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EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

February 2, 1998

Dear Ms. Thurman:

Enclosed is the final draft of the *1998 National Drug Control Strategy*. We have sent it out through OMB for formal interagency clearance. Director McCaffrey has also sent copies to all members of the President's Drug Policy Council. The President is tentatively scheduled to release the *Strategy* next Wednesday (February 10).

Your detailed reading of each draft and substantive comments have been much appreciated and are reflected in this draft *1998 Strategy*. We look forward to receiving your comments on this final draft as soon as possible. They can be sent via fax (202) 395-6641 or via courier to: Francis X. Kinney, Office of Strategic Planning, ONDCP, 8th floor, 750 17th St. NW. Again, thank you for your support.

Sincerely,

Francis X. Kinney
Office of Strategic Planning

Final Draft (February 2, 1998)
for Interagency Clearance

1998 National Drug Control Strategy

Final Draft (February 2, 1998)
for Interagency Clearance
Not for Public Release

I: Drug-Control Strategy: An Overview

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

Introduction

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 illegal use of alcohol and tobacco by youngsters 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. Like a corrosive, insidious cancer, drug abuse diminishes the potential of citizens for growth and development. Not surprisingly, 56 percent of respondents to a survey conducted by the Harvard School of Public Health in 1997 identified drugs as the most serious problem facing children in the United States.[1]

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

A Comprehensive Ten-Year Plan

Strategy determines the relationship between goals and available resources. As an executable plan, it offers ways to achieve ends in an efficient manner. Strategy sets a timetable that adjusts as conditions change. Strategy also embodies will. The *National Drug Control Strategy* proposes a ten-year conceptual framework supported by annually updated five-year budgets in order to reduce illegal drug use and availability 50 percent by the year 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 recorded drug-use rate in American history. Drug-related health, economic, social, and criminal costs will be reduced commensurately. The *Strategy* focuses on prevention, treatment, research, law enforcement, protection of our borders, and international cooperation. It provides general guidance while identifying specific initiatives. This document expresses the collective wisdom and optimism of the American people with regard to illegal drugs.

Mandate for a National Drug Control Strategy

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

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

- Executive Order No. 12564 (1986) made it a condition of employment for all federal employees to refrain from using drugs. This order required every federal agency to develop a comprehensive drug-free workplace program.

- The Anti-Drug Abuse Act of 1988 established as a policy goal the creation of a drug-free America. A key provision of that act was the establishment of the Office of National Drug Control Policy (ONDCP) to set priorities, implement a national strategy, and certify federal drug-control budgets. The law specifies that the strategy must be comprehensive and research-based, contain long-range goals and measurable objectives, and seek to reduce drug abuse and its consequences. Specifically, drug abuse is to be curbed by preventing youth from using illegal drugs, alcohol, and tobacco; reducing the number of users; and decreasing drug availability.

- The Violent Crime Control and Law Enforcement Act of 1994 extended ONDCP's mission to assessing budgets and resources related to the *National Drug Control Strategy*. It also established specific reporting requirements in the areas of drug use, availability, consequences, and treatment.

- Executive Order No. 12880 (1993) and Executive Orders Nos. 12992 and 13023 (1996) assigned ONDCP responsibility within the executive branch for leading drug-control policy and developing an outcome-measurement system. The executive orders also chartered the President's Drug Policy Council and established the ONDCP Director as the President's chief spokesman for drug-control.

Evolution of the *National Drug Control Strategy*

National Drug Control Strategies have been produced annually since 1989. Each defined demand reduction as a priority. In addition, the *Strategies* increasingly recognized the importance of preventing drug use by youth. The various documents affirmed that no single approach could rescue the nation from the cycle of drug abuse. A consensus was reached that drug prevention, education, and treatment must be complemented by supply reduction actions abroad, on our borders, and within the United States. Each *Strategy* also shared the commitment to maintain and enforce anti-drug laws. All the *strategies*, with growing success, tied policy to a scientific body of knowledge about the nation's drug problems. The *1996 Strategy* was a break-through that 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 *1998 Strategy* and will guide federal drug-control agencies over the next decade. In addition, the goals will be useful for state and local government and the private sector.

Elements of the *1998 National Drug Control Strategy*

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

Outcome-oriented: To translate words into deeds, the *Strategy* must ensure accountability. *Performance Measures of Effectiveness: A System for Assessing the Performance of the National Drug Control Strategy*[2] details long and mid-term targets that gauge progress toward each of the *Strategy's* goals and objectives.

Comprehensive: Successfully addressing the devastating drug problem in America requires a multi-faceted, balanced program that attacks both supply and demand. Prevention, education, treatment, workplace programs, research, law enforcement, interdiction, and drug-crop reduction must all be components of the response. Former "Drug Czar" William Bennett laid out in the *1989 National Drug Control Strategy* a principle that still applies today: "... no single tactic -- pursued alone or to the detriment of other possible and valuable initiatives -- can work to contain or reduce drug use." We can expect no panacea, no "silver bullet," to solve the nation's drug-abuse problem.

Long-term: No short-term solution is possible to a national drug problem that requires the education of each new generation and resolute opposition to criminal drug traffickers. Our *Strategy* must be philosophically coherent and consistently followed.

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

Realistic: Some people believe drug use is so deeply embedded in society that we can never decrease it. Others feel that draconian measures are required. The *1998 Strategy* rejects both these views. Although we cannot eliminate illegal drug use, history demonstrates that we can control this cancer without compromising American ideals.

Science-based: Facts rather than ideology or anecdote must provide the basis for rational drug policy.

Goals of the *1998 Strategy*:

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

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

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

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

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

Thirty-two supporting objectives are elaborated in chapter three. The goals and objectives reflect the need for prevention and education to protect children from the perils of drugs; treatment to help the chemically-dependent; law enforcement to bring traffickers to justice; interdiction to reduce the flow of drugs into our nation; and international cooperation to confront drug cultivation, production, trafficking, and use.

Drug Control is a Continuous Challenge

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

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

Endnotes

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

2. Published simultaneously with this document. Both are also available on the ONDCP web site (*http:// www.whitehousedrugpolicy.gov*).

II: America's Illegal Drug Profile

Illegal Drug Use Rates are 50 Percent Lower Than 1979's Historic High Level

In 1996 overall drug use remained stable, and use among youth stopped increasing after five years of rising rates. An estimated thirteen million Americans (6.1 percent of the U.S. household population aged twelve and over) were current drug users.* This figure represents a significant change from 1979 when the number of current users was at its highest recorded level -- twenty-five million (or 14.1 percent of the population).[1] Despite this dramatic drop, 34.8 percent of Americans twelve and older have used an illegal drug in their lifetime; more than 90 percent used either marijuana or hashish, and approximately 30 percent tried cocaine. Fortunately, sixty-one million Americans who once used illegal drugs have now rejected them.

Drug Abuse is a Shared Problem

Many Americans believe that drug abuse is not their problem. They cling to the misconception that illegal drug users belong to a segment of society different from their own or that drug abuse is remote from their environment. These people are wrong. Drug use and its consequences threaten Americans of every socio-economic background, geographic region, educational level, and ethnic or racial identity. No one is immune, and every family is vulnerable. However, the effects of drug use are often felt disproportionately. Neighborhoods where illegal drug markets flourish are plagued by attendant crime and violence. Americans who lack access to comprehensive health care and have smaller incomes may be less able to afford treatment to overcome drug dependence. As a nation, we must make a collective commitment to reducing drug abuse.

Illegal Drug Use Has Begun to Level off Among Youth but Remains Unacceptably High

The University of Michigan's 1997 *Monitoring the Future* (*MTF*) study -- a nationwide school-based report of drug use among eighth, tenth, and twelfth-grade students -- records that drug-use rates are leveling off.[2] Since 1992, there has been a substantial increase in the use of most drugs -- particularly marijuana. In 1997, for the first time in six years, the use of marijuana and other illegal drugs did not increase among eighth graders. Use of marijuana and other illegal drugs among tenth and twelfth graders also appears to have leveled off. Furthermore, attitudes regarding drugs, which are key predictors of use, began to reverse in 1997 after several years of erosion.

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

The 1997 *MTF* partially corroborated earlier finding of the Substance Abuse and Mental Health Administration's (SAMHSA) 1996 *National Household Survey on Drug Abuse* (*NHSDA*) that current drug use among twelve to seventeen-year-olds declined between 1995 and 1996 from 10.9 percent to 9 percent. However, this good news is tempered by the fact that today's drug-use rates among youth, while well below the 1979 peak of 16.3 percent, are substantially higher than the 1992 low of 5.3 percent. One in four twelfth graders is a current illegal drug user while for eighth graders, the figure is approximately one in eight. Elevated drug-use rates are a reflection of pro-drug pressures and drug availability. Almost one in four twelfth graders say that "most or all" of their friends use illegal drugs.[3] A survey conducted by the Columbia University Center on Addiction and Substance Abuse reported that 41 percent of teens had attended parties where marijuana was available, and 30 percent had seen drugs sold at school.[4]

Chronic Users are Difficult to Count

Estimates of the size of the population that uses drugs heavily (termed chronic users) are imprecise because many individuals who are deeply involved in drugs are difficult to locate for interviews. This problem of access tends to produce a negative bias in data gathered in conventional ways. Researchers put the number of chronic users at 3.3 million for cocaine and 810,000 for heroin, with a total of 4.1 million.[5] Learning more about the demographics of chronic users is vital. Chronic users maintain the illegal drug market, commit a great deal of crime, and contribute to the spread of hepatitis and tuberculosis as well as HIV/AIDS, and other sexually-transmitted diseases. Without an accurate estimate of the number of chronic users, initiatives responsive to the scale of the problem are difficult to develop.

An Office of National Drug Control Policy (ONDCP) funded large-scale feasibility study, conducted in Cook County, Illinois, underscored the difficulty of estimating the number of chronic users and the tendency of survey instruments to undercount. The Cook County survey interviewed self-professed chronic users where they are most likely to be found in large numbers: jails, drug-treatment programs, and homeless shelters. Researchers sought to learn about the characteristics of heavy drug-users and the frequency with which they made contact with institutions. The survey estimated that 333,000 chronic drug users were in Cook County. This number is substantially higher than the SAMHSA estimate of 117,000 in the Chicago metropolitan area. The results of this study of drug abuse in one county cannot be extrapolated nationwide. The next step will be applying this approach to an entire region and then, assuming the results are accurate, to the whole country.[6]

Problems Estimating Drug Availability

Information about quantities of illegal drugs imported to the United States or cultivated or produced within the United States is imprecise. So too is wholesale and retail-level price and

purity data for different drugs. Estimation models for cocaine availability are the most rigorous. Estimates of domestic cocaine availability are derived by calculating the quantity of cocaine exported from producer countries based on cultivation and production figures. These numbers are then adjusted to reflect the probable proportion bound for the United States and in-transit seizures. However, similar methodologies for estimating heroin, marijuana, methamphetamine, and other drug availability have not been developed. Domestically, the Drug Enforcement Administration's (DEA) System to Retrieve Information from Drug Evidence (STRIDE) is used to provide broad ranges for retail and wholesale purity and prices. Without accurate estimates, gauging the size of illegal markets or the effects of anti-trafficking programs is difficult. This information shortfall is being addressed by ONDCP's Advisory Committee on Research, Data, and Evaluation.

Cocaine

Overall usage: In 1996, an estimated 1.7 million Americans were current cocaine users. This figure represents 0.8 percent of the household population aged twelve and over and is a substantial decline from the 1985 figure of 5.7 million in 1985 (3 percent of the population). The current-use rate, however, has not changed significantly in the last five years. The number of first-time users (652,000 in 1995) was significantly lower than the number of initiates (first-time users) between 1977 and 1987 when more than one million Americans tried cocaine each year. Estimates of the number of chronic cocaine users vary, but 3.3 million is a widely accepted figure within the research community.[7]

Use among youth: Cocaine use is not prevalent among young people. The 1997 *MTF* survey found that the proportion of students reporting use of powder cocaine in the past year to be 2.2 percent, 4.1 percent, and 5 percent in grades eight, ten, and twelve, respectively. This rate represents a leveling-off in eighth-grade use and no change in tenth and twelfth grades. Among eighth graders, perceived risk also stabilized in 1997, and disapproval of use increased -- both after an earlier erosion in these attitudes. The 1996 *NHSDA* found current use among twelve to seventeen-year-olds to be 0.6 percent, twice the rate of 1992 yet substantially lower than the 1.9 percent reported in 1985. However, young people are still experimenting with cocaine, underscoring the need for effective prevention. This requirement is substantiated by *NHSDA*'s finding of a steady decline in the mean age of first use from 22.6 years in 1990 to 19.1 years in 1995. Crack cocaine use, according to *MTF*, leveled-off in the eighth, tenth, and twelfth grades during the first half of the 1990s.

Availability: Between 287 and 376 metric tons of cocaine are estimated to have been smuggled into the United States in 1995.[8] Consumption-based calculations suggest the U.S. demand for cocaine that year was about 330 metric tons.[9] Powder cocaine retailed at approximately 130 dollars per gram in 1997.[10] Wholesale quantities (kilograms) are generally 80 to 100 percent

pure. Retail purity levels vary widely according to local supply and demand.

Heroin

Overall usage: There are approximately 320,000 occasional heroin users and 810,000 chronic users in the United States.[11] Injection remains the most efficient means of administration, particularly for low-purity heroin. However, the increasing availability of high-purity heroin has made snorting and smoking more common modes of ingestion, thereby lowering inhibitions to use. This change is reflected in the proportion of lifetime users who smoked, sniffed, or snorted, which increased from 55 percent in 1994 to 82 percent in 1996.[12]

Use among youth: While quite low, rates of heroin use among teenagers rose significantly in eighth, tenth, and twelfth grades during the 1990s. Being able to snort or smoke heroin, instead of injecting it, undoubtedly played a major role in increasing use of this drug. The 1997 *MTF* found no change between 1996 and 1997 in tenth and twelfth grades but concluded that use in eighth grade has leveled-off and may have declined. The report also discovered that more young people perceive heroin as dangerous; 56.7 percent of twelfth graders thought that trying heroin was a "great risk" -- the highest percentage recorded in twenty-three years. The 1996 *NHSDA* found that the mean age of initiation declined from 27.3 years in 1988 to 19.3 in 1995. Unfortunately, communities throughout the country are experiencing the results of heroin abuse. Plano, Texas, one of the nation's ten safest cities, had eleven heroin-overdose deaths in 1997; many of the victims were children. Orlando, Florida saw forty-eight heroin deaths in 1995 and 1996; ten victims were twenty-one years of age or younger.

Availability: Information about the price and purity of heroin is extremely imprecise. In 1997, the average retail price for a pure gram of heroin was approximately 1,375 dollars; the mid-level cost was 450 dollars. These prices were significantly lower than in 1981 when the retail price of a gram was estimated to be three thousand dollars and the mid-level price $1,700.[13] Ethnographers suggest that heroin is increasingly available in many cities. High-purity Southeast Asian, Southwest Asian, and Colombian heroin is plentiful in most regions of the country. Lower-purity Mexican black tar heroin is more common in the Southwest.[14]

Marijuana

Overall usage: The 1996 *NHSDA* estimated that 4.7 percent (10.1 million) of the population aged twelve and older were current marijuana or hashish users, which is the same rate as in 1995. Marijuana is the most prevalent illegal drug in the United States; approximately three-quarters (77 percent) of current illegal drug users used marijuana or hashish in 1996. The number of initiates in 1995 declined slightly from the 1994 figure of 2.4 million.

Use among youth: The 1997 *MTF* shows that marijuana continues to be the illegal drug most frequently used by young people. Among high school seniors, 49.6 percent reported using marijuana at least once in their lives. By comparison, the figure was 44.9 percent for seniors in 1996 and 41.7 percent in 1995. After six years of steady increase, current marijuana use fell in 1997 among eighth graders, from 11.3 percent in 1996 to 10.2 percent. There was evidence of a reduction in the rate of increase among tenth and twelfth graders. The 1996 *NHSDA* found that current marijuana usage among twelve to seventeen-year-olds was at 7.1 percent, compared to 8.2 percent in 1995. While there is no statistically-significant difference between the 1995 and 1996 figures, *NHSDA* findings suggest an end of the trend that resulted in a doubling of marijuana usage between 1992 and 1995.

Availability: While marijuana is the most readily available illegal drug in the United States, there is no national survey or accepted estimate of domestic cannabis cultivation. California, Hawaii, Kentucky, and Tennessee are major growing states. Cannabis is frequently cultivated in remote locations and on public land to prevent observation and identification of owners. The drug is also grown commercially and privately indoors, which complicates the task of assessing cultivation. Marijuana is also imported from a wide range of regions; Colombia, Jamaica, and Mexico are major source countries. Eradication and seizure data suggest the magnitude of the illegal marijuana trade.[15] In 1996, three million marijuana plants were eradicated in the United States; their potential yield was 1,389 metric tons.[16] According to the El Paso Intelligence Center, 478 metric tons were seized along the southwest border in 1996, a 50 percent increase over 1995. In 1996, marijuana typically sold at eight hundred dollars a pound.[17] The drug's potency is higher than in the early 1980s as a result of indoor cultivation and manipulation of Delta-9 tetrahydrocannabinol (THC) levels -- THC is the primary psychoactive chemical in marijuana.

Methamphetamine

Overall usage: SAMHSA's 1996 *NHSDA* estimated that 4.9 million Americans tried methamphetamine in their lifetime, up slightly from the 1995 estimate of 4.7 million. The National Institute of Justice's (NIJ) Arrestee Drug Abuse Monitoring (ADAM) system (which regularly tests arrestees for drug use in twenty-three metropolitan areas) reports that methamphetamine use continues to be more common in the western United States than in the rest of the nation. It also found that methamphetamine use fell significantly from 1995 levels. Eight cities (Dallas, Denver, Los Angeles, Omaha, Phoenix, Portland, San Diego, and San Jose), which were cited in the 1995 report as having the highest methamphetamine rates among adult arrestees, experienced substantial declines in 1996. In San Diego, positive test results declined from 37.1 to 29.9 percent, in Phoenix from 21.9 to 12.2 percent, in Portland from 18.7 to 12.4 percent, in San Jose from 18.5 to 14.8 percent, in Omaha from 8.1 to 4.3 percent, in Los Angeles from 7.5 to 7 percent, in Denver from 3.8 to 2.2 percent, and in Dallas from 2.7 to 1.3 percent.[18]

Use among youth: The 1997 *MTF* asked twelfth graders about the use of only crystal methamphetamine, known as "ice." Ice is often smoked or burned in rock form. The survey found that ice use, which had been rising since 1992, leveled-off in 1997 after perceived risk stabilized a year earlier; 2.3 percent of twelfth graders reported use of ice in the past year.

Availability: Methamphetamine is by far the most prevalent synthetic controlled substance clandestinely manufactured in the United States. It is also imported from Mexico. Methamphetamine is cheaper than cocaine in many illegal markets. Long associated with motorcycle gangs that supplied users in western states, this drug has spread eastward. Methamphetamine purity remained at approximately 50 percent or more over the past four years, indicating relatively stable availability. Prices currently range nationwide from $6,500 to twenty thousand dollars per pound, five hundred dollars to $2,700 per ounce, and fifty dollars to $150 per gram. The price of methamphetamine is heavily influenced by the supply of ephedrine and pseudoephedrine, which are key ingredients. Efforts to curtail the supply of precursors have caused the price of methamphetamine to exceed double its earlier cost: from three thousand dollars per pound to $6,500 and ten thousand dollars in Los Angeles and San Francisco.

Other Substances

Overall usage: The 1996 *NHSDA* reported no significant change in the prevalence of inhalants, hallucinogens (like LSD and PCP), or psychotherapeutics (tranquilizers, sedatives, analgesics, or stimulants) used for non-medical purposes between 1995 and 1996. Current rates for both hallucinogens and inhalants remained well below 1 percent in 1996. However, the number of initiates to hallucinogen use, 1.2 million in 1995, has doubled since 1991. Current-use rates for psychotherapeutics were 1.4 percent in 1996. Finally, an estimated three million Americans used prescription drugs for non-medical purposes in 1996.

Use among youth: The 1997 *MTF* reports that inhalant use is most common in the eighth grade where 5.6 percent used it on a past-month basis and 11.8 percent did so on a past-year basis. Inhalants can be deadly, even with first-time use, and often represent the initial experience with illegal substances. Current use of stimulants (a category that includes methamphetamine) declined among eighth graders (from 4.6 to 3.8 percent) and tenth-graders (from 5.5 percent to 5.1 percent) and increased among twelfth graders (from 4.1 to 4.8 percent). Ethnographers continue to report "cafeteria use"** of hallucinogenic or sedative drugs like ketamine, LSD, MDMA, and GHB throughout the country. Treatment providers have noted increasing poly-drug

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

use among young people. *NHSDA* also reported that the mean age of first use of hallucinogens was 17.7 years in 1995, the lowest figure since 1976.

Availability: LSD is inexpensive, with dosage units costing as little as twenty-five cents wholesale. Retail prices vary from one to twenty dollars per dose. This odorless drug, which is often carried on blotting paper, can be purchased via mail-order. PCP production is centered in the Los Angeles metropolitan area. Los Angeles-based street gangs, primarily the Crips, distribute PCP to a number of U.S. cities through cocaine-trafficking operations. Retail PCP prices vary greatly. MDMA (known by such street names as Ecstasy, XTC, Clarity, Essence, and Doctor) is produced in west Texas and on the West Coast or smuggled into the United States from Mexico. It is distributed across the country by independent traffickers and through post or express mail. MDMA is often sold in tablet form with dosage units of 55 to 150 milligrams. Law-enforcement agencies throughout the country continue to report incidents involving various benzodiazepines, including flunitrazepam (Rohypnol), clonazepam (Klonopin), and gammahydroxybulerate (GHB). These substances have been reportedly used to incapacitate victims prior to assault; consequently, they have become called "date rape" drugs.

Underage Use of Alcohol

Despite a minimum legal drinking age of twenty-one, alcohol is the drug most often used by young people. The 1996 *NHSDA* found that past-month use of alcohol among twelve to seventeen-year-olds declined from 21.1 percent in 1995 to 18.8 percent in 1996. The 1997 *MTF* survey reported a gradual upward drift in the low proportion of students who say they have been drunk frequently (twenty or more times in the past month). In 1997, these rates were 0.2 percent, 0.6 percent, and 2 percent in grades eight, ten, and twelve, respectively. *MTF* also concluded that binge drinking increased slightly in the 1990s (defined as having five or more drinks in a row). In 1997, 15 percent, 25 percent, and 31 percent of eighth, tenth, and twelfth graders, respectively, reported binge drinking.

