has revolutionized routes, cargo tracking, port development, and shipping companies. As the lead federal agency for detection and monitoring, the Department of Defense provides support to law enforcement agencies involved in counter-drug operations. A recent study by the Office of Naval Intelligence indicated that over 60 percent of the world's cargo travels by container. Moreover, vessels carrying as many as six thousand containers — which have the ability to offload cargo onto rail or trucks at various ports-of-entry and then transport it into the heart of the United States — further complicate the interdiction challenge. Drug-trafficking organizations take advantage of these dynamics by hiding illegal substances in cargo or secret compartments. False seals have been used on containers so shipments can move unimpeded through initial ports-of-entry. The United States Customs Service seized more than 1.5 million pounds of illicit drugs in FY 2000 — an 11 percent increase over the previous year.[38] To counteract this threat, the federal government is constantly seeking new technologies which, together with capable personnel and timely intelligence, facilitate a well-coordinated interdiction plan responsive to changing drug-trafficking trends.

Organizing Against the Drug Threat

The U.S. Customs Service has primary responsibility for ensuring that all cargo and goods moving 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 shares responsibility for stemming the flow of illegal drugs into the United States via the air and sea. It accomplishes this mission by detecting and apprehending drug-smuggling aircraft and vessels trying to enter the country. The Customs' Air and Marine Interdiction Division provides seamless twenty-four-hour radar 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 detection sensors. In fiscal year 2000, Customs seized 1,442,778 pounds of marijuana, cocaine, and heroin — a 10.1 percent increase over seizures in FY 1999. In addition, Customs has deployed over forty non-intrusive inspection systems as part of its Five-Year Technology Plan. These systems allow for the advanced detection of narcotics and other contraband in various cargo containers, trucks, automobiles, and rail cars.

Such technology has been deployed to ports of entry along the southern tier of the U.S. where it assisted in the seizure of over 180,000 pounds of drugs in the past 3 years.

The U.S. Border Patrol specifically focuses on drug smuggling between land ports of entry. In FY 1998, the USBP seized 395,316 kilograms of marijuana, 10,285 kilograms of cocaine, and fourteen kilograms of heroin. In addition, this agency made 6,402 arrests of suspected traffickers.

The Coast Guard is the lead federal agency for maritime drug interdiction and shares responsibility for air interdiction with the U.S. Customs Service. As such, the Coast Guard plays a key role in protecting our borders. Coast Guard air and surface assets patrol over six million square miles of transit zone that stretches from the Caribbean Basin to the eastern Pacific Ocean. In FY 2000, the Coast Guard set a record for the second consecutive year by seizing 132,920 pounds of cocaine — a 19 percent increase over FY 1999. This success has been a result of the service's Campaign Steel Web counterdrug strategy, intelligence, and deployment of non-lethal technologies to counter go-fast smuggling boats. All the armed forces provide support to law-enforcement agencies involved in drug-control operations, particularly in the Southwest border region.

Drug Trafficking Across the Southwest Border

In FY 2000, 293 million people, eighty-nine million cars, four-and-a-half million trucks, and 572,000 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 come across the Southwest border. Illegal drugs are hidden in all modes of conveyance — car, truck, train, and pedestrian. The success that the Border Patrol and Customs have had at and around ports of entry (through innovative enforcement strategies and physical security improvements) have forced smugglers to move through the vast open spaces between official border crossing points. Approximately, fifty percent of the border with Mexico is under the jurisdiction of the federal land management agencies, almost all of that in rugged, remote areas with limited law enforcement presence. Drugs cross the 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. Operators of ships find gaps in U.S./Mexican interdiction coverage and position drugs close to the border for eventual transfer to the United States. Small boats in the Gulf of Mexico and eastern Pacific seek to deliver drugs directly to the United States. Whenever possible, traffickers try to exploit incidences of corruption in U.S. border agencies. It is a tribute to the vast majority of dedicated American officials that integrity, courage, and respect for human rights overwhelmingly characterize their service. Rapidly growing commerce between the United States and Mexico complicates the attempt to keep drugs out of cross-border traffic. Since the Southwest border is currently the most porous part of the nation's periphery, we must mount a determined effort to stop the flow of drugs there. At the same time, we cannot concentrate resources along the Southwest border at the expense of other vulnerable regions because traffickers follow the path of least resistance and funnel drugs to less defended areas.

Five principal departments — Treasury, Justice, Transportation, State, and Defense — are concerned with drug-control issues along the Southwest border. These agencies have collaborated in six drug-control areas: drug interdiction, anti-money laundering, drug and immigration enforcement, prosecutions, counter-drug support, and counter-drug cooperation with Mexico. During the past decade, the federal presence along the Southwest border expanded. Customs' budget for Southwest border programs increased 72 percent since FY 1993. The number of assigned DEA special agents increased 37 percent since FY 1990. DoD's drug-control budget for the Southwest border increased 53 percent since FY 1990. The number of U.S. attorneys handling cases there went up by 80 percent since FY 1990. The Southwest Border Initiative enabled federal agencies to coordinate intelligence and operational assignments at Customs, DOJ's Special Operations Division, HIDTA, and state and local law-enforcement agencies.

The United States Coast Guard plays a critical role in protecting the maritime flanks of the Southwest Border. Operations *Border Shield* and *Gulf Shield* protect the coastal borders of Southern California and along the Gulf of Mexico from maritime drug smuggling with USCG air and surface interdiction assets. The Coast Guard operations are coordinated, multi-agency efforts that focus on interdiction to disrupt drug trafficking.

All Borders

We must stop drugs everywhere they enter our country — through the Gulf Coast, Puerto Rico, the U.S. Virgin Islands, Florida, the northeastern and northwestern United States, and the Great Lakes. The vulnerability of Alaska, Hawaii, and the U.S. territories must also be recognized. Florida's location, geography, and dynamic growth will continue to make that state particularly attractive to traffickers for the foreseeable future. Florida's six hundred miles of coastline render it a major target for shore and airdrop deliveries in the 1980s. The state is located astride the drug-trafficking routes of the Caribbean and Gulf of Mexico. 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 drug rings. To varying degrees, Florida's predicament is shared by other border areas and entry points.

The Department of Justice's Southern Frontier Initiative focuses law enforcement on drug-trafficking organizations operating along the Southwest border and the Caribbean. *Operation Trinity* resulted in 1,260 arrests, including eight hundred members of the five largest drug syndicates in Mexico and Colombia. DOJ's Caribbean Initiative substantially enhanced its counterdrug capabilities in this region, with more law-enforcement agents, greater communications, and improved interception. A major element of the Coast Guard's comprehensive multi-year strategy (Campaign Steel Web) is "Operation Frontier Shield," which focuses on disrupting maritime smuggling routes into and around Puerto Rico and the U.S. Virgin Islands.

U.S. Seaports

Criminal activity, including the illegal importation of illicit drugs and the export of controlled commodities and drug proceeds, with a nexus to U.S. seaports is a serious problem. In response to the threat that such activities pose to the people and critical infrastructures of the United States and its seaport cities, the Interagency Commission on Crime and Security in U.S. Seaports was created by Executive Memorandum in April 1999. The Commission's report, released in August 2000, provides an overview of criminal activity and security measures at the seaports; an assessment of the nature and effectiveness of ongoing coordination among federal, state, and local governmental agencies; and gives recommendations for improvement.[39]

Organizing for Success

The problems law-enforcement officials face in connection with illegal drugs 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. The Interdiction Committee (TIC), led by the Commissioner of U.S. Customs and comprised of the leads of drug-law enforcement agencies, is working on a review of coordination among federal agencies responsible for anti-drug operations.

Recently, a separate review of the counterdrug intelligence architecture concluded that clear, consistent inter-community and interagency coordination is essential. To this end, the General Counterdrug Intelligence Plan (GCIP) strengthened the El Paso Intelligence Center.

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 is helping to create integrated border management to improve the effectiveness of this joint effort. It emphasizes increased cooperation to support the interdiction of drugs, illegal aliens, and other contraband while maintaining the flow of legal immigration and commerce. BCI plans call for:

- **Port Management –** A Customs and INS Port Management Model that will streamline enforcement, traffic management, and community partnership at each of the Southwest border's twenty-four POEs.
- **Investigations –** A unified strategy for SWB seizures that capitalizes on investigative operations and the dissemination of intelligence to enhance inspections.
- **Intelligence –** Joint Intelligence Collection Analysis Teams (ICATs) — comprised of personnel from Customs, Immigration and Naturalization, and the Border Patrol — gather and disseminate tactical intelligence in regard to drug interdiction, illegal aliens, money laundering, and document fraud.
- **Technology –** A joint plan to capitalize on future technological advances while making better use of existing capabilities.

- **Communications –** Inter-operable, secure, mutually supportive, wireless communications through coordinated fielding, user training, compatible systems, and shared frequencies. USCS is already 100 percent secure with over-the-air re-keying and is working to achieve total voice privacy with the Border Patrol and all other participating agencies.
- **Performance –** Measurement Implementation of measures for the amount of illegal drugs seized and the number of aliens apprehended in Southern California, Arizona, West Texas/New Mexico, and South Texas. The intent is to implement measurements for the twenty four BCI areas and to tie performance to action plans in order to provide a basis for analysis of smuggling trends and the impact of enforcement actions.
- **Integrity –** Customs and INS are structuring the framework for this initiative. Most border crossing locations are currently conducting random lane swaps, lane denial, and integrity training. This core initiative also provides for proactive, joint efforts to prevent integrity violations by law-enforcement officers.
- **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 help 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 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 230,000 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. Intelligence-based information systems provide Customs inspectors with information on suspicious shipments. Customs P-3 aircraft are used as airborne test platforms for military and commercial sensor equipment with counterdrug applications. The U.S. Customs Service is also deploying advanced non-intrusive inspection technologies developed in conjunction with Department of Defense and CTAC to inspect luggage, cars, and shipments from pallet-sized items to large marine containers for concealed drugs at ports of entry. A dedicated breeding program for substance-detecting canines was based upon a cooperative effort with Australian Customs. Canines derived from this program are being placed at key ports-of-entry.

Technology can also help prevent trafficking between ports-of-entry. Over the past two years, efforts have concentrated on finding technological solutions to meet the needs of the "street-level" officer. These technologies provide improved communications, surveillance, and drug-crime information that makes the law-enforcement missions more effective and safe.

Advanced non-intrusive inspection concepts employing gamma ray and neutron technologies have been developed to detect illegal drug shipments concealed within containerized cargo entering the United States. These technologies, along with new ones still being designed in research laboratories will improve our ability to search conveyances and cargo for hidden drugs at ports-of-entry.

Other smaller-scale inspection tools include flashlight-size ultrasonic instruments to detect concealed drugs in liquid-filled tanks, hand-held gamma-based anomaly detectors that an officer can use to identify false compartments in walls or automobiles, canine-breeding strategies that improve substance detection capabilities, and self-contained substance identification kits that fit in an officer's jacket pocket.

Information-sharing networks with case-management tools and data-mining software have been developed and tried in strategic geographic areas throughout the United States. Advanced tracking and surveillance systems have been deployed that can integrate crime and case-related information correlated on a single display with real-time positional data. Miniaturized surveillance and undercover communications devices have been developed in conjunction with federal law enforcement agencies and are now being deployed for use by state and local agencies as part of the Technology Transfer Program.

Review of Counterdrug Intelligence Architecture

In 1997, the Director of ONDCP, the Attorney General, the Director of Central Intelligence, supported by the Secretaries of Defense, Transportation, and State, commissioned a White House Task Force to review the global U.S. counterdrug intelligence system. The work of this Task Force culminated on February 14, 2000, when the President approved the *General Counterdrug Intelligence Plan* (GCIP).

In the eight months since the President's acceptance of the GCIP, drug control agencies moved swiftly to implement the Plan's recommendations in six critical areas:

- **National Counterdrug Intelligence Coordination** – The Counterdrug Intelligence Coordinating Group (CDICG) and its full-time staff, the Counterdrug Intelligence Executive Secretariat (CDX), were created under the GCIP to coordinate implementation of action items contained in the GCIP, promote coordination between the National Centers with counterdrug responsibility, and resolve multi-jurisdictional issues. The CDICG has met six times to oversee the drafting, clearance, and publication of the GCIP; establish the CDX infrastructure; and promote intelligence sharing within the federal counterdrug community. Among its accomplishments, the CDX and CDICG approved new guidelines for information release and security involving foreign liaison officers assigned to the Joint Inter-Agency Task Forces (JIATFs).
- **National Centers** – The GCIP calls for improved coordination and elimination of unnecessary duplication among drug intelligence centers and refines the mission of each:
  - *National Drug Intelligence Center* – NDIC is responsible for the production of domestic strategic counterdrug analysis for use in crafting national policy and by law-enforcement decision-makers.
  - *El Paso Intelligence Center* – EPIC is charged with the production of operational and investigative intelligence.
  - *Financial Crimes Enforcement Network* – FinCEN focuses on the strategic analysis and reporting of domestic and international money laundering and financial crimes, in addition to its money laundering investigative support to law enforcement for both drug and non-drug related investigations.
  - *DCI Crime and Narcotics Center* – CNC's charter addresses the need for foreign strategic counterdrug intelligence by national decision-makers.
- **Regional, State, and Local Cooperation** – The GCIP seeks to consolidate drug intelligence resources and improve information sharing among federal, state, and local agencies. The programs at the center of this effort are the Organized Crime Drug Enforcement Task Force, DEA's and FBI's State and Local Task Forces, DEA's Special Operations Division, HIDTA Investigative Support Centers (ISC), and DOJ-funded Regional Information Sharing Systems (RISS) Centers.
- **Foreign Coordination –** The GCIP works to enhance drug-intelligence cooperation between foreign nations and the U.S. In 2000, information sharing and operational support initiatives were undertaken with many foreign governments, including Austria, Canada, Germany, Great Britain, Australia, Mexico, China, Thailand, and numerous Latin American and Caribbean nations.
- **Analytic Personnel Development and Training** – The GCIP emphasizes the importance of the analyst in the drug-intelligence process. Issues such as basic hiring qualifications, analyst career progression, mobility, promotion, standardized training, mentoring, and continuing professional education are now being addressed for the first time among drug-intelligence agencies. Progress in this area is evidenced by the placement of numerous additional personnel and Supervisory Intelligence Analysts throughout the counterdrug intelligence architecture.
- **Information Technology** – Technology is a tool which can be utilized to increase the timely dissemination of

information and intelligence. As such, the GCIP is working to develop a technical architecture which provides appropriate data security and maximum connectivity between drug-intelligence producers and consumers.

6. REDUCING THE SUPPLY OF ILLEGAL DRUGS

Since 1993, the United States has emphasized that supply reduction is an essential component of a well-balanced strategic approach to drug control. When illegal drugs are readily available, the likelihood increases that they will be abused. Supply reduction has both international and domestic components. The vast majority of illicit drugs used in the United States are produced outside of our borders. Internationally, supply reduction includes working with partner nations within the source zones to reduce the cultivation and production of illicit drugs through drug-crop substitution and eradication; alternative development and strengthening public institutions; coordinated investigations; interdiction; control of precursors; anti-money laundering initiatives; and building consensus through bilateral, regional, and global accords. Within the United States, supply reduction entails regulation (through the Controlled Substances Act), enforcement of anti-drug laws, eradication of marijuana cultivation, control of precursor chemicals, and destruction of illegal synthetic drug laboratories within our borders.

Breaking Cocaine Sources of Supply

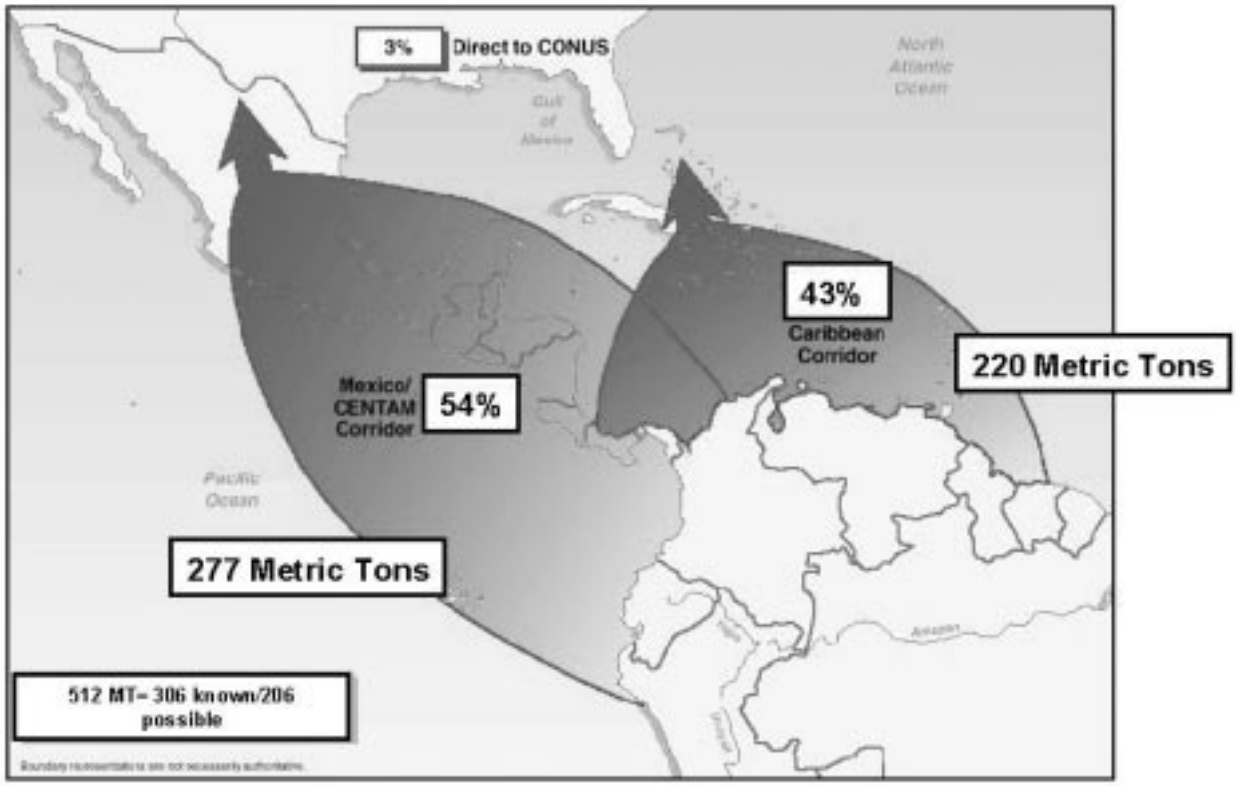
Coca, the raw material for cocaine, is grown primarily in the Andean region of South America. Dramatic successes in Bolivia and Peru have been tempered by the continued expansion of coca cultivation in southern Colombia. Despite more than doubling of the coca crop in Colombia between 1995-1999, successes in the rest of the Andes have helped reduce global cultivation by 15 percent.[40] Although crop estimates for 2000 have yet to be finalized, preliminary indications suggest increases in crop production in southern Colombia that may offset eradication efforts and reduced cultivation in Bolivia and Peru.

Bolivia has achieved remarkable counternarcotics successes over the past half decade. The current Banzer administration achieved a 55 percent reduction in cultivation between 1995 and 1999. This achievement, which is the result of sustained eradication and law-enforcement efforts combined with extensive alternative crop development, reduced cocaine production in Bolivia from 255 metric tons in 1994 to seventy mts in 1999. Bolivia continues to make rapid progress towards its goal of complete elimination of all illicit coca production by the end of 2002. By the end of 2000, the Chapare region — once one of the world's major suppliers of this illegal drug — will probably cease to produce any commercial level of coca. From a high of 33,900 hectares of coca fields in the Chapare in 1994, the government eliminated all but a thousand hectares by November 2000. Bolivia plans to launch an eradication campaign, preceded by alternative-development programs, in the Yungas within calendar year 2001. As eradication efforts move from the Chapare to the Yungas, the government will leave sufficient forces to monitor the region and destroy any replanted fields. More importantly, USAID Bolivia is contributing to alternative-development programs, using both regular and supplemental budgets to turn farmers away from illegal coca in favor of other crops.

Amount of Coca Leaf Cultivated and Eradicated, 1994-1999 (hectares)

YEAR	BOLIVIA cultivated	COLOMBIA cultivated	PERU cultivated	BOLIVIA eradicated	COLOMBIA eradicated	PERU eradicated
1994	48,100	45,000	108,600	1,100	4,910	Not available
1995	48,600	50,900	115,300	5,490	8,750	Not available
1996	48,100	67,200	94,400	7,510	5,600	1,260
1997	45,800	79,500	68,800	7,000	19,000	3,460
1998	38,000	101,800	51,000	11,620	13,650	7,830
1999	21,800	122,500	38,700	15,350	43,246	15,100

Cocaine Flow: 1999



In addition to eradication and alternative development, the United States is helping Bolivia pursue an aggressive drug and chemical precursor-interdiction campaign. Increased success in the interdiction of smuggled substances, particularly in the Chapare region, has raised the price of many essential chemicals, forcing Bolivian lab operators to use inferior substitutes, recycled solvents, and a streamlined production process that virtually eliminates the oxidation stage. The result has been radically diminished drug purity to a record low of 47 percent. This development dramatically affected the marketability of Bolivian cocaine in Brazil and elsewhere.

A limiting factor in Bolivia's continued success against illegal coca cultivation will be the government's ability to work with the coca producers. In Fall 2000, government eradication efforts were beset by civil strife resulting in ten deaths and approximately a hundred injuries. Funnelling alternative-development aid to the Chapare and Yungas will likely determine whether the Banzer government is able to meet its eradication goals.

The government of **Peru** made enormous strides toward eliminating illegal coca cultivation in the past five years. Despite the rehabilitation of some previously abandoned coca fields, 24 percent of Peruvian coca was eliminated in 1999 with an overall reduction of 66 percent over the last four years. Contributing to this figure was a 1999 total of fifteen thousand fewer hectares under manual coca cultivation. Peru's counternarcotics alternative development program, working through a hundred local governments, seven hundred communities, and fifteen thousand farmers significantly strengthened the social and economic infrastructure in these areas and helped shift the economic balance in favor of licit activities.

In 2000, the government of Peru continued its eradication campaign for coca. The country hoped to eliminate some twenty-two thousand acres (nine thousand hectares) of coca. However, a deteriorating political situation increased discontent among coca growers in the Huallaga valley, and potential spillover from southern Colombia could affect the positive direction in Peru. In November 2000, growers in the central upper Huallaga valley conducted the biggest protests in a decade, slowed eradication efforts, and endangered Peru's ability to meet its eradication objectives. However, with sustained U.S. law enforcement, alternative development, interdiction assistance, and support for eradication, Peru will continue to reduce coca cultivation.

In **Colombia**, President Pastrana and his reform-minded government took office in August of 1998. Pastrana faced multiple challenges from the outset of his administration. Ongoing, inter-related crises in Colombia threaten U.S. national interests, including: stemming the flow of cocaine and heroin into the United States, support for democratic government and the rule of law, respect for human rights, promoting efforts to reach a negotiated settlement in Colombia's long-running internal conflict, maintaining regional stability, and promoting legitimate trade and investment.

Rapidly growing cocaine production in Colombia constitutes a threat to U.S. security and the well-being of our citizens. Ninety percent of the cocaine entering the United States originates in or passes through Colombia. Over the last decade, drug production in Colombia has increased dramatically. In spite of an aggressive aerial eradication campaign, Colombian cultivation of coca, the raw material for cocaine, has more than tripled since 1992. New information about the potency of Colombian coca, the time required for crops to reach maturity, and efficiency in the cocaine conversion process has led to a revision in estimates of Colombia's 1998 potential cocaine production from 165 metric tons to 435 metric tons. The 1999 figures indicate that both the number of hectares of coca under cultivation and the amount of cocaine produced from those crops continue to skyrocket. Colombian coca cultivation rose 20 percent to 122,500 hectares in 1999; there was a corresponding 20 percent increase in potential cocaine production to 520 metric tons. Left unchecked, these massive increases in drug production and trafficking could reverse gains achieved over the last four years in Peru and Bolivia. Continued expansion of drug production in Colombia is likely to result in more drugs being shipped to the United States.

President Pastrana's "Plan Colombia" and the U.S.-Colombia Initiative

In the fall of 1999, the Pastrana government developed an integrated strategy, Plan Colombia, which recognizes that solving Colombia's inter-related problems will require significant action on a variety of fronts. Plan Colombia focuses on five strategic issues:

1. The peace process.
2. The Colombian economy.
3. The counterdrug strategy.
4. Reform of the justice system and protection of human rights.
5. Democratization and social development.

These five planks reflect a program that addresses Colombia's most severe problems. At the core is an effort to achieve peace through dialogue and strengthen democratic institutions while increasing the government's capacity to carry out policy initiatives. Repairing the economy will make the Colombian people better able to provide for themselves and decrease the attraction of the drug trade and other illicit activities. Breaking up the drug-trade infrastructure would reduce the threat of corruption, promote legitimate economic development, remove a principal source of support from illegal armed groups, and help make the negotiating table a more attractive setting for conflict resolution than the battlefield. Decreasing the scale of the internal conflict also could facilitate reform of the justice system and improvements in human rights.

The government of Colombia estimates that implementing *Plan Colombia* will cost about $7.5 billion over the next six years. To execute the plan, Colombia is committed to spending $4 billion of its own resources and loans from financial institutions. The Pastrana government is asking the international community to provide the remaining $3.5 billion in bilateral foreign assistance. To date, the United States, Norway, Spain, Japan, and the United Nations have pledged significant support for President Pastrana and *Plan Colombia*. The United States will continue to support Colombian efforts to obtain more funding from the international community, especially in the areas of economic and social development. A European Union donors conference is scheduled for March 2001 to discuss support for Colombia.

The U.S. initiative involves $1.3 billion in assistance carefully crafted to respond to the urgent needs of Colombia and the region. This package provides $442 million for southern Colombia, $465.7 million for Colombian and regional interdiction support, $116 million for the Colombian National Police, $174 million for alternative economic development, and $122 million to promote respect for human rights and Colombia's power to govern. The *Colombia Initiative* supplements ongoing U.S. counterdrug programs of $330 million for fiscal years 2000 and 2001.

By assisting the government of Colombia in implementing the rule of law in drug-producing regions, we are helping to decrease drug production and trafficking and diminish the corrosive influence of drug-related corruption. Hemispheric programs aimed at reducing drug supply before it reaches the United States have produced an estimated 18 percent drop in the amount of cocaine available worldwide over the last four years. That progress and our national interests are at risk in the face of the 140 percent increase in Colombian coca production since 1995.

The Use of Mycoherbicides[41]

Mycoherbicides focus on agricultural-related targets — in this case illicit coca cultivation — using fungal biological control agents in place of chemical herbicides. The reliance on naturally-occurring agents means that mycoherbicide technology involves no genetic engineering or alteration. In this regard, mycoherbicides are potentially cheaper and environmentally safer than chemical herbicides.

The research, development, and potential application of mycoherbicides in a narcotics-control context mirrors the way mycoherbicides are being used to control pests, promote agricultural development, and advance environmentally sound integrated pest management worldwide. So far, the testing of mycoherbicides to control coca has been limited to laboratory research and field testing in the U.S. Nevertheless, results have been promising. Tests have identified a mycoherbicide that attacks only coca plants, kills them, and does not spread to other hosts. This organism has been proven effective and, from environmental and health-safety perspectives, both host and area-specific.

The government of Colombia and the U.N. International Drug Control Program (UNDCP) are discussing potential cooperation to test a biological-control agent that could be used against illicit coca plants. The U.S. allocated $3 million to the U.N. in fiscal year 1999 to help fund these tests. Coca cultivation and processing pose serious hazards to Colombia's ecology. Several hectares of rain forest are slashed and burned for every hectare of coca planted. For each hectare of coca grown and processed into cocaine, farmers and traffickers — with little respect for the environment — dump an estimated two tons of pesticides, fertilizers, and toxic processing chemical waste into Colombia's soil, streams, and rivers.

The proposed test in Colombia would use only mycoherbicides that occur naturally in Colombia. No exogenous biological control agents would be used. The project calls for the creation of an international panel of experts to design and approve the final research program. An international consultant, working with a project manager from the implementing agency in Colombia, would monitor the experiments' progress.

The United States is funding several million dollars worth of complementary research to identify and develop safe and effective biological controls to combat pests that plague cacao, bananas, coffee, and other alternative development crops to replace narcotics production.

Breaking Heroin Sources of Supply[42]

The U.S. heroin problem is supplied entirely by foreign sources of opium. Efforts to reduce domestic heroin availability face significant problems. Unlike cocaine, where the supply is concentrated in the Andean region of South America, heroin available in the United States is produced in four distinct parts of the world: South America, Mexico, Southeast Asia, and Southwest Asia. Worldwide potential heroin production was estimated at 287 metric tons in 1999.

