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# *I. Overview of Annual Report and National Drug Control Strategy*

Annual Report on Implementing the *National Drug Control Strategy*

Prior to this year, 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 only requires the President to submit to Congress an annual report on the progress in implementing the Strategy.*

General reporting requirements of the Annual Report include:

1. Assessment of federal effectiveness in achieving the National Drug Control Strategy goals and objectives (using the Strategy's Performance Measures of Effectiveness system). This analysis includes an assessment of drug use and availability in the United States and an estimate of the effectiveness of prevention, treatment, law enforcement, interdiction, and international programs.

2. Modifications during the preceding year of the *National Drug Control Strategy* or the national drug control performance measurement system.

3. Explanation of how the Administration's budget proposal is intended to implement the *National Drug Control Strategy* and assessment of whether the funding levels contained in this proposal are sufficient to implement the *Strategy*.

4. Measurable data evaluating results reflected in the annual performance measures.

5. An assessment of private sector initiatives and cooperative efforts between Federal, State, and local governments for drug control.

This annual report addresses the specific reporting requirements outlined in PL 105-277.

- Chapter 1 summarizes the *National Drug Control Strategy*.

- Chapter 2 provides information on drug use and availability and their social and criminal consequences. This information is based on the most recent national, state, and local surveys and other special studies. Given that these data instruments cover different time frames, it is not possible to consistently compare data over the same period. The National Household Survey on Drug Abuse (released in August 1999), for example, provides information about drug use in 1998, while the Monitoring the Future Survey (released in

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

December 1999) contains 1999 data. The Data Appendix summarizes the instruments used to prepare this Annual Report and outlines steps being taken to improve the data set 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 the Administration's Fiscal Year 2001 drug control budget proposal. Greater detail of the budget proposal is provided in the companion *Budget Summary* volume.

- Chapter 5 summarizes the consultation process followed by the Office of National Drug Control Policy during 1999 in implementing the *National Drug Control Strategy.*

- The second companion volume – *Performance Measures of Effectiveness 2000* – provides information on ninety-seven specific performance targets used to gauge progress in the Strategy's five goals and thirty-one objectives. The 2000 PME report assesses progress against the base year of 1996 and outlines mid- (2002) and long-term (2007) goals. The report also outlines modifications to the national drug control performance measurement system.

- A third companion volume – *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 is required by 21USC/505a.

- The *National Drug Control Strategy* also includes the separate *Classified Annex*, which is transmitted to Congress separately. This document is the President's interagency plan for countering the international cultivation, production, and trafficking of illicit drugs.

## The National Response to Drug Abuse

Throughout history, the American people have demonstrated a resolve to fortify the nation's democratic structures and improve opportunities for all citizens. In the face of divergent threats, successive generations were determined to build a stronger, healthier country. These essential values remain with us today, especially in connection with the problem of substance abuse. The vast majority of Americans repeatedly assert a desire to be rid of illegal drugs. The United States is committed to reducing drug use and its destructive consequences.

Drug abuse inflicts considerable damage on the U. S. A national problem, it demands a comprehensive solution involving not only federal programs but also efforts on the part of states, counties, cities, communities, families, civic groups, coalitions, and other organizations.

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-three percent of drug users in America are employed. Addicts are found among the elderly as well as people in the prime of their lives. Drug use is prevalent among the young although it is not as widespread as many young people think.

The history of drug use in America over the past hundred years indicates 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 because the psycho-pharmacological effects of this drug were poorly understood while its alleged benefits were touted by health authorities whose claims were repeated in commercial advertising. Only when the negative consequences of cocaine addiction became widespread did perceptions change. Drug abuse was condemned and new laws were passed, creating a healthier nation with a lower crime rate.

When people no longer focused on the problem of drug abuse, it resurfaced. New drugs were developed, some of which were more potent than their predecessors. Attached to these 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 numbers could go up again. We are particularly concerned about drug use among children. 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. That trend continued through 1996 before stabilizing. In 1998, 6.2 percent of Americans 12 and older were current users of illicit drugs. This figure is down 56 percent from the 14.1 percent of the U.S. population 12 and older who were current users in 1979.

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

## The Role of Government

The first duty of government is to provide security for citizens. The Constitution of the United States articulates the obligation of the federal government to uphold the public good, providing a bulwark against all threats, foreign and domestic. Drug abuse, and the illicit use of alcohol and tobacco by those under the legal age, constitute such a threat. Toxic, addictive

substances are a hazard to our safety and freedom, producing devastating crime and health problems. Drug abuse diminishes the potential of citizens for growth and development.

The rule of law and individual freedom are not incompatible. Although government must minimize interference in the private lives of citizens, it cannot deny people the security on which peace of mind depends. Drug abuse impairs rational thinking and the potential for a full, productive life. Drug abuse, drug trafficking, and their consequences destroy personal liberty and the well-being of communities. Drugs drain the physical, intellectual, spiritual, and moral strength of America. Crime, violence, workplace accidents, family misery, drug-exposed children, and addiction are only part of the price imposed on society. Illegal drugs indiscriminately destroy old and young, men and women, from all racial and ethnic groups and every walk of life.

Mandate for a *National Drug Control Strategy*

The federal government has responded to drug abuse and trafficking with the following laws and executive orders:

- **The Controlled Substances Act, Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970** provides an effective approach to the regulation, manufacture, and distribution of narcotics, stimulants, depressants, hallucinogens, anabolic steroids, and chemicals used in the production of controlled substances.

- **Executive Order No. 12564 (1986)** makes refraining from 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** establishes as a policy goal the creation of a drug-free America. A key provision of the Act is the establishment of the Office of National Drug Control Policy (ONDCP) to set priorities, implement a national strategy, and certify federal drug control budgets. The law specifies that the strategy must be comprehensive and research-based; contain long-range goals and measurable objectives; and seek to reduce drug abuse, trafficking, and their consequences. Specifically, drug abuse is to be curbed by preventing youth from using illegal drugs, reducing the number of users, and decreasing drug availability.

- **The Violent Crime Control and Law Enforcement Act of 1994** extends ONDCP's mission to assessing budgets and resources related to the *National Drug Control Strategy*. It also establishes 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)** assigns ONDCP responsibility within the executive branch of government for leading drug control policy and developing an outcome-measurement system. The executive orders also

charters the President's Drug Policy Council and establishes the ONDCP Director as the President's chief spokesman for drug control.

- **The Office of National Drug Control Policy Reauthorization Act of 1998** expands ONDCP's mandate and authority. It set forth additional reporting requirements and expectations, including:

  1) Development of a long-term national drug strategy

  2) Implementation of a robust performance-measurement system

  3) Commitment to a five-year national drug control program budget

  4) Permanent authority granted to the High Intensity Drug Trafficking Areas (HIDTA) program along with improvements in HIDTA management

  5) Greater demand-reduction responsibilities given to the Counter-Drug Technology Assessment Center (CTAC)

  6) Statutory authority for the President's Council on Counter-Narcotics

  7) Increased reporting to Congress on drug control activities

  8) Reorganization of ONDCP to allow more effective national leadership

  9) Improved coordination among national drug control program agencies

  10) Establishment of a Parents Advisory Council on Drug Abuse

Evolution of the *National Drug Control Strategy*

National drug control strategies were produced annually between 1989 and 1999. Each defined demand-reduction as a priority. In addition, the strategies increasingly recognized the importance of preventing drug use by young people. The various documents affirmed that no single approach could rescue the nation from the cycle of drug abuse. A consensus was reached that drug prevention, education, treatment, and research must be complemented by supply-reduction abroad, on our borders, and within the United States. Each strategy shared the 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 *1999 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.

## Overview of the *National Drug Control Strategy*

The *National Drug Control Strategy* takes a long-term, holistic view of the nation's drug problem and recognizes the devastating effect drug abuse has on the nation's public health and safety. The *Strategy* maintains that no single solution can suffice to deal with this multifaceted challenge. The *Strategy* focuses on prevention, treatment, research, law enforcement, protection of 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 expect to achieve a 50 percent decrease in drug use and availability and at least a 25 percent decrease in the consequences of drug abuse by 2007. If this goal is achieved, just 3 percent of the household population aged twelve and over would use illegal drugs. This level would be the lowest documented drug-use rate in American history. Drug-related health, economic, social, and criminal costs would be reduced commensurately.

Decreasing demand remains the *Strategy's* priority. People's desire for illicit substances set the drug cycle in motion. Drugs are supplied by traffickers only because a profit can be made. Thus, demand fuels supply. Realistically, we recognize that some demand for illegal drugs will always be present. Drug traffickers seeking profit will attempt to supply that demand. They must be countered.

Cheap, readily available drugs undercut the effectiveness of otherwise successful demand-reduction programs. Restricted availability and high prices can help hold down the number of first-time users, prevent aggressive marketing, and reduce the human costs of drug abuse.

Preventing drug use in the first place is preferable to addressing the problem later through law enforcement and treatment. The *Strategy* focuses on young people, seeking to educate them about the dangers of drugs, alcohol, and tobacco. If nearly seventy million American children reach adulthood free of substance abuse, the vast majority will avoid drug dependency for the rest of their lives.