Underage Use of Tobacco

SAMHSA's 1996 *NHSDA* found that rates of smoking among youths aged twelve to seventeen did not change between 1995 and 1996. An estimated 18 percent of youngsters in this age group (4.1 million adolescents) were current smokers in 1996. This figure is lower than the rate for the overall population aged twelve and older (29 percent). However, daily cigarette smoking rose 43 percent among high school seniors between 1992 and 1997.[19] The 1997 *MTF* reported that daily cigarette smoking among seniors reached its highest level (24.6 percent) since 1979 while declining slightly among eighth graders. Nine percent of eighth graders reported smoking on a daily basis; 3.5 percent smoked a half-pack or more per day.[20]

Consequences of Illegal Drugs

Illegal drugs cost our society approximately sixty-seven billion dollars each year.[21] Drug-related deaths have increased 42 percent since 1990 and numbered 14,218 in 1995.[22] Accidents, crime, domestic violence, illness, lost opportunity, and reduced productivity are the direct consequences of substance abuse. Drug use by children often leads to other forms of unhealthy, unproductive behavior including delinquency and premature, unsafe sex. Drug abuse and trafficking hurt families, businesses, and neighborhoods; impede education; and choke criminal-justice, health, and social-service systems.

Health Consequences

Drug-related medical emergencies remain near historic highs: SAMHSA's Drug Abuse Warning Network (DAWN), which studies drug-related hospital emergencies, provides a snapshot of the health consequences of America's drug problem.[23] DAWN reported that drug-related episodes dropped 6 percent between 1995 and 1996, from 518,000 to 488,000. The decline was due, in part, to significantly fewer episodes of non-medical use of legal drugs (like aspirin and ibuprofen) and some illegal drugs (methamphetamine and PCP). Nevertheless, pharmaceutically controlled substances accounted for 25 percent of reported medical emergencies.

Estimated emergency episodes for both cocaine and heroin were at their highest levels since 1978. Cocaine-related cases remained about the same in 1995 (137,979) and 1996 (144,180). The increasing incidence of cocaine emergencies among persons aged thirty-five and older continued through 1996, rising 184 percent from the 1990 level. Heroin-related episodes declined slightly between 1995 and 1996 from 72,229 to 70,463 and were 108 percent higher than in 1990. Although the change between 1995 and 1996 is not statistically significant, the decline is the first since 1990. Methamphetamine-related emergency-room episodes decreased 33 percent between 1995 and 1996 from 16,183 to 10,787. This is the second year of decline since the 1994 peak of 17,665 emergency episodes. SAMHSA suggests that the drop in methamphetamine cases may be explained by shortages of that drug in early 1996. While increases in marijuana-related cases between 1995 and 1996 (45,775 to 50,037) are not statistically significant, the 1996 figure is substantially higher than the 1994 figure of 40,183 episodes.

Maternal drug use affects mother, developing fetus, and children: SAMHSA's 1996 *NHSDA* estimates that 3.2 percent of pregnant women (approximately eighty thousand) were current drug users. This rate is substantially lower than for current users among women aged

fifteen to forty-four who were not pregnant and had no children (10 percent). However, women who recently gave birth (who were not pregnant and had children under two years of age) had a current-usage rate of 6.2 percent, suggesting that many women resume drug use after giving birth. Similar patterns are seen for alcohol and cigarette use.[24]

Drug use can affect the health of a developing fetus, and later, the child. The immediate consequences of prenatal drug use may include premature birth and alteration of the newborn's brain function. Although more work needs to be done, researchers studying the potential long-term consequences of prenatal drug exposure are finding that these children may suffer a higher incidence of learning disabilities and other neurological deficits that become manifest later. Many women who use illegal drugs during pregnancy also use alcohol. One to three infants in every one thousand live births are born with fetal alcohol syndrome (FAS) -- a distinct cluster of physical and mental impairments caused by prenatal exposure to alcohol. FAS imposes costs on the health-care system through neonatal intensive care and surgical services; medical treatment for children and adolescents; and educational, residential, and institutional programs for children and adults.[25] Additional costs result from lost productivity due to impairments associated with FAS.[26]

Addiction: Once viewed as essentially a moral or character defect, addiction now is known to be a complex behavioral and medical condition with personal, social, and biological underpinnings. Addicts, once seen as deviant, are now seen as individuals with a chronic, relapsing disease. Research shows that some individuals are at greater risk than others of developing drug-related problems and that addiction is a complicated state, which invariably involves altered brain chemistry.[27] Drug-seeking and use alters thinking patterns and, in essence, re-trains the brain. With heavy, frequent drug use, the change in cerebral function can be profound, and interventions to date -- although effective in modifying behavior -- have not demonstrated the capacity to return brain chemistry to pre-addiction levels. Persons of any background can become addicted to drugs. Approximately 45 percent of Americans know someone with a substance-abuse problem;[28] nearly 20 percent state that drug abuse has been a cause of trouble in their families.[29]

Spreading of infectious diseases: Illegal drug users and people with whom they have sexual contact run higher risks of contracting gonorrhea, syphilis, hepatitis, and tuberculosis. Chronic users are particularly susceptible to infectious diseases and are considered "core transmitters." High-risk sexual behavior associated with crack cocaine and the injection of illegal drugs enhances the transmission and acquisition of HIV and sexually-transmitted diseases. The Centers for Disease Control and Prevention estimate that 35.8 percent of new HIV cases are linked to injecting drug users.[30]

Consequences of underage drinking: While alcohol is a legal drug that many American adults

use without negative consequences, it holds unique dangers for underage drinkers. The younger the onset of drinking, the greater the chances of developing a clinically-defined alcohol disorder.[31] Researchers found that young people who begin drinking before age fifteen are four times more likely to become alcohol dependent and twice as likely to abuse alcohol than individuals who start drinking at age twenty-one. Underage drinking can impair physical and psychological development as well as learning.

Drinking by youth correlates with increases in other high-risk behavior, including unsafe sexual practices. Drinking greatly increases the risk of being involved in a car crash, and this chance is further magnified because young persons are inexperienced with both drinking and driving. More than 2,300 youths aged fifteen to twenty died in alcohol-related crashes in 1996 -- 33.6 percent of total traffic fatalities in this age group.[32] A survey focusing on alcohol-related problems experienced by high school seniors and dropouts revealed that within the preceding year, approximately 80 percent reported getting "drunk," binge drinking, or drinking and driving. More than half said that drinking had caused them to feel sick, miss school or work, get arrested, or be involved in an auto accident.[33] Alcohol use among adolescents has also been closely linked to increased risk for suicide. According to one study, 37 percent of eighth-graders who drank heavily reported attempting suicide, compared with 11 percent who did not drink.[34]

Smoking-related consequences: Tobacco use, particularly among youth, has been shown to be correlated with the later onset of illegal drug use. In addition, tobacco use can cut short one's life expectancy. Most smokers start between ten and eighteen years of age.[35] Approximately 4.5 million American children under eighteen now smoke, and every day another three thousand adolescents become regular smokers.[36] One third of these new smokers will eventually die of tobacco-related diseases.[37] Seventy percent of adolescent smokers say they would not have started if they could choose again.[38]

Cost of Drug Abuse to Workplace Productivity

An estimated 6.1 million current illegal drug users were employed full-time (6.2 percent of the full-time labor force aged eighteen to forty-nine) in 1996, while 1.9 million worked part-time (8.6 percent). Drug users are less dependable than other workers and decrease workplace productivity. They are more likely to have taken an unexcused absence in the past month; 21.1 percent did so compared to 6.1 percent of drug-free workers. Illegal drug users get fired more frequently (4.6 percent were terminated within the past year compared to 1.4 percent of non-users). Drug users also switch jobs more frequently; 32.1 percent worked for three or more employers in the past year, compared to 17.9 percent of drug-free workers. One quarter of drug users left a job voluntarily in the past year. Drug users are three times more likely to be late for work. Overall, drug using employees are 33 percent less productive. They are five times more likely to file worker's compensation claims,

are responsible for 40 percent of industrial fatalities, and incur 300 percent higher medical costs than their drug-free counterparts.[39]

Criminal Consequences

While crime in general continues to decline, arrests for drug-law violations are at record highs. More than 1.5 million Americans were arrested for drug-law violations in 1996. More than 30 percent of the Department of Justice's budget is used for drug-related functions. This estimate is based upon self-reported bureau-by-bureau figures.[40] Many crimes (e.g., assault, prostitution, and robbery) are committed under the influence of drugs or may be motivated by a need to get money for drugs. In addition, drug trafficking and violence go hand in hand. Competition and disputes contribute to violence, as does the location of drug markets in areas where legal and social controls against violence tend to be ineffective. The proliferation of automatic weapons also makes drug violence more deadly.

Arrestees frequently test positive for recent drug use: NIJ's ADAM drug-testing program found that more than 60 percent of adult male arrestees tested positive for drugs in twenty out of twenty-three cities in 1996.[41] In Chicago, 84 percent of males arrested for assault tested positive.[42] For young adult males, the median rate of marijuana prevalence exceeded 64 percent in all cities, up from the 1995 figure of 53 percent.[43] Positive results for cocaine and marijuana increased in 1996 among juvenile males; for marijuana, the rate was 52 percent compared to the 1995 figure of 41 percent. Among females, arrestees charged with prostitution were most likely to test positive for drug use. In Philadelphia, for example, 94 percent of women arrested on prostitution charges tested positive for drugs.[44]

Drug offenders crowd the nation's prisons and jails: According to Bureau of Justice Statistics, as of last June the nation's prisons and jails held 1,725,842 men and women -- an increase of more than 96,100 over the prior year. One in 155 U.S. residents was incarcerated;[45] more Americans were behind bars than on active duty in the armed forces. The increase in drug offenders accounts for nearly three-quarters of the growth in the federal prison population since 1985, while the number of inmates in state prisons for drug-law violations increased by 478 percent from 1985 to 1995. About 60 percent of federal prisoners in 1995 were sentenced for drug-law violations.[46] In fiscal year 1996, 16,251 offenders were sentenced for federal trafficking offenses while 615 were imprisoned for federal possession convictions.[47] In 1993, state correction expenses exceeded $19 billion.[48]

Domestic and family violence: Researchers have found that one-fourth to one-half of men who commit acts of domestic violence also have substance-abuse problems. A recent survey of state child welfare agencies conducted by the National Committee to Prevent Child Abuse found that substance abuse was among the top two problems exhibited by 81 percent of families reported

for child maltreatment.[49] Women who abuse alcohol and other drugs are also more likely to become victims of domestic violence. Studies of the link between parental substance abuse and child maltreatment suggest that chemical dependence is present in at least one half of the families involved in the child welfare system.[50]

Money laundering: Drug-trafficking organizations seek to launder fifty-seven billion dollars a year in profits generated in the illegal U.S. drug market. Information gathered by the U.S. Department of Treasury-led "El Dorado" anti-money-laundering task force in New York City illustrates the magnitude of this problem. El Dorado determined that certain New York money remitters and agents were transferring drug money to Colombia in small quantities to avoid the reporting and record-keeping requirements of the Bank Secrecy Act. Approximately eight hundred million dollars had been transferred to Colombia this way, a figure that could not be explained by legitimate economic activity. Consequently, the Treasury Department issued a Geographic Targeting Order (GTO) requiring licensed money transmitters and their agents to give detailed information about all wire transfers in excess of 750 dollars. As a result, wire transfers to Colombia from New York City dropped 30 percent. Within six months of the GTO issuance, the U.S. Customs Service seized more than fifty million dollars in outbound cash, four times the normal seizure rate.

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III: Strategic Goals and Objectives

The goals and objectives listed in this chapter constitute the framework for all national drug-control agencies and will be linked to budgets and supporting performance measures. State and local governments and non-governmental organizations committed to reducing drug abuse and its consequences are encouraged to adopt these guidelines. The five goals and thirty-two objectives have changed little over the past two years, reflecting the consensus that they continue to be appropriate. They will be assessed in coming years to assure their relevance to emerging challenges.

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

The *National Drug Control Strategy* focuses on youth for both moral and practical reasons. Children must be nurtured and protected from drug use and other forms of risky behavior to ensure that they grow up as healthy, protective members of society. As youngsters grow, they learn what they are taught, and see what they are shown.

Drug abuse is preventable. If boys and girls reach adulthood without using illegal drugs, alcohol, or tobacco, they probably will never develop a chemical-dependency problem. To this end, the *Strategy* fosters initiatives to educate children about the real dangers associated with drugs. The Office of National Drug Control Policy (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 professional sports leagues to join these national anti-drug efforts. In addition to educating children and supporting families, we must limit drug availability and treat young substance abusers.

The *Strategy's* mid-term objectives are to reduce the prevalence of past-month drug use among youth by 20 percent and increase the average age of first use by twelve months before the year 2002. The long-term objectives are a 50 percent reduction in current drug use and an increase of thirty-six months in the average age of first use by the year 2007.

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

The social ruin fostered by drug-related crime and violence mirrors 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, consuming the majority of cocaine and heroin on our streets.

Drug-related crime can be reduced through community-oriented policing, which has been demonstrated by police departments in New York and numerous other cities where crime rates are plunging. Cooperation among federal, state, and local law-enforcement agencies is also making a difference. So, too, are operations targeting gangs, major trafficking organizations, and violent drug dealers. Equitable enforcement of fair laws is a must. 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 available to the chemically dependent in our nation's prisons.

The *Strategy's* mid-term objective is to reduce drug-related crime and violence by 15 percent before the year 2002. The long-term objective is a 30 percent reduction by the year 2007.

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

Drug dependence is a chronic, relapsing disorder that exacts enormous costs on individuals, families, businesses, communities, and nations. Addicted individuals have, to a degree, lost their ability to resist drugs, often resulting in self-destructive and criminal behavior. Effective treatment can end addiction. Treatment options include therapeutic communities, behavioral treatment, pharmacotherapies (e.g., methadone, LAAM, or naltrexone for heroin addiction), outpatient drug-free programs, hospitalization, psychiatric programs, twelve-step programs, and multi-modality treatment.

Providing treatment for America's 4.1 million chronic drug users is both compassionate public policy and a sound investment. For example, a recent Drug Abuse Treatment Outcome Study by the National Institute on Drug Abuse found that outpatient methadone treatment reduced heroin use by 70 percent, cocaine use by 48 percent, and criminal activity by 57 percent, thus increasing employment by 24 percent.[1] The same survey also revealed that long-term residential treatment had similar success.

The *Strategy's* mid-term objectives are to reduce use by 25 percent and health and social consequences by 10 percent by the year 2002. The long-term objectives are a 50 percent reduction in drug use and 25 percent reduction in consequences by the year 2007.

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 and drug traffickers. Interdiction in the transit and arrival zones disrupts drug flow, increases risks to traffickers, drives them to less efficient routes and methods, and prevents significant amounts of drugs from reaching the United States. Interdiction operations also produce intelligence that can be used domestically against trafficking organizations.

Each year, more than sixty-eight million passengers arrive in the United States aboard 830,000 commercial and private aircraft. Another eight million individuals arrive by sea, and a staggering 365 million cross our land borders each year driving more than 115 million vehicles. More than ten million trucks and cargo containers and ninety thousand merchant and passenger ships also enter the United States annually, carrying some four hundred million metric tons of cargo. Amid this voluminous trade, drug traffickers seek to hide approximately 430 metric tons of cocaine, thirteen metric tons of heroin, vast quantities of marijuana, and smaller amounts of other illegal substances.

The *Strategy's* mid-term objective is to reduce the amount of illegal drugs entering the United States by reducing trafficker success rates through the transit and arrival zones 10 percent by the year 2002. The long-term objective is a 20 percent reduction in trafficker success rates by the year 2007.

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 *Strategy's* mid-term objectives are a 15 percent reduction in the flow of illegal drugs from source countries and a 20 percent reduction in domestic marijuana cultivation and methamphetamine production by the year 2002. Long-term objectives include a 30 percent reduction in the flow of drugs from source countries and a 50 percent reduction in domestic marijuana cultivation and methamphetamine production by 2007.

Assessing Performance

Strategy links ends, ways, and means. A supporting performance-measurement system establishes the interrelationship between outcomes, programs, and resources. The purpose of the *National Drug Control Strategy* is to reduce drug abuse and its consequences. The supporting performance measurements detailed in Book III of the *Strategy -- Performance Measures of Effectiveness: A System for Assessing the Performance of the National Drug Control Strategy*[2] -- will gauge progress toward that end using five and ten-year targets. The nucleus of the system consists of twelve impact targets that define strategic end-states for the *Strategy*'s five goals. Ninety-nine supporting performance targets establish outcomes for the *Strategy*'s thirty-two

objectives. These targets were developed by federal drug-control agencies working with ONDCP and were reviewed by state and local agencies and drug-control experts.

While the drug-control performance measurement system can offer valuable information on program effectiveness, it will not determine federal budgets; clearly, the federal government cannot cause a 50 percent reduction in drug use merely by altering its spending. Nor can the United States unilaterally reduce coca cultivation in South America. State and local governments, the private sector, communities, and individuals must all embrace the commitment to reduce demand by 50 percent over the next ten years. The performance measurements will allow policy makers, legislators, and managers to consider the adequacy of specific drug-control programs. Clear performance measures will ensure accountability.

Progress will be gauged using both existing and new survey instruments. The *Monitoring the Future* and *National Household Survey on Drug Abuse,* for example, estimate risk perception, current use rates, age of initiation, and life-time use for most illegal drugs, alcohol, and tobacco. The *Arrestee Drug Abuse Monitoring* system and *Drug Abuse Warning Network* provide indirect measures of consequences. The principal measuring device for international progress is the *International Narcotics Control Strategy Report.*[3] This annual State Department document provides country-by-country assessments of initiatives and accomplishments. It summarizes drug cultivation, eradication, production, seizures, arrests, destruction of laboratories, drug flow and transit, and law-enforcement efforts. The Office of National Drug Control Policy's Advisory Committee on Research, Data, and Evaluation will consider additional instruments and measurement processes required to address the demographics of chronic users, domestic cannabis cultivation, drug availability, and other drug-policy data shortfalls. Annual progress reports will be submitted to Congress.

Goals and Objectives

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

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

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

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

Rationale: Anti-drug messages conveyed through multiple outlets have proven effective in increasing knowledge and changing attitudes about drugs. The trend over the past six years of a decreased perception of risk connected to drug use among all adolescents correlates with a drop in the frequency of anti-drug messages in the media and an increase in images that normalize drug use. Anti-drug publicity by the private sector and non-profit organizations must be reinforced by a government-funded campaign to change young people's attitudes about illegal drugs.

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

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

Objective 4: Provide students in grades K- 12 with alcohol, tobacco, and drug prevention programs and policies that have been evaluated and tested and are based on sound practices and procedures.

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

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

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

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

Rationale: Communities are logical places to form public-private coalitions that can influence young people's attitudes toward drugs, alcohol, and tobacco. More than 4,300 groups around the country have already established broad community-based anti-drug efforts.

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

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

Objective 8: Support and disseminate scientific research and data on the consequences of legalizing drugs.

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

Objective 9: Develop and implement a set of principles upon which prevention programming can be based.

Rationale: The educational and emotional needs of young people change with age, specific risk factors, and different communities as new generations come of age and changing drug challenges emerge. Implementing research-based principles can help increase the effectiveness of ongoing drug prevention.

Objective 10: Support and highlight research, including the development of scientific information, to inform drug, alcohol, and tobacco prevention programs targeting young Americans.

Rationale: Reliable prevention programs must be based on programs that have been proven effective. We must influence youth attitudes and actions positively and share successful techniques with other concerned organizations.

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

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

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

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

Rationale: Areas need special assistance when drug trafficking is of such intensity that it poses extreme challenges to law enforcement. Coordinating federal, state, and local responses with federal resources can reduce drug-related crime.

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

Rationale: Targeting drug-dealer assets and the industries that launder ill-gotten gains can take the profitability out of drug trafficking and drive up to prohibitive levels the cost of laundering money. Law enforcement is most effective when a multi-disciplined approach is combined with anti-money laundering regulations and support from traditional financial institutions.

Objective 4: Develop, refine, and implement effective rehabilitative programs -- including graduated sanctions, supervised release, and treatment for drug-abusing offenders and accused persons -- at all stages within the criminal justice system.

Rationale: The majority of heavy drug users come in contact with the criminal-justice system each year. This interface provides an opportunity to motivate addicts to stop using drugs.

Objective 5: Break the cycle of drug abuse and crime.

Rationale: Our nation has an obligation to assist all who come in contact with the criminal-justice system to become drug-free. Recidivism rates among inmates who were given treatment declines substantially. The reduction of drug abuse among persons touched by the criminal-justice system, crime will decrease.

Objective 6: Support and highlight research, including the development of scientific information and data, to inform law enforcement, prosecution, incarceration, and treatment of offenders involved with illegal drugs.

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

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

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

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

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

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

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

Rationale: Drug abuse decreases productivity. Approximately three-quarters of drug users are employed. Employee assistance programs that include prevention, intervention, treatment, referral, and testing can reduce drug use.

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

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

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

Rationale: The more we understand about the neurobiology and neurochemistry of addiction, the better will be our capability to design interventions. Pharmacotherapies may be effective against cocaine, methamphetamine, and other addictive drugs. Research and evaluation may broaden treatment options, which currently include detoxification, counseling, psychotherapy, and self-help groups.

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

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

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

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

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

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

Rationale: Illegal drugs reaching U.S. markets principally flow across the southwest border, in contiguous waters, and from Puerto Rico and the Virgin Islands. We need to focus our efforts in these places -- without neglecting other avenues of entry -- by improving intelligence and information-guided operations that leverage technologically-capable law enforcement and interdiction. Flexible law-enforcement operations allow us to attack criminal organizations, retain the initiative, and curtail the penetration of drugs into the United States.

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

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

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

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

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

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

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

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

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

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

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

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

Rationale: Drug production, trafficking, and abuse are not solely problems affecting the United States. The scourge of illegal drugs damages social, political, and economic institutions in developed and developing countries alike. The United States must continue providing leadership and assistance to strengthen the international anti-drug consensus. It is in America's interest to

encourage all nations to join together against the threat of illegal drugs. The United States must also support multilateral drug control by maintaining full compliance with the U.N. 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances and the 1996 Organization of American States' Anti-Drug Strategy in the Hemisphere.

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

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

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

Rationale: Research must focus on more effective and environmentally sound methods of eliminating drug crops and move the cultivators of illicit drugs into legal pursuits. Production and movement of drugs around the globe must be understood more thoroughly. Technology can be used to monitor drug shipments and prevent the diversion of precursor chemicals.