Latin America has emerged in recent years as the primary supplier of heroin to the United States. Colombian and Mexican heroin comprises 65 and 17 percent respectively of the heroin seized today in the United States[43] The heroin industry in Colombia is still young and growing. Reports of some opium poppy fields surfaced in the mid-1980s, but not until the early 1990s was any significant cultivation confirmed. By the mid-1990s, the Colombian heroin industry was producing enough high-purity white heroin to capture the U.S. East Coast market. Between 1995 and 1998, opium production in Colombia was sufficient to support more than six metric tons of heroin annually. In 1999, however, increased culti-

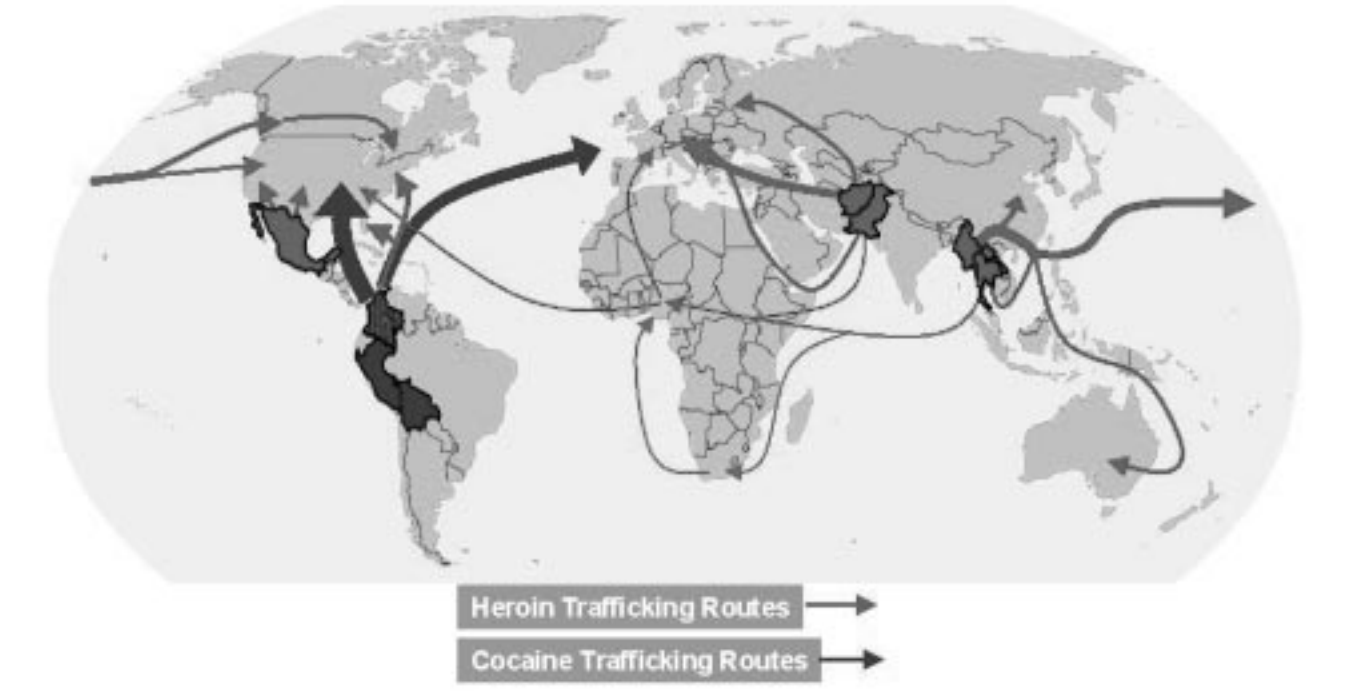
vation resulted in a larger crop, increasing potential heroin production to nearly eight metric tons.[44]

Today, the Colombian heroin trade closely mirrors the heroin industry in Mexico rather than operations in Southeast or Southwest Asia. Heroin processing labs in Colombia operate on a small scale; heroin production is not dominated by large, well-armed trafficking organizations; there are no multi-hundred-kilogram internal movements of opiate products; and Colombian traffickers rarely attempt to smuggle large shipments of heroin into other countries. Like the Mexican industry, the heroin trade in Colombia services the U.S. market almost exclusively. Production of heroin is more fragmented, with smaller trafficking groups playing a major role. Individual couriers smuggle heroin into the United States daily in small, single-kilogram amounts. In addition, Colombia's heroin industry — like Mexico's — must cope with significant government opium-poppy eradication.

Significant diversion of the essential precursor acetic anhydride suggests that Colombian traffickers are prepared to increase heroin production. In 1999, about ninety-six metric tons of acetic anhydride — six percent of Colombia's legal imports of this chemical for pharmaceutical use — were hijacked or stolen after arriving in Colombia. The illegal diversion of acetic anhydride in 1999 alone would be enough to meet heroin production requirements for the next three to five years.

Low-level opium-poppy cultivation in Venezuela and even more limited growing in Peru currently serve only marginal heroin production but could become the foundation for an expanding opium and heroin industry beyond Colombia. Opium-poppy cultivation in Venezuela is limited to the mountains opposite Colombia's growing area and appears to be a spillover from cultivation on the Colombian side of the border. Since 1994, when a thousand hectares of opium poppy were discovered during a joint U.S.-Venezuelan aerial reconnaissance mission, Caracas has conducted periodic eradication operations that reduced the size of the annual crop to fewer than fifty hectares. The cultivation, harvesting, and processing of Venezuela's poppy crop is done primarily by Colombians who access the growing area from Colombia. Many of the farmers arrested by Venezuelan authorities for growing opium are Colombian nationals. The Venezuelan side of the border is readily accessible from trails and unimproved roads originating in Colombia.

Global Trafficking



Reports indicate that opium poppy cultivation in Peru over the last several years is nearly negligible. However, the seizure of more than fifty kilograms of opium by police in 1999 suggests that opium production in Peru may be heading for commercial levels. In Peru, Colombian backers provide farmers with poppy seeds, teach processing methods, and buy Peruvian opium; most of the opium produced in Peru is reportedly shipped to Colombia. While the cultivation pattern in Peru is similar to that in Colombia, so far there has been no widespread deforestation as there was in Colombia when opium-poppy cultivation virtually exploded.

An intensification of eradication efforts in Colombia significant enough to reduce opium production might spur increased cultivation in Peru and Venezuela. Both governments, however, appear committed to preventing opium cultivation from becoming a significant problem. Successful elimination of opium-poppy cultivation in Venezuela will depend, to a large extent, on Colombia's ability to suppress cultivation on its side of the border and for both Bogota and Caracas to control the mountainous region where Colombian guerrillas operate on both sides of the border. The prospects for significant increases in opium production would be greater in Peru if cultivation were firmly established there because the growing areas are isolated and nearly inaccessible to authorities, making large-scale eradication more difficult.

With long-established trafficking and distribution networks and exclusive markets for black tar and brown powder heroin, Mexico's hold on the U.S. heroin market in the West seems secure. Mexico grows only about two percent of the world's illicit opium, but virtually the entire crop is converted into heroin for the U.S. market. Despite significant historical production in Mexico, local consumption of opium and heroin has never been more than marginal. Unlike in the far larger source countries of Southeast and Southwest Asia, opium-poppy cultivation in Mexico — as in Colombia — occur year-round because of the favorable climate. With a hundred-day growing cycle, single opium fields in Mexico can yield up to three crops per year although the size and quality of the plants typically depends on seasonal variations. The largest crop is generally achieved in the relatively mild and wet months of December through April. Mexican officials report that many growers are planting new varieties of opium poppy in an effort to increase opium yields.

Opium cultivation and production in Mexico have been relatively stable through most of the 1990s. Between 1993 and 1998, according to the U.S. government's annual imagery-based crop survey, Mexico's opium harvest averaged fifty-four metric tons, allowing Mexican traffickers to produce five to six metric tons of heroin annually. In 1999, a drought in the best growing season reduced opium cultivation and stunted opium-poppy growth in many of the fields where plants reached maturity.

Poppy-crop eradication is the primary constraint against increased opium production. The Mexican Army's manual eradication effort, using more than twenty-thousand soldiers on any given day, is responsible for roughly 75 percent of the eradicated crop each year. The Attorney General's Office (PGR) destroys about one-quarter of the eradicated crop through helicopter aerial fumigation. However, a lack of roads and infrastructure in the remote growing areas makes manual and spray operations difficult and dangerous. Moreover, counterinsurgency operations and disaster-relief missions in recent years overburdened military personnel and may have caused the transfer of some personnel away from eradication efforts. However, this change does not seem to have had an appreciable impact on overall eradication efforts. The combination of drought and eradication decreased Mexico's heroin production to slightly more than four metric tons in 1999.

Historically, most of the world's illicit opium for heroin has been grown in the Golden Triangle of Southeast Asia. Burma alone has accounted for more than half of all global production of opium and heroin for most of the last decade. In the absence of sustained alternative crop-substitution programs and consistent narcotics crop-eradication efforts (except in Thailand), only weather fluctuations have had a significant impact on opium-poppy cultivation and production. Major droughts in 1994, 1998, and 1999 caused the region's opium production to plummet.

No other country surpasses Burma in terms of hectares of opium cultivation. However, crop yields are much lower than those in Southwest Asia. Consequently, even if normal weather conditions were to again prevail in Southeast Asia, Burma would not challenge Afghanistan as the world's leading source of heroin. Although the Burmese government showed both a willingness and capability to ban poppy cultivation in areas under its control the last two years, authorities refrain from entering prime opium-growing areas controlled by ethnic Wa insurgents.

In Thailand, aggressive eradication and crop-substitution programs have reduced opium production to less than one percent of the region's total. Thailand is now a net importer of opium to meet its addicts' demands. Without a meaningful eradication effort of its own and with little change in the status of UN-supported crop-substitution projects, Laos remains the world's third-largest producer of illicit opium. Opium production in that country was less affected by drought than was Burma. Laos accounted for about 12 percent of Southeast Asia's opium production in 1999, as compared to less than 10 percent through most of the 1990s.

The profitability of growing opium poppy as a cash crop and the lack of resources or commitment by regional governments to implement crop substitution, alternative development, or eradication are key factors that predict a significant rebound in opium production within Southeast Asia. The remote location and rugged terrain of poppy-growing areas in Burma and Laos are major obstacles to establishing crop-substitution programs. The lack of a transportation infrastructure in most opium-producing regions further complicates crop substitution because farmers have difficulty moving alternative crops to distant markets. Opium buyers, by contrast, typically come to the farmer, saving him a long trek to the nearest village or city. Although significant efforts by transit countries over the past led to the seizure of large amounts of heroin, the key to curbing heroin production and trafficking in Southeast Asia lies with the source countries — particularly Burma.

The explosive growth of opium production and development of an imposing opiate-processing infrastructure in Afghanistan during the 1990s made Southwest Asia the world's leading source of heroin. While Southwest Asian heroin is unlikely to penetrate much of the American market share anytime soon, the region's drug trade significantly affects U.S. strategic interests — including political stability and counterterrorism — in that volatile region. In 1999, Southwest Asia produced an estimated 2,898 metric tons of opium, compared to 1,236 metric tons in drought-stricken Southeast Asia. Afghanistan, whose estimated opium production increased 22 percent from 2,390 metric tons in 1998 to 2,861 metric tons, was solely responsible for Southwest Asia becoming the world's leading source of heroin. By comparison, opium production in Pakistan — the region's other source country — declined by half for the second consecutive year to thirty-seven metric tons.

In the coming decade, additional progress is achievable if governments can cordon off growing areas, increase their commitment, and implement counternarcotics programs. U.S.-backed crop-control programs reduced illicit opium cultivation in Guatemala, Mexico, Pakistan, Thailand, and Turkey. Both Colombia and Mexico have aggressive heroin-control programs. Mexico has destroyed between 60 and 70 percent of the crop each year for the past several years. In Colombia, some eight thousand hectares of poppies were fumigated from the air in 1999. However, little progress is likely if the ruling Taliban in Afghanistan doesn't commit to narcotics control. In Burma, the future is also uncertain as long as the country fails to muster the political will to make in-roads against the opium cultivation in areas ruled by the Wa Army.

The United States continues to help strengthen law-enforcement in heroin source countries by supporting training programs, information sharing, extradition of fugitives, and anti-money laundering measures. In addition, America 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.

Countering the Spread of Synthetic Drugs

Methamphetamine – Like cocaine, methamphetamine is a potent central nervous-system stimulant. According to the Drug Enforcement Administration, "meth" represents the fastest-growing drug threat in the U.S. today. The 1999 National Household Survey on Drug Abuse estimated that 9.4 million Americans have tried methamphetamine. This figure shows a marked increase from the 1994 estimate of 3.8 million people.

International Methamphetamine Trafficking – In FY 1999, the U.S. Customs Service seized 41 percent of the total methamphetamine confiscated by all federal agencies and 2,872 pounds of the drug in FY 2000, an indication of the threat international methamphetamine trafficking poses to the United States. According to the DEA, well-organized manufacturing and trafficking groups based in Mexico are the primary source of this illicit drug.[45] Over the past several years, established drug trafficking organizations — based in Mexico and California — took control of approximately 85 percent of the methamphetamine trade. The principal reasons for this new dominance is the exploitation by these organizations of existing, well-established transportation and distribution networks on both sides of the border as well as their abil-

ity to secure large quantities of precursor chemicals. These drug-trafficking organizations have revolutionized the illegal methamphetamine business by operating large-scale laboratories in Mexico that are capable of producing unprecedented amounts of methamphetamine. Because methamphetamine is a synthetic drug created from a mixture of chemicals, traffickers based in Mexico need not rely on other nations to provide coca or finished cocaine for distribution. In addition, fewer controls on precursor chemicals exist in Mexico and overseas than in the United States, a fact that encourages the organizations to produce high purity methamphetamine in clandestine laboratories within Mexico. Methamphetamine organizations based there have developed international connections with chemical suppliers in Europe, Asia, and the Far East, and with these connections, they have been able to obtain large shipments of ephedrine and pseudoephedrine needed to manufacture both methamphetamine and amphetamine.

According to the El Paso Intelligence Center, the amount of methamphetamine seized annually in transit from Mexico to the United States has increased dramatically since 1992. Authorities confiscated 560 kilograms of methamphetamine along the border in 1998, compared with only 6.5 kilograms in 1992. Customs seizures of methamphetamine increased roughly 20 percent in FY 2000, mostly along the Southwest border.

In August 2000, the DEA indicated that it was optimistic about chemical-control efforts which, when combined with aggressive law-enforcement, have been the catalyst for decreases in methamphetamine purity. In the past year, several DEA offices in the Midwest and California reported that the purity of Mexican methamphetamine had dropped significantly. Many law-enforcement agencies in the Midwest and California note that the previous high purity (80 percent + range) of Mexican methamphetamine has dropped to less than 30 percent. Information provided by DEA indicates that nationally, the average purity for methamphetamine decreased from 71.9 percent in 1994 to an average of 31.1 percent in 1999.

Domestic Methamphetamine Production – Because meth production and trafficking used to be concentrated in the West and Southwest United States — particularly California, Arizona, Utah, and Texas — availability and abuse were (and still are) higher in those areas. In fact, most methamphetamine in the U.S. is still produced in large clandestine laboratories in California. However, along with increased international production, the growth of independent domestic laboratories dramatically increased the availability and abuse of meth in the Pacific Northwest, Midwest, and some portions of the Southeast, particularly Georgia, Tennessee, and surrounding states. There is also evidence that meth production and availability are beginning to spread to Mid-Atlantic states like Virginia, and even as far north as New England. In 1998, meth labs were found for the first time in New Jersey, Delaware, and Massachusetts.

Methamphetamine labs and dumpsites on federal public and tribal lands are creating a significant safety risk for the visiting public and Department of Interior and Department of Agriculture/Forest Service employees. In addition, toxic chemicals, pesticides, and fertilizers are negatively affecting soils, vegetation, watersheds, and wildlife. In CY 2000, over 300 labs and dumpsites were taken off of the Mark Twain National Forest in Missouri alone. This is in comparison to 107 found nationwide on National Forest System (NFS) lands in CY 1999.

Land management agencies typically discover small labs run by individuals. Producers are utilizing the back of pickup trucks, small recreation trailers, tents, abandoned buildings, old mine shafts, cabins, house boats and open fields to produce methamphetamine. In at least one instance, a wild land fire was attributed to the explosion of such a lab on NFS lands in Illinois in October 2000. By using rural areas that are difficult to patrol by law enforcement agencies, the drug producers have reduced the possibility of apprehension and arrest. The proliferation of these small, highly mobile clandestine laboratories will continue to increase the incidents of violence and environmental damage from hazardous materials on our public lands.

The 1996 *National Methamphetamine Strategy* (updated in May 1997) remains the basis for the federal response to this problem. Supporting it is 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. Most recently, President Clinton signed the Methamphetamine Anti-Proliferation Act of 2000, which effectively equalized penalties for amphetamine and methamphetamine and directed additional funds toward drug treatment and law enforcement. The legal sales threshold for all such over-the-counter products not packaged in blister packages or

certain liquids will be lowered to nine grams per transaction in the first quarter of FY 2002. As an adjunct to the National Methamphetamine Strategy, the Attorney General issued a Methamphetamine Precursor Chemical Strategy in October of 2000. This strategy commits the Department of Justice to continued enforcement operations and tighter regulations that apply to listed chemicals.

Clandestine Drug Laboratory Cleanup Activities – Cleaning up a seized clandestine drug laboratory is a complex, dangerous, expensive, and time-consuming task. The amount of waste material and chemicals taken from such a site varies from a few pounds to several tons depending on the size of the operation and its manufacturing capability. The chemicals required to manufacture illegal drugs and their by-products include toxic, flammable, corrosive, unstable, reactive, and (in some cases) radioactive substances. These materials are responsible for numerous fires and explosions as well as the contamination of homes, apartments, motels, streams, lakes, septic tanks, and roadways.

Since 1991, DEA has had a program in place to respond to and assist law enforcement in the removal of dangerous wastes. This program helps to ensure officer safety and the proper disposal of hazardous materials at proper facilities. Additionally, property owners, environmental agencies, and health departments are alerted to potential threats as a result of contamination incidents. The average cost per DEA site cleanup has declined from $17,000 in FY 1991 to less than $4,000 in FY 2000. This decline is due to improvements in contracting procedures and services. The average cost to state and local agencies for an illegal laboratory cleanup has increased from $2,300 in FY 1998 to $3,400 in FY 2000 due to the proliferation of larger, more complex clandestine manufacturing sites.

Ecstasy – With the scientific name 3,4-Methylenedioxymethamphetamine (MDMA), Ecstasy is a Schedule I drug under the Controlled Substance Act (CSA). This drug is a synthetic, psychoactive substance possessing stimulant and mild hallucinogenic properties. MDMA can produce stimulant effects like an enhanced sense of pleasure, self-confidence, and increased energy. Its hallucinogenic properties include feelings of peacefulness, acceptance, and empathy. Users claim they experience closeness with others and a desire to touch. Consequently, the MDMA user has embraced the misconception that it is relatively safe.

However, various researchers have shown that this drug can cause serious health problems and, in some cases, death. Used in combination with alcohol, MDMA and others of the so-called "club drugs" become even more dangerous. The long-term psychological effects of MDMA can include confusion, depression, sleep problems, anxiety, and paranoia.

The ecstasy market in the United States is supplied by Western European-based drug traffickers. MDMA is clandestinely manufactured in Western Europe, primarily in the Netherlands and Belgium. An estimated 90 percent of MDMA distributed worldwide is produced in these countries. While a few MDMA labs have been discovered in the United States, the skills and sophisticated equipment needed to manufacture the drug are likely to prevent widespread domestic production like methamphetamine. In recent years, Israeli Organized Crime syndicates — some composed of émigrés associated with Russian Organized Crime syndicates — have forged relationships with Western European traffickers and gained control over a significant share of the European market. Moreover, Israeli syndicates remain the primary source for U.S. distribution groups. The increasing involvement of organized crime signifies the "professionalization" of the MDMA market. These organizations are capable of producing and smuggling significant quantities of MDMA from source countries in Europe to the United States. Their distribution networks are expanding from coast to coast, enabling a relatively few organizations to dominate MDMA markets nationwide.

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. Federal officials estimate that more than one-half of the domestically produced marijuana is grown on America's federal public lands. In recent years, the size of individual gardens has expanded from a few hundreds of plants, to gardens with gardens containing more than 20,000 marijuana plants. The DEA-coordinated Domestic Cannabis Eradication and Suppression Program provides support to state and local law-enforcement agencies. In FY 1998, this program contributed to the seizure of more than 2.5 million marijuana plants, of which more than one third were seized on federal public lands. In calendar year 200, over 630,000 plants were eradicated from National Forest System lands alone.

The Department of the Interior and Department of Agriculture/Forest Service are deeply concerned about marijuana cultivation on the 716 million acres of public and tribal lands and the increasing violence associated with it. As illegal producers invest larger sums of money in their crop, they undertake greater efforts to protect their gardens.

Recognizing that successful domestic cannabis eradication must be supported by information about the acreage of illegal drug cultivation, Congress directed the Secretary of Agriculture in 1998 to submit to the Director of the Office of National Drug Control Policy an annual assessment of illegal drug cultivation in the United States.[46] The detection of cannabis from aerial platforms remains a problem due to difficulty in developing spectral signatures unique to cannabis. This problem is primarily due to the high degree of genetic heterogeneity of illicit cannabis as well as the general practice of concealing small plots within agricultural plantings, e.g. corn, or on public lands. Because the land under cultivation is often small, satellite imagery is not a viable option. Despite these difficulties, the Agricultural Research Service — in cooperation with NASA and the Naval Systems Weapons Laboratory — made progress in developing hand-held sensors for deployment in helicopters.

Interdiction Operations

The U.S. government designs coordinated interdiction operations that anticipate shifting drug-trafficking patterns. These integrated actions are led by the two Joint Inter-Agency Task Forces (JIATF-East based in Key West, Florida and JIATF-West in Alameda, California) that coordinate source and transit zone activities; the Customs' Air and Marine Interdiction Coordination Center (in Riverside, California) 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. The Interdiction Coordinator, responsible for deploying U.S. assets committed to international interdiction, is the Commandant of the U.S. Coast Guard.

JIATF-East counterdrug air detection and monitoring missions are carried out from a number of bases in the continental United States and the Caribbean. Assets

previously based out of Howard Air Force Base, Panama are now operating from three forward operating locations in the Caribbean and South America.

In November 1999, the U.S. government concluded a long-term agreement with Ecuador for use of an airfield in Manta. In March 2000, the United States concluded a long-term agreement with the government of the Netherlands for use of the twin airfields at Aruba and Curacao. Also in March 2000, we finalized an agreement with El Salvador for a forward operating location at Comalapa. All three are currently operational. There has been an increase in the total number of counterdrug detection and monitoring flight hours compared to the ones that previously originated from Howard Air Force Base. Facility upgrades at all these locations in FY 2001 will improve their capability, allowing for flexible source and transit zone operations.

Forward Operating Location Architecture

The closure of Rodman Naval Station in Panama had a significant effect on the cost of operations in the Eastern Pacific. This impact was further exacerbated by changes in cocaine flow that necessitated an increase in operational tempo within the region. International maritime support provided expeditionary forces that increased the number of operations adjacent to these high-threat drug trafficking routes.

The recently-signed bilateral maritime agreement made Costa Rica the obvious choice to initiate the first cooperative operations. The Coast Guard, working with the State Department, developed operating guidelines for the first counterdrug International Maritime Interdiction Support arrangement. Final concurrence for these guidelines was obtained in May of 2000 and the arrangement became operational in July of 2000.

This landmark pact will be the regional model for future negotiations. Maritime ports throughout the region will allow interdiction units to obtain reliable, short-notice fuel, provisions, and maintenance support while providing a staging area for incoming and outbound personnel. This initiative will increase law-enforcement effectiveness by increasing the amount of time ships spend "on-station" conducting interdiction operations. The Coast Guard will continue to work with the interagency and international partners to establish new agreements throughout Central America and develop a funding mechanism to reimburse cooperative states.

Operations in the Transit Zone

Drugs coming to the United States from South America pass through a six million square-mile transit zone roughly the size of the continental U.S. This zone includes the Caribbean, Gulf of Mexico, and eastern Pacific Ocean. The interagency mission is to reduce the supply of drugs from source countries by denying smugglers the use of air and maritime routes. In patrolling this vast area, U.S. federal agencies closely coordinate their operations with the interdiction forces of a number of nations. One example of such successful international cooperation is the U.S. Custom Service's Operation HALCON. Since 1990, this joint U.S.-Mexican operation involving USCS intercept aircraft stationed in Mexico and Mexican government apprehension aircraft has produced significant seizures and arrests. In FY 2000 alone, USCS air and marine interdiction assets participated in the seizure of 5,547 pounds of cocaine, 18,477 pounds of marijuana, 27 aircraft, two maritime vessels, and two vehicles in the transit zone.

Intelligence sources estimate that the annual cocaine flow through the Transit Zone is in excess of five hundred metric tons. Non-commercial maritime conveyances account for more than 80 percent of this transit zone flow. The largest challenge is the elusive, high-speed smuggling boat, or "go-fast." The number of go-fast boats involved in smuggling has increased substantially since 1995. Go-fasts accounted for the majority of known maritime smuggling during FY 2000. Such craft are small, very fast, nearly invisible to radar, and difficult to see in daylight. In the vast majority of cases, interdiction assets lack the speed required to intercept and board suspect vessels. The estimated success rate for go-fast deliveries is close to 90 percent. Until recently, the few successful go-fast interdictions have been either the result of mechanical failure on the part of the suspect vessel or intervention by other nations with a more liberal use of force policy. [47] The Coast Guard is acquiring new equipment and developing capabilities to use armed helicopters, over-the-horizon cutter boats, and non-lethal, vessel-stopping technologies (such as those employed in "Operation New Frontier") to address the go-fast threat.

Record Coast Guard seizures – Coast Guard interdiction efforts resulted in a record year for drug seizures, including 132,919 pounds of cocaine and 50,463 pounds of marijuana. Cocaine seizures surpassed the previous record set in FY 1999: 111,689 pounds.

Throughout the year 2000, the United States Coast Guard enjoyed an effective working relationship with the

Dutch Navy conducting counterdrug operations in the Transit Zone. Coast Guard Law Enforcement Detachments (LEDETs)have deployed aboard Dutch warships since 1994. However, cooperation reached a high point this year with two large cooperative seizures.

- On June 19, 2000, while embarked on HNLMS Van Galen, a Coast Guard LEDET seized 5,258 pounds of cocaine from F/V Paul (of Cape Verde registry) in the eastern Caribbean.
- On October 30, 2000, while embarked on HNLMS Van Galen, a Coast Guard LEDET seized 6,404 pounds of marijuana located onboard S/V Che Ca Che (of Colombia registry), seized the vessel, and detained the crew.

In addition, the U.S. Coast Guard pursued maritime interdiction cooperation initiatives with the Mexican Navy in 2000. This cooperation was instrumental in seizing over thirty thousand pounds of cocaine.

The Coast Guard's Campaign Steel Web continued its success in FY 2000. Under this broad Campaign, the USCG carried out multiple operations including: Frontier Shield, New Frontier, Frontier Saber, Border Shield, and Gulf Shield, all targeting maritime drug trafficking in the transit zone. In FY 2000, Operations Frontier Shield, Border Shield, and Gulf Shield resulted in the seizures of over twenty-three thousand pounds of illicit drugs.[48]

Stopping drugs in the transit zone involves more than intercepting drug shipments at sea or in the air. It entails denying traffickers safe haven in countries within the transit zone and preventing the corruption of institutions or financial systems that could launder profits. During the past year, U.S. law-enforcement agencies — in cooperation with partner nations in the Caribbean and in South America — have been successful in stemming the tide of drugs.

Operation Conquistador in the spring of 2000 was launched simultaneously in twenty-six Caribbean, South American, and Central American countries. Operation Conquistador illustrates what can be achieved through well-coordinated, multinational law-enforcement operations. The arrest of 2,331 individuals, seizure of fifty-five kilos of heroin, 4,997 kilos of cocaine, thirteen boats, 172 vehicles, $132,772 in U.S. currency, and the destruction of 4,274 acres of coca demonstrate the scope of this effort. The operation was highlighted by the expeditious exchange of information through the Unified Caribbean On-line Regional Network (UNICORN) throughout the twenty-six participating countries.

In August 2000, the Drug Enforcement Administration, the U.S. Customs Service, and the Joint Interagency Task Force-East (JIATF-East) concluded Operation Journey. This initiative involved a two-year, multinational effort against a Colombian drug transportation organization that used commercial vessels to haul multi-ton loads of cocaine to twelve countries, most in North America and Europe. The investigation resulted in the arrest of forty individuals, including the alleged leader of the maritime drug transportation organization, Ivan De La Vega, several of his subordinates, and the seizure of more than sixteen tons of cocaine over a two-year period.

International cooperation and assistance is an essential aspect of a comprehensive transit-zone strategy. The United States will continue working with other 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.

Targeting International Drug-Trafficking Organizations

Over the last decade, Latin American drug-trafficking organizations fundamentally changed the way they do business. A diverse group of smaller, specialized Colombian drug rings have emerged following the collapse of the Medellin and Cali cartels. The smaller suppliers in South America and the transportation groups in the Caribbean and Mexico filled the void left by the demise of the large cartels and expanded their roles in the international cocaine industry.

The increase in smaller suppliers, producers, and trafficking groups made targeting drug-trafficking organizations much more difficult. The sheer power, influence, and sophistication of these groups put them in a category by themselves. Whereas traditional Mafia families bribed officers and judges, today's international drug organizations corrupt entire institutions of government.