During the decade of the '90s, the rate of substance abuse among children rose dramatically before leveling off the past few years. This increase was in contrast with an overall decline in drug abuse compared to rates during the 1970s and 1980s. Today's problem is rooted in misperceptions on the part of young people. Beginning in 1990 and 1991, adolescents began underestimating the risks associated with drug abuse and overestimating drug use by other teens. Young people tend to believe that their peers are using tobacco, alcohol, and drugs. In fact, most youngsters don't use drugs.

In addition to drug-prevention for children, intervention programs must help young adults as they leave home to start college, enter the military, or join the workplace as full-time employees. We need drug treatment for more than four million chronic users who constitute a major portion of domestic demand. Without help, these adults will suffer from poor health, unstable family relations, and other negative consequences of substance abuse. Since parental alcohol and drug abuse is a significant predictor of youth drug use and is often the cause of serious child abuse and

neglect, treatment for parents is key to breaking the inter-generational cycle of addiction. Accordingly, the *Strategy* focuses on treatment. Research clearly demonstrates that treatment works. We will take advantage of all opportunities -- in the workplace, the criminal justice system, the community, and on athletic fields -- to encourage drug abusers to become drug-free. Anti-drug programs are offered by the nation's health-care, educational, criminal-justice, welfare, and job-training systems.

Substance abuse by offenders is another area of concern. In 1997, a third of state prisoners and about one in five federal prisoners said they had committed the offenses that led to incarceration while under the influence of drugs. A zero-tolerance drug program that includes treatment for substance abuse, 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 number of incarcerated Americans. The ultimate goal is to help people with drug problems get off welfare, renounce crime, and enter the workforce, as productive, self-sufficient, tax-paying members of society. Education and job-training must accompany treatment.

Effective law enforcement is essential in reducing drug use within the United States. Illegal drug trafficking inflicts violence and corruption on our communities. The criminal activity that comes with 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 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 drug supply more effectively in domestic communities. It emphasizes initiatives to share intelligence and make use of the latest technology in these efforts.[1] As a major gateway for the entry of illegal drugs into the United States, the Southwest border is an important focus of the *Strategy*. Resources have also been allocated to close other avenues into the United States, including the Virgin Islands, Puerto Rico, the Canadian border, and all air and sea ports.

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 as well as some of the heroin supply; Mexico for a significant share of methamphetamine, heroin, and marijuana; and Southeast Asia and South Central Asia for much

of the heroin. Where access to source regions is limited by political complications, we support international efforts to curtail the drug trade.

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 all branches of government, organizations, and individuals.

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, stable nation unfettered by drug traffickers and 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. To this end, the *Strategy* fosters initiatives to educate children about the real dangers associated with drugs. ONDCP seeks to involve parents, coaches, mentors, teachers, clergy, and other role models in a broad prevention campaign. ONDCP encourages businesses, communities, schools, the entertainment industry, universities, and sports organizations to join these national anti-drug efforts.

Researchers have identified important factors that place youth at risk for drug abuse or protect them against such behavior. Risk factors are associated with greater potential for drug use while protective factors reduce the potential for use. Risk factors include a chaotic home environment, ineffective parenting, anti-social behavior, drug-using peers, general approval of drug use, and the misperception that the overwhelming majority of one's peers are substance abusers. Protective factors include parental involvement, success in school, strong bonds with family, school, and religious organizations, knowledge of dangers posed by drug use, and the recognition by young people that substance abuse by their peers is abnormal behavior.

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

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

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

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

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

Drug dependence is a chronic, relapsing disorder that exacts an enormous cost on individuals, families, businesses, communities, and nations. Addicted individuals frequently engage in self-destructive and criminal behavior. Treatment can help them end dependence on addictive drugs. Treatment programs, moreover, can reduce the consequences of addictive drug use on the rest of society. The ultimate goal of treatment is to enable a patient to become abstinent and to improve functioning through sustained recovery. On the way to that goal, reducing drug use, improving the addict's ability to function, and minimizing medical consequences are useful interim outcomes. Providing treatment for America's chronic drug users 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 the threats posed by illegal drugs crossing our borders. Interdiction in the transit and arrival zones disrupts drug flow, increases risks to traffickers, drives them to less efficient routes and methods, and prevents significant quantities of drugs from reaching the United States. Interdiction operations also produce information that can be used by domestic law enforcement agencies against trafficking organizations.

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

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

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

### 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. The chronically addicted should be held accountable for their actions and offered treatment to help change destructive behavior. Addicts need to be helped, not defeated.

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.

## *II. America's Drug Use* Profile*

An estimated 13.6 million Americans age twelve years of age and older were current users of any illegal drug in 1998.** This number is slightly less than the 13.9 million estimate for 1997. Drug use reached peak levels in 1979 when 14 percent of the population age twelve and over were current users. This figure declined significantly between 1985 and 1992, from 23.3 million to twelve million. Since 1996 the number of current users has remained steady, with statistically insignificant changes occurring each year. An estimated 4.1 million people met diagnostic criteria for dependence on illegal drugs in 1997 and 1998, including 1.1 million youths between the ages of twelve and seventeen.[1]

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 among minority and low-income communities.[2] 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's youth in the new millennium.[3] 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.

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* 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 availability.

** Current use is defined as consumption of a controlled substance at least once within the previous thirty days.

## 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 at the time of use and for years to come. Moreover, behavior patterns that result from teen and preteen drug use often produce tragic consequences. The self-degradation, loss of control, disruptive conduct, and antisocial attitudes young people develop in the context of drug abuse can cause untold harm to themselves and their families.

**Juvenile drug-use rates level off** According to the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration's (SAMHSA) 1998 National Household Survey on Drug Abuse (NHSDA), 9.9 percent of youth age twelve to seventeen reported current use of an illegal drug in 1998 – a 13 percent decrease from 11.4 percent in 1997. This decline was the first statistically significant drop in four years.[4] For the cohort between eighteen to twenty-five years of age, current use of any illegal drug has been rising since 1994 and currently stands at 16.1 percent. This increase reflects the maturing of youngsters who 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] According to the 1999 Monitoring the Future survey (MTF), lifetime and past-year use of all illegal drugs did not change from 1998 to 1999 for eighth, tenth, and twelfth graders.

**Marijuana use 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 incidence 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]

**Changing teen attitudes** The Partnership for a Drug-Free America's 1999 Partnership Attitude Tracking Study (PATS) indicates that disapproval of drugs among 7th through 12th graders reflected their knowledge of drug-related risks. The study reported that the percentage of respondents strongly agreeing with the statement: "kids who are really cool don't use drugs" increased from 35 percent in 1998 to 40 percent in 1999. Conversely, the percentage who

strongly agreed that "marijuana users in my school are popular" decreased from 17 to 10 percent. In addition, 68 percent of teens believed that a person who uses marijuana runs a higher risk of getting into trouble with the law – up from 64 percent in 1998.[10] The 1999 MTF data support this trend: disapproval of trying marijuana increased among eighth graders, from 69 percent in 1998 to 70.7 percent in 1999. Likewise, disapproval of regular inhalant use increased among tenth graders, rising from 91.1 percent in 1998 to 92.4 percent in 1999.[11]

**Emerging drug-use trends among youth** The 1999 MTF survey reports increasing use of methylene dioxy methamphetamine (MDMA) and steroids among students in 8th, 10th, and 12th grades. Past-year use of steroids among both 8th and 10th graders increased from 1.2 percent in 1998 to 1.7 percent in 1999. Also, between 1998 and 1999, past-year use of MDMA (also called ecstasy) among 12th graders increased from 3.6 percent to 5.6 percent, respectively. In addition, past-year use of MDMA among 10th graders increased from 3.3 percent to 4.4 percent.

**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 youngsters who start drinking before age fifteen become dependent versus 10 percent of individuals who begin drinking at age twenty-one.[12] 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.[13]

The United States had 10.4 million underage current drinkers of alcohol in 1998 (compared to 11 million in 1997). In this group, 5.1 million engaged in binge drinking, and another 2.3 million were classified as heavy drinkers.[14] The 1999 MTF reports that daily alcohol use by twelfth graders declined 13 percent (from 3.9 percent to 3.4 percent) since 1998. The proportion of tenth graders reporting having been drunk sometime during the past year increased to 40.9 percent in 1999 – up from 38.3 percent in 1998. The number of eighth graders who were binge drinkers increased from 13.7 percent in 1998 to 15.2 in 1999.