Endnotes

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

2. Office of National Drug Control Policy, *The National Drug Control Strategy, 1998: Budget Summary* (Washington, D.C.:Office of National Drug Control Policy, 1998).

3. Bureau for International Narcotics and Law Enforcement Affairs, *International Narcotics Control Strategy Report* (Washington, D.C.: Department of State, 1998).

IV: A Comprehensive Approach

The key to a successful long-term strategy is mobilizing resources toward the achievement of measurable goals. This chapter summarizes initiatives being taken to decrease drug use and its consequences in America. More detailed information about departmental or agency programs can be found in Book III of this Strategy, *Performance Measures of Effectiveness: A System for Assessing the Performance of the National Drug Control Strategy.*

1. Youth-Oriented Prevention Initiatives

Research indicates that youngsters who do not use illegal drugs, alcohol, and tobacco before the age of eighteen are more likely to avoid chemical-dependency problems over the course of their lives. Researchers have also identified important factors that place youth at risk for or protect them from drug use. "Risk" factors are associated with greater potential for drug use, while "protective" factors are associated with reduced potential for such use. Risk factors include chaotic home environments, ineffective parenting, anti-social behavior, drug-using peers, and approval of drug use by others. Protective factors include parental involvement; success in school; strong bonds with family, school, and religious organizations; and knowledge of dangers posed by drug use. The following initiatives seek to reduce risk factors, provide youth the information they need to reject drug use, and assist parents and mentors as they, in turn, raise and influence our children.

The National Youth Anti-Drug Media Campaign

Although the use of drugs by American youth began to level off in 1997, drug-use rates are almost twice as high as they were in 1992. In order to reduce youth drug use by 50 percent in the next ten years, the Office of National Drug Control Policy (ONDCP), with the assistance of the Partnership for a Drug-Free America (PDFA) and the Ad Council, is implementing a multifaceted communications campaign involving parents, mass media, corporate America, and anti-drug coalitions. The National Youth Anti-Drug Media Campaign will counteract media messages and images that glamorize, legitimize, normalize, or otherwise condone drug use. Youth aged nine to seventeen, and the adults who influence them, will be targeted by the campaign. Campaign messages will accurately depict drug use and its consequences and encourage parents to discuss drug abuse with children.

Congress appropriated 195 million dollars for the campaign last year, making it one of the largest paid advertising efforts ever undertaken by government. Over the past year, ONDCP has consulted with hundreds of communications and marketing professionals, educators, prevention and treatment experts, public health specialists, and public officials to inform the campaign's development process. Anti-drug ads began airing in Atlanta, Baltimore, Boise, Denver, Hartford, Houston, Milwaukee, Portland (OR), San Diego, Sioux City, Tucson, and Washington, D.C. in January.

This summer, ONDCP will expand the anti-drug advertising component nationwide, using national and local television (both broadcast and cable), radio, and print media. In the fall, a fully-integrated campaign will reach target audiences through TV, radio, print, Internet, and other media outlets. The campaign's reach will be extended through corporate sponsorship, cooperation with the entertainment-industry, programming changes, and media matches (for example, contributions to cover public-service time and space). Prevention experts believe this public-private campaign will influence attitudes of youths towards drugs within two years.

Prevention in Schools and Universities

The Department of Education's Safe and Drug-Free Schools and Communities Program provides funds for virtually every school district to support drug and violence-prevention programs. This initiative is one of the federal government's primary vehicles for reducing juvenile drug use. The program focuses on improving the quality of drug and violence-prevention instruction and changing attitudes regarding illegal drugs, underage drinking, and smoking. A current goal is ensuring that 25 percent of middle schools have drug-prevention coordinators within two years. School-based prevention programs that are in widespread use include the Hilton Foundation's Project Alert, Drug Abuse Resistance Education (D.A.R.E.), the University of California's Self Management and Resistance Training (SMART), and LifeSkills.

Illegal drug use and the abuse of alcohol and tobacco also are serious problems on our college and university campuses. This current academic year, several college students died as a result of binge drinking, and many more were admitted to hospitals. In 1998, the Department of Education will lead a collaborative federal effort to confront this problem. The near-term objective is to create demonstration prevention programs. In the next ten years, America will need 150,000 additional college-educated teachers. They will constitute the core of our school-based prevention cadre. Prevention must be part of these future teachers' curriculum.

Expanding Community Anti-Drug Coalitions

Not all at-risk children can be reached through school-based prevention. The Drug-Free Communities Act of 1997 recognizes that the problem of illegal drugs must be addressed at the community level. More than 4,300 organizations affiliated with the Community Anti-Drug Coalitions of America (CADCA) are committed to preventing drug use. The Drug-Free Communities Act will provide 145 million dollars in matching grants over the next five years to expand the number of coalitions by ten thousand. The Act authorizes the President to establish a Commission on Drug-Free Communities to advise ONDCP concerning matters related to activities carried out under the program. The National Guard supports communities by providing administrative and logistical support to coalitions, teaching anti-drug courses, and conducting prevention programs like Adopt-A-School. Religious organizations are an integral part of community-responses to substance abuse. Clergy and faith-based groups have been successful in keeping youth away from drugs and providing treatment. After-school programs offer drug-free recreational alternatives. A concerted effort by these organizations can help prevent drug use by youth.

Parenting and Mentoring

Parental involvement in children's lives reduces the likelihood of drug use. Parents must understand that they -- not schools, community groups, or the government -- can make the biggest difference in children's attitudes and values. A number of initiatives are underway to strengthen the role of parents and mentors. The Secretary of Health and Human Services (HHS) has launched an initiative to reduce drug use by youth age twelve to seventeen. The cornerstone of the initiative is the effort to mobilize resources through state and federal collaborative activities and partnerships with national organizations. A key component is the State Incentive Grant Program, which will assist states in developing coordinated statewide substance-abuse prevention systems. A complementary Center for Substance Abuse Treatment (CSAT) program will help disseminate proven prevention strategies. Other aspects of the HHS initiative include awareness-raising activities, parent mobilization, regional symposia, and measurement of outcomes. ONDCP, in cooperation with the Substance Abuse Mental Health Services Administration (SAMHSA), is supporting a "Parenting is Prevention" initiative to mobilize national anti-drug organizations and strengthen their role in schools and communities. The National Institute on Drug Abuse's (NIDA) pamphlet, *Preventing Drug Use Among Children and Adolescents*, provides research-based information for parents.[1]

Promoting Media Literacy/Critical Viewing Skills

Media literacy teaches critical thinking so that individuals can discern the substance and intention of messages relating to drugs, tobacco, and alcohol. Media-literate youth understand the manipulative component of such material and are more likely to reject it. Last year, NIDA, SAMHSA, the Center for Substance Abuse Prevention (CSAP), the National Highway Traffic Safety Administration (NHTSA), the Centers for Disease Control and Prevention (CDC), and the Office of Justice Programs of the Department of Justice (DOJ) incorporated media literacy in their drug-prevention programs. In 1998, HHS, ONDCP, CSAP, and SAMHSA will support an American Academy of Pediatrics "Media Matters" campaign to provide media-literacy training for parents and physicians. The campaign will include a parents' guide: "Understanding the Impact of Media on Children and Teens."[2] ONDCP is also sponsoring a Mediascope-conducted content analysis of music videos and videotapes (two of the most popular forms of entertainment among youth) to quantify and describe how drugs, alcohol, and tobacco are depicted. HHS will also sponsor a national media education conference in Colorado Springs in June 1998.

Civic and Service Alliance

In November of 1997, leaders of forty-five national and international civic and service organizations, representing fifty-five million volunteers, attended a White House prevention conference that included a media literacy workshop for youth. Thirty-three of the organizations signed an agreement creating a civic alliance: "Prevention Through Service." Signatories include 100 Black Men, Big Brothers Big Sisters of America, Boys and Girls Clubs of America, Lions Club International, and the National Masonic Foundation for Children. Highlights of the

alliance include increasing public awareness, promoting communication about effective prevention, networking among organizations and communities, providing leadership and scholarship, and encouraging volunteerism, as well as service to families. Collectively, the organizations will support prevention efforts across the nation with one million volunteer hours.

Expanding Partnerships with Health-Care Professionals

Health-care professionals are vital sources of drug-prevention information. They can help parents influence children in positive ways, prevent drug use, and treat substance abuse. Last year, ONDCP coordinated the distribution of the pamphlet *"Prescription for Prevention"*[3] by fifteen pharmaceutical companies to primary-care physicians throughout the country. ONDCP will continue promoting the involvement of professional medical organizations in drug-prevention programs.

Working with the Child Welfare System

The safety of children and well-being of families are jeopardized by the strong correlation between chemical dependency and child abuse. For example, in 1997, an average of 67 percent of parents involved with the child welfare system needed substance-abuse treatment.[4] If prevention and treatment are not provided to this high-risk population, the same families will remain extensively involved in the welfare and criminal-justice systems. With funding from ONDCP, the Child Welfare League of America is developing resources and other tools for assessing and reducing substance abuse among parents and preventing drug use by abused children from substance-abusing families.

Preventing Alcohol Use and Drunk and Drugged Driving Among Youth

The *Strategy* recommends educating youth, their mentors, and the public about the dangers of underage drinking; limiting access of youth to alcoholic beverages; encouraging communities to support alcohol-free behavior on the part of youth; and creating incentives as well as disincentives that discourage alcohol abuse by young people. As motor vehicle crashes remain the leading cause of death for our nation's youth, NHTSA is addressing alcohol and drug-related crashes among young people. Implementing the President's "Youth, Drugs, and Driving" initiative, NHTSA is providing law enforcement, prosecutors, and judges with training and education for detecting, arresting, and sanctioning juvenile alcohol and drug offenders. States are urged to enact zero-tolerance laws to reduce drinking and driving among teens. Civic and service organizations are encouraged to collaborate with organizations like Mothers Against Drunk Driving and Students Against Destructive Decisions.

Preventing Tobacco Use Among Youth

Several federal agencies are involved in increasing awareness among youth of the dangers of tobacco use. The Food and Drug Administration (FDA) is enforcing regulations that reduce youth access to cigarettes and smokeless tobacco products. The FDA also will conduct a publicity campaign in 1998 to encourage compliance by merchants. State enforcement of laws

prohibiting sale of tobacco products to minors, as required by the Public Health Services Act, will be monitored by SAMHSA/CSAP. CDC supports the "Research to Classrooms" project to identify and expand school-based tobacco-prevention efforts; CDC also will fund initial research on tobacco-cessation programs for youth. The Administration is calling for tobacco legislation that sets a target of reducing teen smoking by 60 percent in ten years. Arizona, California, Florida, Massachusetts, and other states have ongoing paid anti-tobacco campaigns addressing underage use.

International Demand-Reduction Initiatives

Drug use has become a serious international problem requiring multi-disciplinary prevention. The United States supports demand-reduction efforts by the U.N. Drug Control Program, the European Union, the Inter-American Drug Abuse Control Commission (CICAD) of the Organization of American States, and other multilateral institutions. As part of our binational drug-control efforts, the United States and Mexico will conduct a demand-reduction conference in El Paso, Texas, in March 1998. Demand-reduction experts from Caribbean nations will consider regional responses to drug abuse during an ONDCP-hosted conference in Miami in May. Corporate sponsorship of drug education and prevention programs like the *Alianza para una Venezuela sin Drogas, Parceria Contra Drogas* in Brazil, and *Alianza para un Puerto Rico sin Drogas* has heightened public awareness of drug abuse and fostered international demand-reduction.

2. Initiatives to Reduce Drug-Related Crime and Violence

Community Policing

Our police forces continue to be the first line of defense against criminals. Men and women in uniform exhibit supreme dedication and face risks on a daily basis while confronting violent crime, much of it induced by drugs. In 1997, 142 police officers were killed in the line of duty; 117 were killed in 1996. Each year, more than fifty thousand police officers are assaulted.[5] We owe all law-enforcement officers a vote of thanks for their professionalism and courage.

The more we can link law enforcement with local residents in positive ways that create trusting relationships, the more secure our communities will be. Community policing is an operational philosophy for neighborhood problem-solving in which officers interact with residents on an ongoing basis regarding matters of public concern. Law enforcement concentrates on issues that make citizens feel insecure. Resources provided by the Community Oriented Policing Services (COPS) program are bringing a hundred thousand new police officers onto the streets. The strength of the COPS program is its emphasis on long-term, innovative approaches to community-based problems. This program reinforces efforts that are already reducing the incidence of drug-related crime in America.

Coordination between Law-Enforcement Agencies

"In unity there is strength." The more agencies and operations reinforce one another; the more they share information and resources; the more they "deconflict" operations, establish priorities, and focus energies across the spectrum of criminal activities; the more effective will be the outcome of separate activities. Various federal, state, and local agencies have joined forces on national as well as regional levels, to achieve better results. The federal government provides extensive support to state and local law-enforcement agencies through the Edward Byrne Memorial State and Local Law Enforcement Assistance Program. Grants support multi-jurisdictional task forces, demand-reduction education involving law-enforcement officers, and other activities dealing with drug abuse and violent crime. Other major coordinating programs include:

High Intensity Drug Trafficking Area (HIDTA): HIDTAs are regions with critical drug-trafficking problems that harmfully affect other areas of the United States. These locations are designated by the ONDCP Director in consultation with the Attorney General, heads of drug-control agencies, and governors. HIDTAs assess regional drug threats, design strategies to address the threats, and develop integrated initiatives. They provide federal resources to implement approved initiatives. HIDTA executive committees are composed primarily of local, state, and federal law-enforcement officials. HIDTAs facilitate cooperative investigations, intelligence sharing, and joint operations against trafficking organizations. Several HIDTAs, including Miami, Puerto Rico-U.S. Virgin Islands, and Washington-Baltimore, coordinate prevention and treatment initiatives in support of enforcement operations. The Department of Defense provides priority support to HIDTAs in the form of National Guard assistance, assignment of intelligence analysts, and technical training.

There are currently twenty-two HIDTAs (including five Southwest Border HIDTA partnerships). In 1997, Southeastern Michigan and San Francisco were designated HIDTAs. In 1998, ONDCP will consider designating HIDTAs in central Florida (including Orlando and Tampa), the Milwaukee metropolitan area, and the marijuana-growing regions of Kentucky, Tennessee, and West Virginia.

Organized Crime Drug Enforcement Task Forces (OCDETF): Established in 1982, these task forces are an integral part of coordinated law-enforcement operations. OCDETFs target foreign and domestic trafficking organizations, money-laundering activities, gangs, and public corruption. A typical task force consists of agents, attorneys, managers, and technical support personnel from eleven federal agencies and participating state and local entities. Task forces have been established across the nation, in both rural and urban areas, focusing on drug-trafficking networks.

A major 1997 OCDETF success was operation META, which disrupted a large cocaine and methamphetamine organization active in California, North Carolina, and Texas. Centered in the Los Angeles HIDTA, this operation resulted in the apprehension of eighty criminals, 133 pounds of methamphetamine, ninety gallons of methamphetamine solution, 1,100 kilograms of cocaine, 1,300 pounds of marijuana, two million dollars, and a large quantity of firearms. OCDETF was also instrumental in successful operations against the Mexican Amado Carrillo

Fuentes drug-trafficking organization. According to the Drug Enforcement Administration (DEA), this organization was responsible for smuggling approximately fifty tons of illegal drugs into the northeastern United States. As a result of these operations, charges were brought against more than a hundred people and 11.5 metric tons of cocaine were seized. Other OCDETF operations have targeted members of the Mexican Arrellano Felix organization and Nigerian heroin-smuggling organizations active in Chicago, Detroit, Milwaukee, and Minneapolis.

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

Targeting Gangs and Violence

Initiatives targeting gangs and violent crime have reduced drug trafficking. Gangs are active in drug-distribution chains operating in the United States, and drug organizations frequently use violence. The Drug Enforcement Administration leads federal efforts to break up trafficking organizations. The Bureau of Alcohol, Tobacco, and Firearms (ATF) also targets armed traffickers through the Achilles Program, which oversees twenty-one task forces in jurisdictions where drug-related violence is severe. HIDTAs and OCDETFs coordinate multi-agency attacks on criminal drug organizations.

Breaking the Cycle of Drugs and Violence

The correlation between drugs and crime is well established. Drug addicts are involved in approximately three to five times the number of crimes as arrestees who do not use drugs. Approximately three-fourths of prison inmates and over half of those in jails or on probation are substance abusers, yet only 10 to 20 percent of prison inmates participate in treatment while incarcerated. Simply punishing drug-dependent criminals is not enough. If crime is to be reduced permanently, addiction must be treated. Treatment while in prison and under post-incarceration supervision can reduce recidivism by roughly 50 percent. William L. Murphy, president of the National District Attorneys Association, statement makes this point: "Simply warehousing prisoners, without regard to addressing and dealing with the underlying problem of substance abuse, produces unending taxpayer costs. Longer prison terms -- without treatment, training, and follow-up -- make matters even worse. Such practices breed the statistics that feed the system. They don't prevent or seek to put an end to crime."[6]

Clearly, the time in which drug-using offenders are in custody or under post-release correctional supervision presents a unique opportunity to reduce drug use and crime through

effective drug testing, sanctioning and treatment programs. ONDCP, DOJ, and HHS will sponsor two conferences on treatment and the criminal-justice system in March and October 1998. The following initiatives are expanding treatment availability within the criminal justice system:

Drug courts: Drug courts have channeled sixty-five thousand nonviolent drug-law offenders into tough, court-supervised treatment programs instead of prisons or jails. Participants who complete court-mandated treatment have charges dismissed; those who fail are referred to regular courts for prosecution and sentencing. The nation's first drug court opened in Miami in 1989. In 1997, approximately twenty thousand defendants appeared before the nation's 215 drug courts, and 160 drug courts are now in the planning stages. During the past three years, several jurisdictions have considered how the experience of adult drug courts can be adapted to deal more effectively with the increasing number of substance-abusing juvenile offenders. Juvenile drug courts face unique challenges not encountered in the adult court environment, and consequently their development has required special strategies. As of November 1997, twenty-seven juvenile drug courts were operational and forty-six were in the planning process. There are also special drug courts for women and drunk drivers.[7] The National Drug Court Institute -- established in 1997 with ONDCP funding and support of DOJ and the National Association of Drug Court Professionals -- provides training for judges and professional staff.

Drug courts have been proven effective. On average, over 70 percent of drug-court participants stay in treatment. Among drug-court graduates, criminal recidivism ranges from 2 to 20 percent. More than 95 percent of this recidivism is made up of misdemeanors. Estimated savings range from $2,150,000 annually in Denver to an average of $6,455 per client in Washington, D.C. (based on the cost of maintaining an individual in the drug-court program for a year, compared to the cost of incarceration). Since 1989, more than 450 drug-free infants were born to women receiving treatment through drug courts, producing an estimated savings of fifty million dollars in health-care costs.[8]

"Breaking The Cycle" demonstration program: Initiated in Birmingham, Alabama in June of 1997 by ONDCP and the Department of Justice, this program explores the viability of community-supervised rehabilitation instead of incarceration for drug-dependent offenders. During the first six months, 4,602 offenders were screened and 784 became active participants. The National Institute of Justice is evaluating the program and will select additional communities for participation in 1998.

Violent Offender Incarceration and Truth-in-Sentencing Incentive Grant Program:

The FY 1997 Appropriations Act requires states to implement drug testing, sanctions, and treatment program for offenders under corrections supervision by September 1, 1998. On January 12, 1998, the President directed the Attorney General , through the Office of Justice Programs (OJP), to amend guidelines for prison construction grants and require state grantees to establish and maintain a system of reporting on their prison drug abuse problem. The President also instructed the Attorney General to draft and transmit to Congress legislation allowing states to use federal prison construction funds to provide a full range of drug testing, sanctions, and

treatment. A pilot drug-testing program is now underway in twenty-five of the ninety-four federal districts. The program's intent is to allow federal judges to determine appropriate release conditions for defendants.

Denial of Safe Haven to Criminals and Fugitives

Extradition agreements are essential to international anti-trafficking efforts. The United States is currently party to more than a hundred such treaties, having signed seventeen new ones in 1997. The U.S. government will continue to expand these agreements and sign bilateral treaties where none exist. Extradition requests are becoming more frequent. In 1996, the U.S. government sought the extradition of 2,894 criminals, up from 1,672 in 1990. Extradition between domestic jurisdictions is also increasingly frequent as trafficking organizations operate across state lines. As an example, the Department of Justice assisted in the extradition of more than 140 drug criminals in 1996.

Equitable Sentencing Policies

Community support is critical to the success of law enforcement. Sentencing structures that appear unfair undermine law enforcement. Consequently, in 1998 the Administration will seek to revise the cocaine penalty structure so that federal law enforcement will target major distributors of crack and powder cocaine rather than small, street-level dealers.

This change will improve law enforcement in several ways. First, the current sentencing structure for cocaine undermines the effective division of responsibility between federal, state, and local authorities. A defendant who trafficks in five grams of crack faces a five-year mandatory minimum sentence under federal law today. Five grams of crack is worth a few hundred dollars at most, and this sale is characteristic of a low-level dealer. A mid-level crack dealer typically handles ounce or multi-ounce quantities (one ounce equals twenty-eight grams). When federal law-enforcement resources are directed against lower-level street dealers, federal agents and prosecutors are diverted from large-scale drug trafficking operations

Second, a sentencing scheme that punishes crack offenses much more severely than powder offenses has fostered a perception of racial injustice in the court system. This perception arises from the fact that African-Americans make up a large majority of the people convicted of federal crack-cocaine trafficking. We cannot turn a blind eye to the corrosive effect this disparity has on respect for law enforcement in certain communities. When people lose confidence in the fairness of the law, our ability to enforce the law suffers. The closing of the sentencing gap between crack and powder cocaine will help eliminate the perception that these laws unfairly target a single racial group.

Model State Drug Laws

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

3. Initiatives to Reduce Health and Social Problems

Drug dependence is a chronic, relapsing disorder that exacts an enormous cost on the individual, families, businesses, communities, and nation. Treatment can help individuals end dependence on addictive drugs, thereby reducing consumption. In addition, such programs can reduce the consequences of addictive drug use on the rest of society. Treatment's ultimate goal is to enable a patient to become abstinent. However, reducing drug use, allowing addicts to function, and minimizing medical consequences are interim and useful outcomes.