These traffickers model their operations on international terrorism. They maintain tight control of their workers through highly compartmentalized cell structures that separate production, shipment, distribution, money laundering, communications, security, and recruitment. Traffickers have at their disposal the most technologically advanced airplanes, boats, vehicles, radar, communications equipment, and weapons. They have also established vast counterintelligence capabilities and transportation networks.

Efforts to Control Precursor Chemicals

With the exception of cannabis, every illicit drug requires chemicals in order to be refined to its final form (e.g. the coca plant to cocaine, the poppy plant to heroin), or is purely the result of chemical synthesis (e.g. methamphetamine, MDMA, etc.). The strategy of chemical control offers several advantages as an adjunct to traditional law-enforcement measures. Chemical control offers a means of attacking illicit drug production and disrupting the process before the drugs have entered the market.

Law-enforcement agencies have increasingly acknowledged that chemical control is a critical element in the struggle against illegal narcotics and synthetic drugs. Because many legitimate industrial chemicals are also critical to the processing and synthesis of most illicitly produced drugs, preventing the diversion of these chemicals from legitimate commerce to illicit drug manufacturing is a difficult job.

Historically, chemicals critical to the production of cocaine are introduced into the Andean region through legitimate purchases by companies that are registered and licensed as chemical importers. Once in a country, the chemicals are diverted either directly from rogue importers or as a result of coercion on the part of drug traffickers. In response to stricter international controls, drug traffickers have increasingly been forced to divert the chemicals by mislabeling the containers, forging documents, establishing front companies, using circuitous routing, hijacking shipments, bribing officials, or smuggling products across neighboring borders.

Through the DEA, the United States plays a vital role in coordinating chemical-enforcement operations in Latin American countries that produce cocaine or serve as transit points for cocaine chemicals. *Operation Purple* is a DEA-driven international chemical control initiative aimed at disrupting the illicit manufacture of cocaine in the Andean Region by monitoring and tracking shipments of potassium permanganate (PP), the chemical oxidizer of choice for cocaine production. The cornerstone of the operation is the intensive PP tracking program aimed at identifying and intercepting diversion; identifying rogue firms and suspect individuals; gathering intelligence on diversion methods, trafficking trends, and shipping routes; and taking administrative, civil, and/or criminal action as appropriate. Critical to the success of this operation is the communication network that gives notification of shipments and provides the government of the importer sufficient time to verify the legitimacy of the transaction and take appropriate action. The effects of this initiative have been dramatic and far-reaching. *Operation Purple* has exposed a significant vulnerability among traffickers and has grown to almost thirty nations. Since its inception in April 1999, 597 shipments have been tracked, totaling sixteen million kilograms of PP. There have been thirty-five arrests reported during this operation, and fifty-one shipments seized or stopped, which accounts for 2.9 million kilograms of PP. Had this PP been used for processing cocaine, up to twenty-nine million kilograms of cocaine could have been created. DEA's Special Testing and Research Laboratory, through its Cocaine Signature Program, reports that the percentage of highly oxidized cocaine samples is now at an all-time low (8 percent) which may, in part, be a result of the intense international tracking of PP. *Operation Purple* is the first international chemical control initiative of its kind and has become the template for similar initiatives in the future.

Acetic anhydride, the most commonly used agent in heroin processing, is virtually irreplaceable. Among heroin source countries, only Mexico has indigenous acetic anhydride production capability, producing 87,000 metric tons in 1999 alone. All other heroin-producing countries must import large amounts of acetic anhydride. The diversion of this chemical to Colombian heroin laboratories is a continuing problem. In 1999, three major hijackings of tanker trucks of acetic anhydride in Colombia, totaling 95.9 metric tons, were sufficient to supply the Colombian heroin trade for the next five years. However, the largest markets for diverted acetic anhydride continue to be heroin laboratories in Afghanistan and Burma. Of particular note was a March, 2000 seizure of 72.8 metric tons of AA in Turkmenistan, en route to heroin laboratories in Afghanistan. Ton quantity shipments of diverted acetic anhydride are routinely seized by authorities in Uzbekistan, Turkmenistan, Kyrgyzstan, and Kazakhstan.

Operation Topaz, which is still in the initial stages of development, is an effort to develop an international strategy targeting acetic anhydride that will certainly include a monitoring program. DEA fully supports these efforts and already has implemented a comprehensive study to expand its knowledge of this chemical. If international consensus can be reached to deny drug traffickers access to acetic

anhydride, then tracking the movement of this chemical from production to end user can become a significant tool in the worldwide attempt to prevent its diversion.

In addition, DEA is proposing *Operation Acid Wash*, a special enforcement program targeting traffickers and brokers of illicitly obtained acetic anhydride. Such a program would enable DEA to support the criminal investigations targeting heroin production organizations.

The methamphetamine situation changed in the mid-1990s with the entrance of Mexican organized crime into production and distribution. A seizure of 3.5 metric tons of pseudoephedrine in Texas in 1994 revealed that Mexican trafficking groups were using a different method of making methamphetamine and the organization was actually doing so on an unprecedented scale, with potentially serious repercussions for drug abuse throughout the United States.

DEA has developed several strategies to deal with the methamphetamine chemical diversion threat. First, the agency instituted a series of special enforcement operations directed against chemical traffickers, including: *Operation Chemex* targeting Mexican criminal organizations involved in chemical diversion; *Operation Backtrack*, which attacked domestic distributors of precursor chemicals who knowingly sell their products to clandestine laboratory operators; and, most recently, *Operation Mountain Express*. To support enforcement operations, DEA has also embarked on a methamphetamine chemical action plan to tighten controls over these precursor chemicals.

Although many governments, encouraged by the success of *Operation Purple* are considering chemical tracking initiatives for other products, DEA recognizes that international tracking of chemicals alone cannot be successfully utilized for all drugs and chemicals. DEA is, however, currently involved in the development of a program to track those chemicals used in the manufacture of amphetamine-type stimulants. China, India, and the Czech Republic as well as Eastern Europe, Canada, and Mexico will most likely be involved in this initiative.

Since January 1999, DEA's Office of Diversion Control has blocked 163 U.S. chemical shipments totaling 490.2 metric tons and caused additional twelve shipments to be blocked by other countries. During this same period, there have been 73 seizures of methamphetamine-related chemicals in Mexico. In the past year and a half, there have been thirteen seizures of potassium permanganate in Latin America and thirty-eight stopped shipments around the world.

The thirty-five chemicals most commonly used in illicit drug production also have extensive industrial applications. For this reason, an important element in the U.S. drug-control policy is to insure that all countries have a flexible monitoring system that regulates the flow of precursor chemicals without jeopardizing legitimate commerce. The Multilateral Chemical Reporting Initiative, formulated with international consensus under U.S. leadership, encourages governments to exchange information on a voluntary basis in order to monitor international chemical shipments. Over the past decade, key international bodies like the Commission on Narcotic Drugs and the U.N. General Assembly's Special Session (UNGASS) have addressed the issue of chemical diversion in conjunction with U.S. efforts. These organizations raised specific concerns about potassium permanganate (a chemical essential in making cocaine) and acetic anhydride (a heroin precursor).

To facilitate the international flow of information about precursor chemicals, the United States through its relationship with the Inter-American Drug Control Abuse Commission (CICAD), continues to evaluate the use of precursor chemicals and assist countries in strengthening controls. Many nations still lack the capacity to determine whether the import or export of precursor chemicals is related to legitimate needs or illicit drugs. The problem is complicated by the fact that many chemical shipments are either brokered or transshipped through third countries in an attempt to disguise their purpose and destination.

In countries where strict chemical controls were put in place, illicit drug production has been seriously affected. For example, few of the chemicals needed to process coca leaf into cocaine are manufactured in Bolivia or Peru. Most are smuggled in from neighboring countries with advanced chemical industries or diverted from a small number of licit handlers. Increased interdiction of chemicals in Peru and Bolivia has contributed to a rise in samples with of lower quality, minimally oxidized cocaine. Bolivian lab operators are now using inferior substitutes (cement instead of lime, sodium bicarbonate for ammonia), recycled solvents (ether), and a streamlined production process that virtually eliminates oxidation in producing cocaine base. Some laboratories are not using sulfuric acid during the maceration state; consequently, less cocaine alkaloid is extracted from the leaf, producing less HCl. Heroin-producing countries similarly depend on supplies of acetic anhydride from the international market. This heroin precursor continues to account for the largest volume of internationally seized chemicals, according to the International Narcotics Control

Board. Since July 1999, there have been several notable seizures of acetic anhydride in Turkey (amounting to nearly seventeen metric tons) and in Turkmenistan (totaling seventy-three metric tons). These seizures alone indicate the need for expanded DEA training of local authorities in these and other countries targeted by illicit chemical traffickers.

International Money Laundering and Asset Forfeiture

The United States supports global efforts to disrupt the flow of illicit capital, track criminal sources of funds, forfeit ill-gained assets, and prosecute offenders. The Financial Action Task Force (FATF), formed by the G-7 Economic Summit in 1989, is dedicated to promoting anti-money laundering controls around the world. As a result, all members of the FATF have now criminalized money laundering and are working toward implementing a full range of international anti-money laundering standards. In June 2000, the FATF cited fifteen nations as Non-Cooperative Countries or Territories (NCCT). In July 2000, Treasury's Financial Crimes Enforcement Network (FinCEN) followed by issuing advisories on these jurisdictions to the U.S. financial community. The impact of these combined actions was immediately evident as new money laundering legislation was passed by seven of the named jurisdictions. Legislation is pending in several others. Further evidence that the international effort to combat money laundering is working is the voluntary adoption of Global Anti-Money Laundering Guidelines for Private Banking and the Wolfsberg Anti-Money Laundering Principles by twelve of the world's largest banks, including Citigroup, Inc. These guidelines will establish heightened "due diligence" and "know your customer" standards among these banks.

Efforts to build effective international cooperation encompass two major areas of activity: (1) establishing or strengthening countries' financial intelligence unit counterparts, and (2) facilitating the exchange of information among these institutions in support of anti-money laundering investigations. The United States has been working with the Egmont Group* to develop Financial Intelligence Units (FIUs), which receive, analyze, and (where appropriate) refer for prosecution suspicious transactions reported by financial institutions. There are now fifty-three FIUs in operation with more in the planning stages.

The operation of financial intelligence units (FIUs) may prove to be one of the most effective means for combating money laundering around the globe. This development provides a centralized mechanism for tracking criminal proceeds, collecting investigative data, and contributing to international cooperation by combating money laundering. Currently, FinCEN is working with Egmont member governments to share information through a secure Intranet.

During 2000, the governments of the United States, Colombia, Panama, Aruba and Venezuela signed a multilateral agreement to establish a working group of experts to study and make recommendations on combating trade-based money laundering. The Department of State's Bureau for International Narcotics and Law Enforcement Affairs coordinates and funds all U.S. government bilateral and multilateral anti-money laundering training in an effort to increase the number of countries engaged in this fight. All federal law enforcement agencies participate in this endeavor.

Counterfeiting is another threat that is on the rise. The United States Secret Service reports that approximately one-third of all counterfeit currency in circulation originates in Colombia. The established routes and distribution networks for counterfeit currency are being used increasingly for the funneling of currency into the U.S. economy. To combat this threat, the Secret Service has provided equipment and numerous forensic and investigative training seminars for Colombia's DAS, DIJIN, and armed services.[49]

The United States government is also attacking the financial networks of international drug trafficking organizations. In December of 1999, President Clinton signed into law the Foreign Narcotic Kingpin Designation Act, which established a global program targeting the activities of narcotics traffickers. The act provides a statutory framework for the President to institute sanctions against foreign drug kingpins in order to deny their front organizations access to the U.S. financial system and benefits from U.S. trade. Once locked out of American trade, criminal organizations have difficulty participating in open commerce. On June 1, 2000, President Clinton named twelve foreign nationals as drug kingpins, and the Treasury Department's Office of Foreign Assets Control

* The Egmont Group of FIUs, is an international body formed in 1995 to increase the effectiveness of FIUs across national borders, cooperate through information exchange, and reach out to other nations that are starting to develop anti-money laundering programs.

(OFAC) took actions to block all assets and payments belonging to these kingpins and their associated entities.

In response to the goals of the *National Money Laundering Strategy for 2000*, U.S. law enforcement has identified and targeted major money laundering organizations in the United States that attempt to move illicit drug proceeds internationally. Additional scrutiny is needed when monitoring bulk cash smuggling, money services businesses (MSBs), in particular wire remittance businesses, and the Colombian Black Market Peso Exchange (BMPE) system. These potential money laundering systems are being attacked on several fronts: pro-active investigations and prosecutions; civil asset forfeiture and consent decrees with non-compliant businesses; multi-agency training initiatives for law enforcement and the financial and industry components exploited by these money laundering systems; and multi-lateral initiatives with foreign governments.

Certification for Major Illicit Drug-Producing and Transit Countries

The statutorily-mandated certification process is an important instrument in our international narcotics-control policy. Under this law, the president is required to identify major illicit drug-producing and transit countries on an annual basis and then "certify" whether these nations cooperated fully with the United States or took adequate steps on their own to implement the 1988 UN Drug Convention. The president must impose certain economic sanctions on countries that do not meet these requirements unless he certifies that vital interests of the United States preclude such sanctions. The sanctions include cutting off foreign assistance (other than humanitarian and counternarcotics aid) and voting against requests for loans from multilateral lending institutions. The certification process helps underscore the importance the United States attaches to international narcotics control and encourages some countries to take steps they might otherwise have avoided in pursuit of sound drug-control policy.

On November 1, 2000, the president approved and sent to Congress the Majors List for 2000. The twenty-four countries included were: Afghanistan, the Bahamas, Bolivia, Brazil, Burma, Cambodia, China, Colombia, Dominican Republic, Ecuador, Guatemala, Haiti, India, Jamaica, Laos, Mexico, Nigeria, Pakistan, Panama, Paraguay, Peru, Thailand, Venezuela, and Vietnam.

Two international entities, Hong Kong and Taiwan, were removed from the Majors List in 2000. Hong Kong has been considered a major drug-transit country since 1987 when the first Majors List was prepared. Over the past few years, however, Hong Kong's role as a transit point for U.S.-bound drugs has declined markedly. Stringent enforcement measures and extradition agreements with various countries, including the United States, and the risk of having narcotics shipments seized have become effective deterrents to shipping drugs through Hong Kong. Seizure rates in both the United States and Hong Kong suggest that trafficking organizations are no longer using Hong Kong as a transit point for U.S.-destined heroin.

In the early 1990s, Taiwan became a transit point for Asian drug-trafficking organizations moving heroin to the Western Hemisphere. Taiwan's role as a transit point for drugs destined for the United States, however, has changed radically in the past few years. Strict law-enforcement procedures, together with improved customs inspection and surveillance methods, have all but cut off the serious flows of heroin from Taiwan to the United States. Since Taiwan was designated a major drug-transit country, there have been no seizures in the United States of heroin that passed through Taiwan, nor have Taiwan authorities identified any important drug shipments destined for the United States.

International Drug-Control Cooperation

The transnational nature of the drug threat prevents any country from successfully combating it unilaterally. Our efforts to reduce drug availability, abuse, and adverse consequences within the United States are supported by extensive international activities. Global 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, damage to democratic institutions, and economic distortion.

A series of bilateral, multilateral, sub-regional, regional, and global accords creates a network for anti-drug measures. The international community's mature understanding of the scope of this problem is helping dissolve the myth that the U.S. market is the engine driving the global drug trade. In fact, the United States comprises just two percent of the

world's consumers. Even with the relatively high price Americans are willing to pay for illegal drugs, U.S. citizens still account for only 10 to 15 percent of more than four hundred billion dollars spent globally on drugs every year.[50]

Bilateral Cooperation with Mexico

Most of the cocaine and much of the marijuana, heroin, and methamphetamine consumed in the U.S. comes through Mexico. Mexican drug networks control a substantial portion of the illicit substances distributed in the United States. Conversely, cash and firearms derived from illegal drug trafficking move South from the U.S. into Mexico.

The creation of the High-Level Contact Group (HLCG) — a senior level, bilateral consultation mechanism specializing in drug control — has facilitated the decision-making and agreement processes between both governments, allowing the cooperative efforts against drug consumption, trafficking and related crimes to be led effectively. Since the inception of the HLCG, the U.S. and Mexico have proceeded with technical exchanges and joint projects in illicit cultivation control, drug treatment, and demand reduction. In the area of law enforcement, the U.S. and Mexico have cooperated in the arrest of major traffickers. The U.S.-Mexico Bilateral Chemical Control Working Group denies criminal organizations access to precursor chemicals needed for the production of illegal drugs.

Over the past year, the United States and Mexico increased their cooperation among both governmental and NGOs in addressing the causes and consequences of drug abuse in both countries. The third Binational Drug-Demand Reduction Conference was held May 31- June 2, 2000 in Phoenix, Arizona.[51] Four hundred people attended this event, which continued to feature professional-development, a binational research symposium linking public health and safety, treatment methods, prevention strategies, youth coalitions, and dissemination of materials. The conference strengthened a sustainable mechanism for future binational collaboration. Mexico has agreed to host a fourth conference in 2001.

Regional Drug Control in the Western Hemisphere and the Multilateral Evaluation Mechanism

The Organization of American States' Inter-American Drug Abuse Control Commission (OAS/CICAD) has become an essential link in our international drug-control regime.

At the Second Summit of the Americas, held in Santiago, Chile in 1998, thirty-four presidents, including President Clinton, agreed to create a new Hemispheric Alliance against Drugs. The centerpiece of this agreement was a pledge to create a Multilateral Evaluation Mechanism — essentially a hemispheric system of performance measurement. The Multilateral Evaluation Mechanism (MEM) is an unprecedented initiative designed to ensure that every nation in the hemisphere develops and implements comprehensive national drug-control strategies. Specifically, Summit participants agreed to: "...develop, within the framework of the Inter-American Drug Abuse Control Commission (CICAD-OAS), a singular and objective process of multilateral governmental evaluation in order to monitor the progress of their individual and collective efforts in the hemisphere...." After eighteen months of discussion and negotiation, the Multilateral Evaluation Mechanism (MEM) was inaugurated during the twenty-sixth regular session of CICAD in Montevideo, Uruguay in 1999. The establishment of the MEM will have no direct impact on the United States' annual drug-certification process, which is required by law. The MEM, however, should facilitate more effective counterdrug efforts by all the nations in the hemisphere.

The MEM is designed to develop an adequate system to collect and report basic statistics on drug use, production, seizures, arrests, money laundering, chemical diversion, and drug trafficking. Previously, although many countries within the hemisphere had been collecting information on their own strategies, the data was often based on different methodologies. This fact prevented accurate regional comparisons, discouraged information sharing, and interfered with efforts to develop a hemispheric picture of the drug problem.

The initial steps in implementing the MEM have already begun. National evaluation reports, and a hemispheric report — both with recommendations — has been written by an independent MEM Government Experts Group (with representatives from each of our thirty-four countries) and approved by CICAD. Results of the first round of evaluations will be formally reported

prior to the hemisphere's presidents at the third Summit of the Americas in April 2001 in Quebec City, Canada.

U.S. contributions to OAS/CICAD have also produced the following such direct results:

- Model regulations on money laundering and asset forfeiture, chemical diversion, and trafficking in firearms along with training and technical assistance to governments in implementing them.
- The Inter-American Telecommunications Network for Drug Control (RETCOD) to improve the ability of national drug commissions to communicate with each other and CICAD.
- A regional Central American legal development and training center, which assists governments in developing counternarcotics laws and sentencing guidelines.
- A regional demand reduction strategy for the hemisphere, stimulating public awareness and drug-abuse prevention through governmental and non-governmental organizations.
- Coordination of demand-reduction programming for street children and women.
- A standardized system of ongoing epidemiological surveillance, which has been implemented in Central America and is being expanded to other sub-regions.
- Drug abuse prevention programs for under-served indigenous communities in Central America.
- Drug abuse prevention and treatment training for nursing-school personnel, counselors, and others who work with street children along with and research and fellowships for technical personnel.
- Projects to promote communication and cooperation among regional customs services, among port authorities, and drug law enforcement agencies.
- Establishment of a telecommunications network for control of precursor chemicals in Andean Ridge countries and neighboring states.
- Money laundering prevention programs for financial institutions throughout the hemisphere, including training for bank regulators and supervisory agencies, judges, prosecutors, and financial intelligence/analysis units.

Drug-Control Efforts through Other International Organizations

A significant increase in the U.S. contribution to the UN drug effort in 1999 helped foster greater international focus on implementing the commitments of UN conventions — particularly in developing and promoting programs to eliminate illicit crops. The United States was also able to achieve an important objective by developing a useful follow-up program to assess whether nations are implementing the UNGA Special Session goals and key target deadlines. U.S. contributions to UNDCP have had a significant impact on the operations and expansion of UN counternarcotics programs and policy and have led to increased commitment from other donors, whose primary vehicle for international drug-control efforts continues to be the UN.

Recent U.S. contributions to UNDCP fostered an expansion of the Southeast Asia program which targets the second-largest opium producer, Burma, where heroin production is beginning to decline. This UN-led program encompasses China, Thailand, and Laos. It also includes three projects in the Wa-controlled area of Burma and one project for the Kachin-controlled area. A program to support eradication campaign in Afghanistan, the largest opium producer, training and advice to bolster law-enforcement, and customs institutions in areas surrounding Afghanistan.

As a result of the Colombia Plan's regional demand-reduction training in Southwest and Southeast Asia, nations have developed self-sufficient prevention, education, treatment, and after-care programs in addition to national and regional-level networks of public and private sector demand-reduction programs that are designed to build strong public support and strengthen political will. One area of interest to the international community is the model after-care and correctional drug-intervention programs for juveniles developed in Southeast Asia.

U.S. contributions to the Colombo Plan's Drug Advisory Program (DAP) are having a significant impact on the development and administration of demand-reduction programs in Southeast and Southwest Asia. The DAP assisted with the creation of the first-ever international network of drug prevention NGOs through co-sponsorship of an international drug prevention summit in Bangkok in November 1999. The level of U.S. contributions led to increased commitment from other donors, particularly Japan, Korea, and Australia. Recent U.S. contributions to the DAP fostered: development of host

government-funded treatment programs in Pakistan, India, Nepal, Bangladesh, Thailand, Malaysia, China, and the Philippines; development of a coalition of drug prevention programs in Southwest Asia; development of a drug prevention curriculum for Pakistani school systems; a major regional coalition of drug-prevention programs in Southeast Asia (IFNGO); and a number of government-funded community and school-based prevention initiatives in ASEAN countries with IFNGO support.

Promoting International Demand Reduction

All countries are affected by the devastating consequences of drug use and its adverse effects on the health and safety of citizens, families, and communities. Recognizing that no government can reduce drug use and its consequences by itself, the United States works closely with individual countries and regional organizations on demand-reduction initiatives. U.S. objectives in international demand reduction include: (1) strengthening international interest in comprehensive anti-drug policies comparable to those in the U.S.; (2) increasing understanding in key countries and regions of drug-consumption problems through better epidemiological surveys and public-awareness initiatives; (3) educating the international community about U.S. policies, programs, and successes in combating drug abuse; and (4) building multilateral alliances to combat drug use.

The United States enjoys an excellent relationship in counterdrug cooperation with the United Kingdom, whose national drug-control strategy is quite similar to ours. In addition to cooperating on law-enforcement matters, our two nations are helping one another in many other areas, including research, development, and technology exchange; additional drug treatment outcome evaluations; sharing information on the use of drug courts; and policy issues.

Supporting Democracy and Human Rights

Democracies make peaceful neighbors and reliable trade partners. They are good for security and provide an environment for cooperation. Democracies have a greater propensity to respect human rights, are less tolerant of corruption, and are more likely to build legal systems that set fair ground-rules for everybody — including foreign investors. If any areas in the world exhibit a sweeping trend toward greater respect for democratic practices in the past quarter-century, Latin America and the Caribbean can be proud of their efforts. Civil society is still weak in some countries. Greater honesty and ethics in government, improved administration of justice, effective and humane law enforcement, and greater respect for free expression are all needed.The United States Government continues to promote respect for human rights and international humanitarian law. In accordance with current U.S. law and policy, the U.S. Government does not provide assistance to units of foreign security forces if there is credible evidence of unanswered allegations of gross violations of human rights in connection with those units. Our government consistently urges partner nation governments to thoroughly investigate allegations of human rights violations in a timely manner and to bring the alleged perpetrators to justice.

The Department of Defense includes human rights elements in all of its counterdrug training courses for foreign security forces. The Department of Justice and the U.S. Agency for International Development both have programs in several countries to promote respect for human rights, and to train and protect investigators and judges involved in human rights cases.

Reducing Corruption

Around the world, corruption diverts resources from productive use, distorts economies, reduces growth, and causes enormous social tension. High levels of corruption make it difficult for countries to grow and develop, even with good macroeconomic policies. Drug syndicates exacerbate corruption through wealth. Enormous resources give large, illegal drug organizations a nearly open-ended capacity to corrupt. Although individual governments must take the lead in combating corruption, the global community can help. The U.S supports such efforts as the OECD Anti-Bribery Convention and the OAS Inter-American Convention Against Corruption. The OAS corruption convention was the first instrument of its kind to be negotiated. It requires parties to criminalize acts of corruption and has the potential to enhance cooperation among nations of the hemisphere in the battle against both domestic and transnational corruption.

Endnotes

1 Yoshikawa, H., Long Term Effects of Early Childhood Programs on Social Outcomes and Delinquency Future of Children, 1995, 5 (3): 51-75.

2 Listed below are recent publications and reports. These documents are available on-line at www.ed.gov/offices/OESE/SDFS.

2000 Annual Report on School Safety

Safeguarding Our Children: An Action Guide

Report on State Implementation of the Gun-Free Schools Act (GFSA) — School Year 1998-99

The Appropriate and Effective Use of Security Technologies in U.S. Schools: A Guide for Schools and Law Enforcement Agencies

3 On-line resources include: www.whitehousedrugpolicy.org/; www.samhsa.gov/csap/; www.ojjdp.ncjrs.org/; www.health.org/.

4 www.cadca.org.

5 www.jointogether.org.

6 Information about the "Prevention Through Service" Alliance can be obtained at (http://www.ptsa.net/), January 29, 1999.

7 Substance Abuse and Mental Health Services Administration, Office of Applied Studies, Summary of Findings from the 1998 National Household Survey on Drug Abuse, NHSDA Series H-10, DHHS Pub. No. (SMA) 99-3328 (Washington, D.C.: U.S. Department of Health and Human Services, August 1999).

8 U.S. Department of Health and Human Services, SAMHSA, Center for Substance Abuse Prevention, Division of Workplace Programs, *Annual Survey of Federal Agency Drug Free Workplace — 1998*.

9 Quest Diagnostics, Inc., *Quest Drug Testing Index*, Teterboro, New Jersey, June 20, 2000.

10 HHS, *Adolescent Time, Risky Behavior, and Outcomes: An Analysis of National Data*, September 1995; NFHS, The Case for High School Activities, undated, available at www.nfhs.org; Collingwood, T., et al., *Physical Fitness Effects on Substance Abuse Risk Factors and Use Patterns*, 1991 and; Shields, E., *Sociodemographic Analysis of Drug-Use among Adolescent Athletes: Observations — Perceptions of Athletic Directors-Coaches*, Thirty Adolescence 839-861, 1995.

11 Johnston, L.D., O'Malley, P.M., & Bachman, J.G., *National survey results on drug use from the Monitoring the Future study, 1975-1998 Volume I: Secondary School Students*, NIH Publication No. 99-4660, (Rockville, MD: National Institute on Drug Abuse, 1999), c. 420.

13 United Nations International Drug Control Programme, International Narcotics Control Board, "Report of the International Narcotics Control Board for 1998." United Nations Publication. 1999, http://www.incb.org/e/ar/1998/chp2/htm, February 7, 2000.

14 These reports entitled "Addressing Substance Abuse problems Among TANF Recipients: A Guide for Program Administrators," and "Addressing Mental Health Problems Among TANF Recipients: A Guide for Program Administrators" will be available on-line at: http:///www.acf.gov/

15 The following discussion of addiction is based primarily on articles and speeches by Alan I. Leshner, Ph.D. Dr. Leshner is director of the National Institute on Drug Abuse. A fuller discussion of addiction by Leshner can be found in Department of Justice, Office of Justice Programs, *National Institute of Justice Journal*, "Addiction Is a Brain Disease — and It Matters," October 1998.

16 Child Welfare League of America. *Alcohol and Other Drug Survey of State Child Welfare Agencies*, (Washington, D.C.: Child Welfare League of America, 1998).

17 Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. *Substance Use Among Women in the United States*, (Washington, D.C.: 1997).

18 Kessler, R., Nelson, C., McGonagle, K. "The Epidemiology of Co-Occurring Addictive and Mental Disorders: Implications for Prevention and Service Utilization," *American Journal of Orthopsychiatry*, 1996; 66, pp. 17-31.

19 Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. *The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits*, (Washington, D.C.: 1998), available online at (http://www.mentalhealth.org), January 29, 1999.