**Underage use of tobacco** The younger a person is when smoking begins, the greater the risk of contracting disease attributable to smoking. The 1998 NHSDA estimates that every day more than six thousand people age eighteen or younger try their first cigarette, and over three thousand people age eighteen or younger become daily smokers. If these trends continue, approximately five million people now less than eighteen years of age will die early from a preventable disease associated with smoking. Widely available and legal for those of legal 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 1998 NHSDA indicates that youths age twelve to seventeen who currently smoked cigarettes were 11.4 times more likely to use illegal drugs and sixteen times more likely to drink heavily than youths who did not smoke.[15] An estimated 18.2 percent (4.1 million) people in this age group were current cigarette smokers in 1998. This rate has remained relatively stable since 1988.[16] In 1997, 40 percent of white high school students currently smoked cigarettes, compared with 34 percent for Hispanics and 23 percent for African-Americans.[17] According to the 1999 National Youth Tobacco Survey, these numbers decreased to 32.8 percent, 25.8 percent, and 15.8 percent, respectively.[18] This survey also reports that about one in 10 (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.[19]

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.[20] In addition, bidis contain in excess of three times the amount of nicotine and five times the tar than regular cigarettes.[21] Bidi smokers have twice the risk of contracting lung cancer than 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 than regular smokers.[22]

**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.[23] 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 youngsters 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 sex partners than those who refrain from alcohol. Furthermore, more than 50 percent of teenagers

* 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.

say that sex while drinking or on drugs often produces unplanned pregnancies.[24] An Ohio study of high school girls who tried cocaine indicated that these women were five times more likely to have experienced an unintended pregnancy than peers who avoided cocaine.[25]

## MARIJUANA

**Overall usage** In 1998, eleven million (5 percent) of Americans aged twelve and older were current (past-month) marijuana users, down from 11.1 million (5.1 percent) in 1997. Approximately 81 percent of current illegal drug users were marijuana users.[26] An estimated 2.1 million Americans tried marijuana for the first time in 1997. This number increased from approximately 1.4 million in 1991 to 2.4 million in 1994; it has not changed significantly since 1994.[27]

**Use among youth** The 1999 MTF shows that past-month marijuana use among eighth graders was stable during the past year, but has decreased 14 percent since 1996. Lifetime, past-year, and past-month use of marijuana did not change in any grade between 1998 and 1999. In 1999, lifetime rates of marijuana use were 49.7, 40.9, and 22 percent for twelfth, tenth, and eighth graders, respectively. Past-year self-reported marijuana use by twelfth graders remained stable since 1997 (about 38 percent) – down from the 1979 peak of 50.8 percent. Among eighth graders, disapproval of "trying marijuana once or twice" increased from 69 to 70.7 percent between 1998 and 1999. Eighth graders who reported that marijuana was "fairly easy to get" dropped from 50.6 to 48.4 percent in the same time period. The teenage belief that "most people will try marijuana sometime" has declined to 35 percent, from 40 percent in 1998 and 41 percent in 1997.[28]

**Availability** Marijuana is the most readily available illegal drug in the United States. According to the Drug Enforcement Administration (DEA), 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.[29] 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 cultivation.[30] Statistics from the 1998 Domestic Cannabis Eradication/Suppression Program show that the leading states for outdoor cannabis growth were California, Hawaii, Kentucky, and Tennessee. Combined, these four states accounted for approximately 75 percent of the total outdoor-cultivated marijuana plants eradicated in 1998.[31] The largest instance of eradication in 1999 reported by the DEA was the June seizure of over fifty-one thousand outdoor plants near the Mississippi River in Arkansas.[32]

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 232,839 indoor-grown marijuana plants in 1998, an increase from 225,232 in 1997.[33]

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 late 1970s and early 1980s to almost 6 percent in the first quarter of 1999.[34] THC levels in sinsemilla have risen to 12.26 percent in 1998.[35]

* 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 1998. Cocaine use declined from 3 percent of the population (5.7 million) in 1985 to 0.7 percent of the population (1.4 million) in 1992, and did not change significantly through 1998. An estimated 1.8 million Americans were current cocaine users in 1998, a statistically insignificant increase from 1997 (1.5 million) and 1996 (1.7 million). The number of frequent and occasional* users of cocaine remained statistically unchanged since 1992. In 1998, the number of frequent users of cocaine was estimated at 595,000 compared to 682,000 in 1997. The number of occasional users decreased from 2.6 million in 1997 to 2.4 million in 1998.[36] In 1998, there were an estimated 3.3 million hardcore chronic users of cocaine in the United States. Between 1992 and 1998 the estimated number of hardcore chronic cocaine users has remained relatively stable, ranging between 3.3 and 3.6 million.[37] Despite the stabilization of overall use since 1992, the number of first-time users of any form of cocaine rose between 1996 and 1997 from 670,000 to 730,000. This level is still lower than during the early 1980s when the new initiate figures were between 1.1 and 1.4 million per a year.[38]

**Use among youth** The 1999 MTF reported that, among eighth graders, the rate of past-year use of crack cocaine declined 14 percent (from 2.1 to 1.8 percent) from 1998; this was the first such decrease in the 1990s. In 1999 the rate of past-month use of crack cocaine among tenth graders dropped 27 percent (1.1 to 0.8 percent) from 1998; twelfth graders were the only youth group who did not report a decline in past-month use. The perceived harmfulness among twelfth graders for trying crack once or twice fell 8 percent (from 52.2 to 48.2 percent) between 1999 and 1998.[39]

**Availability** Cocaine continues to be readily available in nearly all major metropolitan areas.[40] The August 1999 report of the Semiannual Interagency Assessment of Cocaine Movement estimated that 129 metric tons of cocaine arrived in the United States in the first six months of 1999.[41] Approximately 60 percent of the cocaine smuggled into the U.S. crosses the Southwest Border.[42]

Over the past three years, domestic cocaine availability has been estimated at 347 metric tons for 1996, 281 metric tons for 1997, and 301 metric tons for 1998 (down 13 percent from the 1996 baseline). These estimates were developed by an ONDCP-sponsored drug flow analysis using a

* A frequent user is defined as one who uses a controlled substance on fifty-one or more days during the past year. A occasional user is defined as one who uses a controlled substance on twelve or fewer days during the past year.

composite model that integrates four independent measures of cocaine availability, from both a consumption approach and several supply approaches.[43] Since 1990, the average wholesale purity of cocaine has remained relatively stable – between 65 and 80 percent (with retail purity varying widely according to local supply and demand).[44] Law-enforcement agencies throughout the nation continue to report serious problems with cocaine, crack, and related criminal activity. Approximately 60 percent of agencies queried by NDIC reported cocaine as the greatest threat.[45]

## HEROIN

**Overall usage** Heroin use in the United States remained stable since 1996. The number of new heroin users in 1997 (the most recent data available) was 81,000 – a change that is not statistically significant when compared to the 1996 figure of 149,000.[46] Cautious evaluation of this data is necessary because the NHSDA cannot accurately measure rare or stigmatized drug use, relying as it does on self-reporting and on people residing in households. In alternate research, the number of hardcore* users of heroin in 1998 was estimated to be 980,000, compared to 935,000 in 1997 (also not a statistically significant difference).[47]

Injection remains the most prevalent method of ingestion, particularly for low-purity heroin. The increased availability of high-purity heroin and the fear of infection 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, lifetime use of heroin was 2.3 percent for eighth graders, 2.3 percent for tenth graders, and 2 percent for twelfth graders. Between 1998 and 1999, heroin use did not change in any grade level. However, lifetime use of heroin increased consistently since 1991 when reported rates were 1.2 percent for eighth graders, 1.2 percent for tenth graders, and 0.9 percent for twelfth graders. The average age of new heroin users has become younger since 1994, from 21.2 years to 17.6 years in 1997.[48]

**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.[49] When the drug is hard to find, it is cut with other substances. High purity levels may also reflect changes in

* Defined as one who used a controlled substance at least one or two days a week every week during the past year or more than ten days during the previous month.

trafficking patterns. A decrease in the number of middlemen involved in getting South 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 past-year seizures with purity levels up to 97 percent.[50] High purity can have devastating consequences – 119 heroin overdose deaths occurred in Oregon during the first six months of 1999, a 75 percent increase compared to the first six months of 1998.[51] Consumption-based modeling estimates that U.S. heroin availability increased from 12.5 metric tons in 1998 to 12.9 metric tons in 1999; meanwhile the average price per gram remained constant at just over $1,000.[52] 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 – a highly uncertain figure due to the lack of information on Latin American poppy cultivation.

## 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 cocaine 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.[53] Methamphetamine traffickers display no concern over environmental hazards when manufacturing and disposing of methamphetamine and its by-products.

**Overall usage** In 1998, the estimated number of persons who tried methamphetamine in their lifetime was 2.1 percent of the population (4.7 million). The 1998 figure was similar to 1997 and 1994 (2.5 percent and 1.8 percent), respectively.[54] 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.[55]

**Use among youth** According to the 1999 MTF,* use of ice (crystal methamphetamine) among twelfth graders decrease from 3 percent in 1998 to 1.9 percent in 1999.[56] Data for crystal methamphetamine were only available for this age group. A statistically significant decrease in lifetime methamphetamine use among twelve to seventeen-year-olds occurred during 1997 to 1998, dropping from 1.2 to 0.6 percent.[57]

* The 1999 Monitoring the Future study asked twelfth graders only about their use of crystal methamphetamine on two of six questionnaire forms. Consequently, small estimates resulted, and the reduced sample size may cause a lack of reliability in measuring long-term trends.