SAMHSA's 1997 *Services Research Outcome Study,* CSAT's 1997 *National Treatment Improvement Evaluation Study* (NTIES), the 1994 *California Drug and Alcohol Treatment Assessment*, and other studies demonstrate that treatment reduces drug use, criminal activity, high-risk behavior, and welfare dependency. [9] NTIES' principal conclusions are that:[10]

- Treatment reduces drug use. Clients reported reducing drug use by about 50 percent in the year following treatment.

- All types of programs can be effective. Methadone maintenance programs, non-methadone outpatient programs, and both short and long-term residential programs demonstrated an ability to reduce drug use among participants.

- Criminal activity declines after treatment. Approximately half (48.2 percent) of the NTIES respondents were arrested in the year before treatment and only 17.2 percent were arrested in the year after treatment exit. Similar decreases were observed in the proportion of respondents reporting that the majority of their financial support is derived from illegal activities.

- Health improves after treatment. Substance abuse-related medical visits decreased by more than 50 percent and in-patient mental health visits by more than 25 percent after treatment. So, too, did risk indicators of sexually-transmitted diseases.

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

Our overall challenge is to help the 4.1 million Americans who are chronic users of illegal drugs to overcome their dependency so that they can lead healthy and productive lives and so that the social consequences of illegal drug abuse are lessened. Initiatives to achieve these ends include:

Improving Treatment

Effective rehabilitation programs characteristically differentiate by substances, cause addicts to change lifestyles, and provide follow-up services. However, all treatment programs are not equally effective. That is why efforts are underway to raise the standards of practice in treatment to ensure consistency with research findings. ONDCP and NIDA have focused on treatment in national conferences on marijuana, methamphetamine, heroin, and crack cocaine. Additional conferences on treatment modalities and treatment in the criminal-justice system are planned for the spring of 1998. CSAT continues to develop Treatment Improvement Protocols (TIPS), which provide research-based guidance for a wide range of programs. CSAT also supports eleven university-based Addiction Technology Transfer Centers, which cover twenty-four states and Puerto Rico. These centers train substance-abuse counselors and other health, social-service, and criminal-justice professionals.

Closing the Treatment Gap

Drug treatment is available for only 40 percent of people in immediate need of it, despite a 33 percent increase in federal expenditures for treatment since fiscal year 1993. The expansion of managed care and changes in eligibility requirements for Supplemental Security Income and Supplemental Security Disability Income are contributing factors in the continuing "treatment gap." It is essential to help the nation's 4.1 million chronic users end drug dependence if drug use is to be reduced by 50 percent in the next ten years. ONDCP and HHS will use substance-abuse block grant initiatives and other means to expand the nation's treatment capacity. Special emphasis will be given to expanding treatment that meets the needs of young drug abusers, as well as women and intravenous drug users.

Treatment for Opiate Addiction

For heroin addicts, two treatment modalities have been extensively documented as effective: methadone maintenance (MM) and long-term residential drug-free therapeutic communities (TCs). MM, when an adequate dose of methadone is used (generally 50 to 100 mg daily), is highly effective in retaining heroin addicts in treatment and first decreasing and eventually eliminating heroin abuse. Despite this clear efficacy and high levels of benefit to both patients and society, this modality remains poorly understood among many clinicians and by the general public, primarily due to the stigma often attached to therapy with psychotropic medications. TCs work very well for patients who are able to remain in this treatment, but unfortunately, the drop-out rate is quite high.

Although methadone treatment and long-term residential drug-free therapies have demonstrated effectiveness in addressing heroin addiction, only 115,000 of the nation's

estimated 810,000 heroin addicts currently are in methadone treatment programs. A major reason for this shortfall is over-regulation of methadone programs. In 1995, the Institute of Medicine (IOM) concluded that existing regulations could be safely reduced. ONDCP, together with HHS and DOJ, are developing guidelines to implement the IOM recommendations. The federal government also supports the use of other pharmacotherapies, like levomethadyl acetate hydrochloride (LAAM) and buprenorphine, to treat opiate addiction.

Expanding Knowledge

In the past several years, significant strides have been made in drug abuse research: we have learned not only how drugs affect the brain in ways that affect behavior, but also that behavioral and environmental factors may influence brain function. One of the most significant breakthroughs has been the identification of areas of the brain that are specifically involved in craving, probably the most important factor that can lead to relapse. Working with modern, high resolution, neuro-imaging equipment, scientists discovered many underlying causes of addiction. Research using positron emission tomography scans shows that when addicts experience cravings for a drug, specific areas of the brain show high levels of activation. Armed with this knowledge, scientists are now determining pre-addiction physiological and psychological characteristics so that "at risk" subjects can be identified *before* addiction or drug abuse takes place.

A major focus of NIDA's research has been on developing new medications. During the past year, several compounds have been identified that show promise as long-acting cocaine treatment medications. One compound works on the dopamine system and reduces cocaine taking in monkeys. Of significance, this compound suppresses the desire for cocaine, while not affecting other pleasurable activities controlled by the dopamine reward pathway, such as eating. Until there are viable medications, however, behavioral therapies will remain the principal treatment approach to most dependence problems.

Training in Substance-Abuse Issues for Health-Care Professionals

The recognition of substance abuse is the first step in treatment. Unfortunately, although most medical students are required to have some background in mental-health training, they receive little education regarding substance-abuse. If physicians and other primary-care managers were more attuned to drug-related problems, abuse could be identified and treated earlier. In 1997, ONDCP and SAMHSA/CSAP co-hosted a conference for leaders of health-care organizations to address this issue. All participants are committed to addressing this educational issue.

A related problem is that many competent community-based treatment personnel lack professional certification. The Administration supports a flexible system that would respect the experience of treatment providers while they earn professional credentials. Ongoing CSAT projects like *Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice* will help certify practitioners.

Drug-Free Work Place Programs

The *Strategy* encourages public and private-sector employers, including twenty-two million small businesses, to initiate comprehensive drug-free workplace programs. The Department of Labor's Working Partners program enlists trade associations in encouraging and assisting small businesses to implement programs and disseminates helpful information and materials through its Internet-based Substance Abuse Data Base.[11] Effective programs include written anti-drug policies; education; employee-assistance programs featuring problem identification and referral for both employees and family members; drug testing; and training so that supervisors can recognize the signs of use reflected in job performance and refer employees to help. Workplace anti-drug policies also help prevent drug abuse among millions of young people who have part-time jobs. SAMHSA has awarded nine grants to study the impact of comprehensive drug-free workplace programs on productivity and health-care costs in major U.S. corporations.

As the nations's largest employer, the federal government sets the example. Currently, 120 federal agencies have drug-free workplace plans certified by the Department of Health and Human Services, the Office of Personnel Management, and the Department of Justice. These agencies represent about 1.8 million employees -- the vast majority of the federal civilian workforce. The Department of Transportation (DOT) oversees the nation's largest workplace drug-testing program. The Omnibus Transportation Employees Testing Act of 1991 requires DOT to prescribe regulations that require drug testing of approximately eight million safety-sensitive employees in the United States who work for regulated businesses in the aviation, motor, carrier, rail, transit, rail, pipeline, and maritime industries. The program also requires drug testing for operators of commercial motor vehicles from Canada and Mexico. DOT requires workers in safety-sensitive positions who test positive for drugs to be referred to substance-abuse professionals before returning to work. If substance abuse is diagnosed, the employee must receive treatment before resuming duties. This program has become a model for non-regulated employers throughout the United States and in other countries around the world. It is important to note that there is no legitimate medical explanation for a safety-sensitive worker testing positive for marijuana in the DOT and all other federally-mandated drug-testing program.

Welfare Reform and Drug Treatment

Recent legislation requires states to trim welfare roles. However, one in four of the 4.2 million recipients of Aid to Families with Dependent Children, the federal-state welfare program, require treatment for substance abuse.[12] Clearly, treatment opportunities must be provided to these individuals if they are to join the work force. CSAT conducted workshops in 1997 with state officials to develop solutions to this problem. As a result of these workshops, CSAT and the Department of Labor developed a Welfare-to-Work grant initiative which identifies welfare recipients with substance-abuse problems and refers them to treatment.

4. Initiatives to Shield Our Frontiers

Flexible, In-Depth Interdiction

Drug traffickers are adaptable, reacting to interdiction successes by shifting routes and changing modes of transportation. Large international criminal organizations have nearly unlimited access to sophisticated technology and resources to support their illegal operations. The United States must equal the trafficker's flexibility, quickly deploying resources to changing high threat areas.

Consequently, the U.S. government will conduct interdiction operations that anticipate shifting trafficking patterns in order to keep illegal drugs from entering our nation. Existing interagency organizations and initiatives will remain the building blocks for this effort. These include the ONDCP-established Joint Inter-Agency task forces (East (Key West), West (San Francisco), South (Panama)) which coordinate interdiction in the transit zone; Customs' Domestic Air Interdiction Coordination Center (Riverside CA) which monitors air approaches to the United States; the Armed Forces' Joint Task Force-Six (El Paso) and Operation Alliance (the Justice and Treasury law-enforcement coordination element in El Paso) which coordinate drug-control activities along the southwest border problem; as well as ONDCP's twenty-two HIDTAs. International cooperation is also essential to U.S. success; therefore, bilateral and regional drug-control efforts will be expanded.

Interdiction of Drugs in the Transit Zone

Drugs coming to the United States from South America pass through a six-million square-mile area that is roughly the size of the continental United States. This transit zone includes the Caribbean, Gulf of Mexico, and eastern Pacific Ocean. In 1997 approximately 430 metric tons of cocaine passed through the transit zone toward the United States.[13] An estimated 32 percent of this amount was seized; eighty-four metric tons in the transit zone[14] and fifty-four metric tons in the arrival zone.[15] U.S. Coast Guard and Customs Service-led interagency surge operations reduced the flow of cocaine to Puerto Rico by 46 percent.[16] To further disrupt the flow of drugs in transit to the United States we are:

Building international cooperation: Implementing the Justice and Security Action Plan agreed to at the Barbados Summit in May 1997 which commits Caribbean nations and the United States to a broad drug-control agenda that includes modernizing laws, strengthening law-enforcement and judicial institutions, developing anti-corruption measures, opposing money laundering, and cooperative interdiction activities. Central American nations and the United States similarly agreed at the San Jose, Costa Rica Summit to improve cooperative law-enforcement capabilities. The United States will work closely with the European Union and other donor nations to support these initiatives. We will also expand bilateral counterdrug agreements to assist partner nations enforce their laws, protect their sovereignty, and control their territorial seas and airspace.

Denying traffickers easy access to smuggling routes: Deploying technologically advanced, capable, and flexible interdiction forces to deny the use of high threat trafficking routes, especially those targeted at Mexico and Puerto Rico and the Virgin Islands. Once the threat is reduced, redeploy forces to emerging high threat areas, leaving an enhanced presence to deter subsequent smuggling.

Shielding the Southwest Border

The rapidly growing commerce between the United States and Mexico is good news for America. It also makes the two-thousand mile border between our two countries one of the busiest and most open in the world. During 1996, 254 million people, seventy-five million cars, and 3.5 million trucks and rail cars entered the United States from Mexico through thirty-nine crossings and twenty-four ports of entry (POEs). Unfortunately, more than half of the cocaine on our streets and large quantities of heroin, marijuana, and methamphetamine also enter the United States across this border. The departments of Justice, Treasury, State, and Defense, and other agencies that share responsibility for protecting our borders, are conducting a review of federal efforts to prevent drug trafficking across the southwest border. A detailed assessment and action plan will be completed this summer. This plan will be carefully integrated with the Department of Commerce and Department of Transportation concepts to continue enhancing economic partnership between the United States and Mexico. Areas being examined include:

Reorganization: Improved coordination and integration between federal, state, and local agencies is essential. No individual or agency currently now has overall responsibility for drug-control operations along the length of the border or within individual ports of entry.

Employment of technology: We must create the capability to subject every truck and rail car that crosses the border into the United States to at least three different non-intrusive inspections to detect illegal drugs. This new technology must be carefully cued to high-risk cargo by a more effective intelligence system which works closely with Mexican authorities.

Infrastructure improvements: Access roads, fences, lights, and surveillance devices can prevent the movement of drugs between ports of entry while serving the legal economic and immigration concerns of both nations. For example, along the Imperial Beach, San Diego section of the border, sixty murders took place and ten thousand pounds of marijuana were seized three years ago. Last year, after the installation of fences and lights along with the assignment of more Border Patrol agents, no murders occurred and just six pounds of marijuana were seized. These new initiatives must create strong law-enforcement and Customs partnerships with Mexican authorities all along the border.

Reinforcement: The addition of inspectors and agents and provision of requisite technology can help reduce the flow of illegal drugs. We must create balanced packages of resources, technology, and personnel in the Border Patrol, Immigration and Naturalization Service, DEA,

Customs, U.S. Attorneys offices, ATF, Bureau of Prisons, and National Guard to ensure that we have the capacity to maintain the rule of law along this border of friendship and cooperation.

Bilateral Cooperation with Mexico

The United States and Mexico have made significant progress against drug trafficking in recent years. President Zedillo identified drug trafficking as the principal threat to Mexico's national security. Mexico has criminalized money laundering, expanded law enforcement's ability to investigate organized crime, conducted coincidental maritime interdiction operations, maintained high levels of eradication and seizure, addressed corruption, and passed laws to prevent the diversion of precursor chemicals. Last year, Presidents Clinton and Zedillo signed two major drug-control agreements: a Binational Drug Threat Assessment and an Alliance Against Drugs. These documents establish a comprehensive framework for cooperation under the aegis of the ONDCP-chaired U.S. - Mexico High Level Contact Group on Drug Control.

This year, we will implement a binational drug-control strategy. Our two nations share a commitment to address drug challenges forthrightly while upholding the principles of sovereignty, mutual respect, territorial integrity, and nonintervention. Key areas of cooperation include border task forces, corruption, demand-reduction, information sharing, interdiction, precursor chemicals, prosecution of drug criminals, technology, training, and weapons trafficking.

Working with the Private Sector to Keep Drugs Out of America

Agreements with the private sector can deter drug smuggling via legitimate commercial shipments and conveyances. As the primary drug-interdiction agency on the border, the U.S. Customs Service is implementing innovative programs like the air, sea, and land Carrier Initiative Programs (CIP), the Business Anti-Smuggling Coalition (BASC), and the Americas Counter-Smuggling Initiative (ACSI) to keep illegal drugs out of licit commerce. These initiatives have resulted in the seizure of more than 100,000 pounds of drugs in the past three years.

5. Initiatives to Break Sources of Supply

The United States' international drug-control strategy seeks to:

Promote international cooperation: The United States seeks to improve international cooperation to strengthen regional enforcement efforts and deny sanctuary to international criminal organizations. Because traffickers do not respect sovereignty or national borders; no country can deal effectively with illicit drug trafficking without allies. Multinational efforts are essential for making optimal use of limited assets.

Assist source and transit countries: In nations with the political will to fight drug-trafficking organizations, the United States will help provide training and resources so that these countries can reduce narcotics cultivation, production, trafficking, and consumption.

Support crop eradication and alternative development programs: The elimination of illicit coca and opium cultivation is the best way to reduce cocaine and heroin availability. Cocaine and heroin can be successfully targeted for eradication during cultivation. Alternative development programs can provide farmers with incentives to abandon drug cultivation.

Destroy drug-trafficking organizations: U.S.-supported programs help disrupt and dismantle international drug organizations, including their leadership, trafficking, production infrastructure, and financial underpinnings.

Stop money laundering and chemical diversion: The United States enforces domestic laws and encourages source and transit countries to take similar action. America shares expertise and assists producer and transit countries with training and equipment to foster coordination among investigators, prosecutors, and financial regulators.

Interdict drug shipments: Trafficker routes in source countries are linked to growing areas. Operations against cocaine HCL laboratories disrupt production operations at a critical stage. U.S.-supported source-country interdiction programs can break transportation links, disrupt drug processing, and depress drug-crop prices in support of alternative development programs.

Support democracy and human rights: Democratic principles, human rights, and international drug-control policies are mutually supportive. Wherever drugs are grown or produced in volume, rule of law is corrupted by powerful criminal elements. Consequently, strengthening democracy is integral to international drug control.

Multilateral Drug Control Cooperation

The growing trend toward greater cooperation in the Western hemisphere is creating unprecedented regional drug-control opportunities. The era in which the region's anti-drug efforts were largely driven by a series of distinct, bilateral initiatives between the United States and selected Latin American and Caribbean countries is giving way to one that increasingly includes multilateral approaches. The institutions and many of the mechanisms to make such cooperation succeed are in place or under development. It is in our interest -- and the interests of the other countries in the region -- to enhance these institutions and accelerate multilateral cooperation.

In the past several years, a multilateral framework for increased drug-control cooperation has been developed. Thirty-four democracies that attended the Miami Summit of the Americas in 1994 signed an action agenda that has been implemented over the past three years. All governments endorsed the 1996 Anti-Drug Strategy in the Hemisphere and the 1995 Buenos Aires Communiqué on Money Laundering, which specified principles for

cooperation. In addition, all of the Summit countries have now ratified or acceded to the 1988 U.N. Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

Hemispheric anti-drug officials, working under the auspices of the Organization of American States (OAS), elaborated recommendations for implementing the principles outlined in the OAS's hemispheric anti-drug strategy. The OAS' Inter-American Drug Abuse Control Commission (CICAD) developed model legislation against money laundering and chemical diversion, as well as a system of data collection for supply and demand statistics. CICAD also sponsored several meetings and seminars on a range of issues and helped to conclude negotiation for a regional mutual legal-assistance agreement.

The United States will seek commitments from all nations at the Santiago, Chile Summit of the Americas (April 18-19, 1998) for a hemispheric anti-drug alliance. To be effective, the alliance must include explicit goals and responsibilities and mechanisms to identify weaknesses and provide remedies. The United States also will expand the International Law-Enforcement Academy, which provides professional development for Central American officers and establish, in collaboration with other nations, a Judicial Center in Latin America to train judges and court personnel.

The U.S. process of annually certifying the counter-drug performance of narcotics-producing and transit countries will continue to encourage international cooperation. By law, the President is required to determine whether countries have cooperated fully with the United States or taken adequate steps to meet the counter-narcotics goals and objectives of the 1988 U.N. Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. Denial of certification involves foreign assistance sanctions, as well as a mandatory U.S. vote against multilateral development bank loans.

Targeting International Drug Trafficking

Pressure on illegal drug organizations is paying off. The Colombian National Police (CNP), working in cooperation with military counterdrug units, have killed, arrested, or incarcerated eight of the most important Colombian drug traffickers within the last two years. In Mexico, the leadership of two major organizations has been disrupted. Amado Carrillo Fuentes, the king-pin who organized multi-ton cocaine shipments using airliners, died following radical appearance-changing surgery. Juan Garcia Abrego, head of the Gulf Cartel and one of the FBI's "Ten Most Wanted" fugitives, has been convicted by U.S. courts and is serving a life sentence in a federal penitentiary. Over the past several years, more than twenty-five heroin traffickers have been arrested or extradited to the United States from Southeast and Southwest Asia. Thai law-enforcement agencies and military units, for example, helped dismantle the Mong Tai army which was a major heroin-trafficking organization.

Following the Money

The fifty-seven billion dollars Americans spend on illegal drugs each year fuel the drug trade. They also generate enormous profits that are either invested within the United States or repatriated. In most cases, traffickers seek to disguise drug profits by converting ("laundering") them into legitimate holdings. Trafficking organizations are vulnerable to enforcement actions because of the volume of money that must be processed. The retail value of the 319 metric tons of cocaine consumed each year by Americans is approximately thirty-seven billion dollars. This sum of money weighs fifteen-hundred metric tons.* Clearly, drug dealers prefer placing these funds in the financial system close to drug-dealing locations instead of hauling cash back to Colombia, Mexico, or another country.

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

The United States also is participating in global efforts to disrupt the flow of illicit capital, track criminal sources of funds, forfeit ill-gained assets, and prosecute offenders. For example, with the assistance of Colombian law enforcement and the private sector, the United States has imposed economic sanctions pursuant to the International Economic Emergency Powers Act against more than four hundred businesses affiliated with Colombian criminal drug organizations. Finally, U.S. experts have helped draft regulations to protect foreign financial sectors. Twenty-six nations are members of the Financial Action Task Force, which develops international anti-money-laundering standards and helps member nations develop regulations to protect their financial sectors.

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

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*One billion dollars in small ($5, $10, $20) bills weighs ____ metric tons.

Controlling Precursor Chemicals

Illegal drug production can be disrupted if essential chemicals are denied to traffickers. The importance of controlling precursor chemicals has been established in international treaties and laws. Article 12 of the 1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances establishes the obligation of parties to the treaty to institute controls to prevent the diversion of chemicals from legitimate commerce to illicit drug manufacture.

The twenty-two chemicals most commonly used in the production of cocaine have extensive commercial and industrial uses. The tracking of international shipment and the investigation of potentially illegal diversions is a demanding task. Yet, major strides were made in 1997 in international efforts to prevent the illegal diversion of these chemicals. Recently, the Mexican Senate unanimously approved legislation to control precursor chemicals. Mexican law promotes international cooperation and authorizes the creation of information databases to enable companies to notify authorities about suspicious transactions. In 1997, the United States and the European Union signed a bilateral agreement to enhance U.S. and European cooperation in chemical diversion control. In Brazil, the government regulates the sale of gasoline, which can be used as a precursor chemical and to fuel trafficker aircraft and boats in the Amazon Region. The United States continues to urge the adoption and enforcement of chemical-control regimes by governments that do not have them or fail to enforce them. The goal is to prevent diversion of chemicals without hindering legitimate commerce.

Reducing Corruption

Corruption is a serious impediment to expanded bilateral and multilateral cooperation. The widespread existence of corruption engenders a lack of confidence among law-enforcement agencies in various countries that might otherwise be able to attack drug-trafficking organizations by sharing information and coordinating operations. Ruthless trafficking organizations, with deep pockets for bribes and a demonstrated readiness to use violence, have penetrated the highest reaches of government in some nations. Corruption weakens the rule of law, erodes democratic institutions, and sometimes threatens the lives of U.S. officials. A decade ago, corruption was all-too-often ignored or tolerated. Today, the world's democracies are beginning to take steps to confront the problem. The United States will continue supporting multilateral efforts to fight corruption. The OAS Hemispheric Convention Against Corruption constitutes an important precedent.