20 National Center on Addiction and Substance abuse at Columbia University: "Missed Opportunity: National Survey of Primary Care Physicians and Patients on Substance Abuse," April 2000.

21 *Brown University Digest of Addiction Theory and Application*, July 2000, Vol. 19, No. 7.

22 National Institute of Justice, 1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees, June 2000, p. 1.

23 U.S. Department of Justice, Bureau of Justice Statistics, *Prisoners in 1999*, August 2000, p. 13.

24 U.S. Department of Justice, Bureau of Justice Statistics. *Prisoners in 1999*, August 2000, p. 10.

25 Steven S. Martin, Clifford A. Butzin, Christine A. Saum, James A. Inciardi, "Three-Year Outcomes of Therapeutic Community Treatment for Drug-Involved Offenders in Delaware: From Prison to Work Release to Aftercare," *The Prison Journal, Vol. 79 No.3*, September 1999 294-320 ,Sage Publications, Inc.

26 Kevin Knight, D. Dwayne Simpson, Matthew L. Hiller *Three-Year Reincarceration Outcomes for In-Prison Therapeutic Community Treatment in Texas*, pp.337-351.

27 U.S. Department of Justice, Bureau of Justice Statistics. *Prisoners in 1999*, August 2000, p. 10.

28 Stephen James, "State Prison Expenditures, 1996," Bureau of Justice Statistics, August 1999.

29 More information about drug courts can be obtained at (http://www.drugcourt.org/), January 29, 1999.

30 Belenko S., "Research on Drug Courts: a Critical Review," *National Drug Court Institute Review*, 1 (1), 1998.

31 More information about TASC can be obtained at (http://www.ncjrs.org/txtfiles/tasc.txt), January 29, 1999.

32 Mumola, Christopher, *Substance Abuse and Treatment, State and Federal Prisoners 1997*.

33 National Institute on Drug Abuse, National Institute on Alcohol Abuse and Alcoholism, T*he Economic Costs of Alcohol and Drug Abuse in the United States* (Rockville, MD: U.S. Department of Health and Human Services, 1998), http://www.nida.nih.gov/EconomicCosts/Chapter1.html#1.10, January 11, 2000.

34 The Internal Revenue Service's Criminal Investigative Division estimates that 25 percent of its investigations are drug-related.

35 The Annunzio-Wylie Anti-money Laundering Act (P.L. 102-550) authorized the reporting of suspicious transactions. The Money Laundering Suppression Act of 1994 (P.L. 103-325) expanded the policies of Annunzio-Wylie to include the designation of Treasury as the single collection point for suspicious transaction reports. The Money Laundering Suppression Act of 1994 also expanded Annuzio-Wylie to require registration with the Treasury of money transmitters, check cashiers, and currency-exchange houses.

36 The following discussion is based on memoranda to ONDCP Director McCaffrey from the Departments of the Interior and Agriculture, Forest Service, dated November 7 and 8, 2000 respectively. State and local views are found in responses to the National Drug Intelligence Center's 2000 survey for the 2000 National Drug Threat Assessment.

37 *Ibid*. In addition, there are some 1,100 non-federal Tribal police officers.

38 U.S. Customs Service press release, *U.S. Customs Seizes 750 Tons of Illicit Drugs in FY 2000*, November 16, 2000.

39 Interagency Commission on Crime and Security in U.S. Seaports, *August 2000 Report*, iii.

40 DCI Crime and Narcotics Center, *Major Coca and Opium Producer Nations*, 1995-1999, p. 5.

41 Department of State, "Fact Sheet on Mycoherbicides," July 17, 2000, http://www.state.gov/www/regions/wha/colombia/fs_000717_mycoherbicide.html.

42 "Interagency Global Heroin Threat Assessment," July 2000.

43 The Drug Enforcement Administration, Heroin Factsheet, October 2000, http://www.usdoj.gov/dea/concern/heroin.htm

44 DCI Crime and Narcotics Center, Major Coca and Opium Producing Nations, 1995-99, no date, p13.

45 Statement by Joseph J. Corcoran, Special Agent in Charge, Saint Louis Division, Drug Enforcement Administration before the House Judiciary Subcommittee on Crime, August 8, 2000.

46 Section 705(a)(2)(B)(3) of the ONDCP Reauthorization Act of 1998.

47 U.S. Department of Transportation, U.S. Coast Guard. Comments provided to ONDCP in November 2000 document titled *Coast Guard Accomplishments.*

48 U.S. Department of Transportation, U.S. Coast Guard. Provided to ONDCP in November 2000 memorandum titled *Coast Guard Accomplishments.*

49 U.S. Secret Service. November 22, 2000 memorandum from United States Secret Service Director Stafford to ONDCP Director McCaffrey.

50 *World Drug Report*, p. 124. The report notes that "many estimates have been made of the total revenue accruing to the illicit drug industry —most range from US $300 billion to US $500 billion. However, a growing body of evidence suggests that the true figure lies somewhere around the US $400 billion level. A US $400 billion turnover would be equivalent to approximately 8 per cent of total international trade. In 1994 this figure would have been larger than the international trade in iron, steel, and motor vehicles and about the same size as the total international trade in textiles.

51 The Office of National Drug Control Policy and the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, "Proceedings of the Third United States and Mexico Binational Drug Demand Reduction Conference: May 31 — June 2, 2000. Phoenix, Arizona (unpublished).


WHAT HYPES YOU UP?
WHAT GETS YOU AMPED?
WHAT'S THE THING YOU CAN'T LIVE WITHOUT?
THE THING THAT MAKES YOU FEEL ALIVE? THE THING YOU CHOOSE TO DO INSTEAD OF DOING DRUGS?
WHATEVER IT IS, DRAW IT. WRITE IT. SKETCH IT.
FILM IT. TAPE IT. RECORD IT. PAINT IT. DANCE IT. PLAY IT.
RAP IT. DO IT ALONE OR DO IT WITH YOUR FRIENDS
AND GET IT TO US. YOUR IDEA COULD BE
USED FOR A NATIONAL TELEVISION
COMMERCIAL OR CREATURED ON A
WEBSITE THAT SHOWS THE WORLD WE'VE
GOT BETTER THINGS TO DO THAN DRUGS.
JUST CALL 1.877.958.3900 OR GO TO
WWW.WHATSYOURANTIDRUG.COM
FOR ALL THE DETAILS AND
INSTRUCTIONS. STAY STRONG.
MUCH RESPECT.
WHAT'S YOUR ANTI-DRUG?

IV. The National Drug Control Budget

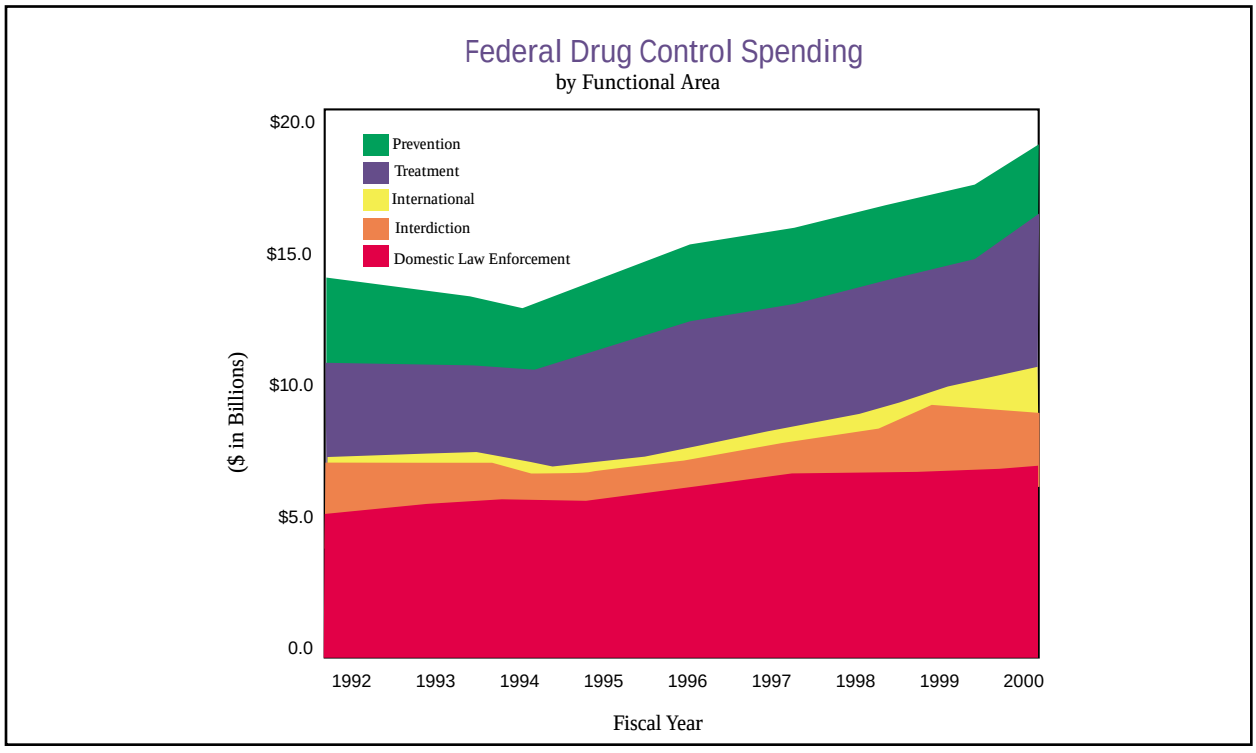
Overview

The Federal drug control budget is the product of budget proposals and appropriations for more than 50 Federal agencies. The budget supports the five goals and thirty-one objectives of the *National Drug Control Strategy* and is structured to make progress toward the targets outlined in the *Performance Measures of Effectiveness (PME)* system. This chapter provides a broad perspective on the state of federal drug control spending and highlights spending in key drug control functional areas from an historical perspective. In addition, funding priorities for the National Drug Control Program are briefly reviewed, and a new ONDCP initiative to improve the integrity and reliability of drug control budget accounting across the government is described.

Historical Perspective

For FY 2000, approximately $18.8 billion was appropriated for federal drug control programs, including supplemental funding of $1.3 billion to support Plan Colombia and drug control activities in the Andean region. The FY 2000 appropriations represent an increase of $6.9 billion, or 58 percent, over the FY 1992 level of $11.9 billion. The majority of the funding increases were achieved during the FY 1996 – FY 2000 period, and funding for every major functional category of drug control programs, with the exception of domestic law enforcement, experienced larger increases in funding during this period.

Appropriations for International and Interdiction programs declined between 1992 and 1996. From FY 1996 to FY 2000, however, funding for these two



functions increased by 46 percent and 432 percent, respectively. The increase in International programs is largely, but not entirely, accounted for by enactment of the $1.3 billion FY 2000 supplemental, based on an Administration request, to support Plan Colombia. Interdiction and international efforts support the *Strategy*'s Goal 4, "Shield America's air, land, and sea frontiers from the drug threat," and Goal 5, "Break foreign and domestic drug sources of supply." Major initiatives include the Andean coca reduction initiative, Southwest border enhancements for Border Patrol personnel and Customs Service non-intrusive technology systems, and enhancements for Caribbean drug interdiction operations.

Prevention funding was essentially stable between FY 1992 and FY 1996. Between FY 1996 and FY 2000, prevention funding increased by 48 percent—second only to the percentage increase in international funding. Increases for prevention programs were targeted at Goal 1 of the *Strategy*, "Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco." The establishment of ONDCP's youth media campaign, funding for the Substance Abuse and Mental Health Services Administration's (SAMHSA) State Incentive Grants program, increased funding for Youth Tobacco prevention in the Department of Health and Human Services and additional funding for Office of Justice Programs drug prevention activities represent several of the key budget priorities supporting the *Strategy*.

Treatment funding increased by 18 percent between FY 1992 and FY 1996 and 26 percent between FY 1996 and FY 2000. Drug treatment funding primarily supports Goal 3 of the *Strategy*, "Reduce the health and social costs to the public of illegal drug use." A major new treatment program in SAMHSA, the Treatment Capacity Expansion Program, along with funding enhancements for the SAMHSA substance abuse block grant and criminal justice treatment programs, all received significant funding increases over the last four years.

Domestic Law Enforcement funding increased by 42 percent between FY 1992 and FY 1996. From FY 1996 to FY 2000, funding for these activities increased by a more modest 22 percent. Domestic law enforcement activities primarily support Goal 2 of the *Strategy*, "Increase the safety of America's citizens by substantially reducing drug-related crime and violence." Funding enhancements for domestic law enforcement activities have supported several key investigations and intelligence initiatives within the Drug Enforcement Administration and the Federal Bureau of Investigation. In addition, ONDCP's High Intensity Drug Trafficking Area Program has been expanded to thirty-one HIDTA areas, up from fifteen in FY 1996.

Several factors (in addition to the Plan Colombia supplemental noted above) account for the increased spending, particularly after FY 1995. One major reason, especially for the increases in domestic law enforcement, is the effect of the Violent Crime Control and Law Enforcement Act of 1994, which was enacted with Presidential and bipartisan Congressional support and provided a balance between law enforcement, prevention programs, and tough new sanctions in federal law. The 1994 Act authorized funding to support, among other things: putting 100,000 police officers on the streets in community policing programs; the establishment of drug courts to provide supervision and specialized services to offenders with rehabilitation potential; expanded substance abuse treatment for federal and state prisoners; additional federal agents to secure our borders; and grant programs to help prevent our Nation's youth from using drugs. The Act also established a new Violent Crime Reduction Trust Fund as a source of funding for programs authorized in the legislation. Much of the subsequent funding increases for drug control programs are attributable, in part, to enactment of this bill.

A second factor contributing to the increased funding was process begun by ONDCP in 1996 for developing a 10-year *National Drug Control Strategy*, a 5-year budget to support the *Strategy*, and the Performance Measures of Effectiveness (PME) to assess progress towards the goals of the *Strategy*. In addition, ONDCP began to issue funding priorities to guide the development of agency drug control budgets. The establishment of this comprehensive process has enabled to work in concert with drug program agencies, the Office of Management and Budget, and the Congress to achieve funding increases for drug control programs.

Federal Funding Priorities

By law (21 U.S.C. § 1703(b)(8)), ONDCP must provide, by July 1 of each year, drug control funding priorities to the heads of departments and agencies with responsibilities under the National Drug Control Program. These funding priorities are to cover a five-year planning period. On June 28, 2000, ONDCP provided the Cabinet with a summary of drug control funding priorities for FY 2002 to FY 2006. The funding priorities cited by ONDCP include the following critical program areas:

- **Support for Plan Colombia and drug control activities in the Andean region** – The democratically elected government of Colombian President Andres Pastrana devised a comprehensive, integrated strategy, Plan Colombia, to address Colombia's drug and interrelated social and economic troubles. The United States' involvement in Plan Colombia has five components, centered around reducing the supply of Colombian drugs to the United States: implementing the Colombia initiative in southern coca growing areas; increased drug interdiction; greater support of Colombian National Police eradication efforts; alternative economic development; and assistance to boost Colombia's local and national governing capacity, including enhanced justice and human rights protection. In FY 2000, Congress provided emergency supplemental appropriations of $1.3 billion for Plan Colombia.
- **National Youth Anti–Drug Media Campaign –** The Media Campaign uses paid media messages to change youth attitudes about drug use and its consequences. Targeted, high impact, paid media ads — at both the national and local levels — are the most cost effective, quickest means of changing drug use behavior through changes in adolescent perceptions of the danger and social disapproval of drugs. It is also the most cost effective means of reaching baby-boomer parents who may be ambivalent about sending strong anti-drug messages to their children.
- **Community Coalitions** – This effort provides technical assistance to community groups on forming and sustaining effective community and anti-drug coalitions that prevent the use of illegal drugs, alcohol, and tobacco by youth. Sustained and comprehensive prevention efforts at the community level are required to deliver a constant and effective anti-drug message.
- **Criminal Justice Treatment Programs.** This priority will increase the capacity of the criminal justice system to refer addicts and heavy drug users to treatment and rehabilitation and employ sanctions and incentives to foster treatment retention, compliance and completion. Activities involve extensive collaboration between public safety and public health officials and focus primarily on non-incarcerated and post-incarcerated juvenile and criminal justice populations. Through drug testing, sanctions, and treatment programs, the number of persons who come into contact with the criminal justice system will be reduced by decreasing the number of repeat drug-related offenders.
- **Drug Courts.** – The criminal justice system often fails to subject nonviolent, substance-abusing adult and juvenile offenders to intervention measures that provide the sanctions and services necessary to change their behaviors. The Drug Court program uses 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.
- **Close the Public System Treatment Gap** – This priority is aimed at reducing the gap between those who are actively seeking substance abuse treatment and the capacity of the public treatment system. This will be accomplished through a variety of approaches, including grant assistance to increase treatment capacity, with a focus on targeted treatment capacity, adolescent treatment, and outreach for chronic users and addicts, including their families. The gap will also be addressed by efforts to promote parity for substance abuse treatment through health insurance programs.
- **School Drug-Prevention Programs** – The *Strategy* has focused national attention on the need to educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco. Support for effective drug education programs is critical for changing attitudes and behaviors. This funding priority includes programs implemented by the Department of Education in conjunction with other federal agencies that support local educational agencies and communities in developing programs that create safe, disciplined, and drug-free learning environments and promote healthy childhood development.
- **High Intensity Drug Trafficking Area (HIDTA) Programs** – Over the five-year planning period, ONDCP's HIDTAs will continue activities that will improve their efficiency and effectiveness through improved intelligence and resource sharing among local, state, and

federal law enforcement agencies, resulting in a reduction of illegal drug availability and related violent crime.

- **Southwest Border Programs** – This initiative is associated with improved security and enhanced drug interdiction along all U.S. air, land, and sea frontiers and at all ports-of-entry. Controlling borders and ports-of-entry is vital in order to ensure the rule of law and prevent the flow of illegal drugs. This priority includes support for the Immigration and Naturalization Service, Customs, Coast Guard, and other federal law enforcement agencies, as well as coordination with state and local agencies along the border. This priority also includes advanced technologies, which unequivocally identify the presence of drugs and contraband in cargo, containers and conveyances at ports-of-entry.
- **Intelligence Architecture Support** – The General Counterdrug Intelligence Plan (GCIP), approved by the President on February 6, 2000, is the Administration's blueprint to streamline and enhance intelligence and law enforcement information sharing throughout the national counterdrug community. Among the GCIP's 73 action items is the creation of a three-tiered coordination and problem-resolution mechanism, which includes a policy guidance committee at the Cabinet level, an interagency coordination group, and a full time interagency support staff. This three-tiered mechanism will ensure effective and collaborative counterdrug intelligence sharing across the drug law enforcement, interdiction, policy, and intelligence communities. It will also oversee the implementation of the GCIP, to include action items that support various intelligence, interdiction, and drug law enforcement activities.
- **Regional Interdiction Architecture** – This program area centers on efforts to infuse U.S. interagency interdiction forces with high-technology capabilities and complete activities to reestablish counterdrug support capabilities resident in U.S. military bases in Panama and other locations throughout the region. This priority supports regional counterdrug operations through aviation and maritime operations support, pierside destructive search support, small unit training, and small boat operations and training.

Drug Budget Accounting Improvements

The National Drug Control Budget includes funding in over 50 federal agencies and accounts. Each agency takes responsibility for carefully accounting for its drug control resources. For the drug budget to be a helpful tool for policymakers, the Congress and the public, it must be presented with an appropriated degree of accuracy and consistency. To ensure the integrity of the methods used to account for drug spending, part of the 1998 law (21 U.S.C. § 1704(d)) that reauthorized the Office of National Drug Control Policy (ONDCP) mandates that the Director of ONDCP shall, "(A) require the National Drug Program agencies to submit to the Director not later than February 1 of each year a detailed accounting of all funds expended by the agencies for National Drug Control Program activities during the previous fiscal year, and require such accounting to be authenticated by the Inspector General for each agency prior to submission to the Director; and (B) submit to Congress not later than April 1 of each year the information submitted to the Director … [by the agencies]."

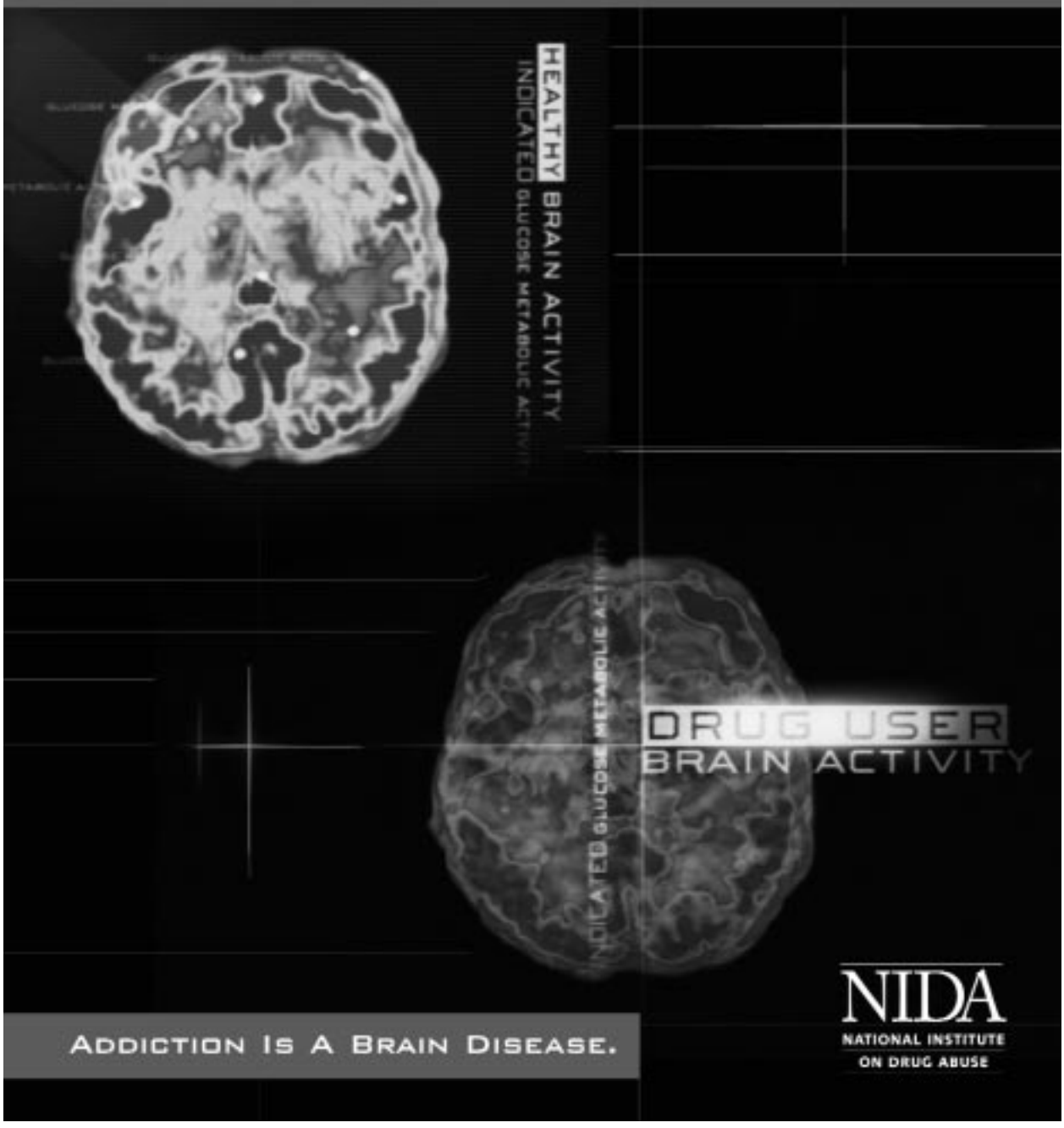
In order to implement this law, since April 1999 ONDCP has worked closely with agency Chief Financial Officers (CFO) and Inspectors General (IG) to develop the form and content of agency drug accounting reports. As a result of this interagency process, on December 17, 1999, ONDCP issued to all drug control agencies a Circular, *Annual Accounting of Drug Control Funds*. This Circular focuses on disclosures and assertions that each agency must make regarding its drug budget methodology. Generally, drug control funding is not separately accounted for in agency financial systems of record. Drug funding is an estimate, based on individual agency drug methodologies for attributing a portion of agency budgets to drug control activities, such as treatment, prevention, interdiction, and several other drug control functions. Therefore, apart from the accuracy and reliability of agency financial systems, the most important aspect of each agency's drug funding calculations is its drug budget methodology.

Although many agencies were able to complete this exercise successfully for FY 1999, the first year covered by this requirement, some agencies had difficulty in presenting a detailed accounting of funds that could be authenticated by their IG. To address the deficiencies identified in agency drug budget methodologies, ONDCP has embarked on an effort to improve these important calculations so that they more accurately reflect counterdrug activities across the government. These improvements will be an iterative process, which will occur over the next few fiscal years.

ONDCP is committed to improving the accuracy and reliability of all financial data associated with the drug control program of the President. In support of this, ONDCP has contracted with independent experts to assist in the analysis of drug budget deficiencies highlighted by Department IGs. This is part of ONDCP's continuing work with agencies to improve their reporting on critical drug-related financial statistics. ONDCP will keep the public apprised of progress in this area and fully disclose any modifications to agency drug budget accounting that would significantly affect how this information is presented. The annual accounting of drug control funds now required by law will serve as a valuable tool to assist in these important efforts.

FY 2000 appropriations are used in this chapter because precise numbers for FY 2001 drug appropriations were not available at the time the *Strategy* was prepared. For FY 2002, the incoming Administration will submit a proposed budget, including funding for drug control programs. That budget proposal is expected in Spring 2001.

KEEP YOUR BRAIN HEALTHY.
DON'T USE DRUGS.



ADDICTION IS A BRAIN DISEASE.

NIDA
NATIONAL INSTITUTE
ON DRUG ABUSE

V. 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.* It requires the ONDCP Director to work with the heads of the National Drug Control Program agencies, Congress, state and local officials, private citizens and organizations with expertise in demand reduction, private citizens and organizations with experience in supply reduction; and appropriate representatives of foreign governments. ONDCP fully met this congressional requirement in 2000.

Consultation with Congress

The development, implementation, oversight, and funding of a comprehensive national drug strategy is an objective we undertake in tandem with Congress. In response, the *Strategy* provides detailed long-term plans for addressing domestic and international trends in drug use, production, and trafficking. Only the federal government has the mandate to pursue international supply-reduction targets. Congress has been concerned about accountability in counter-drug efforts and the long-standing absence of serious performance standards for success. The *Strategy* includes specific benchmarks for the base year (1996) and hard data on results in 1997, 1998, 1999, and 2000 (where such data is available). Finally, the *Strategy* includes initiatives to reinforce parents and families as they work to keep young people drug-free, expand treatment, counter drug legalization, and target international criminal organizations responsible for much of the world's drug trade.

During 2000, the executive and legislative branches worked to implement the *Strategy* and address important issues with new legislation. Major accomplishments during the past year include:

- Passage by Congress with bi-partisan support of $1.39 billion in emergency supplemental funds for counter-drug assistance to Colombia and neighboring countries in the Andean region. The majority of the funds will go toward the U.S. Government's contribution to the Government of Colombia's Plan Colombia.
- Full funding of the Drug-Free Communities Program.
- Bipartisan support and funding for the Youth Anti-Drug Media Campaign.
- Congress was briefed extensively on the achievement of the inter-agency approval for a plan to gather and utilize counterdrug intelligence, which is known as the General Counterdrug Intelligence Plan, which was unveiled in February 2000.
- Continued support of the HIDTA program.

ONDCP was pleased to testify at eleven hearings in 2000 and take part in numerous events with substantial Congressional involvement. ONDCP officials appeared before Congress on all aspects of drug control policy and implementation, including the *Strategy*, the federal drug control budget, the Youth Anti-Drug Media Campaign, emerging global threats, the drug legalization movement, reauthorization of the Safe and Drug Free Schools program, the cocaine and heroin crisis in Colombia, the Southwest border, and the use of performance-enhancing drugs in Olympic competition.

Consultation with National Drug-Control Program Agencies

ONDCP works closely with agencies that have been charged to oversee drug prevention, education, treatment, law enforcement, corrections, and interdiction. 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). 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

ONDCP consults regularly with state and local officials when implementing the *Strategy*. Governors from all states and territories, along with state drug-control agencies, provide input in the areas of prevention, treatment, and enforcement. ONDCP worked closely throughout the year with organizations like the National Governor's Association, Council of State Governments, U.S. Conference of Mayors, and National Association of Counties to coordinate policies and programs. Perspectives were solicited from every mayor of a city with at least 100,000 people as well as key county officials. In addition, local prevention experts, treatment providers, and law-enforcement officials offered "street-level" views of 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, and religious institutions. A list of private-sector groups whose views were considered during formulation of the *2001 Annual Report* is provided at the end of this chapter.

The World Wide Web is a rapidly growing tool for the exchange of information between ONDCP and the public. The ONDCP web site (www.white housedrugpolicy.gov) was accessed 3,260,379 times by 565,106 users in the first ten months of 2000.

The National Youth Anti-Drug Media Campaign has developed Web sites for teens (Freevibe.com) and for parents (TheAntiDrug.com.) Traffic to the Web sites is driven both through advertising and a vigorous outreach effort to earn free placements and content features on other Web sites frequented by youth and adult audiences. Online partnerships have been initiated with media giants such as AOL, Sony, Lycos, About.com, and Oxygen Media.