**Availability** Methamphetamine is the most prevalent synthetic drug clandestinely manufactured in the United States.[58] Historically, the methamphetamine problem has been concentrated in the west and southwestern United States. It is now in most major metropolitan areas and is emerging in small towns and rural communities.[59] Methamphetamine manufacturing is experiencing unprecedented growth. The total number of clandestine laboratories seized in 1998 exceeded 3,800.[60] Clandestine laboratory seizures by the DEA alone increased 23 percent from 1,321 in 1997 to 1,627 in 1998.[61] From January 1998 to June 1999, the Iowa Division of Narcotics Enforcement (operating in conjunction with the Midwest HIDTA) seized 522 labs – a 442 percent increase from 1996 through 1997.[62] This increase in seizures may reflect efforts by individuals operating on the periphery of the methamphetamine market to exploit demand for the drug and satisfy personal use.[63]

Large drug-trafficking organizations continue to be the United States' major source of methamphetamine. According to consumption-based modeling estimates U.S. methamphetamine availability at the retail level increased from 11.7 metric tons in 1997 to 15.9 metric tons in 1998. The average retail price per pure gram remained constant at approximately $140.[64]

## MDMA

**General** MDMA, commonly called ecstasy or XTC, is a synthetic, psychoactive drug possessing stimulant and mild hallucinogenic properties. The drug 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 semi-clandestine, 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 cities. MDMA is considered a "designer drug," which is a substance on the illegal drug 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.[65] 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.[66] 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.[67]

**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 drugs. Emergency room mentions increased from sixty-eight in 1993 to 637 in 1997.[68] MDMA also suppresses the need to eat, drink, or sleep and subsequently allows persons to stay up all night, dancing at raves.[69]

**Use among youth** According to the 1999 MTF, past-year use of MDMA increased from 3.3 percent in 1998 to 4.4 percent in 1999 among tenth graders. Twelfth grade use increased in all three categories by: 38 percent for lifetime use (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) between 1998 and 1999.[70] MDMA use is widespread, particularly among white adolescents in the Northeast.

**Availability** Numerous data points reflect the increasing availability of MDMA in the United States – in metropolitan centers and suburban communities alike.[71] Law-enforcement agencies report a surge in MDMA seizures between 1998 and 1999. The DEA seized more than 216,300 MDMA tablets in the United States in the first five months of 1999; the 1998 total was 143,600.[72] The United States Customs Service (USCS) reports that seizures are up more than 700 percent since 1997. USCS seized three million MDMA tablets in fiscal year 1999 and two million to date in the first quarter of fiscal year 2000.[73] Production of MDMA is centered in Europe (predominately Belgium, the Netherlands, and Luxembourg).[74] 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.[75] Increasing involvement of organized criminal groups – particularly Western European, Russian, and Israeli organized crime syndicates – indicates a move toward "professionalization" of MDMA markets.[76] Law-enforcement reports indicates that 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.[77]

## 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 youngsters.

**Overall usage** There were an estimated 708,000 new inhalant users in 1997, down slightly from 710,000 in 1996.[78] For inhalants, the overall rate of past-month use remained steady since 1991 (between 0.3 and 0.4 percent from 1991 through 1998). Inhalants can be deadly, even with first-time use.[79]

**Use among youth** The 1998 NHSDA reports that among youth, current-use rates for inhalants decreased from 2 percent in 1997 to 1.1 percent in 1998. The 1999 MTF reported that there were no statistically significant differences in inhalant use between 1998 and 1999. However, among eighth graders, disapproval of trying inhalants increased by 3 percent (from 83 to 85.2 percent) from 1998 to 1999. Among tenth graders, the perceived harmfulness (i.e., "great risk") of trying inhalants "once or twice" increased by 5 percent (45.8 to 48.2 percent) from 1998 to 1999. This change was accompanied by a 4 percent increase (from 73.3 to 76.3 percent) in perceived harmfulness of regular inhalant use. During the nine years for which data are available for eighth graders, lifetime, past-year, and past-month inhalant use peaked in 1995. Inhalant abuse continues to be more prevalent among eighth graders than tenth and twelfth graders.

**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 MTF reports that use of hallucinogens, LSD, and PCP remained stable. The 1998 NHSDA reports no major changes in the prevalence of the non-medical use of psychotherapeutics for youngsters aged twelve and older between 1997 and 1998. The rate of current hallucinogens use did not change significantly between 1997 and 1998 (0.8 percent versus 0.7 percent, respectively). There were an estimated 1.1 million new hallucinogen users in 1997, nearly twice the annual average during the 1980s. Data are not available to describe the 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.

Conversely, 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.[80] Many of these effects are irreversible.

**Use among youth** The 1999 MTF reports past-year use of rohypnol among eighth graders decreased from 0.8 percent in 1998 to 0.5 percent in 1999 – a statistically significant change. Past-year use of rohypnol for both 10th and 12th graders was one percent in 1999 – a statistically insignificant change from 1998. Past-year use increased from 1.2 percent in 1998 to 1.7 percent in 1999 for both 8th and 10th graders. Past-month use still remains under 1 percent for 8th and 10th graders, in spite of increases in 1999 (e.g., 0.5 percent in 1998 to 0.7 percent in 1999). Lifetime use of steroids increased among 10th graders from 2 percent in 1998 to 2.7 percent in 1999.[81]

**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.[82] 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.

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* 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.

**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.[83] Of the 2.4 billion prescriptions written in 1998, approximately 254 million were for controlled substances. 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.[84] 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.[85] Likewise, DEA arrests for pharmaceutical diversions increased to 701 in 1999from 410 in fiscal year 1998.[86] The availability of "prescription-free pharmaceuticals" via the Internet and overseas pharmacies represents an emerging challenge for the United States.[87]

**Precursor Chemicals** Of all the major drugs of abuse, only marijuana is available as a natural, harvested product. All of the others must be manufactured using various chemicals or 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.[88] 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.[89] An intensive training program conducted by the DEA's Office of Diversion Control in 1997 and 1998 increased the number and level of chemical diversion investigations in 1999. To address the problem of chemical diversion, various legislative measures, cooperative law-enforcement programs, and multilateral agreements have been enacted.

## 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 1998, they accounted for an estimated $110 billion in expenses and lost revenue.[90] This public health burden is shared by all of society, either 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.[91]

**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.[92] Drug-induced deaths result directly from drug consumption, primarily overdose.* In addition, other causes of death, such as HIV/AIDS, are known to result in part from 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 deaths from drug-related causes.** SAMHSA's Drug Abuse Warning Network (DAWN) also 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.[93]

**Drug-related medical emergencies** More than two thirds of people with addiction see a primary care or urgent care physician every six months, and many others are regularly seen by other medical specialists.[94] The DAWN survey provides information on the health consequences of drug use by capturing data on emergency department (ED) episodes that are induced by or related to the use of an illegal drug or the nonmedical use of a legal drug.* It is important to

* Overdose deaths, including accidental and intentional drug poisoning deaths, accounted for 90 percent of drug-induced deaths in 1995. Other drug-induced causes of death are 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 included: 4.5 percent of deaths from tuberculosis, 30 percent of deaths from hepatitis B, 20 percent of deaths from hepatitis non-A no-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 injury deaths.

*A drug episode is an emergency department visit that was induced by or related to the use of an illegal drug(s) or

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.

In 1998, there were an estimated 542,544 drug-related ED episodes and 982,856 ED drug mentions in the coterminous United States.[95] Nationally, the number of ED episodes and mentions remained relatively stable between 1997 and 1998. Among the drugs mentioned most frequently in ED reports, alcohol-in-combination with drugs (185,002), cocaine (172,014), and heroin/morphine (77,645) were statistically unchanged from 1997 to 1998, while marijuana/hashish mentions increased 19 percent (from 64,744 to 76,870). In drug-related ED episodes, overdose (245,164) was the most frequently cited reason for the drug-related ED visit and suicide (189,897) and dependence (189,094) were the most frequently cited motives for taking the substances – both unchanged from 1997 to 1998.[96] Total drug-related ED episodes were stable across gender, race/ethnicity, and most age subgroups, based on comparisons of 1997 and 1998. However, total episodes increased 9 percent (from 218,630 to 239,172) among patients age 35 and older.[97]

**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 many infectious diseases -- particularly AIDS and other sexually transmitted diseases, hepatitis, and tuberculosis -- and for the infliction of violence.[98] Chronic users are particularly susceptible to infectious diseases and are considered "core transmitters." Of the 18,361 cases of tuberculosis reported to the CDC in 1998, 2.9 percent were drug-related, down from 3.3 percent in 1997. Incidences of drug-related HIV transmission declined from 3,000 in 1997 to 2,081 in 1998. 1995 is the most recent year on which baseline data are available for Hepatitis B cases: injection drug users represent approximately 25 percent (10,216) of the total cases reported for 1995.

**Homelessness** Drug abuse is a contributing factor in the problem of homelessness. Although only a minority (31 percent) of homeless suffers 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."[99] Together, these groups constitute a substantial percentage of the homeless population. This group experiences homelessness of a longer duration and is more likely to be chronically without a residence.[100] Homelessness generates tremendous social and human costs. Safety is jeopardized, primarily for the homeless

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the nonmedical use of a legal drug for patients age six years and older. A "drug mention" refers to a substance that was mentioned (as many as four) during a single drug-related episode.

themselves. The general public is poorly served by having people with serious and chronic illnesses living on the street. Further, addiction treatment tends to be less effective when recipients lack stable housing.[101] Homeless persons may be able to obtain residential detoxification treatment, but with no recovery venue other than a shelter, such treatment is often ineffective.