Breaking Cocaine Sources of Supply

Coca, the raw material for cocaine, is grown in the South American countries of Bolivia, Colombia, and Peru. Regional U.S. anti-cocaine programs have achieved major successes, including a 9.6 percent net reduction in total regional coca production over the last two years. For the past several years, the United States, Colombia, and Peru have targeted drug-laden aircraft flying between coca-growing regions of Peru and processing laboratories in Colombia. As a result of this campaign and development projects that provide economic

alternatives to coca farmers, coca cultivation in Peru (once the source of over half the world's coca cultivation) decreased 40 percent during the last two years. Potential cocaine production also declined by 13 percent in Bolivia over the same period. U.S.-funded alternative development programs reinforced Bolivian coca-control efforts in the Chapare region. Hectarage now devoted to licit crops in the Chapare is 127 percent greater than in 1986.

Progress in Bolivia and Peru over the last two years, however, has been offset by a 56 percent expansion in coca cultivation in Colombia in that same period. This expansion primarily occurred in areas controlled by guerrilla and paramilitary forces. Colombia is attacking this trend with a U.S. supported aerial herbicide spray campaign that has destroyed tens of thousands of hectares of illicit coca and poppy cultivation in recent years. During the next year, the United States will continue to support the eradication and regional air bridge interdiction campaigns, expand anti-trafficking efforts to maritime and riverine routes, support alternate development, provide training and equipment to judicial systems, law enforcement agencies, and security forces, and encourage greater regional cooperation.

Breaking Heroin Sources of Supply

International efforts to reduce heroin availability in the United States face significant challenges. Worldwide illicit heroin production was estimated at 363 metric tons in 1997, of which approximately 90 percent is produced in Burma and Afghanistan where the U.S. has limited access or influence. Moreover, the U.S. heroin market consumes perhaps only 3 percent of the world's production. The existence of widely dispersed organizations and diversified routes and concealment methods makes interdiction difficult without adequate intelligence and resources.

Still, progress is achievable if governments have access to the growing area and the commitment and resources to implement counternarcotics programs. U.S.-backed crop control programs have eliminated or are reducing illicit opium cultivation in countries such as Turkey, Mexico, Guatemala, Pakistan, Thailand, and Laos. Even in Burma, the government has shown initial signs of a stronger counternarcotics interest. While legislation prohibits the use of U.S. Government resources to assist Burma's counternarcotics efforts, we do support UN drug control programs there and encourage other countries to press Burma to take effective anti-drug action. In Afghanistan, the United States and UN are prepared to test the Taliban's commitment to narcotics control. The United States is funding a small alternative development project and the UN is planning a larger one in return for a Taliban commitment to ban poppy cultivation. The United States also supports numerous law enforcement programs including establishing counternarcotics police units, improving intelligence collection, and providing equipment in heroin producing and transit countries.

Domestic heroin demand-reduction programs are essential due to the difficulties in attacking heroin sources of supply. They will, nevertheless, be supported by domestic and international heroin-control measures. Coordinated federal, state and local anti-heroin efforts will be encouraged. The ad-hoc task force established in Plano, Texas is an excellent example

of this approach. It consists of representatives from numerous area sheriffs' offices and police departments, as well as the Texas Department of Public Safety, the U.S. Attorneys' Offices, the U.S. Immigration and Naturalization Service, the Federal Bureau of Investigation, and DEA. U.S. law-enforcement agencies will use intelligence information about domestic heroin distribution rings to pursue international criminal organizations. The United States will also help strengthen law-enforcement efforts in heroin source and transit countries by supporting training programs, intelligence sharing, extradition of fugitives, and anti-money-laundering measures. Finally, the United States will work through diplomatic and public channels to increase international cooperation and support the ambitious U.N. Drug Control Program initiative to eradicate illicit opium poppy cultivation in ten years.

Checking the Spread of Methamphetamine

The apparent decline in methamphetamine use may be the result of increased prevention, law enforcement, and regulatory efforts. However, domestic manufacture and importation of methamphetamine pose a continuing public-health threat. The manufacturing process involves toxic and flammable chemicals. Abandoned labs require expensive, dangerous clean-up. Between January 1, 1994 and September 30, 1997, the DEA was involved in the seizure of over 2,400 methamphetamine laboratories throughout the country, including 946 labs in the first nine months of 1997. State and local law-enforcement authorities, especially in California but increasingly in other states, were involved in thousands of additional clandestine lab seizures.

The 1996 National Methamphetamine Strategy (updated in May of 1997) established the federal response to this problem. It was buttressed by the Comprehensive Methamphetamine Control Act of 1996, which increased penalties for production and trafficking while expanding control over precursor chemicals (like ephedrine, pseudoephedrine, and phenylpropanolamine). The DEA is targeting methamphetamine-dealing organizations and companies that supply precursor chemicals. The DEA also supports state and local law-enforcement agencies by conducting training in Kansas City and San Diego. Many retailers are adopting tighter controls for over-the-counter drugs containing ingredients that can be made into methamphetamine. Useful actions include educating employees, limiting shelf space, and capping sales.

Internationally, the United States is promoting controls of precursor chemicals. For both methamphetamine and the related stimulant amphetamine, cooperation with Mexico is crucial because powerful methamphetamine trafficking organizations are based there. A bilateral chemical-control working group oversees cooperative investigation of cases of interest to both countries and exchanges information on legal and regulatory matters. In late 1997, Mexico passed a comprehensive chemical-control law which, once implemented, should bring the country into compliance with the 1988 U.N. Convention Against Traffic in Narcotic Drugs and Psychotropic Substances.

With regard to reduction of the demand for methamphetamine, efforts are underway to develop effective treatment and prevention regimes for methamphetamine. The Department of Health and Human Services has embarked on a Methamphetamine Research Initiative to

advance our knowledge of the drug and the effects of its use. In 1998, a search will begin for alternative treatment for methamphetamine users.

6. Other Initiatives

Review of Drug-Intelligence Architecture

Intelligence collection, analysis, and dissemination are essential for effective drug-control. An ongoing, comprehensive, interagency review of counterdrug-intelligence missions, activities, functions, and resources is determining how federal, state, and local drug-control efforts can be better supported by intelligence. This review is being conducted by the ONDCP-established White House Task Force on the Coordination of Counterdrug Intelligence Centers and Activities. The Attorney General and Director of Central Intelligence are co-chairs of this critical study. The Task Force will make specific organizational and procedural recommendations to improve intelligence support to the national counterdrug effort.

Countering Attempts to Legalize Marijuana

Marijuana is a "Schedule I" drug under the provisions of the Controlled Substance Act, Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 because of its high potential for abuse and lack of accepted medical use. Federal law prohibits the prescription, distribution, or possession of marijuana and other Schedule I drugs like heroin and LSD strictly controls schedule II drugs like cocaine and methamphetamine. Federal law also prohibits the cultivation of *Cannabis sativa*, the marijuana plant. Marijuana is similarly controlled internationally through inclusion on Schedule I of the U.N. Single Convention on Narcotic Drugs.

In response to anecdotal claims about marijuana's medicinal effectiveness, the National Institute on Drug Abuse sponsored conferences in 1997 involving leading researchers and is supporting peer-reviewed research on the drug's effects on the immune system. ONDCP also is supporting a major study of research on marijuana's potential benefits and harms. This eighteen-month study, conducted by the National Academy of Science's Institute of Medicine, is considering scientific evidence on several topics related to the use of marijuana, including: marijuana's pharmacological effects; the state of current scientific knowledge; the drug's psychic or physiological dependence liability; risks posed to public health by marijuana; its history and current pattern of abuse; and the scope, duration, and significance of abuse.

The U.S. medical-scientific process has not closed the door on marijuana or any other substance that offers potential therapeutic benefits. However, both law and common sense dictates that the process for establishing substances as medicine requires that laboratory and clinical data be submitted to medical experts in the Department of Health and Human Services and Food and Drug Administration for evaluation of their safety and efficacy. If the scientific evidence is sufficient to demonstrate that the benefits of the intended use of a substance

outweigh associated risks, the substance can be approved for medical use. This rigorous process protects public health, allowing marijuana or any other drug to bypass this process is unwise.

Permitting hemp cultivation would result in *de facto* legalization of marijuana cultivation because both hemp and marijuana come from the same plant -- *Cannabis sativa.* Chemical analysis is the only way to differentiate between *Cannabis sativa* variants intended for hemp production and hybrids grown for their psychoactive properties.[17] According to the Department of Agriculture, hemp is not an economically-viable crop. For every proposed use of industrial hemp, there already exists an available product, or raw material, which is cheaper to manufacture and provides better market results. For example, the cheapest hemp linen costs about fifteen dollars a square yard; fine flax linen is half as expensive. The ready availability of other lower-cost raw materials is a major reason for a 25 percent drop in worldwide hemp production over the past three decades.

Ten-Year Counterdrug Technology Plan

ONDCP's Counterdrug Technology Assessment Center (CTAC) was established by the Counter-Narcotics Technology Act of 1990 (P.L. 101-510). CTAC is the federal government's central drug-control research and development organization and coordinates the activities of twenty federal agencies. CTAC identifies short, medium, and long-term scientific and technological needs of federal, state, and local drug-enforcement agencies including surveillance; tracking; electronic support measures; communications; data fusion; and chemical, biological, and radiological detection. CTAC also participates in addiction and rehabilitation research and the application of technology to expand the effectiveness of treatment. Research and development in support of the *Strategy* is being conducted in the following areas:

Demand reduction: to support education and information dissemination in support of prevention and neuroscience research and medications development in support of treatment and.

Non-intrusive inspection: to rapidly inspect people, conveyances, and large shipments at ports-of-entry for the presence of hidden drugs.

Wide-area surveillance: to reduce the supply of illegal drugs by detecting, disrupting, and interdicting drug growth and production facilities, and drug trafficking in source countries, the transit zone, and the United States.

Tactical technologies: to ensure that new technology is quickly assimilated into drug-control operations of federal, state, and local law enforcement agencies.

Specific initiatives include: research on artificial enzyme immunizations to block the effects of cocaine; positron emission tomography scanning to understand the process of addiction; information analysis in support of juvenile diversion programs within the criminal justice system; installation of non-intrusive inspection systems for trucks and rail cars along the Southwest border; and deployment of relocatable over the horizon radars to monitor drug flights in Central and South America.

Endnotes

1. National Institute on Drug Abuse, National Institutes of Health, *Preventing Drug Use Among Children and Adolescents* (Rockville, Md.: National Institutes of Health, 1997).

2. To be published.

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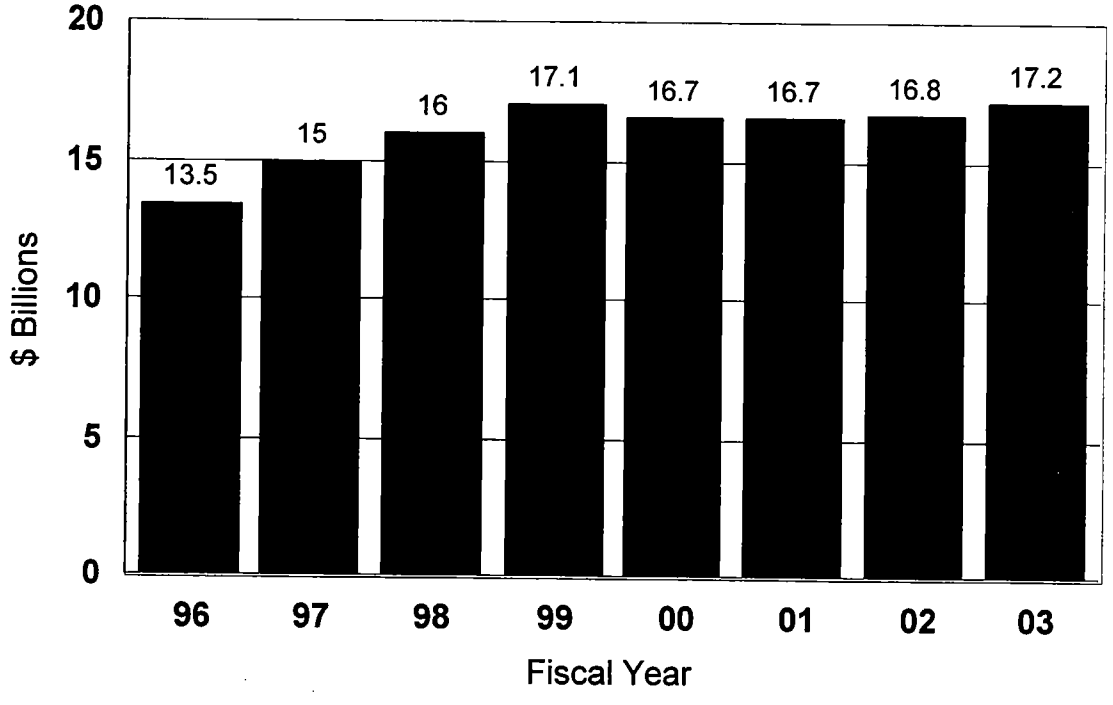
V: Supporting the Ten-Year Strategy: The National Drug Control Budget, FY 1999 - FY 2003

The FY 1999 - FY 2003 National Drug Control Budget supports the five goals and thirty-two objectives of the *National Drug Control 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 1999 is $17.1 billion, an increase of $1.1 billion (6.8 percent) over the FY 1998 enacted level. A summary of drug-control spending for FY 1996 through FY 2003 is presented in Figure 1.

Figure 1: National Drug Control Budget



* "Performance Measures of Effectiveness: A System for Assessing the Performance of the National Drug Control Strategy" will be published to accompany the *1998 National Drug Control Strategy.*

Spending by Department

Proposed funding by executive department for FY 1999 to FY 2003 is displayed in Table 1. Over the five-year planning period, additional resources for supply-reduction programs in the Departments of Justice, Treasury, Transportation, State, and Defense will support security along the southwest border; additional efforts in the Andean Ridge region, Mexico, and the Caribbean; and 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 abuse, and initiate prevention efforts aimed at elementary school children.

Table 1: Drug Spending by Department ($ Millions)

	FY 98	FY 99	Planning Level				% Change
Department	Enacted	Request	FY 00	FY 01	FY 02	FY 03	98-03
Defense	847.7	882.8	870.0	886.1	896.2	911.8	8%
Education	685.3	739.7	741.7	743.9	746.1	748.5	9%
HHS	2,522.5	2,812.9	2,812.9	2,812.9	2,812.9	2,812.9	12%
Justice	7,260.5	7,670.0	7,317.3	7,234.8	7,242.5	7,443.5	3%
ONDCP	428.2	449.4	449.4	449.4	449.4	449.4	5%
State	211.5	256.5	263.5	270.5	278.5	286.5	35%
Transportation	455.0	515.2	528.9	514.9	514.9	514.9	13%
Treasury	1,327.9	1,388.1	1,317.0	1,322.9	1,337.2	1,359.2	2%
Veterans Affairs	1,097.2	1,139.1	1,183.1	1,226.9	1,275.3	1,375.7	25%
All Other	1,141.6	1,215.9	1,217.0	1,236.4	1,258.2	1,280.7	12%
Total	15,977.4	17,069.8	16,700.9	16,698.8	16,811.3	17,183.2	8%

The following increases in drug-control funding are included in the President's FY 1999 budget:

- **Defense:** The FY 1999 budget for the Department of Defense (DoD) would increase by a net of $35.1 million from the FY 1998 enacted level. The total FY 1999 DoD drug budget includes substantial program enhancements of **$75.4 million** to support counterdrug activities in the Andean Ridge region ($60.8 million), operations in the Caribbean ($8.5 million), training of Mexican counterdrug forces ($4.0 million), and air reconnaissance missions ($2.1 million). In addition to these enhancements, the request includes an additional $15 million for the National Guard.

- **Education: School Drug-Prevention Coordinators ($50 million)** -- This initiative will fund about 1,300 paid drug-prevention coordinators. Each coordinator will develop and direct drug-prevention programs in five middle schools. In total, this initiative will provide prevention services for 6,500 middle schools.

- **Health and Human Services**:

  SAMHSA -- To help address the need for treatment, the FY 1999 budget includes an increase of **$200 million ($143 million drug-related)** for the Substance Abuse Block Grant. With this additional funding, SAMHSA will be better able to meet the needs of special populations of chronic drug users who may face economic or geographic barriers to treatment.

  FDA & CDC -- Youth Tobacco Initiative ($146 million) -- In FY 1999, this initiative provides an additional **$100 million** for the Food and Drug Administration (FDA) and **$46 million** for the Centers for Disease Control and Prevention. This program will target cigarette smoking by underage youth, which has been identified as a gateway behavior for drug use. As part of this effort, FDA will expand its enforcement activities and CDC will conduct further research on the health risks of nicotine, additives, and other potentially toxic compounds in tobacco.

  NIDA -- Drug Research ($49 million) -- This initiative will allow NIDA to expand research on drug use. Basic research on drug abuse and addiction among children and adolescents, as well as chronic users, and increased dissemination of research findings, will enhance program effectiveness.

- **Justice**:

  DEA -- Methamphetamine Initiative ($24.5 million) -- This initiative provides DEA with 223 positions, including one hundred special agents, to address the growth of methamphetamine trafficking, production, and abuse across the United States. New funding for DEA in FY 1999 also includes a **Heroin Initiative ($14.9 million)**. This program combats heroin trafficking, production, and distribution networks operating in the United States and increases U.S. investigative and intelligence presence in countries involved in the trafficking of drugs from Southeast and Southwest Asia. This enhancement includes 155 positions, including one hundred special agents.

  Office of Justice Programs (OJP) -- Drug Intervention Program ($85 million) -- This new program seeks to break the cycle of drug abuse and violence by assisting state and local governments, state and local courts, and Native American tribal governments to

develop and implement drug testing, treatment, and graduated sanctions for drug offenders. Because considerable drug use has been documented among people within the criminal-justice system, this program will provide guidance and resources to help eligible jurisdictions institute policies that support treatment for drug offenders.

Border Patrol ($163.2 million, $24.5 million drug-related) -- This enhancement includes one thousand new Border Patrol agents, primarily for the southwest border. These new resources will continue expansion of the Border Patrol's strategy of "prevention through deterrence" along the southwest border. Also included is funding to continue deployment of the Integrated Surveillance Intelligence System and Remote Video Surveillance (ISIS/RVS) equipment. ISIS/RVS will enable the Border Patrol to allocate agents more efficiently based on current information regarding illegal alien traffic. Funding is also included to erect and maintain border barriers and expand infrastructure that will improve enforcement between ports-of-entry.

- **ONDCP: Special Forfeiture Fund ($34 million)** -- The net increase for FY 1999 includes $10 million for a Chronic User Study, which will generate national estimates of the size and composition of this population. A pilot project for this research, conducted in FY 1997 in Cook County, Illinois, concluded that chronic users are significantly under-counted in current surveys. FY 1999 funding for the Special Forfeiture Fund includes $20 million for grants that continue implementation of the *Drug-Free Communities Act of 1997.* This figure is an increase of $10 million over FY 1998.

- **State: International Country Support ($45 million)** -- included in this increase are funds to build on FY 1998 support for Andean Ridge nations involved in interdiction and counterdrug law-enforcement operations. This effort will expand crop eradication and alternative-development programs to reduce illicit coca cultivation.

- **Transportation: U.S. Coast Guard ($35.7 million)** -- Most of the drug-related increase ($32.8 million) requested in FY 1999 will provide for capital improvements to enhance the Coast Guard's interdiction capabilities, particularly in the Caribbean. The FY 1999 request includes funding for improved sensors on C-130 aircraft, additional coastal patrol craft, and expansion of the Coast Guard's deep water assets.

- **Treasury: U.S. Customs Service ($66.4 million)** -- Customs' FY 1999 request includes a total increase of $66.4 million for counterdrug operations. Of this total, $54.0 million is requested for non-intrusive inspection technologies. The request supports two seaport X-ray systems as well as $41.0 million for non-intrusive inspection systems like mobile and fixed-site X-ray systems for land border ports-of-entry along the southwest border.

Spending by Strategy Goal

Funding by *Strategy* goal is summarized in Figure 2 and the accompanying table. Over the five-year planning period, funding priorities include resources to reduce drug use by young people (Goal 1), make treatment available to chronic users (Goal 3), interdict the flow of drugs at our borders (Goal 4), and target sources of illegal drugs and crime associated with criminal enterprises (Goals 2 and 5). By FY 2003, funding for goal 1 will be $2.0 billion, an increase of 14 percent over FY 1998 and nearly $4 billion for goal 3, an increase of 14 percent. Further, multi-agency efforts, which target ports-of-entry and the southwest border, will expand funding for goal 4 to $1.7 billion by FY 2003, an increase of 11 percent. Funding for goal 2 will be $6.6 billion by FY 2003. Resources devoted to goal 5 will reach $2.9 billion by FY 2003, an increase of 10 percent.

Figure 2: Drug Funding by Goal - FY 99

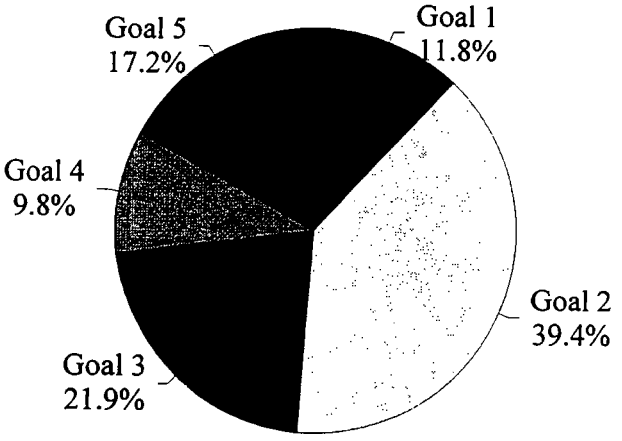


Table 2: Drug Funding by Goal ($ Millions)

Goal	FY 98	FY 99	FY 00	FY 01	FY 02	FY 03	% Change 98-03
1. Reduce youth drug use	1,760.0	2,016.0	2,005.2	2,007.4	2,009.7	2,012.0	14%
2. Reduce drug-related crime	6,522.3	6,724.1	6,327.0	6,270.5	6,334.2	6,559.4	1%**
3. Reduce consequences	3,486.9	3,732.0	3,781.1	3,822.6	3,874.2	3,979.8	14%
4. Shield air, land, and sea frontiers	1,527.3	1,669.3	1,666.2	1,661.9	1,671.8	1,692.0	11%
5. Reduce sources of supply	2,681.0	2,928.4	2,921.5	2,936.3	2,921.4	2,940.0	10%
Total	15,977.4	17,069.8	16,700.9	16,698.8	16,811.3	17,183.2	8%

Federal Funding Priorities: FY 1999 - FY 2003

The *Strategy* is supported by a five-year budget from FY 1999 through FY 2003. The federal budget covers the following programs, which will remain priorities for funding over this planning period. Through at least FY 2003, funding for these programs will be emphasized through ONDCP's drug-budget certification authorities.