Freevibe features an array of interactive tools, providing youth factual information on drug dangers and providing a forum for sharing their drug-free choices and supporting one another in those decisions. Over the past year, page views on Freevibe.com have tripled and the time spent on the site has averaged 10 minutes per visit, an extraordinary amount of time particularly for teens.

The National Youth Anti-Drug Media Campaign launched TheAntiDrug.com in early 2000 to provide parents and other adult influencers with drug information and tips for keeping their kids drug free. Complementary sites were launched in Spanish, Chinese, Korean, Cambodian and Vietnamese. In late 2000, the Media Campaign will enhance the scope and depth of this site, adding new interactive tools and expanding online resources for teachers and other adult influencers.

Teachersguide.org provides educators with tools to integrate drug prevention activities and lessons into their curriculum. The Mediacampaign.org is our key Web site for informing stakeholders and the general public about the activities of the Media Campaign. In addition to fact sheets and press releases, it includes the creative advertisements from the Campaign, allowing others to download them and use them on their own Web sites. Visitors to these National Youth Anti-Drug Media Campaign Web sites exceeded 3 million in 2000.

Consultation with Representatives of Foreign Governments and International Organizations

The United States coordinated international drug-control policies 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). U.S. agencies also worked in partnership with authorities in major transit and source nations to confront international criminal organizations, develop plans to stop money laundering, deny safe havens to international criminals, and protect citizens and democratic institutions from corruption or subversion.

Consultation with Non-Governmental Organizations

Views of the following organizations were considered during formulation of the *2001 Annual Report:*

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 Cares, Inc.
America's Promise: Alliance for Youth
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 Judges Association
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 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 Mentor Initiative
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 of 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
Delta Sigma Theta Sorority
Do Something.org
Drug Free America Foundation, Inc.
Drug Prevention Network of the Americas
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
Fellowship of Christian Athletes
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 Community Services
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
Institute on Global Drug Policy
Inter-American College of Physicians/Surgeons
Inter-American Drug Abuse Control Commission of the Organization of American States
International Association of Campus Law Enforcement Administrators
International Association of Chiefs of Police
International Association of Junior Leagues
International Association of Women Police
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 Narcotic Enforcement Officers Association
International Olympics Committee
International Scientific and Medical Forum on Drug Abuse
International Students in Action
Institute for Behavior and Health, Inc.
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
Millenium 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 Police Organizations
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 Association of Student Assistance Professionals
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
National Federation of State High School Associations
National FFA Organization
National Governors' Association
National Health Council
National High School Athletic Coaches Association
National Hispanic/Latino Community Prevention Network
National Hispanic Leadership Conference
National Hispanic Radio
National Indian Child Welfare Association
National Indian Youth Leadership Development Project
National Inhalant Prevention Coalition
National Institute for Women of Color
National Institute of Citizen Anti-Drug Policy
National Jewish Community Relations Advisory Council
National Latino Children's Institute
National Law Enforcement Officers Memorial Fund
National League of Cities
National League of Counties
National Legal Aid and Defenders Association
National Masonic Foundation for Children
National Medical Association
National Mental Health Association
National Mentoring Partnership
National Middle School Association
National Minority Health Association
National Narcotics Officers' Association 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 Urban League Partnership
National Wellness Association
National Wholesale Druggists Association
National Women's Health Resource Center
Native American Outreach Project, America Society of Internal Medicine
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
Odysey 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
Pathfinders
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)
Prevention Through Service Alliance
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
Sigma Gamma Rho Sorority
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 LINKS, Inc.
The Matrix Institute on Addictions
The National Foundation For Teaching Entrepreneurship
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. Hispanic Leadership Institute
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
White Bison, Inc.
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; Subcommittee on Data, Research, and Interagency Coordination (the Data Subcommittee) 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:

- (I) casual and chronic drug use;
- (II) high-risk populations, including school dropouts, the homeless and transient, arrestees, parolees, probationers, and juvenile delinquents; and
- (III) 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:

- (I) the quantities of cocaine, heroin, marijuana, methamphetamine, and other drugs available for consumption in the United States;
- (II) the amount of marijuana, cocaine, heroin, and precursor chemicals entering the United States;
- (III) the number of hectares of marijuana, poppy, and coca cultivated and destroyed domestically and in other countries;
- (IV) the number of metric tons of marijuana, heroin, cocaine, and methamphetamine seized;
- (V) the number of cocaine and methamphetamine processing laboratories destroyed domestically and in other countries;
- (VI) changes in the price and purity of heroin and cocaine, changes in the price of methamphetamine, and changes in tetrahydrocannabinol level of marijuana;
- (VII) the amount and type of controlled substances diverted from legitimate retail and wholesale sources; and
- (VIII) 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:

- (I) the burden drug users placed on hospital emergency departments in the United States, such as the quantity of drug-related services provided;
- (II) 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 text is quoted directly from PL 105-277.

(III) the extent of drug-related crime and criminal activity; and

(IV) 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:

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

(II) the extent, within each State, to which treatment is available;

(III) the number of drug users the Director estimates could benefit from treatment; and

(IV) 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

(v) 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.

Improving Federal Drug-Related Data Systems

ONDCP is supporting an initiative to develop a comprehensive data system to inform drug policy makers. It will support all ninety-seven targets that constitute the *Strategy*'s Performance Measures of Effectiveness (PME) system. The ONDCP-coordinated Data Subcommittee is reviewing existing data systems to identify "data gaps" and determine what modifications can be made to enhance the system. SAMHSA, for example, has increased the sample size and scope of the NHSDA to provide state-by-state data and greater information about drug use among twelve to seventeen-year-olds. For the first time, for 1999 data, the NHSDA reports on the expanded, state-by-state results. More frequent estimates of the social costs of drug abuse are currently being implemented. ONDCP is continuing the development of a "cocaine flows" estimate model.

This initiative will improve the policy relevance of federal drug-related data systems by bringing them into alignment with the PME system. The Data Subcommittee has supported the following innovations:

- The National Institute of Justice expanding and revising of the Drug Use Forecasting program into the Arrestee Drug Abuse Monitoring (ADAM) system. Plans call for the expansion of ADAM to seventy-five sites with probability-based samples representative of the respective metropolitan areas. The new ADAM instrument will include questions to promote the estimation of the prevalence of drug abuse among arrestee populations comparable to those generated for the general household population. The first ten new ADAM sites were funded by ONDCP in 1998.
- SAMHSA enlarged the sample for the National Household Survey on Drug Abuse — reaching nearly quadruple the size — permitting, for the first time, estimation of drug-use prevalence at the state level. The first wave of new data became available in August 2000.
- SAMHSA/CSAT is expected in FY 2001 to fund the implementation of the National Treatment Outcome Monitoring System (NTOMS). NTOMS will combine the work of two existing data systems currently funded by ONDCP: the Drug Evaluation Network System, which provides real-time data on treatment admission; and the Random Access Monitoring of Narcotics Addicts system, which estimates the size and characteristics of chronic drug-using populations. NTOMS will provide essential data for the PME system on treatment, waiting time, and chronic users.
- SAMHSA/CSAP has several activities to promote state data systems. For example, twenty states now voluntarily collect common process and capacity data using software developed under Minimum Data Set I (MDSI), which permits collection from the provider through the substate, state, and federal system levels. Similarly, states can voluntarily report on five common outcome measures, consistent with ONDCP PMEs, in the pilot SAPT block grant application for FY2000.

ONDCP is currently leading an interagency effort to develop drug-flow models — from source countries through availability in the United States — for cocaine, heroin, marijuana, and methamphetamine. Results from this project are providing critical measures for the PME system, enabling assessment of the nation's supply-reduction programs.

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—1998 (Source for Tables 1, 3, 44, and 50)

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. Abt Associates, Inc. first wrote the report for ONDCP in 1993. It was updated in 1995, 1997, and 1999.

National Household Survey on Drug Abuse (Source for Tables 2 and 4)

The National Household Survey on Drug Abuse (NHSDA) measures the prevalence of drug and alcohol use among household members aged twelve 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. The data collection methodology was changed from paper and pencil interviews (PAPI) to computer-assisted interviews (CAI) in 1999 and the sample was expanded almost four-fold to permit state-level estimates and more detailed subgroup analyses, including race/ethnic subgroups groups and single-year age categories.

Monitoring the Future: A Continuing Study of the Lifestyles and Values of Youth (Source for Tables 5 and 6)

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 follow-up surveys, eighth and tenth graders were added to the study sample in 1991. The University of Michigan has conducted the study under a grant from NIDA since 1975.

Youth Risk Behavior Survey (Source for Tables 7, 8, 11, and 13)

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 (CDC). 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 sub-populations 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 throughout the decade among national probability samples of ninth through twelfth 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 youths in each family selected for the National Health Interview Survey. In 1992, 10,645 youth aged twelve to twenty-one 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. Another component of the YRBSS is the national Alternative High School Youth Risk Behavior Survey (ALT-YRBS). Conducted in 1998, ALT-YRBS results are based on a nationally representative sample of 8,918 students enrolled in alternative high schools, who are at high risk for failing or dropping out of regular high school or who have been expelled from regular high school because of illegal activity or behavioral problems.

PATS Survey (Source for Table 9)

The Partnership Attitude Tracking Study (PATS) has been conducted by the Partnership for a Drug-Free America since 1986 to monitor drug-related behavior and attitudes of youth and adults. Beginning in 1993, the PATS methodology changed from a survey conducted through mall intercepts to a paper-and-pencil survey conducted in schools with pre-teens (grades 4-6) and teens (grades 7-12). In 1995, PATS added a separate telephone survey with parents of youth under age 19. (In 2000, pre-teens were dropped from the school-based survey.) Approximately 150 schools partcipate in the annual surveys.

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 sixth through twelfth 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 1998-99 school year involved approximately 135,000 students in 28 states.

Current Population Survey (Source for Table 12)

As mandated by the U.S. Constitution, Article 1, Section 2, the U.S. Bureau of the Census has conducted a census every ten 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 14 and 15)

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.

Arrestee Drug Abuse Monitoring/Drug Use Forecasting Program (Source for Tables 16 through 25)

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 thirty-five major metropolitan sites across the United States in 1998, up from twenty-three in 1997. 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 data set varies from site to site. The majority of sites each collect data from 300 to 700 adult male arrestees, 100 to 300 female arrestees (at thirty-two sites), and 150 to 300 juvenile male arrestees (at thirteen sites). Together, the 1998 data comprised 20,716 adult male arrestees, 6,700 adult female arrestees, and 3,134 juvenile male arrestees. The ADAM system is expanding to more cities in the coming years.

Substance Abuse among Probationers and State and Federal Prisoners (Source for Table 26)

Conducted by the Bureau of Justice Statistics, Office of Justice Programs, Department of Justice, the 1997 Survey on Inmates in State and Federal Correctional Facilities comprises 14,285 interviews for the state survey and 4,041 for the federal survey using computer assisted personal interviewing (published in December 1998). The survey is conducted every five to six years. The first national survey of adults on probation was conducted in 1995 by BJS and provides information on drug use from personal interviews with a national representative sample of over 2,000 adult probationers under active supervision (published in March 1998).

Homelessness: Programs and the People They Serve (Source for Tables 27 to 29)

The National Survey of Homeless Assistance Providers and Clients provides a full picture of homeless service users in late 1996. It provides updated information about the providers of homeless assistance services and the characteristics of homeless clients who use these services. Information from this survey was intended for use by federal agencies responsible for administering homeless assistance programs and other interested parties. The survey was conceived, developed, and funded by twelve federal agencies under the auspices of the Interagency Council on the Homeless, a working group of the White House Domestic Policy Council. The Census Bureau carried out the data collection on behalf of the sponsoring agencies. The Survey, released in December 1999, provides the first opportunity since 1987 to update the national picture of homelessness in a comprehensive and reliable way.

The Economic Costs of Alcohol and Drug Abuse in the United States (Source for Table 30)

The NIDA and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) commissioned this study to estimate the economic costs of alcohol and drug abuse in the United States. The study, which was released in 1998, is based on 1992 data and includes estimates for 1995. Before this report, the last complete cost estimate using detailed data was for 1985.

National Vital Statistics Report (Source for Table 31)

Data on drug-induced deaths are based on information from all death certificates filed (2.3 million in 1997) in the fifty states and the District of Columbia. Information from the states is provided to the National Center for Health Statistics (NCHS), a component of CDC. NCHS tabulates causes of death attributable to drug-induced mortality, including drug psychoses, drug dependence, nondependent drug use not including alcohol and tobacco, accidental poisoning by drugs, medicaments and biologicals, suicide by drugs, medicaments and biologicals, assault from poisoning by drugs and medicaments, and 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.

Drug Abuse Warning Network (Source for Table 32)

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.

HIV/AIDS Surveillance Report (Source for Tables 33 and 34)

The HIV/AIDS Surveillance Reports contain tabular and graphic information about U.S. AIDS and HIV case reports, including data by state, metropolitan statistical area, mode of exposure to HIV, sex, race/ethnicity, age group, vital status, and case definition category. The Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention, a component of CDC, publishes it semi-annually. Data on mode of exposure to HIV are of interest to the *Strategy* in light of the role of injection drug use in HIV transmission.

Reported Tuberculosis in the United States (Source for Table 35)

The TB Surveillance Reports contain tabular and graphic information about reported tuberculosis cases collected from 59 reporting areas (the 50 states, the District of Columbia, New York City, U.S. dependencies and possessions, and independent nations in free association with the United States). The reports include statistics on tuberculosis case counts and case rates by states and metropolitan statistical areas with tables of selected demographic and clinical characteristics (e.g., race/ethnicity, age group, country of origin, form of disease, drug resistance, etc). The Division of TB Elimination, National Center for HIV, STD and TB Prevention, a component of CDC, publishes the reports annually. The reports also include information on injection drug use and non-injection drug use among TB cases.

Summary of Notifiable Diseases (Source for Table 36)

This publication contains summary tables of the official statistics for the reported occurrence of nationally notifiable diseases in the United States, including hepatitis. These statistics are collected and compiled from reports to the National Notifiable Diseases Surveillance System, which is operated by CDC in collaboration with the Council of State and Territorial Epidemiologists. These data are finalized and published in CDC's Morbidity and Mortality Weekly Review Summary of Notifiable Diseases, United States for use by state and local health departments; schools of medicine and public health; communications media; local, state, and federal agencies; and other agencies or persons interested in following the trends of reportable diseases in the United States. The annual publication of the Summary also documents which diseases are considered national priorities for notification and the annual number of cases of such diseases.

Uniform Crime Reports (Source for Tables 37 and 38)

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 39)

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. The Bureau of Justice Statistics (BJS) has conducted the survey every five to six years since 1972.

Survey of Inmates in Federal Correctional Facilities and Survey of Inmates in State Correctional Facilities (Source for Table 39)

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. The most recent SIFCF and SISCF were conducted in 1997.

National Prisoner Statistics Program (Source for Table 39)

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 40, 41 and 43)

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 twelve 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 42)

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 45)

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 46)

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 Tables 49, 51 to 59)

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 geographic areas. Production estimates by source country also are provided.

Estimating Cocaine Flow: The Sequential Transition and Reduction (STAR) Model, 1996-1998 (Source for Table 44)

ONDCP is developing a flow model for cocaine, called the Sequential Reduction and Transition (STAR) Model. The STAR model takes each of four point-estimates and uses transition matrices to estimate availability at all the other stages. These four independent measures are: (1) potential production estimated, an imagery-based estimate of the coco crop combined with and coca cultivation studies, (2) Interagency Cocaine Movement Assessment estimate, an event-based estimate of cocaine departing source areas, (3) an estimate of cocaine crossing the U.S. border based on the allocation of domestic resources and interdiction efficiency, and (4) a domestic consumption estimate. As a result, availability estimates at each stage of cocaine's movement, from source to consumer, are a composite of point-estimates. Abt Associates, Inc. prepared a report describing this model for ONDCP in 1999.

List of Tables

* The text is quoted directly from PL 105-277.

DRUG USER EXPENDITURES

Table 1. Total U.S. Expenditures on Illicit Drugs, 1988–2000 ($ Billions)

Year	Cocaine	Heroin	Marijuana	Meth-amphetamine	Other drugs	Total
1988	$76.9	$21.8	$11.3	$2.4	$3.3	$115.7
1989	70.8	20.9	11.1	2.4	2.8	108.0
1990	61.3	17.6	13.5	2.4	2.2	97.0
1991	55.0	13.8	12.8	2.0	2.3	85.9
1992	49.4	10.9	12.5	1.6	1.5	75.9
1993	45.9	10.2	11.2	1.7	1.5	70.5
1994	42.2	10.5	11.4	2.1	2.6	68.6
1995	43.0	11.2	9.3	2.5	2.7	66.8
1996	41.3	11.7	9.0	2.1	2.7	66.8
1997	41.8	12.2	10.1	1.8	2.5	68.4
1998	39.0	11.6	10.7	1.5	2.3	65.0
1999*	37.1	12.0	10.2	1.7	2.3	63.2
2000*	36.1	11.9	10.4	1.6	2.3	62.4

*Estimates for 1999 and 2000 are projections.

Note: Amounts are in constant 1998 dollars.

Source: Office of National Drug Control Policy. 2000. *What America's Users Spend on Illegal Drugs, 1988–1998.*

DRUG USE

Table 2. Trends in Selected Drug Use Indicators, 1979–99

Selected drug use indicators	Current use of any illicit drug[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]	Lifetime adolescent[2] inhalant use[3]
			Millions of Users				
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	1.5
1995	12.8	1.5	2.5	9.8	2.5	2.4	1.6
1996	13.0	1.7	2.6	10.1	2.4	2.0	1.3
1997	13.9	1.5	2.6	11.1	2.0	2.6	1.6
1998	13.6	1.8	2.4	11.0	2.4	2.3	1.4
1999-CAI[4]	14.8	1.5	—	11.2	3.1	2.5	2.1
			Rate of Use (Percent)				
1979	14.1	2.6	—	13.2	1.3	16.3	—
1982	—	2.4	—	11.5	1.0	—	—
1985	12.1	3.0	3.7	9.7	0.9	13.2	—
1988	7.7	1.6	2.6	6.2	0.9	8.1	—
1990	6.7	0.9	1.8	5.4	0.8	7.1	—
1991	6.6	1.0	1.9	5.1	1.2	5.8	—
1992	5.8	0.7	1.5	4.7	0.8	5.3	—
1993	5.9	0.7	1.3	4.6	1.0	5.7	—
1994	6.0	0.7	1.2	4.8	1.0	8.2	7.0
1995	6.1	0.7	1.2	4.7	1.2	10.9	7.4
1996	6.1	0.8	1.2	4.7	1.1	9.0	5.9
1997	6.4	0.7	1.2	5.1	0.9	11.4	7.2
1998	6.2	0.8	1.1	5.0	1.1	9.9	6.1
1999-PAPI[4]	7.0	0.8	—	5.4	—	9.0	—
1999-CAI[4]	6.7	0.7	—	5.1	1.4	10.9	9.1

— Data not available.

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

[2] Ages 12 to 17 years.

[3] Prior to a 1994 questionnaire change, data do not allow separate reporting for this age group.

[4] In 1999, the survey methodology changed from a paper-and-pencil interview (PAPI) to a computer-assisted interview (CAI). A PAPI supplement conducted in 1999 provides estimates that are comparable to previous years. When no 1999 PAPI-based estimates are available, estimates based on the new CAI methodology are provided in shaded areas to indicate that these data are not directly comparable to previous 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 (1992–99).

Table 3. Estimated Number of Hardcore and Occasional Users of Cocaine and Heroin (Thousands), 1988–2000

Year	Cocaine users		Heroin users	
	Occasional[1]	Hardcore[2]	Occasional[1]	Hardcore[2]
1988	6,000	3,873	170	923
1989	5,300	3,315	150	886
1990	4,600	3,186	140	797
1991	4,478	3,170	395	681
1992	3,503	3,259	304	630
1993	3,332	3,350	230	694
1994	2,930	3,367	281	795
1995	3,082	3,555	428	855
1996	3,425	3,410	455	917
1997	3,487	3,503	597	935
1998	3,216	3,343	253	980
1999*	2,411	3,348	484	977
2000*	2,155	3,325	514	977

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.

* Estimates for 1999 and 2000 are projections.

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

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

Source: Office of National Drug Control Policy. 2000. *What America's Users Spend on Illegal Drugs, 1988–1998.*

Table 4. Drug Use by Current Employment Status,[1] 1995–99 (Percent Prevalence)

	Full-time	Part-time	Unemployed	Other[2]
Past Month Use of Any Illicit Drug				
1995	5.5	9.0	14.3	3.1
1996	6.2	8.6	12.5	3.0
1997	6.5	7.7	13.8	3.0
1998	6.4	7.4	18.2	2.8
1999 CAI[3]	6.5	8.6	16.4	3.6
Past Month Use of Marijuana				
1995	4.2	7.5	12.6	1.9
1996	4.9	6.2	10.0	2.3
1997	5.0	6.6	12.2	2.4
1998	5.1	6.5	15.1	2.0
1999 CAI[3]	5.1	6.8	12.9	2.4
Past Month Use of Cocaine				
1995	0.7	0.8	2.1	0.4
1996	0.9	1.1	2.4	0.4
1997	0.7	0.9	2.4	0.3
1998	0.9	0.5	3.4	0.4
1999 CAI[3]	0.8	0.8	2.9	0.2

— Data not available.

[1] Data on current employment are for persons aged 18 and older.

[2] Retired, disabled, homemaker, student, or "other."

[3] In 1999, the survey methodology changed from a paper-and-pencil interview to a computer-assisted interview (CAI). Estimates based on the new CAI methodology are provided in shaded areas to indicate that these data are not directly comparable to previous years.

Source: *National Household Survey on Drug Abuse*, Substance Abuse and Mental Health Services Administration (1995–99).

Table 5. Trends in 30-Day Prevalence of Selected Drugs Among 8th, 10th, and 12th Graders, MTF 1991–2000

Selected drug/grade	30-Day Prevalence (Percent)										
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	1999–2000 Change
Marijuana/hashish											
8th grade	3.2	3.7	5.1	7.8	9.1	11.3	10.2	9.7	9.7	9.1	–0.6
10th grade	8.7	8.1	10.9	15.8	17.2	20.4	20.5	18.7	19.4	19.7	+0.3
12th grade	13.8	11.9	15.5	19.0	21.2	21.9	23.7	22.8	23.1	21.6	–1.6
Inhalants[1, 2]											
8th grade	4.4	4.7	5.4	5.6	6.1	5.8	5.6	4.8	5.0	4.5	–0.5
10th grade	2.7	2.7	3.3	3.6	3.5	3.3	3.0	2.9	2.6	2.6	–0.0
12th grade	2.4	2.3	2.5	2.7	3.2	2.5	2.5	2.3	2.0	2.2	+0.2
Hallucinogens[3]											
8th grade	0.8	1.1	1.2	1.3	1.7	1.9	1.8	1.4	1.3	1.2	–0.1
10th grade	1.6	1.8	1.9	2.4	3.3	2.8	3.3	3.2	2.9	2.3	–0.6*
12th grade	2.2	2.1	2.7	3.1	4.4	3.5	3.9	2.8	3.5	3.5	–0.9*
LSD											
8th grade	0.6	0.9	1.0	1.1	1.4	1.5	1.5	1.1	1.1	1.0	–0.1
10th grade	1.5	1.6	1.6	2.0	3.0	2.4	2.8	2.7	2.3	1.6	–0.7*
12th grade	1.9	2.0	2.4	2.6	4.0	2.5	3.1	3.2	2.7	1.6	–1.2*
Cocaine											
8th grade	0.5	0.7	0.7	1.0	1.2	1.3	1.1	1.4	1.3	1.2	–0.1
10th grade	0.7	0.7	0.9	1.2	1.7	1.7	2.0	2.1	1.8	1.8	–0.1
12th grade	1.4	1.3	1.3	1.5	1.8	2.0	2.3	2.4	2.6	2.1	–0.5
Stimulants											
8th grade	2.6	3.3	3.6	3.6	4.2	4.6	3.8	3.3	3.4	3.4	+0.1
10th grade	3.3	3.6	4.3	4.5	5.3	5.5	5.1	5.1	5.0	5.4	+0.5
12th grade	3.2	2.8	3.7	4.0	4.0	4.1	4.8	4.6	4.5	5.0	+0.5
Alcohol (any use)[4]											
8th grade	25.1	26.1	24.3	25.5	24.6	26.2	24.5	23.0	24.0	22.4	–1.7
10th grade	42.8	39.9	38.2	39.2	38.8	40.4	40.1	38.8	40.0	41.0	+0.9
12th grade	54.0	51.3	48.6	50.1	51.3	50.8	52.7	52.0	51.0	50.0	–1.0

* = 0.05 level of significance of 1999-2000 difference. Any apparent inconsistency between the 1999-2000 change estimate and the respective prevalence estimates is due to rounding error.

Approximate Ns	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
8th grade	17,500	18,600	18,300	17,300	17,500	17,800	18,600	18,100	16,700	17,300
10th grade	14,800	14,800	15,300	15,800	17,000	15,600	15,500	15,000	13,600	14,600
12th grade	15,000	15,800	16,300	15,400	15,400	14,300	15,400	15,200	13,600	13,300

[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 2000).

Table 6. Trends in Harmfulness of Drugs as Perceived by 8th, 10th, and 12th Graders, MTF 1991–2000

Drug	Percentage saying "great risk"[1]										
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	1999–2000 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	28.0	29.0	+0.9
• Smoke marijuana occasionally	57.9	56.3	53.8	48.6	45.9	44.3	43.1	45.0	45.7	47.4	+1.8
• Smoke marijuana regularly	83.8	82.0	79.6	74.3	73.0	70.9	72.7	73.0	73.9	74.8	+1.4
• Try crack once or twice[2]	62.8	61.2	57.2	54.4	50.8	51.0	49.9	49.3	48.7	48.5	–0.2
• Take crack occasionally[2]	82.2	79.6	76.8	74.4	72.1	71.6	71.2	70.6	70.6	70.1	–0.5
• Try cocaine powder once or twice[2]	55.5	54.1	50.7	48.4	44.9	45.2	45.0	44.0	43.3	43.3	0.0
• Take cocaine powder occasionally[2]	77.0	74.3	71.8	69.1	66.4	65.7	65.8	65.2	65.4	65.5	+0.1
Approximate N	17,437	18,662	18,366	17,394	17,501	17,926	18,765	18,100	16,700	17,300	
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	19.2	18.5	–0.7
• Smoke marijuana occasionally	48.6	48.9	46.1	38.9	35.4	32.8	31.9	32.5	33.5	32.4	–1.1
• Smoke marijuana regularly	82.1	81.1	78.5	71.3	67.9	65.9	65.9	65.8	65.9	64.7	–1.2
• Try crack once or twice	70.4	69.6	66.6	64.7	60.9	60.9	59.2	58.0	57.8	56.1	–1.7
• Take crack occasionally	87.4	86.4	84.4	83.1	81.2	80.3	78.7	77.5	79.1	76.9	–2.2*
• Try cocaine powder once or twice	59.1	59.2	57.5	56.4	53.5	53.6	52.2	50.9	51.6	48.8	–2.8*
• Take cocaine powder occasionally	82.2	80.1	79.1	77.8	75.6	75.0	73.9	71.8	73.6	70.9	–2.7*
Approximate N	14,719	14,808	15,298	15,880	17,006	15,670	15,640	15,000	13,600	14,600	
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	15.7	13.7	–1.9
• Smoke marijuana occasionally	40.6	39.6	35.6	30.1	25.6	25.9	24.7	24.4	23.9	23.4	–0.4
• Smoke marijuana regularly	78.6	76.5	72.5	65.0	60.8	59.9	58.1	58.5	57.4	58.3	+0.9
• Try crack once or twice	60.6	62.4	57.6	58.4	54.6	56.0	54.0	52.2	48.2	48.4	+0.2
• Take crack occasionally	76.5	76.3	73.9	73.8	72.8	71.4	70.3	68.7	67.3	65.8	–1.5
• Try cocaine powder once or twice	53.6	57.1	53.2	55.4	52.0	53.2	51.4	48.5	46.1	47.0	+0.9
• Take cocaine powder occasionally	69.8	70.8	68.6	70.6	69.1	68.8	67.7	65.4	64.2	64.7	+0.5
Approximate N	2,549	2,684	2,759	2,591	2,603	2,449	2,579	2,500	2,300	13,300	

Note: * = 0.05 level of significance of 1999–2000 difference. Any apparent inconsistency between the 1999–2000 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 2000).