**Drug use in the workplace** According to the 1998 *NHSDA*, most drug users are employed. Of the 11.4 million adult illegal drug users, 8.3 million (73 percent) were employed either full time or part time in 1998.[102] Among full-time workers, 6.4 percent were current drug users in 1998 (compared to 6.5 percent in 1997); 7.4 percent of part-time workers were current drug users in 1998 (compared to 7.7 percent in 1997).[103] While these figures have been steady since 1992, they have declined significantly since 1985, when 17.5 percent of full-time employees were current drug users.[104] As national unemployment rates have decreased, rates of drug use among the unemployed have risen. In 1998, 18.2 of unemployed adults aged eighteen or older were current drug users, compared to 13.8 percent in 1997.[105] Occupations with the highest drug-use rates are food preparers, waiters/waitresses and bartenders (19 percent), construction (14 percent), other service occupations (13 percent), and material movers (10 percent).[106] Workers who reported their workplace lacked written alcohol or drug-use policies were more than twice as likely to say they used an illegal drug in the past month compared to employees whose workplaces had a written policy or drug testing.[107]

Drug use is estimated to cost fourteen billion dollars a year in decreased productivity.[108] In 1997, those who reported current illegal drug use were more likely than those who reported no drug use to have worked for three or more employers in the past year (9.3 percent versus 4.3 percent), to have skipped one or more days of work in the past month (12.9 percent versus 5 percent), or to have voluntarily left an employer in the past year (24.8 percent versus 15.4 percent).[109]

**Status of drug treatment** In 1998, 4.1 million people in the United States were dependent on illegal drugs, an increase from 1997's figure of four million. Drug treatment estimates are not available for the individual years of 1997 and 1998. Instead, the 1998 NHSDA calculated an average annual estimate based on 1997 and 1998 data – 963,000 individuals received treatment or counseling for their drug use.[110] The resulting difference between the number of persons receiving treatment and those in need of treatment (the "treatment gap") is estimated at 76 percent for 1997 and 1998. Starting in 2000, a larger survey and new methodology will be employed by NHSDA. It will provide improved national estimates and more credible treatment statistics at the state level.

## THE LINK BETWEEN DRUGS AND CRIME

While national crime rates in general continue to decline, more than 1.6 million Americans were arrested for drug-law violations in 1998 – a decrease of 1 percent from 1997.[111] Consequently, drug offenders comprise more than half the country's prison population. Many crimes like murder, assault, prostitution, and robbery are often committed under the influence of drugs or may be motivated by a need to obtain money for drugs. Substance abuse is frequently a contributing factor to family violence, sexual assaults, and child abuse.

**Arrestees often test positive for recent drug use** The National Institute of Justice's (NIJ's) Arrestee Drug Abuse Monitoring (ADAM) drug-testing program found that more than two-thirds of adult male arrestees and half of juvenile male arrestees tested positive for at least one drug in fifteen of the thirty-five sites in 1998. Marijuana was the drug most frequently detected among both groups.[112] The percentages of persons who tested positive for cocaine declined between 1997 and 1998 in a majority of the twenty-three sites for which trend data were available, although substantial variation existed between the geographical regions sampled.[113] Multiple drug use remains an endemic problem among arrestees, and more than two-thirds of the individuals who tested positive for opiates also tested positive for another drug.[114]

Heroin use among arrestees continues to remain relatively stable. There has been little change in the prevalence of opiates among ADAM arrestees or the population that uses opiates. As in previous years, male arrestees in 1998 were substantially more likely to test positive for opiates than female arrestees.[115] Marijuana use continues to be a significant problem among young adult offenders, particularly males. None of the thirty-five ADAM sites reported less than 20 percent of the adult male samples testing positive. In Oklahoma City, 87 percent of the fifteen to twenty-year-old male arrestees tested positive for marijuana.[116]

The year 1998 offered relatively little change over 1997 for most communities with respect to methamphetamine use among arrestees. It continued to appear only sporadically outside western ADAM sites and showed no sign of geographic expansion.[117] Such data are unusual considering the violent behavior sometimes associated with methamphetamine use. In fact, in a survey conducted by the National Drug Intelligence Center, approximately 35 percent of the law-enforcement agencies that were queried identified methamphetamine as their greatest threat.[118]

**Nearly one in four inmates are drug offenders** State and federal prison authorities reported that 1,232,900 people were physically in their custody at the end of the 1998.[119] One in every 113 men in the United States was incarcerated in a state or federal prison at that time.[120] More Americans were behind bars than on active duty in the armed forces. The number of sentenced

prisoners rose 4.8 percent in 1998. Between 1990 and 1998, the number of female inmates serving time for drug offenses in state prisons was up by 12,000, and drug offenders accounted for 19 percent of the total growth in the state inmate population.[121] Nearly 60 percent of the inmates in the federal prison system in 1997 were sentenced for drug offenses, up from 53 percent in 1990.[122] In 1997, 19,115 people were sentenced in federal court for drug violations. Almost all (94 percent) these drug offenders were convicted of drug trafficking. Drug offenders in state and federal prison have extensive criminal histories. More than half (53 percent) of state inmates and 24 percent of federal prisoners were on probation or parole at the time of their current offense. More than eight in every ten state inmates and six of ten federal inmates had prior sentences to their current incarceration or probation. Nearly half (45 percent) of state inmates and a quarter of federal inmates had three or more prior sentences. Approximately, one in every four drug offenders within state prison had prior sentences for violent offenses.

This high rate of incarceration is spread disproportionately among different racial/ethnic groups. In 1997 the rate of incarceration for African-American males was 3,209 per 100,000 compared to 1,273 for Hispanic males and 386 for white males.[123] A March 1997 study by the Bureau of Justice Statistics (BJS) found that black men were nearly twice as likely to be incarcerated (28.5 percent) as Hispanic men (16.0 percent) and six times more likely than white men (4.4 percent).[124]

Costs for incarceration continue to rise. In 1996 state correction expenses for prisons exceeded $22 billion, an increase of 83 percent from 1990 (in constant dollars).[125] State costs per resident for corrections have increased faster than costs for education, health, and natural resources. Per resident, outlays for state prison operations alone rose from $40 in 1985 to $79 in 1996, an increase of 7.3 percent per year. Such spending was about twice the annual increase for state education (up 3.6 percent). State spending for corrections totaled $994 per capita in 1998, more than twelve times larger than expenditures for education.

**Substance abuse, family violence, and child maltreatment** Researchers have found that one-fourth to one-half of men who commit acts of domestic violence also have substance-abuse problems. Women who abuse alcohol or drugs are more likely to become victims of domestic violence than non-abusing women. Youngsters in the child welfare system whose parents have substance-abuse problems are more likely to have been victims of neglect than other children in similar situations, and more likely be placed in foster care rather than remaining at home. Children of substance-abusing parents tend to remain in foster care for longer periods of time.[126] In a January 1999 report, the National Center on Addiction and Substance Abuse at Columbia University (CASA) estimated that drug abuse causes or contributes to seven of ten cases of child

maltreatment and accounts for some ten billion dollars in federal, state, and local government spending on child welfare programs.[127]

**Drugs, violence, and sexual crimes** The nexus between drugs, violence, and sexual crimes is abundantly clear. Alcohol is implicated in more incidents of sexual violence, including rape and child molestation, than any other drug. Alcohol use – by the victim, perpetrator, or both – is involved in 46 to 75 percent of date rapes among college students. Two-thirds of sexual offenders in state prison were under the influence of alcohol or other drugs at the time of the crime; 15 percent were under the influence of both along with other drugs. 5 percent were under the influence of drugs alone.[128]

## PERFORMANCE MEASUREMENTS OF EFFECTIVENESS (PME)

The stated intent of the *National Drug Control Strategy* is to reduce drug use and availability by 50 percent and reduce their health and social consequences by 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. Congressional appropriations and authorizing committees utilize the targets and Annual Report to restructure appropriations in support of the *Strategy* to ensure that resources necessary to attain ambitious long-term performance goals are provided.

***INSERT FIGURE 1 (Page 2) FROM PME REPORT***

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 of the National Academy of Public Administration, the General Accounting Office, and other organizations advocating good government practices. The overall performance system is described in detail in a companion volume to this *Strategy -- Performance Measures of Effectiveness: 2000 Report.*[129]

***INSERT FIGURE 2 (Page 3) FROM PME REPORT***

Progress toward each goal and objective is assessed using new and existing data sources. MTF and the 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 ADAM and DAWN surveys indirectly measure the consequences of drug abuse. The State Department's annual *International Narcotics Control Strategy Report* (INCSR) provides country-by-country assessments of initiatives and accomplishments. INCSR reviews statistics on drug cultivation, eradication, production, trafficking patterns, and seizure along with law-enforcement efforts including arrests and the destruction of drug laboratories. The Subcommittee on Data, Research, and Interagency Coordination is developing additional instruments and measurement processes required to address the demographics of chronic users, domestic cannabis cultivation, drug availability, and other data shortfalls.*

The Fiscal Year 2001 *Budget Summary* (a companion volume to this *Annual Report*) associates federal drug-control budget requests with performance objectives. ONDCP's annual budget guidance to federal drug-control program agencies reflects the PME system's logic models and action plans. The federal government alone cannot attain the ambitious goals established by the PME system simply by altering its own spending and programs any more than the United States can unilaterally reduce cocaine production in South America or opium cultivation in Asia. A coalition of government, the private sector, communities, and individuals -- a truly national effort -- must embrace such a commitment for it to be successful.

*The Data Appendix to this Annual Report outlines the specific reporting requirements outlined by Congress, the existing data instruments used to compile this 2000 report, areas where data is insufficient or infrequently collected, and steps being taken to remedy data inadequacies. Appendix J of *Performance Measures of Effectiveness: 2000 Report* outlines specific accomplishments in 1999 by ONDCP's Data Subcommittee to close the PME system data gap.