- National Youth Anti-Drug Media Campaign
- School Drug-Prevention Coordinators
- Close the Public System Treatment Gap
- Port and Border Security Initiative
- Andean Coca Reduction
- Caribbean Violent Crime and Regional Interdiction
- Mexican Initiative

**Most of the change in this Goal from the FY 1999 level is associated with the reduction in FY 2000 and the subsequent expiration in FY 2001 of Community Oriented Policing Services (COPS). For FY 1999, the drug-related portion of the COPS program is $468.6 million.

VI: Consultation

The Anti-Drug Abuse Act of 1988 requires the Office of National Drug Control Policy (ONDCP) to consult a wide array of experts and officials while developing the *National Drug Control Strategy*. ONDCP fully met this congressional requirement in 1997 by consulting with Congress, heads of federal drug-control agencies, state and local officials, medical experts, law-enforcement officials, academics, researchers, scientists, business leaders, civic organizations, community leaders, and private citizens.

Consultation with Congress: ONDCP representatives appeared before numerous congressional committees in 1997. Hearings addressed drug-control priorities, the federal drug-control budget, drug abuse prevention and treatment, counterdrug cooperation in the Western Hemisphere, interdiction of illegal drugs, and drug legalization. ONDCP also participated in congressional field hearings. The views of senators, representatives, and supporting staff were solicited by ONDCP.

Consultation with federal drug-control agencies: Agencies charged with overseeing drug prevention, education, treatment, law enforcement, corrections, and interdiction contributed to the *1998 Strategy*. Input from fifty-two federal agencies was used to establish goals and objectives; develop performance measures; and formulate budgets, initiatives, and programs.

Consultation with state leaders: ONDCP requested suggestions from governors of all states as well as American Samoa, Puerto Rico, and the U.S. Virgin Islands. State drug-control agencies also provided input for the *1998 Strategy* in the areas of prevention, treatment, and law enforcement. ONDCP worked closely with state-based organizations like the National Governors' Association to coordinate programs and initiatives.

Consultation with local leaders: Perspectives were solicited from every mayor of a city with at least 100,000 people and from key county executives. Additionally, local prevention experts, treatment providers, and law-enforcement officials were asked to provide "street-level" views of the drug problem along with potential solutions. ONDCP also worked with the U.S. Conference of Mayors as it developed a *National Action Plan to Control Drugs*.

Consultation with the private sector: ONDCP gathered opinions from community anti-drug coalitions, chambers of commerce, editorial boards, non-governmental organizations, and religious institutions. A list of private sector groups from which views were considered during formulation of the *1998 Strategy* is provided at the end of this chapter.

Keeping the American people informed: ONDCP publishes periodic reports, assessments, and studies to inform the public about the drug threat and plans to counter it. Samples of these publications are described below:

National Drug Control Strategy: Budget Summary contains detailed drug-control budget data by agency, function, and goal. This volume is released as part of the *National Drug Control Strategy*.

Performance Measures of Effectiveness: A System for Assessing the Performance of the National Drug Control Strategy, released in conjunction with the *1998 Strategy*, presents the performance measurement system that will orient drug-control efforts for the next ten years.

U.S.-Mexico Binational Drug Threat Assessment was the first joint appraisal by Mexico and the United States of the drug problem. The document analyzes drug consumption and demand, drug production and trafficking, and drug-related crimes.

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

What America's Users Spend on Illegal Drugs estimates the amount of money Americans devote to cocaine, heroin, and marijuana each year.

Responding to Drug Use and Violence: Helping People, Families, and Communities; A Directory and Resource Guide to Public and Private-Sector Drug Control Grants lists federal funds available in the area of drug control. The directory describes the purpose of the grants, the amount of money available, eligibility requirements, and application processes. Information is also provided on some private-sector grants.

These publications and other reference materials can be viewed on the ONDCP Web site (www.whitehousedrugpolicy.gov). ONDCP policy statements, speeches, editorials, and congressional testimony are also maintained at this site. The ONDCP Web site is visited by more than ten thousand people per month.

ONDCP also informs the public of drug-policy issues through an extensive media and outreach program. In 1997, more than two hundred television and radio interviews were conducted across the United States. Detailed briefings were provided to editorial boards of twenty-one newspapers and magazines. Spanish-language materials were produced for domestic and Latin American organizations. Op-eds, journal articles, and published speeches were placed in major publications.

The ONDCP Drug Policy Information Clearinghouse is another source of information. It

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

Conferences and meetings: ONDCP convened or participated in the following gatherings to coordinate drug-control efforts, evaluate trends, and consult with experts.

President's Drug Policy Council: This cabinet-level organization met in March of 1997 to discuss the *National Drug Control Strategy*. Members of the council include heads of drug-control program agencies and presidential assistants.

High Intensity Drug Trafficking Area (HIDTA) Conference: Representatives of all twenty-two HIDTAs and law-enforcement experts met in Washington, D.C., in December 1997 to consider regional responses to the drug problem and improve coordination among more effective strategies for regional law enforcement.

U.S./Mexico High Level Contact Group on Drug Control: Created in March 1996, this group first met during President Clinton's visit to Mexico in May 1997 and in Washington, D.C., in October. It drafted a binational drug-control strategy that is now being considered by both governments.

National Methamphetamine Conference: Scientists; treatment providers; prevention experts; law-enforcement officials; and federal, state, and local government officials assembled in Omaha, Nebraska, in May 1997 to assess the federal and regional response to the methamphetamine problem. Conference proceedings can be viewed at www.whitehousedrugpolicy.gov.

U.S. Conference of Mayors National Forum on Drug Control: Washington, D.C., May 1997. The meeting focused on urban drug problems and resulted in the *U.S. Conference of Mayors National Plan to Control Drugs.* Participants included mayors, police chiefs, and prosecutors.

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

Southwest Border Trip: In August 1997, ONDCP led a delegation of federal officials on a fact-finding trip along the Southwest border. The group met with state and local officials in each border state to hear perspectives on the drug threat and discuss cooperative efforts with Mexican officials in the border cities of Ciudad Juarez, Nuevo Laredo, Nogales, and Tijuana.

Prevention Through Service Summit: Held in Washington, D.C., May 1997, this summit was attended by thirty national civic, service, and fraternal organizations.

Multilateral Counterdrug Cooperation Conference: Held in Washington, D.C., November 1997, this conference considered a hemispheric alliance to address all aspects of the drug issue. Conference participants outlined the next steps in cooperation on drugs, including U.S. support for international demand-reduction efforts.

National Institutes of Health (NIH) Panel on Possible Medical Uses of Marijuana: Held in Washington, D.C., February 1997, this panel of experts was convened to review scientific data on potential therapeutic uses for marijuana and the need for additional research.

National Institute on Drug Abuse (NIDA) Conference on Heroin Use and Addiction: Convened in Washington, D.C., in September 1997, this conference assembled physicians, treatment providers, and drug-policy experts from across the country to share research findings related to heroin abuse.

National Institute on Drug Abuse (NIDA) and National Institute of Justice (NIJ) Conference on the Crack Decade: Research Perspectives and Lessons Learned: Held in Baltimore, Maryland, in November 1997, this conference examined the historical context of crack cocaine as well as the national response to it. The conference also explored the need for research to inform public health and welfare policies and state and local law-enforcement issues.

Non-governmental organizations: Views of the following organizations were considered during formulation of the *1998 Strategy*:

100 Black Men of America, Inc.
Addiction Research and Treatment Corporation
Administration for Children and Families
Advertising Council
AFL-CIO
African American Parents for Drug Prevention
Alcohol and Drug Problems Association of North America
Alcohol and Drug Problems Association
Alcohol Policy Coalition
Alcohol Policy Foundation
Alcoholics Anonymous World Services
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 Association of Halfway House Alcoholism Programs
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 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 Friends Service Committee
American Legion Auxiliary
American Managed Behavioral Healthcare Association
American Management Association
American Medical Association
American Medical Student Association
American Medical Women's Association
American Methadone Treatment Association, Inc
American Nurses Association
American Occupational Therapy Association
American Pharmaceutical Association

American Physical Therapy Association
American Psychiatric Association
American Psychological Association
American Public Health Association
American Public Welfare Association
American Red Cross
American School Counselors Association
American Society of Addiction Medicine
American Speech/Language/Hearing Association
American Youth Work Center
Amnesty International
AMVETS
Annenberg School of Communications
Asian Community Mental Health Services
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 Junior Leagues
Association of State Correctional Administrators
BACCUS and GAMMA Peer Education
Benevolent and Protective Order of Elks
Bensinger DuPont & Associates
Big Brothers and Big Sisters 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 Narcotics Officers Association
Camp Fire Boys and Girls
Camp Fire, Inc.
Campaign for Tobacco Free Kids
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 Prevention Research, University of Kentucky
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
College on Problems on Drug Dependence
Community Anti-Drug Coalitions
Community Anti-Drug Coalitions of America
Congress of National Black Churches
Cornell University Medical College
Corporate Community
Corporations Against Drug Abuse
Council for Problems of Drug Dependency
Council of State Governments
Council on Foreign Relations
Crime Control and Prevention
D.A.R.E. America
Delancey Street Foundation
Drug Strategies
Drug Watch Institute
Drug Watch International
Drugs Don't Work
Educational Video Center
Elks Drug Awareness Program
Emergency Nurses Association
Employee Assistance Professionals Association.
Employee Assistance Society of North America
Employee Health Programs
Empower America
Entertainment Industries Council, Inc.
Families USA Foundation
Family Research Council
Federal Law Enforcement Officers Association
Florida Alcohol and Drug Abuse Association, Inc.
Florida Chamber of Commerce
Foster Grandparents Program
Fraternal Order of Eagles
Fraternal Order of Police
Gardenzia Program (Pennsylvania)
Gateway Foundation
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 School of Public Health

Hazelden
Heritage Foundation
Hispanic American Command Officers Association
Hispanic American Policer Officers Association
Houston's Drug Free Business Initiative
Human Rights Watch
Independent Order of Odd Fellows
Institute for a Drug-Free Workplace
Institute for Social Research
Inter American College of Physicians/Surgeons
International Association of Chiefs of Police
International Association of Junior Leagues
International Brotherhood of Police Officers
International Brotherhood of Teamsters
International Certification and Reciprocity Consortium
International City Managers Association
International Drug Strategy Institute
Johns Hopkins Medical Institutions
Join Together
Junior Achievement of the National Capital Area, Inc.
Just Say No International

Kaiser Family Foundation
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.
Lindesmith Center
Links, Inc.
Lions Club International
Little League Foundation
Los Alamos Citizens Against Substance Abuse (LACASA)
LULAC
Lutte Contra La Toxicomanie
LUZ Social Services
Major City Chiefs Organization
Maryland Underage Drinking Prevention Coalition
Milton Eisenhower Foundation
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 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 Asian-Pacific American Families Against Substance Abuse
National Assembly of Voluntary Health and Social Welfare Association
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 Alcholism and Drug Abuse Counselors
National Association of Alcohol and Drug Abuse Counselors
National Association of Attorneys General
National Association of Black Narcotics Agents
National Association of Blacks in Criminal Justice
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 Native American Children of Alcoholics (NANACOA)
National Association of Neighborhoods
National Association of Police Organizations
National Association of Prenatal Addiction Research
National Association of Prevention Professionals and Advocates (NAPPA), Inc.
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 (NBAAC)
National Black Caucus of Local Elected Officials
National Black Caucus of State Legislators
National Black Child Development Institute, Inc.
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 Center on Addiction and Substance Abuse
National Clearinghouse on Child Abuse and Neglect Information

National Coalition for the Homeless
National Coalition of Hispanic Health Human Services Organization
National Coalition of Hispanic Health and Human Services Organizations
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 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 Negro Women
National Council on Alcoholism and Drug Abuse
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 Prevention League
National Drug Strategy Network
National Education Association
National Exchange Clubs
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 Health
National Institute on Alcohol Abuse and Alcoholics
National Jewish Community Relations Advisory Council
National Latino's Children Institute
National League of Cities
National League of Counties
National Legal Aid and Defender Association
National Masonic Foundation

National Masonic Foundation for Children
National Medical Association
National Mental Health Association
National Minority Health Association
National Narcotics Officers Associations Coalition
National Network of Runaway and Youth Services
National Nurses Society on Addiction
National Opinion Research Center
National Organization of Black County Officials
National Organization of Black Law Enforcement Executives
National Organization on Fetal Alcohol Syndrome
National Panhellenic Conference
National Parents and Teachers Association
National People's Action
National Pharmaceutical Association
National Pharmaceutical Council, Inc.
National Prevention Network
National Puerto Rican Coalition
National Recreation and Parks Association
National Rural Health Association
National School Boards Association
National Sheriffs Association
National Strategy Center
National TASC
National Telemedia Council
National Treatment Accountability for Safer Communities
National Treatment Consortium
National Troopers Coalition
National Urban Coalition
National Urban League
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
Northwest Center for Health and Safety
Office of Minority Health Resource Center
One Church--One Addict
Operation PAR, Inc.
Optimist International
Organization of American States
Organization of Chinese Americans, Inc.
Orthodox Union
Paid Arizona Anti-Smoking Campaign for Youth
Panhellenic National Conference
Parents' Resource Institute for Drug Education, Inc. (PRIDE)

Partners in Drug Abuse Rehabilitation Counseling
Partnership for a Drug-Free America
Pharmaceutical Research and Manufacturers of America
Phoenix House
Physicians for Prevention (PFP)
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)
Public Agenda, Inc.
Quota International
Rand Corporation
Religious Action Center
Resource Center on Substance Abuse Prevention and Disability
Robert Wood Johnson Foundation
Rotary International
Ruritan National
RWJ Foundation
Safe Streets
San Francisco AIDS Foundation
Scott Newman Center
Sertoma International
Siouxland Cares
Soroptimist International of the Americas
Southern Christian Leadership
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 (ICADRE)
Temple University - Department of Pharmacology
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
Travelers Aid International

Treatment Accountability for Safer Communities
Twentieth Century Fund
U.S. Chamber of Commerce
U.S. Conference of Mayors
U.S. Hispanic Chamber of Commerce
U.S. Junior Chamber of Commerce
UCLA Drug Abuse Research Center
UCLA Graduate School of Management
UCLA Neuropsychiatric Group
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 States Catholic Conference
United States Conference of Mayors
United Synagogue of Conservative Judaism
United Way of America
University of California, Los Angeles
University of Delaware - Division of Criminal Justice
University of Kentucky - 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
University of Pennsylvania 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 Busienss Group on Health
Washington Office on Latin America
Wellness Council of America
World Affairs Council of San Diego
World Affairs Council of Washington DC
Yale University School of Medicine
Yerkes Regional Primate Research Center, Emory University
YMCA-USA
Youth to Youth
Zeta Phi Beta Sorority, Inc.

VII: Drug-Related Data

Up-to-date information on illegal-drug availability, prevalence, and criminal, health, and social consequences of their use is vital to the implementation of the *National Drug Control Strategy*. It is also important for measuring the effectiveness of federal, state, and local drug-control programs. ONDCP's Advisory Committee on Research, Data, and Evaluation coordinates the development and analysis of drug-control information in support of the *Strategy*. The Violent Crime Control and Law Enforcement Act of 1994 extended ONDCP's reporting requirements to include the following areas:

- Assessing the reduction of drug use, including estimating drug prevalence and frequency of use, as measured by national, State, and local surveys and other special studies of the following:
  - — High-risk populations, including those who drop out of school, homeless and transient people, arrestees, parolees, probationers, and juvenile delinquents; and
  - — Drug use in the workplace, including productivity lost;
- Assessing the reduction of drug availability, as measured by the following:
  - — The quantities of cocaine, heroin, and marijuana available for consumption in the United States;
  - — The amount of cocaine and heroin entering the United States;
  - — The number of hectares of poppy and coca cultivated and destroyed;
  - — The number of metric tons of heroin and cocaine seized;
  - — The number of cocaine-processing labs destroyed;
  - — Changes in the price and purity of heroin and cocaine; and
  - — The amount and type of controlled substances diverted from legitimate retail and wholesale sources;
- Assessing the reduction of the consequences of illicit drug use and availability, which include estimating the following:
  - — Burdens that drug users place on hospital emergency rooms, such as quantity of drug-related services;
  - — The annual national health care costs of illicit drug use, including costs associated with people becoming infected with HIV (human immunodeficiency virus) and other communicable diseases;

- The extent of drug-related crime and criminal activity; and

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

- Determining the status of drug treatment in the United States by assessing the following:

  - Public and private treatment capacities within each State, including the number of drug treatment slots available in relation to the number of slots actually used and the number of intravenous drug users and pregnant women;

  - The extent within each State to which treatment is available to and in demand by intravenous drug users and pregnant women;

  - The estimated number of drug users that could benefit from drug treatment; and

  - The success of drug treatment programs, including assessing the effectiveness of the mechanisms in place federally and within each State to determine the relative quality of treatment programs, the qualifications of treatment personnel, and the mechanism by which patients are admitted to the most appropriate and cost-effective treatment setting.

The tables presented in this appendix contain the most current drug-related data on the areas required by the Crime Control Act to be assessed by ONDCP.

DATA SOURCE DESCRIPTIONS

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

What America's Users Spend on Illegal Drugs: 1988-1995 (Source for Tables 1, 3, and 19)

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

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

The National Household Survey on Drug Abuse (NHSDA) measures the prevalence of drug and alcohol use among household members ages 12 and older. Topics include drug use, health, and demographics. In 1991 the NHSDA was expanded to include college students in dormitories, persons living in homeless shelters, and persons living on military bases. The NHSDA was administered by the National Institute on Drug Abuse (NIDA) from 1973 through 1991; the Substance Abuse and Mental Health Services Administration (SAMHSA) has administered the survey since 1992.

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

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

PRIDE USA Survey (Source for Table 6)

The National Parent's Resource Institute for Drug Education (PRIDE) conducts an annual survey of drug use by junior high and high school students. The PRIDE survey collects data from students in 6th through 12th grades and is conducted between September and June of a school year. Participating schools are sent the questionnaires with detailed instructions for administering the anonymous, self-report instrument. Schools participate on a voluntary basis or in compliance with a school or State request. The study conducted during the 1996–97 school year involved 156,609 students in 28 States.

Drug Use Forecasting Program (Source for Tables 7 and 8)

The National Institute of Justice established the DUF program in 1987 to provide an objective assessment of the drug problem among those arrested and charged with crimes. On a quarterly basis, samples of arrestees in 24 cities across the United States are interviewed and asked to provide urine specimens that are tested for evidence of drug use. Urinalysis results can be matched to arrestee characteristics to help monitor trends in drug use. The sample size of the data set varies to some extent from site to site. Generally, each site collects quarterly data from 200 to 250 adult male arrestees, 100 to 150 female arrestees, 100 to 150 juvenile male arrestees (at 12 sites), and a smaller sample of female juvenile arrestees (at 8 sites). Together, the 1996 data comprised 19,835 adult male arrestees, 7,532 adult female arrestees, and a smaller sample of juvenile arrestees.

Current Population Survey (Source for Table 9)

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

Youth Risk Behavior Survey (Source for Table 10)

The Youth Risk Behavior Survey (YRBS) is a component of the Youth Risk Behavior Surveillance System

(YRBSS), maintained by the Centers for Disease Control and Prevention. The YRBSS currently has the following three complementary components: (1) national school-based surveys, (2) State and local school-based surveys, and (3) a national household-based survey. Each of these components provides unique information about various subpopulations of adolescents in the United States. The school-based survey was initiated in 1990, and the household-based survey was conducted in 1992. The school-based survey is conducted biennially in odd-numbered years throughout the decade among national probability samples of 9th through 12th graders from public and private schools. Schools with a large proportion of black and Hispanic students are over sampled to provide stable estimates for these subgroups. The 1992 Youth Risk Behavior Supplement was administered to one in-school youth and up to two out-of-school youth in each family selected for the National Health Interview Survey. In 1992, 10,645 youth ages 12 to 21 were included in the YRBS sample. The purpose of the supplement was to provide information on a broader base of youth, including those not currently attending school, than usually is obtained with surveys and to obtain accurate information on the demographic characteristics of the household in which the youth reside.

The Monetary Value of Saving a High-Risk Youth (Source for Tables 11 and 12)

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

Drug Abuse Warning Network (Source for Table 13)

The Drug Abuse Warning Network (DAWN) provides data on drug-related emergency department episodes and medical examiner cases. DAWN assists national, State, and local drug policy makers to examine drug use patterns and trends and assess health hazards associated with drug abuse. Data are available on deaths and emergency department episodes by type of drug, reason for taking the drug, demographic characteristics of the user, and metropolitan area. NIDA maintained DAWN from 1972 through 1991; SAMHSA has maintained it since 1992.

Uniform Crime Reports (Source for Table 14)

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

Survey of Inmates of Local Jails (Source for Table 15)

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

Survey of Inmates in Federal Correctional Facilities and Survey of Inmates in State Correctional Facilities (Source for Table 15)

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

National Prisoner Statistics Program (Source for Table 15)

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

National Drug and Alcoholism Treatment Unit Survey (Source for Tables 16 and 18)

The National Drug and Alcoholism Treatment Unit Survey (NDATUS) is measures the location, scope, and characteristics of drug abuse and alcoholism treatment facilities throughout the United States. The survey collects data on unit ownership, type and scope of services provided, sources of funding, staffing information, number of clients, treatment capacities, and utilization rates. For 1990 information on waiting lists also was collected. Data are reported for a point prevalence date in the fall of the year in which the survey is administered. Many questions focus on the 12 months prior to that date. The NDATUS has been administered jointly by NIDA and the National Institute of Alcohol Abuse and Alcoholism since 1974.

National Drug Treatment Requirements (Source for Table 17)

The U.S. Department of Health and Human Services (HHS) is mandated by Congress to report to the Office of Management and Budget on its goals for enrolling drug abusers in treatment facilities and the progress it has made in achieving those goals. HHS provides data on the estimated number of drug abusers; goals for treatment enrollment; estimated capacity of Federal, State, local, and private treatment facilities; number of available treatment slots; and number of people served.

System To Retrieve Information From Drug Evidence (Source for Table 20)

The System To Retrieve Information From Drug Evidence (STRIDE) compiles data on illegal substances purchased, seized, or acquired in U.S. Drug Enforcement Administration (DEA) investigations. Data are gathered on the type of drug seized or bought, drug purity, location of confiscation, street price of the drug, and other characteristics. Data on drug exhibits from the FBI; the Metropolitan Police Department of the District of Columbia; and some exhibits submitted by other Federal, State, and local agencies also are included in STRIDE. STRIDE data have been compiled by DEA since 1971.