Table 7. Percentage of High School Students Who Used Selected Drugs by Sex, Race/Ethnicity, and Grade, YRBS 1990, 1991, 1993, 1995, 1997, and 1999

Drug Use Behavior and Year	SEX		RACE/ETHNICITY			GRADE LEVEL				ALL GROUPS
	Male	Female	White, non-Hispanic	Black, non-Hispanic	Hispanic	9th	10th	11th	12th	
Lifetime marijuana										
1990	—	—	—	—	—	20.6	27.9	34.7	42.2	31.4
1991	—	—	—	—	—				—	31.0
1993	36.8	28.6	32.7	33.6	35.4	24.4	28.8	36.0	40.8	32.8
1995	46.2	39.4	40.5	47.2	49.2	33.8	41.4	45.8	47.0	42.4
1997	50.7	42.9	45.4	52.2	49.5	38.8	45.9	50.3	52.4	47.1
1999	51.0	43.4	45.9	48.6	51.0	34.8	49.1	49.7	58.4	47.2
Current marijuana[1]										
1990	—	—	—	—	—	9.5	13.5	13.9	18.5	13.9
1991	—	—	—	—	—	—	—	—	—	15.0
1993	20.6	14.6	17.3	18.6	19.4	13.2	16.5	18.4	22.0	17.7
1995	28.4	22.0	24.6	28.6	27.8	20.9	25.6	27.6	26.2	25.3
1997	30.2	21.4	25.0	28.2	28.6	23.6	25.0	29.3	26.6	26.2
1999	30.8	22.6	26.4	26.4	28.2	21.7	27.8	26.7	31.5	26.7
Lifetime cocaine use[2]										
1990	—	—	—	—	—	3.6	5.8	7.6	9.3	6.6
1991	—	—	—	—	—	—	—	—	—	6.0
1993	5.5	4.2	4.6	1.6	11.3	4.2	3.7	5.1	6.1	4.9
1995	8.8	5.0	6.5	2.0	16.0	5.7	7.5	7.2	7.4	7.0
1997	9.1	7.2	8.0	1.9	14.4	6.7	7.5	9.1	9.2	8.2
1999	10.7	8.4	9.9	2.2	15.3	5.8	9.9	9.9	13.7	9.5
Current cocaine use[1]										
1990	—	—	—	—	—	1.0	2.4	2.5	2.3	2.1
1991	—	—	—	—	—	—	—	—	—	2.0
1993	2.3	1.4	1.6	1.0	4.6	1.6	1.4	2.1	2.1	1.9
1995	4.3	1.8	2.6	1.3	7.5	3.1	2.5	3.6	3.1	3.1
1997	4.0	2.4	3.1	0.7	6.2	3.9	2.6	3.1	3.5	3.3
1999	5.2	2.9	4.1	1.1	6.7	3.4	3.7	4.5	4.8	4.0
Lifetime use of illegal steroids										
1990	—	—	—	—	—	—	—	—	—	—
1991	—	—	—	—	—	—	—	—	—	3.0
1993	3.1	1.2	1.9	2.4	3.0	2.1	2.0	2.2	2.3	2.2
1995	4.9	2.4	3.8	1.6	4.7	4.1	3.6	3.9	2.9	3.7
1997	4.1	2.0	3.1	1.5	3.4	4.3	3.0	2.7	2.5	3.1
1999	5.2	2.2	4.1	2.2	4.1	4.7	3.6	3.0	3.3	3.7
Lifetime injected drug use										
1990	—	—	—	—	—	—	—	—	—	—
1991	—	—	—	—	—	—	—	—	—	—
1993	1.9	0.8	1.3	0.9	1.5	1.4	1.4	1.3	1.2	1.4
1995	3.0	1.0	2.0	1.1	2.2	2.8	2.2	1.7	1.6	2.0
1997	2.6	1.5	1.8	1.0	2.2	3.0	2.5	1.6	1.5	2.1
1999	2.8	0.7	1.6	0.9	1.8	1.6	1.2	2.0	2.3	1.8
Episodic heavy drinking[3]										
1990	—	—	—	—	—	27.7	35.7	39.6	44.0	36.9
1991	—	—	—	—	—	—	—	—	—	31.0
1993	33.7	26.0	32.6	19.1	33.4	22.0	26.2	31.3	39.1	30.0
1995	36.2	28.6	35.6	18.8	37.7	24.5	30.3	34.9	39.0	32.6
1997	37.3	28.6	37.7	16.1	34.9	25.7	29.9	37.5	39.3	33.4
1999	34.9	28.1	35.8	16.0	32.1	21.1	32.2	34.0	41.6	31.5
Current cigarette[1]										
1990	—	—	—	—	—	—	—	—	—	—
1991	28	27	—	—	—	—	—	—	—	28
1993	29.8	30.5	33.7	15.4	28.7	27.8	28.0	31.1	34.5	30.5
1995	35.4	34.3	38.3	19.2	34.0	31.2	33.1	35.8	38.2	34.8
1997	37.7	34.7	39.7	22.7	34.0	33.4	35.3	36.6	36.9	36.4
1999	34.7	34.9	38.6	19.7	32.7	27.6	34.7	36.0	42.8	34.8

— 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, 1997, and 1999)," 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, Race/Ethnicity, and Grade, YRBS 1990, 1991, 1993, 1995, 1997, and 1999

Drug Use Behavior and Year	SEX		RACE/ETHNICITY			GRADE LEVEL				ALL GROUPS
	Male	Female	White, non-Hispanic	Black, non-Hispanic	Hispanic	9th	10th	11th	12th	
Used marijuana on school property[1]										
1993	7.8	3.3	5.0	7.3	7.5	4.4	6.5	6.5	5.1	5.6
1995	11.9	5.5	7.0	12.3	12.9	8.7	9.8	8.6	8.0	8.8
1997	9.0	4.6	5.8	9.1	10.4	8.1	6.4	7.9	5.7	7.0
1999	10.1	4.4	6.5	7.2	10.7	6.6	7.6	7.0	7.3	7.2
Offered, sold, or were given an illegal drug on school property[2]										
1993	28.5	19.1	24.1	17.5	34.1	21.8	23.7	27.5	23.0	24.0
1995	38.8	24.8	31.7	28.5	40.7	31.0	35.0	32.8	29.1	32.1
1997	37.4	24.7	31.0	25.4	41.1	31.4	33.4	33.2	29.0	31.7
1999	34.7	25.7	28.8	25.3	36.9	27.6	32.1	31.1	30.5	30.2
Tried marijuana before age 13										
1993	—	—	—	—	—	—	—	—	—	—
1995	10.2	4.8	5.6	11.1	12.6	9.2	9.1	6.7	5.4	7.6
1997	12.2	6.7	7.5	11.0	13.2	14.9	10.4	8.3	5.8	9.7
1999	14.5	8.0	9.4	14.8	13.8	12.7	12.6	9.5	9.5	11.3
Tried cocaine before age 13[3]										
1993	—	—	—	—	—	—	—	—	—	—
1995	1.8	0.5	0.9	1.3	1.7	1.3	1.3	1.4	0.9	1.2
1997	1.3	0.8	0.9	0.4	1.4	1.8	1.3	1.0	0.3	1.1
1999	—	—	—	—	—	—	—	—	—	—

– 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, 1997, and 1999)," Centers for Disease Control and Prevention, Public Health Service, Department of Health and Human Services.

Table 9. Percentages of Youth Reporting Drug Behaviors and Attitudes, PATS 1993-2000

	Interview year							
	1993	1994	1995	1996	1997	1998	1999	2000
Lifetime marijuana use								
11-12th grade	36	—	51.3	49.6	57.9	56.9	53.9	52.8
9-10th grade	31	—	39.9	44.8	47.1	45.0	42.8	43.3
7-8th grade	20	—	23.9	27.7	27.3	26.8	25.7	24.6
Age 11-12	2	—	2.2	3.3	4.8	5.1	—	—
Age 9-10	1	—	0.9	1.6	2.0	2.2	—	—
Past month marijuana use								
11-12th grade	17	—	29.3	25.6	31.4	29.0	26.0	27.7
9-10th grade	17	—	20.7	27.0	26.0	25.1	21.9	23.3
7-8th grade	10	—	12.6	14.8	14.5	14.6	14.3	12.2
Lifetime inhalant use								
11-12th grade	20	—	19.5	16.5	18.5	19.1	13.1	17.2
9-10th grade	23	—	22.8	22.2	21.0	19.6	18.6	20.2
7-8th grade	27	—	28.2	25.4	28.5	25.7	25.1	25.9
Age 11-12	7	—	6.5	8.3	8.3	8.4	—	—
Age 9-10	3	—	4.3	3.2	4.9	4.8	—	—
Past month inhalant use								
11-12th grade	5	—	4.6	4.4	3.7	4.9	2.5	5.0
9-10th grade	7	—	7.1	7.7	5.9	7.0	4.9	6.5
7-8th grade	13	—	13.3	11.6	13.0	12.4	9.3	10.2
Reporting perceived great risk[a] of any marijuana use								
11-12th grade	18	—	16.5	16.0	13.0	13.8	14.8	14.9
9-10th grade	19	—	17.4	18.5	17.8	15.1	13.8	16.2
7-8th grade	24	—	20.3	20.6	21.9	18.9	18.0	21.5
Reporting perceived great risk[a] of regular marijuana use								
11-12th grade	61	—	55.4	58.6	51.2	54.0	50.6	54.5
9-10th grade	63	—	59.3	60.7	58.1	60.9	62.2	58.2
7-8th grade	70	—	60.4	67.0	65.8	65.3	65.4	68.6

[a] Great risk of harm (physical or in other ways). Responses of "don't know" included in the denominator.

Source: Partnership Attitude Tracking Study, Partnership for A Drug-Free America, 1993-2000.

Table 10. Prevalence of Monthly Drug Use Among 6th–8th, 9th–12th, and 12th graders, PRIDE 1994–95 through 1999-00

	Monthly use (Percent)						
	1994–95	1995–96	1996–97	1997–98	1998-99	1999-2000	Change*
Cigarettes							
6th–8th	15.7	17.2	17.3	15.6	13.2	9.6	–3.6*
9th–12th	31.3	33.4	34.7	33.9	31.1	28.7	–2.4*
12th	34.6	36.2	38.3	40.7	37.5	36.3	–1.2*
Beer							
6th–8th	11.8	12.5	12.1	10.7	10.2	8.7	–1.5*
9th–12th	33.3	34.3	34.4	31.9	31.5	30.9	–0.6*
12th	40.6	41.2	41.7	41.0	39.9	39.1	–0.8
Wine coolers							
6th–8th	9.8	10.8	10.8	9.9	9.6	8.7	–0.9*
9th–12th	23.1	22.3	22.3	21.4	22.9	22.0	–0.9*
12th	25.6	22.9	23.7	23.9	25.5	24.7	–0.8
Liquor							
6th–8th	8.5	9.0	9.1	8.0	8.0	6.5	–1.5*
9th–12th	27.4	28.2	28.7	26.9	28.1	27.6	–0.5
12th	32.5	32.8	34.0	34.1	35.3	35.4	+0.1
Marijuana							
6th–8th	5.7	8.1	8.6	7.1	6.5	5.2	–1.3*
9th–12th	18.5	22.3	22.7	20.8	20.3	19.3	–1.0*
12th	20.9	24.3	24.4	23.6	23.1	23.4	+0.3
Cocaine							
6th–8th	1.2	1.5	1.7	1.6	1.5	1.3	–0.2*
9th–12th	2.6	2.9	3.0	3.1	3.2	2.9	–0.3*
12th	2.9	3.6	3.6	4.0	4.1	3.6	–0.5*
Uppers							
6th–8th	2.0	2.4	2.6	2.5	2.1	1.7	–0.4*
9th–12th	5.1	5.2	5.3	5.4	5.0	5.2	+0.2
12th	5.6	5.8	5.6	6.3	5.8	6.2	+0.4
Downers							
6th–8th	1.5	1.9	2.1	1.9	1.7	1.4	–0.3*
9th–12th	3.4	3.8	3.8	4.2	4.0	4.1	+0.1
12th	3.6	4.1	3.9	4.9	4.5	4.8	+0.3
Inhalants							
6th–8th	2.9	3.5	3.7	3.3	2.7	2.3	–0.4*
9th–12th	3.5	3.4	3.1	3.1	3.0	2.7	–0.3*
12th	3.0	3.1	2.7	2.8	3.0	2.7	–0.3*
Hallucinogens							
6th–8th	1.5	1.8	2.0	1.8	1.7	1.4	–0.3*
9th–12th	4.1	4.5	4.2	3.9	4.2	3.6	–0.6*
12th	4.8	5.1	4.6	4.5	5.2	4.4	–0.8*

* Difference between the 1998–99 and 1999–00 surveys.

	Sample sizes					
Grade	1994–95	1995–96	1996–97	1997–98	1998–99	1999–2000
6th–8th	92,453	58,596	68,071	68,149	58,619	59,243
9th–12th	105,788	70,964	73,006	86,201	79,460	55,075
12th	20,698	14,261	15,532	15,816	16,366	11,680

Source: *PRIDE Questionnaire Report*, 1994–95, 1995–96, 1996–97, 1997–98, 1998-99, and 1999-00.

Table 11. Percentage of Alternative High School Students Who Used Selected Drugs by Sex, Race/Ethnicity, and Grade, 1998

Drug Use Behavior	SEX		RACE/ETHNICITY			GRADE LEVEL				ALL GROUPS
	Male	Female	White, non-Hispanic	Black, non-Hispanic	Hispanic	9th	10th	11th	12th	
Lifetime marijuana	88.0	82.1	89.4	77.7	84.0	81.0	85.3	86.0	86.8	85.4
Current marijuana[1]	58.2	46.7	56.7	47.2	50.6	51.2	52.9	55.7	51.2	53.0
Lifetime cocaine use[2]	38.6	33.0	43.8	5.7	46.4	32.7	36.4	37.8	36.5	36.1
Current cocaine use[1]	17.1	13.1	17.1	3.6	19.4	14.8	16.6	15.9	14.1	15.3
Lifetime crack or freebase use	23.5	19.4	26.2	3.5	26.8	20.9	22.9	24.2	18.9	21.6
Lifetime use of illegal steroids	9.8	7.4	10.5	6.6	6.9	12.0	9.6	6.9	7.6	8.7
Lifetime injected drug use	6.8	4.4	7.0	4.1	4.5	7.6	5.6	5.4	4.9	5.7
Episodic heavy drinking[3]	55.4	42.9	58.7	28.4	52.4	43.8	48.1	51.5	51.7	49.8
Current cigarette[1]	67.7	59.8	78.6	43.3	53.0	64.5	64.3	64.8	62.2	64.1

— 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*, "Youth Risk Behavior Surveillance—National Alternative High School Youth Risk Behavior Survey, United States, 1998," Centers for Disease Control and Prevention, Public Health Service, Department of Health and Human Services.

Table 12. 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 13. 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 (Percent Prevalence)

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 14. 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 15. 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.

Table 16. Percentage[1] of Adult Booked Arrestees Who Used Any Drug,[2] by Sex: 1991–99

	Males									Females								
	1991	1992	1993	1994	1995	1996	1997	1998	1999	1991	1992	1993	1994	1995	1996	1997	1998	1999
Albuquerque	—	—	—	—	—	—	—	65	64	—	—	—	—	—	—	—	73	74
Anchorage	—	—	—	—	—	—	—	43	54	—	—	—	—	—	—	—	58	56
Atlanta	63	69	72	69	74	80	72	66	77	70	65	74	72	68	77	74	—	77
Birmingham	63	64	68	69	73	70	67	67	64	62	59	55	63	57	59	67	74	53
Chicago	74	69	81	79	79	82	80	74	74	—	—	—	—	—	—	—	72	77
Cleveland	56	64	64	66	65	67	64	65	71	79	74	77	82	71	70	57	58	68
Dallas	56	59	62	57	60	63	63	63	61	56	66	61	63	58	58	53	49	56
Denver	50	60	64	67	66	71	71	69	67	54	61	66	68	66	69	69	69	69
Des Moines	—	—	—	—	—	—	—	57	56	—	—	—	—	—	—	—	67	53
Detroit	55	58	63	66	67	66	62	68	65	68	72	76	62	78	69	69	60	69
Ft. Lauderdale	61	64	61	58	58	67	73	74	64	64	62	60	62	60	66	68	67	68
Houston	65	59	59	48	58	64	63	60	60	59	54	53	48	50	54	45	52	43
Indianapolis	45	52	60	69	64	74	63	67	64	54	50	58	69	72	72	67	67	69
Laredo	—	—	—	—	—	—	—	57	58	—	—	—	—	—	—	—	33	22
Las Vegas	—	—	—	—	—	—	—	57	60	—	—	—	—	—	—	—	70	72
Los Angeles	62	67	66	66	62	64	59	64	62	75	72	77	72	68	78	70	71	62
Miami	68	68	70	66	57	67	61	62	66	—	—	—	—	—	—	—	—	—
Minneapolis	—	—	—	—	—	—	—	63	60	—	—	—	—	—	—	—	44	57
New Orleans	59	60	62	63	66	67	67	67	69	50	52	47	32	50	35	40	51	59
New York City[3]	73	77	78	82	83	78	79	77	75	77	85	83	90	84	83	81	82	81
Oklahoma City	—	—	—	—	—	—	—	69	64	—	—	—	—	—	—	—	—	65
Omaha	36	48	54	59	54	63	62	60	62	—	—	—	58	56	51	54	60	62
Philadelphia	74	78	76	76	76	69	67	79	70	75	78	79	76	77	81	75	77	76
Phoenix	42	47	62	65	63	59	64	63	64	61	63	62	67	63	65	66	71	67
Portland	61	60	63	65	65	66	71	72	64	68	73	74	74	68	74	78	74	68
Sacramento	—	—	—	—	—	—	—	71	68	—	—	—	—	—	—	—	73	75
St. Louis	59	64	68	74	77	75	74	72	—	54	70	69	76	69	73	70	69	—
Salt Lake City	—	—	—	—	—	—	—	60	60	—	—	—	—	—	—	—	69	66
San Antonio	49	54	55	52	51	57	52	56	50	45	44	42	39	41	44	37	38	31
San Diego	75	77	78	79	72	71	73	69	64	73	72	78	76	73	62	73	64	67
San Jose	58	50	54	55	52	48	51	48	55	52	56	51	61	50	53	53	42	61
Seattle	—	—	—	—	—	—	—	65	66	—	—	—	—	—	—	—	81	70
Spokane	—	—	—	—	—	—	—	62	62	—	—	—	—	—	—	—	68	71
Tucson	—	—	—	—	—	—	—	63	68	—	—	—	—	—	—	—	57	58
Washington, DC	59	60	60	64	64	66	69	65	69	75	72	71	67	65	58	57	65	—

— 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.

[3] Data prior to the third quarter of 1998 pertain to Manhattan only.

Source: 1991–1996 data from "Drug Use Forecasting" (1991–1996); 1997-1998 data from "Annual Report on Adult and Juvenile Arrestees," (1997 and 1998); 1999 data from "1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees," *Arrestee Drug Abuse Monitoring Program*, National Institute of Justice.

Table 17. Percentage[1] of Adult Booked Arrestees Who Used Marijuana, by Sex: 1991–99

	Males									Females								
	1991	1992	1993	1994	1995	1996	1997	1998	1999	1991	1992	1993	1994	1995	1996	1997	1998	1999
Albuquerque	—	—	—	—	—	—	—	36	37	—	—	—	—	—	—	—	24	24
Anchorage	—	—	—	—	—	—	—	33	38	—	—	—	—	—	—	—	23	31
Atlanta	12	22	26	25	32	37	36	26	44	8	13	16	15	13	26	28	—	34
Birmingham	16	22	28	28	36	44	43	39	39	10	13	12	17	12	22	25	18	26
Chicago	23	26	40	38	41	47	48	42	45	—	—	—	—	—	—	—	20	27
Cleveland	12	17	23	28	29	37	46	37	43	7	11	13	16	11	22	22	27	28
Dallas	19	28	28	33	37	44	44	43	39	11	24	19	22	21	44	28	24	27
Denver	25	34	36	39	33	42	42	41	44	16	19	24	22	21	27	32	30	34
Des Moines	—	—	—	—	—	—	—	42	43	—	—	—	—	—	—	—	15	34
Detroit	18	27	37	38	42	46	44	47	48	4	11	10	16	18	19	28	22	26
Ft. Lauderdale	28	32	30	29	33	38	38	44	39	14	21	20	18	18	24	24	25	29
Houston	17	24	24	23	29	33	24	36	38	8	12	15	13	18	26	17	20	23
Indianapolis	23	35	42	39	38	51	44	45	48	22	26	25	22	24	31	30	31	38
Laredo	—	—	—	—	—	—	—	39	33	—	—	—	—	—	—	—	13	9
Las Vegas	—	—	—	—	—	—	—	26	28	—	—	—	—	—	—	—	22	23
Los Angeles	19	23	23	20	23	30	27	27	32	9	13	15	12	14	38	18	22	21
Miami	23	30	26	28	29	34	32	29	36	—	—	—	—	—	—	—	—	—
Minneapolis	—	—	—	—	—	—	—	45	44	—	—	—	—	—	—	—	23	29
New Orleans	16	19	25	28	32	40	38	38	40	7	8	14	7	16	13	12	22	25
New York City[2]	18	22	21	24	28	38	32	39	41	11	12	19	15	16	19	25	23	26
Oklahoma City	—	—	—	—	—	—	—	53	48	—	—	—	—	—	—	—	—	39
Omaha	26	38	42	44	42	52	33	44	51	—	—	—	28	24	33	33	28	36
Philadelphia	18	26	32	32	34	39	41	45	41	14	15	20	18	20	21	21	24	26
Phoenix	22	22	31	29	29	28	30	32	36	14	15	20	22	19	22	21	25	26
Portland	33	28	30	27	29	35	38	37	35	28	17	17	19	16	26	19	23	23
Sacramento	—	—	—	—	—	—	—	44	44	—	—	—	—	—	—	—	28	33
St. Louis	16	21	28	36	39	52	48	50	—	8	11	15	15	18	29	31	32	—
Salt Lake City	—	—	—	—	—	—	—	37	35	—	—	—	—	—	—	—	29	23
San Antonio	20	28	32	30	34	39	34	41	36	9	16	16	15	16	19	17	18	16
San Diego	33	35	40	36	35	40	38	36	36	20	25	25	20	20	23	24	27	29
San Jose	25	24	27	30	27	27	29	25	34	13	18	17	18	12	19	17	14	26
Seattle	—	—	—	—	—	—	—	35	39	—	—	—	—	—	—	—	38	28
Spokane	—	—	—	—	—	—	—	43	44	—	—	—	—	—	—	—	27	32
Tucson	—	—	—	—	—	—	—	39	45	—	—	—	—	—	—	—	22	24
Washington, DC	11	20	26	30	32	40	39	38	35	6	8	9	10	18	23	19	29	—

— Data not available.

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

[2] Data prior to the third quarter of 1998 pertain to Manhattan only.

Source: 1991–1996 data from "Drug Use Forecasting" (1991–1996); 1997-1998 data from "Annual Report on Adult and Juvenile Arrestees," (1997 and 1998); 1999 data from "1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees," *Arrestee Drug Abuse Monitoring Program*, National Institute of Justice.

Table 18. Percentage[1] of Adult Booked Arrestees Who Used Cocaine, by Sex: 1991–99

	Males									Females								
	1991	1992	1993	1994	1995	1996	1997	1998	1999	1991	1992	1993	1994	1995	1996	1997	1998	1999
Albuquerque	—	—	—	—	—	—	—	39	43	—	—	—	—	—	—	—	59	56
Anchorage	—	—	—	—	—	—	—	20	26	—	—	—	—	—	—	—	50	36
Atlanta	57	58	59	57	57	59	51	51	51	66	58	68	62	62	63	61	—	62
Birmingham	52	49	51	50	49	43	39	41	37	44	46	41	50	48	39	49	57	34
Chicago	61	56	53	57	51	52	49	45	42	—	—	—	—	—	—	—	56	64
Cleveland	48	53	48	48	42	41	27	37	40	76	66	69	74	63	52	39	41	50
Dallas	43	41	44	35	31	32	32	29	34	45	48	43	46	44	36	34	30	40
Denver	30	38	41	40	44	44	40	40	41	41	50	47	51	52	53	50	50	51
Des Moines	—	—	—	—	—	—	—	18	16	—	—	—	—	—	—	—	24	22
Detroit	41	37	34	34	30	27	23	28	27	62	62	64	46	61	53	48	46	46
Ft. Lauderdale	44	46	43	41	39	44	51	50	41	55	47	45	52	50	52	57	53	52
Houston	56	41	41	29	40	39	40	36	36	52	44	43	36	32	34	29	37	23
Indianapolis	22	23	32	47	39	42	31	34	34	26	25	36	56	54	52	45	43	45
Laredo	—	—	—	—	—	—	—	37	42	—	—	—	—	—	—	—	33	21
Las Vegas	—	—	—	—	—	—	—	24	30	—	—	—	—	—	—	—	35	50
Los Angeles	44	52	48	48	44	44	38	43	36	62	58	59	53	49	56	49	45	37
Miami	61	56	61	56	42	52	46	47	49	—	—	—	—	—	—	—	—	—
Minneapolis	—	—	—	—	—	—	—	27	29	—	—	—	—	—	—	—	29	36
New Orleans	50	49	48	47	47	46	46	46	44	42	44	37	25	37	26	32	39	41
New York City[2]	62	62	66	68	68	56	58	47	44	66	72	70	80	71	69	62	67	65
Oklahoma City	—	—	—	—	—	—	—	27	26	—	—	—	—	—	—	—	—	35
Omaha	14	16	19	26	19	24	21	25	22	—	—	—	34	30	28	17	36	32
Philadelphia	62	63	56	54	51	40	34	45	39	64	67	61	61	59	69	58	61	60
Phoenix	20	26	30	28	27	32	32	31	32	45	49	38	36	33	42	33	40	43
Portland	30	35	33	32	30	34	37	29	23	40	54	47	43	40	46	45	37	33
Sacramento	—	—	—	—	—	—	—	18	16	—	—	—	—	—	—	—	31	30
St. Louis	48	50	50	50	51	43	41	35	—	47	62	62	69	57	55	53	44	—
Salt Lake City	—	—	—	—	—	—	—	20	22	—	—	—	—	—	—	—	20	26
San Antonio	31	32	31	31	24	28	26	27	23	25	25	24	22	24	23	18	20	19
San Diego	45	45	37	30	28	27	21	19	17	40	37	36	18	28	22	23	20	23
San Jose	33	28	23	19	18	16	14	8	14	30	32	19	23	16	21	16	10	20
Seattle	—	—	—	—	—	—	—	36	33	—	—	—	—	—	—	—	57	48
Spokane	—	—	—	—	—	—	—	18	18	—	—	—	—	—	—	—	32	31
Tucson	—	—	—	—	—	—	—	39	40	—	—	—	—	—	—	—	41	41
Washington, DC	49	44	37	38	35	33	33	33	38	68	64	62	55	46	40	39	40	—

— Data not available.

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

[2] Data prior to the third quarter of 1998 pertain to Manhattan only.

Source: 1991–1996 data from "Drug Use Forecasting" (1991–1996); 1997-1998 data from "Annual Report on Adult and Juvenile Arrestees," (1997 and 1998); 1999 data friom "1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees," *Arrestee Drug Abuse Monitoring Program*, National Institute of Justice.

Table 19. Percentage[1] of Adult Booked Arrestees Who Used Opiates, by Sex: 1991–99

	Males									Females								
	1991	1992	1993	1994	1995	1996	1997	1998	1999	1991	1992	1993	1994	1995	1996	1997	1998	1999
Albuquerque	—	—	—	—	—	—	—	8	14	—	—	—	—	—	—	—	15	31
Anchorage	—	—	—	—	—	—	—	2	3	—	—	—	—	—	—	—	4	2
Atlanta	3	4	3	2	3	3	2	1	4	4	5	4	4	3	3	3	—	5
Birmingham	5	3	4	4	2	4	5	4	4	11	4	4	3	3	6	5	18	4
Chicago	21	19	28	27	22	20	22	18	20	—	—	—	—	—	—	—	27	32
Cleveland	3	3	4	3	5	3	4	6	4	6	5	4	4	6	6	4	1	8
Dallas	4	4	4	3	5	5	4	2	5	9	8	10	7	5	5	5	5	7
Denver	2	2	4	4	5	5	4	4	3	2	5	6	5	6	5	6	3	3
Des Moines	—	—	—	—	—	—	—	3	1	—	—	—	—	—	—	—	6	3
Detroit	8	8	8	7	7	7	5	7	9	11	15	14	13	15	18	9	22	16
Ft. Lauderdale	1	1	1	1	2	2	3	2	1	4	3	3	3	3	3	4	5	4
Houston	3	3	2	3	5	8	10	8	6	4	4	4	6	3	4	5	7	7
Indianapolis	3	4	4	3	2	3	3	2	3	11	7	4	5	7	3	3	5	5
Laredo	—	—	—	—	—	—	—	11	11	—	—	—	—	—	—	—	0	2
Las Vegas	—	—	—	—	—	—	—	3	5	—	—	—	—	—	—	—	14	9
Los Angeles	10	10	9	10	7	6	6	6	6	18	13	14	12	10	17	11	9	8
Miami	2	2	2	2	3	1	2	2	3	—	—	—	—	—	—	—	—	—
Minneapolis	—	—	—	—	—	—	—	5	4	—	—	—	—	—	—	—	6	9
New Orleans	4	4	5	5	7	7	11	13	14	7	6	5	2	4	3	3	3	7
New York City[2]	14	18	20	19	20	17	19	16	15	21	24	23	30	19	27	20	22	21
Oklahoma City	—	—	—	—	—	—	—	2	2	—	—	—	—	—	—	—	—	3
Omaha	2	2	2	2	1	1	2	2	0	—	—	—	2	2	3	4	5	0
Philadelphia	11	12	11	14	12	11	11	18	15	9	11	14	18	14	16	16	15	14
Phoenix	5	5	6	6	8	9	9	6	8	17	15	14	12	12	13	8	7	12
Portland	9	11	11	12	15	13	14	16	13	17	22	19	21	18	26	27	25	19
Sacramento	—	—	—	—	—	—	—	3	4	—	—	—	—	—	—	—	8	5
St. Louis	6	7	9	11	11	10	10	11	—	7	7	16	8	8	7	9	5	—
Salt Lake City	—	—	—	—	—	—	—	8	9	—	—	—	—	—	—	—	14	15
San Antonio	16	15	14	13	10	10	10	10	10	21	14	14	14	13	13	9	9	10
San Diego	17	16	16	12	8	9	7	9	9	21	17	20	13	12	10	12	7	11
San Jose	8	4	6	6	5	5	6	4	4	7	9	8	10	10	9	12	5	13
Seattle	—	—	—	—	—	—	—	17	14	—	—	—	—	—	—	—	17	20
Spokane	—	—	—	—	—	—	—	9	7	—	—	—	—	—	—	—	17	13
Tucson	—	—	—	—	—	—	—	7	9	—	—	—	—	—	—	—	7	9
Washington, DC	10	11	10	9	8	9	10	10	16	16	19	21	13	16	11	11	10	—

— Data not available.