## Endnotes

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cocaine and heroin. This methodology has been applied consistently to data from 1988 through 1998, thus allowing analysis of trends.

[38] Ibid., 27.

[39] Johnston, L.D., O'Malley, P.M., & Bachman, J.G. (1999). *National survey results on drug use from the Monitoring the Future study, 1975-1998 Volume I: Secondary school students* (NIH Publication No. 99-4660).

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[41] Office of National Drug Control Policy, *Semiannual Interagency Assessment of Cocaine Movement* (Washington, DC:Office of National Drug Control Policy, August 1999), v.

[42] Ibid., 2.

[43] Office of National Drug Control Policy, *Draft - What America's Users Spend on Illegal Drugs, 1988-1998* (Washington, DC: Office of National Drug Control Policy, 1999), 20. The PME analysis is based on a composite model which integrates four independent measures of cocaine availability 1) potential cocaine production developed by the Central Intelligence Agency's Crime and Narcotics Center, 2) the foreign movement analysis derived from the Interagency Assessment Cocaine Movement, 3) an estimate of cocaine crossing the U.S. border, and 4) the cocaine consumption estimate.

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[47] Office of National Drug Control Policy, *Draft - What America's Users Spend on Illegal Drugs, 1988-1998* (Washington, DC: Office of National Drug Control Policy, 1999), 9-11. As with cocaine, estimates for the size of the hardcore heroin using population are derived from mathematical models rather than probability-based population survey estimates. See endnote 36.

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*1999*, 6.

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[62] Office of National Drug Control Policy, *High Intensity Drug Trafficking Area Program* (Washington, D.C.: Office of National Drug Control Policy, 1999), 64.

[63] Drug Enforcement Administration, *Drug Intelligence Brief – Drug Trafficking in the United States, September 1999*, 8.

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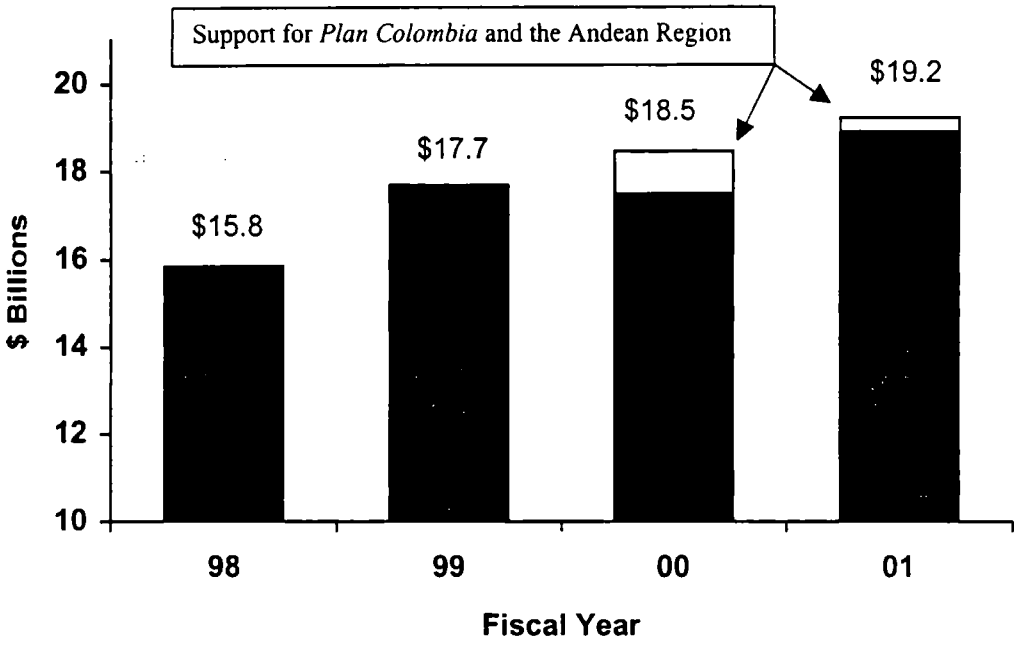
# *IV. The National Drug Control Budget*

The FY 2001 National Drug Control Budget supports the five goals and 31 objectives of the *National Drug Control Strategy* (*Strategy*) and is structured to make progress towards the performance targets outlined in the national drug control *Performance Measures of Effectiveness* (PME) system. In total, funding recommended for FY 2001 is $19.2 billion, an increase of $760 million over the FY 2000 level of $18.5 billion, which includes proposed supplemental funding of $954 million to support *Plan Colombia* and drug control activities in the Andean region. A summary of drug-control spending for FY 1998 through FY 2001 is presented in Figure 4-1.

**Figure 4-1: National Drug Control Budget**




Funding by department for FY 1999 to FY 2001 is displayed in Table 4-1. Additional resources for supply-reduction programs in the Departments of Justice, Treasury, Transportation, State, and Defense will aid efforts in Colombia and the Andean region, support security along the Southwest Border, and continue enforcement operations targeting domestic sources of illegal drugs. Demand-reduction efforts by the Departments of Health and Human Services and Education will support programs to increase public drug treatment, provide basic research on drug use, and continue prevention efforts aimed at school children.

## Table 4-1: Drug Spending by Department ($ Millions)

| Department | FY 99 Actual | FY 00 Estimate | FY 01 Request | FY 00-01 Change | % Change |
|---|---|---|---|---|---|
| Defense | 974.9 | 1,005.2 | 1,029.1 | 23.8 | 2.4% |
| Education | 663.2 | 698.1 | 750.9 | 52.8 | 7.6% |
| HHS | 2,866.1 | 3,078.9 | 3,264.8 | 185.9 | 6.0% |
| HUD | 310.0 | 310.0 | 315.0 | 5.0 | 1.6% |
| Justice | 7,398.5 | 7,443.2 | 8,236.9 | 793.7 | 10.7% |
| ONDCP | 453.2 | 461.4 | 496.8 | 35.4 | 7.7% |
| State | 489.7 | 282.8 | 276.8 | (6.0) | (2.1%) |
| Transportation | 871.1 | 631.0 | 684.9 | 53.8 | 8.5% |
| Treasury | 1,756.5 | 1,499.6 | 1,688.3 | 188.7 | 12.6% |
| Veterans Affairs | 1,041.7 | 1,111.4 | 1,155.5 | 44.1 | 4.0% |
| All Other | 877.3 | 978.8 | 997.5 | 18.7 | 1.9% |
| Subtotal | 17,711.2 | 17,500.6 | 18,896.4 | 1,395.9 | 8.0% |
| *Plan Colombia* & Andean Region | 0.0 | 954.4 | 318.1 | | |
| Total | 17,711.2 | 18,455.0 | 19,214.5 | 759.6 | 4.1% |

### Support for *Plan Colombia* & the Andean Region

The President's budget proposes $1.3 billion in new FY 2000 and FY 2001 funding for counternarcotics efforts in the Andean Region, primarily in Colombia. An estimated 80 percent of the cocaine that enters the United States originates in or passes through Colombia. Colombia also produces up to six metric tons of heroin annually, much of which is shipped to the United States. Cultivation of coca, the raw material for cocaine, has nearly tripled in Colombia since 1992. In addition, Colombian traffickers and coca farmers have recently adopted new cultivation and processing techniques, increasing the amount of drugs processed from each acre of crop. Colombia now cultivates more than half of the coca leaf grown in the world. If unchecked, the rapid expansion of coca crops and cocaine production in Colombia threatens to increase significantly the global supply of cocaine over the next several years.

Government of Colombia efforts to attack the drug trade are hampered by the fact that guerrillas and paramilitary groups, the main actors in Colombia's long internal conflict, control the major drug-producing regions. In addition to these illegal armed groups, organized drug mafias continue to control the international aspects of Colombia's drug trade. The money in the hands of these outlaw groups produced by the drug trade generates violence and corruption and

threatens Colombia's democratic institutions. The drug threat, violence, and insecurity are compounded by the worst economic recession in Colombia in almost 70 years.

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. In support of this plan, the Administration proposes $1.6 billion for assistance, including an increase of $1.3 billion – consisting of a FY 2000 supplemental appropriation of $954 million and new FY 2001 funding of $318 million.

Since there is no single solution to Colombia's difficulty, the program is an integrated combination of funds for Colombian counterdrug efforts and for other programs to help President Pastrana strengthen democracy and promote prosperity. The proposal would enhance alternative development, strengthen the justice system and other democratic institutions, and provide counterdrug equipment, training, and technical assistance to Colombian police and military forces. The Administration is also encouraging U.S. allies and the international institutions to assist Colombia in implementing President Pastrana's *Plan Colombia*. Further, the budget proposal would also provide additional funding to support counterdrug regional interdiction and alternative development programs to shore up significant gains against drug production in Peru and Bolivia and prevent the traffickers from simply moving their operations to avoid law enforcement. It is in the national interest of the United States to stem the flow of illegal drugs and to promote stability and strengthen democracy in Colombia and the Andean region.