Federal-Wide Drug Seizure System (Source for Table 21)

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

International Narcotics Control Strategy Report (Source for Table 22)

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

Tables 1 through 22 following this page present data from the major research sources used to monitor the progress of some of the goals and objectives of the National Drug Control Strategy.

DRUG USER EXPENDITURES

Table 1. Total U.S. expenditures on illicit drugs, 1988–95 (in billions of dollars)

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

Note: Amounts are in constant 1996 dollars.

Source: Abt Associates Inc., *What America's Users Spend on Illegal Drugs: 1988-95,* November 1997.

DRUG USE

Table 2. Trends in selected drug use indicators, 1979-96 (in millions of users)

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

*na = not applicable

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

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

Source: National Household Survey on Drug Abuse, National Institute on Drug Abuse (1979–91), and Substance Abuse and Mental Health Services Administration (1992–96).

Table 3. Estimated number of hardcore and occasional users of cocaine and heroin (Thousands), 1988–95

Cocaine and Heroin Use	1988	1989	1990	1991	1992	1993	1994	1995
Cocaine								
Casual users (use less often than weekly)	6,039	5,313	4,587	4,478	3,503	3,332	2,930	3,082
Heavy users (use at least weekly)	4,140	3,889	3,674	3,501	3,528	3,598	3,610	3,620
Heroin								
Casual users (use less often than weekly)	167	152	136	172	207	199	206	322
Heavy users (use at least weekly)	876	881	784	730	692	787	799	810

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

Source: Abt Associates Inc., *What America's Users Spend on Illicit Drugs: 1988-95,* November 1997.

Table 4. Trends in 30-day prevalence of selected drugs among 8th, 10th, and 12th graders, 1991–97

	30-Day Prevalence							
Selected drug/grade	1991	1992	1993	1994	1995	1996	1997	1996–97 Change
Marijuana/hashish								
8th grade	3.2	3.7	5.1	7.8	9.1	11.3	10.2	-1.1
10th grade	8.7	8.1	10.9	15.8	17.2	20.4	20.5	+0.1
12th grade	13.8	11.9	15.5	19.0	21.2	21.9	23.7	+1.8
Inhalants[1, 2]								
8th grade	4.4	4.7	5.4	5.6	6.1	5.8	5.6	-0.2
10th grade	2.7	2.7	3.3	3.6	3.5	3.3	3.0	-0.3
12th grade	2.4	2.3	2.5	2.7	3.2	2.5	2.5	0.0
Hallucinogens[3]								
8th grade	0.8	1.1	1.2	1.3	1.7	1.9	1.8	-0.1
10th grade	1.6	1.8	1.9	2.4	3.3	2.8	3.3	+0.5
12th grade	2.2	2.1	2.7	3.1	4.4	3.5	3.9	+0.4
LSD								
8th grade	0.6	0.9	1.0	1.1	1.4	1.5	1.5	0.0
10th grade	1.5	1.6	1.6	2.0	3.0	2.4	2.8	+0.4
12th grade	1.9	2.0	2.4	2.6	4.0	2.5	3.1	+0.6 s
Cocaine								
8th grade	0.5	0.7	0.7	1.0	1.2	1.3	1.1	-0.2
10th grade	0.7	0.7	0.9	1.2	1.7	1.7	2.0	+0.3
12th grade	1.4	1.3	1.3	1.5	1.8	2.0	2.3	+0.3
Stimulants								
8th grade	2.6	3.3	3.6	3.6	4.2	4.6	3.8	-0.8 ss
10th grade	3.3	3.6	4.3	4.5	5.3	5.5	5.1	-0.4
12th grade	3.2	2.8	3.7	4.0	4.0	4.1	4.8	+0.7 s
Alcohol (any use)[4]								
8th grade	25.1	26.1	24.3	25.5	24.6	26.2	24.5	-1.7
10th grade	42.8	39.9	38.2	39.2	38.8	40.4	40.1	-0.3
12th grade	54.0	51.3	48.6	50.1	51.3	50.8	52.7	+1.9

Notes: Level of significance of 1996–97 difference: s = 0.05, ss = 0.01. Any apparent inconsistency between the 1996–97 change estimate and the respective prevalence estimates is due to rounding error.

Approximate Weighted N's	1991	1992	1993	1994	1995	1996	1997
8th Grade	17,500	18,600	18,300	17,300	17,500	17,800	18,600
10th Grade	14,800	14,800	15,300	15,800	17,000	15,600	15,500
12th Grade	15,000	15,800	16,300	15,400	15,400	14,300	15,400

[1] For 12th graders: Data based on five of six questionnaire forms; N is five-sixths of N indicated.
[2] Unadjusted for under reporting of amyl and butyl nitrites.
[3] Unadjusted for underreporting of PCP (phencyclidine).
[4] For all grades: In 1993, the question text was changed slightly in one-half of the forms to indicate that a "drink" meant "more than a few sips." In 1993, N is one-half of N indicated for all groups. Data after 1993 were based on all forms for all grades.

Source: Monitoring the Future study, Institute for Social Research, University of Michigan.

Table 5. Trends in harmfulness of drugs as perceived by 8th, 10th, and 12th graders, 1991–97

Drug	Percentage saying "Great risk"*							
	1991	1992	1993	1994	1995	1996	1997	1996–97 Change
8th Grade								
How much do you think people risk harming themselves (physically or in other ways), if they....								
• Try marijuana once or twice	40.4	39.1	36.2	31.6	28.9	27.9	25.3	-2.6sss
• Smoke marijuana occasionally	57.9	56.3	53.8	48.6	45.9	44.3	43.1	-1.2
• Smoke marijuana regularly	83.8	82.0	79.6	74.3	73.0	70.9	72.7	+1.8
• Try crack once or twice	62.8	61.2	57.2	54.4	50.8	51.0	49.9	-1.1
• Take crack occasionally	82.2	79.6	76.8	74.4	72.1	71.6	71.2	-0.4
• Try cocaine powder once or twice	55.5	54.1	50.7	48.4	44.9	45.2	45.0	-0.2
• Take cocaine powder occasionally	77.0	74.3	71.8	69.1	66.4	65.7	65.8	+0.1
Approximate N	17,437	18,662	18,366	17,394	17,501	17,926	18,765	
10th Grade								
How much do you think people risk harming themselves (physically or in other ways), if they....								
• Try marijuana once or twice	30.0	31.9	29.7	24.4	21.5	20.0	18.8	-1.2
• Smoke marijuana occasionally	48.6	48.9	46.1	38.9	35.4	32.8	31.9	-0.9
• Smoke marijuana regularly	82.1	81.1	78.5	71.3	67.9	65.9	65.9	0.0
• Try crack once or twice	70.4	69.6	66.6	64.7	60.9	60.9	59.2	-1.7
• Take crack occasionally	87.4	86.4	84.4	83.1	81.2	80.3	78.7	-1.6
• Try cocaine powder once or twice	59.1	59.2	57.5	56.4	53.5	53.6	52.2	-1.4
• Take cocaine powder occasionally	82.2	80.1	79.1	77.8	75.6	75.0	73.9	-1.1
Approximate N	14,719	14,808	15,298	15,880	17,006	15,670	15,640	
12th Grade								
How much do you think people risk harming themselves (physically or in other ways), if they....								
• Try marijuana once or twice	27.1	24.5	21.9	19.5	16.3	15.6	14.9	-0.7
• Smoke marijuana occasionally	40.6	39.6	35.6	30.1	25.6	25.9	24.7	-1.2
• Smoke marijuana regularly	78.6	76.5	72.5	65.0	60.8	59.9	58.1	-1.8
• Try crack once or twice	60.6	62.4	57.6	58.4	54.6	56.0	54.0	-2.0
• Take crack occasionally	76.5	76.3	73.9	73.8	72.8	71.4	70.3	-1.1
• Try cocaine powder once or twice	53.6	57.1	53.2	55.4	52.0	53.2	51.4	-1.8
• Take cocaine powder occasionally	69.8	70.8	68.6	70.6	69.1	68.8	67.7	-1.1
Approximate N	2,549	2,684	2,759	2,591	2,603	2,449	2,579	

Note: Level of significance of 1996–97 difference: sss = 0.001. Any apparent inconsistency between the 1996–97 change estimate and the respective prevalence estimates is due to rounding error.

* Answer alternatives were: (1) no risk, (2) slight risk, (3) moderate risk, (4) great risk, and (5) can't say, drug unfamiliar.
Source: Monitoring the Future study, Institute for Social Research, University of Michigan.

Table 6. Prevalence of drug use among 6th–8th, 9th–12th, and 12th grade students, 1994–95, 1995–96 and 1996-1997

	Annual Use				Monthly Use			
	1994–95	1995–96	1996-97	Change *	1994–95	1995–96	1996-97	Change *
Cigarettes								
6th–8th	28.1	31.1	31.8	+0.7 s	15.7	17.2	17.3	+0.1
9th–12th	44.4	48.2	50.2	+2.0 s	31.3	33.4	34.7	+1.3 s
12th	46.8	50.0	52.4	+2.4 s	34.6	36.2	38.3	+2.1 s
Beer								
6th–8th	30.8	33.1	33.2	+0.1	11.8	12.5	12.1	-0.4 s
9th–12th	57.4	59.1	59.6	+0.5 s	33.3	34.3	34.4	+0.1
12th	64.0	64.9	65.3	+0.4	40.6	41.2	41.7	+0.5
Wine Coolers								
6th–8th	29.8	33.2	33.6	+0.4	9.8	10.8	10.8	+0.0
9th–12th	51.7	52.6	52.9	+0.3	23.1	22.3	22.3	+0.0
12th	56.5	54.5	55.4	+0.9	25.6	22.9	23.7	+0.8
Liquor								
6th–8th	21.3	22.9	23.7	+0.8 s	8.5	9.0	9.1	+0.1
9th–12th	51.5	53.4	54.9	+1.5 s	27.4	28.2	28.7	+0.5 s
12th	59.5	59.9	62.3	+2.4 s	32.5	32.8	34.0	+1.2 s
Marijuana								
6th–8th	9.5	13.6	14.7	+1.1 s	5.7	8.1	8.6	+0.5 s
9th–12th	28.2	34.0	35.8	+1.8 s	18.5	22.3	22.7	+0.4
12th	33.2	37.9	39.4	+1.5 s	20.9	24.3	24.4	+0.1
Cocaine								
6th–8th	1.9	2.7	3.0	+0.3 s	1.2	1.5	1.7	+0.2 s
9th–12th	4.5	5.6	5.9	+0.3 s	2.6	2.9	3.0	+0.1
12th	5.3	7.1	7.0	-0.1	2.9	3.6	3.6	+0.0
Uppers								
6th–8th	3.3	4.6	4.9	+0.3 s	2.0	2.4	2.6	+0.2 s
9th–12th	9.3	10.5	10.3	-0.2	5.1	5.2	5.3	+0.1
12th	10.6	11.6	10.7	-0.9 s	5.6	5.8	5.6	-0.2
Downers								
6th–8th	2.4	3.5	4.0	+0.5 s	1.5	1.9	2.1	+0.2 s
9th–12th	5.5	7.1	7.2	+0.1	3.4	3.8	3.8	+0.0
12th	5.9	7.4	7.4	+0.0	3.6	4.1	3.9	-0.2
Inhalants								
6th–8th	6.3	8.5	8.9	+0.4 s	2.9	3.5	3.7	+0.2
9th–12th	7.5	7.6	7.1	-0.5 s	3.5	3.4	3.1	-0.3 s
12th	6.6	6.6	5.8	-0.8 s	3.0	3.1	2.7	-0.4 s
Hallucinogens								
6th–8th	2.4	3.3	3.6	+0.3 s	1.5	1.8	2.0	+0.2 s
9th–12th	7.7	9.5	9.5	+0.0	4.1	4.5	4.2	-0.3 s
12th	9.7	12.1	11.7	-0.4	4.8	5.1	4.6	-0.5

* **Note:** Level of significance of difference between the 1995–96 and 1996–97 surveys: s = 0.05, using chi-square with variables year and use/no use.

	Sample Sizes		
Grade	1994–95	1995-96	1996–97
6th–8th	92,453	58,596	68,071
9th–12th	105,788	70,964	73,006
12th	20,698	14,261	15,532

Source: PRIDE USA Survey, 1994–95, 1995–96 and 1996-1997.

Table 7. Drug use[1] by male booked arrestees: 1991–96

	Any drug use[2]						Marijuana use					
	1991	1992	1993	1994	1995	1996	1991	1992	1993	1994	1995	1996
Atlanta	63	69	72	69	74	80	12	22	26	25	32	37
Birmingham	63	64	68	69	73	70	16	22	28	28	36	44
Chicago	74	69	81	79	79	82	23	26	40	38	41	47
Cleveland	56	64	64	66	65	67	12	17	23	28	29	37
Dallas	56	59	62	57	60	63	19	28	28	33	37	44
Denver	50	60	64	67	66	71	25	34	36	39	33	42
Detroit	55	58	63	66	67	66	18	27	37	38	42	46
Ft. Lauderdale	61	64	61	58	58	67	28	32	30	29	33	38
Houston	65	59	59	48	58	64	17	24	24	23	29	33
Indianapolis	45	52	60	69	64	74	23	35	42	39	38	51
Los Angeles	62	67	66	66	62	64	19	23	23	20	23	30
Manhattan	73	77	78	82	83	78	18	22	21	24	28	38
Miami	68	68	70	66	57	67	23	30	26	28	29	34
New Orleans	59	60	62	63	66	67	16	19	25	28	32	40
Omaha	36	48	54	59	54	63	26	38	42	44	42	52
Philadelphia	74	78	76	76	76	69	18	26	32	32	34	39
Phoenix	42	47	62	65	63	59	22	22	31	29	29	28
Portland	61	60	63	65	65	66	33	28	30	27	29	35
St. Louis	59	64	68	74	77	75	16	21	28	36	39	52
San Antonio	49	54	55	52	51	57	20	28	32	30	34	39
San Diego	75	77	78	79	72	71	33	35	40	36	35	40
San Jose	58	50	54	55	52	48	25	24	27	30	27	27
Wash., DC	59	60	60	64	64	66	11	20	26	30	32	40

	Cocaine use						Opiate use					
	1991	1992	1993	1994	1995	1996	1991	1992	1993	1994	1995	1996
Atlanta	57	58	59	57	57	59	3	4	3	2	3	3
Birmingham	52	49	51	50	49	43	5	3	4	4	2	4
Chicago	61	56	53	57	51	52	21	19	28	27	22	20
Cleveland	48	53	48	48	42	41	3	3	4	3	5	3
Dallas	43	41	44	35	31	32	4	4	4	3	5	5
Denver	30	38	41	40	44	44	2	2	4	4	5	5
Detroit	41	37	34	34	30	27	8	8	8	7	7	7
Ft. Lauderdale	44	46	43	41	39	44	1	1	1	1	2	2
Houston	56	41	41	29	40	39	3	3	2	3	5	8
Indianapolis	22	23	32	47	39	42	3	4	4	3	2	3
Los Angeles	44	52	48	48	44	44	10	10	9	10	7	6
Manhattan	62	62	66	68	68	56	14	18	20	19	20	17
Miami	61	56	61	56	42	52	2	2	2	2	3	1
New Orleans	50	49	48	47	47	46	4	4	5	5	7	7
Omaha	14	16	19	26	19	24	2	2	2	2	1	1
Philadelphia	62	63	56	54	51	40	11	12	11	14	12	11
Phoenix	20	26	30	28	27	32	5	5	6	6	8	9
Portland	30	35	33	32	30	34	9	11	11	12	15	13
St. Louis	48	50	50	50	51	43	6	7	9	11	11	10
San Antonio	31	32	31	31	24	28	16	15	14	13	10	10
San Diego	45	45	37	30	28	27	17	16	16	12	8	9
San Jose	33	28	23	19	18	16	8	4	6	6	5	5
Wash., DC	49	44	37	38	35	33	10	11	10	9	8	9

[1] Percent positive by urinalysis, January through December of each year.
[2] "Any drug" includes cocaine, opiates, PCP, marijuana, amphetamines, methadone, methaqualone, benzodiazepines, barbiturates, and propoxyphene.

Source: Drug Use Forecasting Program, National Institute of Justice.

Table 8. Drug use[1] by female booked arrestees: 1991–96

	Any drug use[2]						Marijuana use					
	1991	1992	1993	1994	1995	1996	1991	1992	1993	1994	1995	1996
Atlanta	70	65	74	72	68	77	8	13	16	15	13	26
Birmingham	62	59	55	63	57	59	10	13	12	17	12	22
Chicago	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Cleveland	79	74	77	82	71	70	7	11	13	16	11	22
Dallas	56	66	61	63	58	58	11	24	19	22	21	44
Denver	54	61	66	68	66	69	16	19	24	22	21	27
Detroit	68	72	76	62	78	69	4	11	10	16	18	19
Ft. Lauderdale	64	62	60	62	60	66	14	21	20	18	18	24
Houston	59	54	53	48	50	54	8	12	15	13	18	26
Indianapolis	54	50	58	69	72	72	22	26	25	22	24	31
Los Angeles	75	72	77	72	68	78	9	13	15	12	14	38
Manhattan	77	85	83	90	84	83	11	12	19	15	16	19
Miami	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
New Orleans	50	52	47	32	50	35	7	8	14	7	16	13
Omaha	NA	NA	NA	58	56	51	NA	NA	NA	28	24	33
Philadelphia	75	78	79	76	77	81	14	15	20	18	20	21
Phoenix	61	63	62	67	63	65	14	15	20	22	19	22
Portland	68	73	74	74	68	74	28	17	17	19	16	26
St. Louis	54	70	69	76	69	73	8	11	15	15	18	29
San Antonio	45	44	42	39	41	44	9	16	16	15	16	19
San Diego	73	72	78	76	73	62	20	25	25	20	20	23
San Jose	52	56	51	61	50	53	13	18	17	18	12	19
Wash., DC	75	72	71	67	65	58	6	8	9	10	18	23

	Cocaine use						Opiate use					
	1991	1992	1993	1994	1995	1996	1991	1992	1993	1994	1995	1996
Atlanta	66	58	68	62	62	63	4	5	4	4	3	3
Birmingham	44	46	41	50	48	39	11	4	4	3	3	6
Chicago	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Cleveland	76	66	69	74	63	52	6	5	4	4	6	6
Dallas	45	48	43	46	44	36	9	8	10	7	5	5
Denver	41	50	47	51	52	53	2	5	6	5	6	5
Detroit	62	62	64	46	61	53	11	15	14	13	15	18
Ft. Lauderdale	55	47	45	52	50	52	4	3	3	3	3	3
Houston	52	44	43	36	32	34	4	4	4	6	3	4
Indianapolis	26	25	36	56	54	52	11	7	4	5	7	3
Los Angeles	62	58	59	53	49	56	18	13	14	12	10	17
Manhattan	66	72	70	80	71	69	21	24	23	30	19	27
Miami	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
New Orleans	42	44	37	25	37	26	7	6	5	2	4	3
Omaha	NA	NA	NA	34	30	28	NA	NA	NA	2	2	3
Philadelphia	64	67	61	61	59	69	9	11	14	18	14	16
Phoenix	45	49	38	36	33	42	17	15	14	12	12	13
Portland	40	54	47	43	40	46	17	22	19	21	18	26
St. Louis	47	62	62	69	57	55	7	7	16	8	8	7
San Antonio	25	25	24	22	24	23	21	14	14	14	13	13
San Diego	40	37	36	18	28	22	21	17	20	13	12	10
San Jose	30	32	19	23	16	21	7	9	8	10	10	9
Wash., DC	68	64	62	55	46	40	16	19	21	13	16	11

[1] Percent positive by urinalysis, January through December of each year.
[2] "Any drug" includes cocaine, opiates, PCP, marijuana, amphetamines, methadone, methaqualone, benzodiazepines, barbiturates, and propoxyphene.

NA = Not applicable (data for females not collected at these sites).

Source: Drug Use Forecasting Program, National Institute of Justice.