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

[2] Data prior to the third quarter of 1998 pertain to Manhattan only.

Source: 1991–1996 data from "Drug Use Forecasting" (1991–1996); 1997-1998 data from "Annual Report on Adult and Juvenile Arrestees," (1997 and 1998); 1999 data from "1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees," *Arrestee Drug Abuse Monitoring Program*, National Institute of Justice.

Table 20. Percentage[1] of Adult Booked Arrestees Who Used Methamphetamine, by Sex: 1991–99

	Males									Females								
	1991	1992	1993	1994	1995	1996	1997	1998	1999	1991	1992	1993	1994	1995	1996	1997	1998	1999
Albuquerque	—	—	—	—	—	—	—	3.4	5.1	—	—	—	—	—	—	—	2.4	8.9
Anchorage	—	—	—	—	—	—	—	0.0	0.5	—	—	—	—	—	—	—	0.0	0.0
Atlanta	0.2	0.1	0.4	0.1	0.4	—	0.6	0.0	0.4	0.3	0.0	0.3	0.3	0.6	—	0.7	—	0.8
Birmingham	0.1	0.0	0.0	0.2	0.1	—	0.6	0.0	0.1	0.3	0.0	1.2	1.2	0.0	—	0.5	0.0	0.9
Chicago	0.0	0.0	0.0	0.1	0.0	—	0.3	0.2	0.0	—	—	—	—	—	—	—	0.0	0.0
Cleveland	0.0	0.0	0.0	0.0	0.0	—	0.0	0.0	0.0	0.3	0.0	0.0	0.0	0.0	—	0.0	0.0	0.0
Dallas	0.6	0.9	2.0	2.0	2.2	—	2.6	3.3	2.5	1.5	2.7	3.3	3.3	3.7	—	2.8	4.0	3.2
Denver	0.8	1.0	1.2	2.1	4.1	—	5.0	5.2	3.0	1.7	1.4	2.1	2.1	3.2	—	4.6	4.6	2.4
Des Moines	—	—	—	—	—	—	—	10.2	14.0	—	—	—	—	—	—	—	24.2	22.4
Detroit	0.1	0.0	0.0	0.0	0.0	—	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.6	—	0.0	0.0	0.0
Ft. Lauderdale	0.0	0.0	0.0	0.0	0.1	—	0.1	0.0	0.4	0.0	0.0	0.2	0.2	0.0	—	0.0	0.0	0.0
Houston	0.1	0.1	0.1	0.0	0.1	—	0.0	0.2	0.1	0.9	0.0	0.2	0.2	0.9	—	0.5	0.0	0.1
Indianapolis	0.0	0.1	0.2	0.4	0.8	—	0.2	0.8	0.6	0.3	0.0	0.6	0.6	0.0	—	0.2	0.0	0.5
Laredo	—	—	—	—	—	—	—	0.0	0.2	—	—	—	—	—	—	—	0.0	0.0
Las Vegas	—	—	—	—	—	—	—	13.8	16.2	—	—	—	—	—	—	—	24.3	17.9
Los Angeles	5.4	4.8	8.2	7.7	5.8	—	4.7	8.0	8.9	6.8	8.0	9.8	9.8	11.3	—	8.9	11.8	12.0
Miami	0.0	0.0	0.0	0.0	0.0	—	0.0	0.2	0.0	—	—	—	—	—	—	—	—	—
Minneapolis	—	—	—	—	—	—	—	0.8	1.1	—	—	—	—	—	—	—	0.0	2.5
New Orleans	0.2	0.2	0.0	0.1	0.0	—	0.0	0.2	0.1	0.3	0.5	0.5	0.5	0.0	—	0.0	0.3	0.0
New York City[2]	0.2	0.0	0.1	0.3	0.0	—	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	—	0.0	0.0	0.0
Oklahoma City	—	—	—	—	—	—	—	8.0	8.7	—	—	—	—	—	—	—	—	11.3
Omaha	0.1	0.5	1.4	3.3	7.8	—	9.7	10.2	7.8	—	—	2.7	2.7	10.3	—	13.3	13.6	11.1
Philadelphia	0.5	0.5	0.4	0.1	0.4	—	0.6	0.6	0.2	0.2	0.4	0.7	0.7	1.1	—	0.0	0.3	0.0
Phoenix	4.5	5.1	15.6	25.4	22.0	—	16.4	16.4	16.6	5.6	6.9	26.0	26.0	21.7	—	25.6	22.4	14.3
Portland	7.5	5.9	11.3	16.3	18.1	—	15.9	18.1	19.8	11.5	7.3	21.4	21.4	19.7	—	20.7	22.3	24.8
Sacramento	—	—	—	—	—	—	—	24.6	27.6	—	—	—	—	—	—	—	29.2	32.4
St. Louis	0.2	0.1	0.0	0.5	0.6	—	0.4	0.3	—	0.0	0.0	0.0	0.0	0.3	—	2.1	2.5	—
Salt Lake City	—	—	—	—	—	—	—	20.3	24.8	—	—	—	—	—	—	—	31.4	34.1
San Antonio	1.3	0.8	0.6	1.0	1.1	—	1.7	2.0	1.8	1.6	1.6	0.7	0.7	2.5	—	2.4	1.7	1.4
San Diego	18.0	23.7	35.5	41.0	36.0	—	39.6	33.2	26.0	24.9	25.5	53.0	53.0	40.2	—	42.2	33.3	36.3
San Jose	6.6	5.9	15.3	19.9	16.3	—	18.4	19.7	24.4	7.1	11.3	23.3	23.3	23.6	—	24.9	21.1	31.6
Seattle	—	—	—	—	—	—	—	6.4	9.0	—	—	—	—	—	—	—	5.2	9.5
Spokane	—	—	—	—	—	—	—	15.8	20.1	—	—	—	—	—	—	—	22.0	26.6
Tucson	—	—	—	—	—	—	—	4.0	5.8	—	—	—	—	—	—	—	2.5	9.6
Washington, DC	0.1	0.0	0.1	0.1	0.1	—	0.3	0.0	0.9	0.0	0.0	0.0	0.0	0.0	—	0.0	0.5	—

— Data not available.

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

[2] Data prior to the third quarter of 1998 pertain to Manhattan only.

Source: 1991–1996 data from "Drug Use Forecasting" (1991–1996); 1997-1998 data from "Annual Report on Adult and Juvenile Arrestees," (1997 and 1998); 1999 data from "1999 Annual Report on Drug Use Among Adult and Juvenile Arrestees," *Arrestee Drug Abuse Monitoring Program*, National Institute of Justice.

Table 21. Percentage of Juvenile Male Booked Arrestees Who Used Any Drug,[1] 1994–99

	Any drug use[2]					
	1994	1995	1996	1997	1998	1999
Birmingham	38	44	55	63	51	45
Cleveland	47	53	63	61	62	62
Denver	54	51	61	65	62	62
Indianapolis	30	34	44	42	50	—
Los Angeles	37	42	57	62	61	54
Phoenix	51	48	56	56	69	69
Portland	23	19	38	43	53	43
St. Louis	38	38	56	54	40	—
San Antonio	39	44	50	58	55	56
San Diego	42	53	53	63	56	57
San Jose	35	35	46	52	42	—
Tucson	—	—	—	—	51	56
Washington, DC	64	58	67	66	59	—

— 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: 1994–1996 data from "Drug Use Forecasting" (1994–1996); 1997 to 1999 data from "Annual Report on Adult and Juvenile Arrestees," (1997 to 1999) *Arrestee Drug Abuse Monitoring Program*, National Institute of Justice.

Table 22. Percentage of Juvenile Male Booked Arrestees Who Used Marijuana, 1994–99

	1994	1995	1996	1997	1998	1999
Birmingham	34	42	53	61	47	43
Cleveland	42	47	62	58	60	60
Denver	52	49	60	62	59	59
Indianapolis	26	33	43	39	47	—
Los Angeles	31	34	51	55	56	52
Phoenix	41	41	52	49	64	62
Portland	18	16	36	41	50	41
St. Louis	34	34	56	54	40	—
San Antonio	35	41	48	53	49	53
San Diego	33	48	48	53	49	53
San Jose	28	31	41	45	35	—
Tucson	—	—	—	—	48	53
Washington, DC	61	54	65	65	57	—

— Data not available.

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

Source: 1994–1996 data from "Drug Use Forecasting" (1994–1996); 1997 to 1999 data from "Annual Report on Adult and Juvenile Arrestees," (1997 to 1999) *Arrestee Drug Abuse Monitoring Program*, National Institute of Justice.

Table 23. Percentage of Juvenile Male Booked Arrestees Who Used Cocaine, 1994–99

	1994	1995	1996	1997	1998	1999
Birmingham	6	6	9	8	9	4
Cleveland	17	17	12	12	12	9
Denver	10	8	7	8	13	9
Indianapolis	8	5	6	3	11	—
Los Angeles	8	12	13	12	15	8
Phoenix	11	8	13	14	14	16
Portland	3	2	3	4	4	3
St. Louis	10	5	4	4	2	—
San Antonio	9	6	10	15	8	7
San Diego	2	4	5	4	4	3
San Jose	5	4	4	4	6	—
Tucson	—	—	—	—	5	12
Washington, DC	9	4	4	4	3	—

— Data not available.

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

Source: 1994–1996 data from "Drug Use Forecasting" (1994–1996); 1997 to 1999 data from "Annual Report on Adult and Juvenile Arrestees," (1997 to 1999) *Arrestee Drug Abuse Monitoring Program*, National Institute of Justice.

Table 24. Percentage of Juvenile Male Booked Arrestees Who Used Opiates, 1994–99

	1994	1995	1996	1997	1998	1999
Birmingham	2	1	2	2	0	0
Cleveland	*	0	*	2	0	*
Denver	*	*	*	0	0	*
Indianapolis	1	*	*	1	0	—
Los Angeles	*	1	1	1	1	1
Phoenix	0	1	1	1	1	2
Portland	*	*	*	1	1	3
St. Louis	2	2	0	1	0	—
San Antonio	1	*	4	3	1	3
San Diego	1	1	1	2	1	*
San Jose	*	*	*	0	2	—
Tucson	—	—	—	—	0	1
Washington, DC	*	1	*	0	2	—

— Data not available.

* Less than one percent.

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

Source: 1994–1996 data from "Drug Use Forecasting" (1994–1996); 1997 to 1999 data from "Annual Report on Adult and Juvenile Arrestees," (1997 to 1999) *Arrestee Drug Abuse Monitoring Program*, National Institute of Justice.

Table 25. Percentage of Juvenile Male Booked Arrestees Who Used Methamphetamine, 1997–99

	1997	1998	1999
Birmingham	2.1	0.0	0.0
Cleveland	0.0	0.0	0.0
Denver	1.2	0.7	0.3
Indianapolis	0.2	0.0	—
Los Angeles	6.5	3.6	2.2
Phoenix	6.5	6.0	5.6
Portland	2.5	3.0	0.0
St. Louis	0.0	0.0	—
San Antonio	0.3	0.4	0.0
San Diego	17.2	12.2	15.8
San Jose	13.7	9.0	—
Tucson	—	0.0	0.7
Washington, DC	0.0	0.0	—

— Data not available.

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

Source: "Annual Report on Adult and Juvenile Arrestees," (1997 to 1999) *Arrestee Drug Abuse Monitoring Program*, National Institute of Justice.

Table 26. Substance Abuse among Probationers, State Prison Inmates, and Federal Prison Inmates

	Number	Ever Used	Used Regularly*	Used Month Prior to Offense	Used at Time of Offense
Probation (1995)[1]	2,065,896	69.4%	43.4%	31.8%	13.5%
State Prison Inmates (1997)[2]	1,059,607	83.0%	69.6%	56.5%	32.6%
Federal Prison Inmates (1997)[3]	88,018	72.9%	57.3%	44.8%	22.4%
Jail Inmates (1996)[4]	507,026	82.4%*	64.2%	55.0%	35.6%

* Regular use defined as once a week or more for at least a month

[1]Substance Abuse of Adults on Probation, 1995 (March 1998)

[2]Substance Abuse Among State and Federal Prisoners, 1997

[3]Substance Abuse Among State and Federal Prisoners, 1997 (December 1998)

[4]Profile of Jail Inmates, 1996 (April 1998).

*Note: Includes convicted and non-convicted inmates. Other figures include convicted jail inmates only.

Source: Bureau of Justice Statistics, Office of Justice Programs, Department of Justice. *1995 Survey of Adults on Probation and 1997 Survey on Inmates in State and Federal Correctional Facilities.*

Table 27. Alcohol, Drug, and Mental Health (ADM) Problems Among Homeless Clients, 1996

Any Combination	Past Month (%)	Past Year (%)	Lifetime (%)
Any ADM Problem	66	74	86
Alcohol Problem	38	46	62
Drug Problem	26	38	58
Mental Health Problem	39	45	57
Specific Combinations			
Alcohol Problem Only	13	12	9
Drug Problem Only	7	7	6
Mental Health Problem Only	17	15	10
Alcohol and Drug Problems	7	10	15
Alcohol and Mental Health Problems	10	10	15
Drug and Mental Health Problems	5	7	8
Alcohol, Drug, and Mental Health Problems	8	14	30
No ADM problems	34	26	14

Source: Interagency Council on the Homeless. *Homelessness: Programs and the People They Serve.* U.S. Department of Housing and Urban Development, 1999.

Table 28. Characteristics Perceived by Respondents to Prevent Exit from Homelessness, 1996

	Percentage*
Insufficient Income	30
Lack of a Job	24
No Suitable Housing	11
Addiction to Alcohol or Drugs	9
Other	24

*May not sum to 100% due to rounding.

Source: Interagency Council on the Homeless. *Homelessness: Programs and the People They Serve.* U.S. Department of Housing and Urban Development, 1999.

Table 29. Substance Use Experiences by Homeless Status, 1996

	Currently Homeless (N=2938)	Formerly Homeless Clients (N=677)	Other Service Users (N=518)
When first started drinking3 or more alcoholic beverages a week			
Before age 15	36(%)	29(%)	13(%)
Between ages 15 and 17	29	28	33
When first started using illegal drugs			
Before age 15	31	28	27
Between ages 15 and 17	32	21	22

Source: Interagency Council on the Homeless. *Homelessness: Programs and the People They Serve.* U.S. Department of Housing and Urban Development, 1999.

DRUG USE CONSEQUENCES

Table 30. Lost Potential Productivity Due to Drug Abuse, 1992 and 1995* (Millions of Current Dollars)

	1992	1995
Lost earnings – premature death	$14,575	$16,247
Lost earnings – illness	$15,682	$17,481
Lost earnings – crime victims	$39,164	$43,829
Total	$69,421	$77,557

Source: National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism (1998). *The Economic Costs of Alcohol and Drug Abuse in the United States, 1992.*

Table 31. Number of Deaths and Death Rates for Drug-Induced Causes,[1] by Sex and Race: United States, 1979–98

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
1997	15,973	10,991	4,982	12,863	3,110	2,816
1998	16,926	11,462	5,464	13,811	3,115	2,831
		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
1997	6.0	8.4	3.6	5.8	6.7	8.3
1998	6.3	8.7	4.0	6.2	6.6	8.2

[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: Murphy, S.L. "Deaths: Final Data for 1998." *National Vital Statistics Reports*, Vol. 48, No. 11, Hyattsville, MD: Centers for Disease Control and Prevention/National Center for Health Statistics, 2000.

Table 32. Trends in Drug-Related Emergency Room Episodes and Selected Drug Mentions, 1988–99

Year	Emergency room episodes and drug mentions				
	Total drug episodes	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
1998	542,544	982,856	172,014	77,645	76,870
1999	554,932	1,015,206	168,763	84,409	87,150

Source: *Drug Abuse Warning Network*, National Institute on Drug Abuse (1988–91) and Substance Abuse and Mental Health Services Administration (1992–99).

Table 33. Estimated Number of Persons Living with AIDS[1] by Sex and Exposure Category, 1993–98

	Exposure Category								
	Men who have sex with men (MSM)	Injecting drug use (IDU)	MSM and IDU	Hemophilia/coagulation disorder	Heterosexual contact	Receipt of blood transfusion[2]	Risk not reported or identified	Total	Percent drug-related[3]
Male adult/adolescent									
1993	86,720	34,465	13,645	1,618	6,066	918	1,015	144,467	33.3%
1994	95,171	40,153	14,635	1,698	7,690	947	969	161,463	33.9%
1995	102,717	44,589	15,369	1,728	9,771	1,008	969	175,151	34.2%
1996	111,076	49,074	16,034	1,742	12,219	1,083	1,011	192,239	33.8%
1997	122,874	54,249	17,203	1,788	15,011	1,189	1,064	213,378	33.4%
1998	133,840	58,843	18,181	1,838	17,765	1,313	1,133	232,913	33.0%
Female adult/adolescent									
1993	N/A	13,793	N/A	91	11,829	766	383	26,862	51.3%
1994	N/A	16,175	N/A	108	16,175	854	390	32,667	49.5%
1995	N/A	18,294	N/A	137	18,524	908	392	38,255	47.8%
1996	N/A	20,285	N/A	167	22,588	1,006	429	44,475	45.6%
1997	N/A	22,586	N/A	207	27,017	1,120	477	51,407	43.9%
1998	N/A	24,500	N/A	240	31,336	1,243	519	57,838	42.3%

N/A Not applicable.

[1]Excludes pediatric AIDS cases (<13 years old). These numbers do not represent actual cases of persons living with AIDS. Rather, these numbers are point estimates of persons living with AIDS derived by subtracting the estimated cumulative number of deaths in persons with AIDS from the estimated cumulative number of persons with AIDS. Estimated AIDS cases are adjusted for reporting delays and for redistribution of cases initially reported with no identified risk, but not for incomplete reporting. Annual estimates are through the most recent year for which reliable estimates are available.

[2]Includes receipt of blood components or tissue.

[3]Proportion includes injection drug users and MSM who are injection drug users.

Source: Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report, 1999*; 11 (No. 2), Table 28.

Table 34. Estimated Number of Deaths of Persons with AIDS[1] by Sex and Exposure Category, 1993–98

	Exposure Category								
	Men who have sex with men (MSM)	Injecting drug use (IDU)	MSM and IDU	Hemophilia/coagulation disorder	Heterosexual contact	Receipt of blood transfusion[2]	Risk not reported or identified	Total	Percent drug-related[3]
Male adult/adolescent									
1993	23,786	9,275	3,153	354	1,582	314	172	38,637	32.1%
1994	25,124	10,323	3,451	348	1,987	304	148	41,684	33.0%
1995	24,659	10,764	3,389	328	2,362	262	104	41,869	33.8%
1996	16,684	8,508	2,464	241	2,085	220	67	30,369	36.1%
1997	8,568	5,332	1,421	136	1,447	113	47	17,066	39.5%
1998	6,716	4,419	1,183	107	1,221	82	28	13,755	40.7%
Female adult/adolescent									
1993	N/A	3,124	N/A	17	2,640	237	75	6,093	51.2%
1994	N/A	3,687	N/A	26	3,456	228	55	7,452	49.4%
1995	N/A	3,800	N/A	29	3,963	229	58	8,078	47.0%
1996	N/A	3,275	N/A	30	3,428	174	34	6,942	47.1%
1997	N/A	2,141	N/A	21	2,289	96	20	4,567	46.8%
1998	N/A	1,861	N/A	16	1,994	75	16	3,961	46.9%

N/A Not applicable.

[1]Excludes pediatric AIDS cases (<13 years old). These numbers do not represent actual deaths of persons with AIDS. Rather, these numbers are point estimates adjusted for delays in the reporting of deaths and for redistribution of cases initially reported with no identified risk, but not for incomplete reporting. Annual estimates are through the most recent year for which reliable estimates are available.

[2]Includes receipt of blood components or tissue.

[3]Proportion includes injection drug users and MSM who are injection drug users.

Source: Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report, 1999*; 11(No. 2), Table 31.

Table 35. Reported Tuberculosis Cases and Percent of Cases in Injecting and Noninjecting Drug Users 1996-99

	1996	1997	1998	1999
Total Tuberculosis Cases	21,337	19,851	18,361	17,531
Cases with information on injecting drug use (number)	18,467	17,678	16,849	16,331
Cases with information on injecting drug use (percent)	86.5%	89.1%	91.8%	93.2%
Percent of cases in injecting drug users[1]	***3.8%***	***3.3%***	***2.9%***	***2.6%***
Cases with information on noninjecting drug use (number)	18,265	17,555	16,730	16,232
Cases with information on noninjecting drug user (percent)	85.6%	88.4%	91.1%	92.6
Percent of cases in noninjecting drug users[1]	**7.7%**	**7.8%**	**7.7%**	**7.1%**

[1]Injecting drug use within past 12 months. Percentages shown only for reporting areas with information reported for >=75% of cases.

Source: Centers for Disease Control and Prevention. *Reported Tuberculosis in the United States, 1996, 1997, 1998, and 1999.*

Table 36. Reported Hepatitis Cases, 1995-98

	1995	1996	1997	1998
	Number of Reported Cases			
Hepatitis A	31,582	31,032	30,021	23,229
Hepatitis B	10,805	10,637	10,416	10,258
Hepatitis C	4,576	3,716	3,816	3,518
	Reported Cases per 100,000 Population			
Hepatitis A	12.13	11.70	11.22	8.59
Hepatitis B	4.19	4.01	3.90	3.80
Hepatitis C	1.78	1.41	1.43	1.30

Source: Centers for Disease Control and Prevention. Summary of Notifiable Diseases, United States 1999. *Morbidity and Mortality Weekly Report* 47(53).1999.

Table 37. Total Crime, Violent Crime, and Property Crime, 1989–99

Year	Total crime index[1]	Total crime rate[2]	Violent crime index[1]	Violent crime rate[2]	Total murder victims[1]	Murders related to narcotic drug laws	Property crime[1]	Property crime rate[2]
1989	14,251,400	5,741.0	1,646,040	663.1	21,500	1,402	12,605,400	5,077.9
1990	14,475,613	5,820.3	1,820,127	731.8	23,438	1,367	12,655,486	5,088.5
1991	14,872,883	5,897.8	1,911,767	758.1	24,703	1,353	12,961,116	5,139.7
1992	14,438,191	5,660.2	1,932,274	757.5	23,760	1,302	12,505,917	4,902.7
1993	14,144,794	5,484.4	1,926,017	746.8	24,526	1,295	12,218,777	4,737.6
1994	13,989,543	5,373.5	1,857,670	713.6	23,326	1,239	12,131,873	4,660.0
1995	13,862,727	5275.9	1,798,792	684.6	21,606	1,031	12,063,935	4,591.3
1996	13,493,863	5,086.6	1,688,540	636.5	19,645	843	11,805,323	4,450.1
1997	13,194.751	4,930.0	1,636,096	611.3	18,209	786	11,5558,475	4,318.7
1998	12,485,714	4,619.3	1,533,887	567.5	16,914	679	10,951,827	4,051.8
1999	11,635,149	4,266.8	1,430,693	524.7	12,568	564	10,204,456	3,742.1

[1] Number of offenses reported to law-enforcement agencies.

[2] Rates per 100,000 inhabitants.

Source: *Crime in the United States: Uniform Crime Reports*, U.S. Department of Justice, Federal Bureau of Investigation (1990-2000).

Table 38. Total Estimated Arrests and Drug Arrests, 1989–99

Year	Total arrests	Arrests for all drug abuse violations[1]		Distribution of arrests for drug abuse violations[2]					
				Heroin/cocaine[3]		Marijuana		Other drugs	
		Number	Percent	Sale[4]	Possession	Sale[4]	Possession	Sale[4]	Possession
1989	14,340,900	1,361,700	9.4	19.1	34.7	6.2	23.1	7.0	9.8
1990	14,195,100	1,089,500	7.6	21.0	33.3	6.1	23.9	4.5	11.2
1991	14,211,900	1,010,000	7.1	22.5	32.8	6.1	22.4	4.8	11.5
1992	14,075,100	1,066,400	7.5	20.6	32.4	6.6	25.5	4.6	10.4
1993	14,036,300	1,126,300	8.0	19.2	31.1	6.2	27.6	4.3	11.6
1994	14,648,700	1,351,400	9.2	16.8	30.3	5.8	29.8	4.1	13.2
1995	15,119,800	1,476,100	9.7	14.7	27.8	5.8	34.1	4.4	13.3
1996	15,168,100	1,506,200	9.9	14.2	25.6	6.3	36.3	4.3	13.3
1997	15,284,300	1,583,600	10.3	10.3	25.4	5.6	38.3	4.7	15.8
1998	14,528,300	1,559,100	10.7	11.0	25.6	5.4	38.4	4.8	14.8
1999	14,031,070	1,532,200	10.9	10.0	24.5	5.5	40.5	4.1	15.4

[1]Arrest totals are based on all reporting agencies and estimates for unreported areas from Section IV table entitled "Total Estimated Arrests, Unites States."

[2]Because of rounding, percentages across may not add up to 100%.

[3]Includes heroin or cocaine and their derivatives.

[4] Includes sale/manufacture of drugs.

Source: *Crime in the United States: Uniform Crime Reports*, U.S. Department of Justice, Federal Bureau of Investigation (1990-2000).

Table 39. Adults in Custody of State or Federal Prisons or Local Jails, 1989–99

	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	1,176922	62.6	20.7	567,079
1998*	1,178,978	123,041	1,232,900	58.7	20.7	592,462
1999	1,209,123	135,246	1,366,369	57.8	—	605,943

*The 1998 prison custody count was estimated and rounded to nearest 100.

— Data not available.

Sources: Bureau of Justice Statistics Bulletin, *Prisoners in 1999* (August 2000), *Prisoners in 1998* (August 1999), *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) and unpublished Bureau of Prisons data.

DRUG TREATMENT

Table 40. One-Day Census of Clients in Treatment, by Facility Service Orientation, 1980–98

	Free standing substance abuse treatment[1]	Mental health services[2]	Physical health services[3]	Other community services and settings[4]	Correctional settings and services[5]	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	940,14
1997	479,184	225,777	125,061	39,467	59,597	929,086
1998*	581,119	262,536	145,901	39,316	109,130	1,138,002

* Preliminary data

[1] Free-standing substance abuse treatment includes facilities that provide no medical or mental health services other than substance abuse treatment.

[2] Mental health settings and services include psychiatric hospitals and community mental health centers or other mental health facilities that provide a range of mental health services in addition to substance abuse treatment.

[3] Physical health settings and services include hospitals and community health centers that provide medical services in addition to substance abuse treatment. These facilities may also provide mental health services.

[4] Community settings and services are community or religious agencies or organizations that provide social services in addition to substance abuse treatment. Schools are included in this category.

[5] Criminal justice system includes jails, prisons, juvenile detention facilities, TASC pretrial diversion, court referral, probation, parole, community corrections, and drug courts.

Note: Changes in data collection methods include: 1) Prior to 1992, no attempt was made to adjust for survey non-response. Beginning in 1992, survey non-respondents were contacted to obtain a minimum data set. This is reflected in larger and more consistent numbers of clients. 2) The number of possible responses to the 'Facility service orientation' question increased from 7 in 1980 to 16 in 1998. Beginning in 1995, facilities were permitted to select more than setting. While this table summarizes facility service orientation in broad categories, some misclassification is possible. 3) Prior to 1995, facilities providing programs for DUI/DWI offenders could not be distinguished. In 1995 and 1996, these facilities were identified and classified in the above table as 'Correctional settings'. 2) In 1997 only, facilities providing programs for DUI/DWI offenders did not complete the full survey, and did not provide client counts.

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), 1995-98.