## Major Increases in FY 2001

The following major increases in drug-control funding are included in the President's FY 2001 budget for **supply reduction** programs:

- **Prison Construction: +$420 million** (drug-related). This enhancement is a multi-year project that includes program increases for partial site and planning of two penitentiaries and three medium security facilities in FY 2001. The balance of funds for these five institutions is requested for FY 2002 as advance appropriations. Funding is also requested in FY 2001 to complete the construction of ongoing projects, including one penitentiary and five medium security facilities. Further, advanced appropriations are being requested (FY 2002 $467 million drug-related, and FY 2003 $316 million drug-related) for a secure female unit, four medium security institutions and one penitentiary. The Bureau of Prisons (BOP) is experiencing dramatic increases in the number of inmates due to higher number of prosecutions, particularly drug cases. This, as well as the recent sharp increase in immigration cases, is the primary cause of current BOP inmate population growth.

- **Southwest Border: +$105.9 million** (drug-related). These resources will support interdiction and investigations enhancements for the U.S. Customs Service and Immigration and Naturalization Service (INS) for activities primarily along the Southwest Border.

> **INS:** For the INS, the initiative includes $24.5 million ($163.3 million drug and non-drug) for an additional 430 Border Patrol agent positions, $3.0 million (drug-related) to continue deployment of the Border Patrol's Integrated Surveillance Intelligence System (ISIS) program, and $7.5 million (drug-related) for Border Patrol construction projects. In addition, the INS request includes $3.8 million (drug-related) for additional Immigration Inspector positions to staff three new ports along the southern border.

> **Customs:** The Customs Service request includes an increase of $59.1 million to mount a comprehensive investigative effort to identify and dismantle major drug smuggling organizations and $8.0 million ($15.8 million drug and non-drug) for additional personnel and equipment needed to interdict the outbound illicit proceeds generated from narcotics trafficking.

- **Forward Operating Locations (FOLs) – DoD: $77.9 million.** The drug control budget for the Department of Defense includes these resources in FY 2001 for restructuring SOUTHCOM's theater counterdrug architecture, which includes Military Construction funding for FOLs in Ecuador, Aruba and Curacao. This will replace much of the counterdrug support capabilities that had been resident in U.S. military bases in Panama.

- **Customs Enforcement Infrastructure Enhancements: +$112.5 million** (drug-related). This initiative will primarily enhance and modernize the Customs Air Program. Funds will be used to purchase additional flight safety systems, as well as upgrades to radar systems and computer capabilities. Aircraft operated by Customs include jet interceptors and long-range trackers equipped with radar and infrared detection sensors. Customs also has high-performance helicopters, single and multi-engine support aircraft, and sensor-equipped air-to-air detection platforms, including the P-3 fleet, which operate in the source and transit zones.

- **Coast Guard's Campaign Steel Web Enhancements: +$43.8 million** (drug-related). These additional resources will support the United States Coast Guard's drug-interdiction efforts, primarily in the transit zone region of the Caribbean and Eastern Pacific. In particular, funding will be used to expand the implementation of the Coast Guard's non-lethal use-of-force initiative that has proven effective at disabling non-commercial maritime craft used to transport illicit narcotics.

- **DEA Law Enforcement Support & Financial Management: +$65 million.** This funding will expand several DEA activities, including infrastructure support for the FIREBIRD system, Southwest Border and money laundering operations, intelligence capabilities, and financial management oversight functions. The principle component of this initiative ($56 million) is for FIREBIRD. FIREBIRD is DEA's primary office automation infrastructure, which provides essential computer tools for agents and support staff.

The following major increases in drug-control funding are included in the President's FY 2001 budget for **prevention and treatment** programs:

- **Stop Drugs – Stop Crime: +$112 million.** In order to break the cycle of drug use and its consequences, drug-abusing inmates in local, state and federal correctional systems need access to drug treatment. The President's FY 2001 budget includes several enhancements in support of this effort:

  > **OJP & ONDCP Support: +$100 million.** New funding is requested to helping states and localities implement new systems of drug testing, treatment, and graduated sanctions for persons under supervision of the criminal justice system, including prisoners, parolees and probationers. This funding consists of $75 million provided through the Office of Justice Programs (OJP) and $25 million from ONDCP's Special Forfeiture Fund. Also, part of OJP's support includes $25 million to assist local jails in developing or enhancing programs to treat inmates' drug use and address other related problems.

  > **Drug Courts: +$10 million.** These additional resources will bring total funding for the Drug Courts program to $50 million in FY 2001. This initiative provides alternatives to incarceration through using the coercive power of the court to force abstinence and alter behavior with a combination of escalating sanctions, mandatory drug testing, treatment, and strong aftercare programs.

  > **Residential Substance Abuse Treatment (RSAT) Program: +$2 million.** This funding will continue expansion of the RSAT program. RSAT is a formula grant program that provides funds to states for state and local correctional agencies to establish and expand residential substance abuse treatment programs for offenders.

- **National Youth Anti-Drug Media Campaign: +$10 million.** These additional resources bring total funding for ONDCP's Media Campaign to $195 million in federal funds in FY 2001, matched by private sector contributions. ONDCP, in conjunction with other federal, state, local, and private experts, is implementing a $2 billion, multi-year national media campaign, including paid advertisements. The campaign targets youth, their parents and other influential adults on the consequences of illicit drug use. The anti-drug media campaign is fully integrated nationwide, including utilization of television, the Internet, radio, newspapers, and other media outlets.

- **Safe and Drug-Free Schools Program: +$50 million.** These additional resources include $40 million to expand the Safe Schools/Health Students initiative, which supports community prevention activities. Also, the budget includes $50 million to continue the School Coordinator Initiative, started in FY 1999. In FY 2001, this effort will support the hiring of drug prevention coordinators in 700 middle schools across the country to ensure that local programs are effective and link school-based prevention programs to community-based drug prevention efforts.

- **Targeted Capacity Expansion (TCE) Program: +$53.8 million.** This additional funding will help the Substance Abuse and Mental Health Services Administration (SAMHSA) expand the availability of drug treatment in areas of existing or emerging treatment need. Further, these new resources will enable SAMHSA to provide additional states with State Incentive Grants. These grants aid in the coordination of substance abuse prevention funding streams within a state.

- **Substance Abuse Block Grant Program: +$31.0 million** ($22 million drug-related). This increase for SAMHSA's Substance Abuse Block Grant will provide funding to states for treatment and prevention services. This program is the backbone of federal efforts to reduce the gap between those who are actively seeking substance abuse treatment and the capacity of the public treatment system.

- **Treatment and Prevention Research: +$37.3 million.** The FY 2001 budget includes new funding for research conducted by the National Institutes of Health. Research is the lynchpin of efforts to educate and enable America's youth to reject drugs and to decrease the health and social cost of drugs to the American public. Funding supports activities of the National Institute on Drug Abuse (NIDA). NIDA programs include the National Drug Abuse Treatment Clinical Trials Network, prevention research, medications and behavioral therapies, and understanding and preventing relapse.

- **Community Anti-Drug Coalitions: +$5 million.** With this enhancement, total funding for this ONDCP grant program will be $35 million in FY 2001. This initiative provides resources to groups to build and sustain effective community coalitions that help prevent drug use by youth. Sustained and comprehensive prevention efforts at the community level are required to deliver a constant anti-drug message. These activities include the involvement of local leaders in the areas of drug prevention, treatment, education, law enforcement, government, faith, and business.

## Spending by Strategy Goal

Funding by *Strategy* Goal is summarized in Table 4-2. Funding priorities include resources to reduce drug use by young people (Goal 1), make treatment available to chronic users (Goal 3), interdict the flow of drugs at our borders (Goal 4), and target international and domestic sources of illegal drugs and crime associated with criminal enterprises (Goals 2 and 5). In FY 2001, funding of $2.2 billion is requested for Goal 1, a net increase of almost $68 million over FY 2000, and $3.7 billion for Goal 3, an increase of $202 million (5.7 percent) over FY 2000. Further, multiagency efforts, which target ports-of-entry and the Southwest border, will expand funding for Goal 4 to $2.5 billion in FY 2001, an increase of 11.4 percent. Funding requested for Goal 2 is $8.2 billion in FY 2001, an increase of $665 million, and resources devoted to Goal 5 will reach $2.5 billion in FY 2001. The budget for Goal 5 includes proposed

funding of $954 million in FY 2000 and $318 million in FY 2001 to support *Plan Colombia* and drug control activities in the Andean region.

**Table 4-2: Drug Funding by Goal ($ Millions)**

| Goal | FY 99 Actual | FY 00 Estimate | FY 01 Request | FY 00-01 Change | % Change |
|---|---|---|---|---|---|
| 1. Reduce youth drug use | 2,028.8 | 2,166.4 | 2,234.8 | 68.3 | 3.2% |
| 2. Reduce drug-related crime | 7,574.5 | 7,568.8 | 8,233.8 | 665.0 | 8.8% |
| 3. Reduce consequences | 3,300.6 | 3,539.2 | 3,741.6 | 202.4 | 5.7% |
| 4. Shield air, land, and sea frontiers | 2,724.9 | 2,243.4 | 2,500.3 | 256.8 | 11.4% |
| 5. Reduce sources of supply | 2,082.5 | 1,982.6 | 2,185.9 | 203.3 | 10.3% |
| Subtotal | 17,711.2 | 17,500.6 | 18,896.4 | 1,395.9 | 8.0% |
| *Plan Colombia* & Andean Region (Goal 5) | 0.0 | 954.4 | 318.1 | | |
| Total | 17,711.2 | 18,455.0 | 19,214.5 | 759.6 | 4.1% |

## Federal Funding Priorities: FY 2001 - FY 2005

By law, ONDCP must annually report its program and budget priorities over a five-year planning period. These priorities also are highlighted in ONDCP's consolidated five-year *Drug Control Budget: FY 2001 to FY 2005*. This volume, required by statute, is produced by ONDCP each November. Through FY 2005, funding for the following major program areas will be emphasized through ONDCP's drug-budget authorities.