Table 9. Dropout rates for persons 18 to 24 years old by sex and race/ethnicity: 1980–95

	All Races, Both Sexes			All Races, Male			All Races, Female			White, Both Sexes			White, Male			White, Female		
	All Persons	High School Dropouts		All Persons	High School Dropouts		All Persons	High School Dropouts		All Persons	High School Dropouts		All Persons	High School Dropouts		All Persons	High School Dropouts	
		Number	Rate		Number	Rate		Number	Rate		Number	Rate		Number	Rate		Number	Rate
1995	24,900	3,471	13.9	12,351	1,791	14.5	12,548	1,679	13.4	19,866	2,711	13.6	9,980	1,430	14.3	9,886	1,281	13.0
1994	25,254	3,365	13.3	12,557	1,804	14.4	12,696	1,561	12.3	20,171	2,553	12.7	10,123	1,377	13.6	10,048	1,175	11.7
1993	24,100	3,070	12.7	11,898	1,575	13.2	12,202	1,494	12.2	19,430	2,369	12.2	9,641	1,379	12.9	9,790	1,125	11.5
1992	24,278	3,083	12.7	11,965	1,617	13.5	12,313	1,466	11.9	19,671	2,398	12.2	9,744	1,300	13.3	9,928	1,098	11.1
1991	24,572	3,486	14.2	12,036	1,810	15.0	12,536	1,676	13.4	19,980	2,845	14.2	9,896	1,520	15.4	10,119	1,324	13.1
1990	24,852	3,379	13.6	12,134	1,689	13.9	12,718	1,690	13.3	20,393	2,751	13.5	10,053	1,430	14.2	10,340	1,322	12.8
1989	25,261	3,644	14.4	12,325	1,941	15.7	12,936	1,702	13.2	20,825	2,926	14.1	10,240	1,572	15.4	10,586	1,354	12.8
1988	25,733	3,749	14.6	12,491	1,950	15.6	13,242	1,799	13.5	21,261	3,012	14.2	10,380	1,594	15.4	10,881	1,418	13.0
1987	25,950	3,751	14.5	12,626	1,948	15.4	13,324	1,803	13.5	21,493	3,042	14.2	10,549	1,593	15.1	10,944	1,449	13.2
1986	26,512	3,664	13.8	12,921	1,937	15.0	13,591	1,741	12.8	22,008	2,974	13.5	10,803	1,581	14.6	11,205	1,393	12.4
1985	27,122	3,687	13.9	13,199	2,015	15.3	13,923	1,804	13.0	22,632	3,050	13.5	11,108	1,637	14.7	11,524	1,413	12.3
1984	28,031	4,142	14.8	13,744	2,184	15.9	14,287	1,958	13.7	23,347	3,281	14.1	11,521	1,744	15.1	11,826	1,535	13.0
1983	28,580	4,410	15.4	14,003	2,379	17.0	14,577	2,031	13.9	23,899	3,428	14.3	11,787	1,865	15.8	12,112	1,563	12.9
1982	28,846	4,500	15.6	14,083	2,329	16.5	14,763	2,171	14.7	24,206	3,523	14.6	11,874	1,810	15.2	12,332	1,713	13.0
1981	28,965	4,520	15.6	14,127	2,424	17.2	14,838	2,097	14.1	24,486	3,590	14.7	12,040	1,960	16.3	12,446	1,629	13.1
1980	28,957	4,515	15.6	14,107	2,390	16.9	14,851	2,124	14.3	24,482	3,525	14.4	12,011	1,883	15.7	12,471	1,642	13.2

	Black, Both Sexes			Black, Male			Black, Female			Hispanic Origin,* Both Sexes			Hispanic Origin,* Male			Hispanic Origin,* Female		
	All Persons	High School Dropouts		All Persons	High School Dropouts		All Persons	High School Dropouts		All Persons	High School Dropouts		All Persons	High School Dropouts		All Persons	High School Dropouts	
		Number	Rate		Number	Rate		Number	Rate		Number	Rate		Number	Rate		Number	Rate
1995	3,625	522	14.4	1,660	235	14.2	1,965	287	14.6	3,603	1,250	34.7	1,907	653	34.2	1,696	598	35.4
1994	3,661	568	15.5	1,733	303	17.5	1,928	265	13.7	3,523	1,224	34.7	1,896	685	36.1	1,628	539	33.1
1993	3,516	578	16.4	1,659	258	15.6	1,857	319	17.2	2,772	907	32.7	1,354	470	34.7	1,418	439	31.0
1992	3,521	575	16.3	1,676	259	15.5	1,845	315	17.1	2,754	936	33.9	1,384	531	38.4	1,369	405	29.6
1991	3,504	545	15.6	1,635	252	15.4	1,869	296	15.8	2,874	1,139	39.6	1,503	668	44.4	1,372	473	34.5
1990	3,520	530	15.1	1,634	223	13.6	1,886	306	16.2	2,749	1,025	37.3	1,403	559	39.8	1,346	455	34.5
1989	3,559	583	16.4	1,654	307	18.6	1,905	277	14.5	2,818	1,062	37.7	1,439	580	40.3	1,377	482	35.0
1988	3,568	631	17.7	1,653	312	18.9	1,915	318	16.6	2,642	1,046	39.6	1,375	553	40.2	1,267	492	38.8
1987	3,603	611	17.0	1,666	312	18.7	1,937	298	15.4	2,592	849	32.8	1,337	461	34.5	1,256	387	30.8
1986	3,665	605	16.6	1,687	300	17.8	1,966	311	15.8	2,514	864	34.4	1,339	500	37.4	1,175	365	31.1
1985	3,716	655	17.6	1,720	323	18.8	1,996	332	16.6	2,221	700	31.5	1,132	405	35.8	1,091	295	27.0
1984	3,862	712	18.4	1,811	362	20.2	2,052	349	17.0	2,018	691	34.2	956	338	35.4	1,061	353	33.2
1983	3,865	832	21.5	1,807	435	24.1	2,058	398	19.3	2,025	759	37.5	968	396	40.9	1,057	363	34.3
1982	3,872	851	22.0	1,786	458	25.6	2,086	393	18.8	2,001	740	37.0	944	347	36.8	1,056	393	37.2
1981	3,778	821	21.7	1,730	419	24.2	2,049	402	19.6	2,052	790	38.5	988	428	43.3	1,064	362	34.0
1980	3,721	876	23.5	1,690	440	26.0	2,031	436	21.5	2,033	820	40.3	1,012	431	42.6	1,021	389	38.1

NOTES: Data for 1980 through 1993 use 1980 Census-based population estimates; data for 1994 and 1995 use 1990 Census-based population estimates; data for previous years are adjusted; numbers are in thousands.

* Persons of Hispanic origin may be of any race.

Source: Current Population Survey, Bureau of Census.

Table 10. Prevalence of past-month drug use for youth ages 12-21, by age, dropout status, type of drug used, and race/ethnicity: 1992 Youth Risk Behavior Survey (in percentages)

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

* Low precision, no estimate reported.
— No respondents.

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

Table 11. The lifetime costs of dropping out of high school (1993 dollars)

	Total Costs	Present Value (2% discount rate)	Present Value (10% discount rate)
Lost Wage/Productivity	$360,000	$186,500	$15,300
Fringe Benefits	$90,000	$46,600	$3,800
Nonmarket Losses	$113,000-450,000	$58,300-233,200	$4,900-19,200
TOTAL	$563,000-900,000	$291,000-466,000	$24,000-38,300

Note: Numbers may not add due to rounding.

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

Table 12. Summary of the monetary value of saving a high-risk youth

	Total Costs	Present Value (2% discount rate)	Present Value (10% discount rate)
Career Criminal	$1.2-1.5 million	$1.0-1.3 million	$650,000-850,000
Heavy Drug User	$435,000-1,051,000	$333,000-809,000	$159,000-391,00
High School Dropout	$563,000-900,000	$291,000-466,000	$24,000-38,000
LESS Duplication: (Crimes committed by heavy drug users)	($252,000-696,000)	($196,000-540,000)	($96,000-264,000)
TOTAL	$1.9-2.7 million	$1.5-2.0 million	$0.7-$1.0 million

Note: Numbers may not add correctly due to rounding.

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

DRUG USE CONSEQUENCES

Table 13. Trends in drug-related emergency room episodes and selected drug mentions, 1988–96

Emergency room episodes and drug mentions	1988	1989	1990	1991	1992	1993	1994	1995 *	1996 *
Total drug episodes (person cases)	403,578	425,904	371,208	393,968	433,493	460,910	518,521	517,764	487,564
Total drug mentions	668,153	713,392	635,460	674,861	751,731	796,762	900,317	908,434	860,260
Total cocaine mentions	101,578	110,013	80,355	101,189	119,843	123,423	142,878	137,979	144,180
Total heroin mentions	38,063	41,656	33,884	35,898	48,003	63,232	64,013	72,229	70,463
Total marijuana mentions	19,962	20,703	15,706	16,251	23,997	28,873	40,183	45,775	50,037

* Note: Estimates for 1995 and 1996 are preliminary.

Source: Drug Abuse Warning Network, National Institute on Drug Abuse (1988–91) and Substance Abuse and Mental Health Services Administration (1992–95).

Table 14. Total crime, violent crime, and property crime and drug arrests, 1989–96

Crime Category	1989	1990	1991	1992	1993	1994	1995	1996
Total crime index	14,251,400	14,475,600	14,872,900	14,438,200	14,144,800	13,989,543	13,862,727	13,473,614
Total crime rate[1]	5,741.0	5,820.3	5,897.8	5,660.2	5,484.4	5,373.5	5275.9	5,078.9
Violent crime index	1,646,040	1,820,130	1,911,770	1,932,270	1,926,020	1,857,670	1,798,792	1,682,278
Violent crime rate[1]	663.1	731.8	758.1	757.5	746.8	713.6	684.6	634.1
Total murder victims[2]	21,500	23,440	24,700	23,760	24,530	23,326	21,606	19,645
Murders related to narcotic drug laws	1,402	1,367	1,353	1,302	1,295	1,239	1,031	819
Property crime	12,605,400	12,655,500	12,961,100	12,505,900	12,218,800	12,131,873	12,063,935	11,791,336
Property crime rate[1]	5,077.9	5,088.5	5,139.7	4,902.7	4,737.6	4,660.0	4,591.3	4,444.8
Arrests for drug abuse violations	1,361,700	1,089,500	1,010,000	1,066,400	1,126,300	1,351,400	1,144,228	1,128,647

[1] Rates per 100,000 population.
[2] Total number of murder victims for whom supplemental homicide information was received.

Source: *Crime in the United States—1996: Uniform Crime Reports*, U.S. Department of Justice, Federal Bureau of Investigation, 1997.

Table 15. Federal and State prison and local jail inmate custody populations, 1989–96

Prison/Jail	1989	1990	1991	1992	1993	1994	1995	1996*
State prisons	629,995	629,995	728,605	778,495	828,371	906,112	989,007	1,018,059
Federal prisons	53,387	58,838	63,930	72,071	80,815	85,500	89,538	93,167
Total State and Federal prisons	638,382	743,382	792,535	850,566	909,186	991,612	1,078,545	1,111,226
Percent of Federal prisoners who are drug offenders	49.9	53.5	55.9	58.9	69.2	60.5	59.9	NA
Local jails	395,553	405,320	426,479	444,584	459,804	486,474	507,044	518,492

Sources: Bureau of Justice Statistics Bulletin, January 1998; *Correctional Populations in the United States*, 1995; 1994; 1993; 1992; 1991; 1990; 1989. *Jails and Jail Inmates*, 1993–94. *Jail Inmates*, 1992. Jail Inmates, 1990. Survey of Inmates in Federal Correctional Facilities, and Survey of Inmates in State Correctional Facilities (population data), Bureau of Justice Statistics; Bureau of Prisons (drug offender percentage), Department of Justice.

*1996 figures are based on mid-year totals. NA=not yet available.

DRUG TREATMENT

Table 16. One-day census of clients in treatment, by institutional setting, 1980–94

	1980	1982	1984	1987	1989	1990	1991	1992	1993	1994
Free standing/outpatient	197,255	172,562	291,441	306,406	376,575	383,182	426,562	506,774	503,625	503,313
Community mental health center	95,086	97,201	139,411	89,182	110,386	130,387	133,670	146,941	140,685	140,598
General hospital (including VA hospital)	49,529	53,389	83,950	63,039	65,729	61,902	62,338	91,720	95,826	95,767
Other specialized hospital	18,907	17,260	23,207	26,852	25,011	18,753	15,891	26,878	22,773	22,759
Halfway house/recovery house	17,891	14,434	27,142	17,049	18,306	17,358	15,830	23,125	24,343	24,328
Other residential facility	31,112	26,063	28,183	45,320	51,089	48,672	51,575	64,369	70,398	70,354
Correctional facility	12,143	9,983	13,303	9,434	14,196	26,082	39,270	30,658	38,353	38,329
Other and unknown	66,929	75,520	63,642	56,841	73,663	81,493	66,683	54,413	48,205	48,175
Total	488,852	463,412	670,279	614,123	734,955	767,829	811,819	944,880	944,208	943,623

Note: Data are estimated based on projections and simulations from historical NDATUS data and other sources.

Source: Substance Abuse and Mental Health Services Administration, Overview of the FY95 National Drug and Alcoholism Treatment Unit Survey. Data from 1994 and 1980–94, June 1996, Table 5.

Table 17. Treatment need and percent treated and not treated (treatment gap)

Year	1989	1990	1991	1992	1993	1994
Total Treatment Need	8,539	8,066	7,554	7,224	6,778	7,090
Level 1*						
Needs treatment	3,938	3,733	3,304	3,329	2,864	3,537
Level 2*						
Needs treatment	4,601	4,333	4,250	3,895	3,914	3,553
Clients treated	1,570	1,633	1,649	1,815	1,848	1,847
Percent treated	34%	38%	39%	47%	47%	52%
Percent not treated	66%	62%	61%	53%	53%	48%

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

Source: Substance Abuse and Mental Health Services Administration, "The Need for Delivery of Drug Abuse Services: Recent Estimates" (February 22, 1996). A version of this report was subsequently published (Woodward, A., et al. 1997. "The Drug Abuse Treatment Gap: Recent Estimates" *Health Care Financing Review* 28(3):5-17).

Table 18. One-day census of clients in alcohol and/or drug abuse treatment, by age group and by sex, 1980–94

Age/Sex	1980	1982	1987	1989	1990	1991	1992[1]	1993[2]	1994
Age Group									
20 years and under	74,451	63,115	98,052	114,818	86,326	82,242	95,773	105,359	109,121
21-44 years	292,331	289,935	400,731	474,210	527,815	553,067	710,877	697,735	691,463
45-64 years	99,580	89,274	74,827	82,191	91,401	95,598	129,275	131,352	134,408
65 years and over	7,194	6,734	6,569	7,134	7,214	7,464	8,954	9,762	9,137
Unknown	—	—	33,206	56,602	55,073	73,448	—	—	—
Total	473,556	449,058	613,385	734,955	767,829	811,819	944,880	944,208	943,623
Sex									
Male	358,021	337,245	430,132	494,095	535,836	562,388	671,438	664,067	663,367
Female	120,490	113,407	164,495	207,510	206,861	213,681	273,442	280,141	280,256
Unknown	—	—	19,076	33,350	25,132	35,750	—	—	—
Total	478,511	450,652	613,703	734,955	767,829	811,819	944,880	944,208	943,623

Note: Data are estimated based on projections and simulations from historical NDATUS data and other sources.

[1] Includes data imputed for 2,009 nonresponding providers based on a representative sample survey of nonresponding providers.

[2] Includes data for 2,070 nonresponding providers based on a survey of all nonresponding providers.

Source: National Drug and Alcoholism Treatment Unit Survey (NDATUS): Data for 1994 and 1980–94, National Institute on Drug Abuse, and National Institute on Alcohol Abuse and Alcoholism, June 1996, Tables 4A and 4B.

DRUG AVAILABILITY

Table 19. Trends in cocaine supply, 1989–95 (in metric tons)

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

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

[2] INCSR, 1996 (and previous years); Royal Canadian Mounted Police, National Drug Intelligence Estimate, 1994 (and previous years) and International Narcotics Control Board, Narcotic Drugs Statistic for 1991 (and previous years). The category excludes seizures of cocaine not destined for the United States.

[3] Drug Enforcement Administration, Federal-wide Drug Seizures System, 1989-1996.

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

Source: Abt Associates Inc., *What America's Users Spend on Illegal Drugs, 1988–95*, November 1997.

Table 20. Average price and purity of cocaine in the United States, 1981–96

	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
Cocaine:																
Purchases of 5 oz. or less																
Price per pure gram	275.12	286.54	242.57	208.76	212.50	162.17	120.03	105.13	105.09	159.41	114.05	106.77	110.45	92.70	101.49	94.52
Purity	47.53	46.87	54.53	58.62	55.00	67.76	76.77	79.16	76.75	67.05	75.43	75.72	72.01	73.52	68.89	68.61
Heroin:																
Purchases of 5 grams or less																
Price per pure gram	3,374.40	3,320.90	3,322.63	3,066.56	2,652.71	2,673.96	2,281.05	1,835.09	1,457.89	1,935.32	2,023.48	1,715.83	1,404.20	1,252.51	1,311.25	1,126.57
Purity	6.73	9.07	11.34	13.77	14.16	16.34	21.80	30.18	30.31	24.24	26.37	34.22	37.20	48.54	46.35	41.48

Source: System To Retrieve Information From Drug Evidence, Drug Enforcement Administration, 1981–96.

Table 21. Federal-wide cocaine, heroin, and cannabis seizures, Fiscal Years 1989–96

Drug	1989	1990	1991	1992	1993	1994	1995	1996
Cocaine (metric tons)	99.2	107.3	111.7	137.6	110.8	140.5	106.2	115.3
Heroin (kilograms)	1,095.2	815.0	1,374.4	1,157.2	1,594.8	1,309.6	1,164.5	1,532.3
Cannabis (metric tons)	509.0	227.0	307.2	357.6	362.1	473.1	607.3	663.6

Source: Federal-Wide Drug Seizure System, Drug Enforcement Administration.

Table 22. Worldwide potential net production, 1988–96 (in metric tons)

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

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

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

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

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

As of February 2, 1998

GLOSSARY

ACFO--Amado Carrillo Fuentes Organization, a major drug trafficking organization based in Juarez, Mexico.

ACSI--the Americas Counter-Smuggling Initiative, an ongoing initiative of the U.S. Customs Service.

ADAM--Arrestee Drug Abuse Monitoring System. Run by the National Institute of Justice, it is the successor to the DUF program, and allows for national sampling of arrestee drug abuse rates.

AFO--Arellano Felix Organization, a major drug trafficking ring based in Tijuana, Mexico.

AIDS--Acquired Immunity Deficiency Syndrome.

ASEAN--Association of South East Asian Nations.

ATF -- Bureau of Alcohol, Tobacco and Firearms.

BASC--Business Anti-Smuggling Coalition, a program of the U.S. Customs Service.

CADCA--Community Anti- Drug Coalitions of America, an umbrella organization of groups devoted to stopping drug abuse.

CASA--Center on Addiction and Substance Abuse, a research organization based at Columbia University.

CDC-- Centers for Disease Control and Prevention.

CICAD-- Inter-American Drug Abuse Control Commission, a body of the Organization of American States.

CIP-- Carrier Initiative Programs, an ongoing initiative of the U.S. Customs Service.

CNP--Colombian National Police.

COPS -- Community Oriented Policing Services, a program of the Department of Justice.

CSAP-- Center for Substance Abuse Prevention

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CSAT - Center for Substance Abuse Treatment

CTAC--Counter-Drug Technology Assessment Center.

DAICC--Domestic Air Interdiction Coordination Center

DATOS-- Drug Abuse Treatment Outcome Study, run by the National Institute on Drug Abuse.

DAWN--Drug Abuse Warning Network, a program which monitors drug abuse among persons admitted at hospital emergency rooms.

DEA--Drug Enforcement Administration, part of the Department of Justice.

DOD--U.S. Department of Defense.

DOJ--U.S. Department of Justice.

DOL--U.S. Department of Labor.

DOT--U.S. Department of Transportation.

DUF--Drug Use Forecasting. Run by the National Institute of Justice, it samples arrestees for drug abuse in various cities. It is being replaced by ADAM.

EAP--Employee Assistance Program

EPA--U.S. Environmental Protection Agency.

FATF--Financial Action Task Force, an international grouping of nations which fights money laundering.

FBI--Federal Bureau of Investigation, part of the Department of Justice.

FDA--Food and Drug Administration, part of the Department of Health and Human Services.

GHB--gamma-hydroxybutyrate

GTO--Geographic Targeting Order, a tool used to fight money laundering.

HHS--U.S. Department of Health and Human Services.

HIDTA--High Intensity Drug Trafficking Area, a counterdrug initiative overseen by the Office of National Drug Control Policy.

HIV--Human Immunodeficiency Virus, thought to cause AIDS.

HUD--U.S. Department of Housing and Urban Development.

IEEPA--International Emergency Economic Powers Act, a law which deals with money laundering and the financial proceeds of drug trafficking.

ILEA--International Law Enforcement Academy.

INS--U.S. Immigration and Naturalization Service.

IOM--Institute of Medicine, part of the National Academy of Science.

JIATF--Joint Interagency Task Force.

LSD--Lysergic acid diethylamide, a hallucinogenic.

MCC--Multinational Counternarcotics Center, a hemispheric counter-drug center to be based in Panama.

MDMA-- 3,4 methylenedioxymethamphetamine, an illegally produced stimulant possessing hallucinogenic properties.

MTA--Mong Tai Army, a drug trafficking organization in Burma.

MTF--Monitoring the Future, a long-term study of youth drug abuse and attitudes, run by the University of Michigan and funded by SAMHSA.

NDCS--National Drug Control Strategy.

NHSDA--National Household Survey of Drug Abuse, the most comprehensive national survey of drug abuse, funded by SAMHSA.

NHTSA--National Highway and Transportation Safety Administration, part of the Department of Transportation.

NIAAA--National Institute on Alcohol Abuse and Alcoholism, one of the National Institutes of Health and part of the Department of Health and Human Services.

NICCP--National Interdiction Command and Control Plan.

NIDA-- National Institute on Drug Abuse, one of the National Institutes of Health and part of the Department of Health and Human Services.

NIH--National Institutes of Health, part of the Department of Health and Human Services.

NIJ- National Institute of Justice, part of the Department of Justice.

NRC--U.S. Nuclear Regulatory Commission.

OAS--Organization of American States.

OCDETF--Organized Crime Drug Enforcement Task Forces, a program of the Department of Justice.

OJJDP--Office of Juvenile Justice and Delinquency Prevention, part of the Department of Justice.

ONDCP--Office of National Drug Control Policy.

OPM--Office of Personnel Management.

PCP-- phencyclidine, a clandestinely manufactured hallucinogen.

PDFA--Partnership For a Drug-Free America, a private organization which produces and airs anti-drug messages.

POE--Port of Entry.

SAMHSA--Substance Abuse and Mental Health Services Administration. Part of the Department of Health and Human Services.

SIDS--Sudden Infant Death Syndrome.

STD--Sexually transmitted disease.

SWBI--South West Border Initiative.

THC--Tetrahydrocannabinol, the psycho-active family of substances in marijuana.

As of February 2, 1998

UN--United Nations.

UNDCP--United Nations Drug Control Program.

USAID--U.S. Agency for International Development.

USCG--United States Coast Guard.

USCS--United States Customs Service.

USG-- United States Government.

USIC--United States Interdiction Coordinator.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

January 14, 1998

Jacob J. Lew
Deputy Director
Office of Management and Budget
Old Executive Office Building, Rm. 252
Washington, D.C. 20503

Dear Mr. Lew:

Director McCaffrey has reviewed OMB's recommended changes to the statutory language, which loosen the criteria for the use of Federal funds for needle exchange programs. It is the Director's strong view that these changes could undermine national drug control policy and that such changes in drug control policy are subject to concurrence by the Director of National Drug Control Policy, in consultation with other agency principals.

It is ONDCP's position that sound policy in this area should include the following elements:

- The Ryan White CARE Act retain the complete prohibition on funding;
- The SAMHSA Block Grant retain the two existing criteria
  - Reduce the spread of HIV,
  - Reduce drug use;
- Other HHS programs be subject to the criteria for the SAMHSA Block Grant;
- The Secretary of HHS determine whether criteria are satisfied;
- The Secretary of HHS not establish criteria for the operation of such programs; and
- HHS continue to review the science regarding the satisfaction of both criteria.

To maintain this continuity in policy, ONDCP recommends retention of the following language.

> *"Notwithstanding any other provisions of this Act, no funds appropriated under this Act shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug unless the Secretary of Health and Human Services determines that such programs are effective in preventing the spread of HIV and reduce the use of illegal drugs."*

I hope you find this information helpful.

Sincerely,

Janet L. Crist
Chief of Staff