Table 41. One-Day Census of Clients in Alcohol and/or Drug Abuse Treatment, by Age Group and Sex, 1987–98

Year	Age Group							Sex		
	Under 18 years	18-24 years	24-34 years	35-44 years	45-64 years	65 years and over	Total	Male	Female	Total
1987	63,245	123,384	199,362	141,612	79,151	6,949	613,703	443,931	169,772	613,703
1989	75,204	144,457	244,156	174,360	89,049	7,729	734,955	517,581	217,374	734,955
1990	49,107	143,340	269,040	200,108	98,463	7,771	767,829	553,968	213,861	767,829
1991	48,045	147,617	286,066	216,778	105,107	8,206	811,819	588,295	223,524	811,819
1992	51,223	155,936	332,330	267,162	129,275	8,954	944,880	671,997	272,883	944,880
1993	59,818	153,040	325,330	264,906	131,352	9,762	944,208	663,968	280,240	944,208
1995	70,050	143,750	314,003	299,620	167,757	13,947	1,009,127	707,252	301,875	1,009,127
1996	76,687	122,739	283,673	295,780	145,819	15,443	940,141	640,369	299,772	940,141
1997	81,456	160,376	270,286	264,549	135,758	16,661	929,086	632,113	296,973	929,086
1998*	102,340	201,302	312,030	325,326	179,205	17,799	1,138,002	779,873	358,129	1,138,002

* Preliminary data

Note: Changes in data collection methods are reflected in the table: 1) Prior to 1992, no attempt was made to adjust for survey non-response. Beginning in 1992, survey non-respondents were contacted to obtain a minimum data set. This is reflected in larger and more consistent numbers of clients. 2) In 1997 only, facilities providing programs for DUI/DWI offenders did not complete the full survey, and did not provide client counts.

Source: Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *National Drug and Alcoholism Treatment Unit Survey (NDATUS) 1987-1993*; Uniform Facility Data Set Survey (UFDS), 1995-98.

Table 42. Estimates of Number of Persons Needing and Receiving Treatment for Drug Abuse Problems, 1991–98 (Thousands)

	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
1997	9,474	3,748	5,726	2,137	37	63	3,589
1998	8,993	3,962	5,031	2,137	43	57	2,894

* 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 1991–98 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.

Due to improvements in coverage in the Uniform Facility Data Set (UFDS) in 1998, UFDS counts of clients in treatment are not comparable to earlier counts. Therefore, the 1997 estimate of number treated was used to estimate treatment gap in 1998. 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* (1991–1998).

Table 43. Number of Clients in Treatment Aged 12 and Over by Substance Abuse Problem, According to State or Jurisdiction:[1] October 1, 1997 and October 1, 1998

State or Jurisdiction[2]	Substance abuse problem							
	Total		Both alcohol and drug abuse		Drug abuse only		Alcohol abuse only	
	1997	1998	1997	1998	1997	1998	1997	1998
Clients in treatment	916,637	1,030,028	376,482	509,784	299,593	275,924	240,562	244,924
Alaska	10,664	8,933	2,385	4,274	5,808	2,929	2,471	1,730
Alabama	5,261	2,915	2,101	1,439	894	215	2,266	1,261
Arizona	12,307	19,804	4,297	8,795	4,612	5,883	3,398	5,126
Arkansas	4,129	7,006	1,652	4,096	1,588	1,480	889	1,430
California	88,876	126,340	36,421	57,515	39,646	41,512	12,809	27,313
Colorado	13,530	24,079	4,388	10,890	4,297	4,280	4,845	8,909
Connecticut	15,592	16,037	5,949	7,079	7,199	6,192	2,444	2,766
Delaware	3,567	3,767	2,256	1,912	624	1,059	687	796
District of Columbia	8,201	6,499	2,722	3,949	4,033	1,654	1,446	896
Florida	41,663	45,591	19,358	24,867	13,908	11,961	8,397	8,763
Georgia	16,118	15,775	7,299	7,231	4,883	4,452	3,936	4,092
Hawaii	2,177	3,012	893	1,700	784	663	500	649
Idaho	2,464	2,896	1,717	1,858	360	430	387	608
Illinois	39,040	45,872	17,967	22,638	10,839	12,088	10,234	11,146
Indiana	18,458	16,855	7,597	7,384	4,334	3,695	6,527	5,776
Iowa	5,373	7,287	2,580	3,646	870	1,028	1,923	2,613
Kansas	8,288	8,951	3,906	5,022	1,637	1,557	2,745	2,372
Kentucky	12,119	14,656	4,093	6,597	3,365	2,712	4,661	5,347
Louisiana	12,185	16,991	6,273	9,664	3,595	4,162	2,317	3,165
Maine	8,188	8,577	3,948	4,306	1,496	1,195	2,744	3,076
Maryland	23,794	23,960	10,088	11,001	8,868	7,921	4,838	5,038
Massachusetts	33,219	42,508	13,984	23,781	10,235	9,871	9,000	8,856
Michigan	49,788	48,963	18,123	19,858	14,135	13,266	17,530	15,839
Minnesota	7,593	10,403	3,621	5,532	1,275	2,227	2,697	2,644
Mississippi	5,334	8,877	2,515	5,028	1,391	1,882	1,428	1,967
Missouri	11,090	17,596	5,789	11,330	2,740	2,913	2,561	3,353
Montana	2,298	2,470	1,135	1,326	482	317	681	827
Nebraska	4,197	5,515	2,140	3,065	444	746	1,613	1,704
Nevada	5,279	7,962	1,697	4,678	2,158	1,590	1,424	1,694
New Hampshire	2,507	3,374	1,028	1,741	465	312	1,014	1,321
New Jersey	20,594	24,666	9,147	11,999	7,928	8,882	3,519	3,785
New Mexico	6,452	10,304	2,469	4,280	1,132	2,051	2,851	3,973
New York	127,272	115,870	35,175	49,495	64,260	49,257	27,837	17,118
North Carolina	17,379	25,358	8,358	13,535	3,427	4,538	5,594	7,285
North Dakota	2,086	3,011	856	1,418	242	365	988	1,228
Ohio	40,401	42,490	20,864	23,839	7,950	7,413	11,587	11,238
Oklahoma	7,572	8,750	2,511	3,480	2,415	2,587	2,646	2,683
Oregon	22,627	18,116	10,731	9,644	5,154	4,631	6,742	3,841
Pennsylvania	36,382	36,536	17,957	21,460	10,231	8,282	8,194	6,794
Rhode Island	5,084	6,390	1,874	2,957	1,914	2,143	1,296	1,290
South Carolina	10,862	9,648	3,943	3,661	2,513	2,443	4,406	3,544
South Dakota	1,880	2,785	739	1,261	229	205	912	1,319
Tennessee	13,166	12,903	6,113	5,111	4,069	4,502	2,984	3,290
Texas	40,693	47,379	14,860	28,033	14,346	11,108	11,487	8,238
Utah	13,621	11,650	5,771	5,815	3,709	3,431	4,141	2,404
Vermont	1,638	2,577	721	1,414	215	317	702	846
Virginia	21,039	20,888	10,839	10,595	4,810	4,431	5,390	5,862
Washington	31,260	31,953	17,295	18,864	4,392	4,438	9,573	8,651
West Virginia	4,704	4,658	1,159	1,360	748	792	2,797	2,236
Wisconsin	16,535	18,916	6,333	8,279	2,659	3,089	7,543	7,548
Wyoming	2,091	1,709	845	812	285	223	961	674

— Data not available.

[1] Excludes jurisdictions outside the United States and the District of Columbia.

[2] Facilities operated by Federal agencies are included in the States in which the facilities are located.

Source: *Uniform Facility Data Set (UFDS): 1997* and *1998*. Substance Abuse and Mental Health Services Administration (1999 and 2000).

DRUG AVAILABILITY

Table 44. Trends in Cocaine Supply, 1989–99 (Metric Tons)

Year	Cocaine HCl available for export from producing countries[1]	Cocaine destined for the United States	Cocaine shipped to the United States	Cocaine available for consumption in the United States	Retail value of cocaine in the United States (1998 dollars, billions)[2]
1989	709–842	603–716	547–660	432–545	$70.8
1990	714–851	595–709	509–624	413–528	$61.3
1991	777–931	635–760	539–664	412–532	$55.0
1992	834–972	667–778	583–694	437–555	$49.4
1993	581–692	455–542	375–462	364–463	$45.9
1994	558–670	428–513	371–456	258–345	$42.4
1995	616–738	462–553	421–513	287–376	$43.0
1996*	523	382	333	288	$41.3
1997*	570	385	337	312	$41.8
1998*	567	375	337	291	$39.0
1999*	566	336	301	276	$37.1[3]

* Estimates derived from the implementation of the Office of National Drug Control Policy's *Sequential Transition and Reduction* (STAR) Model, December 1999.

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

[3] Retail value for 1999 is projected.

Source: 1989 to 1998 data from Office of National Drug Control Policy. 1999. *What America's Users Spend on Illegal Drugs, 1988–1998.* Cocaine HCl data for 1996 to 1998 are from ONDCP's *Sequential Transition and Reduction* (STAR) Model, December 1999.

Table 45. Average Price and Purity of Cocaine and Heroin in the United States, 1981–98

Year	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	44.51	66.79	1,798.80	24.49	317.97	51.33

[1] Quantities purchased at the "retail" level.
[2] Quantities purchased at the "dealer" level.
[3] 1998 data are preliminary, based on first 2 quarters of data.

Source: *System To Retrieve Information From Drug Evidence* (STRIDE), Drug Enforcement Administration, 1981–98.

Table 46. Federalwide Cocaine, Heroin, Methamphetamine, and Cannabis Seizures, 1989–2000 (Kilograms)

Year	Cocaine	Heroin	Metham-phetamine	Cannabis	
				Marijuana	Hashish
1989	114,903	1,311	—	393,276	23,043
1990	96,085	687	—	233,478	7,683
1991	128,247	1,448	—	224,603	79,110
1992	120,175	1,251	—	344,899	111
1993	121,215	1,502	7	409,922	11,396
1994	129,378	1,285	178	474,856	561
1995	111,031	1,543	369	627,776	14,470
1996	128,555	1,362	136	638,863	37,851
1997	101,495	1,624	1,099	698,799	756
1998	118,398	1,475	2,559	825,303	240
1999*	132,318	1,094	2,641	1,175,373	761
2000**	56,004	581	1,756	645,693	—

*Figures are preliminary and subject to updating.

**Figures for 2000 are for January through June only.

Source: *Federalwide Drug Seizure System*, Drug Enforcement Administration, 1989–2000.

Table 47. Eradicated Domestic Cannabis by Plant Type, 1982–99 (Number of Plants in Thousands)

	Cultivated Plants Outdoors[1]	Ditchweed	Indoor Plants	Total Plants Eradicated
1982	2,590	—	—	2,590
1983	3,794	—	—	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
1998	2,283	132,407	233	134,924
1999	3,205	130,192	208	133,605

— Data not available.

Note: Federal data only.

[1] May include tended ditchweed.

Source: Drug Enforcement Administration, 1982-1999.

Table 48. Methamphetamine Lab Seizures, by State: 1995–99

State	1995	1996	1997	1998	1999
Alaska	0	1	0	0	10
Alabama	2	5	4	1	26
Arizona	16	83	129	222	364
Arkansas	19	74	164	148	130
California	108	155	178	118	164
Colorado	13	17	26	51	85
Connecticut	0	0	0	0	0
Delaware	1	0	1	0	0
District of Columbia	0	0	1	0	0
Florida	3	0	1	6	13
Georgia	3	4	10	3	21
Hawaii	0	0	3	0	2
Idaho	1	3	3	4	1
Illinois	0	5	14	45	67
Indiana	0	1	4	3	3
Iowa	4	10	22	19	16
Kansas	16	43	43	29	44
Kentucky	1	3	1	8	6
Louisiana	1	1	1	3	6
Maine	0	0	0	1	0
Maryland	0	0	0	0	1
Massachusetts	0	0	0	3	0
Michigan	3	2	4	3	7
Minnesota	10	14	14	21	20
Mississippi	0	1	0	5	9
Missouri	37	235	396	315	195
Montana	1	1	2	1	16
Nebraska	1	1	1	7	7
Nevada	23	37	19	15	20
New Hampshire	0	0	0	1	0
New Jersey	0	1	3	0	0
New Mexico	4	7	20	26	44
New York	0	0	0	0	1
North Carolina	0	0	2	1	4
North Dakota	1	1	1	0	6
Ohio	0	1	7	6	14
Oklahoma	8	71	106	102	200
Oregon	2	8	10	25	10
Pennsylvania	2	12	6	5	1
Rhode Island	0	0	0	0	0
South Carolina	0	0	0	0	0
South Dakota	1	1	2	0	1
Tennessee	2	2	22	50	60
Texas	10	12	24	31	101
Utah	29	63	112	91	204
Vermont	0	0	0	0	0
Virginia	0	0	2	1	8
Washington	2	1	4	8	23
West Virginia	0	0	0	1	4
Wisconsin	2	2	0	0	0
Wyoming	1	1	0	8	4
Total	327	879	1,362	1,387	1,919

Note: Federal data only.

Source: Drug Enforcement Administration (1995–1999).

Table 49. Estimated Worldwide Potential Net Production of Opium, 1988–2000 (Metric Tons)

Year	Afghanistan[1]	India	Iran[2]	Pakistan	Total Southwest Asia	Burma	China	Laos	Thailand	Total Southeast Asia	Colombia	Lebanon[3]	Guatemala	Mexico	Vietnam	Subtotal	Total All Regions
1988	750	—	—	205	955	1,280	—	255	25	1,560	—	—	8	67	—	75	2,590
1989	585	—	—	130	715	2,430	—	380	50	2,860	—	45	12	66	—	123	3,698
1990	415	—	—	165	580	2,255	—	275	40	2,570	—	32	13	62	—	107	3,257
1991	570	—	—	180	750	2,350	—	265	35	2,650	—	34	11	41	—	86	3,486
1992	640	—	—	175	815	2,280	—	230	24	2,534	—	—	—	40	—	40	3,389
1993	685	—	—	140	825	2,575	—	180	42	2,797	—	4	—	49	—	53	3,675
1994	950	90	—	160	1,200	2,030	25	85	17	2,157	—	—	—	60	—	60	3,417
1995	1,250	77	—	155	1,482	2,340	19	180	25	2,564	65	1	—	53	—	119	4,165
1996	2,099	47	—	75		2,560	—	200	30	2,790	63	1	—	54	25	143	4,285
1997	2,184	30	—	85		2,365	—	210	25	2,600	66	—	—	46	45	157	4,137
1998	2,340	—	—	65		1,750	—	140	16	1,906	61	—	—	60	20	141	3,462
1999	2,861	—	—	37		1,090	—	140	6		75	—	—	43	11		
2000	3,656	—	—	11		1,085	—	210	6		N/A	—	—	N/A	15		N/A

— Data not available.

[1] Crime and Narcotics Center, October 2000. The procedure to estimate opium gum in Afghanistan was revised and estimates were adjusted back to 1996.

[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 (1988–2000)*, U.S. Department of State.

Table 50. Estimated Worldwide Potential Net Production of Cannabis, 1988–99 (Metric Tons)

Year	Mexico	Colombia	Jamaica	Belize	Other	Total
1988	5,655	7,775	405	120	3,500	17,445
1989	30,200	2,800	190	65	3,500	36,775
1990	19,715	1,500	825	60	3,500	25,600
1991	7,775	1,650	641	49	3,500	13,615
1992	7,795	1,650	263	0	3,500	13,208
1993	6,280	4,125	502	0	3,500	14,407
1994	5,540	4,138	208	0	3,500	13,386
1995	12,400	4,133	206	0	3,500	11,489
1996	11,700	4,133	356	0	3,500	11,389
1997	8,600	4,133	214	0	3,500	10,347
1998	8,300	4,000	—	0	3,500	9,800
1999	3,700	4,000	—	0	3,500	11,200

— Data not available.

Source: *International Narcotics Control Strategy Report,* March 2000. U.S. Department of State.

Table 51. Estimated Worldwide Potential Net Production of Coca Leaf, 1988–99 (Metric Tons)

Year	Bolivia	Colombia	Peru	Ecuador	Total
1988	78,400	27,200	187,700	400	293,700
1989	77,600	33,900	186,300	270	298,070
1990	77,000	32,100	196,900	170	306,170
1991	78,000	30,000	222,700	40	330,740
1992	80,300	29,600	155,500	100	265,500
1993	84,400	31,700	155,500	100	271,700
1994	89,800	35,800	165,300	—	290,900
1995	85,000	40,800	183,600	—	309,400
1996	75,100	53,800	174,700	—	303,600
1997	70,100	63,600	130,200	—	263,900
1998	52,900	81,400	95,600	—	229,900
1999	22,800	521,400*	69,200	—	N/A

— Data not available.

*Wet leaf.

Source: *International Narcotics Control Strategy Report,* March 2000. U.S. Department of State.

Table 52. Domestic Drug Consumption, Calendar Years 1996-2000 (Metric Tons)

Year	Cocaine	Heroin	Marijuana	Methamphetamine
1996	288	12.4	874	14.3
1997	312	13.1	960	11.9
1998	291	12.5	952	15.9
1999*	276	12.9	982	15.5
2000*	269	12.9	1,009	15.5

*Estimated.

Source: Office of National Drug Control Policy. 2000. *What America's Users Spend on Illegal Drugs, 1988–1998.*

Table 53. Trends in Heroin Supply, 1996–2000 (Metric Tons)

Year	Heroin availability prior to border entry	Heroin availability after border entry	Heroin available for consumption in the United States	Retail value of heroin in the United States (1998 dollars, billions)
1996	13.3	12.7	12.4	$11.7
1997	14.2	13.3	13.1	$12.2
1998	13.5	12.8	12.5	$11.6
1999*	13.7	13.1	12.9	$12.0
2000*	13.7	13.0	12.9	$11.9

*Retail values for 1999 and 2000 are projected.

Sources: Office of National Drug Control Policy (2000) "Estimating Heroin Availability." Retail value data are from Office of National Drug Control Policy (2000). *What America's Users Spend on Illegal Drugs, 1988–1998.*

Table 54. Amount of Coca Leaf Cultivated and Eradicated, Calendar Years 1987-99 (Hectares)

Year	CULTIVATED			ERADICATED		
	BOLIVIA	COLOMBIA	PERU	BOLIVIA	COLOMBIA	PERU
1987	41,400	22,960	109,155	1,040	460	355
1988	50,400	34,230	115,530	1,475	230	5,130
1989	55,400	43,400	121,685	2,500	640	1,285
1990	58,400	41,000	121,300	8,100	900	0
1991	53,386	38,472	120,800	5,486	972	0
1992	50,649	38,059	129,100	5,149	959	0
1993	49,600	40,493	108,800	2,400	793	0
1994	49,200	49,610	108,600	1,100	4,910	0
1995	54,093	59,650	115,300	5,493	8,750	0
1996	55,612	72,800	95,659	7,512	5,600	1,259
1997	52,800	98,500	72,262	7,000	19,000	3,462
1998	49,600	115,450	58,825	11,621	13,650	7,825
1999	38,000	135,900	51,000	16,200	13,400	12,300

Source: *International Narcotics Control Strategy Report*, March 2000. U.S. Department of State.

Table 55. Amount of Opium Poppy Cultivated and Eradicated, Calendar Years 1990-98 (Hectares)

Year	Afganistan	Pakistan	Burma	Laos	Thailand	Colombia	Guatemala	Mexico
				CULTIVATED				
1990	12,370	8,405	150,100	30,580	3,435	—	1,930	10,100
1991	17,190	8,645	160,000	29,625	3,000	2,316	1,721	10,130
1992	19,470	9,147	153,700	25,610	2,050	32,858	1,200	10,170
1993	21,080	7,136	146,600	26,040	2,880	29,821	864	11,780
1994	29,180	7,733	154,070	18,520	2,110	23,906	200	12,415
1995	38,740	6,950	154,070	19,650	1,750	10,300	125	13,500
1996	37,950	4,267	163,100	25,250	2,170	12,328	12	13,000
1997	39,150	4,754	155,150	28,150	1,650	13,572	10	12,000
1998	41,720	5,224	130,300	26,100	1,350	—	15	15,000
				ERADICATED				
1990	—	185	—	0	720	—	1,085	4,650
1991	—	440	1,012	0	1,200	1,156	576	6,545
1992	—	977	1,215	0	1,580	12,858	470	6,860
1993	—	856	604	0	0	9,821	426	7,820
1994	—	463	3,345	0	0	3,906	150	6,620
1995	—	0	0	0	580	3,760	86	8,450
1996	—	867	0	0	880	6,028	12	7,900
1997	—	654	0	0	1,050	6,972	3	8,000
1998	—	2,194	0	—	715	—	12	9,500

— Data not available.
Source: *International Narcotics Control Strategy Report*, March 1999. U.S. Department of State.

Table 56. Amount of Marijuana Cultivated and Eradicated, Calendar Years 1990-99 (Hectares)

Year	CULTIVATED			ERADICATED		
	Mexico	Jamaica	Colombia	Mexico	Jamaica	Colombia
1990	—	2,250	2,000	6,750	1,030	500
1991	—	1,783	2,000	10,795	833	0
1992	28,520	1,200	2,049	12,100	811	49
1993	21,190	1,200	5,050	9,970	456	50
1994	19,045	1,000	5,000	8,495	692	14
1995	18,650	1,000	5,000	11,750	695	20
1996	18,700	1,000	5,000	12,200	473	—
1997	15,300	1,060	5,000	10,500	743	—
1998	14,100	—	5,000	9,500	705	—
1999	23,100	—	5,000	19,400	894	—

— Data not available.
Source: *International Narcotics Control Strategy Report*, March 2000. U.S. Department of State.

Table 57. Amount of Cocaine Seized, Calendar Years 1990-99 (Metric Tons)

Year	South America	Caribbean	Central America	Mexico
1990	71	7	21	49
1991	112	7	28	50
1992	69	8	24	39
1993	65	3	25	46
1994	102	3	15	22
1995	91	5	10	22
1996	94	3	18	24
1997	95	4	28	35
1998	142	7	24	23
1999	81	5	15	34

Source: *International Narcotics Control Strategy Report*, March 2000. U.S. Department of State.

Table 58. Amount of Heroin Seized by Foreign Countries, Calendar Years 1990-99 (Kilograms)

Year	Pakistan		Thailand		China		Laos		Colombia	
	heroin	opium	heroin	opium	heroin	opium	heroin	opium	heroin	opium
1990	6,400	8,200	1,100	800	1,445	720	40	575	0	0
1991	5,700	5,900	1,500	1,500	2,621	2,327	15	165	0	0
1992	2,900	3,400	992	600	4,489	2,660	2	281	50	430
1993	3,900	4,400	2,100	2,200	4,459	3,354	1	54	261	261
1994	6,200	14,360	1,100	600	3,881	1,737	62	54	181	128
1995	18,040	215,520	690	900	2,376	1,110	43	194	419	78
1996	4,050	8,080	390	600	3,500	1,400	16	216	183	36
1997	5,070	8,540	320	700	5,470	1,600	72	200	261	120
1998	3,330	5,020	530	1,500	—	—	80	442	317	100
1999	3,900	11,500	310	440	—	—	15	226	504	183

Source: *International Narcotics Control Strategy Report*, March 2000. U.S. Department of State.

Table 59. Amount of Marijuana Seized by Foreign Countries, Calendar Years 1990-99 (Metric Tons)

Year	Mexico	Jamaica	Colombia	Pakistan	Thailand	Other
1990	408	29	664	241	130	10
1991	255	43	329	237	54	17
1992	405	35	206	188	87	71
1993	495	75	549	189	98	130
1994	528	46	200	178	71	32
1995	780	37	166	544	46	31
1996	1,015	5,299	235	202	44	64
1997	1,038	24	136	109	9	85
1998	1,062	36	69	65	6	29
1999	1,459	56	65	70	45	22

Source: *International Narcotics Control Strategy Report*, March 2000. U.S. Department of State.

Table 60. Number of Drug Labs Destroyed, Calendar Years 1990-99

Year	Bolivia		Brazil	Colombia		Ecuador	Peru	Mexico	Thailand		Pakistan
	Coca base	Cocaine HCl	Cocaine HCl	Cocaine & base	Morphine & Heroin	Cocaine HCl	Coca base	Not specified	Heroin labs	Meth labs	Not specified
1990	1,446	33	3	269	—	1	151	13	2	—	—
1991	1,461	34	3	239	5	4	89	9	5	—	18
1992	1,393	17	0	224	7	0	88	4	0	—	11
1993	1,300	10	5	401	10	0	38	5	2	—	13
1994	1,891	32	0	560	9	0	21	9	0	—	18
1995	2,226	18	0	396	11	0	21	19	1	—	15
1996	2,033	7	0	861	9	1	14	19	2	1	10
1997	1,022	1	0	213	9	0	18	8	—	—	4
1998	1,205	1	2	311	10	2	—	7	—	15	0
1999	893	1	2	156	10	2	—	—	—	14	2

— Data not available.

Source: *International Narcotics Control Strategy Report*, March 2000. U.S. Department of State.

Table 61. DEA-Reported Seizures of MDMA, 1998–99

Year	Reported Weight[1] (grams)			Reported Tablets[1] (dosage units[2])		
	Without analysis	With analysis	Total seized powder	Without analysis	With analysis	Total seized tablets
1998	20,977	3,833	24,811	184,211	143,613	327,824
1999	289,982	30,832	320,813	629,416	1,032,819	1,662,235

[1] Seizures were reported in weight units (grams) or as tablet counts. These are non-duplicative sets. Totals within weight or tablets category may not add up due to rounding.

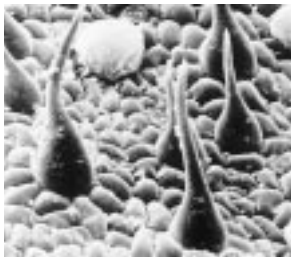
[2] Dosage units calculated at 0.125 grams per tablet.

Source: *STRIDE* and DEA *Information-7* reports.

HONESTY.

THE ANTI-DRUG.

Your kids ask if you ever used drugs. What do you say? You want to be honest because you love them and respect their intelligence. It's a very difficult question. But remember, **the issue isn't your past. The issue is their present and future.** How you respond is entirely up to you. (Perhaps tell them when they're older.) What's important now is that your kids understand that you don't want them to use drugs. Studies show that parents who give their kids **clear rules and reward them for good behavior** are far more effective in keeping their kids off drugs than those who don't. For more information, visit www.theantidrug.com or call 800.788.2800. We can help you.



This is where THC comes from. THC is the active ingredient in marijuana. It looks the same today as it did in 1960. The difference is how much of it is in marijuana today. Pot today is often grown hydroponically and can be genetically altered to produce more THC in each plant. The production of marijuana is a commercial industry that in many ways has created a drug much different than it was in the 70's.

Smoking marijuana is harmful. The younger you are, the more harmful it is. Research has shown that people who smoke marijuana before the age of 15 are 7 times more likely to use other drugs than people who don't smoke marijuana. Studies also show that people who did not smoke marijuana by the time they were 21 were more likely to never smoke marijuana. This message is brought to you by the Office of National Drug Control Policy/Partnership for a Drug-Free America®

Glossary: Abbreviations and Acronyms

ACF — Administration for Children and Families.

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.

CAI — Computer Assisted Interview.

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.

DEFY — Drug Education for Youth.

DENS — Drug Evaluation Network SysteM.

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.

FINCEN — Financial Crimes Enforcement Network.

FY — Fiscal Year.

GAO — Government Accounting Office.

GBL — Gamma-Butyrolactone.

GCIP — General Counterdrug Intelligence Plan.

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.

IDU — Injection Drug User.

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.

INCASE — International Coalition of Addiction Studies Educators.

INCB — International Narcotics Control Board.

INCSR — International Narcotics Control Strategy Report.

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.

MEM — Multilateral Evaluation Mechanism.

MET — Mobile Enforcement Team.

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.

NASADAD — National Association of State Alcohol and Drug Abuse Directors.

NATA — Narcotic Addict Treatment Act.

NCHS — National Center for Health Statistics.

NDATUS — National Drug and Alcoholism Treatment Unit Survey.

NDIC — National Drug Intelligence Center.

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.

NIMH — National Institute of Mental Health.

NMLS — National Money Laundering Strategy.

NNICC — National Narcotics Intelligence Consumers Committee.

NRC — U.S. Nuclear Regulatory Commission.

NTIES — National Treatment Improvement Evaluation Study.

NTOMS — National Treatment Outcome Monitoring System.

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.

PAPI — Paper and Pencil Interview.

PATS — Partnership Attitude Tracking Study.

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.

PSA — Public Service Announcement.

RSAT — Residential Substance Abuse Treatment.

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.

SDFSCA — Safe and Drug Free Schools and Communities Act.

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.

SOD — Special Operations Division.

SROS — Services Research Outcomes Study.

STD — Sexually Transmitted Disease.

STRIDE — System To Retrieve Information from Drug Evidence, a program of the Drug Enforcement Administration.

SWB — Southwest Border.

TASC — Treatment Accountability for Safer Communities.

TCA — Therapeutic Communities of America.

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.

USMS — United States Marshals Service.

WtW — Welfare to Work.

XTC — A street name for MDMA.

YRBS — Youth Risk Behavior Survey.