- Support for *Plan Colombia* and drug control activities in the Andean region.
- National Youth Anti-Drug Media Campaign
- Community Coalitions
- Criminal Justice Treatment Programs

- Drug Courts
- Close the Public System Treatment Gap
- School Drug-Prevention Programs
- High Intensity Drug Trafficking Area (HIDTA) Programs
- Southwest Border Programs
- Intelligence Architecture Support
- Regional Interdiction Architecture: Forward Operating Locations.

# *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 consult with the heads of the National Drug Control Program agencies; Congress; state and local officials; private citizens and organizations with experience and expertise in demand reduction; private citizens and organizations with experience and expertise in supply reduction; and appropriate representatives of foreign governments. ONDCP fully met this congressional requirement in 1999.

## CONSULTATION WITH CONGRESS

The development, implementation, oversight, and funding of a comprehensive national drug strategy is an objective that we undertake in tandem with the Congress. In response, the *Strategy* provides detailed long-term plans for addressing domestic and international trends in drug use, production, and trafficking. It also recognizes that only the federal government has the mandate and accountability to pursue international supply reduction targets. Congress has been particularly concerned about accountability in our counter-drug efforts and the long-standing absence of any serious presentation of performance standards or measures of success. The *Strategy* includes specific benchmarks for the base year (1996) and hard data on results in 1997,1998 and 1999 (where such data is available). Finally, the *Strategy* includes initiatives to reinforce parents and families as they work to keep our young people drug free, expands treatment, counters drug legalization at home and abroad, and takes aim at the growing problem of the major international criminal organizations responsible for much of the world's drug production and trafficking.

During 1999, the executive and legislative branches worked effectively to continue implementation of the *Strategy* and address important issues with new legislation. Major accomplishments of this past year include:

- Impressive funding and programmatic support of the Youth Anti-Drug Media Campaign on a bipartisan basis.

- Full funding of the Drug Free Communities Program.

- Passage of the Foreign Narcotics Kingpin Designation Act, part of the Intelligence Authorization Act for FY2000. It provides a statutory framework for the President to institute sanctions against foreign drug kingpins when appropriate with the objective of denying their businesses and agents access to the U.S. financial system . This new tool will enhance our ability to combat the national security threat posed by international drug trafficking.

- Achieving inter-agency approval of a plan to more effectively gather and utilize counterdrug intelligence, known as the General Counterdrug Intelligence Plan, which will be announced and briefed extensively to Congress in early 2000.

- Continued support of the HIDTA program.

ONDCP was pleased to testify at fourteen hearings in 1999 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 those agencies charged with overseeing 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*. The governors from all states and territories, and state drug-control agencies provide input in the areas of prevention, treatment, and enforcement. ONDCP worked closely throughout the year with organizations such as the National Governor's Association, Council of State Governments, the U.S. Conference of Mayors, and the National Association of Counties to coordinate policies and programs. Perspectives were solicited from every mayor of a city with populations of at least 100,000 people and key county officials. Additionally, local prevention experts, treatment providers, and law-enforcement officials provided "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, professional organizations, and religious institutions. A list of private sector groups whose views were considered during formulation of the *2000 Annual Report* is provided at the end of this chapter.

The World Wide Web is a rapidly growing tool for the exchange of information and opinion between ONDCP and the public. The ONDCP web site (www.whitehousedrugpolicy.gov) was accessed 2,348,674 times by 632,567 users in 1999. ONDCP-sponsored and affiliated web sites are a vital part of the National Youth Anti-Drug Media Campaign. During the past year these sites were accessed by hundreds of thousands of parents, teachers, mentors and youth seeking reliable information and strategies on drugs and how to combat drug use. Current ONDCP sponsored sites for parents and youth include: www.theantidrug.com
www.freevibe.com
www.mediacampaign.org.

In addition, AOL, ONDCP and the Partnership for a Drug-Free America have collaborated on an AOL Parent's Drug Resource Center at AOL Keyword: Drug Help

## CONSULTATION WITH REPRESENTATIVES OF FOREIGN GOVERNMENTS AND INTERNATIONAL ORGANIZATIONS

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

## CONSULTATION WITH NON-GOVERNMENTAL ORGANIZATIONS

Views of the following organizations were considered during formulation of the *2000 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
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 Psychological Association
American Public Health Association
American Public Welfare Association
American Red Cross
American School Counselors Association
American Society for Pharmacology and Experimental Therapeutics
American Society of Addiction Medicine
American Speech/Language/Hearing Association
American Youth Work Center
Amnesty International
AMVETS
Annenberg School of Communications
Asian Community Mental Health Services
ASPIRA
Association for Health Services Research
Association for Hospital Medical Education
Association for Medical Education and Research in Substance Abuse (AMERSA)
Association for Worksite Health Promotion
Association of Academic Health Centers
Association of Caribbean Commissioners of Police
Association of Jesuits Colleges and Universities
Association of Junior Leagues
Association of State Correctional Administrators
Association of Southeast Asian Nations
BACCHUS and GAMMA Peer Education
Baltimore Council of Foreign Affairs
Benevolent and Protective Order of Elks
Bensinger DuPont & Associates
Big Brothers Big Sisters of America
Black Psychiatrists of America
Bodega de la Familia (New York City)
Boy Scouts of America
Boys and Girls Clubs of America
Brookings Institute
Business Roundtable
B'nai B'rith International
B'nai B'rith Youth
California Border Alliance Group
California Narcotics Officers Association
California School Board Association
Camp Fire Boys and Girls
Caribbean Common Market and Community
Caribbean Customs Law Enforcement Council
Carter Center
Catholic Charities U.S.A.
Center for Alcohol and Drug Research Education
Center for Health Promotion
Center for Media Education, Inc.
Center for Media Literacy
Center for Medical Fellowships in Alcoholism and Drug Abuse
Center for Science in the Public Interest
Center on Addiction and Substance Abuse of Columbia University (CASA)
Chicago Project for Violence Prevention
Child Welfare League of America, Inc.
Children's Defense Fund
Christian Life Commission
Church of Jesus Christ 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
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
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 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 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 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 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 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
Patrician Movement
Pediatric AIDS Foundation
Penn State University
Pharmaceutical Research and Manufacturers of America
Phoenix House
Physicians for Prevention (PFP)
Physicians Leadership on National Drug Policy
Pilot International
Points of Light Foundation
Police Executive Research Forum
Police Foundation
Presbyterian Women-Presbyterian Church USA
Pretrial Services Resource Center
Prevention, Intervention and Treatment Coalition for Health (PITCH)
Professional Actors Guild
Professional Directors Guild
Professional Writers Guild
Public Agenda, Inc.
Public Relations Society of America
Quota International
RAND Corporation
Religious Action Center
Resource Center on Substance Abuse Prevention and Disability
Robert Wood Johnson Foundation
Rotary International
Ruritan National
Safe Streets
San Diego World Affairs Council
San Francisco AIDS Foundation
Scott Newman Center
Sertoma International
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 Church of Jesus Christ of Latter-Day Saints
The LINKS, Inc.
The Matrix Institute on Addictions
The North American Committee
The Recovery Network

The Robert Wood Johnson Foundation
The Salvation Army
The Village, Inc.
Therapeutic Communities of America
Town Hall of Los Angeles
Travelers Aid International
Treatment Accountability for Safer Communities
Treatment Alternatives for Safe Communities (TASC)
Troy Michigan Communities Coalition
Twentieth Century Fund
Two Hundred Club of Greater Miami
U.S. Chamber of Commerce
U.S. Conference of Mayors
U.S. Hispanic Chamber of Commerce
U.S. Olympic Committee Union of American Hebrew Congregations
United Church of Christ
United Methodist Association of Health and Welfare
United Methodist Church, Central Pennsylvania Conference
United National Indian Tribal Youth, Inc.
United Nations Economic and Social Council
United Nations International Drug Control Programme
United States Catholic Conference
United States Conference of Mayors
United Synagogue of Conservative Judaism
United Way of America
University of California, Los Angeles
  Drug Abuse Research Group
  Graduate School of Management
  Neuropsychiatric Group
University of Delaware, Division of Criminal Justice
University of Kentucky
  Center for Prevention Research and
  Department of Communication
University of Maryland, Center for Substance Abuse Research (CESAR)
University of Michigan Survey Research Center
University of Nebraska Medical Center
University of North Carolina, Department of Curriculum and Instruction
University of Pennsylvania
  Health System
  Treatment Research Center
University of Southern California, Center for Prevention Policy Research
University of Washington, College of Education and Alcohol and Drug Abuse Institute
Urban Institute
Urban League
Veterans of Foreign Wars
Virginia Association of Alcoholism and Drug Abuse Counselors
Visiting Nurses Association of America
Washington Business Group on Health
Washington Office on Latin America
Wellness Council of America
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